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

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

RECOMMENDATIONS

That the Health and Wellbeing Board notes:

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

INFORMATION

1. Introduction:

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

2. Context: The Strategic Priorities of the JLHWBS:

There are six thematic priorities of the JLHWBS, to:

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

This is delivered through six enabling workstreams:

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

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

3. Strategy Implementation: Interim progress within Year 2:

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

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

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

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

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

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

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

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

Early Years:

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

Promoting Healthy Eating in Schools:

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

schools.

School Superzone Project: Hayes:

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

Priority for Year 2:

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

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

Current Year 2 Progress:

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

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

Examples of projects that are in place include:

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

Priority for Year 2:

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

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

Current Year 2 Progress:

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

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

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

Priority for Year 2:

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

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

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

Current Year 2 Progress:

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

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

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

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

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

Priority for Year 2:

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

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

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

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

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

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

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

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

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

Current Year 2 Progress:

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

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

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

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

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

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

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

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

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

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

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

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

Current Year 2 Progress:

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

The following are strategic priorities are being delivered this year:

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

All Borough Hypertension Prevalence

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

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

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

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

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

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

New Hypertension NHS Operating Plan target 24/25

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

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

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

Calculated by:

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

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

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

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

obesity.			

Current Year 2 Progress:

Agreed approach to develop WSA has been developed.

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

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

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

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

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

Current Year 2 Progress:

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

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

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

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

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

Current Year 2 Progress:

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

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

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

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

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

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

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

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

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

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

Current Year 2 Progress:

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

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

where appropriate.

Falls Prevention Training has been implemented:

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

Training uptake by residents:

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

Care Home Provision:

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

Wider use of training for at risk residents:

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

Oversight and Governance of the Falls Prevention Programme:

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

Priority for Year 2:

PH will commission in 24/25:

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

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

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

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

Current Year 2 Progress:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.6.1. NHSE Inequalities funded projects.

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

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

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

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

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

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

	Invest PHM Neighbourhood Leadership: Initiation	Clinical Director leadership	✓		

3.6.1.2. The Governance Process for the NHSE Funding agreement:

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

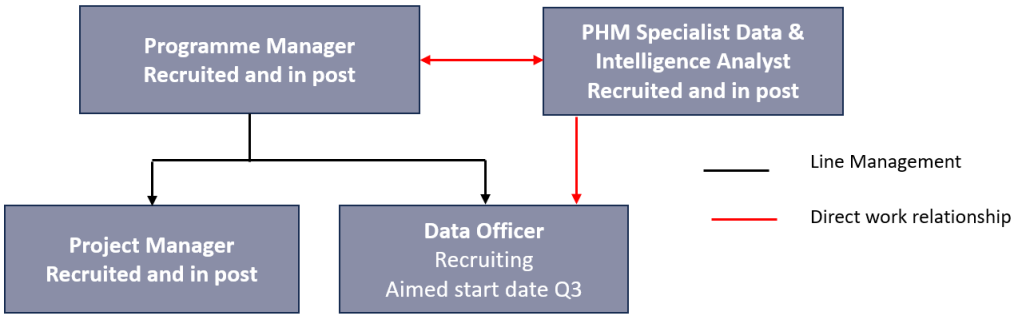
- Priorities for the business case have been agreed by HHCP Governance Committees (January to March 2024).
- The draft business case was approved by NWL Director of Strategy & Population Health (4th April 2024).
- The business case was taken to NWL Contract & Performance Oversight Group (CPOG) for approval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

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

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

3.6.2.1. Building Population Health Management capacity and capability

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

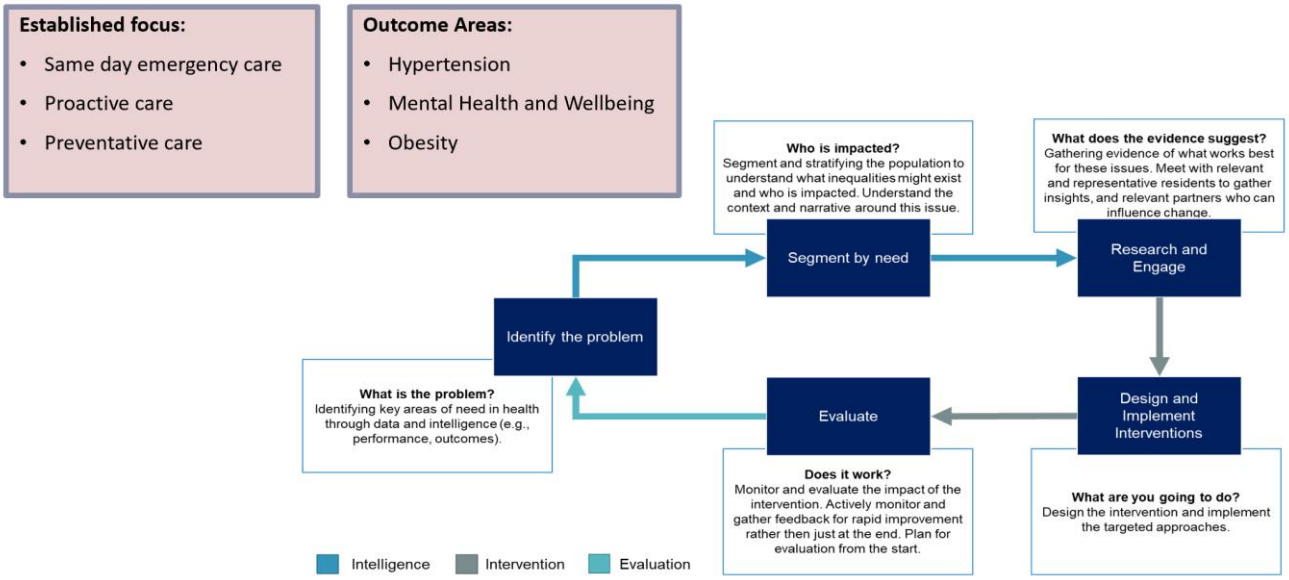


Of the four positions, three have been recruited, two are in post, the Programme Manager and the specialist BI Manager, a third, the Project Manager will start before August and the fourth, the Data Officer role is currently being advertised.

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

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

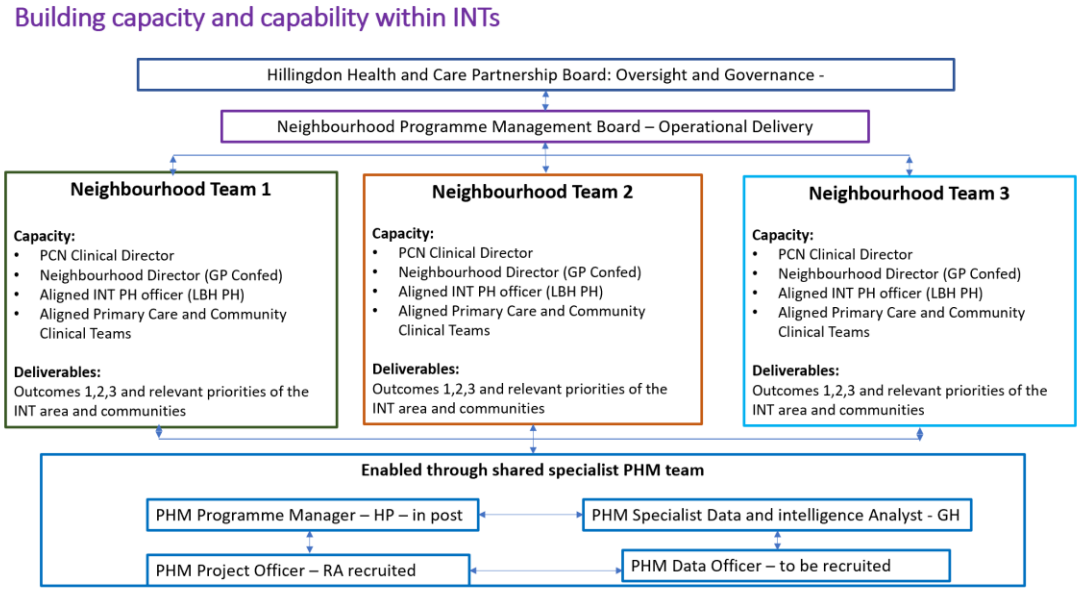
Figure 1: PHM Framework: Implementation priorities for INTs:



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

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

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



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

to:

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

3.6.4. Next Steps

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

4. Financial Implications

None.

5. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

5.1. What will be the effect of the recommendation?

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

5.2. Consultation Carried Out or Required

Engagement with officers leading workstreams has informed this report.

6. CORPORATE IMPLICATIONS

None.

7. BACKGROUND PAPERS

None.