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Health and Wellbeing Board

Date: **TUESDAY, 30 JULY 2024**

Time: **2.30 PM**

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

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To Members of the Board:

- Cabinet Member for Health and Social Care (Co-Chair)
- Hillingdon Health and Care Partners Managing Director (Co-Chair)
- Cabinet Member for Families, Education and Wellbeing (Vice Chair)
- 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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Agenda

CHAIR'S ANNOUNCEMENTS

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4	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	-

Health and Wellbeing Board Reports - Part I (Public)

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Health and Wellbeing Board Reports - Part II (Private and Not for Publication)

That the reports in Part 2 of this agenda be declared not for publication because they involve the disclosure of information in accordance with Section 100(A) and Part 1 of Schedule 12 (A) to the Local Government Act 1972 (as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

5 March 2024

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

	Board Members Present: Councillors Jane Palmer, Keith Spencer, Susan O'Brien (Vice-Chair), Richard Ellis, Claire Eves (In place of Vanessa Odlin), Lynn Hill, Derval Russell, Ed Jahn, Julie Kelly, Sandra Taylor and Patricia Wright **Officers Present:** Gary Collier (Health and Social Care Integration Manager), Professor Naomi Low-Beer (Dean of Brunel Medical School), Abi Preston (Head of Education Improvement & Partnerships) and Nikki O'Halloran (Democratic, Civic and Ceremonial Manager)
36.	**APOLOGIES FOR ABSENCE** *(Agenda Item 1)* Apologies for absence had been received from Professor Ian Goodman (North West London Intergrated Care Board), Ms Vanessa Odlin (Ms Claire Eves was present as her substitute) and Mr Tony Zaman (the Council's Chief Executive).
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 28 NOVEMBER 2023** *(Agenda Item 3)* The Co-Chair noted that, at the last meeting, the *2023/24 Integrated Health and Care Performance Report* had incorrectly stated that the wellbeing bus in Heathrow Villages had been scheduled to run from 10am to 5pm when it had actually been scheduled to run from 10am to 4pm. It was agreed that the wording of the third sentence in the third paragraph on page two of the minutes be amended to: "Councillor Sue O'Brien, Vice Chair, noted her disappointment that there had been little progress with regard to childhood obesity and that partners ~~couldn't do~~ *hadn't done* more." **RESOLVED: That the minutes of the meeting held on 28 November 2023, as amended, 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 5 to 9 would be considered in public and Agenda Items 10 to 11 would be considered in private.
40.	**BRUNEL UNIVERSITY MEDICAL SCHOOL COMMUNITY ENGAGEMENT - VERBAL UPDATE** *(Agenda Item 5)* The Chair welcomed those present to the meeting. Professor Naomi Low-Beer, Dean of Brunel Medical School (BMS), advised that BMS was a new institution designed for

a changing world by providing the opportunity to rethink the future of medical education and the type of doctors that could be developed (considering global challenges such as climate change, pandemics and conflict).

BMS had been envisaged in 2016 and had been established under Professor Low-Beer's leadership from 2020. The medical school was able to focus on the future of healthcare, team-based care, person-centred care, the use of technology, health and wellbeing, tackling health inequalities, patient empowerment and the transformation of healthcare through local partnerships.

Professor Low-Beer outlined three ways in which the medical school could make a difference: education; research and innovation; and local engagement. She described Brunel as a research-intensive, technologically focused university with a diverse student population and excellent healthcare partners. Brunel had a strong track record of widening access to its professional programmes which included nursing, OT physiotherapy, physician associates and social work.

The Board was provided with information about the medical school, including its MBBS degree programme and a physician associate MSc programme. The first cohort was currently in its second year of study and all of the students were international and self-funding. However, Professor Low-Beer advised that UK students would be starting at BMS from September 2024, with interviews for the first UK students taking place the following week.

BMS aimed to produce doctors that were aware of the importance of kindness, professionalism, lifelong learning and resilience and who adopted a teamwork ethos. The BMS programme had distinctive features such as team-based learning, a strong focus on communication skills and contact with patients in the local community from the first term of the first year.

As well as positive feedback about the first cohort, successes of the programme so far included the development of an identity as a London medical school, and interest from other UK medical schools in BMS's team-based learning approach. Professor Low-Beer noted that BMS had developed hospital partnerships and connections with the local community through primary care partnerships and community engagement projects.

Action was being taken to widen access events and outreach activities, including a STEM outreach programme called Girls in STEM. Key priorities and challenges for the future included successfully graduating the first cohort, recruiting local medical students from widening access backgrounds, expanding the Bachelor of Medicine, Bachelor of Surgery (MBBS) and Physician Associate (PA) programmes, and growing the BMS reputation for education. Action was being taken to introduce a new four-year MBBS programme, increasing the range of community placements, focusing on interprofessional learning and driving the local public health research agenda. This would secure BMS's position as a medical school in the community, for the community.

The Board commended BMS's team-based learning approach and queried how the school planned to show its students the benefits of early intervention and keeping people out of hospital, in line with the Borough's vision. Consideration would need to be given to how they could demonstrate what staying out of hospital looked like in Hillingdon and ensure that GPs referred correctly to social care when a medical intervention was not necessary.

	Professor Low-Beer was open to facilitating sessions for anyone interested in observing team-based learning. The community projects currently being undertaken by the students were their first exposure to seeing how patients were kept well out of hospital. Consideration was being given to formalising these projects into clinical placements for the later years for a more immersive experience. Concern was expressed in relation to the growth of the medical school in the next few years and how partners could work together to build the capacity required for the students, especially in primary care. The Board also questioned how the school would retain some of the great students within Hillingdon so that they could get involved longer term with the local community. Professor Low-Beer advised that, even among international students, they expected around 70% to stay for some years after they had graduated, if not even longer term. Consideration was also being given to adopting live streaming technology to accommodate more students. Ms Kelly O'Neill, Hillingdon's Director of Public Health, commended the inclusion of public health and community-based understanding in the medical school's agenda. She asked what difference the school expected to see when their first graduates finished in five years and how they could help their students understand how people lived and how that affected their health and wellbeing. Professor Low-Beer advised that BMS was aiming to create generalist doctors with an awareness of what the community had to offer in terms of care and the importance of health promotion and prevention. She would welcome having Ms O'Neill in to talk to their students. **RESOLVED: That the presentation and discussion be noted.**
41.	**HILLINGDON'S JOINT HEALTH & WELLBEING STRATEGY 2022-2025** *(Agenda Item 6)* It was agreed that this item be deferred to a future meeting. **RESOLVED: That this item be deferred to a future meeting.**
42.	**2023/24 Q3 INTEGRATED HEALTH AND CARE PERFORMANCE REPORT** *(Agenda Item 7)* Mr Gary Collier, the Council's Health and Social Care Integration Manager, advised that the Council had recently received an 'Outstanding' Ofsted inspection result for its Children's Services. Adult Services was currently preparing to undergo a similar process with the Care Quality Commission later in the year. It was agreed that the Q3 performance template would be signed off under delegated arrangements. With regard to preparation time for the 2024-2025 Better Care Fund submission, it was likely that Hillingdon would only receive around six weeks' notice. The Board was advised that the population health management infrastructure posts were currently being advertised. It was hoped that the interviews would take place in April so that the outcome could be reported back to the Board at its next meeting on 11 June 2024. Other positive news included the opening of the second same-day urgent care hub in October 2023. Mr Collier had updated the Cabinet and the Health and Social Care Select Committee on the Carers' Strategy. A high number of carers had been declining to have a carers assessment (the route to statutory support from the local authority). He would keep the Board updated on any progress that was made in improving uptake.

Ms Kelly O'Neill, the Borough's Director of Public Health, advised that action was being taken to align the Public Health Officers in the Integrated Neighbourhood Teams with the Population Health Management work that was being undertaken. The NWL Integrated Care Partnership had prioritised the need to undertake further work to increase the uptake of cervical screening and expand the promotion of cancer checks to drive the uptake amongst young women. The emphasis needed to be on keeping their families and themselves safe and making it as easy as possible to access screening / tests. The communications also needed to be as simple as possible.

The Board queried the data related to the number of people still at home after 91 days of reablement. Mr Collier advised that there had been some issues getting the data together, but the data for the national metric would be the number of people admitted to hospital in Q3 and whether they were still at home during Q4. He also mentioned that this metric would be discontinued from this year and expanded to all adults from next year. There had been an increase in the number of long length patients at Hillingdon Hospital which had, in part, been driven by elective patients' length of stay during the recent junior doctor strikes. The length of stay for non-elective patients had decreased. The average length of stay needed to reduce from 10.7 days (the NWL average was 7 days).

Mr Keith Spencer, Co-Chair and Managing Director of Hillingdon Health and Care Partners (HHCP), advised that work had been undertaken with Mr Steve Curry at Harlington Hospice/Michael Sobell Hospice to be more clear about what good end of life care looked like. Metrics had been agreed.

Concern was expressed about underage girls accessing contraception and the morning-after pill, particularly in the north of the Borough. Ms O'Neill advised that sexual health was the responsibility of the local authority, not the NHS, and that Public Health was in the process of transitioning to a new contract with London Noth West who provided this service. A central location was needed but only a small number of pharmacies provided emergency contraception so action was needed to identify the barriers and make this happen. As there was currently a gap in the north of the Borough, this would be included in discussions moving forward with the contract.

Mr Spencer noted that he had attended a meeting of the Health and Social Care Select Committee where they had discussed services to the Heathrow Villages. After that meeting, representatives from a number of the partners had gone to meet with the residents in the Villages. They had shared a draft of an evaluation report that had been written in relation to the recent wellbeing bus pilot, which had been set up to provide health services to the area.

The meeting with the residents from the five villages had been very positive and, having identified a number of preferred options with the residents, amendments were being made to the evaluation report. Mr Spencer would be meeting with colleagues from Heathrow Airport the next day. Heathrow owned a number of sites in the Heathrow Villages that could potentially be used for future provision of health services. He would report back to the next Board meeting on 11 June 2024.

RESOLVED: That:

1. **the content of the report be noted;**
2. **approval of the Quarter 3 2023/24 performance template be delegated to the Council's Corporate Director of Adult Social Care and Health in consultation with the Health and Wellbeing Board Co-Chairs, the NHS NWL**

	Borough Director and the Healthwatch Hillingdon Chair; and **3. Mr Spencer provide an update on the use of Heathrow Airport estate for the provision of health services in the Heathrow Villages.**
43.	**HILLINGDON LOCAL AREA SEND AND AP STRATEGY 2023-2028** *(Agenda Item 8)* Ms Abi Preston, the Council's Director of SEND and Education, noted that the Hillingdon Local Area SEND and AP Strategy 2023-2028 had been a collaborative effort (not solely Council-owned) and highlighted the importance of partnerships in addressing SEND issues. The updated Strategy had incorporated alternative provision elements that aligned with national SEND and AP improvement guidelines. Initially, a draft Strategy with three key priorities had been developed but, after considering consultation feedback from parents, families and schools, broader ambitions had been identified. The Strategy aimed to achieve several key ambitions, notably emphasising early intervention, inclusive education, tailored provision for Hillingdon children and ensuring children lived happy and fulfilled lives within their communities. Ms Preston advised that there had been extensive data analysis to ensure that the Strategy aligned with local needs and national SEND and AP improvements, including Green Paper developments. Challenges highlighted by schools had centred on national priorities such as increased inclusion in mainstream schools and funding constraints which could not be changed at a local level. Action was now being taken to establish a systematic approach to SEND, collaborating closely with counterparts from the local area, and included the development of systematic leadership training and updating the funding model (the current model was eight years old). Additionally, new needs and provision matrices were being created for a uniformed approach to supporting children and clear admission guidance was being produced for special needs schools. Concerns were raised about funding pressures in mainstream schools and the increasing complexity of student needs. Ms Preston advised that collaborative work was being undertaken with these schools to deal with these issues as one size would not fit all. Although Harefield had a low total number of EHCPs, the number per 100,000k population was high. It was noted that there was a gender imbalance with regard to EHCPs, particularly related to Autism Spectrum Disorder (ASD), with more boys identified than girls (possibly as a result of girls being more likely to mask their needs). The Board noted that the Strategy did not include ethnicity data due to the document's comprehensive nature – 32% were White British with the next highest group being Any Other Asian Background. The Board asked about the support available for families and primary carers within the Strategy, emphasising early intervention and the need to ensure that families could access necessary information and support. Children and families were central to everything in the Strategy and the collaboration undertaken between health services and voluntary sector partners had been integral to addressing waiting lists and providing timely support. Thinking about the challenges, it would be important to ensure that families had access to information but that the support available would develop over time to meet the needs.

	There was acknowledgment of the collaborative approach taken and the need to continue refining pathways for families to access support whist waiting for assessments without solely relying on diagnoses. Clarity was needed on how partners could provide and promote this support. **RESOLVED: That the Local Area Special Educational Needs and Disability (SEND) and Alternative Provision (AP) Strategy 2023-2028 be noted.**
44.	**BOARD PLANNER & FUTURE AGENDA ITEMS** *(Agenda Item 9)* Consideration was given to the Board Planner and future agenda items. It was agreed that Ms Tina Benson be invited to attend the Board's next meeting on 11 June 2024 to provide an update on the Hillingdon Hospital planning and redevelopment. **RESOLVED: That the 2024/2025 Board Planner, as amended, be agreed.**
45.	**TO APPROVE PART II MINUTES OF THE MEETING ON 28 NOVEMBER 2023** *(Agenda Item 10)* Consideration was given to the Part II minutes of the meeting held on 28 November 2023. **RESOLVED: That the Part II minutes of the meeting held on 28 November 2023 be agreed as a correct record.**
46.	**UPDATE ON CURRENT AND EMERGING ISSUES AND ANY OTHER BUSINESS THE CHAIR CONSIDERS TO BE URGENT** *(Agenda Item 11)* Consideration was given to the Better Care Fund, NWL ICB governance review and the implementation of the CERNER system. **RESOLVED: That:** **1. the Board receive an update on the implementation of the CERNER system at its next meeting on 11 June 2024;** **2. the Board receive an update on the NWL ICB governance review at its next meeting on 11 June 2024; and** **3. the discussion be noted.**
	The meeting, which commenced at 2.30 pm, closed at 4.47 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.

HILLINGDON JOINT LOCAL HEALTH AND WELLBEING STRATEGY 2022-2025 YEAR 2 INTERIM UPDATE

Relevant Board Members	Councillor Jane Palmer: Joint Chair of the Health and Wellbeing Board Keith Spencer: Joint Chair of the Health and Wellbeing Board Sandra Taylor: Executive Director ASC and Health, LBH
Organisation	London Borough of Hillingdon
Report author	Kelly O'Neill, Director of Public Health. LBH
Papers with report	None

RECOMMENDATIONS

That the Health and Wellbeing Board notes:

1) **progress of strategy implementation within year 2 with the year 2 full progress report planned for the next Health and Wellbeing Board meeting.**
2) **new funded workstreams that are contributing to the strategy's achievements.**
3) **recommended process for periodic oversight and assurance, monitoring outcomes achieved, and escalation where improvement milestones are not being achieved.**

INFORMATION

1. Introduction:

This paper updates the Board of the interim progress to achieving the priorities agreed in the Joint Local Health and Wellbeing Strategy (JLHWBS) during year two implementation and the new programmes of activity that are in development that are supporting strategy delivery.

2. Context: The Strategic Priorities of the JLHWBS:

There are six thematic priorities of the JLHWBS, to:

1. Support children, young people and their families to have the best start and to live healthier lives.
2. Tackle unfair and avoidable inequalities in health, access to and experience of services.
3. Help people to prevent the onset of long-term health conditions such as dementia and heart disease.
4. Support people to live well, independently and for longer in older age, through to the end of life.
5. Improve mental health services through prevention and self-management.
6. Improve the way we work within and across organisations to offer better health and social care.

This is delivered through six enabling workstreams:

Workstream 1	Neighbourhood-based Proactive Care
Workstream 2	Urgent and Emergency Care
Workstream 3	End of Life Care
Workstream 4	Planned Care

Workstream 5	Care and Support for children and young people
Workstream 6	Care and support for people with mental health challenges (incl. addiction) and/or learning disabilities and/or autism

3. Strategy Implementation: Interim progress within Year 2:

This section aims to demonstrate that progress and improvement is being achieved. Each table focuses on the priorities stated in the Strategy, and where available, the data is provided based on the KPIs that responsible groups and officers are working towards achieving.

The RAG status is based on national benchmarking, using published thresholds when this data is available. When a national benchmark is not available and a local assessment has been used, the priority has been asterisked.

Each indicator has a progress report which states the current position and next steps to show the direction of action being taken. This information will be updated in the end of year two evaluation report that will be presented at a later H&WB Board meeting in 24/25.

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

Focus Areas	Priority	Current Data	Status
***We will transform the support offered across partner organisations to CYP and their families to promote a healthy weight and reduce obesity.**	1, 5, 6.	**Overweight and Obesity: NCMP measure:** Hillingdon Year R children: 19.4% overweight and obese. Data 22/23 Hillingdon Year 6 children: 38.3% overweight and obese. The prevalence of overweight (including obesity) children in Year 6 in Hillingdon continues to remain significantly above the England and London averages. **Child Obesity Year 6:** • Hillingdon: 23.7% (900 children in year group). • London: 24.8% • England: 22.7% **This is rated AMBER due to the prevalence of overweight and obesity continuing to be significantly higher than London and England.**	**Amber**
Current Year 2 Progress:			
In 2023 the year 1 report stated that further work to develop a child weight management offer is needed. The low uptake and lack of impact of the school nurse service 'My Choice' programme has resulted in decommissioning through the 0-19 retender process to reinvest in an effective evidence-based programme. The Hillingdon borough level prevalence for YR and Y6 does not show the variation between localities and schools in the borough. This variation is known and has been the basis of agreed action that has been the outputs of a series of place-based workshops: Healthy Hayes, a whole system approach (February 2024), the Fitter and Healthier Children workshop (March 2024), and the School Superzone initiative resulting in the development of a			

specification for a child weight management service that brings together a community level (Tier 1) service provision, with professionals trained to build their confidence to raise the issue of healthy weight, improve signposting to the local offer, and to develop options for an effective early intervention (Tier 2) service to be commissioned.

This work is being overseen by the new Hillingdon Strategic Obesity Group with task and finish sub-groups progressing Early Years, Children and Young People, Adults, the Food Environment, and Physical Activity.

Examples of current projects that are contributing to the priority are:

Early Years:

- Children Centres are running a four-week little cooks programme that supports families to try new menus, eat well plates, healthy recipes and understand healthy food alternatives. The programme runs termly in each of the three Hillingdon localities. There have been 434 attendances across the nutrition programmes.
- Little Tasters (a 4-week course) for children who have sensory processing needs is being delivered. This course has been developed in response to evidence with Health partners to support children to develop their senses as they experience different tastes and textures of foods (part of the ASD pathway).
- Let's get active group 6-week programme is delivered weekly in all three localities. The programme supports gross and fine motor skills development and helps connect both indoor and outdoor environments, educating parents can do this at home is delivered weekly across all 3 localities. There have been 5,482 attendances at physical activity groups.
- Post natal baby group has started in all localities to support all new parents and includes a 6-week programme for five to thrive delivered with the health visiting service.
- Baby massage is a referral-based group where there are issues around bonding or separation. There were 299 attendances at baby massage groups when this was a universal group in 2023-2024.
- Wellbeing for mums provided through talking therapies. This group is available across the borough with a creche to make it more accessible to parents.

Promoting Healthy Eating in Schools:

- Schools' health related behaviour survey has been offered to all schools: 31 Primary schools registered, and 16 primary schools completed; 7 secondary schools registered and 5 completed. Questions include a section on food choices and behaviours.
- Schools engaging in the Healthy Schools London programme have been focusing on becoming Sugar Smart and Water Only (4 schools are currently active).
- A School Food Audit reviewing primary school food policies and food standards starting in June 2024 will be the starting point for engagement with school and school caterers.
- Training for EHOs and Primary Education school improvement advisor on school food standards (SFS) to explore feasibility on SFS being assessed as part of food hygiene inspections. This came as a result of a polit in the school Superzone.
- The above intervention findings aim to influence school policy supporting healthy eating and weight management.
- GLL/ Better Health has partnered with NHS Northwest London to promote a health and wellbeing app to families; 'GRO HEALTH' focuses on healthy behaviours from childhood for families https://www.grohealth.com/ and has been shared with all

schools.

School Superzone Project: Hayes:

- Work with Hayes Muslim Centre to promote and educate on healthy eating with healthy cooking sessions delivered, and recipes shared with the local community. The Centre has set up a working group to adopt an organisation wide food and drink policy, starting with a water only position (from mid-June) and will work with the youth group on healthier food and drink options.
- In partnership with Higgins Partnership developers, a cookery book, showing healthy swaps for cultural recipes has been published and shared by Minet Junior School.
- Three Primary schools have active plans to become water only, sugar smart and to establish growing projects.
- A focus on active travel has led to an increase in children walking to school.
- To encourage physical activity, a community walking map has been created showing the location of local parks and walking distance from Hayes Town and has been shared with families in the 3 primary schools and with community groups.

Priority for Year 2:

- The Strategic obesity group has been reviewed with a clear purpose to improve healthy weight across all ages.
- A T2 child healthy weight service specification has been developed and an evidence-based programme with face to face and online provision will be commissioned.

Focus Areas	Priority	Current Data	Status
Increase breastfeeding initiation and sustained feeding with breast milk.	1,2.	**Breastfeeding initiation: 2018/19:** • Hillingdon: 68.3% (2,550 women) • London: 76.3% • England: 67.4% **This is rated AMBER due to low initiation compared with London.**	**AMBER**

Current Year 2 Progress:

Breastfeeding is a high impact public health intervention which delivers optimal infant nutrition and is a protective factor for child social and emotional attachment and early child health, reducing the risk of infection and other child illnesses. Breastfeeding also plays a key protective role in child healthy weight and oral health.

Hillingdon has been part of a NWL ICS steering group that is working collaboratively across all NWL boroughs and NHS providers to make every contact count for pregnant people and new parents to be understand the benefits of breastfeeding.

Examples of projects that are in place include:

- Initiated plans with GLL leisure sites to be breastfeeding friendly spaces.
- Healthy Start (DH programme to increase vitamin supplementation for pregnant people and infants) training for all Children Centre Staff.
- Healthy Start information and delivery process requirements sent to all pharmacies (through PH and updated through the Superzone project)
- Children centres run Breastfeeding Support appointments across the borough. There are also four drop-in sessions for parents to see peer support workers and/or lactation consultants. 1,103 visits to gain breastfeeding support from April 2023- March 2024.

Priority for Year 2:

- We will complete a health need assessment, supported by THH, early years services and NHS 0-5 services with the objective to increase breastfeeding uptake, especially amongst areas in the borough with the lowest levels. There have been data issues that may contribute to reported low initiation.
- A review of breastfeeding education and initiation support at maternity services needs to be reviewed to understand the low initiation rate compared with London.
- We will also align with the NWL work that the DPH is leading with NWL commissioners and provider organisations regionally to ensure opportunities for collaboration are acted on and there is improved access to education and support for new mothers.

Focus Areas	Priority	Current Data	Status
We will work to see the levels of tooth decay reduced.	1,2.	Prevalence of dentinal decay %: • Hillingdon (n=357) – 28.2% • London 25.8% • England 23.7% **Whilst there has been improvement in children's oral health, this priority is rated RED due the higher prevalence of dental decay compared to the England and to London.**	**RED**

Current Year 2 Progress:

The brush for life intervention, supports parents to understand the importance of oral health and toothbrushing form the eruption of their first tooth throughout early childhood, and to reduce sugar, providing healthy food education that reduces the risk of decayed teeth, laying the foundations of healthy lifetime habits. This service is available in all children centres and Family Hubs. To date this year, 1,386 families have received oral health information.

The bottle to cup initiative reduces reliance of parents on bottles for infant drinks and the impact that bottle use on exposure of drinks to drink, supporting speech and language development and the natural, growth of infant's teeth. This intervention also discourages the use of oral dummies. Education on sugar swaps is also available to parents.

The oral health provider carries out online and face to face training – for early years practitioners online and for resident's face to face workshops in libraries, children centres and community settings that family's access.

Priority for Year 2:

Hillingdon has used the NHSE Inequalities funding to provide additional evidence-based activity to improve children's oral health. With the support of the NHS colleagues a new Service Level Agreement has been developed introducing a targeted approach to implementing "Supervised toothbrushing" via schools and early years settings in areas of high need of the borough, with the aim of complementing and enhancing the existing provision of NHS funded Children's Oral Health Promotion Service in Hillingdon, that's embedded within the Whittington Community Dental Services, provided by Whittington Health.

This will be a 1-year SLA with a plan to commission for 2-year contract starting April 2025that offers further increased activity, targeted interventions to children at higher risk of dental decay; children with SEND needs, and children living in more deprived communities.

Focus Areas	Priority	Current Data	Status
We will work to reduce smoking in families.	1,2,3,4.	There are three national PH indicators: **Smoking at time of delivery (22/23):** • Hillingdon: Reduced to 3.4% • London: 4.6% • England: 8.8% **Smoking prevalence adults:** • Hillingdon: 8.1% • London: 11.7% • England: 12.7% **Smoking prevalence routine and manual group:** • Hillingdon: 7.2% • London: 20.2% • England: 22.5% **This is rated GREEN due sustained lower prevalence amongst the three priority target groups compared with London and England.**	**GREEN** **GREEN** **GREEN**

Current Year 2 Progress:

The Hillingdon stop smoking service has been retendered. CNWL has been awarded the new contract which started on 1/6/2024. This contract focuses on the nationally defined priority groups:

- Children and young people under 18 years.
- Pregnancy and after child birth - including partners.
- Those with mental health issues including substance misuse.
- People with disabilities and long-term conditions.
- Routine and manual occupations

The service works in partnership, with referral pathways to satellite clinics in varied settings, including Hillingdon Hospital NHS Foundation Trust, Primary Care, local libraries and MH services & drop-ins at Arch. In addition to other targeted work within areas of high prevalence.

There has been additional funding of £280,000 for 24/25 to implement the national 'Stop the Start Strategy'. The planning assumption is that this funding will be available for 5 years to significantly increase the number of smoking quitters. The majority of this funding will be allocated to recruit additional stop smoking advisors to provide 121 support and group sessions across the borough and education sessions on the harms of smoking and vaping for Children and Young People through training in education settings.

There is currently a bid to implement 'Swap to Stop' that will increase funding for vaping products as a harm reduction programme for current smokers. The outcome of this bid is pending.

Priority for Year 2:

- Mobilise the new stop smoking service contract.
- Recruit the additional stop smoking advisors for the Stop the Start Programme.
- Pending the Swap to Stop outcome, implement local services that moves smokers to vaping.

Focus Areas	Priority	Current Data	Status
*Consolidate the integration of therapy services for children and young people and redirect resources into early intervention.	1,2,5,6.	The contract is at the early stages and data for this new contract it not provided. **This is rated AMBER due to the collaboration agreement through which the contract has been awarded being early in its implementation.**	**AMBER**
Current Year 2 Progress:			
The new Children's integrated therapy service (CITS) contract has been collaboratively procured with CNWL as part of the 0-19 contract. Speech and language, physical and occupational therapy early intervention services work within Children Centres to mitigate and address early concerns in child development and reduce avoidable escalation of need that is coordinated with the health visitor 10-month reviews and 2-year progress checks. There have been 4,586 attendances across three localities for the health checks for families. Referrals for early intervention can also so be made to CITS via a stronger family team referral. There have been 2,440 attendances at CITS sessions/speech and language sessions and appointments in 2023/24. **Priority for Year 2:** Mobilise the year 1 of the 0-19/CITS contract.			

Focus Areas	Priority	Current Data	Status
*Hillingdon Domestic Abuse Advocacy Service (HDAAS): Providing help and support for victims experiencing domestic abuse.	1,2,6.	Due to data sensitivity the data available is from the PHOF data set which shows for domestic abuse incidents for persons aged 16 years and over: • Hillingdon – 34.5 per 1000 population • London – 34.5 per 1000 population • England – 30.6 per 1000 population **This is rated AMBER due to the rate being above the national average and no data that shows an improvement.**	**AMBER**
Current Year 2 Progress:			
The Domestic Abuse Steering Executive has agreed a delivery plan to progress the priorities in the 2023-25 Hillingdon Domestic Abuse Strategy. The plan includes actions by key partners intended to: • To ensure delivery of statutory responsibility in respect of domestic abuse (including Part 4 safe accommodation duties and Domestic Abuse Related Death Reviews). • To ensure that Hillingdon has the right range of programmes and services in place to support residents experiencing domestic abuse. • To provide comprehensive support systems for survivors, including legal, psychological, and safeguarding. • To enhance community awareness and education on domestic abuse and violence against women and girls.			

The Hillingdon Domestic Abuse Advocacy Service continues to provide direct support to domestic abuse victims.

Domestic abuse support service contract extensions have been made to the therapeutic service for child victims of domestic abuse and the emergency safe accommodation service. Hillingdon Women's Centre are also commissioned to provide a community support service. These services will continue until 2025. A needs assessment is being undertaken to inform future support service commissioning decisions required by the end of this year.

The IRIS (Identification and Referral to Improve Safety) programme is being implemented in Hillingdon. This programme supports General Practices to better identify and support victims of domestic abuse.

A DRIVE programme pilots is underway which is a perpetrator programme for high-risk perpetrators of domestic abuse.

3.2: Tackle unfair and avoidable inequalities in health and in access to and experience of services.

Focus Areas	Priority	Current Data	Status
Reducing homelessness	1,2,5.	**Households owed a duty under the Homeless Reduction Act (HRA): 2022/23 (PHOF Data):** • Hillingdon: 19.2/1000 population • London: 15.7/ 1000 • England: 12.4/ 1000 **This is rated RED due to higher rates than London and England and the rate is increasing from previously published data.**	**RED**

Current Year 2 Progress:

P3 continue to work with homeless and potentially homeless young people in the borough providing them with advice and onward referrals to appropriate agencies.

The first stage of Project Neptune has completed, a second Phase now seeks to embed improvements with a focus on prevention and early intervention to reduce homelessness.

Care leavers protocol is in place and will be reviewed again following changes to government guidance.

Ending Rough Sleeper Plan has been updated for 2024 and signed off by 'DLUHC'.

Significant funding is in place under Rough Sleeping Initiative, Rough Sleeping Drug and Alcohol Treatment Grant, and Rough Sleeping Accommodation Programme. We continue to work closely with pan London colleagues, GLA and DLUHC to highlight the importance of continuing funding post March 2025.

There is a continuing proactive outreach presence at Heathrow including patrols and an in-borough outreach presence.

Successful work to target 'long term' rough sleepers; 9 of 13 people have been placed in some form of off-street accommodation.

Additional funding secured under Supported Housing Accommodation Programme, Local Authority Housing Fund and Refugee Housing Programme. A further LAHF funding bid has been submitted. Commissioning strategy in place to increase affordable housing provision through a variety of sources including new build, acquisitions, private rented sector supply, Extensions, Under Occupiers schemes, and Cash incentives. There are ongoing partnership arrangements through collaborative forums to support the above initiatives.

Focus Areas	Priority	Current Data	Status
*Undertake a Public Health review of disparities and inequalities in Hillingdon and recommend actions.	2.	There is data and intelligence that is supporting the inequalities agenda for live work programmes and projects, for example the Integrated Neighbourhood Teams, WSA projects and current NHSE funded programmes. A systematic review of disparities and inequalities has been delayed, timed to coincide with the start of the JSNA update and development of the Population Health Management programme which will start to systematically identify and update how the health and care partnership tackle inequalities. **This is rated RED.**	**RED**
Current Year 2 Progress:			
There has been training across HHCP to better use Population Health Management (PHM) as a toolkit for tackling health disparities through a systematic targeted programme and examples of using this approach to achieve improved and sustainable outcomes. NHSE funded PHM capacity and capability needs to be developed to support the ambitious programmes that HHCP has aspired to and embedded through a public health approach to enable system-wide transformation. **Priority for Year 2:** Refer to section 3.6.2 of this report.			

3.3: Help people to prevent the onset of long-term health conditions such as dementia and heart disease.

Focus Areas	Priority	Current Data	Status
1. Preventative Care: Hypertension workstream • Implementation of Fuller Report: Integrated Neighbourhood Teams. Hypertension was	2.	KPI's are being monitored for 24/25 in relation to the Hypertension Preventative and Proactive workstreams. Hypertension data: April 2024: WSIC: • Hillingdon: 13.2% (44,920 people) are hypertensive, the second highest borough in NWL. See table below.	**AMBER**

identified as a focus for the Preventative Care workstream. 2. Proactive Care: Management of Hypertension • Further supported and embedded by the NWL Enhanced Service for Hypertension; a focus of which is on the 'management' of existing patients with Hypertension.		Residents aged 79 years and under with a BP recording of 140/90 mmHg or less: • Hillingdon: 60.3% • NWL: 60.3% Residents aged 80 years and over with a BP recording of 150/90 mmHg or less: • Hillingdon: 77.6% • NWL: 76.7% Mortality from circulatory disease: 2022: Per 100,000 population: • Hillingdon: 77.9 • London: 75 • England: 77.8 **This is rated AMBER recognising that mortality data lag does not give a contemporary position for the borough, however hypertension prevalence is the second highest in NWL.**	

Current Year 2 Progress:

This priority focuses on the prevention, detection, diagnosis and treatment of hypertension to prevent the onset of long-term health conditions such as strokes and heart attacks.

The following are strategic priorities are being delivered this year:

- Expand upon the MECC offer and develop a model of support; embedded within INTs to include the delivery of BP checks across wider system partners as part of daily operations. This will support with the detection and management of hypertension, while creating additional capacity, access and system alignment.
- Develop a sustainable model for community engagement, coproduction, opportunistic health checks and education – linked in to Neighbourhoods and supported by a robust data system in order to strengthen our approach to population health management.
- Review integration of technological systems across services, Neighbourhood partners and organisations within Hillingdon, alongside DSA's, to better enable a 'tell us once' approach and ensure (where possible) that patient information is available and fed through at all levels.

All Borough Hypertension Prevalence

Data Source: *WSIC de-ident, data as at 26/03/2024*

CCG_Name	Registered population	Hypertensive patients	Prevalance	Weighted per 1,000	Ranking
Brent	504,761	54,526	10.8%	108	5
Central London	277,080	20,149	7.3%	73	8
Ealing	460,668	58,312	12.7%	127	3
H&F	341,898	25,819	7.6%	76	7
Harrow	294,047	39,244	13.3%	133	1
Hillingdon	338,103	44,564	13.2%	132	2
Hounslow	345,641	42,869	12.4%	124	4
West London	284,287	27,210	9.6%	96	6
NWL Total	**2,846,485**	**312,693**	**11.0%**	**110**	

- The table above shows that Hillingdon is the 2nd highest borough in terms of Hypertension prevalence. Prevalence has increased over the last three FY as shown below:
  - 12.4% in 21/22

- 12.8% in 22/23
- 13/2% in 23/24

- There is more work focused work planned on recording BP rates and increasing proactive hypertension case finding for black and Black British males.
- Uncontrolled to controlled hypertension < 79yrs (Sep 23-March 24) increased by 41.6%.
- Uncontrolled to Controlled hypertension >80yrs (Sept 23 –March 24) increased by 34.03%.

Priority for Year 2:
To implement the New NHS Operating Plan for 24/24

New Hypertension NHS Operating Plan target 24/25

As of March 2024 our hypertension target is: Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025.
Previously this was separated into:

Ensure 77% of patients aged 79 years or under, with hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less by March 2024 (WSIC)

Ensure 80% of patients aged 80 years or over, with hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (WSIC)

Calculated by:

(No. of Patients with Hypertension age 80+ with the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less + No. of Patients with hypertension age 79 years or under, with last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg as a proportion of the total hypertensive population) / Total number of hypertensive patients

*note only 86.5% of hypertensive patients have had BP reading in the past year

For the INTs to serve as a mechanism (supported by wider partners across the system) to better align and join up services and provisions for residents, both within health and across the wider determinants of health and target the 6,564 adults in Hillingdon who do not have a recorded blood pressure through the PHM aligned work of the INTs.

Focus Areas	Priority	Current Data	Status
***We will implement a Whole System Approach (WSA): Healthy Hayes:** This is an asset-based community development approach to tackle unhealthy weight and inequalities, piloted in Hayes, the area of the borough with the highest levels of	1,2,3,6.	**Adult overweight and obesity: 22/23:** • Hillingdon: 59.2% • London: 57.2% • England: 64% **Physically active adults:** • Hillingdon: 59.4% • London: 66.3% • England: 67.1% **This is rated RED due to no recorded improvement in the nationally published data at borough level. Hillingdon has one of the highest rates of obesity and physical inactivity in London.**	**RED**

obesity.			

Current Year 2 Progress:

Agreed approach to develop WSA has been developed.

A health needs assessment, review of evidence, asset mapping and national toolkit completed, engaged community leaders and local insight collected, including stakeholder feedback on overweight and healthy weight, breastfeeding and food behaviours. This has been supported through place-based workshops to develop insight and shared understanding of the scale of the overweight/obesity/ health challenges in Hayes was reached, and causes, challenges and potential solutions were identified. Systems maps have been developed.

School Superzone grant awarded by GLA for Minet school (Hayes Town ward) with 10 Council Teams engaged and HHCP represented in delivery. See section 3.1.

Significant increase in funding to widen capacity in adult weight management service with sustained coordinated physical activity opportunities commissioned in the borough.

Priority for Year 2:
Recognising that a WSA requires collaboration and partnership, through the development of this work the wide scope of work currently being focused on Hayes has required the project to be embedded as part of a cross system partnership in Hayes.

Focus Areas	Priority	Current Data	Status
We will increase the uptake of NHS Health Check, targeting under screened population groups. The NHS Health Check (NHSHC), the national risk assessment, awareness and management programme to reduce the risk of LTC, increased uptake and completion.	2,3.	NHS Health Check performance for 2023/24 as reported to OHID on 16 May 2024: **Number of people receiving a first offer of an NHSHC (in a five-year period):** ▪ Target: 16,804 (20.0% of the eligible cohort). ▪ Actual: 14,362 (17.1% of the eligible cohort) **Number of people receiving a completed NHSHC:** ▪ Aspirational target: 12,603 (15.0% of the eligible cohort), however, 2023/24 budget only allowed for around 8,600 (10.2%) checks. ▪ Actual: 7,777 (9.3% of the eligible cohort) ▪ Take-up rate: 54.1% **This is rated AMBER due to under-performance in uptake against the national target for Hillingdon.**	**AMBER**

Current Year 2 Progress:

The NHSHC contract has been updated and the Confederation has been commissioned to co-ordinate NHSHC delivery through its 42 general practice members and 5 extended hours hub clinics from April 2024.

- Programme funding has been increased to enable the future achievement of OHID's aspirational 75% uptake target.
- There has been increased collaboration with the Confederation, for example, participating in PCN roadshows, sharing resources and data, writing a grant application and developing promotional materials.

- PH has commissioned the GP Confederation to work in partnership to increase uptake and the completeness of health checks. The target for 24/25 is 70% uptake from a current uptake of 50% in 23/24.

Priority for Year 2:
In 2023/24 PH has increased funding to support increased activity recognising the key role of the HC is to reduce long term conditions, therefore the higher the eligible population screened the greater the awareness of risk and action. To ensure that support is available for those residents at risk, PH is reviewing the borough healthy lifestyle offer to respond more effectively to people referred post health check for lifestyle improvement.

Focus Areas	Priority	Current Data	Status
***We will support residents with dementia and their carers**	4.	**Dementia Diagnosis Rate** (people aged 65+ per 100 people in that age group) 2023: Indicator benchmarked against goal. • Hillingdon: 64.9% • London: 65.6% • England: 63% **Whilst this is RED solely due to the national benchmark that neither London nor England achieve. The Q4 report states an outturn of 66.2% was achieved in 2023/24 against a target of 66.7%. The England average was 62.2%, therefore rated AMBER**	**AMBER**

Current Year 2 Progress:

- Borough awarded Dementia Friendly Community Status with 10 venues accredited under the Dementia Friendly Venue Charter;
- Residents living with dementia and their carers can now access 13 different activities weekly, offering 230 free spaces;
- 62 new referrals were made from the Memory Clinic, Alzheimer Society and Admiral nurses into the Council's early intervention programme, and
- A new online dementia pathway has been introduced to enable residents to access information on services/ activities for dementia from point of diagnosis to end of life.

A training programme is delivered by LBH with Carers, HHCP staff and Hillingdon Hospital and LBH staff. Around 260 residents are engaged in the Dementia Friendly programme.

The Dementia Friendly Hillingdon Programme offers activities to support residents living with dementia; cognitive function, mobility and reduce social isolation and offer a wide range of post-diagnostic services and activities with partner organisations aimed at increasing social connectedness and promoting wellbeing through relevant person-centred activities.

The strategic lead through the Dementia Action Alliance to ensure that statutory, third sector and private organisations are working together to offer an improved resident experience of the dementia pathway in Hillingdon including prevention, diagnosis, support services, social activities and end of life.

Work is ongoing to ensure that residents living with dementia and their carers have access to the support they need through partnership working with the Alzheimer Society, Admiral Nurses, Age UK and Social Care.

Focused action to ensure carers have access to the information they need through the provision of regular monthly training and an online dementia pathway tool.

Ensure staff across organisations have a better understanding of what dementia is and how their services can be dementia friendly through a range of regular staff training opportunities.

Ensure the voices of residents living with dementia and their carers are heard and listened to and help shape planning for services and activities in the future.

3.4: Support people to live well, independently and for longer in older age and through to the end of life.

Focus Areas	Priority	Current Data	Status
We will tackle falls and focus on falls prevention amongst older residents in Hillingdon.	4,6.	**Hip Fractures** (persons aged over 65 years) per 100,000 population: • Hillingdon: 515/100k (225 people) • London: 502/100k • England: 558/100k **This is rated AMBER due to the data showing no improvement from the last reporting period. Note the data is for 2022/23.**	**AMBER**
		Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rat per 100,000. On track to meet target which is a 1% reduction fr 23/24 – the target for 23/24 was 865 (population 41,314) to achieve fewer than 856 in 24/25. Data from the National BCF Team was significantly lower than was considered realistic. It has therefore been assumed that this is inaccurate and the 2023/24 plan taken as the outturn.	**GREEN**

Current Year 2 Progress:

In 2023, the Optum Falls Prevention Project was previously reported to the Health and Wellbeing Board, this was an example of the PHM approach in practice and led to:

- A refresh of the Falls referral pathways,
- Production of a Falls Directory of Services,
- Development of a Falls Decision Support Tool (DST),
- Production of a resource pack for falls prevention and management in care homes,
- Developed a falls prevention training programme for care home and extra care housing staff,
- Piloted evidenced-based strength and balance training, and
- Developed a community falls education programme with in-person workshops and a self-assessment guide.
- The clinical pathway for Falls is overseen by the CARS team and includes a multi-factorial risk assessment with exit routes back into the community-based provision

where appropriate.

Falls Prevention Training has been implemented:

- Falls Prevention Training targeted staff in care home who had high ED and hospital admissions (Jan to Mar 2024).
- There have been 4 in-person training events.
- 35 'Falls Champions have been identified for Hillingdon Care homes.
- Training outputs:-
  - Completed a pre and post knowledge check, in falls risk prevention and management.
  - Simulation for falls risk assessment, management and exercise initiation.
  - Case study and group discussions on falls risk prevention and management.
  - Care Home staff have developed posters on what they had learnt and will bring back to care homes to reduce falls.
  - The Falls Resources booklet has been distributed to the care homes. Certificates given out the end of the sessions to participants.
  - Two key data sources are not available to assess impact due to incomplete data i.e., NWL and THH data. Data issues have been escalated. Intermediate plan is to use LAS Conveyances (assume they are admitted to hospital). Analysis in progress. Data only currently available up until March 24.

Training uptake by residents:

- 430 residents attended strength and balance exercise classes in 23/24. There are now 19 classes available a week.
- -280 residents attended falls prevention workshops to better understand their own risk of falling and implement a self-care management plan to reduce that risk.

Care Home Provision:

- There has been an online falls champion training developed for Care Home staff that is delivered by CNWL.
- Development of an online exercise programme for Care Home residents: a seated and standing programme focused on strength and balance.

Wider use of training for at risk residents:

- The online exercise programme being developed for Care Homes will be cascaded to Extra Care, Sheltered Housing and be made available to housebound residents through the Council website and the social ability equipment is now available to borrow in libraries.
- Three social ability devices are being trialled in libraries offering a range of exercise opportunities to assist residents unable to access community provision in increasing their mobility at home.

Oversight and Governance of the Falls Prevention Programme:
The falls work is being brought under the frailty agenda and opportunities for exercise and learning are being linked to frailty assessments (initially in sheltered housing) to ensure that residents at risk of frailty are able to access provision in a timely matter to help reduce that risk.

Priority for Year 2:

PH will commission in 24/25:

- Later Life Care to Move training for top ten Care Homes. This training looks at how to

incorporate movement throughout the day in a Care Home setting and maximise opportunities for increasing mobility beyond traditional exercise.
- PSI training for 12 staff including physios and exercise instructors to support Care Homes in setting up in-house exercise provision and identifying appropriate cohorts of patients for different exercise types.

In 24/25 PH will re-launch a community-based falls prevention pathway including
- Community falls prevention workshops to continue and be delivered within each PCN at neighbourhood level. This will encourage self-management of falls risk.
- PH will deliver a train the trainer programme to be implemented from June 24 to train community falls champions within PCNs to deliver community falls prevention workshops and one to one self-assessments. This training will be aimed at Health and wellbeing coaches and social prescribers within GP surgeries to build their capacity to deliver falls prevention.
- The community-based OTAGO strength and balance programmes and the seated exercise programmes will be brought under one falls prevention programme from June 24 to offer an exercise programme that responds to varying levels of mobility but also offers progression opportunities from seated to standing exercise and identifies exit routes into paid for maintenance classes.
- Referrals are being received into this programme from social prescribers, the CARS team, Physio and GP surgeries. Self-referrals are also accepted.

Focus Areas	Priority	Current Data	Status
We will reform 'intermediate tier' services and support hospital discharge and admission prevention.	2,4,6.	Please refer to section 12 of the 2023/24 Q4 Integrated Health and Care Performance Report submitted for the July 2024 Board.	**GREEN**

Current Year 2 Progress:

The key activity is:
- The HHCP Integrated Discharge Hub is fully operational.
- The number of step-down beds has increased from 10 to 15.
- EOL beds have increased to 12. Hillingdon are leaders in the EoL offer in NWL.
- There is a 6 bedded Frailty Assessment Unit at the front door of THH to reduce avoidable admissions,
- Review of the Care Home Support Group and Care Connection Teams to strengthen their offer.

Maximising the Home First model:
Under the Home First/Discharge to Assess approach to hospital discharge, the majority of people are expected to be discharged to their usual place of residence. The Discharge to Assess model is based on evidence that the most effective way to support people is to ensure they are discharged safely when they are clinically ready, with timely and appropriate recovery support if needed.

Hillingdon was one of the first health and care systems in the country to implement this model which requires that an assessment of longer-term or end of life care needs takes place once

the individual has reached a stage of recovery where it is possible to make an accurate assessment of their longer-term needs. This assessment will not usually take place in an acute hospital setting.

There are four pathways in the Home First model – these are described in the 2023/24 Q4 Integrated Health and Care Performance Report.
The model has achieved:

- A fully utilised D2A and Comfort Care capacity to increase discharge rates,
- Reduced discharge delays, able to flex resources and increase care home capacity, and
- Reablement is developing exit pathways for residents to support on-going physical and mental wellbeing and reduce the risk of requiring LTC care packages. This is being achieved through staff training, identifying activities for residents and working with social prescribing and the JOY app.

High Impact Change Model (HICM) for thee Transfers of Care tool: Self-Assessment (March 2024):

Hillingdon was assessed as having a mature system based on a default position that staff will steer people to the appropriate Home First pathway.

HICM provides a model of good practice for systems to self-assess how they are working, and plan for action that would improve service-user flow throughout the year.

The tool is multi-professional and since 2018 its implementation has been performance managed through the Better Care Fund (BCF).

Fully utilised D2A and Comfort Care capacity to increase discharge rates:
A bridging care service provided by Comfort Care Services has been contracted since 2018 to support timely discharge on the P1 pathway. The service provides home care in a person's usual place of residence until an assessment of longer-term care needs can take place. This model has enabled Hillingdon to have the best performance on P1 discharges in the NWL ICS. Consequently, during 2023/24 this model has been rolled out across all boroughs in North West London.

During 2023/24 the service supported 1,795 people and of these 81% also received therapy from CNWL's Therapy Bridging Service. Issues with utilisation rates for these services are addressed in the integrated performance report also on the Board's agenda.

Increasing care home capacity:
Hillingdon currently has 44 active registered care homes providing 1,365 beds. 26 are residential and nursing care homes for older people and 18 are residential carer homes focused on supporting people of working age with mental health needs and/or learning-disabilities.

Plans are in place to secure additional nursing care home provision for older people; this is subject to continuing negotiations.

Review of Care Home Support Group and Care Connection Teams to strengthen their offer:

- **Care Connection team (CCT):**
  The CCT model is being reviewed to align with system-wide requirements and ensure

it stays within our current budget. The proposed model has been shared with staff, and ASC are working with the GP Confederation to progress the consultation process that is expected to take place in Q2 24/25, with the CCT model being embedded within the three Integrated Neighbourhood Teams to take effect in Q3.

- **Care Home Support Team (CHST):**
  The team are progressing with the updated model and are realigning matrons/Nurse practitioner and GP's allocations to all Nursing/Residential/ LD and MH homes to ensure full cover for weekly contacts/rounds and to support the completion of personalised support plans and advance care planning (UCP) within budget.
- **The Frailty Assessment Unit (FAU):**
  initially opened as a pilot in 2022 and then became BAU in June 2023. There is a direct referral pathway in place and an advice line open from GPs/LAS/RRT/Care home support team and community matrons M-F 9-8 and support ED 7 days a week. The service is Consultant led Monday – Friday from 9am – 8pm and MDT led at the weekends.

  Approximately 180 patients are seen monthly, and on average 80% of the patients assessed are discharged from the unit and an admission is avoided.

NWL ICS have a community frailty task and finish group in place to establish what the current community frailty core offer is, determine what gaps there and identify the improvements required in order to offer a gold standard common core frailty offer. Recruitment is underway to employ a substantive workforce. Future development also includes working with the site team to ensure the Rockwood ward is maintained as a 72-hr unit to enable free flow from FAU to Rockwood for those pts not fit to leave within 23 hours.

Focus Areas	Priority	Current Data	Status
We will support carers to enable them to continue in their caring role	4,6.	Data shows that there are: • 4,790 (21.3% of people identifying as adult carers in 2021 Census) adult carers and 1,187 (48.4% of people identifying as young carers in 2021 Census) young carers on the Hillingdon Carer Register as at 31/3/2023, • 41 (5.1%) increase in carers assessments, • 780 (20.6%) reduction in refused carers assessments, • £837,000 in carer-related benefits secured to improve incomes of 231 households, • Support groups for bereaved carers and bereavement counselling service for carers established, • New co-produced 'Are you a carer?' leaflet developed, • 33 out of 44 (75%) GP practices have identified a carers champion and 26 have carer support service access information on their websites, • THH visiting rules updated to reflect recognition of unpaid carers, • 1,203 attendances by 192 individual young	

		carers at school support, and • 2,644 breaks delivered for adult carers and 2,586 for young carers. **This is rated GREEN. Success criteria needs to be developed for this indicator.**	
Current Year 2 Progress:			
Please refer to 2023/24 Q4 Integrated Health and Care Performance Report			

3.5: Improve mental health services through prevention and self-management.

Focus Areas	Priority	Current Data	Status
Implementing the Autism Strategy*	5.	The Autism Strategy is in draft format and KPIs are to be developed pre-agreement of the strategy. **This is rated RED as the strategy has not been agreed.**	**RED**
Current Year 2 Progress:			
• Autism Partnership Board established, • Brent Harrow and Hillingdon Adult Autism Diagnostic Service led by CNWL has been established, • Private organisation commissioned by CNWL to address the current waiting list backlog, • One-year pilot programme initiated to provide post-diagnosis support through a voluntary organisation, • Dynamic Support Register established for both children and adults, • Enhanced specification for Severe Mental Illness (SMI) and Common Mental Health Issues (CCMI) within NWL developed, • Increased SMI health checks to 75% on the QOF register, viii) MIND and Confederation commissioned to provide training for patients and healthcare providers and support the uptake of annual health checks for patients who are difficult to reach, and • Learning disability annual checks: these are now included in social worker annual reviews; training has been provided for all GP practices and 76% of people with learning disability received an annual health check. **Priority for Year 2:** To review draft strategy, confirm KPI measures and through governance process, agree strategy for implementation.			

3.6: Improve the way we work within and across organisations to offer better health and social care.

This section will focus on key new developments that are contributing to strategy delivery, notably:

- the NHSE funded Health Inequalities projects that are supporting the borough delivery of the inequalities agenda, including the Core20+5 priorities.
- Building PHM capacity and capability, and
- The progress on the implementation of the three borough Integrated Neighbourhood Teams.

3.6.1. NHSE Inequalities funded projects.

NHS England has funded Integrated Care Systems (ICS) with a three-year resource to address health inequalities through Population Health Management (PHM) funding. For NWL ICB, this is £7.022 million.

To date 60% of this funding has been allocated to Borough Based Partnerships (BBP). For Hillingdon the funding allocation for 22/23 was £615,127k, for 23/24 was £666,100k and for 24/25 the funding allocation has increased to £679,688.

All boroughs have been required to submit business cases. To access 22/23 and 23/24 funding the HHCP business case was approved for two years by NWL ICB in February 2023. For 24/25, 25/26 & 26/27 HHCP partners have developed a further three-year business case based on borough priorities informed by:

- NWL priorities: child immunisations, child oral health and cancer screening.
- HHCP priorities: hypertension (adults), excess weight (adults & children) and common mental health conditions: anxiety & depression (adults & children).
- Gaps in service provision for existing PHM programmes.
- Capacity and capability mapping exercise and identification of gaps.

Table 1: The NHSE Inequalities 3-year funded workstreams:

Strategic Priority	Workstream	Details	Funded		
			24/25	25/26	26/27
Core 20+5	**Hypertension, excess weight, common MH conditions and cancer screening**	Use of NWL ICB 'Focus on Methodology' with shared learning from the NWL Optum programme (Hayes & Harlington)	✓	✓	✓
	CYP Oral Health	To increase targeted activity, supervised toothbrushing in schools, workforce training and development, and a full need assessment leading to new service procured.	✓	✓	✓
	Community Champions	Pilot a volunteer champion model based on Westminster model. The outreach is directed at core health needs in a designated area, and n evaluated programme of intervention.	✓		
	Proactive Care: Falls and Frailty	Primary care review of the identified cohort and set up processes in preparation for the NWL ES proactive are that is due to starts in 25/26 – a priority for the HHCP proactive care that underpins the INT development	✓		
PHM Infrastructure	**Building specialist capacity (3 posts)**	Recruit a shared resource, programme manager, project manager and BI analyst	✓	✓	✓

	Invest PHM Neighbourhood Leadership: Initiation	Clinical Director leadership	✓		

3.6.1.2. The Governance Process for the NHSE Funding agreement:

There has been an inclusive agreement process to ensure the priorities are the right ones for the borough, and throughout the agreement process we have worked in collaboration with the ICB partners. Stakeholder engagement and agreement has included:

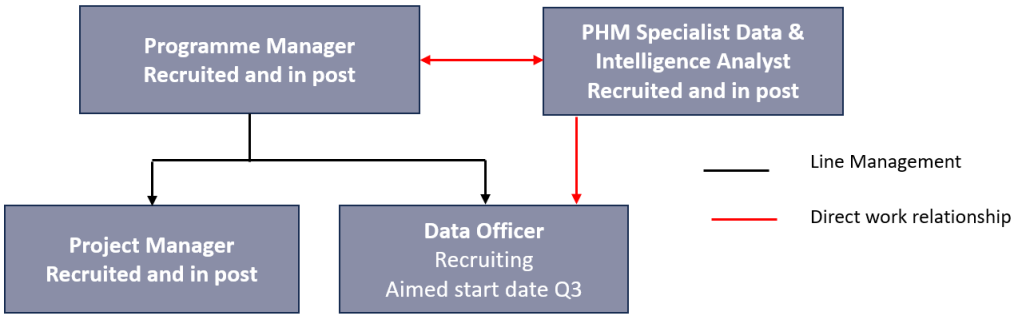
- Priorities for the business case have been agreed by HHCP Governance Committees (January to March 2024).
- The draft business case was approved by NWL Director of Strategy & Population Health (4th April 2024).
- The business case was taken to NWL Contract & Performance Oversight Group (CPOG) for approval (17th April 2024) and agreed subject to additional information of Y2 and Y3 funding for the Core20+5 schemes.
- A meeting held with Hillingdon PHM Relationship Manager to complete information and progress actions for the confirmed allocation of funding (13th May 2024).
- The work has been completed and updated information shared with NWL Finance lead. A meeting is taking place on 5th June to confirm approval, next steps and process to draw down the funding.

3.6.2. Implementing placed-based Population Health Management capacity and capability to support Integrated Neighbourhood Teams.

The Board will be aware that HHCP has been an early adopter of the Population Health Management Framework (PHM) and recognised the importance of this as a tool to target action at communities and population groups where there are disparities in access to health and care services and poorer health outcomes. In 2022/23, NWL ICB commissioned Optum to support the NWL BBPs to implement locally agreed projects with Hillingdon having the sole borough-wide programme, focusing on falls and frailty, and a PCN project tackling mental health, obesity and hypertension in Hayes and Harlington PCN. There has been wider use in projects across the borough, and to further accelerate capability we have invested the NHSE Inequalities funding for a 2-year fixed term specialist team that will support PHM projects, prioritising the work of the Integrated Neighbourhood Teams.

3.6.2.1. Building Population Health Management capacity and capability

The PHM team will provide specialist capacity and will support the INTs. The team will be aligned to Public Health, LBH.

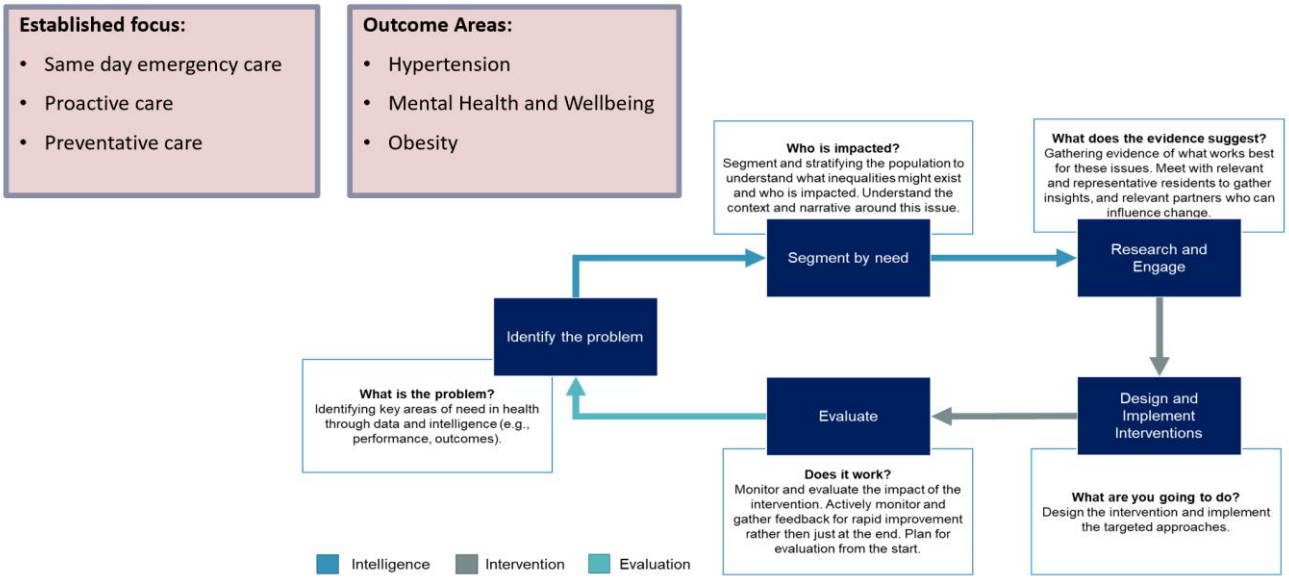


Of the four positions, three have been recruited, two are in post, the Programme Manager and the specialist BI Manager, a third, the Project Manager will start before August and the fourth, the Data Officer role is currently being advertised.

Figure 1 shows the priority work of the PHM team, who will be supported by ICB Borough and

Public Health colleagues, and how this will be applied using our locally agreed framework. HHCP priorities are aligned to the NWL ICB Joint Forward Plan (April 2024) that states the importance to “use population health as an exemplar for how we introduce and scale innovations … across NWL.’

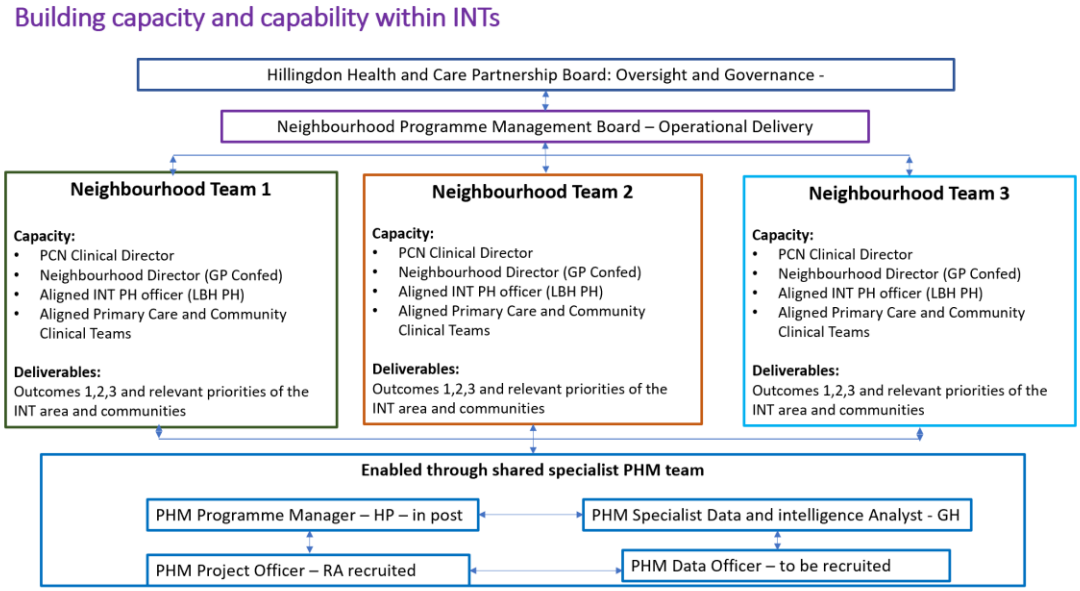
Figure 1: PHM Framework: Implementation priorities for INTs:



3.6.3. The foundations of the three borough Integrated Neighbourhood Teams.

The Joint Forward Plan recognizes that ‘Health and care services are designed around the needs of our communities, using PHM principles as the methodology for transformation is a systematic approach to tackle disparities in health and care access, experience and outcomes’ using INTs as the delivery vehicle for locality based focused action.

Figure 2 shows the current infrastructure of the INTs that is being supported through the Neighbourhood Programme Board, which is delivering the SDEC, proactive care and preventative care workstreams.



The PNM team will see the INTs are the primary driver for change, and will work collaboratively

to:

- Embed Population Health Management across INTs, and HHCP organisations, building capacity and capability so that PHM principles support and underpin future service design and delivery, upskilling professionals.
- Lever emerging and existing trends, data, and risks to inform and forecast changing health and social needs more effectively.
- Collaboration, co-production, and co-development will be is vital for real and sustained change.

3.6.4. Next Steps

There is considerable coordinated joint working required as the PHM team and INTs are in the early stages of their development which has the opportunity for both to work together, start to use data, insight and intelligence, understand the needs of their communities and start to effect change that can be evaluated for impact and outcomes. This work aligns to the Joint Local Health and Wellbeing strategy Prioritise and allows for new and ever more creative ways of working that can achieve the change at the scale needed.

4. Financial Implications

None.

5. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

5.1. What will be the effect of the recommendation?

The recommendations are to provide regular updates to the Board that demonstrate progress and priorities where progress has not been achieved. This provides the board with oversight of the strategy and opportunities to support officers to achieve the outcomes stated.

5.2. Consultation Carried Out or Required

Engagement with officers leading workstreams has informed this report.

6. CORPORATE IMPLICATIONS

None.

7. BACKGROUND PAPERS

None.

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2024/25 BETTER CARE FUND PLAN

Relevant Board Member(s)	Councillor Jane Palmer – Co-chair, Hillingdon Health, and Wellbeing Board Keith Spencer – Co-chair, Hillingdon Health, and Wellbeing Board
Organisation	London Borough of Hillingdon
Report author	Gary Collier - Adult Social Care and Health Directorate, LBH Sean Bidewell – Integration and Delivery, North West London ICB
Papers with report	**Appendix 1** – Discharge Fund Spending Plan 2024/25

HEADLINE INFORMATION

Summary	The Better Care Fund (BCF) is a national initiative that has been in place since 2015. Its vision is 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 sets out the financial arrangements for the updated 2024/25 BCF plan. Approval by the Health and Wellbeing Board is a requirement under the BCF national conditions. The report is seeking ratification of the Co-chairs' decision to approve the plan on behalf of the Board.
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 value for the BCF for 2024/25 is £100,025,164 comprising of a Council contribution of £70,173,307 and an ICB contribution of £29,851,857.
Ward(s) affected	All

RECOMMENDATIONS

That the Health and Wellbeing Board:

1. **ratifies the decision of the Co-chairs to approve the 2024/25 Better Care Fund Plan as described in the report, including the proposed financial arrangements and proposed targets for the national metrics.**
2. **notes the position regarding Equality and Health Impact Assessments as set out in the report.**

INFORMATION

Strategic Context

1. The policy framework that set out broad principles to be followed for the 2024/25 Better Care

Fund (BCF) plan was published on the 12th April 2024. The detailed planning requirements for 2024/25 were also published on the same date. The plan developed in 2023/24 was intended to cover a two-year period and the policy framework and planning requirements published in April 2024 as an addendum to what was agreed last year. The detailed narrative plan submitted in 2023/24 is available via the following link Better Care Fund - Hillingdon Council.

2. The submission date for the 2024/25 plan set out in the April 2024 planning requirements was 10th June 2024 and the planning template was submitted as a draft pending the Board's formal approval. As the Board meeting was postponed in compliance with purdah requirements following the declaration of the General Election, the Co-chairs approved the plan on the Board's behalf to ensure that there was no delay in the plan assurance process.

3. The following key aspects of the 2024/25 planning template can be accessed using the link shown in paragraph 1:

- Income and expenditure
- Metrics: targets and rationale
- 2024/25 narrative update

4. The Board is reminded that the 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.

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

Table 1: Alignment of BCF Schemes and Transformation Workstreams

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

6. 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 have taken advantage of this opportunity and feedback has been reflected in the completed template.

7. The BCF objectives and the Place-based transformation workstreams are also aligned to the NWL Joint Forward Plan priorities, particularly the following:

- ***Priority 3:*** Establish Integrated Neighbourhood Teams (INTs).
- ***Priority 4:*** Improve mental health services in the community and for people in crisis.

- ***Priority 6:*** Optimise patient flow across the system – right care, right place.

ICB Review of BCF Schemes

8. The North West London Integrated Care Board instigated review of BCF schemes discussed at previous meetings of the Board over the last year is currently in progress. This will not affect the 2024/25 plan. A more detailed update on the review will be provided to the Board at its meeting on 30 July 2024.

Key Changes from 2023/24 Plan

9. The 2024/24 plan is largely a roll forward from 2023/24, with the exception of the following key changes:

- **NHS additional contribution reduction**: The funding, i.e., £2,464k, for the H4All Wellbeing Service, The Confederation Integrated Care Programme and Care Connection Teams, has been removed from the BCF. These services are continuing in 2024/25 but are subject to a separate review being undertaken by the ICB.
- **Mental Health Adult Social Care capacity**: A new mental health service manager post within Adult Social Care will create increased capacity to improve the flow of hospital discharge cases as well as reduce the length of time between reviews. This will be funded from NHS additional contribution paid to Adult Social Care and is linked to the capitalisation of community equipment.
- **Commissioning infrastructure capacity:** The intention is to create dedicated commissioning posts with lead responsibility for carers, prevention and community support services and bed-based services to address gaps identified in the self-assessment against the CQC assurance framework for Adult Social Care. It is proposed that the posts are funded from a combination of an increase in the minimum NHS contribution to the protection of Adult Social Care and reprioritisation of existing funding. This will ensure the increased effectiveness of the discharge of the Council's market development and management responsibilities under section 5 of the Care Act, 2014.
- **Step-down block contracts:** Direct awards for three years are in progress with two providers for 15 nursing and nursing dementia beds. This follows an abortive competitive tender exercise in 2023/24. Funding for these beds cuts across income streams within the BCF.

2024/25 BCF Plan National Requirements

<u>National Conditions Compliance</u>

10. There are four national conditions that roll forward into 2024/25 and these are summarised below.

11. ***National Condition 1:*** **A jointly agreed plan** - A plan that has been agreed by the HWB.

<u>Commentary</u>: The decision of the Co-chairs to approve the plan on behalf of Board means that Hillingdon is compliant with this condition.

12. ***National Condition 2:*** **Demonstrating delivery of BCF national objective 1 - *Enabling people to stay well, safe, and independent at home for longer*.** The requirements for this condition are addressed in the narrative plan submitted in 2023/24 and have not changed.

Commentary: The narrative update tab of the planning template has been completed in accordance with national requirements.

13. **National Condition 3: Demonstrating delivery of BCF national objective 2 - *Providing the right care in the right place at the right time***. The main requirements for 2024/25 concern:

- How additional discharge funding will be used.
- How discharge funding will impact on discharge-related metrics.

Commentary: The expenditure and narrative update tabs of the planning template describe how this funding will be used during 2024/25 and therefore demonstrate compliance with national requirements.

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

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

Commentary: The expenditure tab within the planning template demonstrates that Hillingdon is compliant with this requirement.

National Metrics

15. The 2024/25 metrics are aligned to the two national conditions concerned with the implementation of the national BCF objectives. The continuing approach taken by partners in agreeing targets is that they should be realistic and achievable. The detail of all targets and the supporting rationale can be found by following the link shown in paragraph 1.

16. The Board is asked to note that Hillingdon is one of five boroughs in North West London where there has been an issue with the accuracy of the nationally published performance data against NHS metrics. This has manifested itself in performance figures in the second half of the year being much lower than it is realistic to expect.

17. The national metrics linked to the *Enabling people to stay well, safe, and independent at home for longer* objective in 2024/25 are outlined below.

18. **Avoidable admissions for ambulatory sensitive chronic conditions**. The conditions within the scope include acute bronchitis, angina, heart disease, heart failure, dementia, emphysema, epilepsy, high blood pressure, diabetes, chronic obstructive pulmonary disease (COPD) and fluid on the lungs (pulmonary oedema).

19. As this metric is the indirectly standardised rate of admissions per 100,000 population, it gives an indicator rate rather than number of people. Due to there being a dramatic drop in the indicator value between August 2023 and November 2024 an average of the previous months has been taken and a 1% reduction applied to calculate the Indicator Value for the 2024/25

plan.

20. **Permanent admissions to care homes by people aged 65 and over**. This is an Adult Social Care Outcomes Framework (ASCOF) measure and data submitted for it are based on what the social care professional believes is likely to happen, i.e., whether the placement will be permanent or temporary. The target has been set by applying a 1.5% reduction on the 2023/24 outturn. This has not been set lower because Hillingdon has a robust process in place for ensuring that a residential placement is the most appropriate means of addressing assessed need, i.e., permanent placements must be approved at service manager or assistant director level.

20. **Emergency hospital admissions due to falls in people aged 65 and over**. Due to the published national data being significantly lower than could reasonably be expected, it was decided actuals alone could not be used to set a realistic baseline for 2023/24 activity. The 2023/24 delivery has been estimated based on actual results for Q1 and Q2 of 2023/24 plus the highest 2 actual quarters in 2022/23. This gives us the most realistic outcome based on actual results, removing any periods of data concerns. A 1% reduction has been applied to the 2024/25 plan indicating a planned improvement on these levels as our local services continue to improve and develop.

21. The national metric linked to the *Providing the right care in the right place at the right time* objective in 2024/25 is outlined below.

22. **Percentage of people resident in HWB discharged to usual place of residence**. As the figures for February and March from the national data set seemed too low to be realistic, April 2023 to January 2024 actuals have been taken and averages provided for February and March 2024. A 1% increase has then been applied to this figure to create the plan for 2024/25.

Intermediate Care Demand and Capacity Analysis

23. Intermediate care services (IMC) are a range of short-term services provided to people 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.

24. Completion of a demand and capacity worksheet as part of the plan submission in 2023/24 was a national requirement and an update of this is required for 2024/25. Capacity has been arrived at using formulae contained within the planning guidance. An issue for the Co-chairs to note is the accuracy of discharge demand data as OPTICA continues to be implemented across acute trusts in the NWL sector.

25. **Community demand and capacity**: The focus of intermediate care resource in Hillingdon is more on supporting people out of hospital than preventing them from getting there in the first instance, hence the drive to move towards the new operating model discussed at previous Board meetings that is intended to support our residents to stay healthier and fitter in the community.

26. There is no bed-based step-up provision in Hillingdon and there is no evidence of demand for it as this is not recorded. Mitigation to address demand during the winter period is through the deployment of Reablement and the Community Adult Rehab Service (CARS) and Urgent Community Response. Scope has been built into the BCF in 2024/25 to increase Reablement community capacity if required.

27. **Hospital discharge demand and capacity:** The template is constructed using the Home First/Discharge to assess (D2A) categories explained below. These categories reflect revisions in the updated statutory *Hospital Discharge and Community Support* guidance published in January 2024.

Home First/Discharge to Assess Pathways Explained

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

28. The key points of the submission in respect of hospital discharge-related capacity that the Co-chairs are asked to note are as follows:

- ***Pathway 0*:** The vast majority of people will not require any type of intervention and it is considered that the short-term post discharge assistance available to older people provided by Age UK is sufficient to meet demand. It is expected that 2,410 residents will be supported by these services in 2024/24. A deep clean and house clearance contract funded via the Council's Discharge Fund is also in place.
- ***Pathway 1*:** There is sufficient capacity to meet projected demand due to the Bridging Care Service that supports people to leave hospital. Approximately 75% of people supported by Bridging Care proceed to receive Reablement. 81% of people receiving Bridging Care also receive therapy input to assist with improving functioning to reduce the level of ongoing care required and maximise independence.
- ***Pathway 2*:** The main provision for this pathway is the Hawthorn Intermediate Care Unit (HICU) for general physical rehab needs and the Alderbourne Rehab Unit (ARU) for people with neuro rehab needs. An Integrated Care System Intermediate Care Escalation (ICE) Hub has been introduced to coordinate access to NHS provided rehab facilities across NWL. Another key facility that will be used by Hillingdon residents is Furness Ward in Willesden. Capacity includes assumptions about availability of block beds provided at Michael Sobell House to support P2 needs where not required for people at end of life.
- ***Pathway 3*:** Included within the capacity calculation are 15 blocks beds at Parkfield House (10 beds) and Drayton Village (5 beds) as well as spot purchased provision. On this basis it is projected that there will be sufficient capacity to meet demand; however, figures do not take into consideration the reluctance of providers to accept placements of people with more complex needs.

Hospital Discharge Fund

29. The Co-chairs are reminded that the Discharge Fund comprises of a local authority aspect, which is funding paid directly to the Council via a grant under section 31 of the Local Government Act, 2003, and also an ICB aspect. The ICB aspect is distributed on a Health and Wellbeing Board basis. A detailed breakdown of the 2024/25 Discharge Fund can be found, for ease of reference, in **Appendix 1**. The key points for the Co-chairs' attention are explained below.

30. **Local Authority Discharge Fund**: Nearly 92% (£1,604k) of the Council's allocation is committed to discharge-related homecare and placement costs that support the financial implications of the Home First model and ensuring that assessment of long-term care needs primarily take place in the community and not in hospital. The remaining 8% is funding additional social work and brokerage capacity to ensure weekend and bank holiday coverage as well as a contract to address requirements for deep cleans.

31. **ICB Discharge Fund:** 49% (£1,268k) of the funding is intended to support P3 and 36% (£920k) to support P1. £121k has been allocated to contribute to the cost of P2 bedded rehab provision in Willesden. Each HWB will also be contributing nearly £221k to support the management by the ICB's Continuing Healthcare (CHC) Team of cases that fall outside of eligibility for CHC but have long lengths of stay in hospital because they also fall outside of eligibility for Adult Social Care. Each HWB will also contribute £50.5k to central ICB business intelligence support for borough-based teams.

Equality and Health Impact Assessments

32. Equality and health impact assessments (EIA & HIA) have not been undertaken for the plan as it is largely a roll over from previous years. Where there are differences, these are either positive, e.g., additional posts to support discharge from hospital of people with mental health needs, or of neutral effect, e.g., removal of some service lines from NHS additional contribution. The impact is neutral because there is no intention to discontinue any services from the additional NHS contribution in 2024/25. Any changes in funding and provision arising from the review of current BCF schemes will not take effect until 2025/26 and an EIA & HIA will be undertaken as part of the review process.

Next Steps

33. The result of the assurance process is now awaited. It is understood that all of the London plans submitted have been recommended for approval but this is not final until the letter of conformation is received.

34. It will not be possible for the Council and ICB to enter into an agreement under section 75 (s75) of the NHS Act, 2006, to give legal effect to the financial and partnership arrangements under the BCF until such time as written notification of '*assured*' status for the plan has been received from NHS England. Formal approval letters are due to be issued from 31st July 2024.

Risk Share Arrangements

35. The arrangement for previous iterations of the plan has been that each organisation manage its own risks and it is proposed that this will continue for 2024/25. The detail of risk share arrangements will also be reflected in the s75 agreement referred to previously.

Financial Implications

Financial Uplift

36. Tables 2 and 3 below show the split of the 2023/25 BCF allocations.

Table 2: Financial Contributions by Organisation 2023/24 and 204/25 Compared		
Organisation	**2023/24**	**2024/25**
NHS	29,658,745	29,851,857
LBH	66,875,873	70,173,307
TOTAL	**96,534,618**	**100,025,164**

Table 3: Financial Contributions by Funding Stream 2023/24 and 2024/25 Compared		
FUNDING SOURCE	**FUNDING**	
	2023/24	**2024/25**
Minimum NHS Contribution	22,869,590	24,164,009
Additional NHS Contribution	5,524,379	3,096,967
ICB Discharge Fund	1,264,776	2,590,881
NHS TOTAL	**29,658,745**	**29,851,857**
Minimum LBH Contribution	12,578,861	13,042,692
Additional LBH Contribution	53,250,038	55,385,658
LBH Discharge Fund	1,046,974	1,744,957
LBH TOTAL	**66,875,873**	**70,173,307**
TOTAL BCF VALUE	**96,534,618**	**100,025,164**

37. The increase in the Council's additional contribution is mainly attributable to the roll forward of £2,154k DFG underspend from 2023/24. This funding has been included in the Council's additional contribution at the direction of NHS England's Better Care Support Team.

Table 4: BCF MINIMUM CONTRIBUTIONS SUMMARY 2023/25		
Funding Breakdown	**2023/24**	**2024/25**
NHS MINIMUM CONTRIBUTION BREAKDOWN		
➢ Protecting Social Care	8,339,569	8,811,589
➢ Out of Hospital	6,489,889	6,866,726
➢ Other minimum spend	8,040,132	8,385,694
TOTAL	**22,869,590**	**24,164,009**
LBH MINIMUM CONTRIBUTION BREAKDOWN		
➢ Disabled Facilities Grant (DFG)	5,111,058	5,574.889
➢ Improved Better Care Fund (iBCF)	7,467,803	7,467,803
TOTAL	**12,578,861**	**13,042,692**
MINIMUM BCF VALUE	**35,448,451**	**37,106,701**

38. Table 5 below summarises the Council and NHS contributions for the period of the 2023 to

2025 plan by scheme.

Table 5: ICB and LBH Financial Contribution by Scheme Summary							
Scheme		2023/24			2024/25		
		LBH (£,000)	NHS (£,000)	TOTAL (£,000)	LBH (£,000)	NHS (£,000)	TOTAL (£,000)
1.	Neighbourhood development	3,052	3,025	**6,077**	5,527	640	**6,167**
2.	Supporting carers	690	471	**1,161**	671	308	**979**
3.	Reactive care	5,489	19,990	**25,479**	6,267	22,240	**28,507**
4.	Improving care market management and development.	26,232	5,083	**31,315**	26,336	5,489	**31,825**
5.	Integrated care and support for people with learning disabilities and/or autistic people.	31,412	993	**32,405**	31,372	1,075	**32,447**
	Programme Management	0	97	**97**	0	100	**100**
	TOTAL	**66,875**	**29,659**	**96,534**	**70,173**	**29,852**	**100,025**

39. The additional voluntary contribution from the Council reflects existing budgets for the long-term residential and nursing care home provision for people aged 65 and above and also long-term homecare provision. It does not represent an additional cost pressure to the local authority. Neither does it reflect the total expenditure by the Council on these services.

Improved Better Care Fund Grant (iBCF)

40. The £7,467k 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 2023/25 are the same as for the last three years, namely that the funding is used for:

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

41. As for the last four 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.

BACKGROUND PAPERS

Hospital discharge and community support guidance (DHSC updated January 2024) Hospital discharge and community support guidance - GOV.UK (www.gov.uk)

Appendix 1

Discharge Fund Spending Plan 2024/25

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

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

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

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 2024/2025

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 2024/2025 Board Planner, attached at Appendix 1.

3. INFORMATION

Supporting Information

Reporting to the Board

The draft Board Planner for 2024/2025, 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-Chairs' 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-Chairs.

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-Chairs, 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 2024/2025 were considered and ratified by Council at its meeting on 18 January 2024 as part of the authority's Programme of Meetings for the new municipal year. The proposed dates and report deadlines for the 2024/2025 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 Chairs 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 2024/2025

10 Sep 2024 2.30pm Committee Room 6	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Thursday 29 August 2024 **Agenda Published:** 2 September 2024
	Hillingdon Joint Health and Wellbeing Strategy 2022-2025	LBH	
	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-Chair considers to be urgent	All	

26 Nov 2024 2.30pm Committee Room 6	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Thursday 14 November 2024 **Agenda Published:** 18 November 2024
	Hillingdon Joint Health and Wellbeing Strategy 2022-2025	LBH	
	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-Chair considers to be urgent	All	

4 Mar 2025 2.30pm Committee Room 6	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Thursday 20 February 2025 **Agenda Published:** 24 February 2025
	Hillingdon Joint Health and Wellbeing Strategy 2022-2025	LBH	
	Integrated Health and Care Performance Report and BCF Progress	LBH/HHCP	
	PART II - Update on current and emerging issues and any other business the Co-Chair considers to be urgent	All	

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