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Health and Wellbeing Board

Date: **TUESDAY, 13 JUNE 2023**

Time: **2.30 PM**

Venue: **COMMITTEE ROOM 6 - CIVIC CENTRE, HIGH STREET, UXBRIDGE UB8 1UW**

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

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To Members of the Board:

- Cabinet Member for Health and Social Care (Co-Chairman)
- Hillingdon Health and Care Partners Managing Director (Co-Chairman)
- Cabinet Member for Families, Education and Wellbeing (Vice Chairman)
- LBH Chief Executive
- LBH Executive Director, Adult Services and Health
- LBH Executive Director, Children and Young People's Services
- LBH Director, Public Health
- NWL ICS - Hillingdon Board representative
- NWL ICS - nominated lead
- Central and North West London NHS Foundation Trust - nominated lead
- The Hillingdon Hospitals NHS Foundation Trust Chief Executive
- Healthwatch Hillingdon - nominated lead
- Royal Brompton and Harefield NHS Foundation Trust - nominated lead
- Hillingdon GP Confederation - nominated lead

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Putting our residents first

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Head of Democratic Services
London Borough of Hillingdon,
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Agenda

CHAIRMAN'S ANNOUNCEMENTS

Health and Wellbeing Board Reports - Part I (Public)

Health and Wellbeing Board Reports - Part II (Private and Not for Publication)

That the reports in Part 2 of this agenda be declared not for publication because they involve the disclosure of information in accordance with Section 100(A) and Part 1 of Schedule 12 (A) to the Local Government Act 1972 (as amended), in that they contain exempt information and that the public interest in withholding the information outweighs the public interest in disclosing it.

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Minutes

HEALTH AND WELLBEING BOARD

7 March 2023

Meeting held at Committee Room 6 - Civic Centre, High Street, Uxbridge UB8 1UW

	Board Members Present: Councillors Jane Palmer (Co-Chairman) and Susan O'Brien (Vice-Chairman), Keith Spencer (Co-Chairman), Richard Ellis, Professor Ian Goodman, Lynn Hill, Nick Hunt, Ed Jahn, Kelly O'Neill, Sandra Taylor, Patricia Wright and Tony Zaman **Otheres Present:** Kevin Byrne (Head of Health and Strategic Partnerships), Gary Collier (Health and Social Care Integration Manager), Jane Hainstock (Head of Joint Commissioning, NWL ICS), Derval Russell (Harefield Hospital Site Director) and Nikki O'Halloran (Democratic Services Manager)
36.	**APOLOGIES FOR ABSENCE** *(Agenda Item 1)* Apologies for absence had been received from Ms Julie Kelly, Ms Vanessa Odlin and Mr Graeme Caul.
37.	**DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING** *(Agenda Item 2)* There were no declarations of interest in matters coming before this meeting.
38.	**TO APPROVE THE MINUTES OF THE MEETING ON 29 NOVEMBER 2022** *(Agenda Item 3)* **RESOLVED: That the minutes of the meeting held on 29 November 2022 be agreed as a correct record.**
39.	**TO CONFIRM THAT THE ITEMS OF BUSINESS MARKED PART I WILL BE CONSIDERED IN PUBLIC AND THAT THE ITEMS MARKED PART II WILL BE CONSIDERED IN PRIVATE** *(Agenda Item 4)* It was confirmed that Agenda Items 1 to 8 would be considered in public and Agenda Items 9 to 11 would be considered in private.
40.	**2022/2023 INTEGRATED HEALTH AND CARE PERFORMANCE REPORT** *(Agenda Item 6)* Mr Gary Collier, the Council's Health and Social Care Integration Manager, advised that a lot of work had been undertaken with regard to shaping the future health and care system but that the publication of the planning requirements for the Better Care Fund were still awaited. Insofar as the system wide winter key performance indicators in respect of Hillingdon Hospital activity were concerned, the Board was advised that 74% of patients attending Hillingdon A&E each day were individuals registered with a GP in the Borough. As the

majority of people in all age groups who attended A&E were not admitted (63% in 2021 and 2022), it was queried how these patients could be educated to understand that A&E was not the most appropriate place for them to present. It was also queried why over one third of patients presenting at A&E were admitted. Ms Patricia Wright, Chief Executive at The Hillingdon Hospitals NHS Foundation Trust (THH), advised that the Urgent Treatment Centre (UTC) sat at the front end of A&E and only passed on patients that had had an accident or emergency. As such the percentage of patients who were admitted from A&E was likely to be high as these were the patients that were most in need and were therefore in the right place.

Professor Ian Goodman, North West London Integrated Care System (NWL ICS), advised that the running of the UTC had recently been changed. The UTC had been commissioned by the Urgent Care Board and had been transferred back to THH to maintain at short notice.

With regard to the Discharge to Assess pathway, it was requested that data be provided at a future meeting on the delays to hospital discharge, perhaps grouped by type of blockage. Whilst Hillingdon had one of the best track records with regard to discharge, there were still patients that were staying in hospital longer than necessary and further work was needed on Emergency Department avoidance. Ms Wright advised that there was lots of data available but that this varied on a day-to-day basis so a conversation was needed to determine what would be useful and achievable.

Mr Keith Spencer, Co-Chairman and Managing Director at Hillingdon Health and Care Partners (HHCP), stated that the report had been useful but that it needed to include information about what partners were going to do about each of the issues. He would be happy to take this action forward.

With regard to addressing the budget deficit, Mr Tony Zaman, the Council's Interim Chief Executive, queried whether there was a tolerance level. Ms Wright advised that there had been some discussion about whether the deficit sat at a place level or with the hospital and noted that THH was unable to control factors such as demand. The NWL Integrated Care Board (ICB) held the budget and would be the body that set any tolerance levels (if they were to exist) but that it would need to set a balanced plan for 2023/2024. The acute trusts in NWL were required to submit a collective balanced plan and the mental health trusts were being required to do something similar. It was queried whether the plans being put in place addressed the historical deficit that had been caused by the funding formula and whether it would even balance. Ms Wright advised that negotiations had been undertaken with the ICB at a Trust and place level.

Mr Spencer advised that, at a place level, the root cause of the deficit had been investigated. Work had been commissioned to look at how a balanced plan could be put in place for the next five years that would unlock discussions with NWL ICB. In addition, the hospital would need to identify and achieve efficiencies and action would need to be taken at a place level to reduce the demand on the hospital. It was hoped that this plan would be shared with the Health and Wellbeing Board once developed.

Professor Goodman noted that there was a focus on the money when the focus should actually be on the impact on patients. Patients expected much more from the NHS now than they had before the pandemic which had created a backlog in primary and secondary care. In local government too, the money to provide residents with support around Covid had gone but the expectation to deliver had remained.

There was a large number of GPs aged 65+ who would be retiring in the next few years

	and this loss would need to be mitigated. It was noted that only around half of those training as GPs went into practice (they were instead working as a locum, etc). It was clear that the status quo was not an option. **RESOLVED: That the discussion be noted.**
41.	**PUBLIC HEALTH UPDATE** *(Agenda Item 5)* Ms Kelly O'Neill, the Council's Interim Director of Public Health, advised that the whole system approach to obesity had identified Hayes as being an area of need. Action had been undertaken to establish how best to engage with these communities and a pilot had been completed. The core team had been set up to lay the structures that would be needed to then build a framework to understand the community better. Initial work had been completed to target communities where obesity was prevalent and where these individuals were less likely to seek help. This included targeting obese young people too with initiatives such as active travel, for which three bids had been submitted. Minet School had been successful in its bid and the outcome of the other two bids was still awaited. The Board was advised that a workshop would be held at the end of March and consideration had been given to who would need to attend. It would be important to develop sustainable long term engagement plans and mobilise those who had already been identified whilst also trying to identify others that were currently unknown. Consideration would need to be given to questions such as: was there a limited ability to walk to school?; was there a perception of poor safety when walking? A reference group would be built up over the next few months with the community. This could then be developed so that it identified what the community saw as barriers and came up with solutions and options to tackle obesity. Measures of success would need to be identified that meant something to residents and which they would think were important. Although this might be the achievement of a healthier weight, it might be a feeling of being fitter or a greater sense of wellbeing. Concern was expressed that there had been a wave of messages being sent out to residents from local GP surgeries stating that they were overweight and that they could sign up to a programme to get help. It was noted that GPs had been incentivised to identify overweight patients and refer them on to a specific programme that had been funded by the NHS. Unfortunately, there had been limited spaces on this programme (which had quickly become overwhelmed with referrals) which meant that there was a 13 week wait before anything would happen. It would be important to change behaviour with the integrated neighbourhood process and that some of this could be facilitated by non-clinicians. A meeting had taken place on 6 March 2023 to set up networks of community champions to go into neighbourhoods and develop a programme of health improvements and integration. Ms O'Neill suggested that more sustainable ways of getting active were needed and less reliance on GPs as the impact on them had been huge. Council officers had been working with communities to get them more physically active and local sports facilities had been reviewed to ensure that they were affordable. Consideration now needed to be given to the wider assets available in the community and whether or not they could be used more effectively. It was noted that there would be greater links in a whole system approach to obesity and links to integrated neighbourhoods. Neighbourhood working and the purpose of

	neighbourhoods went hand in hand, especially in relation to conditions such as hypertension. Priorities and actions would need to be identified on the neighbourhood agenda. NHS Health Check was a mandated national screening programme, delivered in Hillingdon by GPs, which had been useful in identifying previously undiagnosed long term conditions. However, it was queried what happened after diagnosis. Interventions needed to be put in place and patients needed to take ownership of their own conditions. Consideration also needed to be given to how to engage with GPs and how to reduce the GP variation. Ms O'Neill advised that the NHS Health Check was supposed to be undertaken every five years. It would be important to identify those communities that were not taking part in the initiative as they were the ones that were less likely to have registered with a GP but most likely to have undiagnosed conditions. Although it varied across ethnic groups, uptake of the Health Checks was less than 50%. It was suggested that the situation with obesity felt like déjà vu from about ten years ago. The Royal Borough of Kensington and Chelsea (RBKC) had taken an advertising approach to negotiate with residents: if the 'place' did something for them, what would they do in return. Rather than medicalising the issue, initiatives such as lunch clubs for older people had been established. Ms O'Neill would be interested in looking into the work undertaken by RBKC. Ms Wright queried whether digital interventions had been used to make a difference as there were some low cost options available. NWL was part of the digital accelerator for London and lots of technology would be available to do Health Checks at community events. Ms O'Neill confirmed that digital options, uptake and access were being investigated, especially for those who wanted to help themselves. Momentum needed to be generated around School Superzones using digital to reach large numbers at a relatively cheap cost. It was deemed encouraging that schools were engaging and that they had signed up to the Superzones. It was queried whether dental nurses would return to schools or whether dentists would visit schools to talk to children about oral health. Ms O'Neill noted that poor oral health had so many interdependencies with other issues such as obesity so was deemed a key issue. Preventative measures, such as the provision of water in schools, was thought to be the panacea. **RESOLVED: That the discussion be noted.**
42.	**THRIVE UPDATE** *(Agenda Item 7)* Ms Jane Hainstock, Head of Joint Commissioning at North West London Integrated Care System (NWL ICS), advised that information from Central and North West London NHS Foundation Trust (CNWL) / Child and Adolescent Mental Health Services (CAMHS) had not been available when the agenda had been published. This information would be circulated to the Board after the meeting. Ms Hainstock advised that a cultural change was needed in the approach to children's mental health and wellbeing. The old tiered model had felt like young people and their parents were having to climb a ladder to move from one tier to the next and it would be important to not create a new set of challenges in the move to Thrive. The set up and governance needed to be established before the structural features could be

	determined. The implementation of the Thrive methodology was thought to be ambitious and a service mapping exercise had already been undertaken with partners. This exercise had tried to align the language used by the different organisations and had identified a number of gaps and some short, medium and long term actions. The voluntary sector had identified the need for more peer support and the need to increase capacity. It was noted that CAMHS was not the appropriate place for some mental health issues and that sometimes young people might be experiencing emotional distress rather than mental ill health. Action was being taken regarding the criteria for using the CAMHS service and what was needed by those young people and their families that did not meet the threshold. Ms Hainstock advised that the activity data illustrated the level of pressure on the system with one in four children and young people now having a diagnosable mental health condition. It would be important to understand why these young people were unwell to then be able to address the causes rather than medicalising the issue. The population health management project had set out an aspiration to have a single front door for all young people's services. This would mean that young people would not have to tell their story more than once and that a plan could be put together. Following on from the first two Thrive meetings, a third meeting with partners had been scheduled for April 2023 where consideration would be given to what was being done well and what was not so good. This would show where the focus needed to be so that the right teams could be pulled together, which might take time. Ms Patricia Wright, Chief Executive at The Hillingdon Hospitals NHS Foundation Trust (THH), advised that the NWL Integrated Care Board (ICB) had agreed three programmes of work, one of which was in relation to children and young people's mental health. It would be important that the work being undertaken locally in relation to Thrive was fed into that research work. It was confirmed that the Children and Young People's Transformation Board had received a presentation on that part of the research project and a two year pilot project for London was being introduced to provide a single front door. Ms Kelly O'Neill, the Council's Interim Director of Public Health, noted that a similar approach to the Thrive methodology had been introduced in Northamptonshire some time ago. Although adults had been prioritised in work undertaken in the Borough, it was time to take a good look at services for children and young people. Having been underfunded previously, increased investment meant that the needs of young people could be addressed at an earlier stage so that they are prevented from escalating into crisis. **RESOLVED: That the update be noted.**
43.	**BOARD PLANNER & FUTURE AGENDA ITEMS** *(Agenda Item 8)* Mr Gary Collier, the Council's Health and Social Care Integration Manager, advised that it was possible that the Better Care Fund Plan would need to considered at the Health and Wellbeing Board meeting on 13 June 2023. Mr Tony Zaman, the Council's Interim Chief Executive, advised that there were wider

	changes being introduced across London and consideration needed to be given to the role of the Health and Wellbeing Board in the new arrangements. Rather than the Board receiving reports that provided a descriptive narrative, it was suggested that this should be more of an in-depth look at issues or that workshops should be undertaken. Ms Kelly O'Neill, the Council's Interim Director of Public Health, noted that the Health and Wellbeing Strategy had been published about a year previously and that now would be a good time to evaluate the impact of the action taken to help the Board refocus. It was agreed that this would be included for the next meeting on 13 June 2023. **RESOLVED: That the 2023/2024 Board Planner, as amended, be agreed.**
44.	**TO APPROVE PART II MINUTES OF THE MEETING ON 29 NOVEMBER 2022** *(Agenda Item 10)* **RESOLVED: That the Part II minutes of the meeting held on 29 November 2022 be agreed as a correct record.**
45.	**BETTER CARE FUND - NEXT STEPS - VERBAL UPDATE** *(Agenda Item 9)* Consideration was given to the future state operating model for Hillingdon. **RESOLVED: That the discussion be noted.**
46.	**UPDATE ON CURRENT AND EMERGING ISSUES AND ANY OTHER BUSINESS THE CHAIRMAN CONSIDERS TO BE URGENT** *(Agenda Item 11)* Consideration was given to the impact of strikes on Hillingdon Hospital. **RESOLVED: That the discussion be noted.**
	The meeting, which commenced at 2.30 pm, closed at 4.42 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.

2022/23 INTEGRATED HEALTH AND CARE PERFORMANCE REPORT

Relevant Board Member(s)	Keith Spencer Councillor Jane Palmer
Organisation	Hillingdon Health and Care Partners London Borough of Hillingdon
Report author	Gary Collier - Social Care and Health Directorate, LBH
Papers with report	None

HEADLINE INFORMATION

Summary.	This report provides an update on the delivery of the transformation workstreams established to deliver the priorities within the Joint Health and Wellbeing Strategy. This report also seeks approval for the content of the 2022/23 Better Care Fund end of year reporting template to the Department of Health and Social Care.
Contribution to plans and strategies.	The Joint Health and Wellbeing Strategy and Better Care Fund reflect statutory obligations under the Health and Social Care Act, 2012.
Financial Cost.	The total of the BCF for 2022/23 was £111,570k, made up of a Council contribution of £58,900k and an NHS contribution of £52,670k.
Ward(s) affected.	All

RECOMMENDATIONS

That the Health and Wellbeing Board:

a) **approves the content of the 2022/23 end of year template; and**
b) **notes and comments on the content of the report.**

INFORMATION

Strategic Context

1. This report provides the Board with an update on delivery of the priorities within the Joint Health and Wellbeing Strategy for the January to March 2023 period (referred to as the '*review period*'), unless otherwise stated. The report also seeks approval for the content of the 2022/23 Better Care Fund (BCF) end of year template.

2. The focus on development of the BCF plan in time for the 28 June 2023 submission date means that this report focuses on key issues and achievements.

3. This report is structured as follows:
   A. Key Issues for the Board's consideration.
   B. Achievements and challenges.

A. Key Issues for the Board's Consideration

2022/23 End of Year Better Care Fund (BCF) Template

4. All health and wellbeing board areas in England were required to submit an end of year template summarising 2022/23 activity on 23 May 2023. A draft template has been submitted, subject to the Board's sign-off. The template is an excel spreadsheet containing five worksheets. **Appendix 1** includes the detail of some of these tabs for the Board's consideration; however, the key points are highlighted below. The draft completed template can be accessed via the Council's website using this link: https://www.hillingdon.gov.uk/bcf.

5. **Appendix 1: National Conditions** – This asks if Hillingdon met the four 2022/23 national conditions for the BCF, which it did.

6. **Appendix 1A: Metrics** – This is seeking the end of year status against the targets for avoidable admissions ambulatory care sensitive conditions, length of stay (LoS), discharge to usual place of residence, permanent admissions to care homes of people aged 65 and over and percentage of people still at home 91 days after discharge from hospital having received a period of reablement. In summary, Hillingdon's end of year position against the metrics was:

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

Ambulatory Care Sensitive Conditions Expanded

Ambulatory care sensitive conditions (ACSCs) are conditions where effective community care and case management can help prevent the need for hospital admission. They include conditions such as 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).

7. **Appendix 1B: Year End Feedback** – This asks for responses against three pre-set questions and the identification of two successes and two challenges.

8. **Income and Expenditure Actuals** – The full financial breakdown can be found via the link shown in paragraph 4 above. In summary, the total expenditure was £113.6m which comprised of a combination of £111.6m against core BCF and £2m against the Adult Social Care Discharge Fund.

9. The actual expenditure by the ICB BCF was £53.5m, which shows an over performance of £2m compared to the planned ICB expenditure. This over performance was largely due to increase in costs of £2.4m for 75 new clients for physical disabilities, and 45 new clients for Funded Nursing Care, off-set by under-spend of £0.4m against Population Health Management. This funding will roll forward into 2023/24 in accordance with section 75 provisions. Actual expenditure by the Council was in-line with the plan. Discharge Fund expenditure was also in-

line with the plan. Detail of how this fund was spent can be accessed using the Council website link referred to above.

B. Achievements and Challenges

2022/23 Achievements Aligned to BCF Scheme

10. Some key achievements of Hillingdon's health and care system in 2022/23 are shown below.

11. ***Workstream 1 (Neighbourhood development)*** achievements include:

- **Primary Care:** There were 690,900 face to face GP attendances taking place in 2022/23, compared to 587,811 in 2021/22, which is a 15% increase. There was also a 6.4% increase in GP appointments attended, i.e., 1,135,045 in 2022/23 compared to 1,066,363 in 2021/22. This demonstrates the pressures on general practice due to the level of appointments practices have had to make available to meet demands.

- **Admission rate for people 65 years with severe frailty:** Hillingdon has the lowest rate across NWL at 667.1 admissions per 1,000 population.

- **% of People with a Serious Mental Illness receiving a Physical Health Check:** Hillingdon has improved its performance from 66% to 70.4% for the six mandated health checks against a NWL target of 60%.

- **Annual health checks for people with learning disabilities >14:** Hillingdon exceeded the NWL target of 50% with a performance of 81%.

- **Diabetes delivery of 9 care processes:** Hillingdon's performance is 52% of people with diabetes receiving the 9 care processes against a NWL target of 50%.

12. ***Workstream 2 (Reactive Care)*** achievements include:

- **Discharge from Hospital**: Achieving best performance across London for the highest proportion of hospital discharges by 5pm each day, as well as for the lowest overall period of stay for patients needing to stay longer than a week.

- **Same day urgent primary care hubs:** It is intended that there will be three hubs established with the objective of creating increased capacity in primary care to see more patients on the same day and diverting activity away from Hillingdon Hospital's Emergency Department. Joint work with the Council has led to the identification of premises that means that two of the three will be able to open in 2023/24.

13. ***Workstream 3 (Planned Care)*** achievements include:

- 78 week waits for elective treatments have been eliminated.

14. ***Workstream 4 (Care and support for adults with mental health challenges and/or people with learning disabilities and/or autism)*** achievements include:

- **Crisis care pathway:** A six bed mental health crisis recovery house called The Retreat

opened in August 2022 under a pilot that will continue until August 2024 as part of the transformation of the mental health crisis pathway. This represents a collaboration between CNWL, the Council and an independent sector provider called Comfort Care Services. Since opening, 50 people have received support in a non-institutional environment and avoided admission to a hospital emergency department.

- **Mental Health Clinical Assessment Service (MHCAS):** This opened in November 2022 and offers a calm and therapeutic mental health setting to treat the majority of emergency mental health presentations. Patients requiring the service in Hillingdon Hospital A&E are transported there and offered full emergency mental health assessments and onward care planning in the department with a diverse and highly skilled mental health workforce incorporating nurses, doctors, support workers and access to drug and alcohol workers and psychology.

15. ***Workstream 5 (Care and support for children and young people)***

- **CAHMS:** In March 2023 there were 66 children waiting for their first appointment and 137 waiting for treatment. This represents reductions of 67% and 63% respectively on the same point in 2022.

16. ***Enabling workstream 1 (Supporting carers)*** achievements include:

- A new joint strategy for the 2023-2028 period has been drafted for consultation in 2023/24.

- The co-produced '*Are you a carer?*' information leaflet was completed and distributed to system partners to issue to carers.

- 39 out of the 42 GP practices now have an identified Carers Champion.

- Hospital discharge checklists and roles and responsibility descriptors in discharge guidance now include involvement of carers. Carer information booklets are provided in Hillingdon Hospital to show how carers can get support.

17. ***Enabling workstream 2 (Improved market management and development)*** achievements include:

- Short-term block care home bed provision was successfully procured to support the care system during the winter period.

- Market sustainability and fair cost of care plan was completed. Implementation will impact on care home providers for people aged 65 and above and homecare providers for people aged 18 and above in 2023/24 and 2024/25.

Challenges 2023/24 and Beyond

18. Challenges facing Hillingdon's health and care system have been discussed at previous Health and Wellbeing Board meetings and include:

- **Managing Population Health and its associated demand:** 6% of Hillingdon's population who have multiple conditions or are at the end of their life account for: 65%

of all Hillingdon GP appointments; 66% of all emergency admissions; 74% of all acute occupied bed days; 70% of all Adult Social Care resource and have average lengths of stay of twice as long as other population groups.

- **Tackling inequality and deprivation:** 87% of the Hillingdon's population with more than one long term condition are from the White and Asian or Asian British ethnic groups. The most prevalent long term conditions in Hillingdon are hypertension, anxiety and depression and obesity.

- **Underlying health and care system deficit:** As discussed at the Board's March meeting, addressing the underlying causes of the system deficit is critical to securing delegation of health budgets to place.

- **New Hillingdon Hospital business case activity assumptions:** The business case is predicated on the new hospital delivering a different level of capacity to what is currently in place. This is itself predicated on the implementation of new models of care that will manage demand.

- **Health and care workforce challenges:** Age of current workforce, e.g**.,** 16% of GP's, 30% of practice nurses are over 60; nearly 30% of Adult Social Care workforce aged 55 and above, and competition for limited pool of staff in some professions.

- **Fragility of the independent sector care market:** This is linked to workforce issues, increased costs of doing business and implementation of fair cost of care.

- **Constraints of the acute and primary care estates:** Age and design of existing buildings that are no longer fit for purpose to meet the current and future health and care needs of residents and/or located in the wrong place and impact on delivery of new models of care.

Addressing the Challenges

19. The approach to addressing these challenges has previously been discussed by the Health and Wellbeing Board and is summarised below. It includes:

- **Developing and implementing the new integrated care models** required to address growing service demand, deliver better services, tackle the place-based deficit, and deliver the activity shifts required for the new hospital development programme.

- **Embedding population health management** and addressing our areas of inequality.

- **Developing a place-based financial recovery plan** to ensure best use of resources to address the local health-based financial deficit.

- **Making change happen on the ground** through:

  - **Integrated Neighbourhood Team development** building from a population health approach to tackle health inequalities.

  - **Reactive care service development** that will result in a new 24/7 place based out of hospital reactive care delivery model for those with complex needs, including

people with multi long-term conditions and also moving Hillingdon from good to great in respect of hospital discharges.

- **Implementing an integrated end of life service model** that joins up services to care for people at the end of their life in their preferred care setting.

20. Hillingdon's approach to addressing some of the challenges facing its health and care system is reflected within the draft 2023/25 Better Care Fund, which is a separate item on the Board's agenda.

Finance

21. There are no direct financial implications of this report.

BACKGROUND PAPERS

Joint Health and Wellbeing Strategy, 2022-2025

Appendix 1 – 2021/22 National BCF Conditions

National Conditions	Confirmation
National Condition 1: **A Plan has been agreed for the Health and Wellbeing Board area that includes all mandatory funding and this is included in a pooled fund governed under section 75 of the NHS Act 2006?** (This should include engagement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes
National Condition 2: **Planned contribution to social care from the CCG minimum contribution is agreed in line with the BCF policy?**	Yes
National Condition 3: **Agreement to invest in NHS commissioned out of hospital services?**	Yes
National Condition 4: **Plan for improving outcomes for people being discharged from hospital?**	Yes

Appendix 1A – Metrics

Metric	Definition	For information - Your planned performance as reported in 2022-23 planning	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements
Avoidable admissions	**Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)**	874.0	On track to meet target	Target achieved based on SUS data M1 - M12. Outturn 871 Workforce shortages due to vacancies and sickness has presented a challenge in both the primary identification and treatment of chronic ambulatory care sensitive conditions.	Community teams at PCN level are managing increased acuity levels.
Discharge to normal place of residence	**Percentage of people who are discharged from acute hospital to their normal place of residence**	93.2%	Not on track to meet target	Based on SUS data M1 - M12 performance achieved is 92.11%	• Better joint working between local authorities and NHS. • All trusts continually reviewing and improving discharge process, with standardisation and sharing of good practice in place.
Residential Admissions	**Rate of permanent admissions to residential care per 100,000 population (65+)**	776	Data not available to assess progress	Approximately 55% of permanent placements comprise of conversions from short-term placements to permanent. Permanent placements are subject to rigorous management scrutiny to ensure that there are no alternative	Older residents continue to be supported in Hillingdon's four extra care housing schemes

Metric	Definition	For information - Your planned performance as reported in 2022-23 planning	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements
				solutions, e.g., extra care housing or a return to their own home. Increasing acuity levels being seen and demand from people living with dementia.	and close working with NHS partners enables need to be appropriately met to avoid moves to more restrictive settings.
Reablement	**Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services**	90.5%	On track to meet target	Reablement service provider has faced issues with recruitment.	Establishing a closer working relationship between Reablement service provider and District Nursing and Community Adult Rehabilitation Services delivered by NHS community health provider to support independence of residents in a community setting.

Appendix 1C – Year End Feedback

The purpose of this survey is to provide an opportunity for local areas to consider and give feedback on the impact of the BCF.

Part 1: Delivery of the Better Care Fund
Please use the below form to indicate to what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	**Response:**	**Comments: Please detail any further supporting information for each response.**
1. The overall delivery of the BCF has improved joint working between health and social care in our locality.	Strongly agree	Health and care partners continue to explore utilising the BCF section 75 (s75) as the vehicle for establishing a place-based health and care budget, which aligns with proposals set out in the health and social care integration white paper published in February 2022. Under consideration is expansion of the scope of the BCF to include Adult Mental Health in 2023/24 and for an NHS provider to become a signatory to the BCF s75.
2. Our BCF schemes were implemented as planned in 2021/22.	Strongly agree	This is largely the case, although slippage in delivering some schemes during 2022/23 attributed to limited capacity within the local health and care.
3. The delivery of our BCF plan in 2021/22 had a positive impact on the integration of health and social care in our locality.	Strongly agree	See 1 above.

Part 2: Success and Challenges
Please select two Enablers from SCIE Logic model which you have observed demonstrable success in progressing and two Enablers which you have experienced a relatively greater degree of challenge in progressing. Please provide a brief description alongside.

4. Outline two key success observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2021/22.	SCIE Logic Model Enablers Response category:	Response – Please detail your greatest successes
Success 1	9. Joint commissioning of health and social care	Commissioning arrangements to support timely discharge during the pandemic have worked well, e.g., D2A pathway 1 bridging care, step-down. This also includes strong working relationships between the acute hospital, community health and the Council's contracted provider for intermediate care services. Hillingdon's D2A model is perceived by NWL neighbouring LAs as the preferred model of delivery especially on Pathway 1.
Success 2	2. Strong, system-wide governance and systems leadership	Wide ranging review of how services are delivered at place undertaken to define a future state operating model with the goal of delivering care closer to people's homes in six integrated neighbourhoods, preventing unnecessary hospital attendances through greater same day primary care capacity, promoting earlier hospital discharge, and delivering activity assumptions underpinning the Hillingdon Hospital redevelopment programme.

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2021/22.	SCIE Logic Model Enablers Response category:	Response – Please detail your greatest successes
Challenge 1	1. Local contextual factors (e.g., financial health, funding arrangements, demographics, urban vs rural factors)	The under-lying system deficit poses a risk to local ambition as will influence the willingness of the ICB to delegate health budgets to place. However, this also poses an impetus to drive change and stop established practices producing the same results.
Challenge 2	6. Good quality and sustainable provider market that can meet demand	Inflationary pressures and recruitment and retention issues present challenges for regulated providers that influence behaviours, e.g., willingness of care homes to accept people with more complex needs. These are issues that are not easily addressed, especially as funding available to meet cost of inflation as well as support fees that reflect a fair cost of care is insufficient.

Footnote:
Questions 4 and 5 answers should be assigned to one of the following categories:

1. Local contextual factors, e.g., financial health, funding arrangements, demographics, urban vs rural factors.
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users.
4. Empowering users to have choice and control through asset based approach, shared decision making and co-production.
5. Integrated workforce: joint approach to training and upskilling of workforce.
6. Good quality and sustainable provider market that can meet demand.
7. Joined-up regulatory approach.
8. Pooled or aligned resources.
9. Joint commissioning of health and social care.

Appendix 2 – NWL ICB Place-based Metrics

NWL Metric	ICS Objective	Population Group/Pathway	Place Function	Measure	Goal (Increase/ decrease)	Target	Benchmark	NWL Average Position	Hillingdon Actual
People with diabetes who have received nine care processes in the last 15 months.	**Improve outcomes in population health and health care.**	**Long Term Conditions**	**Robust local care offer**	**%**	**Increase**	**50%**	**N/A**	**61.6%**	**61%**
Children (17 or under) with asthma who have completed an asthma check.	**Prevent ill health and tackle inequalities in outcomes, experience and access.**	**Children and Young People**	**Robust local care offer**	**%**	**Increase**	**68%**	**N/A**	**59%**	**48%**
People with severe mental illness (SMI) receiving a full physical health check.	**Prevent ill health and tackle inequalities in outcomes, experience and access.**								
People over age of 14 on a doctor's learning disability register who have had an annual health check.									
Estimated diagnosis rate for people (aged 65 and over) with dementia.									

NWL Metric	ICS Objective	Population Group/Pathway	Place Function	Measure	Goal (Increase/ decrease)	Target	Benchmark	NWL Average Position	Hillingdon Actual
Two hour urgent community response rate.									
Percentage of patients aged 61 to 74 with a Bowel Cancer Screening for patients in the last 30 months.									
Patients aged 79 years or under with hypertension who have a blood pressure reading of 140/90 mmHg or less.									
Patients aged 80 years and over with hypertension who have a blood pressure reading of 150/90 mmHg or less.									

2023/25 BETTER CARE FUND PLAN

Relevant Board Member(s)	Sandra Taylor – Executive Director, Adult Services and Health Richard Ellis – Joint Borough Director Keith Spencer – Managing Director, HHCP
Organisation	London Borough of Hillingdon North West London Integrated Care Board Hillingdon Health and Care Partners
Report author	Gary Collier, Adult Services and Health Directorate, LBH
Papers with report	Appendix 1 – Draft Narrative Plan

HEADLINE INFORMATION

Summary	The Better Care Fund (BCF) is a government initiative intended to to support people to live healthy, independent, and dignified lives through joining up health, social care and housing services seamlessly around the person. This report outlines the proposed plan for the 2023 – 2025 period, including outline financial proposals. The report also seeks delegated arrangements to agree the final provisions of the plan to comply with national conditions.
Contribution to plans and strategies	The Better Care Fund is a key part of Hillingdon's Joint Health and Wellbeing Strategy and meets certain requirements of the Health and Social Care Act 2012.
Financial Cost	The minimum value for the BCF for 2023/24 is £36,495k comprising of minimum contributions from the Council of £13,625k and the ICB of £22,869k. The minimum value for 2024/25 is £37,807k and this comprises of minimum contributions from the Council of £13,643k and from the ICB of £24,164k.
Ward(s) affected	All

RECOMMENDATIONS

That the Health and Wellbeing Board:

a) approves the 2023-2025 BCF plan as outlined in the report and supporting documents.

b) delegates authority to approve the final plan to the Executive Director for Adult Services and Health in consultation with the Board Co-chairmen, the NHS North West London Borough Director and Healthwatch Hillingdon Chairman.

c) delegates authority to amend the draft plan in response to feedback as part of the assurance process to the Executive Director for Adult Services and Health in consultation with the Board Co-chairmen, the NHS North West London Borough Director and Healthwatch Hillingdon Chairman.

INFORMATION

Strategic Context

1. The Department Health and Social Care's policy framework that set out broad principles to be followed for the 2023 to 2025 Better Care Fund (BCF) Plan was published on 4 April 2023. NHS England also published the detailed planning requirements for the next iteration of the BCF on the same day. This mandated that health and wellbeing board areas submit their BCF plan on 28 June 2023.

2. The Board is reminded that Department of Health and Social Care's vision for the BCF is that it support people to live healthy, independent and dignified lives through joining up health, social care, and housing services seamlessly around the person. The vision 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.

3. The approach with the BCF taken in Hillingdon thus far is that it is seen as a tool for securing integration between health and social care or closer working between the NHS and the Council where this will contribute to the delivery of the agreed priorities within the statutory Joint Health and Wellbeing Strategy and address the challenges facing Hillingdon's health and care system. A guiding principle that has also been applied is that the BCF should not be seen as something separate from the broader transformation agenda but as an enabler.

2023/25 BCF Plan and National Requirements

4. The challenges facing Hillingdon's health and care system are summarised in the integrated performance report also on the Board's agenda. The BCF schemes have been aligned to the workstreams attributed to the emerging place-based health and care operating model and this is illustrated in table 1 below. The delivery priorities for 2023/25 are summarised in the draft BCF narrative plan document attached to this report as **Appendix 1**.

Table 1: Alignment of BCF Schemes and Transformation Workstreams	
BCF Scheme	**Transformation Workstream**
Scheme 1: Neighbourhood development.	**Workstream 1:** Integrated Neighbourhood Working.
Scheme 2: Supporting carers.	Enabler
Scheme 3: Reactive care	**Workstream 2:** Reactive Care
Scheme 4: Improved market management and development.	Enabler
Scheme 5: Living well with dementia.	**Workstream 4:** Care and support for adults with mental health challenges and/or people with learning disabilities and/or autism.
Scheme 6: Integrated care and support for children and young people.	**Workstream 5:** Care and support for children and young people
Scheme 7: Integrated support for people with learning	**Workstream 4:** Care and support for adults with mental health challenges and/or people with learning disabilities

disabilities and/or autistic people.	and/or autism.

5. Workstream 3 is planned care and is outside of the scope of the BCF.

6. The Board will be aware that for the last two years the following proposals have been under consideration:

- **Development of the BCF section 75 as the governance framework for a place-based community health and care budget:** The rationale behind this is that it would give transparency about investment in community health and care services that would create an opportunity to rationalise spend and avoid duplication of provision. An incremental step towards this would be inclusion of adult mental health community services in 2023/24 and equivalent for children and young people in 2024/25. It has not been possible to secure the necessary agreement to this from the ICB as yet and this has been alluded to within the BCF narrative plan as work in progress during 2023/24.
- **A local NHS provider, i.e., CNWL, becoming a party to the BCF section 75 agreement**: The rationale supporting this proposal is that the position where the Council and the ICB are the sole parties to the s75 does not reflect the evolving health and care landscape linked to the Health and Care Act, 2022 where some commissioning responsibilities and funding routes may sit with and through provider organisations. Taking this forward also requires the approval of ICB and is reflected in the narrative plan as being under discussion in 2023/24.

Key Changes from the 2022/23

7. The main development since the 2022/23 plan and linked to the Hillingdon challenges referred to paragraph 3 is the implementation of a new health and care operating model based on:

- *Integrated Neighbourhood Development:* Delivering more care closer to people's homes via six Integrated Neighbourhoods and increasing capacity within Primary Care to see more people requiring urgent care on the same day.
- *Reactive Care:* Tackling unnecessary Emergency Department attendances through the development of a new 24/7 place-based out of hospital reactive care delivery model for people with complex needs. This includes delivering integrated care for people at the end of life.

8. Proposed changes to financial arrangements that are subject to ICB approval are summarised in paragraph 23.

Table 2: National Conditions and Local Response	
Condition	**Local Response**

1. A jointly agreed plan - A plan that has been agreed by the HWB. This must demonstrate:
 	
• That a plan that has been agreed by the HWB.
 	
  • 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, VCSE and housing must be involved in development of the plan.
	This is dependent on the recommendation being agreed and subsequent agreement under delegated authority.
	
	Subject to '*assured*' status being awarded, the Council's Cabinet and the ICB will be asked to approve the s75 in October.

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.	These requirements are addressed in the narrative plan.
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. It also needs to identify: • 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.	These requirements are addressed in the narrative and also the planning template
4. Maintaining the NHS's contribution to adult social care and investment in NHS commissioned out of hospital services.	*Minimum contribution to adult social care:* This will be £8,339k in 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.

National Conditions

9. Table 2 below summarises the national conditions set out in BCF planning requirements. The table describes the local position.

National Metrics

10. The 2023/25 metrics are aligned to the two national conditions concerned with the implementation of the national BCF objectives. The metrics associated with national condition 2 are shown in the table below.

National Condition 2: Enabling people to stay well, safe and independent for longer	
2023/24	
Metric	**Commentary**
1. Unplanned admissions for ambulatory care sensitive conditions.	• This metric was introduced in 2021/22 and is intended to measure a reduction in people aged 18 + admitted to hospital for ambulatory care sensitive 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).
2. Permanent admissions to care homes of people aged 65 +.	• This is a continuing Adult Social Care Outcomes Framework (ASCOF) measure that has been in place since the inception of the BCF. The objective is for the admissions figure to be as low as possible.
3. Proportion of older people (65 +) who were still at home 91 days after discharge from hospital into reablement or rehabilitation services.	• This is a continuing Adult Social Care Outcomes Framework (ASCOF) measure that has been in place since the inception of the BCF. It is a flawed measure and 2023/24 will be its last year.
4. New: Emergency hospital admissions due to falls in people aged 65 +.	• This is a new but logical inclusion. A query is whether NWL BPI team will provide the data.
2024/25	
1. Metrics 1, 2 and 4 above will roll forward.	• Areas will be asked to review ambitions for 2024/25 metrics in Q4 2023/24.
2. New: Outcomes following short-term support to maximise independence.	• More information will be provided about this new metric in Q4 2023/24.

11. The metrics associated with national condition 3 are shown below.

National Condition 3: Provide people with the right care, at the right place, at the right time.	
2023/24	
Metric	**Commentary**
1. Discharge to usual place of residence.	• This metric rolls forward from 2022/23. In 2022/23 NWL identified targets for the eight boroughs and provided performance data.
2. **New:** Discharge metric ahead of winter 2023.	• It is expected that by the autumn a new metric will be in place that measures the time from the discharge ready date that will be recorded by acute trusts from April 2023 to the actual date of discharge.
2024/25	
1. Discharge to usual place of residence.	• Areas will be asked to review ambitions for this metric for 2024/25 in Q4 2023/24.
2. **New:** Discharge metric ahead of winter 2024.	• Subject to introduction of the new metric in 2023/24, areas will be asked to review ambitions for this metric for 2024/25 in Q4 2023/24.
3. **New:** Proportion of people discharged who are still at home after 91 days.	• This new ASCOF measure replaces the outdated metric associated with people being discharged into reablement or rehabilitation services.

12. The targets for the metrics, supporting rationale and identification of schemes that will contribute to delivery are currently under discussion and will be addressed in the final approval report. For the Board's assurance, the approach that will be taken with all targets is that they should be achievable.

Reporting Requirements

13. It is important that the Board is aware that the new BCF plan entails additional reporting requirements and these are:

- Fortnightly reporting on use of the Discharge Fund.
- Monthly reporting on hospital discharge capacity.
- Quarterly reporting on delivery of the BCF plan and related expenditure.

14. The Discharge Fund will be top sliced to engage additional capacity to support the reporting requirements. The grant conditions allow for 1% of the grant to be used for administrative purposes.

Submission Requirements

15. Hillingdon's 2023/25 BCF submission consists of a:

- **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. The number and scope of the key lines of enquiry have increased since the 2022/23 planning process, which has contributed to this submission being more complex to complete than previous iterations. A non-mandatory template was provided, which has been used and is attached as **Appendix 1**.

- **Completed template:** This details the financial arrangements, including for the Discharge Fund aspect of the BCF, and the local targets for the national metrics and supporting rationale.

- **Intermediate care demand and capacity template:** Integral to the planning template is this additional template, which builds on the 2022/23 prototype. This is intended to develop a single picture of intermediate care needs and resources across the system. Unlike in 2022/23, the template will be considered as part of the 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.

16. As in previous years, NHS England's Better Care Support Team made available an offer to review BCF plans prior to submission to ensure that the key lines of enquiry in the planning requirements are addressed. Officers intend to take advantage of this opportunity and feedback will be reflected in the final narrative plan document.

Delegation of Sign-off Authority

17. The Board is being asked to delegate final plan sign-off authority as the complexity of the 2023/25 planning requirements and the late publication of North West London Integrated Care Board's (ICB) allocation to Hillingdon from the Discharge Fund money it has received from the Department of Health and Social Care (DHSC) means that it has not been possible to complete the plan in time for the meeting on the 13th June. The Board will be aware that delegation of sign-off responsibility is not unusual and has been necessary several times since the inception of the BCF.

18. The Board is also being asked to approve delegation arrangements to make changes to the plan in response to feedback arising from the assurance process. Feedback is likely to be received from the Better Care Support Team, which is part of NHS England.

Next Steps

19. Subject to the Board approving the sign-off recommendation, delegation arrangements will be utilised to secure local approval of the 2023/25 plan and it will then be submitted in accordance with the national deadline.

20. Hillingdon's submitted plan will be subject to an assurance process involving NHS England, the Local Government Association, the Ministry for Levelling Up, Housing and Communities and

the Association of Directors of Adult Social Services (ADASS). Notification of the results of the assurance process should be known the week starting the 8th September 2023. The outcome of the process will be that the plan will either be '*assured*' or '*not assured'*.

21. Once assured status has been obtained it will be possible for the Council and NWL to enter into a s75 agreement. The target date for this being signed is the 31st October 2023.

Risk Share Arrangements

22. The arrangement for previous iterations of the plan has been that each organisation manage its own risks and no changes are proposed for the 2023/25 plan. The detail of risk share arrangements will also be reflected in the s75 agreement referred to previously.

Financial Implications

Financial Uplift

23. Table 3 below provides a breakdown of the mandated financial requirements for the 2022/25 period where information is currently available. The table also identifies where further information and discussion is awaited.

Table 3: BCF FUNDING SUMMARY 2022/25			
Funding Breakdown	**2022/23**	**2023/24**	**2024/25**
	(£,000)	***(£,000s)***	***(£,000s)***
MINIMUM NHS CONTRIBUTION	**21,645**	**22,869**	**24,164**
Required Spend			
• Protecting Social Care	7,892	8,339	8,811
• Out of Hospital	6,150	6,498	6,866
• Other minimum spend	7,603	8,031	8,485
MINIMUM LBH CONTRIBUTION	**13,447**	**13,626**	**13,643**
Required Spend			
• Disabled Facilities Grant (DFG)	5,111	5,111	5,111
• Improved Better Care Fund (iBCF)	7,468	7,468	7,468
• Discharge Fund LBH Contribution	868	1,046	1,064
ADULT SOCIAL CARE DISCHARGE FUND	**1,985**		
• LBH Contribution	868	1,046	1,064
• NHS Contribution	1,118	Tbc	Tbc
ADDITIONAL VOLUNTARY	**75,361**	Tbc	Tbc
• Additional NHS Contribution	29,907	Tbc	Tbc
• Additional LBH Contribution	45,454	Tbc	Tbc
TOTAL BCF VALUE	**111,570**	Tbc	Tbc

24. Detailed financial arrangements for the 2023/25 plan await the outcome of discussions with NWL and approval will be sought under delegated arrangements in due course, subject to the Board agreeing the recommendations in this report. Proposals include:

- *Scheme 1: Neighbourhood development* – Inclusion of NHS England health inequalities funding passported to the Council to support Population Health Management (PHM) implementation initiatives.
- *Scheme 3: Reactive care* – Inclusion of services that it is proposed by funded from either the local authority or ICB allocations from the ASC Discharge Fund. This would include provision funded in 2022/23 from underspend from 2021/22 winter pressures money, e.g., additional 7-day social worker capacity, additional 7-day brokerage capacity and step-down beds to expedite timely discharge. It would also include new provision such as additional floating support capacity to aid timely discharge of people with mental health needs, additional mental health social work capacity and additional Approved Mental Health Practitioner (AMHP) capacity to support discharge. It is also proposed to include bed-based step-up capacity to prevent hospital admission and address a gap identified through the intermediate care demand and capacity analysis. The main funding for this provision would be the NHS minimum contribution to protecting Adult Social Care.
- *Scheme 6: Integrated care and support for children and young people* - Inclusion of NHS England health inequalities funding passported to the Council to support the development of a pilot service to address the mental health needs of children and young people. This would be a PHM implementation initiative funded via NHS England health inequalities money.

25. The Board may wish to note that it is intended to utilise the 1% allowance within the ASC Discharge Fund grant conditions to support administration costs. This is in response to the additional capacity implications of the reporting requirements outlined in paragraph 15 above.

Improved Better Care Fund Grant (iBCF)

26. The £7,468k iBCF funding is paid directly to the Council 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 2022/23 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.

27. As for the last two years, the Council is intending to use the funding to support the local care market. 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.

EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

28. The recommendation will ensure that Hillingdon complies with the BCF national conditions, which impacts on access to £22,869k additional funding via the NHS as well as £13,625k that is paid directly to the Council by the Department of Levelling Up, Housing and Communities (DLUHC).

Consultation Carried Out or Required

29. HHCP representatives were involved in the development of the 2023/25 plan. The timescale for submitting the BCF plan restricted the scope for consulting with stakeholders about the plan's content.

BACKGROUND PAPERS

2023 to 2025 Better Care Fund policy framework (DHSC 4/04/23)
Better Care Fund planning requirements, 2023 - 25 (NHSE 4/04/23 PR00315)

Appendix 1

2023/25 Better Care Fund Narrative Plan

Health and Wellbeing Board (s)

Hillingdon

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

The 2023/25 Better Care Fund plan has been developed in partnership with the organisations within Hillingdon's borough-based partnership known as Hillingdon Health and Care Partners (HHCP). HHCP includes The Confederation that represents 43 of the borough's 45 GP practices; the Central and North West London NHS Foundation Trust (CNWL), the local community health and community mental health provider; The Hillingdon Hospitals NHS Foundation Trust (THH), the local acute hospital; and a third sector consortium known as H4All. This includes four of the largest third sector organisations operating in Hillingdon, i.e., Age UK, Carers Trust Hillingdon, Disablement Association Hillingdon (DASH) and Harlington Hospice. We also engaged with Healthwatch Hillingdon.

Care home and homecare providers have also been involved, but there has been limited time available to involve a broader range of stakeholders. We have also engaged local stakeholders, the third sector and Healthwatch Hillingdon in the development of a new local operating model through participation in a series of transformation sprints as well as formal HHCP governance.

How have you gone about involving these stakeholders?

The '*place-based'* governance structure for delivering the priorities within the joint Health and Wellbeing Strategy has been the route through which HHCP partners have been involved in the development of the BCF plan. This is expanded on in section 2: *Governance*.

As with the development of the 2022/23 BCF, the involvement of care home and homecare providers has been through their respective forums. a series of transformation workshops to agree the priorities outlined in schemes 1, 3 and 6 in the section 1 below and all stakeholders were involved in the workshops.

1. Executive Summary

This should include:

- Priorities for 2023/25.
- Key changes since previous BCF plan.

1.1 Priorities for 2023/25.

<u>Strategic Priorities</u>

It is intended that during the lifetime of the plan it will contribute to:

a) Addressing the long-term financial sustainability of the place-based health and care system.

b) Combating the drivers of the place-based system deficit by delivering a new operating model focused on:

- Development of six Integrated Neighbourhoods to deliver care and support closer to home.

- Establishing a Reactive Care model that will maximise the *Homefirst* approach and deliver a new end of life model of care.

c) Securing delegation to place by the ICB of health budgets and functions consolidated within the BCF legal framework, i.e., section 75 agreement.

Scheme Specific Priorities

The 2023/25 BCF plan includes seven schemes, and these are as follows:

- Scheme 1: Neighbourhood development
- Scheme 2: Supporting carers
- Scheme 3: Reactive care
- Scheme 4: Improving care market management and development
- Scheme 5: Living well with dementia.
- Scheme 6: Integrated care and support for children and young people
- Scheme 7: Integrated care and support for people with learning disabilities

The priorities for 2023/25 by scheme are:

Scheme 1

- 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.

Scheme 2

- 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.

Scheme 3

- Implementing the new End of Life Coordination Hub Operating Model.
- Implementation of '*Maximising HomeFirst'* programme to reduce length of stay.
- Establishing block contracts for pathway 2 and 3 discharges.
- Establishing bed-based step-up arrangements to support admission avoidance.

Scheme 4

- Implementing Market Sustainability Plan in respect of care homes for people aged 65 + and providers of homecare for people aged 18 +.

Scheme 5

- Improve dementia diagnosis rates.

Scheme 6

- Delivering integrated family hub services.
- Developing 0 – 19 services focussed on needs of local populations.

Scheme 7

- 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 - 2026.

1.2 Key changes since previous BCF plan.

The main change since the 2022/23 plan is the development of a new operating model, which is explored in more detail in section 3: *National Condition 1: Overall BCF plan and approach to integration.* Discussions are in progress that could result in an increase in scope during 2023/24 to include Adult Mental Health and the inclusion of a local NHS provider as a signatory to the section 75 agreement. To avoid repetition, changes pertinent to national conditions are described in sections 4, 5 and 6 as appropriate.

2. Governance

Briefly outline the governance for the BCF plan and its implementation in your area.

2.1 BCF schemes and transformation workstream alignment

The alignment of BCF schemes with the transformation workstreams reported in the 2022/23 plan remains current and are illustrated in the table below.

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: Living well with dementia.	**Workstream 4:** Care and support for adults with mental health challenges and/or people with learning disabilities and/or autism.
Scheme 6: Integrated care and support for children and young people.	**Workstream 5:** Care and support for children and young people
Scheme 7: 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.

Workstream 3: *Planned care*, is outside of the scope of the BCF plan.

2.2 2023/25 governance arrangements

Annex A summarises the current governance structure for Hillingdon's transformation programme, including the BCF plan. Although the governance arrangements have not changed significantly since 2021/22 it is expected that these will evolve as Hillingdon's health and care system moves to implement a new operating model during 2023/24. Please see section 1: *National Condition 1* for further explanation.

Under current governance arrangements, there is a transformation board with an executive lead from one of the health and care partners or the Council for all workstreams, e.g., workstream 1 is led by the chief executive from The Confederation, workstream 2 by the

managing director for HHCP, workstream 4 by the Managing Director (Goodall Division) of CNWL and workstream 5 is by the Director of Public Health.

The HHCP Senior Operational Leads Team (SOLT) that also includes Council representation monitors delivery at a more operation level. This meets fortnightly and is chaired by the HHCP Managing Director. More strategic monitoring is undertaken by the HHCP Delivery Board that has executive level membership and also meets on a monthly basis. This includes the Council's Executive Director for Adult Services and Public Health among its membership and reports to the Health and Wellbeing Board (HWB), which provides senior "*Leadership of Place*" across the system and has the statutory responsibility for the development and implementation of the Joint Health and Wellbeing Strategy. The HWB is co-chaired by the Cabinet Member for Health and Social Care, an elected Member of the Council and the HHCP Managing Director. The HWB meets quarterly and the co-chairs each chair two meetings a year.

The importance of housing as one of the key social determinants of health is recognised in Hillingdon. The Strategic Housing Board, which is chaired by the Director of Housing, has responsibility for monitoring delivery of Hillingdon's Housing Strategy. **Annex A** illustrates how this board fits into the broader place-based health and wellbeing strategy delivery governance structure.

The HWB considers a performance report on the delivery of the priorities within the Joint Health and Wellbeing Strategy as a standing item at each of its meetings. The June 2023 report to the Board can be accessed via the following link _____.

3. National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person-centred health, social care and housing services, including:

- Joint priorities for 2023/25
- Approaches to joint/collaborative commissioning.
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023 – 2025 and how they will support further improvement of outcomes for people with care and support needs.

3.1 Overview

Joint Health and Wellbeing Strategy

As reported in the 2022/23 BCF plan, Hillingdon's Joint Health and Wellbeing Strategy, 2022 – 2025, aims to '*improve the health and wellbeing of all our residents and to reduce disparities in health and care across our communities'.* The strategy identifies priorities for achieving this aim that reflect the national policy direction, including the NHS Long-term Plan and feedback from our residents. Our priorities for 2022 – 2025 are:

Priority 1: Support for children, young people and their families to have the best start and to live healthier lives.

Priority 2: Tackling unfair and avoidable inequalities in health and in access to and experiences of services.

Priority 3: Helping people to prevent the onset of long-term health conditions such as dementia and heart disease.

Priority 4: Supporting people to live well, independently and for longer in older age and through their end of life.

Priority 5: Improving mental health services through prevention and self-management.

Priority 6: Improving the way we work within and across organisations to offer better health and social care.

Now we are at the mid-point in the life of the strategy its delivery is currently under review. This is being considered in the context of the following strategic drivers:

- *An underlying system financial deficit:* NHS organisations in Hillingdon are carrying historic debt that pre-dated the pandemic but has been exacerbated by it.

- *Hillingdon Hospitals new build*: The new hospital business case is predicated on a different level of capacity to what is currently in place. This is itself predicated on the implementation of new models of care that will manage demand.

- *Integrated Care Board (ICB) delegation of budgets to place*: Dependency of place-level delegation of health budgets on plans to address the underlying causes of the system deficit.

Borough-based Partnership and the BCF

HHCP is the borough-based partnership that serves as the delivery vehicle for integration across health services and the BCF provides the legal framework for delivering the place-based priorities set out in the Joint Health and Wellbeing Strategy that are dependent on integration between health and social care and/or closer working locally between the NHS and the Council for delivery. The BCF section 75 is identified as enabling delivery of a place-based health and care budget as reflected in the Government's health and care integration white paper '*Joining up care for people, places and populations: The government's proposals for health and care integration'* (DHSC Feb 2022) and discussions are in progress to develop this further in 2023/24.

Under discussion for 2023/24 is the inclusion of an NHS provider organisation as a signatory to the BCF section 75 to increase system flexibility and reflect the new NHS architecture under which funding can go directly to providers rather than through ICBs.

Evolving Operating Model

A series of workshops with partners across Hillingdon's health and care system have taken place in Q4 to consider a future state operating model with the ultimate goal of preventing hospital attendances. The future state operating model has been framed around the conceptual model of place-based health and care functions shown in **Annex B**. **Annex C** illustrates the new operating model. The three transformation programmes that this will deliver can be summarised as:

- *Integrated Neighbourhood Development:* Delivering more care closer to people's homes via six Integrated Neighbourhoods and increasing capacity within Primary Care to see more people requiring urgent care on the same day.

- *Reactive Care:* Tackling unnecessary Emergency Department attendances through the development of a new 24/7 place-based out of hospital reactive care delivery model for people with complex needs.

- *End of Life Care:* Delivering integrated care for people at the end of life.

3.2 Joint Priorities for 2023 – 2025

Please see section 1: *Executive Summary* and also section 6: *Supporting unpaid carers*.

3.3 Approaches to joint/collaborative commissioning

Hillingdon's approach to joint/collaborative commissioning remains consistent with our previous BCF plans.

HHCP has to date used an '*alliance agreement'* to underpin shared resources, information sharing and the use of partnership investments with agreed benefits and outcomes. This mechanism has enabled the development and delivery of integrated services designed to deliver proactive joined up care to our residents. The BCF continues to provide an opportunity to take a more integrated approach to market management and development which underpins the broader health and care system. Our approach continues to be shaped by recognition that:

- 70% of the Council's gross spend on Adult Social Care is on independent sector provided services and is commissioning for significantly greater numbers than the NHS, therefore making it the dominant purchaser in the marketplace;

- 47% of the Council's gross spend on social care for Children and Young People is on independent sector provided services, which once again makes the local authority the dominant purchaser in the local market.

- Commissioning jointly with the local authority avoids the NHS paying a premium that can impact on the supply and overall cost of care for the local system;
- Local residents want locally based care and support solutions and longer lengths of stay in hospital are more likely to occur where only out of borough care solutions are offered or where these are the only ones available.

- The care and support providers necessary to enable residents to live independently in the community operate on a borough or locality basis rather than across an '*ICS*' footprint;

- In respect of children and young people's services, a combination of the Council's statutory children's social care responsibilities, an understanding of the independent sector market for service provision to this population group and established strategic relationship with schools mean that the local authority is best place to act as lead commissioner.

The Council has long undertaken the brokerage function to access independent sector provided services on behalf of the NHS NWL in respect of people with learning disabilities in receipt of Continuing Healthcare funding, children and young people and also people subject to

s117 of the Mental Health Act. The role of the brokerage team in supporting hospital discharge is addressed in section 5: *National Condition 3: Delivering National BCF Objective 2.*

Approaches to joint/collaborative commissioning in respect of hospital discharge are also addressed in section 5*.*

3.4 How BCF funded services are supporting Hillingdon's approach to continued integration of health and social care.

Hillingdon's approach to the continued integration of health and social care is influenced by the following:

- There is partner recognition that integration is not an end unto itself but must be the identified solution to address a particular problem.

- Since the inception of the BCF the majority of funding contained within the pooled budget has comprised of investment locked into pre-existing contracts and most of these contribute to the delivery of the two national BCF objectives, which is expanded on in section 4 and 5. However, inclusion within the BCF serves the valuable point of providing visibility and transparency about investment by both NHS NWL and the Council into key services that consequently provides opportunities to secure efficiencies.

3.5 Changes from the 2022/23 plan and how they will support further improvement of outcomes for people with care and support needs.

Changes relevant to BCF national objectives 1 and 2 are addressed in sections 4 and 5 and unpaid carers in section 6. Other changes are summarised as follows:

- **Scheme 1:** There is much greater focus implementing Population Health Management initiatives to address health inequalities and reduce or delay demand for health and care services. Please see section 4 for more detail.

- **Scheme 2:** This scheme includes local authority funding to provide short breaks for parent carers of disabled children and reflects clarification of the offer to parent carers in the new carers strategy.

4. National Condition 2. Delivering BCF Objective 1: Enabling people to stay well, safe and independent at home for longer.

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- Steps to personalise care and deliver asset-based approaches.
- Implementing joined-up approaches to population health management, and proactive care, and how schemes commissioned through the BCF will support these approaches.
- Multi-disciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake.
- How work to support unpaid carers and deliver housing adaptations will support this objective.

4.1 Approach to integrating care to support people to remain independent at home.

In-line with but pre-dating the Fuller Stocktake, in Hillingdon neighbourhoods have been established as the building block of place based care building to deliver improvements to meet the needs of residents by multi-disciplinary teams arranged arounds groups of general practices that form six primary care networks. There are a range of neighbourhood-based models of care in place and these include:

- Same Day Urgent Primary Care Hubs
- Care Connection Teams (CCTs)
- Integrated Paediatric Clinics
- Care Home Support Team
- Population health and Preventative Care
- High Intensity User (HIU) Service

4.2 How primary, intermediate, community and social care services are being delivered to help people to remain at home.

Overview: Data Analysis

HHCP analyse data obtained through the NWL whole systems integrated care database (WSIC), practice-level intelligence, the PAR30 risk analysis tool used in Hillingdon Hospital and the Patient Activation Measure (PAM) tool used by the Wellbeing Service (explained further in section 4.3 (e) below) to assess need. This assists with the deployment of resources either within HHCP or through services secured through a procurement process, e.g., a telehealth system in care homes. Effectiveness is then managed through SOLT and reflected in the performance reports considered by the HHCP Delivery Board (see section 2: *Governance*).

Care Connection Teams

The CCTs comprise of Guided Care Matrons, Care Coordinators, Wellbeing Advisers, a Mental Health Practitioner and GPs. They undertake active case management at neighbourhood level of the top 2% of individuals aged over 18 years at high risk of hospital admission or hospital attendance addressing their escalating care need before they cause any deterioration and therefore reducing acute activity. The Mental Health Practitioners are provided by CNWL. CNWL has also aligned its Community Nursing Service to match the neighbourhoods and the intention is to further integrate this service during the period of the plan. This means that patient caseloads will be aligned to, and managed within, multi-agency Integrated Neighbourhoods rather than CNWL specific localities. Health staff operating at Neighbourhood level will have a single integrated leadership structure operating across provider.

As shown in section 1: *Executive Summary*, a priority for the period of the plan is to create an Active Recovery Service (see also **Annex C**) that includes a vertically integrated Rapid Response and place-based community therapy services. The intention is to improve efficiency and effectiveness through single line management arrangements. The Reablement Service is

delivered by an independent sector provider under a contract with the Council and it is intended that its operation will align with the Active Recovery Service.

The structure of the Council's Adult Social Work teams has been aligned to the neighbourhoods with named links provided.

The Council has commissioned two block providers to deliver homecare, one in the north of the borough and one in the south with the dividing line broadly being the A40. Implementation of these contracts is in progress but they provide an opportunity to establish relationships between neighbourhoods and the providers. Relationships are at different stages, but this will help to support BCF Objective 1 by providing the means of flagging early signs of deterioration and addressing health need to prevent avoidable hospital attendances and/or admissions.

Same Day Urgent Primary Care Hubs

The intention is to open three hubs in the borough that will provide urgent care for people with non-complex needs and include diagnostics, such as bloods, x-ray, electro-cardiogram (ECG) and swabs. Joint work between The Confederation and the Council means that the intention is to open two hubs in 2023/24, one in the north of the borough and the other in the south. This is with the intention to divert 18% and 28% respectively of the non-complex cases attending the Emergency Department and Urgent Treatment Centre (UTC) at Hillingdon Hospital.

Integrated Paediatric Clinics

The clinics provide a joined up, out of hospital model of care for families who would otherwise be attending outpatient clinics. Clinics have been running since 2018 and rotate through different practices across the borough in order to provide access to residents and clinicians. As well as providing a community setting for specialist care and reducing the outpatient waiting lists the clinics support the development of relationships between primary care and specialist teams. They also provide an opportunity for education and training as clinics are shared by GPs and consultants. In 2022/23 the model expanded to include MDT discussions about children with complex needs (including mental health). Representatives from the Council, CAMHS, the Hospital and community paediatricians, school nursing, voluntary sector as well as GPs attend.

Care Home Support Team

This multi-agency team includes six care home matrons who each have responsibility for supporting specific care homes as well as the four extra care housing schemes developed by the Council. The team also includes a mental health nurse, care home pharmacist, a dietician, speech and language therapist and tissue viability capacity. Specialist medical advice and support is provided by a care of the elderly consultant at Hillingdon Hospital. The team has responsibility for delivering care home direct enhanced services (DES) contract, although it predates the DES as was piloted in 2017.

The team are in daily contact with care homes supporting older people and also the extra care housing schemes. They are in weekly contact with care homes supporting people with learning disabilities and/or those with mental health needs. The team also works closely with the Council's Quality Assurance Team, which has responsibility for monitoring regulated providers in the borough. The joint working is an integral part of the place-based approach to managing the local care market.

High Intensity User (HIU) Service

This service is delivered by H4All and was launched to reduce the attendances and admittances to Hillingdon Hospital of the top 50 patients. The team deliver a holistic model of support that utilises health coaching, integrative counselling, and social prescribing for these patients who do not fit into traditional systems of support. The service won the Health Service Journal (HSJ) *Urgent and Emergency Care Initiative of the Year 2021 Award* and is a partnership with the Hillingdon Hospital, London Ambulance Service, Police, housing, substance misuse and mental health services.

4.3 Steps to personalise care and deliver asset-based approaches.

The components of Hillingdon's approach that are intended to maximise resident choice and control are:

- *Self-help through access to information and advice* **–** As part of the implementation of its obligations under the Care Act, the Council has developed an online directory the functionality of which has evolved over time. The new care and support directory called '*Marketplace*' now includes provision for children and young people as well as adults.

- *Self*-assessment – Included within the functionality of Marketplace is the ability of adults to undertake their own self-assessment to identify whether they are likely to satisfy the National Eligibility Criteria for adult social care. This option is also available for carers. Financial assessments can also be undertaken online.

- *Promotion of Personal Health Budgets (PHB) as Direct Payments and Integrated Budgets* – Partners identify the willingness of an individual to take their PHB as a Direct Payment as a proxy measure for how engaged they are in managing their own health condition (s). With the exception of PHB direct payments for wheelchairs, the Council has managed the process since 2014. This has avoided the necessity of establishing systems that replicates the direct payment process already operated by the local authority. There were 15 people taking their PHBs as Direct Payments supported by the Council on 31st March 2023, which is no change on the same period in 2022. As of 31st March 2023, there were 331 people in receipt of Direct Payments from the Council, which is 6 lower than the same point in 2022.

- *Empowering the resident voice* – The provision of advocacy ensures that people who may have difficulty expressing themselves are able to give and make informed decisions. The Council has in place an integrated advocacy contract with a provider to deliver statutory advocacy services such as:
  - Independent Mental Capacity Advocacy (IMCA).
  - Independent Mental Health Advocacy (IMHA).
  - Care Act Advocacy.

  A separate arrangement is in place to support people who wish to make complaints against NHS bodies. The contract for this provision will be retendered in 2023/24 and additional capacity will be built into Care Act advocacy provision to reflect the expectation of increased demand arising from the Adult Social Care funding reforms that are to be implemented from October 2025.

- *Strong partnership with the voluntary and community sector* – The H4All consortium has a highly active role within HHCP and is commissioned by NHS NWL to deliver the Wellbeing Service, which has staff attached to PCNs. The Wellbeing Service, the funding for which is

included within the BCF, supports people with long-term conditions who are at risk of escalating needs via multi-disciplinary work undertaken by the CCTs and works with them taking a strengths or asset-based approach to make best use of the positive attributes that a person already has. The Patient Activation Measure (PAM) tool is used to identify how motivated a person is to manage their long-term condition at the start of a period of person and whether this has improved at the end. Social prescribing is a tool available to the service to address identified need.

H4All is part of an alliance of third sector organisations across NWL boroughs called *3rd Sector Together* (‘*3ST*’). This is intended to provide a strategic and commissioning link between the third sector and NWL Integrated Care System.

- *Strengths-based social work practice* – This focuses on the personal strengths and assets that an individual brings with them as well as the strengths and assets of their local community. This approach is integral to the discharge of the social care assessment duty under the Care Act as it maximises the independence and control that people have over managing their care needs.

4.4 Implementing joined-up approaches to population health management, and proactive care, and how schemes commissioned through the BCF will support these approaches.

Please see section 8: equality and health inequalities.

4.5 How work to support unpaid carers and deliver housing adaptations will support this objective.

Unpaid Carers

Carer leads in GP practices, development of carer registers in GP practices, referral to Carer support Service. See section 6: *Supporting unpaid carers*.

Housing Adaptations

An outcome from multi-disciplinary working is identification of the scope for major adaptations and/or assistive technology to assist with maintaining the independence of residents in the community. This is expanded on in section 7: *Disabled Facilities Grant and Wider Services*.

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- Learning from 2022/23, such as
  - Where number of referrals did and did not meet expectations.
  - Unmet demand, i.e., where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected).
  - Patterns of referrals and impact of work to reduce demand on bedded services, e.g., admissions avoidance and improved care in community settings, plus evidence of under-utilisation or over-prescription of existing intermediate care services.

- Approach to estimating demand, assumptions made and gaps in provision identified:
  - Where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
- How have estimates of capacity and demand (including gaps in capacity) been taken on board and reflected in wider BCF plans?

4.6 Rationale for Hillingdon's estimates of demand and capacity for intermediate care to support people in the community.

4.6.1 Learning from 2022/23.

4.6.2 Approach to estimating demand, assumptions made and gaps in provision identified.

4.6.3 How estimates of capacity and demand (including gaps in capacity) have been taken on board and reflected in wider BCF plans.

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023 – 2025, and how these services will impact on the following metrics:

- Unplanned admissions for chronic ambulatory care sensitive conditions.
- Emergency hospital admissions following a fall for people aged 65 and above.
- The number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

4.7 Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023 – 2025.

The BCF services that support the objective are primarily those within scheme 1: *Neighbourhood development*, the focus of which is prevention. The full breakdown of services within this scheme can be found in tab 6a: *Expenditure* of the planning template but can be summarised as follows:

- Access to online information about services (Marketplace and Online Coordinator post)
- Provision of community-based information, advice and support via VCS providers, including provision of services to address, for example, social isolation.
- H4All Wellbeing Service
- Staffing to fund integrated care at neighbourhood level, including Care Connection Teams.
- Falls Prevention Service
- Telecare to support people in their own home (see also section 7: *Disabled Facilities Grants and wider services*)
- Care Home Support Team and Council's Quality Assurance Team supporting care home providers and also homecare providers in respect of the latter.

Further examples of services within the BCF that support the objective include the

Reablement Service in scheme 3: *Reactive care* and integrated homecare in scheme 4: *Market management and development*, the dementia resource centre referred to in scheme 5: *Living well with dementia* and the range of community services delivered by CNWL referred to in section 5 below regarding delivery of BCF objective 2.

PHM-specific funded provision within the BCF includes:

- Pilot falls staying steady champions.
- Falls prevention training.
- Community champions.
- Warm welcome centres.
- Hypertension active case finding.
- Blood pressure monitors.
- PHM infrastructure.

4.7 Describe how these services will impact on the following metrics:

See also tab 7: *Metrics* of the submission template.

- **Unplanned admissions for chronic ambulatory care sensitive conditions.**

Proactive case management at neighbourhood level supported by Care Connection Teams and H4All Wellbeing Service to identify people most at risk of admission. The relevant services to address need are then identified, depending on level of complexity of need. People living in the community with ongoing care needs who satisfy the National Eligibility Criteria for Adult Social Care would be supported with homecare or more personalised approaches to addressing their need (see section 4.3).

- **Emergency hospital admissions following a fall for people aged 65 and above.**

Hillingdon's approach is two-fold, i.e., seeking to prevent falls from occurring in the first instance and then preventing recurrence where a person has fallen.

The CNWL falls service offers a multidisciplinary, consultant-led clinic that provides comprehensive assessment and specialist diagnostics to people who have had a fall or are at risk of falling. Referrals are via CCTs. The clinic can refer people to specialities and signpost them to relevant agencies, e.g., Age UK. The service also provides an 8-week, evidence-based falls prevention exercise programme either in people's homes or in group settings at Northwood Health Centre and Riverside Unit.

In addition to proactive case management at neighbourhood level, a pilot Frailty Assessment Unit at the Hospital, the funding for which is not included within the BCF, also identifies people living with frailty who are most at risk of falling and proactive case management is provided by CCTs and direct support delivered by the Rapid Response Team for people with the most complex needs.

Falls-related injuries constitute one of the main causes of hospital admission from care homes. PHM funded falls training enables the CNWL falls service to deliver training to care homes in the borough supporting the 65 and over population.

The staying steady pilot being delivered by Age UK and funded via PHM funding within the BCF is intended to test the extent to which exercise can build strength in older people to

prevent or reduce the risk of falling.

- **The number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.**

Early identification of people at risk of admission and/or loss of independence through active care planning in primary care and multi-disciplinary team approach. Support through Wellbeing Service and other VCS partners to address contributors to deterioration, e.g., social isolation. Joint VCS and community provider role, i.e., via Rapid Response, Community Adult Rehabilitation Service in addressing falls and risk of falls. Support via Reablement and homecare and use of assistive technology, e.g., telecare. Intensive review at head of service level within Adult Social Care to ensure that permanent admission is most appropriate means of addressing care needs. This would be after considering the feasibility of extra care.

5. National Condition 3: Delivering National BCF Objective 2: Providing the right care in the right place at the right time.

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and time discharge, including:

- Ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.

- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

5.1 Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time.

Hillingdon has a single general acute trust within its geographical boundaries and approximately 80% of its activity is from people resident in the borough. 94.4% of activity relating to people registered with Hillingdon GPs is also attributed to people resident in the borough. For general acute, the focus of the Hillingdon health and care system is therefore on preventing admission to Hillingdon Hospital and expediting discharge from it. All partners within HHCP and the Council have a significant role in securing timely discharge from hospital and have had regard to the High Impact Change Model (HICM) in developing our approach. Section 5.6 describes Hillingdon's current position following a review of the self-assessment undertaken in July 2022 and actions arising from it.

5.2 Please describe how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and time discharge, including:

5.2.1 Ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.

Please see section 5.6.

5.2.2 How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

The following summarises how the discharge funding will be used:

- Additional Hospital Reablement Service capacity.
- Discharge-related homecare.
- Discharge-related residential placements.
- Discharge-related nursing placements.
- Block short-term residential placements.
- Block short-term nursing placements.
- Additional hospital social work capacity (7-day).
- Additional brokerage capacity (7-day).
- Discharge Support AMHP.
- Mental Health Floating Support Service.

5.2.3 Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

Through integrating active recovery services (see **Annex C**) it is intended to reduce the average length of stay in Medicine and Rehabilitation at THH initially for **the 21+ day long length of stay cohort by 5.2 days** and then the **7+ cohort by 1.7 days**.

Improving the end of life care model is also key to achieving the ministerial priority and 2023/24 will see the implementation of a new end of life coordination hub model. This is illustrated in **Annex C1** and will be delivered by Harlington Hospice (a member of the H4All consortium) who will link with the Hospital's Emergency Department and Care of the Elderly Team (COTE), community services and care homes.

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- Learning from 2022/23, such as
  - Where number of referrals did and did not meet expectations.
  - Unmet demand, i.e., where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected).
  - Patterns of referrals and impact of work to reduce demand on bedded services, e.g., improved provision of support in a person's own home, plus evidence of under-utilisation or over-prescription of existing intermediate care services).

- Approach to estimating demand, assumptions made and gaps in provision identified.

- Planned changes to your BCF plan as a result of this work, including:

- Where, if anywhere, have you estimated there will be gaps between capacity and the expected demand?

- How have estimates of capacity and demand (including gaps in capacity) been taken on board and reflected in the wider BCF plans.

5.3 Rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital.

5.3.1 Learning from 2022/23

5.3.2 Approach to estimating demand, assumptions made and gaps in provision identified.

5.3.3 Planned changes to Hillingdon's BCF plan as a result of this work

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023 – 2025 and how these will impact on the following metrics:

- Discharge to usual place of residence.

5.4 Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023 – 2025.

Discharges of people who are able to return home with a package of care are supported by a service delivered by an independent sector provider and funded through NHS additional contribution. This service supports people who have been discharged from hospital pending a full assessment of their need in their home environment. The same provider is also responsible for the Reablement Service, which is funded partly through the NHS minimum contribution to protecting Adult Social Care and also from the NHS additional voluntary contribution. The Hospital Social Work Team that is responsible for undertaking assessments is funded via the protecting social care funding stream.

Age UK is a key partner in supporting the return home of older people attending the hospital who do not require an admission. They also support the discharge of older residents who do not require a package of care but would benefit from short-term support after returning home, i.e., D2A pathway 0. These services are funded through a combination of the protecting social care and NHS minimum contribution to out of hospital services.

Care home and homecare provision to support discharge is funded through a combination of protecting social care money, iBCF and local authority additional voluntary contribution.

Included within the out of hospital mandated NHS contribution to the BCF are a range of services that are provided by CNWL, and these include:

- Rapid Response
- Community Adult Rehab
- Community Homesafe
- Community Matrons
- District Nursing
- Continence Service

- Tissue Viability Service
- Twilight Service

Pathway 2 services funded from the NHS minimum contribution to out of hospital provision include:

- Hawthorn Intermediate Care Unit (HICU)
- Parkfield House step-down beds

5.5 Describe how these services will impact on the following metrics:

5.5.1 Discharge to usual place of residence.

The Reablement Service and community-based NHS provided services referred to in section 5.4 above provide wrap-around care and support to address the specific needs of people thereby supporting discharge to their usual place of residence where possible. Partners are also working together to implement virtual wards in line with national policy to reduce length of stay and release hospital beds.

Set out any progress in implementing the High Impact Change Model for Hospital Discharge.

5.6 Progress in implementing the High Impact Change Model for Hospital Discharge.

The 2022/23 BCF plan identified actions resulting from a self-assessment against the nine changes in the model that took place in July 2022. This section describes Hillingdon's approach and progress in implementing the changes identified in the self-assessment.

HICM Change 1: Discharge planning.

Current Position

Patient Flow Coordinators (PFCs) have allocated wards and facilitate identification of people who do not meet the criteria to reside and the referral of people to the Integrated Discharge Team (IDT). This team comprises of Hospital Discharge Coordinators and PFCs; CNWL's Rapid Response Team reps; Adult Social Care reps as well as representatives from the independent sector company contracted with the Council to provide the Hospital Reablement Service (previously called the Bridging Care Service), i.e., Comfort Care Services.

Update on 2022/23 Self-assessment.

Identified Actions	Update
Implementation of the medical admissions proforma called Redcoat.	Completed and will standardise record keeping.
Completion of patient discharge passport following consideration by the Hospital's Patient Forum.	Completed. A standardised discharge booklet now in place following collaboration with the NHS NWL.
Continued roll out of SAFER patient flow bundle, including criteria-led discharge.	This is a priority for 2023/24.
Explore scope for re-establishing the '*red bag'*	Partners agreed not to proceed in response

scheme.	to feedback from care home providers and lack of dedicated resource.
Developing a discharge checklist for the Hospital Emergency Department.	Completed
Developing a standardised discharge checklist for all adult inpatient wards.	This will take place in 2023/24 as part of the implementation of the Cerner patient record system.

HICM Change 2: Monitoring and responding to system demand and capacity.

Current Position

Discharge monitoring and escalation meetings are taking place three times a day Monday to Friday and twice daily at weekends. These are led by an executive level partner representative. These are supported by daily activity data updates provided to senior partner representatives that include information about system capacity, i.e., Rapid Response, Hawthorn Intermediate Care Unit, Parkfield House step-down beds, Hospital Reablement, Age UK services, etc. Independent sector capacity is monitored by the Council's Brokerage Team which has responsibility for brokering ongoing homecare packages of care for people supported by the Hospital Reablement Service and care home placements for people requiring short and long-term care home placements. It is intended to retain the additional brokerage capacity introduced in 2022/23 funded from rolled forward 2021/22 winter pressures funding as business as usual for the period of the 2023/25 plan.

Capacity Tracker is a key tool used to identify potential provider capacity but is proving more useful in identifying care home capacity and less effective so far with home care providers.

Update on 2022/23 Self-assessment.

Identified Actions	Update
Implement results of the short-term bed-based care block contract tender, which will result in a contract to deliver four beds for people who are non-weight bearing for up to four years.	Procurement exercise did not produce a solution and short-term arrangements were established for 2022/23. Now intending to go to the market for three-year contracts.

HICM Change 3: Multi-disciplinary working.

Current Position

The MDT approach is embedded within operational practice. IDT triage meetings are taking place three times daily Monday to Friday and twice daily Saturday and Sunday. Monday to Friday meetings include Adult Social Care as well as CCS and Rapid Response. The focus on securing discharge at weekends means that CCS involvement is a priority.

PFCs coordinate data for ward based MDTs that support Adult Social Care triage calls to expedite discharge, especially for people on Pathway 3.

The IDT also works closely with CNWL's Psychiatric Liaison Team (PLT) who are based at the Hillingdon Hospital main site and are available 24/7 to support people who present with a mental health need. The PLT also works in close liaison with the Hospital Discharge Mental Health Social Work Team.

The Hospital employs a Learning Disability Nurse Specialist who liaises with the IDT to provide support to improve the discharge experience of people with learning disabilities and their families.

A further initiative that started in 2022/23 and will continue into 2023/24 is the co-location of a Community Diabetic Nurse within the Hospital.

The 2022/23 self-assessment did not identify any actions.

HICM Change 4: Home First.

Current Position

The existence of the CCS Hospital Reablement Service that has been funded by the NHS via its voluntary contribution to the BCF since 2018/19 supports timely pathway 1 discharges. This service provides an onward referral route to long-term packages of care where required.

A delirium pathway support service pilot has been established to increase discharges on pathway 1 and reduce discharges on pathways 2 and 3. The pilot started in March 2023 and is being delivered by CCS.
P2 support is provided via HICU or in step-down bedded provision pending access to active rehab via HICU.
Ward assessments are being undertaken for people on pathway 3 only, who represent the lowest number of hospital discharges.
The 2022/23 self-assessment did not identify any actions.

HICM Change 5: Flexible working patterns.

Current Position

Decision making arrangements in the hospital, including criteria-led discharge, as well as improvements to pharmacy and transport availability have led to improvements in weekend discharges but work continues to ensure that this is maintained consistently. Most care homes do not have the resources available to undertake assessments for long-term care more than five days a week. Rapid Response and the Hospital Reablement Service are also available at weekends.

The 2022/23 self-assessment did not identify any actions.

HICM Change 6: Trusted assessment.

There is a single referral form used in the Hospital that is accepted by all statutory partners, but no one form that is accepted by community providers. Changes to the D2A funding arrangements during 2022/23 meant that it was not possible to achieve the ambition that 9 out of 10 assessments would be undertaken in the right setting and within time limits by March 2023 was not achievable. This is due to, as previously stated, pathway 3 assessments taking place on wards. It should be noted that no assessments for people on pathway 1 are taking place in the Hospital and this is a much larger number of people.

The 2022/23 self-assessment did not identify any actions.

HICM Change 7: Engagement and choice.

Current Position

As said under change 1, a standardised information booklet is available for patients and their families. NHS NWL is developing a choice framework in the absence of a refreshed national choice policy.

HICM Change 8: Improved discharge to care homes.

Current Position

A key route for Hillingdon's health and care system to engage with care home providers continues to be through the monthly care home managers' forum that is chaired by the Council. Discharge is a regular item for which the health and care system's Head of Integrated Care attends. As previously stated, the Council's Brokerage Team is responsible for brokering short-term placements for people being discharged from hospital and the process also features regularly as part of the discussion about discharge.

Admissions to care homes of people discharged from hospital at weekends continues to be a regular topic of discussion. A combination of staffing issues in care homes at weekends and negative discharge experiences also continues to make this a very difficult goal to achieve at this time.

Direct support to care homes is provided through the Care Home Support Team and all care homes have a named Care Home Matron who contacts the homes for older people on a daily basis and those supporting people with learning disabilities and/or mental health needs on a weekly basis.

Update on 2022/23 Self-assessment.

Identified Actions	Update
Ensure that LAS attendance, conveyance and hospital admissions data is used more systematically to support care homes and their residents.	Quality Assurance Team (QAT) work with the Care Home Matrons to look at trends and identify homes that may need some additional support. A review of the QAT will consider how capacity can be built into the team to systemise data analysis.

HICM Change 9: Housing and Related Services.

This is addressed under section 7: *DFGs and Wider Services*.

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered.

5.7 How Hillingdon has used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered.

Use of BCF funding against the Council's responsibilities under the Care Act is summarised below:

- **Information and advice:** Funding from the NHS minimum contribution supports the online information and directory of services platform 'Market Place' and well as the online services coordinator post that has responsibility for its development and promotion. Core grant provision to voluntary and community organisations, i.e., Age UK, Centre for ADHD and Autism, Disablement Association Hillingdon, Hillingdon Autistic Care and support and Hillingdon Mind.

- **Preventing, reducing or delaying needs:** Funding addressing these responsibilities includes core grant to VCS organisations (schemes 1 and 7); DFGs to fund telecare (scheme 1) and community equipment (scheme 3); the PHM funded services within scheme 1 shown in section 4.7; the hospital reablement and community reablement services shown in scheme 3, which are funded from a combination of minimum and additional NHS contribution; the dementia resource centre in scheme 5, which is funded via NHS minimum contribution; and extra care team manager post funded from NHS minimum contribution to social care.

- **Market shaping and commissioning of adult social care and support:** The key activities and related funding under this Care Act responsibility include:
  - *Hospital discharge-related homecare* - NHS minimum/iBCF/Discharge Fund
  - *Hospital discharge-related residential care* - NHS minimum/iBCF/Discharge Fund.
  - *Hospital discharge-related nursing care* - NHS minimum/iBCF/Discharge Fund.
  - *Community-related homecare* - NHS minimum/iBCF.
  - *Permanent residential care placements* - NHS minimum/iBCF.
  - *Permanent nursing placements* - NHS minimum/iBCF.
  - *PLD homecare* - NHS minimum/LBH additional.
  - *PLD placements (residential & nursing)* – NHS minimum and additional contribution and LBH additional.
  - *PLD Supported living placements* – LBH additional contribution.
  - *PLD Outreach provision* - LBH additional contribution.
  - *PLD Day opportunity services* - LBH additional contribution.
  - *Quality Assurance Team* - NHS minimum.

  PLD: People with learning disabilities

- **Assessment and eligibility/Care and support planning:** The Hospital Discharge Social Work Team is funded via the minimum NHS contribution to social care and this is supported by an additional social work post to support Continuing Healthcare assessments that is funded from additional NHS voluntary contribution. A dedicated social work post for the four extra care housing schemes is funded from the minimum contribution to social care. The Adult Social Care staffing

- **Supporting unpaid carers:** This is addressed in section 6: *Supporting unpaid carers*.

- **Safeguarding:** Under scheme 4 funding from the NHS minimum contribution contributes to staffing resources within the Adult Safeguarding Team.

6. Supporting Unpaid Carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers. This should include how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

6.1 Overview

The importance of supporting carers continues to be recognised by all health and care partners as being critical to the sustainability of the local health and care system.

At a strategic level, the all-age, multi-agency Carers Strategy Group (CSG) has responsibility for the development of the Joint Carers Strategy, a refresh of which is due to be consulted on early summer 2023. The CSG is chaired by the Council and its membership includes the ICB, CNWL (community health and mental health), The Confederation and Hillingdon Hospital. This is in addition to representatives from Adult, Children and Education Services within the Council. The VCS has a critical role in supporting carers and is crucial to the proper functioning of the CSG. The sector is therefore represented by Carers Trust Hillingdon.

A major achievement in 2022/23 has been to secure carer and parent carer representation on the CSG as experts by experience. This is a significant achievement because of the challenge in identifying people both willing to be involved and who have the necessary objectivity.

Annex 1 shows the CSG's position within the governance arrangements for Hillingdon's health and care system. As an illustration of the importance attributed to supporting carers, an annual update on the implementation of the carers' strategy delivery plan is considered by the Council's Cabinet and the HHCP SOLT group. Prior to going to Cabinet, the Council's Health and Social Care Select Committee is given the opportunity to review and comment on the implementation of the delivery plan and subsequent year's priorities. The July meetings of the Select Committee and of Cabinet will consider the update on 2022/23 delivery plan and the new strategy.

The draft Joint Carers Strategy can be accessed via the following link _____.

6.2 Delivering Outcomes for Carers

Partners are working with and for carers to deliver the following outcomes:

- **Outcome 1:** Carers are identified, recognised and able to make a positive contribution.
- **Outcome 2:** The physical and mental health and wellbeing of carers of all ages is supported.
- **Outcome 3:** The financial impact of being a carer is minimised.
- **Outcome 4:** Carers have a life alongside caring.
- **Outcome 5:** Carers have access to quality information and advice at any point in their caring journey and know where to find this.
- **Outcome 6:** Carers have the skills they need for safe caring.
- **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.

Section 1.1: *2023/25 Priorities*, also includes the priorities for unpaid carers for the duration of the BCF plan.

The main offer of support to young and adult (including parent) 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 VCS 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 funding for this service, i.e., £690k, is included in the Better Care Fund (BCF) from the Council's additional voluntary contribution as well as £19k from the ICB's . The scope of this contract is summarised below and addresses key aspects of the Council's Care Act responsibilities to carers:

- Information, advice and support to access health and wellbeing and universal services
- Home-based short break provision for carers who would satisfy the national eligibility criteria.
- Development of recreational activities that provide short break opportunities for carers.
- Counselling and emotional support.
- Undertaking triage carer assessments under a trusted assessor model. The purpose of the triage assessment is to enable a carer to identify whether they are likely to meet the National Eligibility for Carers, therefore necessitating a full carer's assessment as a precursor to receiving financial support from the Council.

The intention is that triage assessments will be extended to both parent carers and young carers under the new contract due to start in 2024/25 following a competitive tender.

6.3 Unpaid Carers and the Care Act

Carers Assessments

Carers are routinely identified by Adult Social Care through the Care Act assessment of need process and a carer assessment offered. There were XXX carers' assessments undertaken in 2022/23, which includes XXX triage assessments completed by Carers' Trust (see above). This compares to 897 assessments in 2021/22 and 299 triage assessments undertaken by Carers' Trust. Our experience is that many carers decline the offer. The reasons 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 identifying themselves as carers and those who feel that the services available through Carers' Trust meets their needs.

The inclusion of triage assessments for parent carers and young carers in the new Carer Support Service contract from April 2024 is currently under consideration.

Respite Services and the BCF

The Carer Support Service contract includes a replacement care aspect. £79k is also being contributed from the ICB's minimum contribution to social care is funding respite provision. A further contribution of £165k is made from this funding stream to secure provision of respite placements for carers of people with learning disabilities, which is supplemented by £1,240k from the Council's additional voluntary contribution.

In addition to the above, the Council has a contract for the provision of short breaks to parent carers valued at £88.9k per annum that discharges duties under the Children Act, 1989.

6.4 Carer Engagement

Apart from carer issues identified as a result of day to day operational interaction with carers, there are two structured carer forum meetings that take place each year. Since 2022 these have been conducted in person. Issues raised are fed through to the CSG to inform priorities. Ensuring that issues identified through the surveys, peer support groups and engagement events held by partners are systematically fed through to the CSG continues to be work in progress.

7. Disabled Facilities Grant (DFG) and Wider Services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

7.1 Overview

Hillingdon is a unitary authority and therefore incorporates housing responsibilities contained within the Housing Grants, Construction and Regeneration Act, 1996, i.e., DFGs. The re-housing and homelessness provisions of the Housing Act, 1996, also fall within the Council's sphere of responsibility.

Strategic approach to using housing support, including DFG funding, to support independence at home.

The expectation is that the interrelationship between health partners, care providers and housing services in order to address the needs of our residents and support the health and care system referred to in our 2022/23 BCF plan to support the independence of our residents will continue for the duration of the 2023/25 plan. Our approach can be summarised as follows:

- ***DFGs****:* DFGs will continue to be utilised to support older and disabled residents to remain in their own homes. In 2022/23 347 people were assisted with DFGs and of these 45% (155) were people aged 65 and over, 44% (151) were aged 18 to 64 and the remaining 11% (41) were aged 0 – 17.

- ***Community equipment***: The community equipment service comprises of equipment loans, minor adaptations and door entry systems and is funded through DFGs. Hillingdon is part of the pan-London community equipment consortium led by the Westminster City Council and the Council acts as the lead commissioner on behalf of the ICB. Following a competitive tender in 2022/23 a contract with a new provider started on 1st April 2023. The new contract brings together provision of beds and pressure relieving equipment together under a single provider to avoid coordination issues that can impact on hospital discharge.

- ***Telecare:*** DFG funding is used to purchase telecare equipment and there are currently 7,470 residents in receipt of equipment that ranges from the simple lifeline system to a range of sensors and detectors. 6,323 users of the service are people aged 75 and over to whom it is currently available free of charge. The Council's telecare offer also includes

access to responder service for people who may not have relatives or friends who can assist in the event of a call going through the lifeline service, known as TeleCareLine. 3,834 people subscribe to this service that is delivered by an independent sector provider via the Reablement Service. The operating model for the telecare service is under review and the intention is that it will be subject to a competitive tender during 2023/24 for implementation in 2024/25.

- ***Hospital discharge housing links:*** As identified in the 2022/23 plan, named links within the Council's Housing Service for staff within Hillingdon Hospital's Integrated Discharge Team have been established and an equivalent arrangement to support discharge from acute mental health wards at the Riverside Centre and Woodlands Centre on the Hillingdon Hospital main site continues.

- ***Extra care:*** There are 234 apartments in the Council's four extra care schemes. One of the two consulting rooms within the 88 apartment scheme called Grassy Meadow Court provides a base for the 6 Care Home Matrons employed by the Care Home Support Service. The matrons also have to the treatment room at Park View Court to accommodate additional staff. It is intended that during 2023/24 the treatment room at Triscott House extra care scheme will be used by HHCP to deliver physiotherapy to residents of Hayes as part of the drive to reduce elective care waiting lists.

- ***Supported living programme:*** The Council continues to work in partnership with independent sector providers to deliver additional supported living capacity for people with learning disabilities and/or mental health needs. The new provision will comprise of a combination of self-contained flats and shared houses and the programme is due to complete in the autumn of 2023.

7.2 Use of flexibilities under the Regulatory Reform (Housing Assistance) (England and Wales) Order, 2002.

The Council has a track record of utilising Regulatory Reform Order flexibilities and this will continue and can be summarised as follows:

- ***Hospital Discharge Grant***: Since 2018/19 the Council has used DFG flexibilities to establish and maintain the Hospital Discharge Grant. This funds house and/or garden clearances, deep cleans and a range of other home-based activities where difficulties in arranging help can delay the return home of people no longer needing to be in hospital for treatment. £10k has been identified within the BCF for the Hospital Discharge Grant for 2023/24 and between April 2022 and March 2023 this assisted 17 people to return home to a safer environment. The current intention is to maintain funding at this level for 2024/25, although this will be subject to review. This is available to support discharges from Hillingdon Hospital and CNWL's acute mental health wards at the Riverside Centre and Woodlands Centre.

- **Additional discretionary grants**: These include:

  - *Essential Repair Grant*: Up to £5,000 to address repairs where the resident is aged 60 and above and is in imminent danger.

  - *Safe and Warm Grant*: Up to £5,000 for replacement boilers, draught proofing to doors, windows and loft insulation, solid wall and flat roof insulation and security measures.

The grant is available to people aged 60 and above.

- *Burglar Alarm Assistance*: A free burglar alarm for residents aged 65 and over who are owner occupiers.

8. Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking into account people with protected characteristics? This should include:

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered.
- How these inequalities are being addressed through the BCF plan and BCF funded services.
- Changes to local priorities related to health inequality and equality and how activities in the document will address these.
- Any actions moving forward that can contribute to reducing these differences in outcomes.
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

8.1 Overview

People with Protected Characteristics

The people with protected characteristics most affected by the 2023/25 BCF plan are:

- Older people
- People with learning disabilities
- Autistic people
- Children with special education needs and disabilities (SEND)

The Hillingdon practice reported in the 2022/23 plan of considering being an unpaid carer as a protected characteristic continues for the 2023/25 plan.

Health Inequalities

The NHSE/I Core20PLUS5 approach to drive targeted action in health inequalities improvement is progressing in Hillingdon. It should be noted that of the five areas of clinical health inequality maternity and serious mental illness are currently outside of the scope of the 2023/25 BCF plan. As previously stated, discussions with partners could see serious mental illness coming in scope during the lifetime of the plan.

Public Health England's index of multiple deprivation (2019) showed that Hillingdon was the 13th least deprived London borough and that our index level was below the average for both England and the London region. However, the 2019 index of multiple deprivation data from the Ministry for Levelling-up, Housing and Communities shows that the average scoring for the Townfield, Yiewsley, West Drayton and Botwell wards is significantly above the average for England, London and the borough average for Hillingdon.

The main causes of death in Hillingdon in 2020 (the most recent year for which data is available) was cancer which accounted for 23% of all deaths in 2020 (25% in males and 21% in females) and circulatory diseases which also caused 23% of all deaths (23% in males and 22% in females). Levels of obesity in school reception age children, Year 6 and the 18 years

and over population are significantly higher than the average for England and London and are concentrated in the less affluent areas in the south of the borough.

Covid-19 has exacerbated some of the pre-pandemic challenges faced by older people and people with disabilities, e.g., social isolation, and has contributed to an escalation of people within these population groups with mental health needs. Opportunities for identifying and addressing some of these needs through multi-agency working at neighbourhood level have previously been addressed.

Key inequalities faced by carers concern their physical and mental health and wellbeing that can be detrimentally impacted by the financial implications of undertaking a caring role, e.g., loss of employment or reduction hours available for work. These are addressed within section 5: *Supporting unpaid carers,* which also addresses how services funded via the BCF will address them.

8.2 Inequalities addressed through BCF plan and BCF funded services and changes from 2022/23 plan.

NHS NWL commissioned a company called Optum to work with HHCP in 2022/23 to build an understanding of Population Health Management (PHM) across partners and identify priorities, this methodology was initially applied at place to tackle falls prevention and frailty, and at neighbourhood level, building capacity and capability to use PHM as a tool to target health and wellbeing inequalities and take coordinated joint action. As a result of this work partners have agreed via the Health Protection Board and Health and Wellbeing Board the following priorities:

- *Embedding PHM as an approach to system working* – The creation of two additional posts funded via NHSE Health Inequalities funding, administrated through NWL ICB, contained within the BCF and under the direction of the Director of Public Health will build capacity and capability within HHCP to embed PHM as a system of working.

- *Addressing falls and frailty in Hayes:* This initiative will be targeting older people in the more economically deprived locality of the borough. The BCF funded services that will contribute to the delivery of this priority include:
  - CNWL's Falls Prevention Service (scheme 1)
  - Telecare Service (scheme 1)
  - Wellbeing Service (scheme 1)
  - Reablement (scheme 3)
  - Homecare (schemes 3 and 4)
  - CNWL's Care Home Support Service (scheme 4)

- A pilot falls staying steady pilot concerning access of older people with frailty accessing exercise and established in 2022/23 will be evaluated to determine whether it should be extended to other parts of the borough. Funding for this provision is contained within the BCF.

- Falling is one of the major causes of hospital admissions from care homes and PHM funding in the BCF is enabling the provision of falls prevention training to care home staff to be provided by CNWL on a train the trainer basis.

- *Developing a whole systems approach to addressing obesity* – Obesity is an established

risk factor for many chronic conditions including diabetes, arthritis and heart failure. 36% of Hillingdon's population live in the Hayes and Harlington locality, which has the highest obesity prevalence in the borough for both the 18 and above population and Year 6. The highest proportion of Hillingdon's Black, Asian and minority ethnic population also live in this locality. PHM funding in the BCF is supporting the development of community champions.

- The BCF funded services that will contribute to the delivery of this priority include:
  - Integrated care programme (scheme 1)
  - Care Connection Teams (scheme 1)
  - Community champions (scheme 1)

- *Improving the health checks programme* – Partners are working together to:
  - Reduce variation of uptake and completion among individual General Practices.
  - Improving access and targeting under-served groups, e.g., people with learning disabilities and people with serious mental illness.
  - Raise the profile of the importance of attending for an NHS Health Checks.
  - Plan the implementation of new technological developments for programme delivery.
  - Address the expansion of eligibility to the 40 to 74 age group to detect early signs of illnesses such as heart disease, stroke, diabetes, and dementia.

- In addition, as all PCNs have high numbers of residents with hypertension, proactively testing for this condition is a priority. Although there is a primary care contract in place to address inequalities that includes hypertension, PHM funding included within the BCF has been directed at opportunistic testing of people with undiagnosed hypertension e.g., community roadshows, blood pressure monitors in libraries and in other community areas such as shopping centres.

- *Delivery of health checks for people with learning disabilities (PLD) to national target:* In 2022/23 81% of people with learning disabilities on GP registers aged 14 and above received an annual health check against the national target during the period of the plan. The BCF funded services that will contribute to the delivery of this priority include:
  - Integrated care programme (scheme 1)
  - Care Connection Teams (scheme 1)
  - Social care staffing (scheme 7)
  - Supported living (scheme 7)
  - PLD CHC case management service (scheme 7)

- *Winter flu vaccination programme*: As in 2022/23, this will be led by the PCNs with support from other HHCP partners and the Council and will target the homeless population and improve uptake in pregnant women in addition to the pre-covid priority groups.

- *Winter Covid booster vaccination programme and care homes:* The aim is that joint working between Primary Care, the Care Home Support Team and the Council's Quality Assurance Team will replicate the success of 2022/23 in respect of the proportion of residents and staff in care homes accepting the booster. The BCF funded services that will support this initiative include:
  - Care Home Support Team (scheme 4)
  - Quality Assurance Team (scheme 4)

- *Developing the children's integrated therapy service model:* This service is intended to

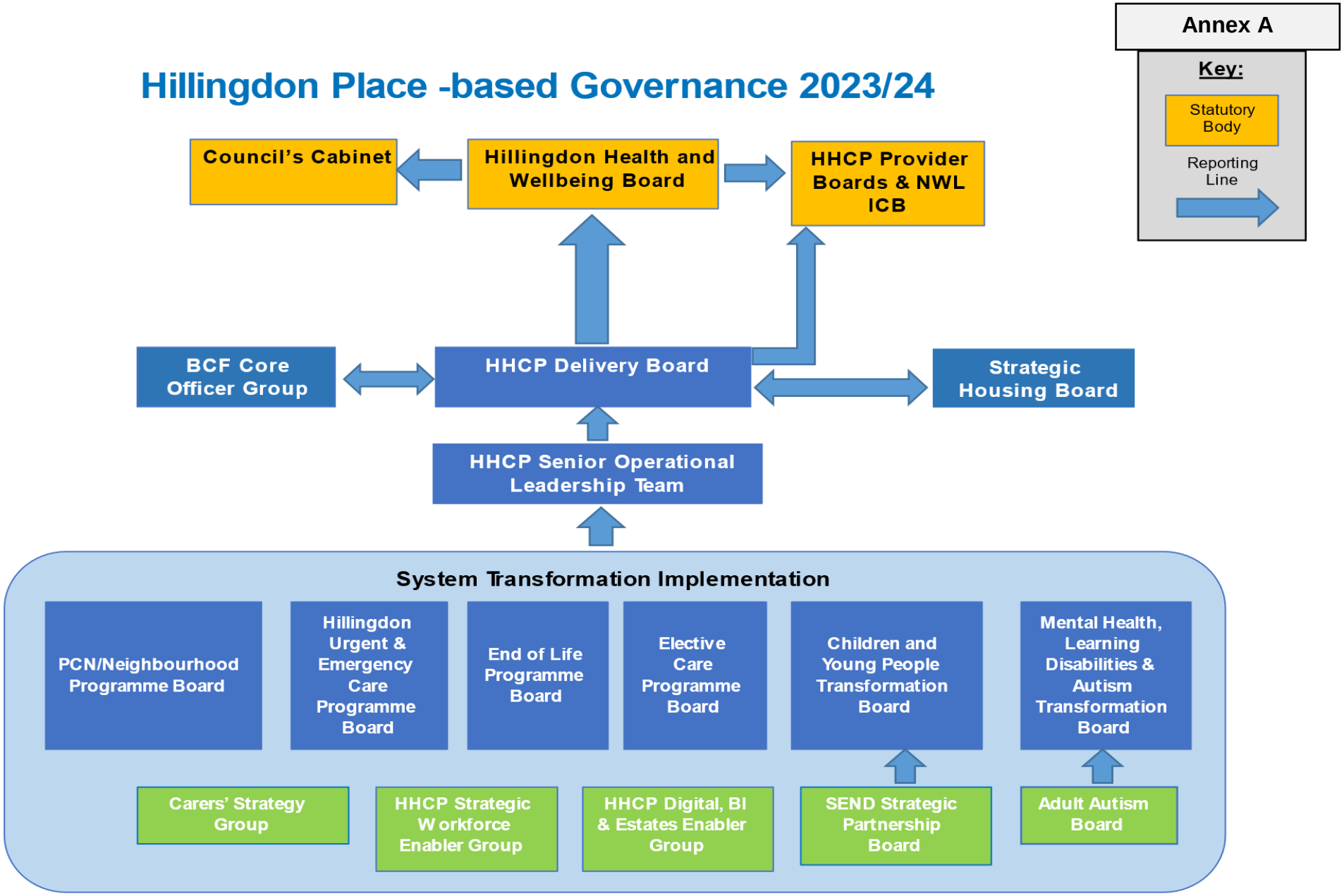
meet the needs of children with Special Education and Development Needs (SEND) aged 0-19 years who live in the borough, or attend a mainstream school, or are registered with a Hillingdon GP. The service is also for people aged 18-25 years attending an education setting in Hillingdon with a special education need who have a Hillingdon GP. This service will be subject to a competitive tender during the lifetime of the plan.

- *Enhancing emotional and wellbeing offer for children and young people:* Based on feedback from young people the availability of face to face 1-1 counselling or Cognitive Behaviour Therapy (CBT) support in a young people friendly environment or approach will be provided and funded via the BCF with PHM funding (scheme 7).

- *Promotion of PHBs and integrated budgets as direct payments*: These give residents greater opportunity to have both greater control over how their needs are met that is more personalised, e.g., directly employing care workers from their own cultural background. However, the reality is that workforce supply issues means that this approach is not without challenges. The BCF funded services that will contribute to the delivery of this priority includes:
  - DP/PHB Team (scheme 4)
  - CHC homecare (scheme 4)

Annex A

Hillingdon Place -based Governance 2023/24

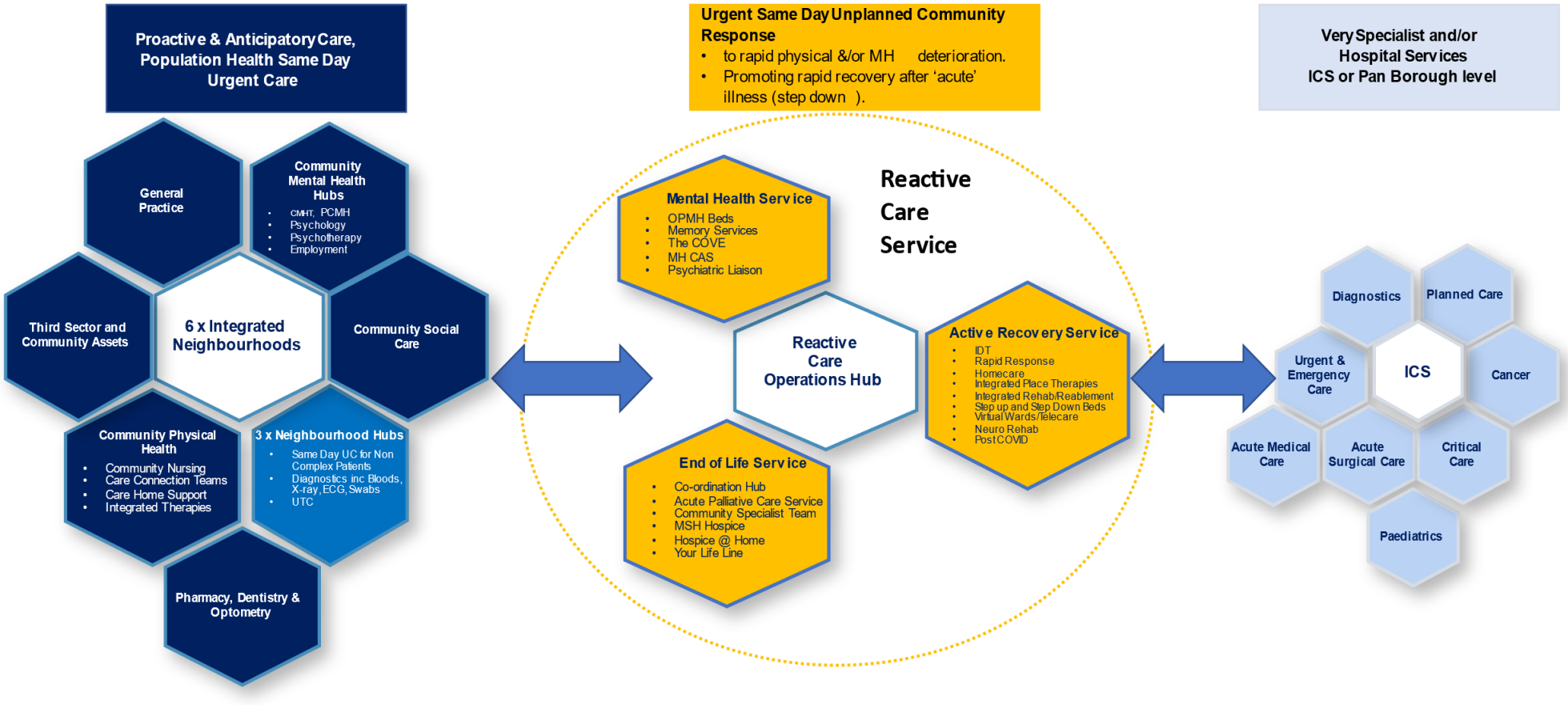


Annex B

Place Based Functions		
Neighbourhoods	**Place**	**Integrated Care System**
Maintaining Whole Population Health and Wellbeing	**Providing Reactive Care**	**Delivering Very Specialist and/or Hospital Services**
• Streamlining same day access to care and advice for people who get ill but only use health services infrequently. • Providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including those with multiple long-term conditions. • Helping people to stay well for longer as part of a more ambitious and joined up approach to population health and prevention.	Services that provide a time limited same day community based response to: • Unplanned rapid physical and/or mental health deterioration in the health of a person with complex needs or multiple long-term conditions to prevent unnecessary hospital admission or an emergency department attendance and/or premature admission to long-term care. • Promote faster recovery from acute (mental) illness to support timely discharge from hospital and maximise independent living.	• Patient safety, i.e., low demand for very specialist care skills or issues of critical mass leading services to be organisation on ICS or pan-borough level.

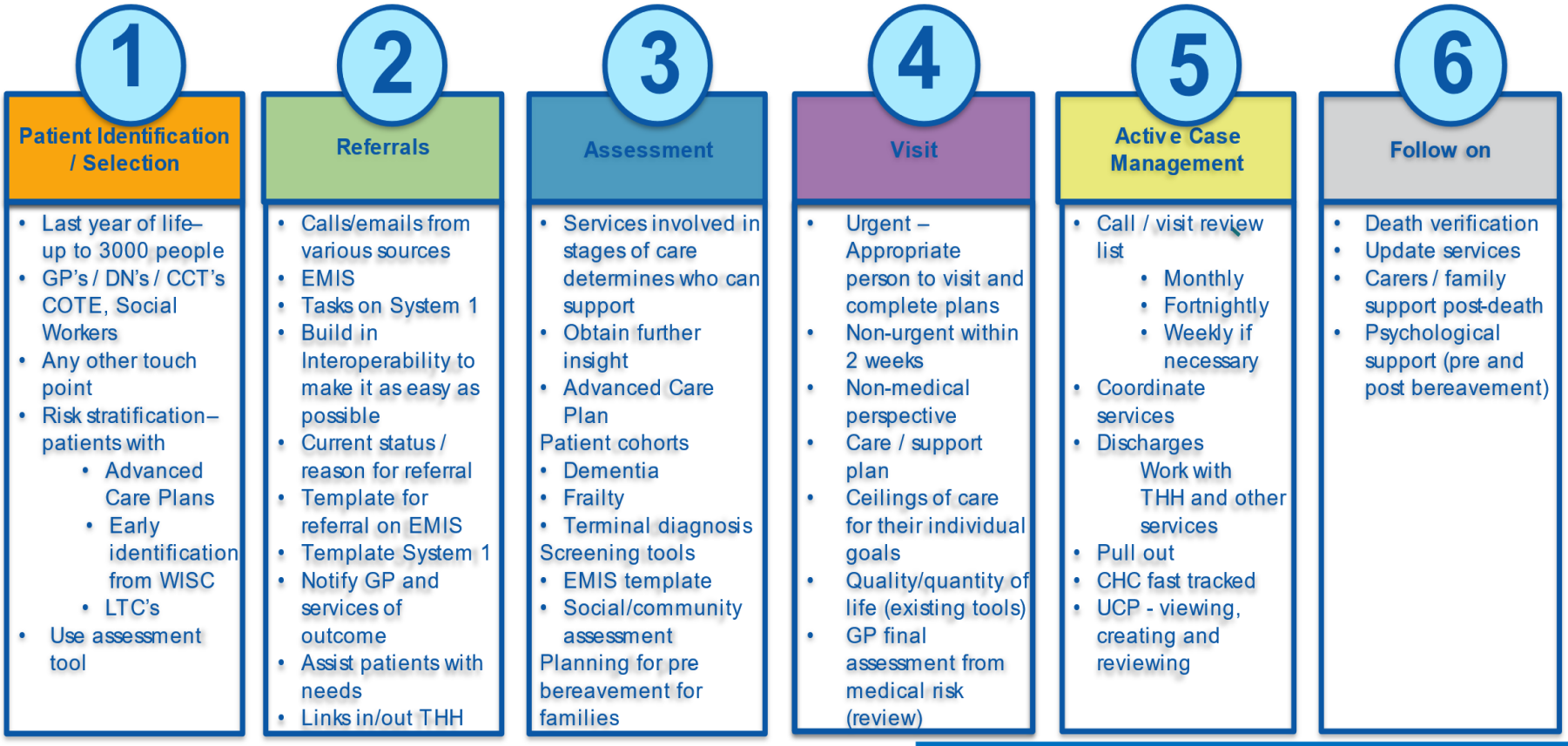
Annex C

Future State Operating Model



End of Life Coordination Hub Operating Model

- For new referrals to initiate care planning and coordinated holistic care.
- Point of contact for ED/GPs/LBH/care homes and others for support if service not known.



HEALTH AND CARE STRATEGY FOR NORTH WEST LONDON

Relevant Board Member(s)	Keith Spencer
Organisation	Hillingdon Health and Care Partners
Report author	Toby Lambert
Papers with report	Appendix A – Summary Document Appendix B – ICS Health and Care Strategy for North West London

1. HEADLINE INFORMATION

Summary	To consider the Health and Care Strategy for North West London.
Contribution to plans and strategies	Joint Health & Wellbeing Strategy
Financial Cost	None
Relevant Select Committee	Health and Social Care Select Committee
Ward(s) affected	N/A

2. RECOMMENDATION

That the Health and Wellbeing Board challenges and comments on the Health and Care Strategy for North West London.

3. INFORMATION

Supporting Information

In common with all Integrated Care Systems, North West London Integrated Care System is required to produce a strategy. This strategy must cover both health and care (i.e., health and relevant local authority services). The NHS and local authorities are required to 'have regard' to the strategy and the strategy must be adopted by the North West London's Integrated Care Partnership. The Partnership brings together local authorities and the NHS across our eight boroughs.

The strategy has taken, as its starting point, the Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies developed for each borough and incorporated resident insights. The strategy aims to highlight where boroughs and the NHS can go further, faster for our residents by working together. It does not attempt to collate everything that each partner in the ICS is doing. For example, the 'shared outcomes' reflect the judgment of the DPHs of the outcomes that could be improved faster by working together. It is structured around the ICS'

programmes, which are the delivery vehicles for the strategy. It informs the one year delivery plans of all the ICS programmes. Priorities for the programmes are then grouped into six cross cutting themes.

The draft strategy was published on 21 May 2023. The Health and Wellbeing Board is asked to challenge and comment on the strategy, in particular, what areas members of the Board believe should be emphasised, amended or removed. Input from all Health and Wellbeing Boards, alongside input from residents, will then be synthesised into the next draft of the strategy.

Appendix A

NHS

North West London

Health and care strategy for North West London

Summary document

Contents

Introduction

We have published a first draft of our health and care strategy for North West London. The strategy is intended to set out our plans for healthcare services across our eight boroughs. This document is a summary of that strategy.

We know:

- that in some areas and communities in NW London people have poorer health than in others.
- the conditions in which we are born, grow, live, work and age can impact our health and wellbeing.
- the waiting times and access for some services and specialist doctors are too long and difficult to get to.
- some conditions, including cancers are being diagnosed too late.

We have plans to improve, but we would like to know what you think of our plans so far and what is important to you.

Your feedback will help us develop our strategy and shape services over the next five years.

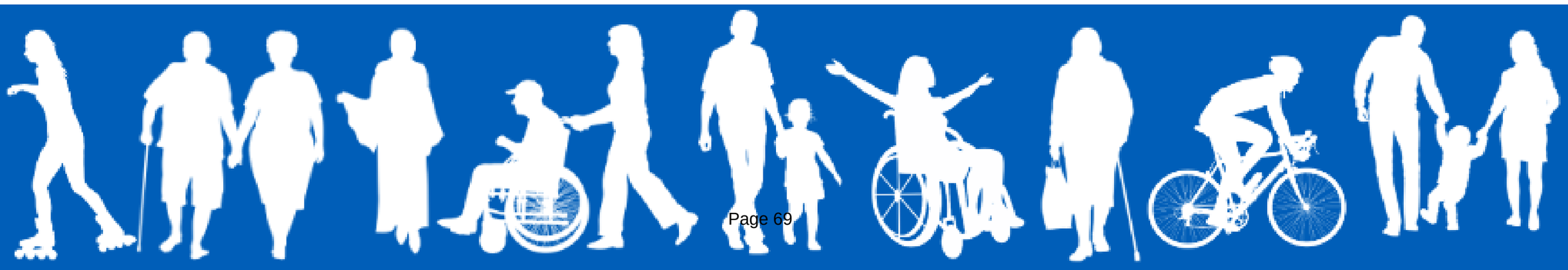
Please do complete our survey about the strategy. All comments will be considered as we develop the final draft.

Complete our survey and share your views

Scan the QR code or use the link to complete the survey and a chance to win £100 voucher

SCAN ME

bit.ly/nwlhealthsurvey



Proactive population health and reducing inequalities

North West London

We know that in some areas and communities in NW London people have poorer health than in others.

The conditions in which we are born, grow, live, work and age can impact our health and wellbeing. Health inequalities are unfair differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them.

We are working to improve the health of everyone in NW London, no matter who they are.

This work involves local people, the NHS, and other public services including councils, schools, housing associations and social services working together. This lets us build services that meet the needs of people in each area, improve people's health, prevent illnesses, and make better use of public resources.

All of our plans have been informed by our ongoing community engagement – you can read our regular insight reports online.

Our plans to reduce inequalities over the next five years include:

- Making sure we have a clear understanding of the health of our population, including the differences between population groups and how many people have health conditions.
- Improving access to care, experience of care and health outcomes for more vulnerable people.
- Working in partnership to improve access to education, training and employment opportunities for our most disadvantaged communities.
- Working with public health partners to keep our communities healthy to reduce high blood pressure, reduce smoking rates, increase healthy weight initiatives and support our youngest residents to have a better start in life.

What are your thoughts?
Are these the right things for us to work on?

Mental health, learning disabilities and autism

North West London

We all have mental health – it's about how you feel on any given day.
If you have a mental health problem, it can impact how you think, feel and behave.

We know that more people, and increasingly younger people, need help and support from mental health services.

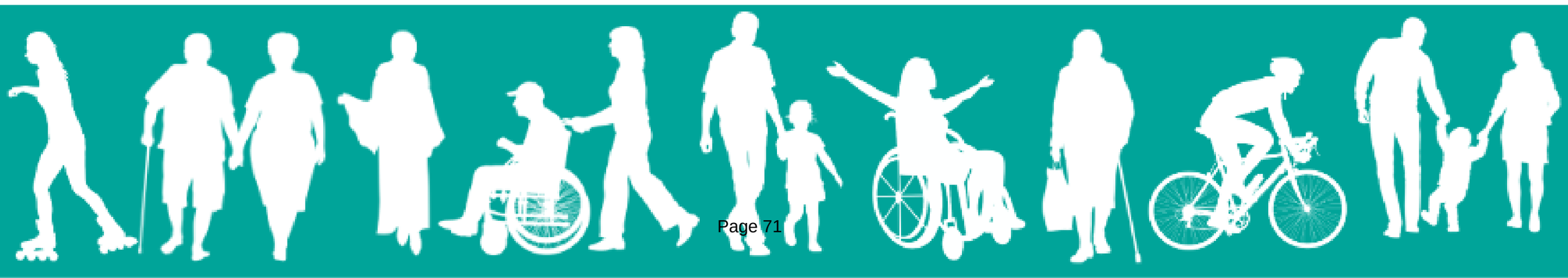
We are working with people who use mental health services and those with learning disabilities and autism, to develop the right support for people and making sure it is in the right place for them.

All of our plans have been informed by our ongoing community engagement – you can read our regular insight reports online.

Our plans over the next five years to improve the mental health outcomes include:

- Putting more mental health support teams in schools.
- Creating more local (non-clinical) spaces for people to access help and support, for example adult community mental health services.
- Continuing to integrate community mental health services (adults and children's) into local 'neighbourhood' teams.
- Continuing to improve community based services for autistic people with learning disabilities to further reduce the reliance on hospital (inpatient) beds.
- Promoting alternatives to A&E for those in crisis, including expanding 24/7 helplines and linking these to 111.
- Providing appropriate therapeutic spaces to support people in crisis.
- Improving communication and support for people waiting for assessment and care.

What are your thoughts?
Are these the right things for us to work on ?



Local care (including primary care)

NHS North West London

This work looks at care and support provided in the community rather than a hospital, including support in your own home.

We will improve access to health and social care teams, including your GP, and develop flexible support that meets the different needs of our diverse communities.

This work covers residents of all ages and supports better care for people who are ‘mostly healthy’ and people with complex and long standing health conditions.

All of our plans have been informed by our ongoing community engagement – you can read our regular insight reports online, and also targeted engagement updates for people with complex needs, such as at the end of life.

Our plans to improve local care over the next five years include:

- Creating ‘neighbourhood’ teams for local communities of roughly 50,000 people with the NHS and local councils working in partnership to support residents with their health and care needs. GP services are at the heart of these ‘neighbourhood’ teams and include other NHS services such as physio or nursing in patient’s own homes.
- Talking to the public about how and where services are provided, and how they can be best accessed, when care ‘on the day’ is needed – including digital and remote support where this works well for individual patients.
- Improving the early planning and the support people receive at the end of their life.
- Identifying earlier when people have a long term condition such as diabetes or hypertension and then making sure the best treatment plan is in place based on what the individual wants.
- When people do need a stay in hospital making sure they return home quickly and safely (including if their home is a care home) with the ongoing support they, and their family or carers, need.

What are your thoughts?
Are these the right things for us to work on ?

Acute care

North West London

This is care that is provided in a hospital. We know that patients are now waiting longer for emergency and planned care.

This work looks at improving access to specialist care and improving how we provide urgent and emergency care such as our A&Es and urgent treatment centres (UTCs).

All of our plans have been informed by our ongoing community engagement – you can read our regular insight reports online.

Our plans to improve acute care over the next five years include:

- Making sure residents have timely access to specialist doctor's expertise whenever they need it.
- Reducing waiting times for surgery.
- Making sure residents have convenient and timely access to diagnostic tests, including x-rays and scans.
- Improving urgent and emergency care to reduce delays.
- Making sure residents experience the same quality of care regardless of where they receive it.

What are your thoughts?
Are these the right things for us to work on ?

North West London

Cancer care

Cancer is an illness which affects many people over their lifetime. There are many different types and it is important that we are able to find out about it early.

We know that there is inequality in people who go for their free NHS cancer screening. Waiting times to see a cancer specialist are also longer than they should be.

All of our plans have been informed by our ongoing community engagement – you can read our regular insight reports online.

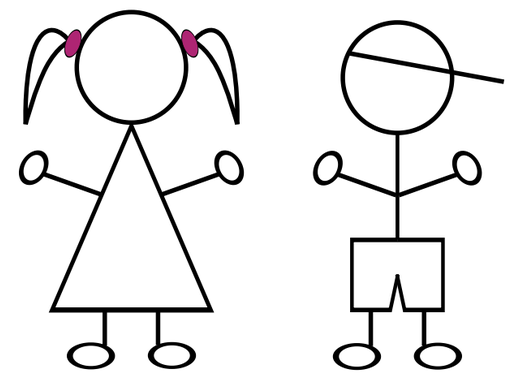
Our plans to improve cancer care over the next five years include:

- Making sure patients are seen within two weeks of a GP cancer referral.
- Finding cancers earlier through education sessions, standardising referrals and developing new interventions.
- Improving health outcomes by improving follow-up care for patients.
- Working with our partners and community groups to encourage residents with possible cancer symptoms to contact their doctor earlier.
- Working with our community to better understand the reasons why some people do not attend free NHS cancer screenings.

What are your thoughts?
Are these the right things for us to work on ?

Babies, children and young people

North West London



We know that there are differences in how healthy children are in NW London.

That can be for many reasons including because of where we are born, live and grow. Children from more deprived backgrounds will often have poorer health and we want to change that.

This work looks at providing support for families in NW London and working with communities to improve the health of our children and young people.

All of our plans have been informed by our ongoing community engagement – you can read our regular insight reports online.

Our plans to improve care for babies, children and young people over the next five years include:

- Developing child health and family hubs and making sure the core services they provide are the same across NW London. These local hubs will be part of 'neighbourhood' teams and provide services from the NHS, local authority and voluntary care services.
- Working with families, children and young people to design services that meet their needs, especially in areas where we see the biggest differences in health.
- Working with Imperial College London and The School of Public Health to use the latest innovations to better care for our patients.
- Working with families to understand the reasons why some are not up to date with vaccinations.
- Improving the health of children's teeth.
- Making sure that families and children will feel listened to and at the centre of making decisions for their care.

What are your thoughts?
Are these the right things for us to work on ?

North West London

Maternity and neonatal

This work looks at the care you and your baby receive during pregnancy.

We know that there is more we can do to improve the experience, quality and safety of care for mothers and partners across our maternity services.

We want to support our midwifery workforce and develop new ways to support mothers and their families in our care.

All of our plans have been informed by our ongoing community engagement – you can read our regular insight reports online.

Our plans to improve maternity and neonatal care over the next five years include:

- Setting up new pre-term birth clinics to help reduce the number of babies born early.
- Supporting staff with improved training opportunities and continuing to recruit new staff into maternity and neonatal services.
- Making maternity and neonatal services more efficient with better use of digital tools for parents and families, for those who can use them e.g the NW London Mum and Baby app.
- Joining services together where it will mean we can better support patients.
- Working with Maternity and Neonatal Voice Partnerships to make sure we have maternity & neonatal champions to be the voice of the patient and support our family.
- Integrating maternity services into family hubs to better support families.
- Working with our communities to understand how midwifery and neonatal services need to be different to support the needs of different groups.
- Prioritising continuity of care for those who will benefit most - Black, Asian and mixed ethnicity women, and women from our most deprived areas of NW London.

What are your thoughts?
Are these the right things for us to work on ?

North West London

Involvement

Hearing from our residents across NW London is so important. We want to have NHS services that work for you and we can't do that without your help.

Our communities want to be listened to and involved in the development of their local health services.

This work looks at how we will work with local people and use their feedback to improve and develop services.

All of our plans have been informed by our ongoing community engagement – you can read our regular insight reports online.

Our plans to involve our local communities over the next five years include:

- Regularly asking 'what matters to you' as we listen to all our communities across NW London.
- Placing as much importance on what we hear from our residents and populations as we do with other data.
- Working with grassroots voluntary sector organisations and residents to build trusted relationships with our communities.
- Designing future plans in partnership with people and communities.
- Empowering people to take control of their own health and increase confidence in managing long term conditions.
- Making sure our residents have a voice in all our work.

What are your thoughts?
Are these the right things for us to work on ?

North West London

Data and digital

Using technology is not something that everyone wants to do, or can do. However, for many people, new technology can support their health - for example to help keep them out of hospital by monitoring and managing health from home.

We know we have work to do to update our IT systems to improve efficiency. This work looks at how we can make better use of technology to support patients and health and care staff, to improve care.

All of our plans have been informed by our ongoing community engagement – you can read our regular insight reports online.

Our plans to further develop our use of digital and data over the next five years include:

- Using new and innovative technologies to improve and support clinical decision making.
- Creating new ways to provide care using advances in technology, for example virtual wards and home monitoring.
- Developing a single dataset of timely, detailed health and care information, that can help clinicians provide the right care and support for patients.
- Developing systems to provide a NW London wide overview and management of demand, capacity and patient flows across hospitals and primary care services.
- Automating advice and guidance from clinical specialists to support GPs with referrals.
- Implementing shared records, so all clinicians supporting the health and care of an individual can see their information.
- Standardising clinical systems across hospitals and care settings, to allow all our hospital systems to talk to each other.
- Reducing the need for patients to repeat information at each appointment.

What are your thoughts?
Are these the right things for us to work on ?

NHS
North West London

Workforce

We know that recruitment and retention of staff in health, is becoming more challenging.

This work looks at how we can better support staff through training and new ways to provide care with new job roles that benefit both staff and patients.

All of our plans have been informed by our ongoing community engagement – you can read our regular insight reports online.

Our plans to improve support for our workforce over the next five years include:

- Creating flexible career pathways across all the organisations within the NW London Integrated Care System.
- Addressing racism and developing inclusive practices and culture.
- Improving staff wellbeing and providing better support.
- Doing things differently - looking at hard to recruit roles and redesigning models of care to make services and roles better for staff and patients.
- Working with primary care and social care to develop joined up workforce plans.
- Making sure effective education and training programmes are in place to deliver future ways of providing care, new roles, and new apprenticeships through a NW London health and care skills academy.

What are your thoughts?
Are these the right things for us to work on ?

North West London

Estates

This looks at the building space we have within NW London. It is everything from hospitals and GP surgeries to local clinics and offices.

We know that some of our buildings are not fit for purpose and that it is not all being used as effectively as it could be.

This work looks at how we can improve environments and better use our spaces to provide care.

All of our plans have been informed by our ongoing community engagement – you can read our regular insight reports online.

Our plans to improve our use of buildings over the next five years include:

- Working together with clinical programs and stakeholders to develop proposals to make estate fit for purpose now and for the future.
- Progressing the developments of two new hospital builds for Hillingdon and Imperial hospitals.
- Making better use of empty spaces and using space efficiently.
- Working together across ICS organisations to use space collectively.
- Reviewing all leases in primary care to better serve local communities through primary care hubs supporting local ‘neighbourhood’ teams.

What are your thoughts?
Are these the right things for us to work on ?

Research & innovation

North West London

We know that there is more we can learn and there are better ways to prevent and diagnose disease earlier.

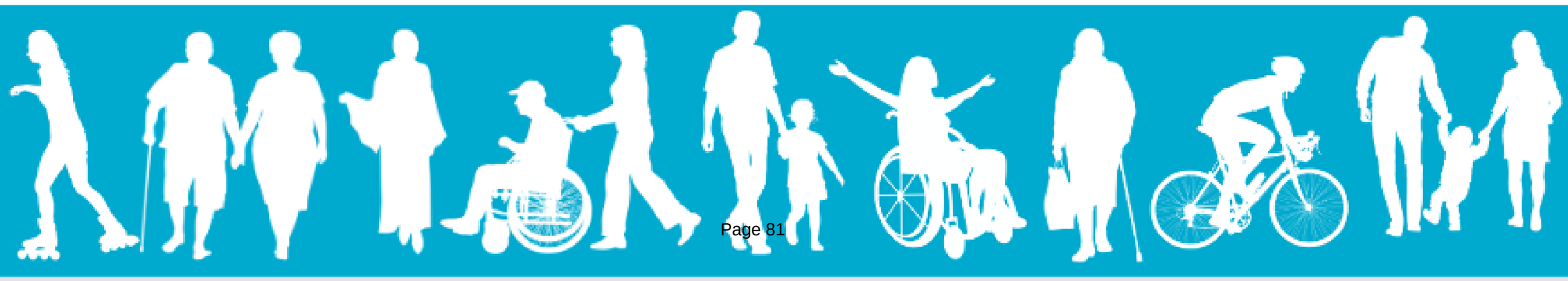
This work looks at how we can improve the health of our patients by being more ambitious with the research we undertake.

All of our plans have been informed by our ongoing community engagement – you can read our regular insight reports online.

Our plans for research and innovation over the next five years include:

- Concentrating our research effort on fewer areas to support the adoption and roll out of new methods of prevention and treatment. These include:
  - Maximising the experience and outcomes for residents with chronic disease, by preventing, diagnosing and better treating patient needs. This work will start by looking at cardiovascular disease.
  - Minimising the harm suffered by patients being in the wrong care setting.
  - Ensuring that children and young adults have the best start in life, with a particular focus on promoting positive mental health.
- Supporting and incentivising how research and innovation works across, and improves the lives of, all our communities in NW London .

What are your thoughts?
Are these the right things for us to work on ?



If you require this document in another language please contact nhsnwl.communications.nwl@nhs.net

Translation requested

Appendix B

North West London Integrated Care System
Working together for better health and care

ICS Health and Care Strategy for North West London

Health & Wellbeing Board - Hillingdon

13th June 2023

Cover note

- In common with all Integrated Care Systems, North West London Integrated Care System is required to produce a strategy
  - The strategy must cover both health and care (i.e., health and relevant local authority services)
  - The NHS and local authorities are required to 'have regard' to the strategy
- The strategy has been prepared for, and must be adopted by, the North West London's Integrated Care Partnership. The Partnership brings together local authorities and the NHS across our eight boroughs
- The strategy has taken, as its starting point, the Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies developed for each borough, and incorporated resident insights
- The strategy aims to highlight where boroughs and the NHS can go further, faster for our residents by working together. It does not attempt to collate everything that each partner in the ICS is doing. For example, the 'shared outcomes' reflect the judgment of the DPHs of the outcomes that could be improved faster by working together
- It is structured around the ICS' programmes, which are the delivery vehicles for the strategy. It informs the one year delivery plans of all the ICS programmes. Priorities for the programmes are then grouped into six cross cutting themes
- The draft strategy was published on 21st May. The Health and Wellbeing Board is asked to challenge and comment on the strategy – in particular, what areas members of the HWB believe should be emphasised, amended or removed
- Input from all HWBs, alongside input from our residents, will then be synthesised into the next draft of the strategy.

North West London Integrated Care System

Strategy engagement – we want to hear from you

Hearing from a wide range of voices throughout communities who will feel the impact of the delivery of the top priorities in health and care services in North West London helps ensure this strategy fits the needs of residents. We want to make sure that resident insight is embedded into the heart of this draft strategy. Insights captured includes the 'what matters to you' outreach, borough collaborative spaces and insight from local authority, Healthwatch and voluntary & community sector colleagues.

- Joining up with local authority engagement on Health and Wellbeing Strategies
- NW London Residents Forum, open to all with an anticipated 200 attendees
- Citizen Panel with access to 3.8k members
- Next Door survey with 600k registered residents

North West London Integrated Care System

Strategy development – why we need a health and care strategy

As we launch the ICS, we have the opportunity to set an exciting vision and strategy for North West London that builds on our achievements to date, and takes advantage of our strengthening collaboration across health and care to improve outcomes for our residents and communities, address long standing inequalities in access, experience and outcomes, level up, improve value for money and deliver wider benefits across North West London.

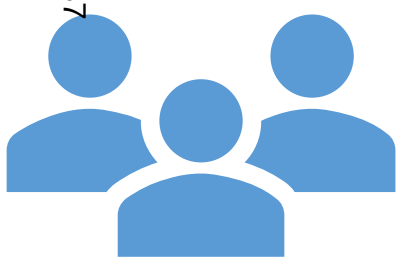
Four objectives of integrated care systems

A	Improve outcomes in population health and wellbeing
B	Prevent ill health and tackle inequalities in outcomes, experience and access
C	Enhance productivity and value for money
D	Support broader economic and social development

North West London Integrated Care System

Strategy development – how we have built on what has gone before using resident insight

Involvement and insights



Joint Strategic Needs Assessment

- Context and needs of NW London
- Case for change

Health and Wellbeing Strategies

- Shared outcomes

Programme and Networks

- Plans
- Actions

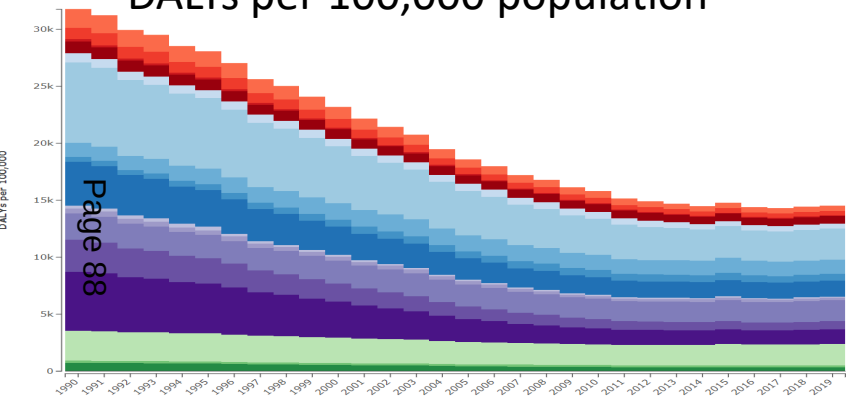
Delivery	Networks	Enablers
• Proactive population health & inequalities • Local care • Mental health, learning disabilities & autism • Acute care	• Cancer • Maternity • Children & young people	• Involvement & Community • Data & Digital • Workforce • Finance & Estates • Research & Innovation

North West London Integrated Care System

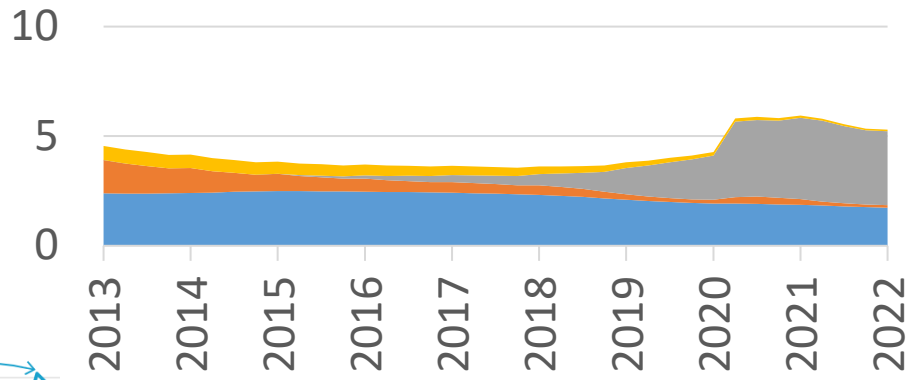
Challenges – areas of concern for NW London

Improvement in health status have appeared to stall, we have an almost record number of people on out of work benefits and the cost of living crisis continues

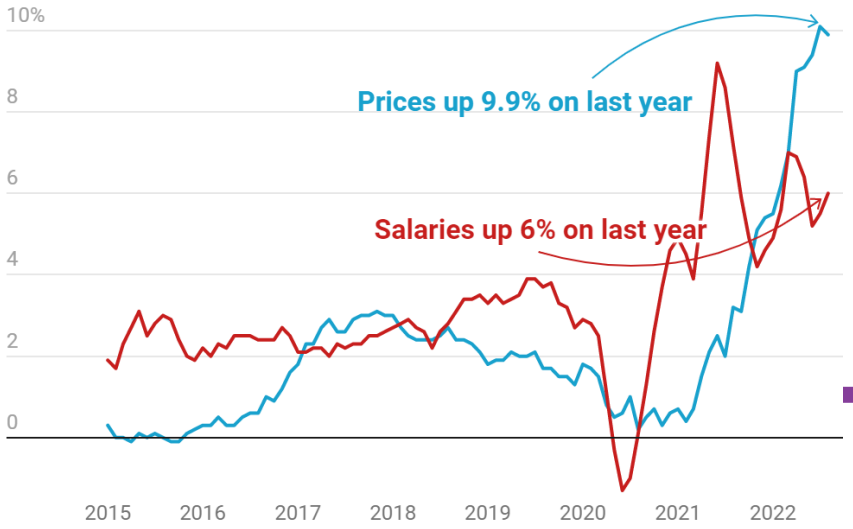
DALYs per 100,000 population



Number on out of work benefits, UK



Inflation vs income

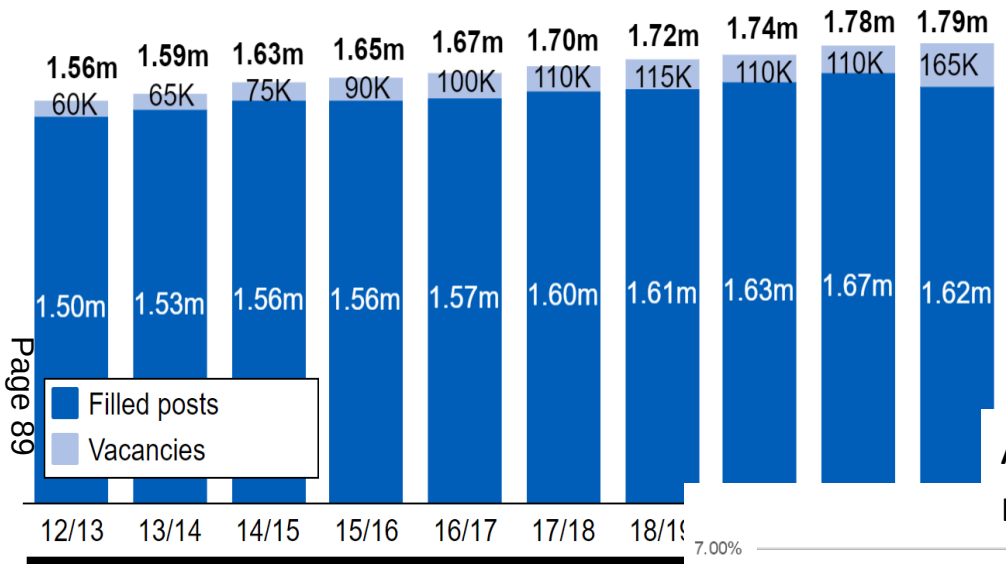


Source: GBD Compare tool, HBAI Stat-Xplore)

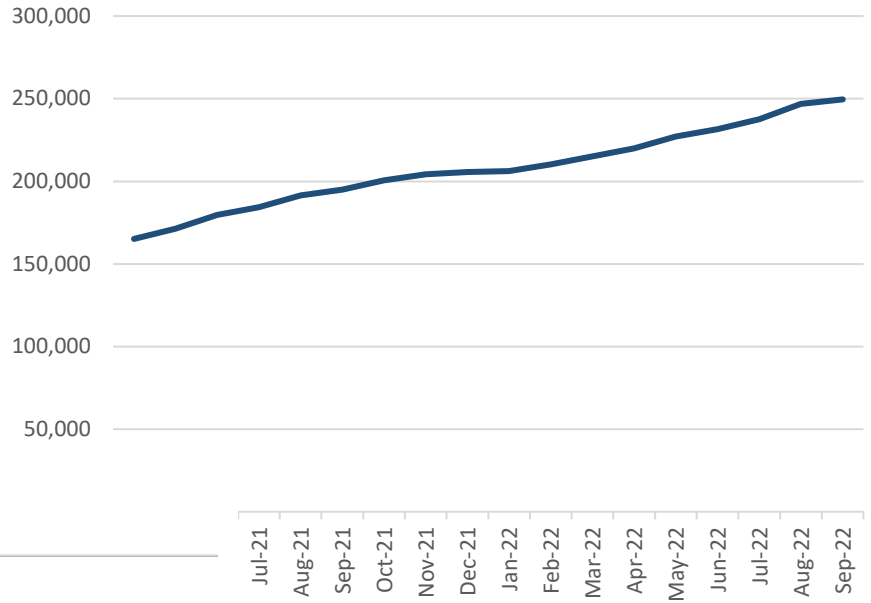
North West London Integrated Care System

Challenges – health and care systems struggling to respond

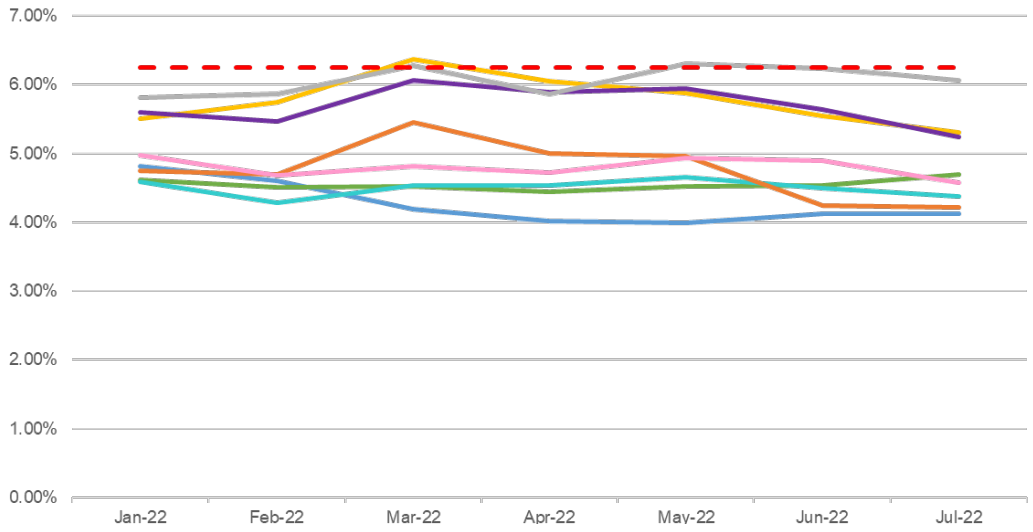
Social care workforce



Elective care - Overall Waiting List



Access rate to mental health care



North West London Integrated Care System

Residents - what residents in NW London communities are telling us

Inpatient services

Top 3 inpatient services*	
Hospital planned surgery	52%
Cancer services	44%
Orthopaedic services	42%

Bottom 3 inpatient services*	
Long terms conditions care	48%
Mental health services	45%
A&E inpatient	40%

Outpatient services

Top 3 Outpatient community services*	
Ophthalmology services	61%
Dental NHS services	60%
Cancer services	53%

Bottom 3 Outpatient community services*	
Mental health services	51%
Long term conditions care	39%
A&E outpatients	37%

12% said they found it very easy to book an NHS appointment

45% indicated that they found it very difficult to book an NHS appointment

81% indicated that they were treated equally by the NHS

19% indicated that they were not treated equally

Top 3 % = Very good and good combined ratings
Bottom 3 % = Very poor and poor combined ratings
~
Data from Citizen Panel (3.8k membership) '*what matters to you*' survey

* Respondents were asked to pick their three top/ bottom inpatient and community services
Source: Citizens panel 'what matters to you' survey

North West London Integrated Care System

Outcomes – how we've developed this draft framework

FOR COMMENT

Health and social care services in North West London will focus on the needs of the individual to promote their health and wellbeing, in particular to enable people to live healthier lives in their communities.

- Reducing inequalities is a golden thread across everything that we all do in North West London.
- The outcomes framework, drawn up by the Directors of Public Health and the Integrated Care Board,
  - Focuses on those areas where LAs and NHS working together can go further and faster in delivering for our residents (it is not intended to cover everything each partner is doing)
  - Starts from the Professor Marmot's *Fair Society, Health Lives* (The Marmot Review)

Six areas in Fair Society, Healthy Lives

A. Give every child the best start in life

B. Enable all children, young people and adults to maximise their capabilities and have control over their lives

C. Create fair employment and good work for all

D. Ensure healthy standard of living for all

E. Create and develop healthy and sustainable places and communities

F. Strengthen the role and impact of ill health prevention

Framework – suggested outcomes against the health equity framework

A. Give every child the best start in life

- Identify inequalities by reviewing ethnic breakdown indicators, including:
  - Neonatal mortality and still birth rate
  - Smoking status at time of delivery
  - Vaccination uptake
  - Maternal mortality
  - Breastfeeding at 6-8wks post birth

B. Enable all children, young people and adults to maximise their capabilities and have control over their lives

- Drug &Alcohol and substance misuse in under 18
- Increased community participation rates. Reduction in mental health, problem drug use, offending and antisocial behaviour rates
- Levels of overweight and obesity in CYP at Reception and Year 6

C. Create fair employment and good work for all

- Gap in the employment rate between those with a physical or mental long- term health condition and the overall employment rate
- Gap in the employment rate for adults known to MH services v overall adult population
- Adult social care vacancy and retention rates below or equal to averages for benchmarking group of councils

D. Ensure healthy standard of living for all

- Households in temporary accommodation
- Food insecurity - percentage of households experiencing food insecurity

E. Create and develop healthy and sustainable places and communities

- Reduced gradients in ill health associated with social isolation and adverse impacts of travel e.g. Pollution, and accidents

F. Strengthen the role and impact of ill health prevention

- Patients are referred to appropriate health promotion, support and education services:
- Improve secondary prevention outcomes for patients with diabetes
- NHS Health Checks
- The rate of unplanned hospitalisations per 100,000 by neighbourhood by ethnic group
- Admissions for alcohol related condition
- Smoking prevalence
- Proportion of people with mental health condition receiving a physical health check
- Density of fast food outlets
- Decayed missing or filled teeth in under 5s

Focuses on those areas where LAs and NHS working together can go further and faster in delivering for our residents

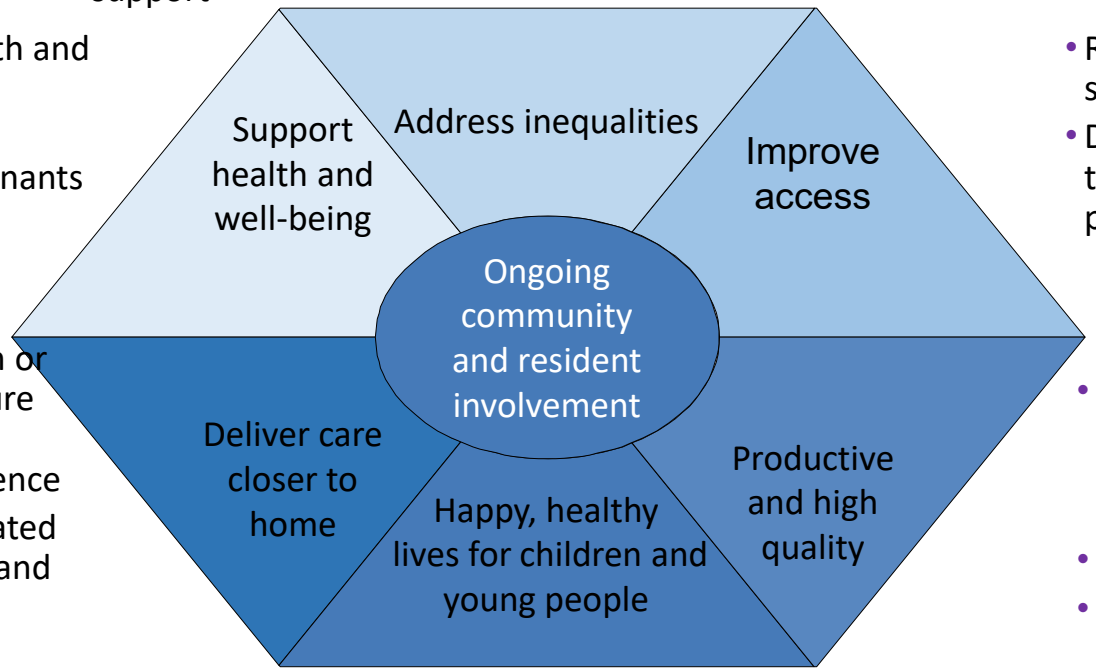
*Not intended to cover **everything** each partner is doing*

Emerging headlines – with example priorities

WORK IN PROGRESS

- Focus resource and differentiate the offer for groups experiencing poor outcomes, for example Black women and childbirth
- Build confidence in our communities to come forward for care and support

- Improve access to employment in the health and care system for our residents
- Utilise the strength of borough based partnerships to focus on the wider determinants and inequalities



- Rationalise channels for simple urgent care and streamline access
- Develop/ roll out Integrated neighbourhood teams to bring community mental health, primary community and social care

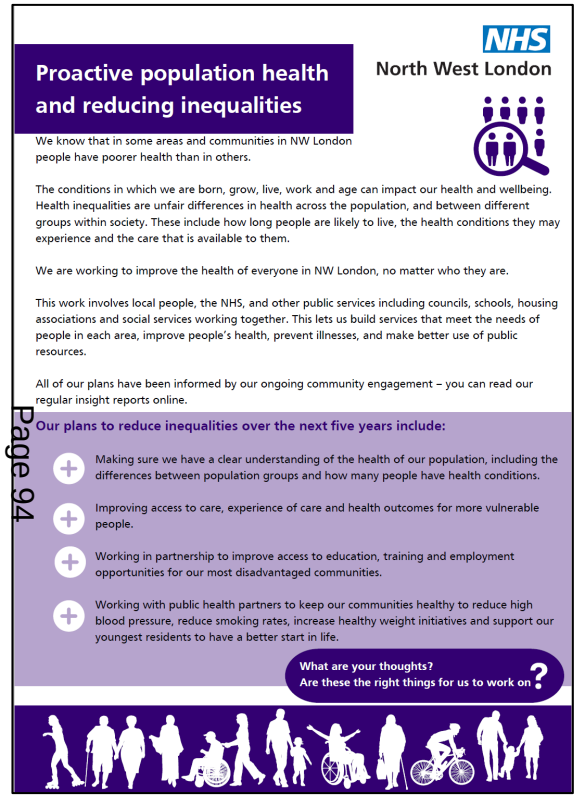
- Identify people who have an ongoing health or care need, with a care plan in place, to ensure they receive continuity of care and as much treatment as feasible in their place of residence
- Work with social care to develop the integrated health and care approach to avoid hospital and care home admissions and support patients moving from hospital to home care

- Continue to develop innovative and cost effective models of care, starting with cardiovascular, cancer and children's mental health
- Develop workforce transformation plans
- Ensure that our estate is fit for purpose

- Develop consistent, 'right person first time' core models of care for children and young people
- Expand access to mental health support

North West London Integrated Care System

Engagement – the one page summaries capture actions by programme



NHS North West London

Proactive population health and reducing inequalities

We know that in some areas and communities in NW London people have poorer health than in others.

The conditions in which we are born, grow, live, work and age can impact our health and wellbeing. Health inequalities are unfair differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them.

We are working to improve the health of everyone in NW London, no matter who they are.

This work involves local people, the NHS, and other public services including councils, schools, housing associations and social services working together. This lets us build services that meet the needs of people in each area, improve people's health, prevent illnesses, and make better use of public resources.

All of our plans have been informed by our ongoing community engagement – you can read our regular insight reports online.

Our plans to reduce inequalities over the next five years include:

- Making sure we have a clear understanding of the health of our population, including the differences between population groups and how many people have health conditions.
- Improving access to care, experience of care and health outcomes for more vulnerable people.
- Working in partnership to improve access to education, training and employment opportunities for our most disadvantaged communities.
- Working with public health partners to keep our communities healthy to reduce high blood pressure, reduce smoking rates, increase healthy weight initiatives and support our youngest residents to have a better start in life.

What are your thoughts? Are these the right things for us to work on?

NHS North West London

Mental health, learning disabilities and autism

We all have mental health – it's about how you feel on any given day. If you have a mental health problem, it can impact how you think, feel and behave.

We know that more people, and increasingly younger people, need help and support from mental health services.

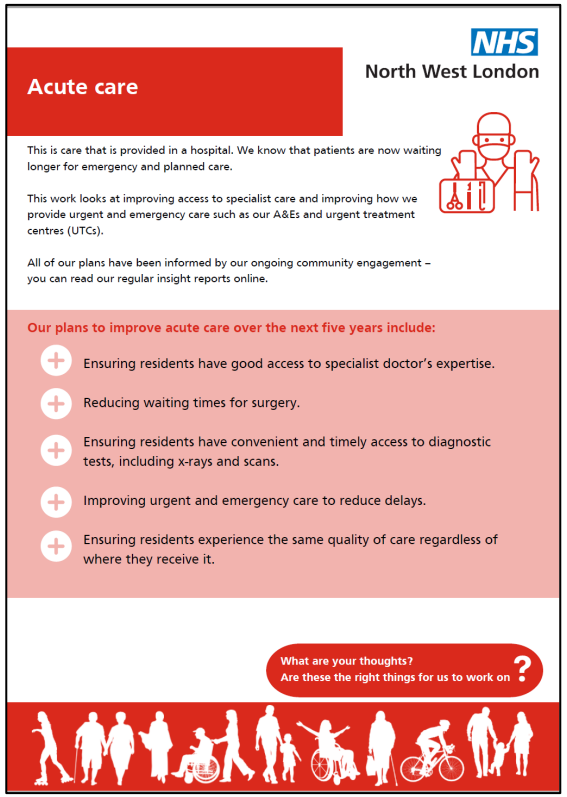
We are working with people who use mental health services and those with learning disabilities and autism, to develop the right support for people and making sure it is in the right place for them.

All of our plans have been informed by our ongoing community engagement – you can read our regular insight reports online.

Our plans over the next five years to improve the mental health outcomes include:

- Putting more mental health support teams in schools.
- Creating more local (non-clinical) spaces for people to access help and support, for example adult community mental health services.
- Continuing to integrate community mental health services (adults and children's) into local 'neighbourhood' teams.
- Continuing to improve community based services for autistic people with learning disabilities to further reduce the reliance on hospital (inpatient) beds.
- Promoting alternatives to A&E for those in crisis, including expanding 24/7 helplines and linking these to 111.
- Providing appropriate therapeutic spaces to support people in crisis.
- Improving communication and support for people waiting for assessment and care.

What are your thoughts? Are these the right things for us to work on?



NHS North West London

Acute care

This is care that is provided in a hospital. We know that patients are now waiting longer for emergency and planned care.

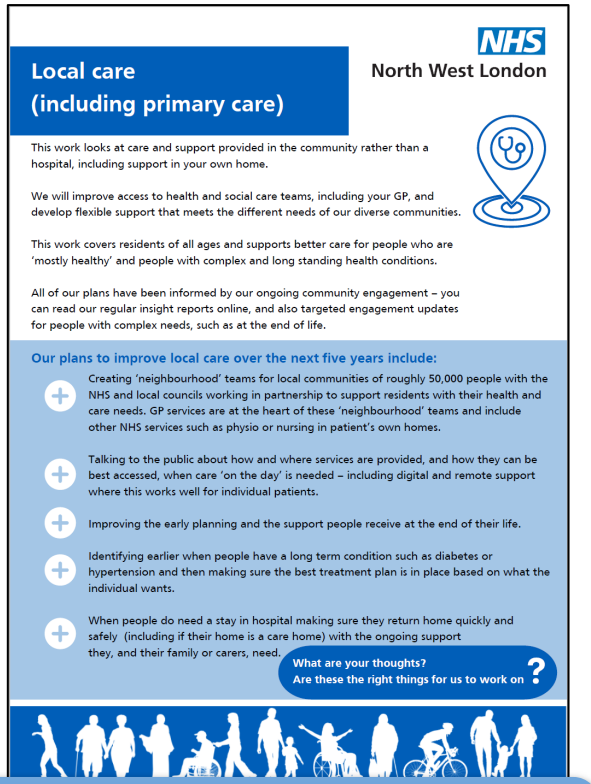
This work looks at improving access to specialist care and improving how we provide urgent and emergency care such as our A&Es and urgent treatment centres (UTCs).

All of our plans have been informed by our ongoing community engagement – you can read our regular insight reports online.

Our plans to improve acute care over the next five years include:

- Ensuring residents have good access to specialist doctor's expertise.
- Reducing waiting times for surgery.
- Ensuring residents have convenient and timely access to diagnostic tests, including x-rays and scans.
- Improving urgent and emergency care to reduce delays.
- Ensuring residents experience the same quality of care regardless of where they receive it.

What are your thoughts? Are these the right things for us to work on?



NHS North West London

Local care (including primary care)

This work looks at care and support provided in the community rather than a hospital, including support in your own home.

We will improve access to health and social care teams, including your GP, and develop flexible support that meets the different needs of our diverse communities.

This work covers residents of all ages and supports better care for people who are 'mostly healthy' and people with complex and long standing health conditions.

All of our plans have been informed by our ongoing community engagement – you can read our regular insight reports online, and also targeted engagement updates for people with complex needs, such as at the end of life.

Our plans to improve local care over the next five years include:

- Creating 'neighbourhood' teams for local communities of roughly 50,000 people with the NHS and local councils working in partnership to support residents with their health and care needs. GP services are at the heart of these 'neighbourhood' teams and include other NHS services such as physio or nursing in patient's own homes.
- Talking to the public about how and where services are provided, and how they can be best accessed, when care 'on the day' is needed – including digital and remote support where this works well for individual patients.
- Improving the early planning and the support people receive at the end of their life.
- Identifying earlier when people have a long term condition such as diabetes or hypertension and then making sure the best treatment plan is in place based on what the individual wants.
- When people do need a stay in hospital making sure they return home quickly and safely (including if their home is a care home) with the ongoing support they, and their family or carers, need.

What are your thoughts? Are these the right things for us to work on?

These are included in the papers circulated for the meeting, and available on the ICB's website at: https://www.nwlondonicb.nhs.uk/about-us/nw-london-health-and-care-strategy

Feedback – Where you can read more and let us know your thoughts

Read more and feedback

www.nwlondonicb.nhs.uk/about-us/nw-london-health-and-care-strategy

Contains:

- Intro
- Link to the summaries
- Link to the easy read (*coming soon*)
- Link to the full draft strategy
- Link to a feedback form

Give us your views

Please do complete our survey about the strategy. Not only will you be helping to shape the future of health and care in NW London but you could win a £100 voucher!

We will be talking to local residents, health and care staff, Healthwatch and the voluntary and community sectors during May and June to seek feedback, challenge and discussion on the strategy. We appreciate that the draft strategy is wide-ranging, and so to support engagement we have produced single page summaries for each programme's strategic objectives. There will also be a North West London Residents Forum (open to everyone), where local people will be invited to discuss and comment on our plans. We would encourage local people to join this virtual meeting, which will be advertised in due course.

If you have additional comments or questions about it, please email nhsnwl.communications.nwl@nhs.net. All comments will be considered as we develop the final draft.

Read the full strategy | Read the summary | Complete the survey

North West London Integrated Care System

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HILLINGDON TOBACCO CONTROL: IMPLEMENTING SMOKEFREE 2030

Relevant Board Member(s)	Councillor Jane Palmer Kelly O'Neill Interim DPH
Organisation	London Borough of Hillingdon
Report author	Viral Doshi
Papers with report	The Hillingdon Tobacco Control Strategic plan

HEADLINE INFORMATION

Summary	This report provides an update on: 1. The renewed commitment from the Government on Tobacco Control. 2. The Hillingdon Tobacco Control Strategic plan 2023 – 2026. 3. A call for action in Hillingdon to refocus and prioritise stop smoking to reduce the long-term morbidity and smoking related mortality inequalities. 4. To agree the Hillingdon Tobacco Control Strategy and Plan.
Contribution to plans and strategies	The Joint Health and Wellbeing Strategy HHCP Delivery and Health Protection Boards
Financial Cost	N/A
Ward(s) affected	All

RECOMMENDATIONS

That the Health and Wellbeing Board notes:

1. **Stopping smoking is the single most effective modifiable health intervention to reduce disparities in health across populations and has a societal and economic impact.**
2. **The ASH data tool states that the adult smokers in Hillingdon generate a cost pressure of £107.1 million pounds annually on the economy that equates to a cost pressure of £7.6M on health services, productivity, £94.0M, social care, £3.9M and house fires, £1.6M.**
3. **That the evidenced based review led by Dr Javed Khan (published June 2022) identifies 4 critical interventions to deliver a Smokefree 2030; a target that fewer than 5% of the population will smoke by that date.**
4. **That Health and Wellbeing Board Members, Hillingdon's Health and Care leaders work with Public Health to ensure that stop smoking as a health inequalities intervention is prioritised and agree the Tobacco Control Plan and support implementation.**

INFORMATION

Tobacco smoking remains the leading cause of preventable illness and premature death in England[1]. Almost 7 million people still smoke in England and smoking is one of the largest drivers of health disparities and disproportionately impacts our most disadvantaged families and

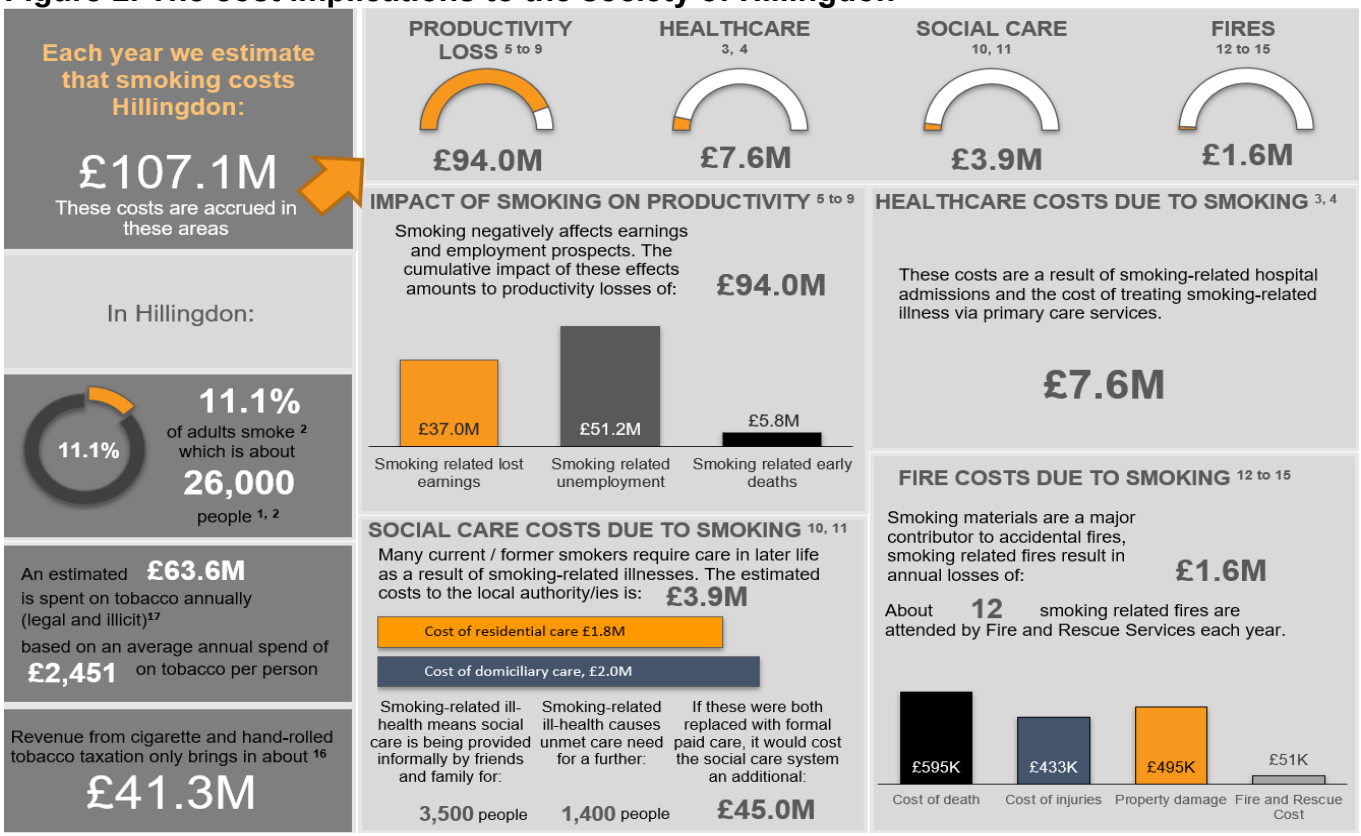
communities[2].

Tobacco control is an internationally recognised, evidence-based intervention to tackle the harm caused by tobacco[3]. Comprehensive tobacco control is more than just providing local stop smoking services or enforcing smokefree legislation; it's about reducing the burden of disease, disability and death related to tobacco use[4].

The harmful effects of tobacco on the health of an individual and those around them are widely acknowledged[5]. However, there is reduced awareness of the significant impact and cost to the local economy that further aggravates the burden imposed by tobacco use.

The ASH data tool[6] shown in the figure 1 below – May 2023, states that the adult smokers in Hillingdon generate a cost pressure of £107.1 million pounds annually on the economy e.g. (Healthcare – £7.6M, productivity - £94.0M, social care - £3.9M, House fires - £1.6M).

Figure 1: The cost implications to the society of Hillingdon



Source: Action on Smoking and Health

The independent, evidenced based review led by Dr Javed Khan, published on 9th June 2022[7] assessed the government's current tobacco control policies[8] and identified the most impactful interventions for tackling the health disparities associated with tobacco use. The Review recommended 15 actions (4 of which critical) for the Government to include in the new Tobacco Control plan to deliver a Smokefree 2030, the target that only 5% of the population will smoke by that date.

Khan review, 4 Critical Recommendations nationally are to:

1. Urgently invest an additional £125 million per year into a comprehensive Smokefree 2030 programme. A tobacco industry Levy is a preferred option to generate funds.

2. Raise the age of sale of tobacco from 18, and raise this by one year, every year until no one can buy tobacco products in this country (similar to the New Zealand model).
3. Offer vaping as a substitute for adults who smoke, alongside training all healthcare professionals to provide accurate information on the benefits of switching, prevent uptake by young people, reduce the attractiveness of branding, packaging, and flavouring.
4. Embed prevention as part of the NHS' DNA. To reduce the £2.4 billion that smoking costs the NHS every year, the NHS must deliver on its commitments in the Long-Term Plan by doing more, offering smokers advice and support to quit at every interaction they have with health services, through GPs, hospitals, psychiatrists, midwives, pharmacists, dentists or optometrists. The NHS should invest to save, committing resource for this purpose.

Ministerial speech: Achieving Smokefree 2030: Cutting Smoking and Stopping young people Vaping.

Following the Khan Review, on 11th April 2023, the Public Health Minister[9], confirmed Government would be:

- Rolling out a national "Swap to Stop" scheme to support 1 million adult smokers to quit smoking by switching from cigarette smoking to vaping. This scheme will initially target at-risk and high smoking prevalence groups.
- Offering financial incentives to all pregnant women who smoke by the end of 2024.
- Investing £3m in a comprehensive enforcement package to tackle illicit tobacco and underage (below 18 years of age) vape sales including:
    - A commitment to close a loophole that allows retailers to give free samples of vapes to children[10].
    - Reviewing rules around the sale of nicotine free vapes to under 18s and fines for shops selling illicit vapes.
    - Increasing education and dedicated school police liaison officers to keep illegal vapes out of schools.
- Opening a call for evidence on youth vaping.
- Announcing that at a minimum, all mental health practitioners will be able to signpost to specially developed digital resources to support people with mental health problems to quit smoking.
- Backing joined up working between the NHS and local authorities to support smokers to quit, facilitated by Integrated Care Boards.
- Consulting on the introduction of mandatory pack inserts with messages and information to help smokers quit.

NOTE: A study[11] from King's College London demonstrated that standardising e-cigarette (vape) packaging, by removing brand imagery, is associated with a decrease in vapes appeal among teenagers without reducing appeal to adults. This is a vital difference, as it means that vapes can still appeal to adult smokers as a tool to stop smoking. Currently e-cigarette packaging has eye catching, colourful and enticing designs.

The Hillingdon Tobacco Control Strategic plan document (attached)

This plan sets out an ambition to work towards a 'smokefree' Borough by 2030. Through collaboration and local partnerships and requires a shared commitment to deliver this plan and focus on tobacco control in an effort to make Hillingdon a healthier and safer place to live.

The plan is in 3 sections:

SECTION 1: The smokefree strategy and delivery plan:

This provides a comprehensive review of the health risks of cigarettes and different products, making recommendations for how collectively Hillingdon Health and Care Partnership (HHCP) implement the recommendations, weighting resources to those groups most vulnerable to the health risks of smoking, to improve health outcomes and reduce the burden of ill-health and associated health and care costs associated with smoking.

The recommendations are to:

- Reduce overall smoking prevalence.
- Reduce exposure to second-hand smoke.
- Tackle illicit tobacco sales.
- Tackle the underage sale of cigarettes and e-cigarettes to reduce the risk of young people smoking at a younger age.
- Target groups that are more vulnerable to the health risks from smoking.
- Reduce the promotion of tobacco that results from communication and marketing.
- Contribute to the national challenge of health risk incurred at every stage of the tobacco supply chain; the environmental consequences, deforestation, use of fossil fuels and the illegal disposal of waste products into the natural environment; post consumption, cigarette butt littering that represents a public nuisance and exerts hazardous and toxic effects on the environment and ecosystems.

NOTE: The long-term risks of vaping are not yet understood, consequently whilst the use of e-cigarettes is agreed by public health experts as an effective harm-reduction intervention, it is indicated for use ONLY for those adults ALREADY smoking and who wish to stop smoking. E-cigarettes must not be seen as an alternative to smoking for people, especially non-smokers under the age of 18.

SECTION 2: Tobacco control strategy for Hillingdon:

The strategy focuses on the implementation of evidence-based activities to reduce overall smoking prevalence inspiring a smoke free generation by 2030.

The vision is to reduce tobacco related harms and protect health across the resident population, focusing on those groups who are most vulnerable.

The objectives are to reduce uptake of tobacco, and tackle the smoking-related health inequalities in the Borough by reducing smoking prevalence amongst:

- Children and young people under 18 years.
- Pregnant women, targeting support after childbirth, for new mothers and their partners.
- Residents with mental ill-health including those people with substance misuse needs.
- Residents with disabilities and long-term conditions.
- Residents employed in routine and manual occupations.

Comprehensive Tobacco Control requires strategic decision-making support form a wide range of partners with varied expertise to collaborate and engage at different levels.

SECTION 3: Setting up the Hillingdon Tobacco Control Alliance:

The formation of the Tobacco Control Alliance in Hillingdon will be the means through which we bring together agencies as a whole systems partnership approach to address tobacco control,

smoking prevention and cessation. The Alliance will oversee the Hillingdon Tobacco Control Strategy and annual action plans in line with local, regional and national policy. The Alliance terms of reference includes actions that reduce:

- Illicit tobacco.
- Second Hand Smoke.
- Smoking and mental Health.
- Smoking in Pregnancy.
- Smokeless and Niche Tobacco Products such as E-Cigarettes, Shisha and smokeless tobacco.
- Smoking Cessation Service.

The overall objective is to ensure that education is delivered, and legislation is being followed and leads to an increase in uptake into the stop smoking service from the priority groups.

Summary

The strategic delivery plan demonstrates that we need to build on the commitment of statutory and voluntary sector organisations in Hillingdon to work together to achieve these ambitions for improving health in the borough and tackling the single biggest health disparity. By implementing smokefree 2030 the outcome is that smoking no longer affects the health of our population, and together we tackle the inequalities in healthy life expectancy caused by smoking.

THERE ARE CURRENTLY NO FINANCIAL IMPLICATIONS

BACKGROUND PAPERS

- Joint Health and Wellbeing Strategy, 2022 – 2025
- Hillingdon Tobacco Control Strategic plan, 2023 - 2026

References:

[1] NHS Digital - Statistics on Smoking, England 2020 – NHS - https://digital.nhs.uk/data-and information/publications/statistical/statistics-on-smoking/statistics-on-smoking-england-2020

[2] The health of people from ethnic minority groups in England | The King's Fund (kingsfund.org.uk)

[3] PDF download: A Comprehensive Guide to Achieving Effective Local Tobacco Control: Evidence, Support & Publications Developed by the Tobacco Control National Support Team.

[4] PDF download: Healthy Lives, Healthy People: A Tobacco Control Plan for England

[5] https://www.gov.uk/government/publications/smoking-and-tobacco-applying-all-our-health/smoking-and-tobacco-applying-all-our-health

[6] https://ash.org.uk/resources/view/ash-ready-reckoner

[7] https://www.gov.uk/government/publications/the-khan-review-making-smoking-obsolete

[8] https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england

[9] https://www.gov.uk/government/speeches/minister-neil-obrien-speech-on-achieving-smokefree-2030-cutting-smoking-and-stopping-kids-vaping

[10] https://www.gov.uk/government/news/no-more-free-vapes-for-kids

[11] https://www.kcl.ac.uk/news/standardised-packaging-on-vapes-reduces-appeal-to-teenagers

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HILLINGDON
LONDON

THE HILLINGDON TOBACCO CONTROL STRATEGIC PLAN

2023 – 2026

NAME	JOB TITLE AND ORGANISATION	ACTION
Viral Doshi	Public Health Officer. London Borough of Hillingdon.	Lead Author
Kelly O'Neill	Interim Director of Public Health. London Borough of Hillingdon.	Peer Review
Shikha Sharma	Consultant in Public Health, London Borough of Hillingdon.	Peer Review

TABLE OF CONTENTS

The London Borough of Hillingdon
Tobacco Control Strategic Plan
2023 - 2026

EXECUTIVE SUMMARY.

This plan sets out our ambition to work towards a 'smokefree' Borough by 2030. Through collaboration and local partnerships, we call for a shared commitment to deliver this plan and focus on tobacco control in an effort to make Hillingdon a healthier and safer place to live.

The plan is divided into **3 sections**:

Section 1 sets out here our smokefree strategy and delivery plan and provides a comprehensive review of the health risks of cigarettes and different products, making recommendations for how collectively Hillingdon Health and Care Partnership (HHCP) implement the recommendations, weighting resources to those groups most vulnerable to the health risks of smoking, to improve health outcomes and reduce the burden of ill-health and associated health and care costs associated with smoking.

The recommendations are to:

- Reduce overall smoking prevalence.
- Reduce exposure to second-hand smoke.
- Tackle illicit tobacco sales.
- Tackle the underage sale of cigarettes and e-cigarettes to reduce the risk of young people smoking at a younger age.
- Target groups that are more vulnerable to the health risks from smoking.
- Reduce the promotion of tobacco that results from communication and marketing.
- Contribute to the national challenge of health risk incurred at every stage of the tobacco supply chain; the serious environmental consequences, including deforestation, the use of fossil fuels and the dumping or leaking of waste products into the natural environment; the post consumption, cigarette butt littering that represents not only a public nuisance and exerts hazardous and toxic effects on the environment and ecosystems.

Section 2 recommends a tobacco control strategy for Hillingdon including the implementation of evidence-based activities to reduce overall smoking prevalence inspiring a smoke free generation by 2030.

The vision is to reduce tobacco related harms and protect health across the resident population, focusing on the most vulnerable.

The objectives are to reduce uptake of tobacco, and tackle the smoking-related health inequalities in the Borough by reducing smoking prevalence amongst:

- Children and young people under 18 years.
- Pregnant women, targeting support after childbirth, for new mothers and their partners.
- Residents with mental ill-health including those people with substance misuse needs.
- Residents with disabilities and long-term conditions.
- Residents employed in routine and manual occupations.

Comprehensive Tobacco Control requires strategic decision-making support form a wide range of partners with varied expertise to collaborate and engage at different levels.

Section 3 presents action points for the Hillingdon Tobacco Control Alliance members to implement. This includes actions on:

- Illicit tobacco.
- Second Hand Smoke.
- Smoking and mental Health.
- Smoking in Pregnancy.
- Smokeless and Niche Tobacco Products such as E-Cigarettes, Shisha and smokeless tobacco.
- Smoking Cessation Service.

The overall objective is to ensure that education is delivered, and legislation is being followed. Also, we want to see an increase in uptake into the stop smoking service from the priority groups.

In summary, the strategic delivery plan demonstrates the commitment of statutory and voluntary sector organisations in Hillingdon to work together to achieve our ambition; that smoking no longer affects the health of our population, and together we tackle the inequalities in healthy life expectancy caused by smoking.

The formation of the Tobacco Control Alliance in Hillingdon will be the means through which we bring together agencies as a whole systems partnership approach to address tobacco control, smoking prevention and cessation. The Alliance will oversee the Hillingdon Tobacco Control Strategy and annual action plans in line with local, regional and national policy.

1. BACKGROUND AND CONTEXT.

Tobacco control is an internationally recognised, evidence-based intervention to tackle the harm caused by tobacco[1]. Comprehensive tobacco control is more than just providing local stop smoking services or enforcing smokefree legislation; it's about reducing the burden of disease, disability and death related to tobacco use[2].

The harmful effects of tobacco on the health of an individual and those around them are widely acknowledged. However, there is reduced awareness of the significant impact and cost to the local economy that further aggravates the burden imposed by tobacco use[3].

This Tobacco control strategic plan brings together local partner expertise through the formation of a Tobacco Control Alliance that will focus on specific work areas, which will:

- Reduce overall smoking prevalence.
- Reduce exposure to second-hand smoke.
- Tackle illicit tobacco sales.
- Tackle the underage sale of cigarettes and e-cigarettes that consequently aims to reduce the risk of young people smoking at a younger age.
- Target groups that are more vulnerable to health risk from smoking; pregnant women, people who experience severe mental health.
- Reduce the promotion of tobacco as a result of communication and marketing.
- Contribute to the national challenges that are a result of every stage of the tobacco supply chain; the serious environmental consequences, including deforestation, the use of fossil fuels and the dumping or leaking of waste products into the natural environment. Post consumption, cigarette butt littering represents not only a public nuisance but are exerting hazardous and toxic effects on the environment and ecosystems where they end up[4].

1.1 National Context.

In May 2021, Professor Sir Chris Whitty, England's Chief Medical Officer, noted that "by the end of last year at least as many and probably more people will have died of smoking-related disease than of COVID-19."[5] For most people that smoke, no other aspect of their life will impact their health as significantly. Smoking prematurely kills half of all long-term users,[6] on average cutting ten years from a person's life.[7] Quality of life is also affected – for every person killed by smoking, another 30 are living with serious smoking related illness.[8]

Smoking harms nearly every organ of the body and dramatically reduces both quality of life and life expectancy. Smoking causes lung cancer, respiratory and heart disease as well as cancers in other parts of the body including the lips, mouth, throat, bladder, kidney, stomach, liver and cervix. About half of all lifelong smokers will die prematurely, losing on average about 10 years of life.

In 2020, tobacco smoking accounted for 74,600 deaths a year in England[9] and killed more people than the following preventable causes of death combined [10]:

- Obesity (34,100)
- Alcohol (6,669)
- Road traffic accidents (1,850)
- Illegal drugs (1,605)
- HIV infection (504)

The Secretary of State for Health and Social Care has set out a commitment to upscale smoking prevention in the NHS Long Term Plan[11]. The NHS Long Term Plan identifies the contribution the NHS can make to tackling tobacco dependence, especially for hospital inpatients, pregnant women and long-term users of mental health services and by focusing on these groups, in time, this will bring new opportunities for reducing local inequalities in smoking prevalence.

Scale of the challenge.

Tobacco smoking remains the leading cause of preventable illness and premature death in England[12]. Almost 7 million people still smoke in England and smoking is one of the largest drivers of health disparities and disproportionately impacts our most disadvantaged families and communities[13].

Smoking accounts for half the difference in life expectancy between the richest and poorest in society. Research on 15,000 UK adults found that the relative mortality rate of smokers in the highest socioeconomic group was (211%), significantly higher than non-smokers in the lowest socioeconomic group (43%), and the general population[14].

The adverse health outcomes of smoking are not impacting communities equally; there are significant differences in rates of smoking across the country. Whilst smokers from the most deprived communities are as likely to want and try to quit, they are significantly less likely to succeed. To tackle the health and wealth inequity, the government must tackle the crippling burden that smoking has on the most disadvantaged communities.

The impact of smoking is clear:

- Approximately one third of adult tobacco consumption is by people with a current mental health condition and 26 % of people with long term mental health conditions are smokers.
- Approximately 10% of pregnant women smoke at the time of giving birth. Smoking in pregnancy increases the risk of stillbirth, miscarriage, and sudden infant death syndrome. Children of parents who smoke are almost 3 times likely to take up smoking.
- People in routine and manual occupations are 2.5 times more likely to smoke than people in other occupations.
- In 2019, a quarter of all cancers were connected to smoking.
- Smokers are 36% more likely to be admitted to hospital and on average, need social care when they are 63 years old, ten years earlier than non -smokers.
- During the pandemic there was an increase of smoking prevalence from 25% to 30% amongst young adults (18- to 24-year-olds) smoking.
- There is a stark correlation between smoking rates and deprivation and as the cost-of-living crisis increases, the impact for smokers will be considerable. The average smoker spends £38 pounds each week (around £2000 per year) on tobacco products

and quitting could restore thousands of pounds to household budgets across the country, an estimated £11.4bn overall.

- Making smoking obsolete in England would lift approximately 2.6 million adults and 1 million children out of poverty.

1.2 Towards a Smokefree Future by 2030

The independent, evidenced based review led by Dr Javed Khan, published on 9th June 2022[15] assessed the government's current tobacco control policies[16] and identified the most impactful interventions for tackling the health disparities associated with tobacco use. The Review recommended actions for the Government to include in the new Tobacco Control plan to deliver a Smokefree 2030 to be published later this year.

In 2019, the government set the objective for England to be smokefree by 2030[17], the target that only 5% of the population will smoke by that date. The current reduction of smoking prevalence is 0.5% per year and the review concludes that at this current rate, England will miss the smokefree 2030 target by at least 7 years, with the poorest areas not achieving smokefree until at least 2044[18].

To meet the smokefree 2030 target there must be a 40% acceleration to the rate of decline of people who smoke. If there is not a significant immediate change in action, by 2030 another half a million people will die due to smoking.

The review is calling for an ambitious, realistic target to:

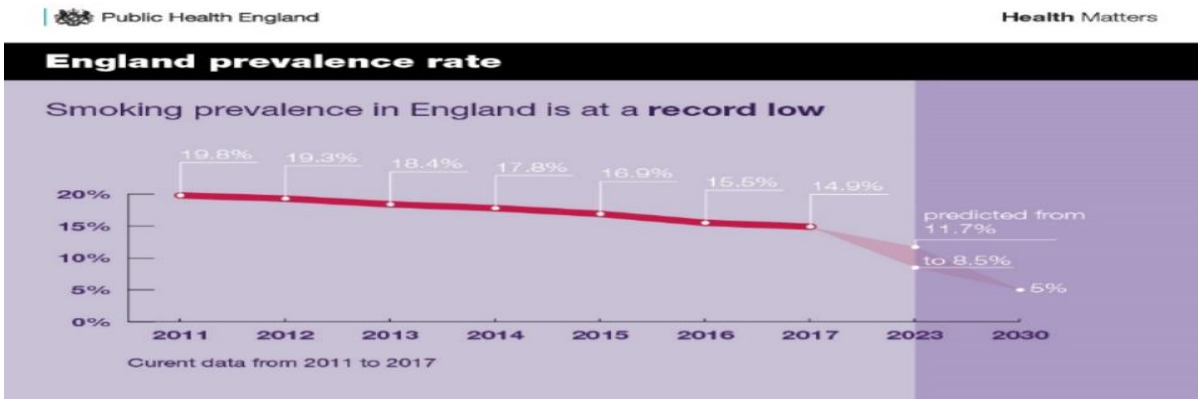
- Ensure that smoking prevalence in every community in every area is below 5% by 2030 – 2035.
- Drive a new ambition to make smoking obsolete by 2040.

Figure 1 below demonstrates that since 2011, there has been a steady decline in smoking prevalence in England. This has been achieved through historical commitments that have now been implemented[19]. These Included:

- The standardised packaging of tobacco which came into effect on 20th May 2016.
- A ban on the sale of cigarettes from vending machines in October 2011.
- A ban on the display of tobacco products at point of sale which came into force on the 6th of April 2015[20].

The recommendations of the Khan review focus on further commitments to achieve a 5% prevalence by 2035.

Figure 1: National Prevalence Rate.

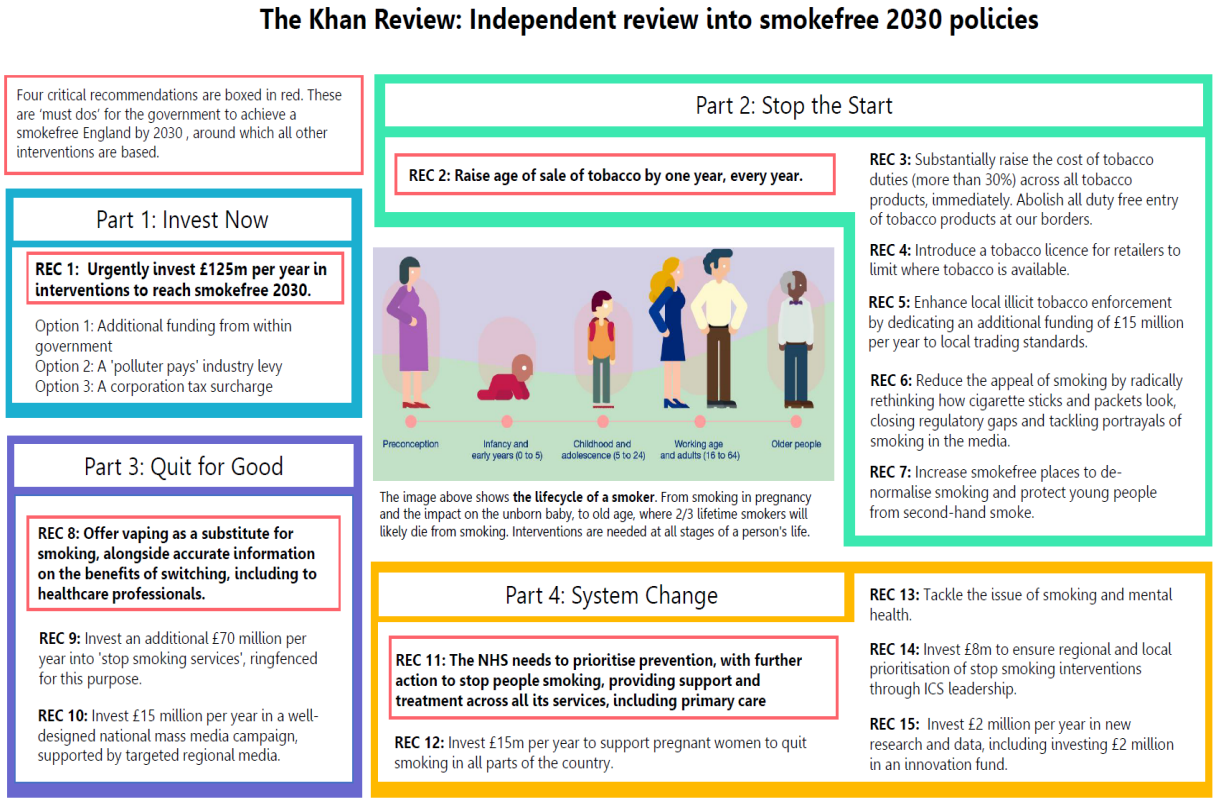


Source: Public Health England

Key messages in The Khan Review:

The Review makes 15 recommendations, of which 4 are referred to as a 'critical Interventions' and 'must dos' for the Government to meet the Smokefree 2030 target.

Figure 2: Making smoking obsolete: A visual summary of recommendations[21]



Khan review Recommendations:

1. **Critical Intervention:** Urgently invest an additional £125 million per year into a comprehensive Smokefree 2030 programme. A tobacco industry Levy is a preferred option to generate funds.

2. **Critical Intervention:** Raise the age of sale of tobacco from 18, and raise this by one year, every year until no one can buy tobacco products in this country (similar to the New Zealand model).

3. **Critical Intervention:** Offer vaping as a substitute for smoking, alongside training all healthcare professionals to provide accurate information on the benefits of switching, prevent uptake by young people, reduce the attractiveness of branding, packaging, and flavouring.

4. **Critical Intervention:** Prevention must become part of the NHS's DNA. To reduce the £2.4 billion that smoking costs the NHS every year, the NHS must deliver on its commitments in the Long-Term Plan by doing more, offering smokers advice and support to quit at every interaction they have with health services, through GPs, hospitals, psychiatrists, midwives, pharmacists, dentists or optometrists. The NHS should invest to save, committing resource for this purpose.

5. Substantially raise the cost of tobacco duties for all tobacco products.

6. Introduce a tobacco license for retailers. Ban supermarkets and online sales of tobacco products.

7. Invest £15M per year to enhance local illicit tobacco enforcement.

8. Reduce the appeal of smoking through tackling positive portrayal in the media and how cigarette sticks, and packs should look:

Figure 3: Cigarette sticks with health warnings – Smoking Kills!

9. Increase smokefree places to denormalise smoking and protect young people from second-hand smoke.

10. Invest an additional £70M per year to provide high quality stop smoking services.

11. Invest £15M per year into mass media campaigns and targeted regional media.

12. Tackle the issue of smoking and mental health.

13. Invest £8M per year to ensure regional and local prioritisation of stop smoking through ICS leadership.

14. Invest £2M per year into new research and data to provide a better understanding of the health impact of shisha, chewed tobacco and the prevalence of vaping among school age children.

15. Invest £15M per year to support pregnant women to quit and offering financial incentives which have shown 2.5 times more likely to quit[22].

Conclusions from the Khan Review.

Whilst there has been considerable success in reducing smoking rates overall, the annual rate of decline is now minimal. If there is no change in the way England tackles smoking, there will be over half a million smoking associated deaths by 2030.

Alongside the emotional impact, the cost to society is considerable and estimated to be billions of pounds. The benefits of making smoking obsolete are massive; overall positive

impact on population health, social or economic benefits, and tackling inequalities; the impact will be significant on the poorest, most deprived families and communities who suffer the most from smoking and its effects. The government's levelling up ambitions cannot be fully delivered without tackling smoking and by implementing the four critical interventions listed in the recommendations. Exponential gains in reducing health disparities can be achieved.

Ministerial speech: Achieving Smokefree 2030: Cutting Smoking and Stopping young people Vaping.

Following the Khan Review, on 11th April 2023, the Public Health Minister[23]:

- Confirmed the government will be rolling out a national "Swap to Stop" scheme to support 1 million adult smokers to quit smoking by switching to vaping. This scheme will initially target at-risk and high smoking prevalence groups[24].
- Pledged to offer financial incentives to all pregnant women who smoke by the end of 2024.
- Confirmed the government will be investing £3m in a comprehensive enforcement package to tackle illicit tobacco and underage vape sales:

    - a commitment to closing a loophole that allows retailers to give free samples of vapes to children[25].
    - reviewing rules around the sale of nicotine free vapes to under 18s and fines for shops selling illicit vapes.
    - increased education and dedicated school police liaison officers to keep illegal vapes out of schools.

- Confirmed the government will be opening a call for evidence on youth vaping.
- Announced as a minimum, all mental health practitioners will be able to signpost to specially developed digital resources to support people with mental health problems to quit smoking.
- Stated the government will be backing joined up working between the NHS and local authorities to support smokers to quit, facilitated by Integrated Care Boards.
- Announced a government consultation on the introduction of mandatory pack inserts with messages and information to help smokers quit.

1.3 Tobacco Control Priorities.

Hillingdon Health and Care Partnership recognises that tackling smoking and tobacco use has a considerable overall impact on residents' health and wealth. By reducing the prevalence of smoking we collectively reduce the economic burden that smoking has on health and care services and support commissioners and providers of services working together through the Tobacco Control Alliance to implement targeted action that tackles the disparities in health experienced by vulnerable population groups who smoke. Our strategic plan will address:

1.3.1 Illicit Tobacco.

Illicit Tobacco described as not having had the duty paid through smuggled or illegally produced products[26] has a serious impact on our ambition to be smokefree.

Illicit tobacco can be categorised under four key types:

- **Smuggling:** The unlawful movement of tobacco products from one jurisdiction to another, without applicable tax being paid.

- **Counterfeiting:** Illegal manufacturing of an apparently lawful and well-known product with 'trademarks' but without consent.

- **Bootlegging:** Legally bought tobacco purchased in one country and transferred to a country with a higher tax rate, in an amount beyond personal use allowances.

- **Illegal Manufacturing:** Tobacco products that are manufactured without declaration to the relevant authorities.

Illicit tobacco is often sold to under-age young people. It is an offence to sell tobacco products to anyone under the age of 18. It is also an offence for an adult to buy tobacco on behalf of someone under 18. The sale of loose cigarettes is illegal[27].

Within the UK in 2016 standardised packaging was implemented, to help law enforcement and other agencies with identifying counterfeit and illicit tobacco[28]. The most commonly employed tobacco industry argument against the introduction of standardised ("plain") packaging of cigarettes and other tobacco products is that it would lead to an increase in illicit trade. However, the key security features on existing packaging that help identify illicit products will also be present on standardised packaging, specifically: a covert mark on each illicit pack, which can be read by enforcement authorities using a simple scanner to determine whether or not a pack is counterfeit.

1.3.2 Second-hand Smoke (SHS).

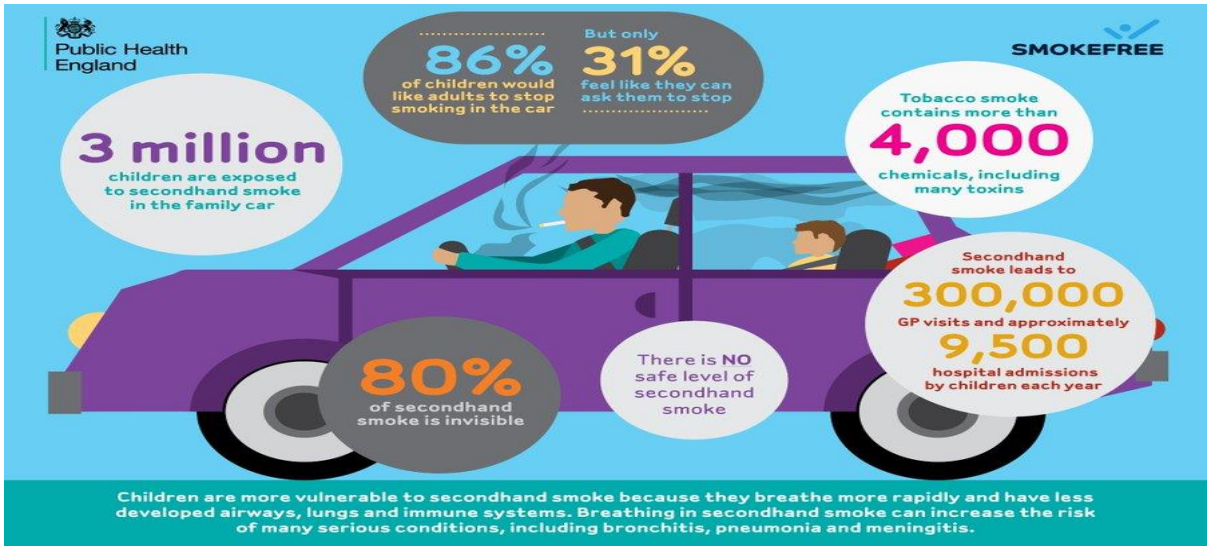
The White Paper, '*Smoking Still Kills[29]'* presents the picture that children and young people are on the front line of the smoking epidemic. Every year, tens of thousands of infants, children and young people are harmed by tobacco[30]; exposed to second-hand smoke in homes and cars over, which they have little control[31].

Breathing in other people's cigarette smoke is called passive, involuntary or second-hand smoking. SHS, also called "environmental tobacco smoke" comprises of "side stream" smoke from the burning tip of the cigarette and "mainstream" smoke which is smoke that has been inhaled and then exhaled by the smoker[32].

The particulates in tobacco smoke include tar. Some of these have marked irritant properties and there are more than 50 cancer-causing chemicals in SHS. This smoke has a devastating effect on young children whereby and exposure increases the risk of, glue ear, asthma and other respiratory disorders, including emphysema later in life and sudden infant death syndrome (SIDS)[33] which is the sudden and unexpected death of a healthy baby.

Research has highlighted significant risks to babies associated with SHS exposure in pregnant women. These include low birth weight, congenital anomalies, smaller head circumferences and increased risk of still birth[34].

Figure 16: The effects of SHS.



Source: Public Health England

Youth smoking: 80% per cent of all adult smokers started smoking before they were 20 years old[35]. People who start smoking at a young age have higher age-specific rates for all types of tobacco related cancers. Young smokers are also exposed to more short and long term respiratory symptoms than their non-smoking peers, such as coughing, wheezing and phlegm. Smoking aggravates asthma symptoms in those already diagnosed and increases the risk of asthma in young people with no history of the condition. It can also lead to impaired lung growth in children and young adults**.**

Evidence shows that children and young people aged 11 to 16 years who smoke can also become dependent on cigarettes, showing signs of addiction within four weeks of starting to smoke. It has even been suggested that smoking a single cigarette is a risk indicator of becoming a regular smoker up to three years later[36].

Starting smoking is associated with a wide range of risk factors including: the ease of obtaining cigarettes, smoking by peer group, socioeconomic status, tobacco marketing, smoking in films, television, and other media**.**

Children who live with parents or siblings who smoke are up to 3 times more likely to become smokers themselves than children of non-smoking households**.** There is a strong association between smoking and other substance use, including alcohol. Young people who truant from school or who had been excluded are twice as likely to smoke regularly compared to those who had never been truant or excluded[37]**.**

1.3.3 Smoking and Mental Health.

Smoking rates amongst people with a severe mental health condition and those who misuse alcohol and drugs is significantly higher than the general population and there is a strong association between smoking and mental health conditions[38].

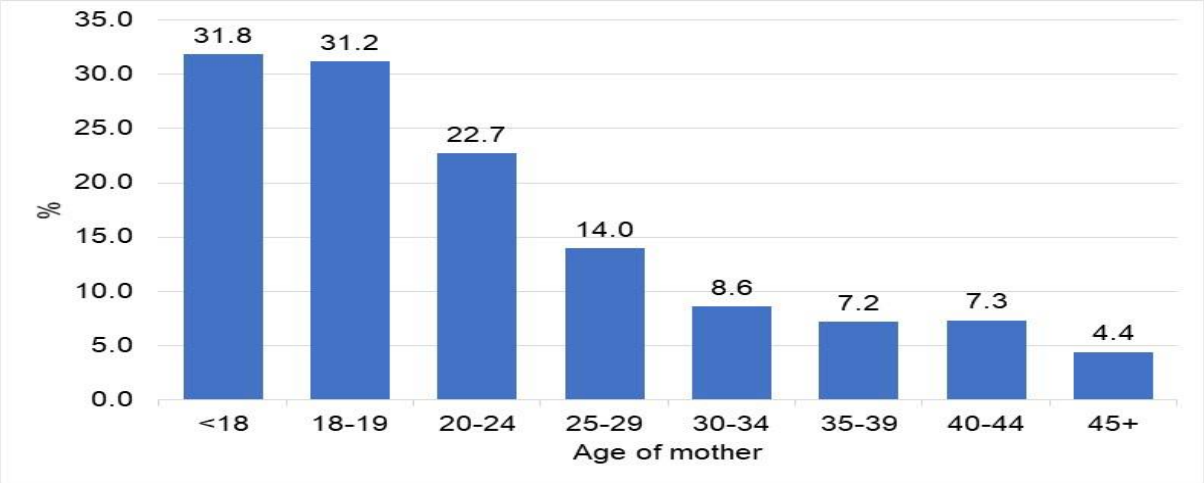
Many vulnerable smokers wish to stop smoking, and this can be achieved with appropriate support. People with mental ill-health need good access to stop smoking services aimed at improving health.

1.3.4 Smoking in pregnancy.

Smoking can affect the health of pregnant women, the unborn child and the health of young children in the family[39].

Smoking during pregnancy is higher amongst routine and manual socio-economic groups and contributes to inequalities in childbirth morbidity and mortality. Smoking in early pregnancy is prevalent in all age groups, **Figure 21**, especially below 18 years to 24 years groups.

Figure 21: Age distribution of women smoking in early pregnancy



Effects of smoking during pregnancy[40]: Smoking even one cigarette exposes the mother and baby to over 4,000 chemicals and means less oxygen and important nutrients can reach the baby through the placenta. If a pregnant woman smokes or is exposed to smoke, there will be increased levels of the poisonous gas carbon monoxide (CO) in the body, and the amount of oxygen that the baby receives will be restricted.

The harmful effects of smoking while pregnant can include[41]:

- Miscarriage.
- Stillbirth.
- Ectopic pregnancy.
- Birth defects in babies.
- Premature birth (before 37 weeks of pregnancy).
- Low birth weight.
- Increased risk of sudden infant death syndrome, or cot death.
- Increased risk of infant mortality.

Longer term effects of smoking whilst pregnant on children: Smoking in pregnancy can have further health implications for the child. Babies and children whose mothers smoke during pregnancy are at increased risk of[42]:

- Asthma, chest and ear infections, pneumonia and bronchitis
- Psychological problems in childhood, such as attention and hyperactivity issues, as well as adverse behaviour and Performing poorly at school.
- When a woman stops smoking during pregnancy[43], all the risks described above decrease.

1.3.5 Smokeless and Niche Tobacco Products.

(A) Smokeless tobacco.

This refers to any product containing tobacco that is placed in the mouth or nose and not burned. Types of smokeless tobacco products most used in the UK often contain a mix of ingredients including slaked lime, areca nut and spices, flavourings and sweeteners[44].

Products include:

• Gutka, Khaini, Pan Masala or Supari (betel quid) - these are sucked or chewed.

• Qiwam, or Mawa (chewed).

• Dantmanjan, Gadakhu (dental products which are used as toothpaste or rubbed on gums).

• Nass (can be used either nasally or sucked or chewed).

Figure 17: Types of smokeless tobacco.

Source: GOV.UK Guidance Chapter 11: Smoking and tobacco use - Updated 9 November 2021

These products are associated with several health problems[45]; nicotine addiction, mouth and oral cancer, periodontal disease, heart attack and stroke, pregnancy and adverse pregnancy outcomes.

A particularly vulnerable group is South Asian women who are 3.67 times more likely to have oral cancer and 2.06 times more likely to have pharyngeal cancer associated with the use of these products: areca nut mixed with South Asian varieties of smokeless tobacco, is linked to the prevalence of oral cancer among this group.

Around 85% of the different product types are sold without any regulatory health warning and are significantly less expensive than cigarettes. There are no local estimates available to show the scale of these products in Hillingdon.

(B) Shisha.

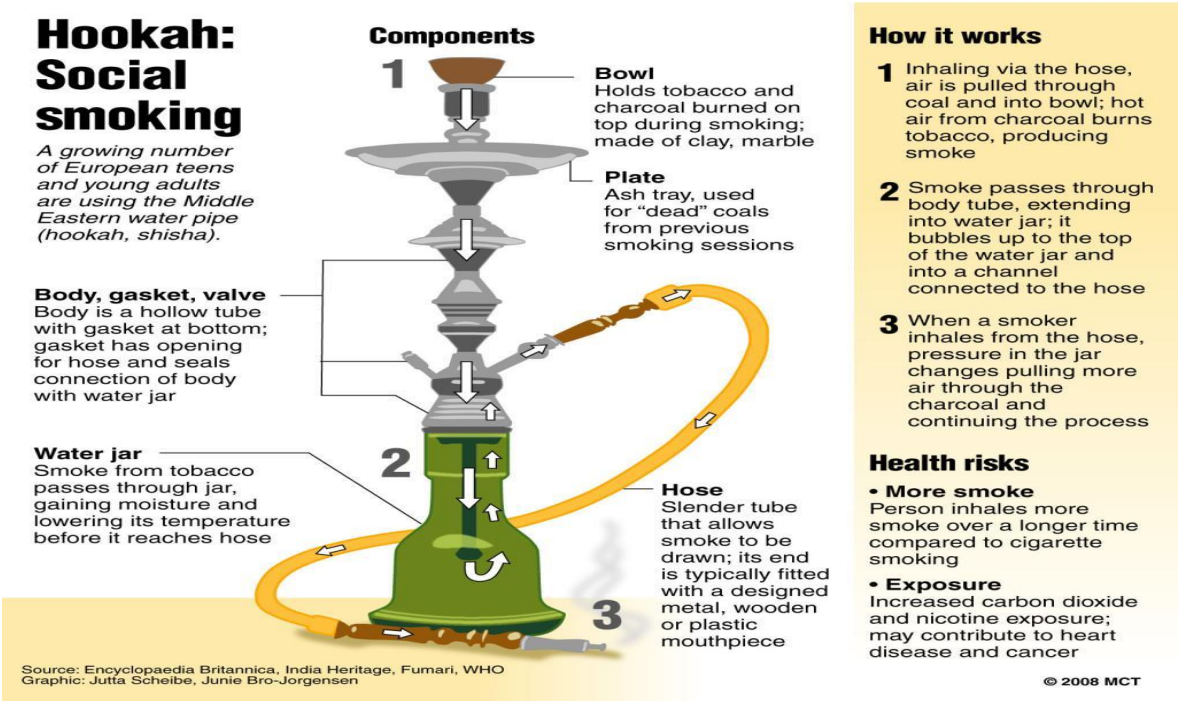
Shisha, referred to as waterpipe, hookah, narghiles or hubble-bubble has traditionally been used in the Middle East and parts of Africa and Asia. Shisha is growing in popularity in western countries and in the UK and appears to be more popular among young people[46].

There is a common belief that shisha smoking is less harmful and less addictive than cigarette smoking. The water does not filter out harmful substances in the smoke and although not as extensively researched as cigarette smoking, preliminary research suggests that shisha smoking is associated with the same risks as cigarette smoking.

This is evidenced through a summary of several studies that estimate that one shisha session, smoked alone for approximately 45 minutes, may produce 22-50 times more tar, 6-13 times more Carbon monoxide (CO) and 1-10 times more nicotine than a single cigarette[47]. Shisha is also known to produce significant levels of cancer-causing chemicals (carcinogens), including 3-39 times more benzo[a]pyrene. Reports also reveals that a Shisha session was equivalent to 100 cigarettes worth of smoke.

A common misconception is that the smoke passing through the bowl of water 'filters' the smoke. In actual fact, it cools the smoke making it more palatable and therefore users deeply inhale and are exposed to 'longer' puff sessions. Some evidence suggests the use of illicit drugs with Shisha as well as the water in the bowl being replaced by alcohol[48].

Figure 18: Shisha apparatus.



Source: Encyclopaedia Britannica

Shisha also has the following health implications[49]:

- **Cancer:** One of the most serious concerns of Shisha is cancer. The smoke increases the risk of various cancers such as lung cancer and cancer of the mouth. In addition to cancer, there are various gum diseases that are linked to Shisha as well as the development of COPD (chronic obstructive pulmonary disease).

- **Addiction:** According to the U.S. News & World Report, Shisha also carries a risk of addiction. Shisha is a danger to health because it can lead to daily water pipe use. In just one puff of shisha, the smoker inhales the same amount of smoke as they would inhale from a whole cigarette. In a shisha session (which usually lasts 20-80 minutes), a shisha smoker can inhale the same amount of smoke as a cigarette smoker consuming over 100 cigarettes.
- **Shisha while pregnant:** Smoking Shisha while pregnant can cause breathing complication and lower birth weight is also reported among the new-borns of Lebanese woman who smokes water-pipes.
- **Secondhand Shisha:** Shisha emits four times the number of carcinogens in comparison to a single cigarette.

Shisha premises are routinely monitored by organisations with health enforcement responsibilities, Licensing, Food and Workplace Safety, Planning enforcement, Trading Standards and Environmental Health. These premises are inspected and supplied with advice on compliance including information on appropriate health warnings that are required on marked tobacco products. Environmental health in partnership with police licensing have the enforcement responsibility to identify and seize illegal tobacco.

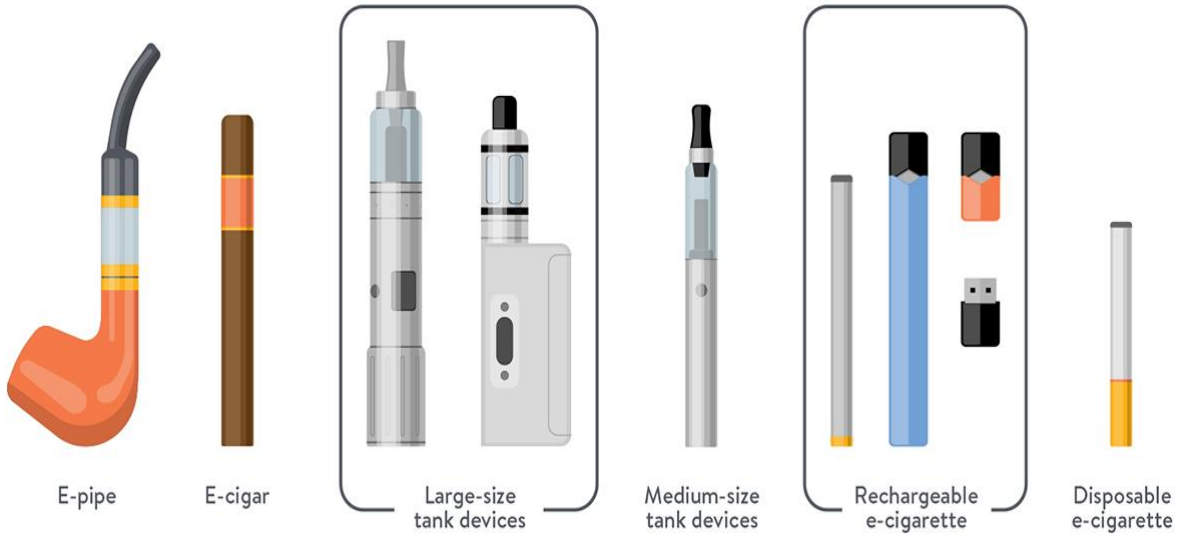
(C) Electronic Cigarettes & Vaping.

E-cigarettes have become a popular effective stop smoking harm reduction aid in the UK. Also known as vapes or e-cigs, they're far less harmful than cigarettes, and can help quit smoking for good. They are not recommended for non-smokers and cannot be sold to people under 18 years old[50].

An e-cigarette is a device that allows inhalation of nicotine in a vapour form rather than smoke. E-cigarettes do not burn tobacco and therefore do not produce tar or carbon monoxide, two of the most damaging elements in tobacco smoke (which contain over 4000 harmful chemicals).

E-cigarettes come in a variety of models and work by heating a solution (e-liquid) that typically contains nicotine, propylene glycol and or vegetable glycerine and flavourings[51].

Figure 19: Types of E-Cigarettes.



Source: Google images

Data on Vaping in England.

Data from national studies of adults in England shows that[52]for adults:

Adults:

- Smoking prevalence in England (2021) was between 12.7% and 14.9% which equates to between 5.6 and 6.6 million adults who smoke.
- Vaping prevalence in England (2021) was between 6.9% and 7.1%, which equates to between 3.1 and 3.2 million adults who vape.
- The popularity of disposable vaping products has increased among adults who vape, with 15.2% using them in 2022 compared with 2.2% in 2021.
- Tank type products remained the most popular vaping devices (used by 64.3% of adult vapers in 2022).
- Vaping products remain the most common aid used by people to help them stop smoking.
- Stop smoking services (2020 – 2021), quit attempts involving a vaping product were associated with the highest success rates (64.9% compared with 58.6% for attempts not involving a vaping product).

The latest data from the ASH-Youth 2022 survey of 11- to 18-year-olds in England[53] focuses on smoking amongst young people shows that:

- Current smoking prevalence (including occasional and regular smoking) is 6% in 2022, compared with 4.1% in 2021 and 6.7% in 2020.
- Current vaping prevalence (including occasional and regular vaping) is 8.6% in 2022, compared with 4% in 2021 and 4.8% in 2020. *In Hillingdon:* a **2014/15** WAY survey[54] of 15-year-olds showed that (16.6% of 15-year-olds) of young people were currently vaping or have tried. Current data is not available but as seen nationally, it can be presumed that this figure has increased.
- Most young people who have never smoked are also not currently vaping (98.3%).
- Use of disposable vaping products has increased, with 52.8% of current vapers using them in 2022, compared with 7.8% in 2021 and 5.3% in 2020.

Licensing of E-cigarettes.

At present, there are no medicinally licensed e-cigarette products available on the UK market and therefore, are not currently available from the NHS on prescription and cannot be prescribed from a GP unlike Licensed NRT (Nicotine Replacement Therapy) such as Patches, Gum, Lozenges, Sprays etc.

The UK has some of the strictest regulation of e-cigarettes in the world and under the Tobacco and Related Products Regulations 2016[55], e-cigarette products are subject to minimum standards of quality and safety, as well as packaging and labelling requirements to provide consumers with the information they need to make informed choices.

All e-cigarette products must be notified by manufacturers to the UK Medicines and Healthcare products Regulatory Agency (MHRA), with detailed information including the listing of all ingredients[56].

Safety of E-cigarettes:

Leading UK health and public health organisations including the RCGP, BMA and Cancer Research UK now agree that although not completely risk-free, e-cigarettes are far less harmful than smoking. An assessment of the available international peer-reviewed evidence; PHE and the RCGP estimate the risk reduction to be at least 95%[57].

However, the long-term risks of vaping are not yet understood, consequently whilst the use of e-cigarettes is agreed by public health experts as an effective harm-reduction intervention, **it is indicated for use ONLY for those adults ALREADY smoking. E-cigarettes must not be seen as an alternative to smoking for people, especially young people who do not smoke.**

Youth Vaping.

Figure 20: Disposable e-cigarettes are now the most used product among current vapers. Example shown are the most popular 'elf' and 'geek' bar.

Source: Google images

There has been growing concern about the increasing popularity of disposable vapes with young people. Disposable e-cigarettes are now the most used product for vapers and use has increased from 7% of e-cigarette product use in 2020 to 52% in 2022. The overall increase in vaping shown by the survey is a cause for concern and needs close monitoring.

'Just to give it a try' is still the most common reason cited by never smokers for using an e-cigarette (65%). For young smokers the most common reason for using an e-cigarette was 'because I like the flavours' (21%) followed by 'I enjoy the experience' (18%) then 'just to give it a try' (15%), but they stated was 'because I'm trying to quit smoking' (11%) or 'I use them instead of smoking' (9%).

Despite it being illegal to sell vapes to under 18s, the most common source of supply for underage vapers is shops (47%). The Department of Health and Social Care (DHSC), the MHRA (the regulator of e-cigarettes) and trading standards have been monitoring the situation. The Chartered Trading Standards Institute (CTSI) was commissioned to conduct a rapid review of compliance.

Of 442 attempted test purchases of vapes by underage young people conducted between February and March 2022, illegal sales were made on 145 occasions. Underage sales were highest in mobile phone and discount shops at 50% and 52% respectively. A quarter of the products purchased were illicit products not up to UK standards.

The maximum penalty for selling a nicotine inhaling product to a person under 18 years is a fine of £2500.

The ASH policy brief on vaping[58] sets out recommendations for the Government in the light of growing evidence of increases in underage vaping. Recommendations include:

Reducing appeal of vapes to children by:

- Taxing disposable vapes which are the cheapest and most popular vape for children.
- Stricter regulation of advertising and promotion, particularly at point of sale in shops.
- Stricter regulation of packaging, labelling and product design features. New research from Kings college and ASH found that standardising e-cigarette (vape) packaging is associated with a decrease in vapes appeal among teenagers.

Reducing underage access to vapes by:

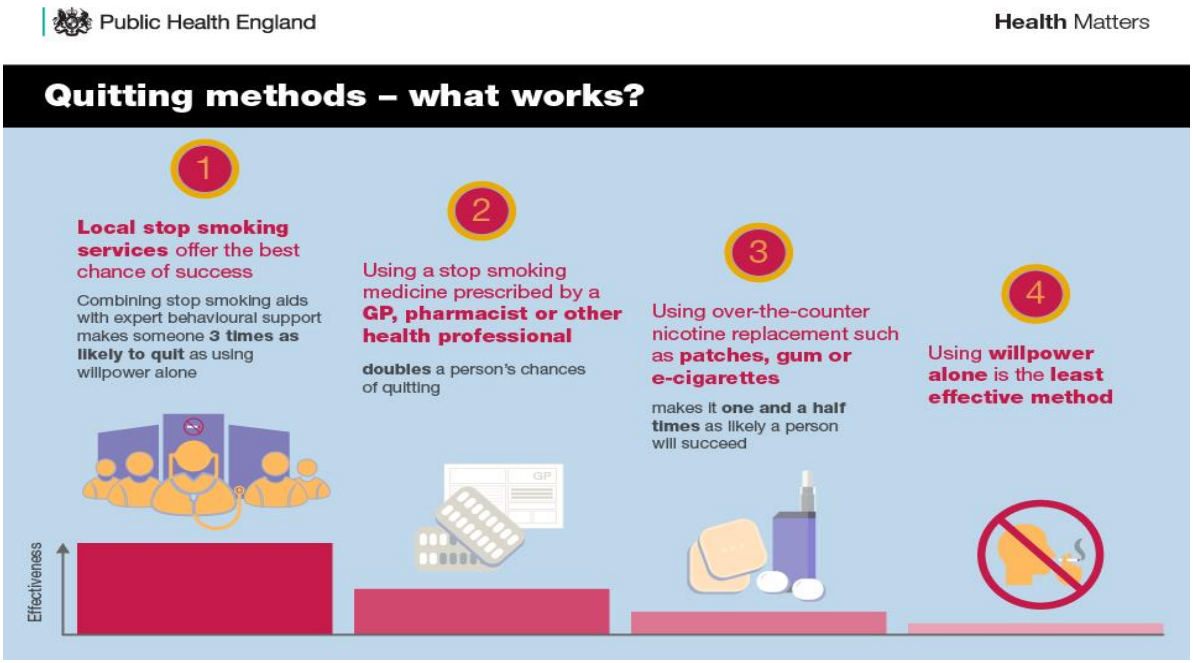
- Adequate funding for enforcement using MHRA e-cigarette notification fees.
- Putting vapes behind the counter.
- Mandatory age verification in shops for anyone looking under 25 years of age.
- Prohibiting free distribution (currently legal to anyone of any age).

1.3.6 Smoking Cessation Service.

NHS stop smoking services provide cost-effective ways for people to stop smoking, whether these people are young, pregnant, have mental ill-health, co-morbidities and whose background places them at risk of health inequalities[59].

Currently, approximately half of all smokers in England try to quit without the support of stop smoking services. Accessing support can significantly increase a person's chances of quitting successfully.

Figure 22: Quitting Methods – what works?



Source: Public Health England

Hillingdon Local Authority commissions a stop smoking service that provides a high quality, targeted and evidenced based approach to smoking cessation.

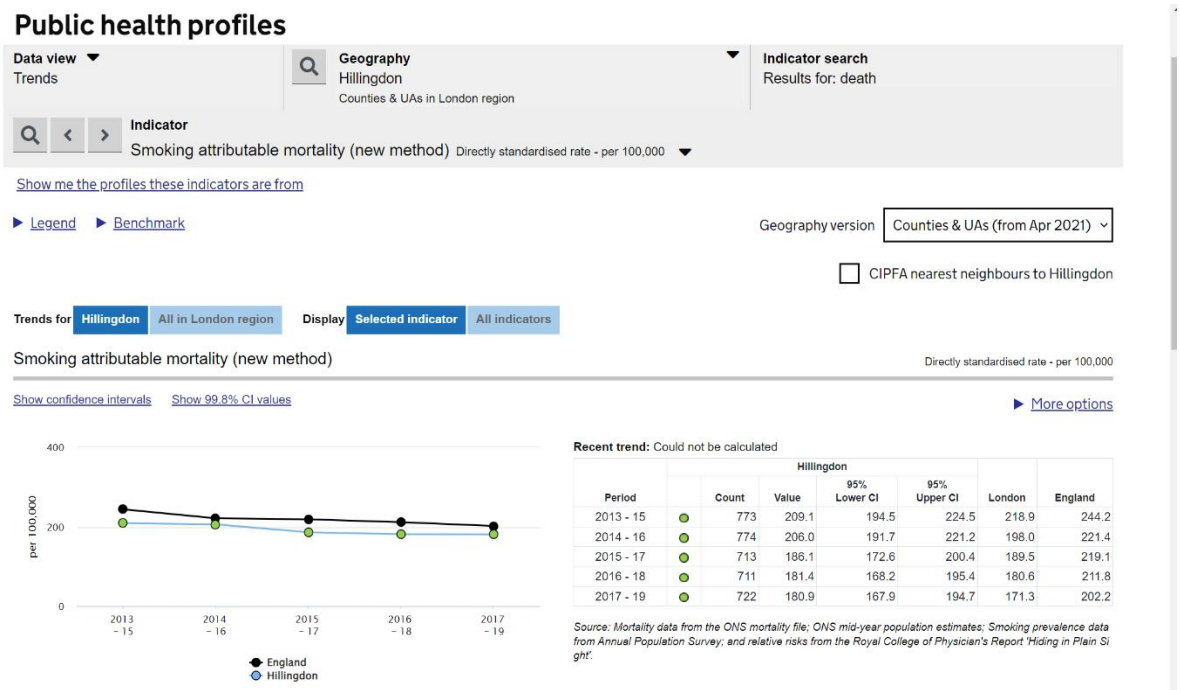
To facilitate a quit attempt, a combination of behavioural support with licensed smoking cessation products is provided to eligible residents of Hillingdon who meet the agreed priority group criteria.

The service' primary aim is to reduce smoking prevalence of people in these priority groups, Borough Pharmacies and specialist core advisors based in ARCH provide expert support to residents through a variety of mechanisms including face to face, text messaging, telephone, video conferencing and mobile phone apps.

1.4 Local Context.

Smoking disproportionately affects the most disadvantaged in the community and contributes to health inequalities in the borough[60]. ONS, Census 2021[61] states that from a Hillingdon population of 305,900, OHID estimates an 11.1% (25,250 people) prevalence of adult smoking, compared to the London prevalence of 11.5% and England, 13.0%[62]. In 2017-19 there were 722 smoking attributable deaths recorded in Hillingdon **(Figure 4):**

Figure 4: Smoking attributable deaths in Hillingdon.

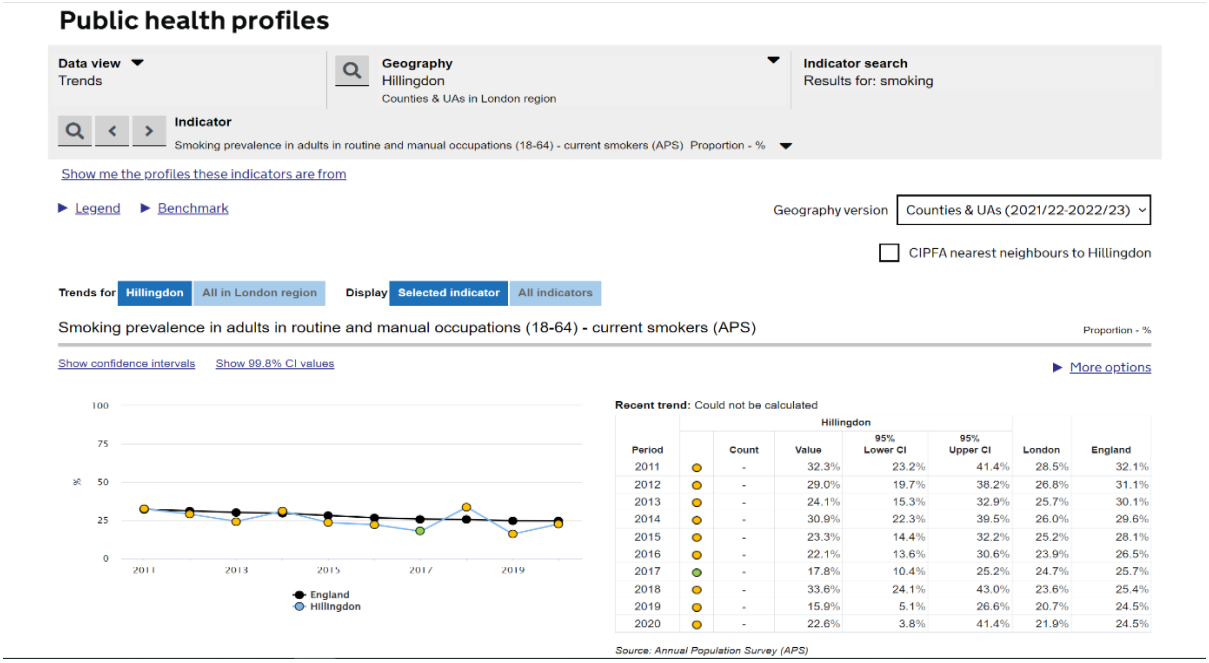


Source: OHID Fingertips Public Health Data[63]

The Government Tobacco Control Plan for England (2017) strategy, targets and guidelines suggest that by the end of 2022, we aim to[6465]:

- Reduce the inequality gap in smoking prevalence between those in routine and manual occupations and the general population.
  Those who are in routine and manual occupations (18-64) in Hillingdon, **Figure 5***, have a smoking prevalence of (22.6%) compared to London (21.9%) and England (24.5%). 2020[66] data.*

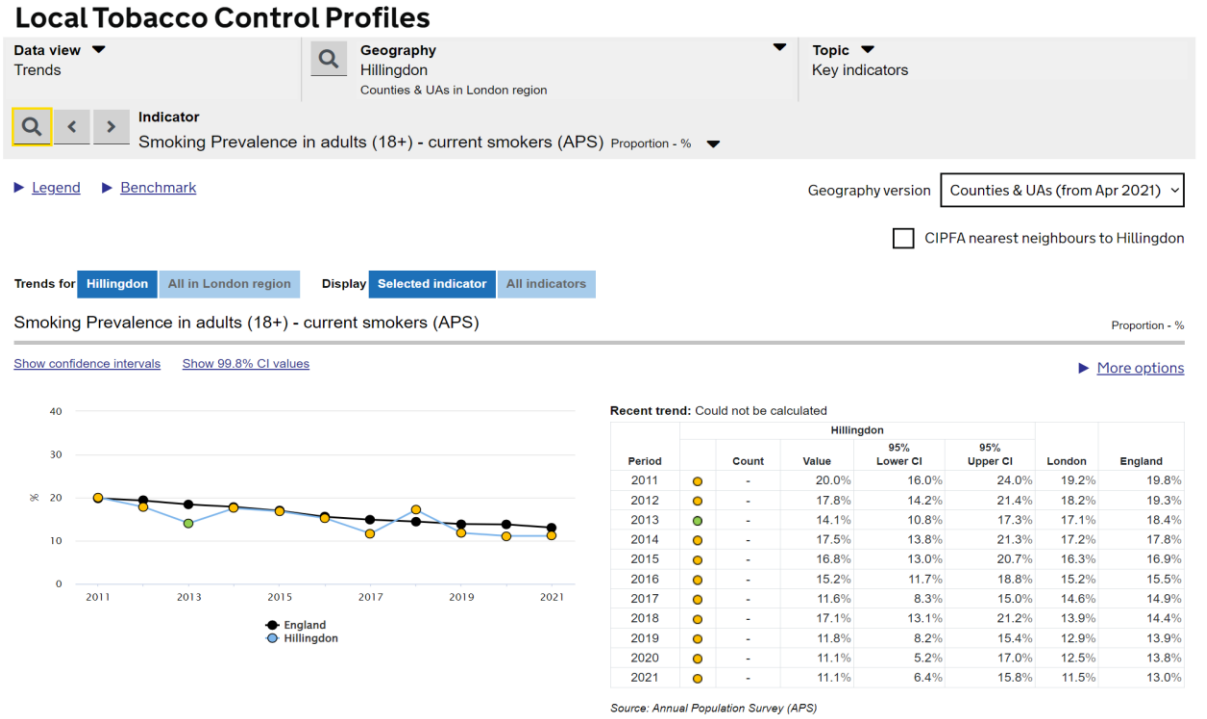
Figure 5: Smoking prevalence in those who are in routine and manual occupations (18-64) in Hillingdon.



Source: OHID Fingertips Public Health Data[67]

➢ Reduce adult smoking prevalence in England from 15.5% to 12% or less.
Currently Hillingdon has achieved the target with a rate of 11.1% (2021) in comparison to 20% (2011) **Figure 6**. *However, a further reduction of 6.1% is required if we are to reach the smokefree ambition of 5% by 2030.*

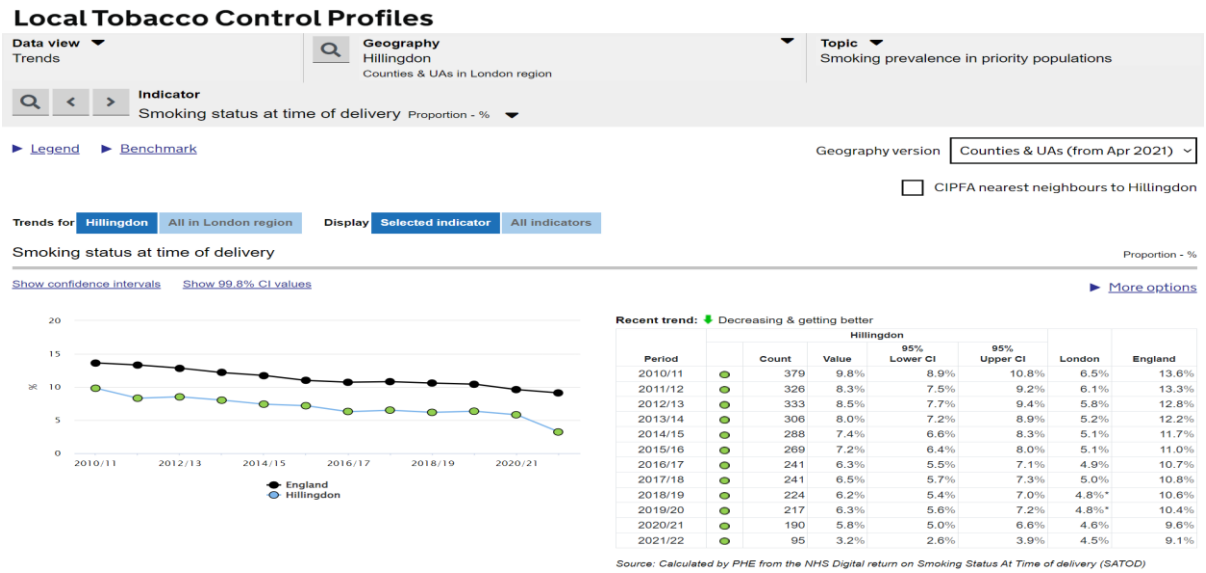
Figure 6: A comparison of Adult Smoking prevalence in Hillingdon vs London and England.



Source: OHID - Local Tobacco Control Profiles[68]

- Reduce the prevalence of smoking in pregnancy (Smoking at Time of Booking (SATOB) from 10.7% to 6% by 2026 and 2% by 2030.
  Currently Hillingdon has a rate of 3.2% (Smoking status at time of delivery 2021/22)[69] which is lower compared to London, 4.5% and England, 9.1% **Figure 7**. *However, this low rate could be due to recording issues.*

Figure 7: Smoking status at time of delivery for Hillingdon.

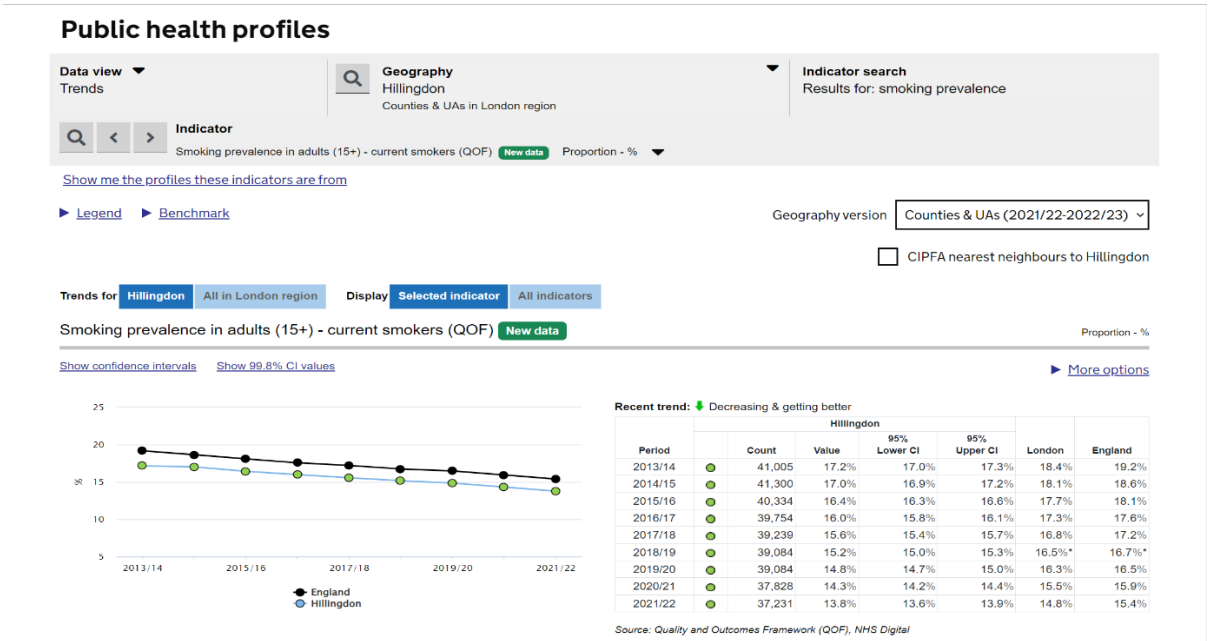


Period		Hillingdon Count	Value	95% Lower CI	95% Upper CI	London	England
2010/11		379	9.8%	8.9%	10.8%	6.5%	13.6%
2011/12		326	8.3%	7.5%	9.2%	6.1%	13.3%
2012/13		333	8.5%	7.7%	9.4%	5.8%	12.8%
2013/14		306	8.0%	7.2%	8.9%	5.2%	12.2%
2014/15		288	7.4%	6.6%	8.3%	5.1%	11.7%
2015/16		269	7.2%	6.4%	8.0%	5.1%	11.0%
2016/17		241	6.3%	5.5%	7.1%	4.9%	10.7%
2017/18		241	6.5%	5.7%	7.3%	5.0%	10.8%
2018/19		224	6.2%	5.4%	7.0%	4.8%*	10.6%
2019/20		217	6.3%	5.6%	7.2%	4.8%*	10.4%
2020/21		190	5.8%	5.0%	6.6%	4.6%	9.6%
2021/22		95	3.2%	2.6%	3.9%	4.5%	9.1%

Source: Public Health England Fingertips

- Reduce the prevalence of smoking amongst 15-year-olds who regularly smoke from 8% to 3% or less.
  Figure 8 *shows that Currently Hillingdon has a rate of 13.8% (2021/22)[70] lower than London, 14.8% and England, 15.4%.*

Figure 8: Smoking prevalence of 15+ year-olds who regularly smoke.

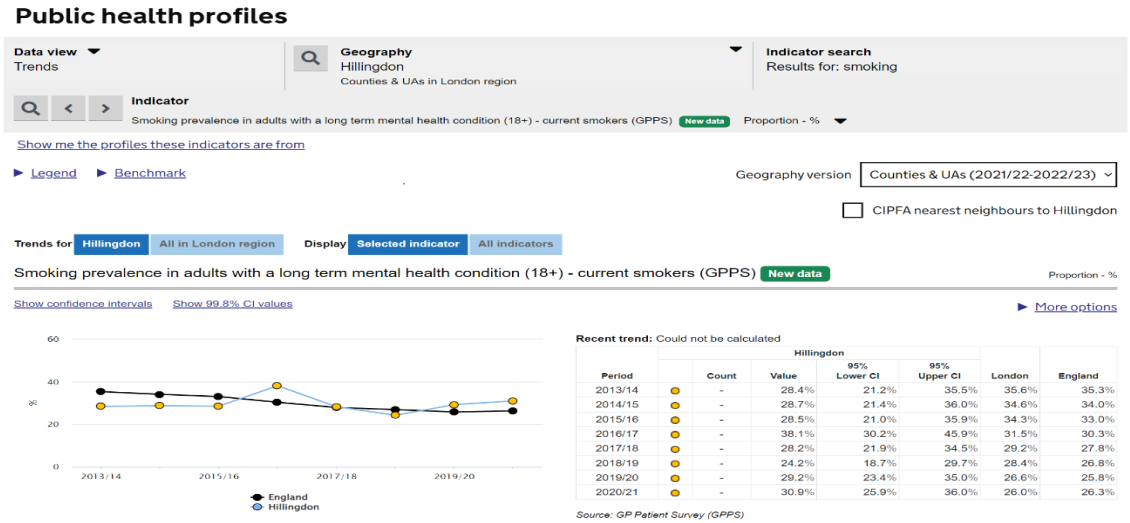


Period		Hillingdon Count	Value	95% Lower CI	95% Upper CI	London	England
2013/14		41,005	17.2%	17.0%	17.3%	18.4%	19.2%
2014/15		41,300	17.0%	16.9%	17.2%	18.1%	18.6%
2015/16		40,334	16.4%	16.3%	16.6%	17.7%	18.1%
2016/17		39,754	16.0%	15.8%	16.1%	17.3%	17.6%
2017/18		39,239	15.6%	15.4%	15.7%	16.8%	17.2%
2018/19		39,084	15.2%	15.0%	15.3%	16.5%*	16.7%*
2019/20		39,084	14.8%	14.7%	15.0%	16.3%	16.5%
2020/21		37,828	14.3%	14.2%	14.4%	15.5%	15.9%
2021/22		37,231	13.8%	13.6%	13.9%	14.8%	15.4%

Source: OHID: Fingertips Public Health Data

➢ Those with a long-term mental health condition (18+) in Hillingdon, **Figure 9**, has a higher prevalence rate of (30.9%) compared to London (26.0%) and England (26.3%). 2020/21[71] data.

Figure 9: Smoking prevalence in adults with a long-term mental health conditions.



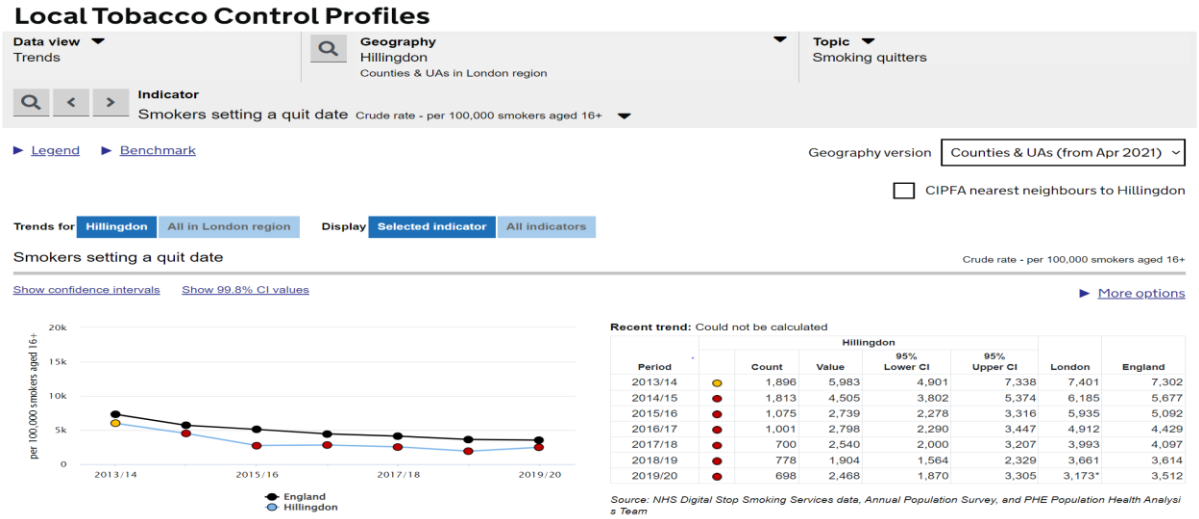
Source: Public Health England Fingertips

The Hillingdon stop smoking service provides a targeted and evidenced based approach to smoking cessation for those people in the agreed priority groups:

- Children and young people under 18 years of age.
- Pregnant women, and targeted support for new mothers and their partners.
- Residents with mental ill-health including people with substance misuse needs.
- Residents with disabilities and long-term conditions.
- Residents employed in routine and manual occupations.

The priority groups are those most at risk and most complex to support to quit smoking. The overall reduction in smokers setting a quit date as illustrated in **figure 10** shows minimal improvement from 2017/2018 (700) to 2019 / 2020 (698).

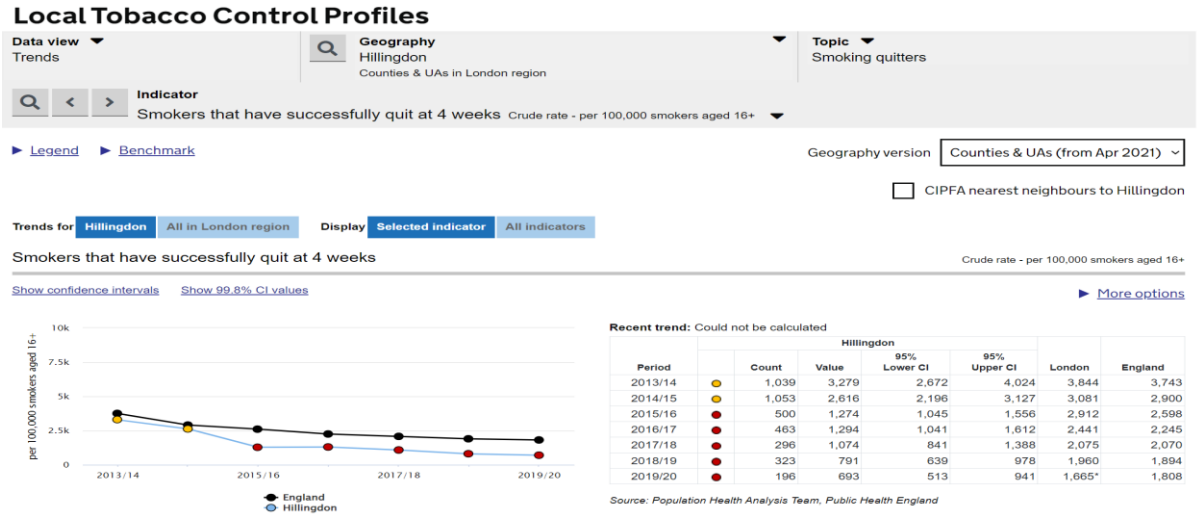
Figure 10: Hillingdon Smokers setting a quit date.



Source: OHID Fingertips Public Health Data[72]

There has been a reduction in the number of Hillingdon smokers that have successfully quit at 4 weeks **Figure 11.** There were 1039 smoking quitters in 2013/14, reducing to 196 quitters in 2019/2020. There are a number of reasons for this decline, ceasing universal access by all smokers and Covid-19.

Figure 11: Hillingdon smokers that have successfully quit at 4 weeks:



Source: OHID - Local Tobacco Control Profiles

The Hillingdon Tobacco Control Plan aims to build on the progress to date and create a platform for innovative evidence-based initiatives that will effectively contribute to reducing the harm caused by tobacco and smoking; reducing the prevalence of smoking and improve health and reduce health inequalities in the borough.

Reducing smoking prevalence needs collaboration between local government and the NHS, recognising that smoking remains the leading preventable cause of ill-health. Reducing smoking is also a means to tackle health inequalities[73].

Figure 12: Hillingdon economic and health inequalities dashboard – May 2023[74].

Source: ASH Dashboard

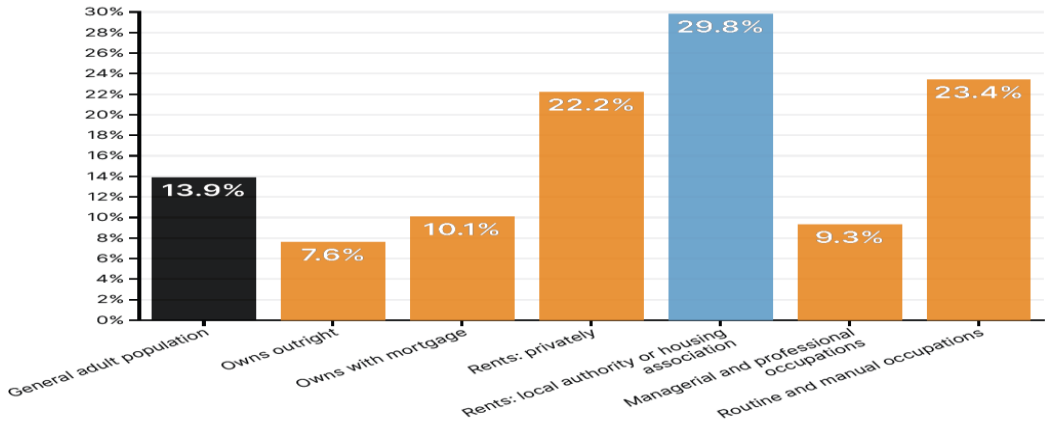
1.5 Smoking and social housing.

The smoking rate among social housing residents is one of the highest in England – around 1 in 3 people in social housing smoke, compared to around 1 in 10 people who own their home and 1 in 7 in the general adult population[75].

In May 2021, there were 10,101 council owned, lower cost rented homes in the Hillingdon borough. The council also has 3,341 leaseholders and 98 shared owners.

Higher rates of smoking mean people living in social housing are disproportionately affected by the health and economic inequalities caused by smoking. The rates of smoking between people living in social housing, **Figure 13**, compared with people living in other types of housing has increased, exacerbating inequalities[76].

Figure 13: Smoking Prevalence comparing inequalities in smoking rates by socio-economic measure – 2019 data.



The most disadvantaged groups in the population have higher rates of smoking and have seen significantly slower declines in rates of smoking compared with the rest of the population.

Children growing up in environments where smoking is normalised are more likely to smoke themselves, exacerbating generational inequalities. Successfully delivering on this agenda would radically improve the lives of social housing residents. Therefore, embedding tobacco control within the social housing sector presents an opportunity for all partners across the social housing to radically improve the health, wellbeing, and lives of residents and society.

The Suggested actions include:

- Engage social housing providers to help support residents who smoke to stop.
- Allocate budget for targeted programmes supporting people to quit in social housing.
- Set targets for reducing smoking prevalence in social housing.

1.6 The Cost of Tobacco.

The cost of smoking to society is high. Smoking places a considerable burden not only on individuals, but also on the NHS and the wider economy and society[77]. In Hillingdon there were 1386 smoking attributable hospital admissions in 2020[78]. According to NHS Digital[79] there were an estimated 506,100 smoking-related admissions to hospital in England in 2020,

equating to over 1,300 admissions per day[80]. Smokers are also more likely to see their GP over a third more frequently compared with non-smokers. These costs are a considerable activity and economic burden to a system already dealing with growing demand[81].

Figure 14: Costs of smoking to society.

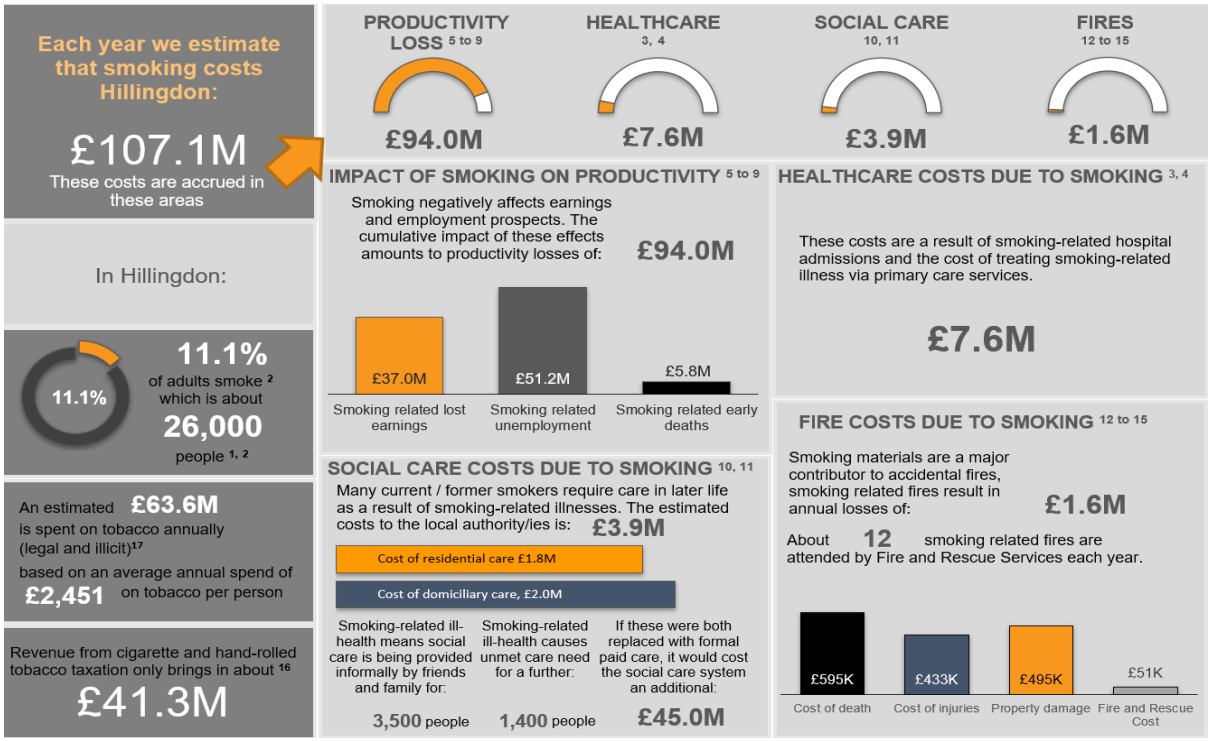
Source: Public Health England

Action on Smoking & Health (ASH) has produced a ready 'reckoner' that provides estimates based on national surveys and research[82]. The ASH model estimates the impact of tobacco control strategies on the number of quitters, the number of new smokers, the level of passive smoking in society and the cost of lost productivity from smoking.

The Hillingdon Joint Strategic Needs Assessment 2022[83] states that in 2020, using the ASH data tool – May 2023, there are an estimated 26,000 (11.1%) adult smokers who generate a cost pressure of £107.1 million pounds annually on the economy e.g. (Healthcare – £7.6M, productivity - £94.0M, social care - £3.9M, House fires - £1.6M).

The burden of tobacco use is not confined to personal health harms alone. Other costs to society which are less apparent includes litter and waste service costs, air quality and criminality and other associated costs including loss of tax revenue of the illicit tobacco trade.

Figure 15: The cost implications to the society of Hillingdon[84].



Source: ASH READY RECKONER

Introduction of a 'polluter pays' levy on tobacco manufacturers[85].

A letter to the secretary of state and social care, coordinated by Action on Smoking and Health (ASH) and Cancer Research UK, highlights the significant financial pressure smoking places on local councils and the NHS, with an estimated £3.6 billion spent on smoking-related health and social care in England every year. In addition to £13.2 billion each year in lost economic productivity resulting from premature death and disability caused by smoking.

The author argues that bold national action to reduce smoking rates would help to ease the pressure on household budgets and put money back into the pockets of struggling families. The average smoker who quits successfully will see their disposable income rise by around £2,450 a year[86].

Smoking is the leading cause of death and cancer in the UK, leading to 125,000 deaths per year and around 150 new cancer cases every day. A 'polluter pays' levy on tobacco manufacturers would raise an estimated £700 million per year which could be used to fund measures to help smokers quit[87]. Tobacco companies should be liable to pay to address the damage caused from addiction.

Tobacco companies should also be liable for the costs of litter created by cigarettes under plans being explored by ministers to protect the environment and save local councils money. The move comes after fresh evidence reveals that cleaning up littered cigarette butts currently costs UK local authorities around £40 million per year.

Littered cigarette filters can persist in the environment for many years and release these chemicals to air, land and water, harming plant growth and wildlife.

SECTION 2

2. THE NEED FOR A TOBACCO CONTROL STRATEGY.

The purpose of a tobacco control strategy is to outline the tobacco control priorities for Hillingdon and to implement comprehensive evidence-based activities to reduce smoking prevalence and work towards a smokefree generation. The strategy supports a reduction in overall smoking prevalence, inspiring a smoke free generation by 2030[88] and reducing exposure to second-hand smoke which will contribute to improving the health of Hillingdon's population.

It is widely understood that people become addicted to smoking tobacco at a younger age and consequently more needs to be done to reduce the uptake of smoking at a younger age. In addition, smoking affects communities differently; those with lower economic background or from certain ethnic groups show higher incidence of smoking and therefore are likely to face severe health consequences of smoking[89].

2.1 Tackling tobacco in Hillingdon.

- **The Vision:** To create smokefree Hillingdon by reducing the prevalence of smoking and tobacco related harms and protecting health across the resident population, focusing on the most vulnerable. To be achieved by de-normalising the use of tobacco and strengthening collaborations, implementing the recommendations that will help achieve smokefree 2030 in Hillingdon that supports wider health and wellbeing priorities.

- **The Objectives:** The objectives of the Hillingdon tobacco control strategy are to:

  - Reduce the adverse effects of tobacco use and consequently improve the health of residents in Hillingdon.
  - Reduce the uptake of tobacco, and health inequalities in the Borough by targeting reduced smoking prevalence amongst:

    - ✓ Children and young people under 18 years.
    - ✓ Pregnant women, targeting support after childbirth, for new mothers and their partners.
    - ✓ Residents with mental ill-health including those people with substance misuse needs.
    - ✓ Residents with disabilities and long-term conditions.
    - ✓ Residents employed in routine and manual occupations.

  - In line with the existing Government Tobacco Control Strategy and the Khan review, lowering the overall smoking prevalence to less than 5% by 2030, pending the new tobacco control plan.
  - Enhance collaborative working with stakeholders to drive forward the Tobacco Control agenda in Hillingdon.
  - Support smokers to quit with support from the Hillingdon Stop Smoking Service with targeted interventions especially for those in the eligible criteria.
  - Tackle Shisha use and use of other forms of tobacco.
  - Build intelligence about vaping use in young people and develop a strategy to reduce uptake.

- **Form a committed Tobacco Control Alliance:** Comprehensive Tobacco Control requires an operational framework that supports strategic decision-making whilst allowing for a wide range of partners with a variety of expertise and interests to engage at different levels.

  The formation of Tobacco Control Alliance in Hillingdon will bring together agencies to address tobacco control, smoking prevention and cessation. The Alliance will oversee the Hillingdon Tobacco Control Strategy and annual action plans in line with local, regional and national policy.

  The Alliance will meet quarterly, and suggested members[90] will include:

  - Trading Standards.
  - Environmental Health.
  - Licensing.
  - The commissioned Hillingdon Stop Smoking Service - ARCH.
  - Social Housing.
  - Local Pharmaceutical Committee including Borough community pharmacists.
  - Public Health.
  - Hillingdon NHS CCG
  - Primary Care Networks (PCN's)
  - HHCP, Healthwatch, H4ALL, The Confederation.
  - Education representatives (Primary, Secondary, College)
  - Fire and rescue Services.
  - Police.
  - Cancer alliances.
  - Children's Centre Services.
  - Parks & Leisure Services.
  - Youth leaders.
  - Locally Elected Members.
  - NHS Trusts, including representatives such as local acute or Mental Health Trusts, Maternity teams and Respiratory Services.

2.2 STRATEGY.

2.2.1 The Hillingdon ambition for 2023 – 2026.

Tobacco control is an umbrella term used to describe the broad range of activities that aim to reduce smoking prevalence and/or reduce exposure to second-hand smoke and the morbidity and mortality it causes.

A comprehensive tobacco strategy should include the commissioning of a Stop Smoking Service, an evidence-based approach to e-cigarettes as a tool to quit smoking, activity to tackle the illicit trade in tobacco and local quit campaigns.

Stopping smoking is the single, most effective action that an individual can take to improve their health and well-being and the overall health of a population. The overall aim is to reduce the prevalence of smoking in Hillingdon (currently at 11.1%) to below 5% by 2030.

This Strategy provides a blueprint for whole system working; all partners have a role to play.

Lead members for health are well placed to drive political and financial support for effective tobacco control within the Health and Wellbeing Board, Sustainability and Transformation Partnerships and with wider partners.

Overall Objectives:

The overall objectives of tobacco control strategy are:

- Reduce the adverse effects of tobacco use to the health of residents in Hillingdon.
- Reduce the overall uptake of tobacco, hence reducing the associated health inequalities in the Borough.
- In line with the Khan Review and Government Tobacco Control Strategy, lower the smoking prevalence to 5% by 2030.
- Enhance collaborative working with stakeholders to drive forward the Tobacco Control agenda in Hillingdon.
- Support smokers to quit with support from the ARCH; Hillingdon Stop Smoking Service with targeted interventions especially for those in the eligible criteria.

The Hillingdon Tobacco Control Plan 2023 – 2026 will focus on the following objectives:

1. System leadership
2. Whole systems partnership
3. Supporting delivery
4. Marketing and engagement
5. Evidence base, data and monitoring

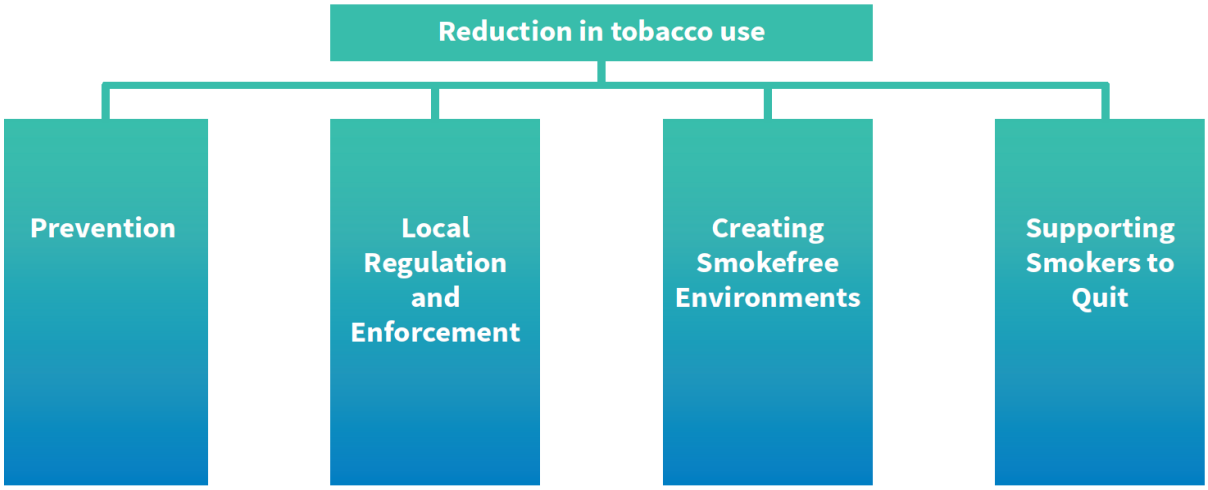
2.2.2 System Leadership.

Actions:

- The Health and Wellbeing Board are asked to endorse this plan and all member organisations to support the goals and ambitions of the plan to support smokefree and tobacco policy implementation across all sectors and organisation.
- Tobacco Control Alliance members to provide information, and work with councillors in understanding the scale and context of the challenge and how best to collaborate with vulnerable communities.
- London Borough of Hillingdon being an exemplar borough, driving a smokefree policy for all staff, residents and visitors who use council premises.

2.2.3 Whole Systems Partnership.

Figure 23: The objectives for reducing tobacco control in Hillingdon will be to adopt a whole system approach across the four pillars shown below:



Local authorities are best placed to create a whole systems approach in tackling tobacco use. The impact of council services is invaluable in raising awareness and promoting quitting smoking through frontline contact with residents, communication, planning and commissioning services.

Example: Establish working relationships across all council departments to promote the Tobacco Control Plan 2023 – 2026.

As well as working intrinsically within the council, collaboration and joint working is essential. Hillingdon has a legacy of successful partnership working and owes the reduced rate of smoking prevalence in the borough to previous successful collaboration. To implement further change, renewed commitment from partners is a priority with shared resources.

Example: Hillingdon Tobacco Control Alliance will involve a wide range of members from community healthcare providers within both primary and secondary care organisations, maternity and acute, the ICB, public health, planning and legislation to ensure the governance of the implementation of Hillingdon Tobacco Control Plan 2023-2026

The NHS Long Term Plan has prioritised preventative action and highlighted the contribution the NHS can make to tackling tobacco dependence, especially for hospital inpatients, pregnant women, and long-term users of mental health services.

Integrated Care systems need to embed tobacco control in their workstreams.

Action Points:

- All health providers and frontline services (such as Housing and Social Care) to support service users to access stop smoking services or signpost users to the Hillingdon stop smoking service.
- Health organisations, council and other partners to support stop smoking campaigns through their communication channels as and when campaigns run (including Stoptober, No Smoking Day and other campaigns).

- Stakeholders collaborating with council and health providers support smokefree workplace (i.e., third sector partners, leisure providers, construction providers and local businesses).
- Elected members to sign up to the Local Government Declaration on Tobacco Control.
- NHS Organisations sign up to the NHS Smokefree Pledge.
- Other organisations (e.g., schools, colleges, and higher education settings) reaching at least 1000 children and young people per year through direct events to prevent uptake of smoking.

2.2.4 Supporting Delivery.

The crucial element of implementing the Hillingdon Tobacco Control Pan 2022 -2025 is to create a seamless pathway of integrated smoking cessation delivery system.

The Hillingdon Tobacco Control Plan 2023 -2026 will focus support to the most disadvantaged communities through innovative methods, and by building workforce capacity, and using the Making Every Contact Count (MECC) approach for smoking cessation.

The focus will be preventative, including outreach to collaborate with schools, workplaces, hospitals, housing estates, community, cultural and religious settings in tackling tobacco use including smoking, shisha and illicit tobacco.

Action includes:

Continue evidenced based smoking cessation support through the borough provider by:

- Supporting quitters relative to the Local Authority Stop smoking service specification targeting the eligible population.
- Educating up to 1000 children and young people on the dangers of smoking and tobacco use.
- Offering Making Every Contact Count (MECC) approach through brief advice training (Level 1) and stop smoking advisor training (Level 2) to frontline staff.
- Ensuring outreach programmes are provided across the borough to engage and reach communities widely.
- Ensuring services are provided in various locations that most benefit residents e.g., Local groups in target areas, GPs, pharmacies, youth services etc.
- Enhancing the referral pathways across healthcare organisations, community services, voluntary organisations, workplaces, local business, faith groups and other stakeholder organisations.

Example: Use of innovative technology to support smokers to quit such as IT formats including, Skype, Teams, Zoom etc.

Collaborative working with the local acute and maternity service at Hillingdon Hospital to continue and further strengthen stop smoking through the NHS Long Term Plan by:

- Signing up to a smokefree NHS.
- Offering mandatory carbon monoxide tests to all newly expectant mothers.
- Offering advice and onward referral to a specialist stop smoking midwife or the Hillingdon Stop Smoking Service.
- Offering second hand smoking advice to partners and family of expectant mothers and provide information on local stop smoking support.
- Encouraging expectant mother to sign up to the smokefree homes and cars pledge.

- Supporting patients admitted to hospitals with stop smoking support including seamless referrals to The Hillingdon Stop Smoking Service.
- Promote level 1 training to all staff including (VBA) Very Brief Advice.
- Increase the number of level 2 trained stop smoking advisors (and specialist smoking in pregnancy advisors).

Example: Work across maternity, health visiting and school nursing teams to ensure every contact with a smoking adult in a home where children live is offered information on local support to quit, encouraged to sign up to smokefree homes and communicate the dangers of passive smoking.

It is important to continue to engage and work in partnership with various council organisations e.g., housing, parks and leisure and open spaces, adult education, social care, regeneration to signpost to local support, promote smokefree environment and smokefree homes and cars through their services.

Ensuring all tobacco used in the borough is lawfully permitted. This work will be robustly monitored through the council's:

- Planning, licensing and enforcement department who provide information and advice to local business such as smoking in public spaces, setting up local shisha bars / lounges, sale of tobacco to over 18 to ensure local business adhere to the law.
- Enforcement when business fail to comply after information and advice is provided with notice of improvement.
- Trading standards departments responsible for ensuring illicit tobacco is not traded locally through wide range of initiatives such as:

    - ✓ Raising awareness of illicit tobacco through training and education.
    - ✓ Taking part in the annual Stop Smoking Campaigns such as 'Stoptober'.
    - ✓ Working in partnership with local business to ensure that they are not trading illicit tobacco.
    - ✓ Joint operation with the police and HMRC in ceasing illicit tobacco in the borough.

2.2.5 Marketing and Engagement.

The Hillingdon Tobacco Control Plan 2023-2026 will support the national and regional tobacco control campaigns to ensure the key messages of the campaigns reach wide across the borough.

The Hillingdon Stop Smoking Service and the Local Authorities communications team will lead on promoting public health stop smoking campaigns and will ensure partners are engaged in this process as well as using innovative communication methods including digital such a display screens across various settings, social media, email, and newsletters.

Behaviour change techniques will be embedded across varied marketing and communication channels to target opportunistic life transitions such as moving home, pregnancy, attending higher education, changing employment, and receiving a health check.

Example: To provide information on all local tobacco control initiatives to new social housing tenants via their handbook.

Action includes:

- 1 or 2 campaigns per year using the most effective communication channels.

to reach the smokers in the borough.

- All stakeholder organisations request to support and augment campaigns.
- All frontline organisations including voluntary sector to ensure that staff have the knowledge and information about the stop smoking services, and how to signpost and refer people.
- Use a range of communication channels to reach people, supported by local data and community experts based on the best way to communicate, using, printed materials, easy read materials, display screens, digital platforms such as websites and social media, text messages, email, regular newsletters, and face to face events.

2.2.6 Evidence base, data and monitoring.

The local tobacco control initiatives will be based on the OHID Local Tobacco Control Profiles and will ensure that programmes are targeted at those who most need it. Use of local intelligence such as GP data, and other local data available to ensure effectiveness of the programmes.

Example: Use GP data to establish best form of communication with patients registered as smokers and invite them to the Hillingdon Stop Smoking Service specialist stop smoking support.

To monitor the progress of the Tobacco Control Plan 2023-2026, PHE'S CLeaR assessment tool will be used to evaluate the effectiveness of local tobacco control initiatives and benchmark progress against other boroughs over time. The tool will provide an opportunity to choose an area to 'deep-dive'; local initiatives that support stop smoking during and after pregnancy, in acute and maternity settings, in mental health settings and tackling the supply of illicit tobacco. CLeaR stands for three linked domains:

- **C**hallenge the existing service provision; whether they are fit for purpose and are grounded on strong up to date evidence.
- **L**eadership for supporting action on tobacco control.
- **R**esults to illustrate outcomes against national and local priorities.

Action Point:

- Continue to review local services to ensure that the most up to date and evidence-based approaches are being used.
- Make use of behavioural insight approaches to increase effectiveness.
- Undertake at least one CLeaR assessment of the Hillingdon services in the plan period (i.e., between 2023 and 2026).

2.2.7 Summary and monitoring:

The Hillingdon Tobacco Control Plan 2023-2026 sets out the aspirations of creating a smokefree generation. Tobacco use has significant impact on the health of individuals and negatively burdens families and society. To reduce inequalities, tackling tobacco use is essential.

This Hillingdon Tobacco Control Plan 2023-2026 builds on the successful work of reducing smoking prevalence in the borough and focuses on both quick wins and long-term system-change.

The implementation of this policy will be governed through the Tobacco Control Alliance and an action plan to develop short-, medium- and long-term outcomes.

Monitoring:

An annual report of this plan will be presented to the Hillingdon Health and Wellbeing Board. The report will comprehensively measure progress against all actions from an initially established baseline measure, using the following on indicators:

- Smoking prevalence in Hillingdon.
- Four-week quitters from each of the 5 eligible categories.
- Number of children and young people educated on the dangers of smoking.
- Number of smokefree homes and cars pledge.
- Number of people trained on level 1 and level 2 smoking cessation.
- Number of campaigns supported i.e., STOPTOBER, No Smoking Day.

The report will also include other outcomes such as:

- New initiatives on tobacco control through joint partnership working.
- Implementation of new approaches embedded within practice to improve the smoking prevalence in Hillingdon and the illicit tobacco traded in the borough.

SECTION 3

3. ACTION POINTS.

3.1 Illicit Tobacco.

Actions:

- To work with the Trading Standards team and determine the measures in place to tackle illicit tobacco sales in Hillingdon. Council Trading Standard services play a key role at a local level detecting and seizing illicit tobacco products as appropriate.
- Tackling the supply of illegally imported tobacco, which is then sold to young people.
- Improved enforcement action against the illegal sale of tobacco.
- Visits to traders and check correct labelling and signage is on display and give information about underage sales.
- Advise retailers on compliant containment and how to hide the display of tobacco products from customers who are present within the shop but are not requesting tobacco products.
- Inspect businesses to establish compliance with the health warnings on tobacco products.

3.2 Second-hand Smoke (SHS).

Action points:

- To provide expert advice through the Tobacco Control Strategy to reduce exposure to young children, underage and illegal sales (trading Standards) and provide mentoring and level 1 smoking cessation education to schoolteachers and youth services so that the harms of smoking can be relayed on to the young.
- The overall aim of this strategy is to reduce the prevalence of 15-year-olds who regularly smoke from 8% to 3% or less. Early intervention in the younger years is a key to success.
- Assertively target settings where families of young people at risk of exposure to SHS may access support, for example Children Centres, Paediatric Unit, Hillingdon Homes and Housing Sector.
- Ensure implementation of the borough wide Smokefree homes initiative.
- Identify opportunities to implement joint strategy in conjunction with key partners (Hillingdon Community Trust, Hillingdon Hospital and Hillingdon council) to address staff and client exposure to SHS, where not covered by legislation.
- Support Hillingdon Environmental Health to maintain high compliance with Smokefree Legislation.
- Support London Borough Hillingdon Fire Service to promote Home Fire Safety Visits
- Apply a range of Smokefree messages that promote a positive health, environmental, financial and ethical approach to reduce tobacco consumption – especially hard to reach groups.
- Training of Maternity HCP's on educating pregnant ladies on the harms of SHS to their babies.
- Deliver Level 1 training to Children Centres front line staff.
- Deliver SHS Very Brief Advice (VBA) training to Health Visitors.
- Continue to promote Smokefree Homes Campaign.
- Work with Veterinarian surgeries to target pet owners.

3.3 Smoking and Mental Health.

Action Points:

- Increase awareness of 'Kick It' and the ability to influence change- ASK, ACT, ADVISE.
- Provide access to training for all health professionals on smoking cessation, particularly those working with mental health patients.
- Tool kit, working with the wider Mental Health Trust to establish effective pathways resulting in a greater success to support smokers in mental health settings.
- Provide appropriate licensed pharmacotherapy and follow NICE guidelines.
- Work with the Mental Health and Smoking Partnership of Royal Colleges, third sector organisations and academic institutions to consider the evidence on how to reduce the prevalence of smoking among people with mental health conditions.
- Support the implementation of commissioning levers, which includes a requirement for clinicians to undertake assessment and arrange for intervention where appropriate in relation to smoking status.

3.4 Smoking in pregnancy.

Actions:

- Collaborative partnership working with secondary care such as the Hillingdon Hospital maternity services.
- Train midwives and improve confidence levels on counselling a pregnant lady on the harms of smoking and the treatment options available such as Nicotine Replacement Therapy.
- Ensure that VBA (Very Brief Advice) on smoking cessation is embedded into every antenatal clinic.
- Ensure that systems are in place so that **ALL** pregnant woman will have a carbon monoxide (CO) check **at their first midwife appointment.** This is part of routine antenatal care.
- Train Children's centre staff on the harms of smoking and pregnancy.
- Robust pathways are in place from secondary care to the Hillingdon Stop Smoking service.

3.5 Smokeless and Niche Tobacco Products.

Smokeless tobacco & **Shisha.**

Actions:

- Work with Trading standards, Licensing team, food and workplace safety and planning enforcement to ensure that Shisha bars in the Borough comply with tobacco regulations and are aware of the fines and closure if they do not adhere to legal requirements.
- Visits to check correct labelling and signage is on display and give information about underage sales.
- Ensure that Shisha bars are aware of the regulations and are not serving or promoting Shisha to under 18-year-olds.
- Educate children and young people regarding the harms of Shisha. Provide level 1 training to schoolteachers and youth workers.
- Educate adults, particularly in the ethnic communities highlighting the harms associated with Chewing tobacco.

- Engage with dentists providing level 1 training on smoking and VBA – Very Brief Advice.

3.6 Electronic Cigarettes & Vaping.

Actions:

- Provide education, guidance and support school policies on vaping.[91]
- Trading Standards and Licensing team continue to ensure that vape shops are selling products to adult residents which are adhering to the defined regulations set up by the Tobacco and Related Products Regulations[92].
- Local policy should aim to prevent the uptake of EC by young people in line with a voluntary code of EC vendors[93] but explore how to best accommodate ECs as an aid to quitting smoking in established smokers**.**
- Explore possible regulation of the number of vape shops within Hillingdon.
- Monitor the impact of regulation and policy on e-cigarettes and novel tobacco products in England, including evidence on safety, uptake health impact and effectiveness of these products as smoking cessation aids to inform our actions on regulating their use.

3.7 Smoking Cessation Service

Actions:

- Evaluate performance relative to the KPI's set out in the contract.
- Identify areas where strategies are necessary to improve quit rates such as advertising through online social networks.
- Ensure collaborative working with partner organisations such as the CCG, PCN's, Confederation, H4ALL, Healthwatch, to increase exposure to residents and increase referral rates into the service.
- Evaluate examples of good practice from other London services with an aim to integrate these ideas into the current Hillingdon service.
- Ensure preparations for PHE campaigns such as: Stoptober and No Smoking Day are fully covered.
- Ensure that the members of the smoking cessation team are actively attending network meetings arranged by ASH, PHE and the London Tobacco control network.
- Ensure collaborative working with GP surgeries ensuring that a referral pathway for their smoking population of patients is in place to the pharmacy or core service.
- Ensure collaborative working with schools and colleges to highlight the harms associated with smoking and education on the take up of vaping.
- Address health inequalities through CORE20Plus5 and population health methodology.
- Ensure that the smoking cessation team are engaged in promoting the service through the Local Authority funded LSCTP[94] (London Smoking Cessation Transformation Programme).
- Ambition to reduce smoking prevalence among adults in Hillingdon to 5% or less
- Reduce the prevalence of 15-year-olds who regularly smoke to 3% or less
- Reduce the prevalence of smoking in pregnancy to 6% or less.
- Work towards the NHS Log Term Plan commitments – by 2025
- Ensure that there are systems in place so that all people admitted to hospital who smoke will be offered NHS funded tobacco dependency treatment support.
- Ensure that a partnership exists with the Hillingdon maternity services so that expectant mothers and their partners, with a new smoke-free pregnancy pathway.
- Ensure that an outpatient stop smoking support offer will be available as part of specialist mental health services including learning disability services.

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HEALTHY HAYES: WHOLE SYSTEMS APPROACH TO OBESITY

Relevant Board Member(s)	Councillor Jane Palmer Kelly O'Neill Interim DPH
Organisation	London Borough of Hillingdon
Report author	Shikha Sharma
Papers with report	Appendices 1 and 2

HEADLINE INFORMATION

Summary	This report provides an update on: 1. Progress on Healthy Hayes Project 2. Feedback from the Healthy Hayes Workshop held on 28th March 3. Background to Whole Systems Approach. 4. Proposed plan for HWBB agreement
Contribution to plans and strategies	The Joint Health and Wellbeing Strategy HHCP Delivery and Health Protection Boards
Financial Cost	None
Ward(s) affected	Hayes / ALL

RECOMMENDATIONS

That the Health and Wellbeing Board notes that:

1. **Obesity remains a significant challenge for Hillingdon with around a quarter of Hillingdon's adults and over a quarter of children in year 6 (25.6%) estimated having BMI ≥ 30 (obese). Food-related ill health, including high BMI, is second only to smoking as a contributor to poor health outcomes in the UK.**

2. **England's Whole Systems Approach (PHE, 2019) recognises that complex issues like obesity require sustained and systemic action and buy in from systems leaders which is essential to support implementation.**

3. **Social care and NHS costs related to obesity are estimated at £58 bn (3% of GDP); and are going to increase as the adult population with obesity and severe obesity increases and ages. Effectively preventing and treating obesity will tackle health inequalities and has the potential to significantly improve quality of life and wellbeing, in addition to reducing health and social care costs (estimated at £35 million for every 4 percentage points) (Frontier Economics, 2022)**

4. **The Health and Wellbeing Board Members, Hillingdon's Health and Care leaders are requested to consider investment into weight management lifestyle services and children's oral health to reduce food and obesity related inequalities and reduce obesity related health and social care costs.**

Healthy Hayes Progress Report

1. Introduction and background

This report summarises the progress on implementing 'Healthy Hayes Whole Systems Approach' for reducing overweight and obesity. The report describes the outcomes of a stakeholder workshop (HHW1) held on 28th March. The aim of the workshop was to share information with stakeholders from health, social care, education, leisure and voluntary sector about taking systems approach to addressing obesity; and develop a shared understanding about the issues that influence weight gain at population level. Group discussions were held to gather insights from people with varying degree of expertise who have been working in the field on strengths, challenges and opportunities for tackling obesity and agreeing a way forward.

In September 2022, Hillingdon Health and Wellbeing Board had approved the use of the nationally recognised Whole Systems Approach (WSA) for obesity recognising that the causes of excess weight are complex and closely linked with not only to health inequalities, but also to the wider societal and economic inequalities that affect people's lives. Hence acting on systems and disrupting factors which cause and contribute to people adopting unhealthy behaviours must form part of the strategy for reducing obesity and excess weight.

Hayes has been identified as the geographic focus for this work where factors affecting the health of the population will be studied and tested through engaging with the local communities living in that area.

Implementation of Whole Systems Approach requires a clear vision and recognition of the challenges and opportunities in partnership with stakeholders and residents which was the focus of the workshop held on 28th March 2023 at the Navnat Centre, Hayes.

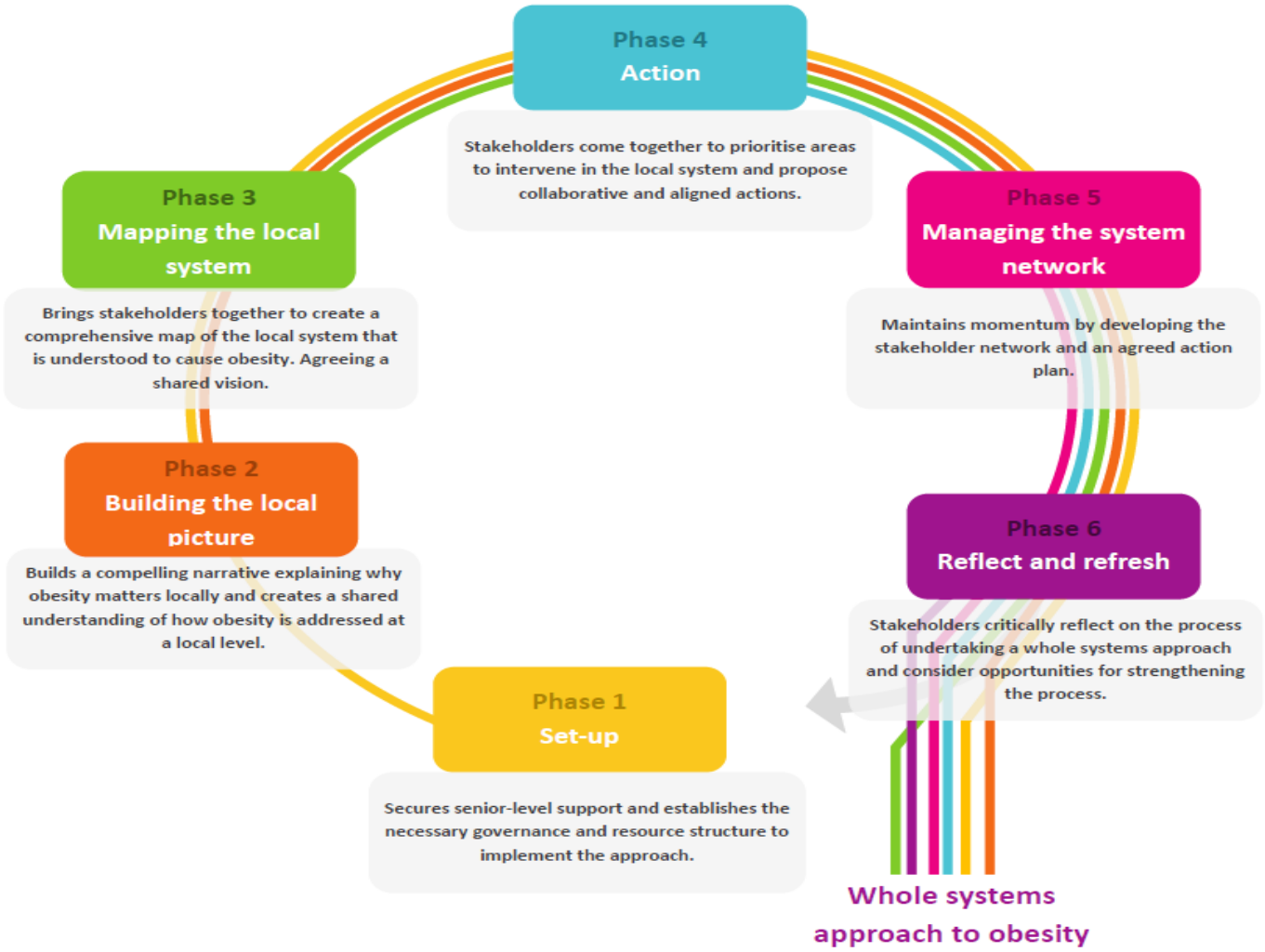
2. The Local Whole Systems Process

Obesity is a complex issue which requires embracing whole systems working as opposed to single organisations working on parts of the system while other parts of the system continue to contribute to the issue.

England's Whole Systems Approach responds to complexity through an ongoing, dynamic and flexible way of working. It is about engaging stakeholders from different parts of the system and understanding how a change in one part of the system affects other parts of the system. WSA enables local stakeholders, including communities, to come together, share an understanding of the reality of the challenge, and identify the greatest opportunities for change. Stakeholders agree actions and decide as a network how to work together in an integrated way to bring about sustainable, long-term systems change.

A phased approach to WSA is recommended which we are following for our local 'Healthy Hayes' programme as it also aligns to the Borough Population Health Management framework (Figure 1). These phases are based around the core idea that it should be easy for everyone in an area (Hayes) to eat healthily and lead active lives from childhood and throughout their lives. However, this is not currently the case, as is evident in our local indicators (Figure 2). It is important that we create healthier environments locally for every child, and every resident and we achieve this led by evidence of what works, through the (WSA) methodology agreed with HWBB last September.

Figure 1: Process for implementing whole systems approach



3. ACTIONS TAKEN SO FAR

The 6- phase process described above can be used flexibly by local authorities and for Hayes, we have adapted the methodology based on the work that had already taken place in relation to actions, capacity, structures and relationships.

PHASE 1: Set up (August 2022- December 2022)

Aim	Actions taken
To secure support from the senior leadership and agree a way forward	1. Set up the core group (Table 1 below) and agreed to develop WSA local approach for tackling obesity 2. Review of evidence and national toolkit by core group members 3. Collation and review of local demographic data, health outcomes and identification of Hayes as the local area for testing the WSA approach for Hillingdon. 4. Secured support from the HWBB, the senior leaders of PLACE and key stakeholders 5. Started Assets Mapping exercise. 6. Met with education team to identify actions for progressing work with schools. 7. Applications submitted to OHID for School Superzone Funding for 3 schools.

Table 1: The Core Working Group	
Purpose	To undertake the day-to-day operations and coordinate the approach
Responsibilities	- Identify and prepare stakeholders - Maintain momentum - Produce and collate project plan, workshop materials - Operationalise workshops and the system network - Start focus groups - Feedback to senior leaders
Members	Junior and senior public health officers who have strong connections internally and externally plus administrative support
Membership	Kelly O'Neill, Claire Hallett, Viral Doshi, Becky Manvell, Priscilla Simpson, Julia Heggie, Sarah Durner, Mekaya Gittens and Shikha Sharma
Frequency of meetings	Weekly or fortnightly during phases 2, Fortnightly / monthly thereafter

PHASE 2: Building the Local Picture (January 2023- March 2023)

Aim	Actions taken
Engaging with local stakeholders, build a compelling narrative explaining why obesity matters locally and create a shared understanding Engagement with communities, organisations, early years settings, schools, transport, leisure, health services, businesses, social care, voluntary sectors to start work on the environment for supporting children and families to achieve and maintain a healthier weight.	1. Collated key information about Hayes 2. Scoping with community leaders, orientation tour of the busy high street, visit to Hayes Muslim Centre and discussion with Imam, visit to Navnat Centre, Hayes: management waived booking cost for the workshop. 3. Secured leadership support from Portfolio holder for Adult Social Care and Health: Cllr. Palmer Chaired the workshop. 4. Identify local stakeholders for holding a workshop in HAYES for developing common understanding about local strengths, weaknesses, opportunities and challenges for children and families. 5. Collected stakeholder feedback on Excess Weight 6. Collected stakeholder feedback on Breastfeeding Campaign and Weight Management 7. Put together an agenda and share information packs in advance of the workshop 8. Held Healthy Hayes workshop on 28th May 2023 9. Analysis of themes emerging from workshop discussion 10. Success in securing School Superzone funding for 1 school. Asked to submit revised applications for the other 2 schools in the next funding round. 11. Start to understand community capacity and interest to work on obesity / healthy weight

HEALTHY HAYES WORKSHOP: SUMMARY OF STAKEHOLDER FEEDBACK FROM THE WORKSHOP AND STAKEHOLDER SURVEYS

KEY THEMES	FEEDBACK / COMMENTS
FOOD ENVIRONMENT AND FOOD SYSTEM	**Food availability, food security, economy and quality:** Too many fast-food shops with low-cost food and easy access to poor quality of food, Fast food options, take aways everywhere - sweet shops on school routes, easy availability of sugary drinks, chicken and chips. Nice, healthy restaurants are closing only fast-food options thriving. Children go there it's cheap. Parents taking young children to chicken and chips shop straight from school. Unhealthy, cheap and very tempting. There is lots of fresh food to be bought but too many fast-food shops and sweets as easily available and cheap solution for parent. CoL and Energy crisis have played to limit choices. Consequences for child weight and oral health. **Food safety:** Need clarity on quality control by the Council, on-line restaurants/personal catering companies registered. - Crime linked to take away shops **Food Policy:** Prioritise health in all policies, Apply Legislation (fat, sugar) How to prioritise health in decision making? Formulation: mindset of businesses needs to change ways of making food
COMMUNITY PARTNERSHIP ACTION: KNOWLEDGE, SKILLS, CULTURE AND BEHAVIOURS	**Knowledge and information**: Unaware of calorie content, food labelling, lack of understanding about processed food Misconceptions about what's healthy, need to go back to basics re healthy eating, Portion sizes are unknown - Inadequate public knowledge - Understanding of overweight from people - "I tell my kids why do you think this is cheap? What oil are they using, how many times has it has been used" **Skills building for frontline professionals and public:** - How to address the issue of weight with parents? - Parents don't know how to cook / only cook on certain days - Generation lacking cooking skills - I teach my kids to cook they get pizza as a reward. - I make quick foods and freeze, like kebabs, keema." **Culture and Behaviour:** Cultural influences on eating, learnt behaviours, fasting In school setting, noticeable cultural differences in obesity amongst children. "Information

	- Residents from certain backgrounds might not understand how bad fast foods are and might view those as western foods, and therefore good for you. When local professionals have tried to mention to people about how bad they can be their reaction is often what are you talking about. - Minority parents have a lack of culturally appropriate information of how bad these foods are. They think easy access, easy food but they do not understand the long-term impact."
CHILDREN'S SETTINGS / SCHOOLS	**Start Early in Life** Lots of evidence on breastfeeding and prevention of obesity – needs support from PLACE. BF rates stayed same / deteriorated Lack of funding for BF groups to form to provide consistent opportunities" Promotion of Healthy Start Scheme needed Limit sugary drinks and foods high in fats, sugar and salt (HFSS) at children's settings. - Maternity support depleted over the years **School meals:** - Standard of school meals (refer to schools' survey) - Why serving deserts to children at lunchtime? - Lack of healthy choice options, small quantity of healthy meals - HAF food not always healthy" - "Packed lunches less / more balanced than school dinners - Pack lunches high in sugar" - Packed lunches good / healthy alternative - Water only schools for positive impact on general health and teeth **Access to healthcare services and support: capacity and Investment** - Lack of access to health care NHS obesity services (T3/ T4) and support services - Lack of access to T2 obesity services - Poor capacity to support demand and need (My Choice): School nurse capacity issues - 1 nurse covers 6 schools" **Sedentary behaviour of children - to get out and less reliance on technology**
PHYSICAL ACTIVITY	**Environment: Availability of open, accessible spaces** - Lack of exercise opportunities, no cycle networks, the parks provide exercise space, **Time:** - Not walking to school because of time constraints - Lack of parental time to take children to activities

	Cost:- - Lack of free access - Family cost for a couple of hours high. - Need more affordable gyms or programmes - Lots of gyms but not affordable-£21/month for my 15-year-old - Accessible health centres (exercise, badminton, gym) for young people. It needs to be affordable. - Families have many children in Hayes, so it becomes too expensive. **Safety:** - Perceived and actual fears around safety- Make roads safe and accessible for cycling - Safety- open environment" **Awareness:** - How to use Green Spaces, lack of awareness of green spaces; open people's eyes to parks/green spaces locally - there are lots of parks which now have gyms in it
CROSS-CUTTING THEME: COMMUNICATION	**Language and messaging:** - Messaging is negative - Terms overweight / obesity can be a barrier to engaging - Over-reliance on social media not conducive with communities - Word of mouth might work better for some BMEs - YouTube ads targeting kids. - Social influence via media" **Campaigns:** - Not sufficient numbers engage in mass media campaigns - Difficult to engage families
CROSS-CUTTING THEME WIDER DETERMINANTS: HEALTH IN ALL POLICIES	**Economy / Income / cost of living** - Free school meals available - Yes, it would be good to have access to cheaper foods. I sometimes go to the foodbank and try to eat as healthily as possible, but it is not easy with the cost of living. - Cost of fruit and vegetables too expensive. I don't buy mine and this is why they go to chicken and chips it's filling and cheap. - Younger kids' parents don't cook. Ingredients for a meal is more expensive than buying fast food. **Deprivation:** - Easy access to gambling - Substance abuse - Deprivation in the local area - People living in deprived conditions can't afford healthy food.

	Education and unemployment - Lower education outcomes and employment opportunities rife **Health risk factors:** - Parental weight as a risk factor - Cultural / ethnic risks for health conditions **Workplaces and Sedentary behaviours:** - Sedentary behaviour is the norm. - Longer hours. - Technological advances.

4. Where do we want to be?

We want Hillingdon to be a place where excess weight is no longer a significant health issue for children and their families. Our actions to tackle obesity at local level won't just benefit people's health. They will have positive impact on other local agendas including employability and productivity of local populations and in future years reduce the demand for social care.

By aligning the WSA with a 'Health in All Policies' approach, we want to be able to address complexity and tackle inequalities. The Logic model in APPENDIX 1 demonstrates the outcomes that can be seen in Hillingdon at population level by initiating changes in the way we work together. We plan to develop our own Logic Model with stakeholders as part of our work during Phases 3 &4.

There are pressing strategic and financial reasons to tackle the current burden of overweight and obesity starting early in childhood and following through the life course.

Over a fifth of children aged 4 to 5 (21.8%) are overweight or obese and the proportion of overweight and obese children increases to 41.7% by the time they are 10–11-year-olds (Fig. 2)

Over half of all adults are either overweight or obese with nearly a quarter with their BMI in the clinically obese range.

Younger generations are becoming obese at earlier ages and staying obese for longer and therefore it is important to have long term plans and strategies for obesity which is a major driver of inequalities in future generations. In the most deprived areas almost a third of primary school leavers are obese compared with just 13.5% in the least deprived areas.

The government ambition is to halve childhood obesity rates by 2030 and significantly reduce the health inequalities that persist. This is important in order to reduce the risk of a wide range of long-term conditions, reduce the financial burden on the NHS and reduce the risks of obesity into adulthood**.** Obesity increases the risk of many preventable diseases including type 2 diabetes, cardiovascular disease and some cancers. Additionally, obesity can reduce life expectancy, sometimes by up to nine years; an effect comparable to that of smoking.

Obesity is certainly not just a health issue. Costs to social care, of long term care, adaptations and specialist equipment are under-recognised and insufficiently identified. A recent study by Frontier Economics (Frontier Economics, 2022) has strengthened the case for tackling obesity by quantifying the huge economic costs associated with its impacts on individual quality of life, as well as the

pressure it puts on care services and the wider economy.

The report estimated that the annual cost of adult obesity to UK society is around £58bn, roughly equivalent to 2-3% of GDP or the total annual funding allocated to schools in England.

In order for Hillingdon to provide an environment where healthy behaviours become the easier choice and eventually the 'norm'; local leaders can help by encouraging 'buy in' from all parts of the system, enabling better use of local assets and resources.

We would like to propose actions to progress work areas highlighted by stakeholders so far, allocating dedicated time, reasonable investment (e.g. to establish weight management services) and policy support (Health in All Policies) for this work.

Figure 2: Hillingdon Obesity Profile

Indicator	Period	Hillingdon			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Reception: Prevalence of underweight	2021/22	→	110	3.0%	1.9%	1.2%	4.6%		0.3%
Reception: Prevalence of healthy weight	2021/22	→	2,770	75.1%	76.2%	76.5%	69.9%		
Reception: Prevalence of overweight (including obesity)	2021/22	→	805	21.8%	21.9%	22.3%	28.9%		
Reception: Prevalence of overweight	2021/22	→	410	11.1%	11.1%	12.1%	7.0%		%
Reception: Prevalence of obesity (including severe obesity)	2021/22	→	400	10.8%	10.8%	10.1%	14.9%		
Reception: Prevalence of severe obesity	2021/22	→	115	3.1%	3.4%	2.9%	5.8%		0.9%
Year 6: Prevalence of underweight	2021/22	→	80	2.1%	1.7%	1.5%	4.4%		0.6%
Year 6: Prevalence of healthy weight	2021/22	→	2,120	56.2%	57.8%	60.8%	49.0%		
Year 6: Prevalence of overweight (including obesity)	2021/22	→	1,575	41.7%	40.5%	37.8%	49.1%		
Year 6: Prevalence of overweight	2021/22	→	610	16.2%	14.7%	14.3%	9.3%		17.4%
Year 6: Prevalence of obesity (including severe obesity)	2021/22	→	965	25.6%	25.8%	23.4%	34.0%		
Year 6: Prevalence of severe obesity	2021/22	→	220	5.8%	6.6%	5.8%	10.4%		
Reception: Prevalence of obesity (including severe obesity), 5-years data combined	2017/18 - 21/22	–	-	9.9%	10.3%	9.7%	13.6%		
Year 6: Prevalence of obesity (including severe obesity), 5-years data combined	2017/18 - 21/22	–	-	23.3%	23.9%	21.0%	30.2%		

Source: OHID Fingertips

5. Proposed actions for Phase 3 (April – December 2023)

Our forward plan below is based on what we have learnt from the first two phases: the assets mapping, stakeholder analysis, insights, surveys and the 'Healthy Hayes' workshop.

In the next phase, we plan to start open discussions amongst stakeholders around aspirations and challenges around addressing the food environment and food systems, actions to be taken in

children's settings and schools, communication with communities and the role of 'Health in All Policies".

The role of systems leaders represented on the Health and Wellbeing Board is crucial for this approach to work due to the culture, environment, behaviour change and resourcing that will be required on a sustained and continued basis. Our proposals for the next phase are:

1. **Set up a systems network and engage senior officers, managers, stakeholders from across the system who will contribute to WSA and support the Core Team**

   In order to maintain stakeholder accountability and support for the local whole systems approach, we will need to continuously connect with the system partners, learn about mutual priorities and create the space to bring people together. This can have members of the current Hillingdon Obesity Strategy Group but there are gaps and we would want greater involvement from teams working in Hayes area.

2. **Develop collective ownership of the local vision and milestones**

   Develop a clear and aspirational vision with stakeholders and communities for what our whole systems approach is trying to achieve and influence and facilitate stakeholders across the system to take responsibility and own their actions, and
   a) Create a comprehensive local systems map
   b) Identify resources for supporting work on stakeholder mapping and action mapping: i.e. which current local actions / interventions impact on inequalities

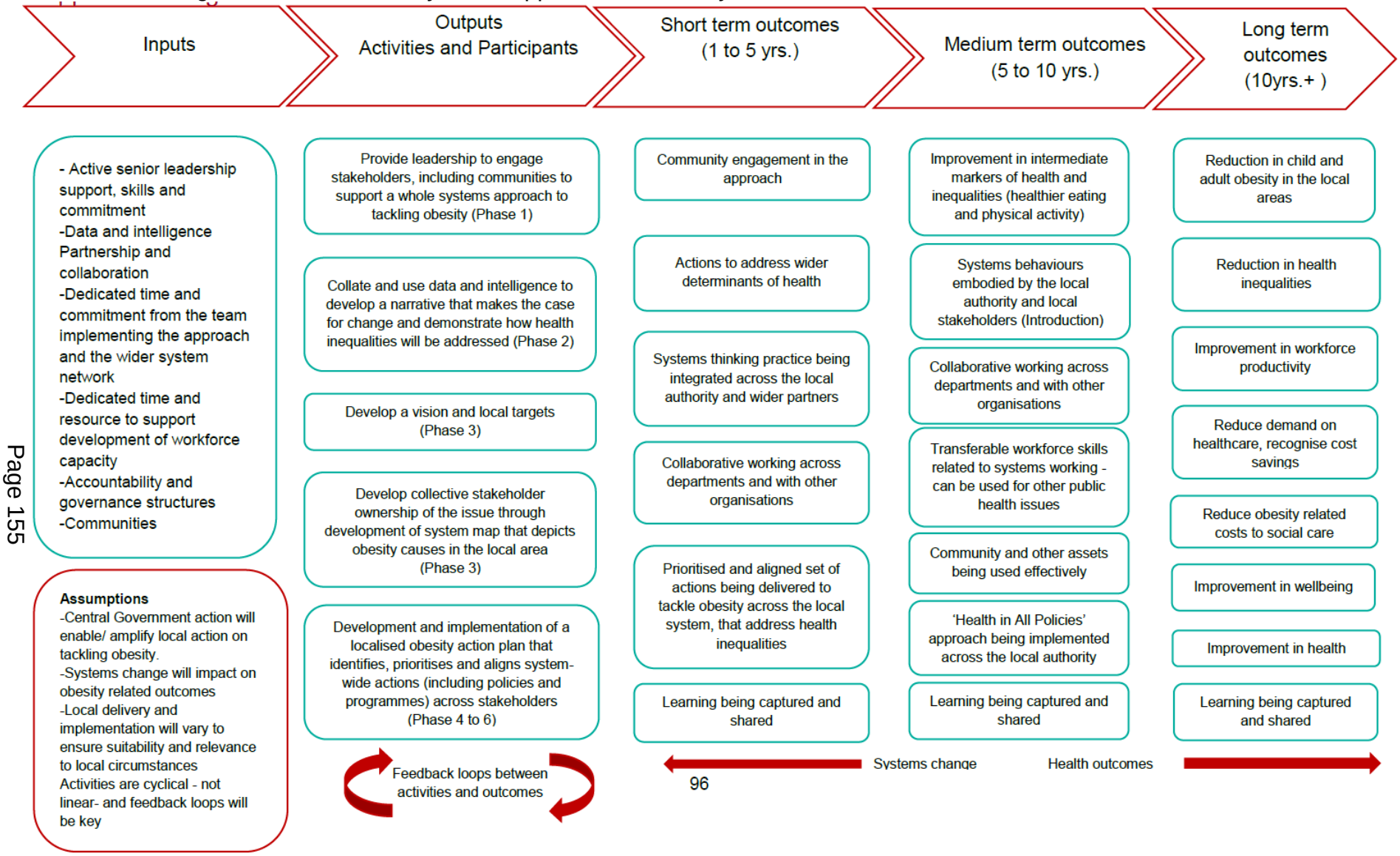
3. **Investment in weight management services to increase access to adults Tier 2 weight management and children's Tier 2 weight Management:**

   In order to create capacity to address the current and growing burden of overweight and obesity, this is one area of the system which requires investment. We have estimated 55,000 obese adults and 15,000 obese children in our population (conservative estimates) and our only commissioned adults weight management programme has the capacity to serve 200 adults.

4. **Finalise Physical Activity Needs Assessment and Strategy** to improve local rates for adults and children

5. **Start delivery of School Superzone starting with Minet School.**

APPENDIX 1: Logic Model for Whole Systems Approach for Obesity



APPENDIX 2

HEALTHY HAYES WORKSHOP: Delegate Evaluation Feedback

28th March 2023

64 delegates confirmed prior to the workshop
36 delegates attended (33 from main invite list, and there were 3 walk-ins on the day)
26 evaluations received
Scale: (1 = Poor, 2=Average, 3 = Good, 4 = Very good 5 = Excellent)

Presentations (Opening address, rethinking obesity, systems approach).	Very Good / Excellent
Group Discussion 1 (Rethinking How We Tackle obesity)	Very Good / Excellent
Group discussion 2 (Taking a Systems Approach)	Very Good / Excellent *****1 person said they didn't get to discussion point 2
Plenary / Next Steps	Good / Very good/ Excellent
If there is <u>one change</u> that you would like to see actioned in Hayes because of today, what would that be?	• Less chicken shops • Root causes identified and prevention pre-birth • More health promotion to empower communities to make healthier lifestyle choices • Educate all communities • Review of Food licencing laws in Hayes Town • Community communication between institutions • A core resource of expertise to signpost and contacts for interventions • Projected data to change for the better • More events like this and to include residents in next steps – don't implement something that isn't wanted or needed • Improved local networking and listening events • Healthy eating/shopping workshops • Improved working habits & lifestyle • Organisation/Committees working together who already offer services in our communities • Greater collaboration like this • To devise an anti-natal – year 7 workshop for parents • Tackling childhood obesity • Eliminate unhealthy school snacks
How would you like to be involved in this work?	• To provide registered list • Working closer with communities • Community involvement to ensure services are responsive to the need and communicating effectively • To be part of events delivering information

	• Communication with food businesses • Educate and attend workshops • Being part of a working group • Discussions and follow up • MyHealth is happy to facilitate workshop in support • Using local contacts in Hayes • Involvement in meetings to update on progress • Involving the voluntary sector at length • More public awareness/education • Working with young people
Information provided in delegate packs	Very Good - Excellent
Venue/Catering	Very Good – Excellent

Other Comments

- Good opportunity to meet other agencies and explore ways to work together
- Great discussion, lots of ideas
- Really pleased to be involved in this piece of work
- Thank you for a truly wonderful afternoon and great networking opportunities
- Good involvement from all participants, inputs felt valued
- Good venue and accessibility via public transport
- Thank you, the food was lovely!
- More time for focused discussions next time
- Clear, hopeful acknowledgement that more work needs doing

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BOARD PLANNER & FUTURE AGENDA ITEMS

Relevant Board Member(s)	Councillor Jane Palmer Keith Spencer
Organisation	London Borough of Hillingdon Hillingdon Health and Care Partners
Report author	Nikki O'Halloran, Democratic Services
Papers with report	Appendix 1 - Board Planner 2023/2024

1. HEADLINE INFORMATION

Summary	To consider the Board's business for the forthcoming cycle of meetings.
Contribution to plans and strategies	Joint Health & Wellbeing Strategy
Financial Cost	None
Relevant Select Committee	N/A
Ward(s) affected	N/A

2. RECOMMENDATION

That the Health and Wellbeing Board considers and provides input on the 2023/2024 Board Planner, attached at Appendix 1.

3. INFORMATION

Supporting Information

Reporting to the Board

The draft Board Planner for 2023/2024, attached at Appendix 1, is presented for consideration and development in order to schedule future reports to be considered by the Board. Members may also wish to consider any standing items (regular reports) and on what frequency they are presented.

The Board Planner is flexible so it can be updated at each meeting or between meetings, subject to the Co-Chairmen's approval.

Board agendas and reports will follow legal rules around their publication. As such, they can usually only be considered if they are received by the deadlines set. Any late report (issued after the agenda has been published) can only be considered if a valid reason for its urgency is agreed by the Co-Chairmen.

Advance reminders for reports will be issued by Democratic Services but report authors should note the report deadlines detailed within the attached Board Planner. Reports should be presented in the name of the relevant Board member.

With the Co-Chairmen, Democratic Services will review the nature of reports presented to the Board in order to ensure consistency and adequate consideration of legal, financial and other implications. It is proposed that all reports follow the in-house "cabinet style" with clear recommendations as well as the inclusion of corporate finance and legal comments.

The agenda and minutes for the Board will be published on the Council's website, alongside other Council Committees.

Board meeting dates

The Board meeting dates for 2023/2024 were considered and ratified by Council at its meeting on 23 February 2023 as part of the authority's Programme of Meetings for the new municipal year. The proposed dates and report deadlines for the 2023/2024 meetings have been attached to this report as Appendix 1.

Financial Implications

There are no financial implications arising from the recommendations in this report.

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

Consultation Carried Out or Required

Consultation with the Chairman of the Board and relevant officers.

5. CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

There are no financial implications arising from the recommendations in this report.

Hillingdon Council Legal comments

Consideration of business by the Board supports its responsibilities under the Health and Social Care Act 2012.

6. BACKGROUND PAPERS

NIL.

APPENDIX 1

BOARD PLANNER 2023/2024

12 Sept 2023 2.30pm Committee Room 6	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Thursday 31 August 2023 **Agenda Published:** 4 September 2023
	2023/2024 Integrated Health and Care Performance Report and BCF Progress	LBH/HHCP	
	Health and Wellbeing Strategy – One Year On	LBH	
	Board Planner & Future Agenda Items	LBH	
	PART II - Update on current and emerging issues and any other business the Co-Chairman considers to be urgent	All	

28 Nov 2023 2.30pm Committee Room 6	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Thursday 16 November 2023 **Agenda Published:** 20 November 2023
	2023/2024 Integrated Health and Care Performance Report and BCF Progress	LBH/HHCP	
	Board Planner & Future Agenda Items	LBH	
	PART II - Update on current and emerging issues and any other business the Co-Chairman considers to be urgent	All	

5 Mar 2024 2.30pm Committee Room 6	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Thursday 22 February 2024 **Agenda Published:** 26 February 2024
	2023/2024 Integrated Health and Care Performance Report and BCF Progress	LBH/HHCP	
	Board Planner & Future Agenda Items	LBH	
	PART II - Update on current and emerging issues and any other business the Co-Chairman considers to be urgent	All	

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