2023/25 BETTER CARE FUND PLAN

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

HEADLINE INFORMATION

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

RECOMMENDATIONS

That the Health and Wellbeing Board:

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

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

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

INFORMATION

Strategic Context

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

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

- ***National BCF Objective 1:*** Enable people to stay well, safe, and independent at home for longer.

- ***National BCF Objective 2:*** Provide the right care in the right place at the right time.

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

2023/25 BCF Plan and National Requirements

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

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

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

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

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

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

Key Changes from the 2022/23

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

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

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

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

1. A jointly agreed plan - A plan that has been agreed by the HWB. This must demonstrate:
 	
• That a plan that has been agreed by the HWB.
 	
  • Funding is placed in one or more pooled budgets in an agreement under section 75 (s75) of the NHS Act, 2006.
 	
  • NHS trusts, social care providers, VCSE and housing must be involved in development of the plan.
	This is dependent on the recommendation being agreed and subsequent agreement under delegated authority.
	
	Subject to '*assured*' status being awarded, the Council's Cabinet and the ICB will be asked to approve the s75 in October.

2. Demonstrating delivery of BCF national objective 1: *Enabling people to stay well, safe and independent at home for longer*. This includes demonstration of: • How personalised care and asset-based approaches are embedded. • Implementation of joined up approaches to population health management and proactive care. • Multi-disciplinary teams at place or neighbourhood level. • Additional support to unpaid carers and availability of adaptations for people at risk of reduced independence.	These requirements are addressed in the narrative plan.
3. Demonstrating delivery of BCF national objective 2: *Providing the right care in the right place at the right time*. This must show how the ICB and social care commissioners will continue to: • Support safe and timely discharge from hospital to usual place of residence. • Implement ministerial priority to tackle delayed discharges. It also needs to identify: • How additional discharge funding will be used for 2023/24 and outline plans for 2024/25. • How discharge funding will impact on discharge-related metrics. • Summarise progress against 2022/23 high impact change model for discharge self-assessment.	These requirements are addressed in the narrative and also the planning template
4. Maintaining the NHS's contribution to adult social care and investment in NHS commissioned out of hospital services.	*Minimum contribution to adult social care:* This will be £8,339k in 2023/24 and will rise to £8,811k in 2024/25. *Minimum contribution to out of hospital services:* The minimum amount in 2023/24 is £6,498k and in 2024/25 will be £6,866k. Most of this funding is locked into a community health contract between the ICB and CNWL.

National Conditions

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

National Metrics

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

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

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

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

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

Reporting Requirements

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

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

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

Submission Requirements

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

- **Narrative plan:** This is intended to demonstrate how the BCF national conditions are being met. It is also intended to address key lines of enquiry set out in the planning guidance. The number and scope of the key lines of enquiry have increased since the 2022/23 planning process, which has contributed to this submission being more complex to complete than previous iterations. A non-mandatory template was provided, which has been used and is attached as **Appendix 1**.

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

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

Intermediate Care Services Explained

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

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

Delegation of Sign-off Authority

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

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

Next Steps

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

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

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

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

Risk Share Arrangements

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

Financial Implications

Financial Uplift

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

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

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

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

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

Improved Better Care Fund Grant (iBCF)

26. The £7,468k iBCF funding is paid directly to the Council under Section 31 of the Local Government Act 2003, with specific grant conditions, including a requirement that the funding is pooled in the BCF. The grant conditions for 2022/23 are the same as for the last three years, namely that the funding is used for:

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

27. As for the last two years, the Council is intending to use the funding to support the local care market. This will fund the annualised effect of the fee uplifts as well as additional fee increases to reflect the financial pressures faced by regulated care providers due to higher staff, energy, and supply costs.

EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

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

Consultation Carried Out or Required

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

BACKGROUND PAPERS

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

Appendix 1

2023/25 Better Care Fund Narrative Plan

Health and Wellbeing Board (s)

Hillingdon

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

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

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

How have you gone about involving these stakeholders?

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

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

1. Executive Summary

This should include:

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

1.1 Priorities for 2023/25.

<u>Strategic Priorities</u>

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

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

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

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

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

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

Scheme Specific Priorities

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

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

The priorities for 2023/25 by scheme are:

Scheme 1

- Implementation of leadership and governance arrangements for six Integrated Neighbourhood Teams.

- Integration of community nursing at Neighbourhood level.

- Integration of therapies at Neighbourhood level.

- Implementation of three Same Day Urgent Primary Care Hubs.

- Alignment of Adult Social Care staff to Neighbourhoods.

- Development and implementation of a third sector Neighbourhood offer.

- Delivery of three Same Day Urgent Primary Care Hubs, including community diagnostics.

Scheme 2

- Consulting on the draft all-age 2023 – 2025 Joint Carers Strategy.

- Completing restoration of carer leads in GP surgeries.

- Establishing carer registers in 100% of GP practices that are members of The Hillingdon

[GP] Confederation.

- Reviewing the carers assessment process for parent carers and young carers.
- Retendering the Carer Support Services contract.
- Explore options for increasing the percentage of adult carers supported by the Council having needs met via Direct Payments.
- Supporting schools to develop their own support provision for young carers.
- Refresh the Memorandum of Understanding between health and care partners on an integrated approach to identifying and assessing carer need in Hillingdon.

Scheme 3

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

Scheme 4

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

Scheme 5

- Improve dementia diagnosis rates.

Scheme 6

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

Scheme 7

- Continuing the development of crisis pathways for people with learning disabilities and/or autistic people.
- Reviewing integration options for the LBH Learning Disabilities and CNWL Learning Disabilities Health Teams.
- Completing the All-age autism strategy, 2023 - 2026.

1.2 Key changes since previous BCF plan.

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

2. Governance

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

2.1 BCF schemes and transformation workstream alignment

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

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

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

2.2 2023/25 governance arrangements

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

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

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

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

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

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

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

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

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

3.1 Overview

Joint Health and Wellbeing Strategy

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

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

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

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

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

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

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

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

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

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

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

Borough-based Partnership and the BCF

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

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

Evolving Operating Model

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

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

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

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

3.2 Joint Priorities for 2023 – 2025

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

3.3 Approaches to joint/collaborative commissioning

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Overview: Data Analysis

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

Care Connection Teams

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

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

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

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

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

Same Day Urgent Primary Care Hubs

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

Integrated Paediatric Clinics

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

Care Home Support Team

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

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

High Intensity User (HIU) Service

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

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

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

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

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

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

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

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

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

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

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

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

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

Please see section 8: equality and health inequalities.

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

Unpaid Carers

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

Housing Adaptations

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

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

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

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

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

4.6.1 Learning from 2022/23.

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

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

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

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

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

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

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

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

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

PHM-specific funded provision within the BCF includes:

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

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

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

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

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

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

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

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

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

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

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

prevent or reduce the risk of falling.

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

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

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

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

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

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

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

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

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

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

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

Please see section 5.6.

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

The following summarises how the discharge funding will be used:

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

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

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

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

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

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

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

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

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

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

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

5.3.1 Learning from 2022/23

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

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

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

- Discharge to usual place of residence.

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

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

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

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

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

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

- Tissue Viability Service
- Twilight Service

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

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

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

5.5.1 Discharge to usual place of residence.

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

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

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

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

HICM Change 1: Discharge planning.

Current Position

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

Update on 2022/23 Self-assessment.

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

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

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

Current Position

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

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

Update on 2022/23 Self-assessment.

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

HICM Change 3: Multi-disciplinary working.

Current Position

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

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

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

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

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

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

HICM Change 4: Home First.

Current Position

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

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

HICM Change 5: Flexible working patterns.

Current Position

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

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

HICM Change 6: Trusted assessment.

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

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

HICM Change 7: Engagement and choice.

Current Position

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

HICM Change 8: Improved discharge to care homes.

Current Position

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

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

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

Update on 2022/23 Self-assessment.

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

HICM Change 9: Housing and Related Services.

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

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

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

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

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

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

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

  PLD: People with learning disabilities

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

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

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

6. Supporting Unpaid Carers

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

6.1 Overview

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

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

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

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

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

6.2 Delivering Outcomes for Carers

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

- **Outcome 1:** Carers are identified, recognised and able to make a positive contribution.
- **Outcome 2:** The physical and mental health and wellbeing of carers of all ages is supported.
- **Outcome 3:** The financial impact of being a carer is minimised.
- **Outcome 4:** Carers have a life alongside caring.
- **Outcome 5:** Carers have access to quality information and advice at any point in their caring journey and know where to find this.
- **Outcome 6:** Carers have the skills they need for safe caring.
- **Outcome 7:** Young carers are supported from inappropriate caring and provided with the support they need to learn, develop and thrive and enjoy being a young person.

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

The main offer of support to young and adult (including parent) carers in the borough comes

through the Carer Support Service contract between the Council and Carers' Trust Hillingdon (CTH), which is the lead organisation for the Hillingdon Carers' Partnership. The latter is a consortium of local VCS organisations that has been created to support carers in the borough. In addition to Carers' Trust, the consortium includes the Alzheimer's Society, Harlington Hospice (including their homecare arm called Harlington Care) and Hillingdon Mind. The funding for this service, i.e., £690k, is included in the Better Care Fund (BCF) from the Council's additional voluntary contribution as well as £19k from the ICB's . The scope of this contract is summarised below and addresses key aspects of the Council's Care Act responsibilities to carers:

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

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

6.3 Unpaid Carers and the Care Act

Carers Assessments

Carers are routinely identified by Adult Social Care through the Care Act assessment of need process and a carer assessment offered. There were XXX carers' assessments undertaken in 2022/23, which includes XXX triage assessments completed by Carers' Trust (see above). This compares to 897 assessments in 2021/22 and 299 triage assessments undertaken by Carers' Trust. Our experience is that many carers decline the offer. The reasons for declining an assessment include people who consider that the assessed care package for the person they are caring for sufficiently addresses their needs; people not identifying themselves as carers and those who feel that the services available through Carers' Trust meets their needs.

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

Respite Services and the BCF

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

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

6.4 Carer Engagement

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

7. Disabled Facilities Grant (DFG) and Wider Services

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

7.1 Overview

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The grant is available to people aged 60 and above.

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

8. Equality and health inequalities

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

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

8.1 Overview

People with Protected Characteristics

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

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

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

Health Inequalities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

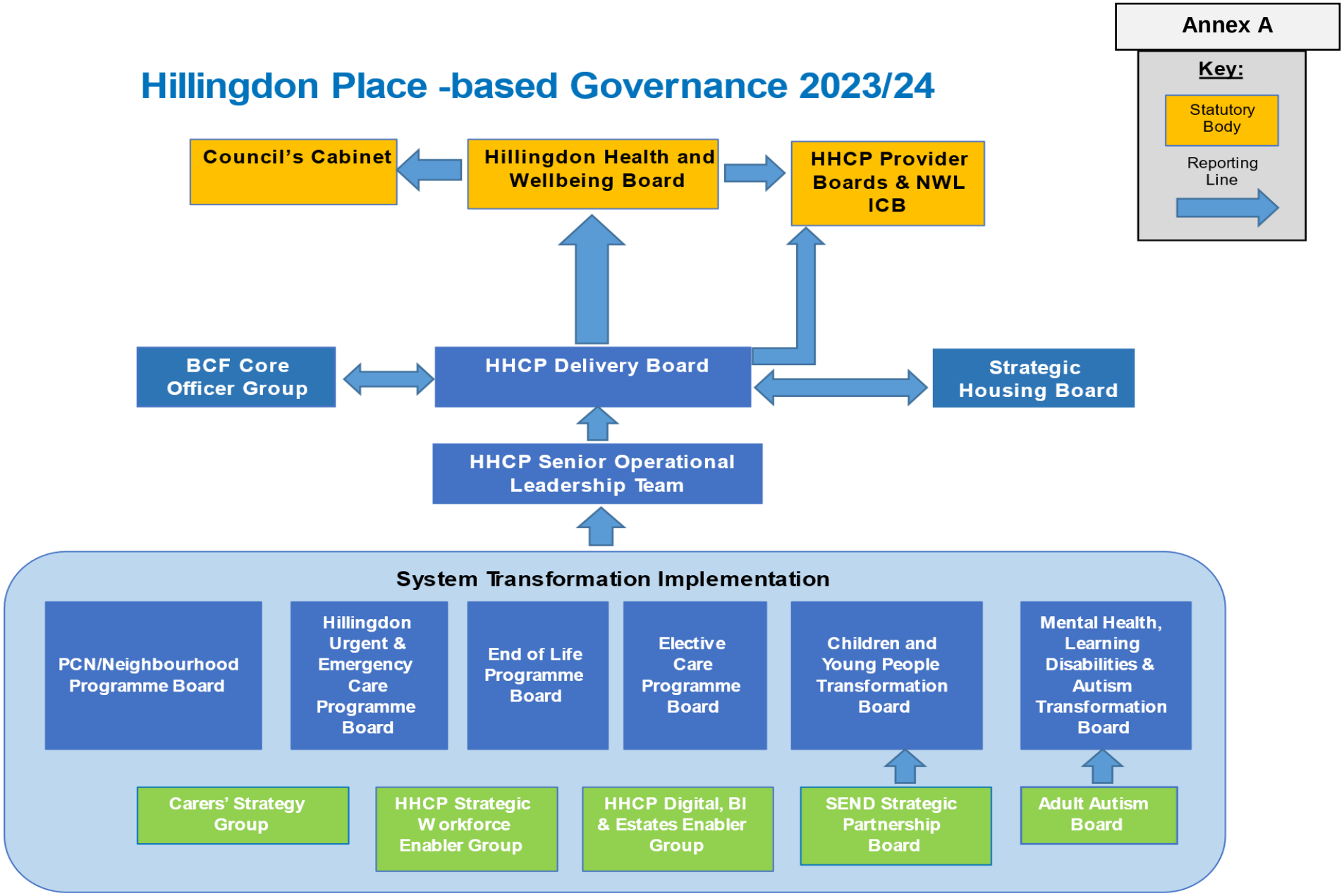
- *Developing the children's integrated therapy service model:* This service is intended to

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

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

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

Annex A

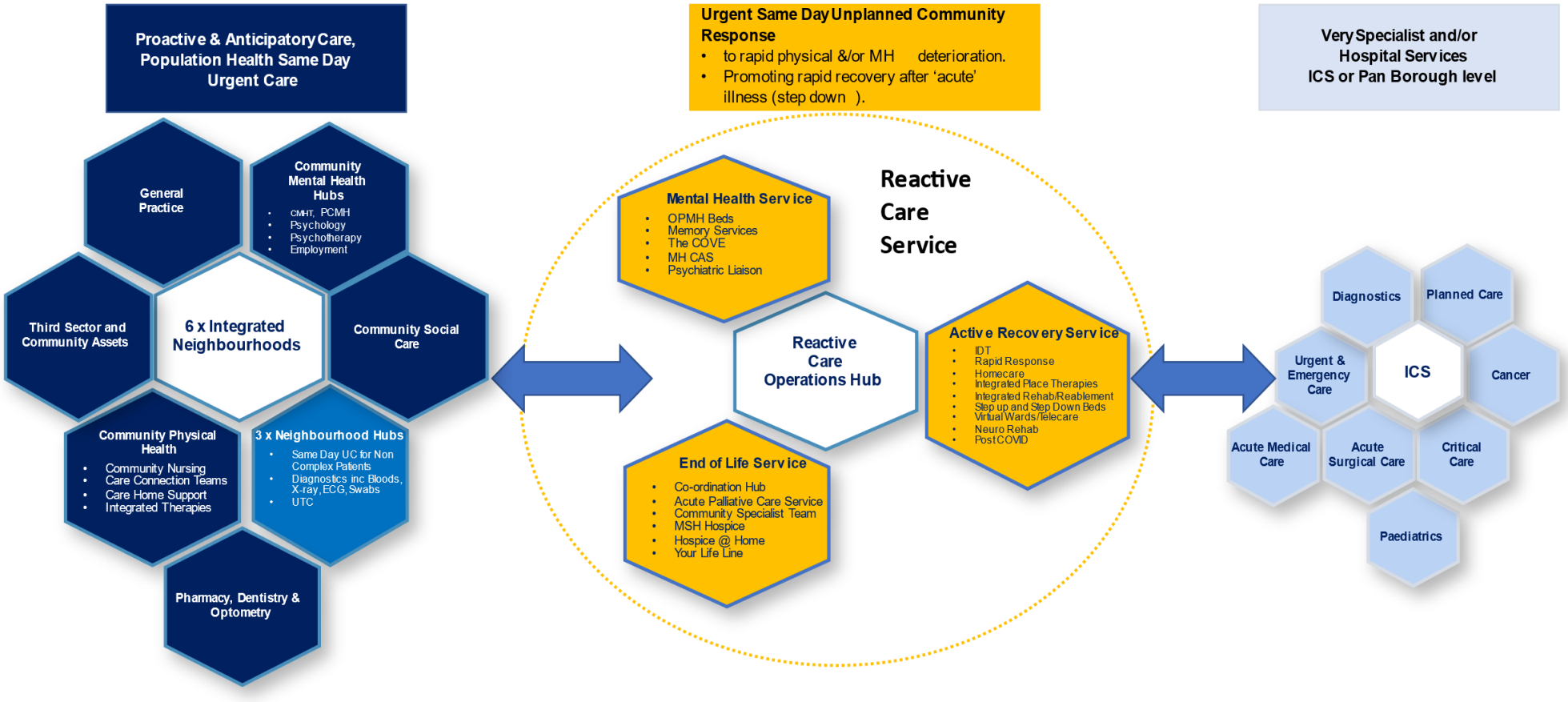

Hillingdon Place -based Governance 2023/24
Key:
Statutory Body
Reporting Line
Council's Cabinet
Hillingdon Health and Wellbeing Board
HHCP Provider Boards & NWL ICB
BCF Core Officer Group
HHCP Delivery Board
Strategic Housing Board
HHCP Senior Operational Leadership Team
System Transformation Implementation
PCN/Neighbourhood Programme Board
Hillingdon Urgent & Emergency Care Programme Board
End of Life Programme Board
Elective Care Programme Board
Children and Young People Transformation Board
Mental Health, Learning Disabilities & Autism Transformation Board
Carers' Strategy Group
HHCP Strategic Workforce Enabler Group
HHCP Digital, BI & Estates Enabler Group
SEND Strategic Partnership Board
Adult Autism Board

Annex B

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

Annex C

Future State Operating Model



End of Life Coordination Hub Operating Model

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