HILLINGDON JOINT LOCAL HEALTH AND WELLBEING STRATEGY 2022-2025: END OF YEAR 2 REPORT

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: Corporate 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) **the reported activities that demonstrate the progress that has been achieved between year 1 and year 2 of the implementation of the Joint Local Health and Wellbeing Strategy (JLHWBS) by lead officers collaborating with HHCP partner organisations, what has been achieved since the strategy was implemented and the plans for year 3 2024/25. .**
2) **planning and implementation progress of the Health Inequalities funded projects.**
3) **that the JLHWBS three-year cycle will end in 2025 and that the Board delegate responsibility to the Director of Public Health to develop a new strategy, the timetable of which will be concurrent with the updating of the JSNA and ensure that there is effective planned and systematic engagement and consultation with Hillingdon professionals, residents, neighbourhood and community groups across the borough at all stages of the Strategy's development that brings insight and understanding.**
4) **that the Year 2 interim report is planned to be presented in January 2025, the combined Year 3 final report that includes strategy closure will be presented with the new Health and Wellbeing Strategy in September 2025.**

INFORMATION

1. Introduction:

This paper updates the Board on progress and achievements against the priorities agreed in the 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. JLHWBS Implementation: Year 2 Evaluation:

This section demonstrates reported progress and improvement is being achieved between year 1 and year 2 of the JLHWBS implementation.

Each table focuses on the priorities stated in the Strategy, and where available, the data is provided based on the KPIs that responsible officers and aligned groups 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 2024/25.

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	Baseline Data	Year 1: Year 2022/23	RAG	Year 2: 2023/24	RAG
***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 obese children – Year R: aged 4/5 years (1:5 children): 2021/22 • Hillingdon: 21.8% • England: 22.3% Overweight and obese children – Year 6: • Hillingdon: 41.7% • England: 37.8%	Data used in year 1 is 21/22 – therefore data is unchanged from the baseline.	**R**	**NCMP measure:** Overweight and obese Children Year R: 2022/23 • Hillingdon: 19.4% overweight and obese. • London: 20% • England: 21.3% Overweight and obese Children Year 6: • Hillingdon: 38.3% • London: 38.8% • England: 36.6% There has been a reduction in child overweight and obesity for both YR and Y6. For YR the prevalence is below London and England, for Y6 Hillingdon is comparable with London and continues to remain above the England average, however the gap has reduced. For solely child obesity Year 6: • Hillingdon: 23.7% (900 children in year group). • London: 24.8% • England: 22.7% **There is clear progress and a reduction in the gap between Hillingdon and England – this is rated AMBER due to the prevalence of overweight and obesity in Y6 continuing to be higher than England.**	**A**

What has been achieved since 2022/23	Plan for Year 3: 2024/25
• There has been greater focus on understanding the healthy eating and healthy weight of school aged children and the promotion of healthy eating in schools: • Completed a schools' health related behaviour survey for school aged children with questions on food choices and behaviours. Primary Schools: - 31 schools registered, - 16 schools completed. Secondary Schools: - 7 registered - 5 completed. • Schools engaging in the Healthy Schools London programme have been focusing on becoming Sugar Smart and Water Only (4 schools are currently active). • HHCP Fitter and Healthier Children workshop that brought stakeholders together to understand the scale of need, current service provision, including infrastructure that makes healthier choices the easiest, and gap analysis. • Hillingdon Strategic Obesity Group established with a clear purpose to take a whole system approach to healthy weight for children, YP and their families. • A tier 2 child healthy weight service specification has been developed, soft market testing completed and an evidence-based programme with face to face and online provision will be commissioned.	1. **Action:** Public Health will procure a tier 2 weight management programme. 2. **Action:** Engage Early Years providers, schools and partner organisations delivering the 'Expanded Early Years Entitlements & Wraparound Childcare' to support key messages around healthy diets and lifestyle choices. 3. **Action:** School Food survey reviewing primary school food June in July 2024 will be the starting point for engagement with school and school caterers. 54 responses received to date. Aim is for: - A minimum of 20 primary schools to assess compliance and adherence to School Food Standards (Sept – Dec 2024) - Using data and insight to influence school policy supporting healthy eating. 4. **Action:** Training for EHOs and Primary Education school improvement advisor on school food standards (SFS) to explore feasibility on SFS being assessed alongside food hygiene inspections – this was identified as a gap in the school Superzone; the pilot will run between September 2024 and March 2025 with 8 schools targeted due to their higher levels of obesity from NCMP data. 5. **Action:** Family Hub directory will be updated to include information on healthy eating, parenting skills and physical activity for CYP 6. **Action:** Healthy Food Advertising programme and sugar reduction campaign across childcare and education settings planned.

Focus Areas	Priority	Baseline Data	Year 1: Year 2022/23	RAG	Year 2: 2023/24	RAG
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%	Data used in year 1 is unchanged from the baseline.	**R**	**Breastfeeding initiation: 2020/21 – PHOF identifies a new reporting method** • Hillingdon: 48.7% • London: 87.7% • England: 71.3% **6–8-week sustained breastfeeding: 2022/23** • Hillingdon: Not published due to incomplete data • London: Not published due to incomplete data • England: 49.2% **This is rated RED due to low initiation recorded by PHOF as part of their new methodology compared with London and England and a lack of data due to insufficient recording of data for sustained BF at 6 weeks.**	**R**

What has been achieved since 2022/23	Plan for Year 3: 2024/25
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. The Breastfeeding Strategy Group has implemented: • Pans 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.	1. **ACTION:** There must be a review of the very low recorded initiation in maternity services to explain the significantly low breastfeeding uptake. 2. **ACTION:** To review data recording for 6–8-week sustained breastfeeding to ensure local feeding rates are understood. 3. **ACTION:** Review the effectiveness of the Breastfeeding Strategy and ensure the actions above are included as a priority, with key objectives and SMART action plan for increasing initial rates and sustained feeding and educate families of the wider health benefits linked to breastfeeding i.e. reduced levels of childhood obesity and dental caries. 4. **ACTION:** complete a breastfeeding and infant feeding health need assessment with the Hillingdon Hospital, EY services and 0-19 NHS services 5. **ACTION:** Review breastfeeding education and initiation support 6. **ACTION:** align the work with NWL that the DPH is leading that maximises opportunities for collaboration.

Focus Areas	Priority	Baseline Data	Year 1: Year 2022/23	RAG	Year 2: 2023/24	RAG
We will work to see the levels of tooth decay reduced.	1,2.	Child Oral Health: DMF teeth by age 5 years (mean per child) Hillingdon: 1.20 England: 0.80 2018/19	Child Oral Health: DMF teeth by age 5 years (mean per child) Hillingdon: 1.20 England: 0.80 2018/19	**R**	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.**	**R**

What has been achieved since 2022/23	Plan for Year 3: 2024/25
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.	1. **ACTION:** Use 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. 2. **ACTION:** Planning for procurement of a 2-year contract that includes the evidence-based activity that is being led by the NWL ICP which is bringing together the NHS, providers and the 8 local authorities to collaborate, and link together oral health, with breastfeeding, health weight, and inequalities between population groups. The new contract from April 2025 will include increased activity, targeted interventions to children at higher risk of dental decay; children with SEND needs, and children living in more deprived communities. 3. **ACTION:** Promote the importance of toothbrushing with parents and professionals in Early Years settings via training delivered by the Oral Health Promotion Service and continuation of Brush for Life delivery through Family Hubs, Children's Centres.

Focus Areas	Priority	Baseline Data	Year 1: Year 2022/23	RAG	Year 2: 2023/24	RAG
We will work to reduce smoking in families.	1,2,3,4.	Smoking prevalence in adults (15+), 2021/22; 37,231 persons Hillingdon: 13.8% England: 15.4%	Smoking prevalence in adults (15+), 2021/22; 37,231 persons Hillingdon: 13.8% England: 15.4% **Smoking cessation levels:** Reduced LBH adult smoker prevalence 11.1% (26,200) down from 13.8%. Prevalence of smoking amongst 15-year-olds (regularly smoke) - currently LBH rate is 13.8% (2021/22) lower than London (14.8%) and England, (15.4%). Long-term mental health condition (18+) in Hillingdon, have a higher prevalence rate of (30.9%) compared to London (26.0%) and England (26.3%). Smoking at time of delivery: LBH 3.2% (Smoking status at time of delivery 2021/22), lower than London (4.5%) and England (9.1%).	**A**	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.**	**G**

What has been achieved since 2022/23	Plan for Year 3: 2024/25
• Tobacco Control Plan: The 2022 – 2025 Tobacco Control Plan was ratified by the Health & Wellbeing Board in June 2023 and sets out the shared ambition for a 'smokefree' Borough by 2030. • Agreed with the Hillingdon Tobacco Control Alliance to initiate the strategy delivery plan and clarify roles and responsibilities of Alliance organisations to reduce overall smoking prevalence, and exposure to second-hand smoke, tackle illicit tobacco sales and underage sale of cigarettes and e-cigarettes; target vulnerable	1. **ACTION:** Mobilise the new stop smoking contract with CNWL 2. **ACTION:** Align the new 5-year investment from the national Stop the Start Strategy – Year 1 there has been additional funding of £280,000 – this has increased the number of stop smoking advisors and is funding new training programmes. 3. **ACTION:** Deliver the Swap to Stop new vaping programme which was a successful bid to DHSC for vaping equipment as a harm reduction intervention. For 2024/25, to implement the national 'Stop

priority; reduce marketing and tackle the supply chain. • 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 clinics in varied settings, including Hillingdon Hospital, Primary Care, local libraries and MH services and drop-ins at Arch. In addition to other targeted work within areas of high prevalence.	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.

Focus Areas	Priority	Baseline Data	Year 1: Year 2022/23	RAG	Year 2: 2023/24	RAG
***Consolidate the integration of therapy services for children and young people and redirect resources into early intervention.**	1,2,5,6.	**No data provided**	85% referral are reviewed by the MDT panel – with referral communicated to the referrer within 2 weeks	**A**	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 and there are contractual issues that need to be agreed.**	**A**

What has been achieved since 2022/23	Plan for Year 3: 2024/25
• The new Children's integrated therapy service (CITS) contract has been collaboratively procured with CNWL as part of the 0-19 contract. There are areas of this contract that have yet to be agreed. • 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.	1. **ACTION:** Agree Key Performance Indicators for this service to enable the progress and improvement of this provision as a priority of the JLHWBS to be published. 2. **ACTION**: Embed the Child Health Collaboration Agreement between LA/ICB/CNWL to develop new and alternative ways of delivering services, including completion of a review of CNWL Children's Services to deliver efficiencies and a robust service offer.

• 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.	

Focus Areas	Priority	Baseline Data	Year 1: Year 2022/23	RAG	Year 2: 2023/24	RAG
*Hillingdon Domestic Abuse Advocacy Service (HDAAS): Providing help and support for victims experiencing domestic abuse.	1,2,6.	**NA**	Since June 2022, the Hillingdon domestic abuse provision has evolved and is now known as HDAAS (Hillingdon domestic abuse advocacy service). The service has become more robust and grown in capacity and now offers help and support for victims experiencing domestic abuse at any level of risk. The service now consists of IDVAs (independent domestic violence advocates) for high-risk cases and Floating Support workers for low-medium risk cases. Hillingdon has been granted funding for the implementation of the IRIS programme. There is a significant need for this programme in Hillingdon and the programme will assist in reaching out to clients who may not be known to or come to the notice of other services such as the police or social care. Referrals from health services remain low, 5 years ago an IDVA was introduced into Hillingdon Hospital resulting in a significant increase in referrals.	**NK**	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.**	**A**

What has been achieved since 2022/23	Plan for Year 3: 2024/25
The Domestic Abuse Steering Executive has agreed a delivery plan to progress the priorities in the 2023-25 Hillingdon Domestic Abuse Strategy and: • 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. 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.	1. **ACTION:** Planning for the update of the 2023-25 strategy with new measures that can be included in this strategy and a DA dashboard to be developed. 2. **ACTION:** complete the need assessment to inform future service commissioning decisions including, the commissioning and procurement of new DA service offer 3. **ACTION:** Review the process for the implementation of routine enquiry across system 4. **ACTION:** Housing to commence work on DAHA accreditation 5. **ACTION:** DRIVE programme to be concluded in March 2025 and findings reported 6. **ACTION:** MARAC steering group o be mobilised following the MARAC review 7. **ACTION:** Pilot of domestic abuse CVS standards 8. **ACTION:** White Ribbon and 16 days of activism campaign to be a published campaign and supported by HHCP organisations. **9. ACTION:** Launch of DA child practice standards

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

Focus Areas	Priority	Baseline Data	Year 1: Year 2022/23	RAG	Year 2: 2023/24	RAG
Reducing homelessness	1,2,5.	**Not available**	Households in temporary accommodation: 2022/23: • Hillingdon: • England: Households owed a duty under the HRA: 2022/23: • Hillingdon: 19.2/1000 • London: 15.7/1000 • England: 12.4/1000 Hillingdon is RAG rated RED on all PHOF indicators and not improving. • In 2022/23 there were 3886 approaches to LBH by homeless households: 706 show mental health as a support need and 195 show drug and/or alcohol use as support need • There were 772 bookings per month into temporary accommodation (TA) and a further 321 rehoused without a prior TA booking.	**R**	**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.**	**R**

What has been achieved since 2022/23	Plan for Year 3: 2024/25
Progress achieved: • In place there are partnering arrangements ongoing with P3 in relation to young people 18 to 25, particularly care leavers, who are homeless or potentially homeless.	1. **ACTION:** Maintain P3 provision and continue to work with homeless and potentially homeless young people in the borough providing them with advice and onward referrals to appropriate agencies. 2. **ACTION:** with the first stage of Project Neptune completed, a second

• Homeless services have been restructured, work is continuing with the transformation team under Project Neptune to refocus service on prevention • A full skills review has been carried out and extensive training programme being rolled out for staff • A care leavers protocol is in place and is being reviewed • Hospital discharge protocol in now in place with a clear focus on duty to refer • An ending Rough Sleeper Plan is in place co-produced with DLUHC • There has been significant funding approved under the Rough Sleeping Initiative, Rough Sleeping Drug and Alcohol Treatment Grant, and Rough Sleeping accommodation Programme • There has been proactive outreach work at Heathrow including patrols and in borough outreach areas. • Successful work with target 1000, most entrenched rough sleepers. • Additional funding secured under Supported Housing Accommodation Programme, Local Authority Housing Fund and Refugee Housing Programme • Additional provision via new build, acquisitions, supported shared housing, extensions, under occupiers' schemes, and cash incentives, Olympic House first stage accommodation, Beechwood supported provision, Saviour's Housed temporary accommodation • Increased collaboration via partnership forums	Phase now seeks to embed improvements with a focus on prevention and early intervention to reduce homelessness. 3. **ACTION:** care leavers protocol is in place and will be reviewed again following changes to government guidance. 4. **ACTION**: to update the Ending Rough Sleeper Plan has been updated for 2024 and signed off by 'DLUHC'. 5. **ACTION:** to be taken to work closely with pan-London colleagues, GLA and DLUHC to highlight the need for continued funding via the Rough Sleeping Initiative, Rough Sleeping Drug and Alcohol Treatment Grant, and Rough Sleeping Accommodation Programme. 6. **ACTION:** Additional funding secured under Supported Housing Accommodation Programme, Local Authority Housing Fund and Refugee Housing Programme. A further LAHF funding bid has been submitted. 7. **ACTION:** 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. 8. **ACTION:** There are ongoing partnership arrangements through collaborative forums to support the above initiatives.

Focus Areas	Priority	Baseline Data	Year 1: Year 2022/23	RAG	Year 2: 2023/24	RAG
*Undertake a Public Health review of disparities and inequalities in Hillingdon and recommend actions.	2.	**NA**	**Information not available.**	**NK**	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	**R**

					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.**	

What has been achieved since 2022/23	**Plan for Year 3: 2024/25**
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.	1. **ACTION:** The development of an updated JSNA and the new JLH&WBS will generate the information required to ensure that key health inequalities that affect the population are understood and future action to mitigate are driven by evidence and insight. 2. **ACTION:** link the Population Heath Management and NHSE funded projects to this agenda.

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

Focus Areas	**Priority**	**Baseline Data**	**Year 1: Year 2022/23**	**RAG**	**Year 2: 2023/24**	**RAG**
1. **Preventative Care: Hypertension workstream** • **Implementation of Fuller Report: Integrated Neighbourhood**	2.	**See Year 1 data**	**Hypertension: QOF prevalence (all ages): 2022/23** • Hillingdon: 12.8% • London: 10.9% • England: 14.4% **Mortality from hypertensive diseases: 2020/22: Per 100,000 population:** • Hillingdon: All: 214.5	**A**	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.	**A**

Teams. Hypertension was 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.**			• London: All: 198.5 • England: All: 140.6 • Hillingdon: Men: 255.7 • London: Men: 242.6 • England: Men: 163.6 • Hillingdon: Women: 179.6 • London: Women: 163.6 • England: Women: 118.5		**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.**	

What has been achieved since 2022/23	**Plan for Year 3: 2024/25**
• Designed and rolled out a Hillingdon Health Inequalities Hypertension Dashboard which includes a summary of: - PCN and Practice Hypertension prevalence figures - Targets for increasing prevalence and management of Hypertension in line with NICE and NHSE ambitions by 2025 and 2029 - A breakdown of prevalence, management and targets for all	1. **ACTION:** Further develop and scale up the work that has taken place across the Hypertension prevention Neighbourhood Programme within the local Integrated Neighbourhood Teams as BAU (and led by the three Neighbourhood Directors) 2. **ACTION:** Implement the NHS Operating plan 23/24 3. **ACTION:** Greater focus on the following areas: • Increasing overall prevalence across Hillingdon (Hillingdon

ethnic groups across Hillingdon
• Developed a capacity and demand predictive modelling tool to help in identifying stakeholder support required to drive the increase in prevalence and support the management of this; thus, reducing pressures on Primary Care
• Implemented a clinical code to track, audit and review the customer journey for patients who had received a blood pressure check at local engagement events; in addition to understanding the number of newly diagnosed patients detected at these events.
• Devised a series of hypertension webinars available in several languages which are hosted on The Confederation website and have also been publicised across GP, partner and local organisation websites.
  • Created a hypertension comms campaign with a variety of resources publicising the community pharmacies across Hillingdon offering free blood pressure checks
  • Developed a Hillingdon engagement calendar highlighting opportunities for partners to further collaborate and engage with patients about their health, while offering support with some of the wider determinants
  • Developed processes and pathways to enable blood pressure checks captured within the community to be sent directly to General Practices, alongside protocols to escalate high risk patients
	currently has a prevalence of 13.4%)
	  • Increasing prevalence of the Black British population across Hillingdon (Hillingdon is currently performing the lowest across NWL (11%) and is below the NWL average of 13.8%
	  • Increase the overall management of Hypertension and ensure that 80% of the number of people diagnosed with Hypertension are treated to target (and have had a blood pressure check in the last 12 months)
	  • Increase the management of Hypertension among the Black British Population (particularly age group 0-79) as Hillingdon is currently performing the lowest across NWL (54%) and below the NWL target of 60%
	4. **ACTION:** 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.
	5. **ACTION**: 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.
	6. **ACTION:** 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.

Focus Areas	Priority	Baseline Data	Year 1: Year 2022/23	RAG	Year 2: 2023/24	RAG
***We will implement a Whole System Approach**	1,2,3,6.	**Adults overweigh and obese % of population:** Hillingdon: 62.3% England: 63.8% 2021/22	Adults overweigh and obese % of population: Hillingdon: 62.3% England: 63.8% 2021/22	**R**	**Adult overweight and obesity: 22/23:** • Hillingdon: 59.2% • London: 57.2% • England: 64%	**R**

(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 obesity.		**Levels of physical activity:** Percentage of physically active adults – 2021/22: H: 64.9%, E: 67.3%, L: 66.8% Percentage of physically inactive adults – 2021/22: H: 26.3%, E: 22.3%, L: 22.9% Percentage of physically active children and young people – 2021/22: H: 40.5%, E: 47.2%, L: 45.3%	**Whole System Approach (WSA): Healthy Hayes:** Agreed by the board that an asset-based community development approach to tackle health weight and inequalities to be piloted in Hayes, the area of the borough with the highest levels of obesity		**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.**	

What has been achieved since 2022/23	**Plan for Year 3: 2024/25**
New Healthy Hayes HHCP Project that takes a whole-system approach to healthy weight introduced. This has led to: • A core group established with an agreed approach to develop WSA agreed. • 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	• **Healthy Hayes – build on the** *Healthy Hayes* workshops held in February 2024 with a focus to look at current provision, key themes, challenges, areas for development • **Hillingdon Strategic Obesity Group** (HSOG) re-established in April 2024. A new Terms of Reference, Membership and new sub-groups set up; focus on leadership and delivery of agreed system-wide partner led actions with a strategic focus to address prevention, wider determinants of health and early intervention. HSOG to meet quarterly. • **HSOG Sub-groups set up** delivering on the following themes: - **Early Years, Children & Young People** (membership: Maternity Services; Paediatric Dietician, Children's Centre, Stronger Families, Public Health) Developing a Communication and Training Plan for professionals and

reached, and causes, challenges and potential solutions were identified. Systems maps have been developed. • Engaged community leaders and local insight collected, including stakeholder feedback on overweight and healthy weight, breastfeeding, food behaviours • Workshop held on 28 March 2023 through which gained a shared understanding of the scale of the overweight/obesity challenges in Hayes reached; causes, challenges and solutions identified, and 'Areas of Focussed work' identified • School Superzone grant awarded by GLA for Minet area (Hayes Town ward) with 10 Council Teams engaged and HHCP represented in delivery **Included in this project is the School Superzone: Hayes: this project has resulted in:** • Partnership development with Hayes Muslim Centre to promote and educate on healthy eating with healthy cooking sessions delivered, and recipes shared with the local community. • Three Primary schools have active plans to become water only, sugar smart and to establish growing projects. • One school has achieved Health School London Silver award • Greater focus on active travel has led to an increase in children walking to school. • In partnership with Higgins Partnership developers, a cookery book, showing healthy swaps for cultural recipes has been published and shared by Minet Junior 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	residents; Tier 2 Pre- Procurement Scoping in progress - **Food Environment** (membership: LBH Strategic Planning and Regeneration; Public Health). High Street Food Advertising survey completed - **Physical Activity and Active Travel** (membership LBH Active Travel and Transport Lead; GLL; Public Health). Developing 'Activating Hayes' – universal offer - **Adult Weight Management** (membership: The Confederation; H4All; Learn Hillingdon; Public Health; CNWL). Developing pathways between Prevention and Early Intervention to address waiting lists and establish exit routes to healthy lifestyle options and to support ongoing behaviour change **School Superzone Project: Hayes:** • Hayes Muslim Centre to 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. • To partner with Mayors Fund for London to deliver cooking session as part of the universal youth offer • To develop a local running pathway that includes The Daily Mile, Junior parkrun and participation in i the Mini Marathon and other London Marathon Events. **Wider development:** • Align with work of Hillingdon Obesity Strategic Group and develop action plans that reflect resident insight, wider stakeholder groups and evidence based best practice • Share School Superzone insight project to reinforce the scale of challenges to impact obesity rates. • Programme with LBH School Improvement and Partnerships to plan for health improvement; Schools Health Related Behaviour Survey commissioned, baseline data at school and borough wide level. • Develop universal support offer through Healthy Schools London Framework • Minet School Superzone achievements 2023/24

groups.	• Very Brief Advice developed: pharmacies to promote Healthy Start (HS) via LPC. • Children Centres trained for Healthy Start eligibility • Improve school food provision

Focus Areas	Priority	Baseline Data	Year 1: Year 2022/23	RAG	Year 2: 2023/24	RAG
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.	Total number of people who are eligible for a health check and received a health check 2019/20 – 23/24: 45.7% (27,998 people)	**Cumulative total received an NHS HC: 2023/24** • Hillingdon: 45.7% • London: 44.9% • England: 40.6% **People invited for a HC per year: 23/24:** • Hillingdon: 17.1% • London: 30.4% • England: 22.1% **People receiving a HC per year:** • Hillingdon: 9.3% • London: 12% • England: 8.8%	**R**	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.**	**A**

What has been achieved since 2022/23	Plan for Year 3: 2024/25

• 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 for 7 years from 2024/25.
• 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.
• NHSHC 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%
• NHSHC performance for Q1, 2024/25:
  ○ Number of people receiving a first offer of an NHSHC (in a five-year period):
  ▪ Target: 17,033 (20.0% of the eligible cohort).
  ▪ Actual: 3,381 (4.0% of the eligible cohort)
  ○ Number of people receiving a completed NHSHC:
  ▪ Aspirational target: 12,775 (15.0% of the eligible cohort).
  ▪ Actual: 2,438 (2.9% of the eligible cohort)
	1. **ACTION:** Work with the Confederation to mobilise the new NHSHC contract.
	2. **ACTION:** Undertake a training audit for general practice staff and produce a training plan.
	3. **ACTION:** Carry out a patient survey for NHS Health Checks
	4. **ACTION:** Roll out the new NWL NHSHC EMIS template once this is available and update the NHSHC quarterly reports.
	5. **ACTION:** Design and implement an intervention/s to increase NHS Health Check uptake among working age men, particularly those from an ethnic minority background, in the Hayes locality

Focus Areas	Priority	Baseline Data	Year 1: Year 2022/23	RAG	Year 2: 2023/24	RAG
***We will support residents with dementia and their carers** **We will support carers to enable them to continue in their caring role**	4.	NK	• 4,790 adult carers were on the carer register in 2021: 21.3% of the population. • 1,187 young carers were on the carer register on 31/03/23. 1,000 new adult carers and 317 young or young adult carers were registered on the carers register in 2022/23. 910 new adult carers and 321 young or young adult carers were registered in 2023/24. • 851 carers assessments completed compared to 810 in 2022/23. • 3,003 offers of carer assessments refused compared to 3,783 in 2021/22. • New co-produced 'Are you a carer?' leaflet developed. • 33 out of 42 GP practices have identified carers champion. • £837k in carer-related benefits secured to improve incomes of 231 households. • Support groups for bereaved carers and bereavement counselling service for carers established. • By 31/03/23 60% of GP practices had carer support service access information on their websites. • Hillingdon Hospitals visiting rules updated to reflect recognition of unpaid carers. • 1,203 attendances by 192 individual young carers at school support sessions during 2022/23. • 2,644 breaks delivered for adult carers. • 2,586 breaks offered for young carers.	**A**	**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**	**A**

What has been achieved since 2022/23	Plan for Year 3: 2024/25
Progress and Achievements: • In 2022/23 3,970 carers were supported with respite or another carers service increasing to 4,789 in 2023/24. • £2.4m in additional carer-related benefits was secured for carers over the 2022/24 period. • £935k additional funding was attracted to Hillingdon to deliver carer-related services informed by carers. • The information leaflet *'Are you a carer?'* was coproduced with carers and is in use across the Hillingdon Place. • The Triangle of Care was introduced in community mental health services to embed a 'think carer' approach amongst professionals. • Two carer experts by experience were identified to be members of the Carers Strategy Group. • 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, • 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.	1. **ACTION:** to finalise the 2024 – 2029 Joint Carers Strategy. 2. **ACTION:** Retender the Carer Support Service contract to secure service stability for up to eight years. 3. **ACTION:** Roll out Triangle of Care across community health services 4. **ACTION:** Include information about how to access support services for carers on 100% of GP websites 5. **ACTION:** Expand the number of GP practice members of the [GP] Confederation with identified carer leads. 6. **ACTION:** Make changes to the new electronic patient record system (Cerner) at Hillingdon Hospitals to support identification of carers. 7. **ACTION:** Explore options for increasing the percentage of adult carers supported by the Council having needs met via Direct Payments. 8. **ACTION**: Review carers assessment process to simplify it as much as possible and encourage carers to register, including young carers assessment process. 9. **ACTION:** Increase the number of schools participating in a young carer recognition programme from 15 to 30.

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

Focus Areas	Priority	Baseline Data	Year 1: Year 2022/23	RAG	Year 2: 2023/24	RAG
We will tackle falls and focus on falls prevention amongst older residents in Hillingdon.	4,6.	Identified as a priority for HHCP and a focus for the NWL funded OPTUM population health management programme for Hillingdon	Falls Prevention is an example of how HHCP has achieved shared outcomes is the OPTUM population health management approach to reduce falls in the over 65 population group. The partnership between ICB, CARS, Age UK and Public Health has designed, with community engagement, and established a Hillingdon falls prevention programme, that includes a more effective falls pathway when a resident has fallen, and to reduce first falls, a prevention workstream.	**A**	**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.**	**A**
					Emergency hospital admissions due to falls i people aged 65 and over directly age standardised r per 100,000. On track to meet target which is a 1% reduction from 23/24 – the target for 23/24 was 865 (population 41,314) achieve fewer than 856 in 24/25. Data from the National BCF Team was significan lower than was considered realistic. It has therefore be assumed that this is inaccurate and the 2023/24 plan taken as outturn.	**G**

What has been achieved since 2022/23	Plan for Year 3: 2024/25
With the implementation of strengths and balance sessions, 430 residents attended exercise classes in 2023/24. There are now 19 classes available a week in the borough. 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.	1. **ACTION:** to 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.

Brunel University have undertaken an evaluation of the programme. From 110 responses:

- 79% of participants were female and 21% male
- 31% reported having a diagnosis of anxiety or depression.
- 74% self-reported an improvement in balance function; and
- 80% self-reported an improvement in perceived control over falling.

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:

- Targeting 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.
  - PH will deliver a train the trainer programme to be implemented from June 2024 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.

2. **ACTION:** evaluate 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.
3. **ACTION:** PH will commission 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.
4. **ACTION:** to develop an online exercise programme for Care Home residents including both a seated and standing programme focused on strength and

- 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.

balance.

5. **ACTION**: PH will commission 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.
6. **ACTION**: 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.

Focus Areas	Priority	Baseline Data	Year 1: Year 2022/23	RAG	Year 2: 2023/24	RAG
We will reform 'intermediate tier' services and support hospital discharge and admission prevention.	2,4,6.	**Not Available**	HHCP Integrated Discharge Hub is fully operational. The number of step-down beds has increased from 10 to 15. Increase of EOL beds to 12 Frailty Assessment Unit is a 6 bedded unit is in place at the front door of THH to prevent admissions. Review of CCT and Care Home teams to strengthen the offer.	G	This information is captured in the Integrated Health and Care Performance Report.	G

What has been achieved since 2022/23	Plan for Year 3: 2024/25
• There has been an achievement of operational targets. • The care home team realignment work completed • 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, • The Care Home Support Group and Care Connection Teams have been reviewed to strengthen their offer. **Maximising the Home First model:** • Hillingdon was one of the first health and care systems in the country to implement 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	**Care Connection Team (CCT):** • currently being restructured to ensure stay within funding model for the service whilst responding to patient needed • Neighbourhood model being reflected in CCT approach after restructure • CCT covering extra care housing as majority of patients more appropriate for caseload, team supports high need patients **Care Home Support Team (CHST):** • GPs and Matrons allocated care homes working with to ensure close working relationships with the homes • Consistently about 95% of patients dying in their preferred place of death • GPs continue to attend the huddle • Matrons regularly attend the care homes for ward rounds • 1 matron completed prescribing course, 1

take place in an acute hospital setting. 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 has been assessed as having a mature system based on a default position that staff will steer people to the appropriate Home First pathway. **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.	matron due to prescribing course shortly to complete by next year • Working with LAS around ambulance call out to care home

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.	

3.5

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

Focus Areas	Priority	Baseline Data	Year 1: Year 2022/23	RAG	Year 2: 2023/24	RAG
Implementing the Autism Strategy*	5.	**NA**	• 23 young people with a learning disability or ASD gained paid employment having attended one of the Hillingdon supported internships and graduating in the summer of 2022 (a success rate of approximately 72%). • 34 additional young people were accepted on to programmes in September 2022. • Hillingdon Getting Ready for Work event for young people with SEN, LD and ASD took place in November 2022 with attendance from approximately 240 residents. This event is to promote to residents with SEN and their families, the various opportunities and next steps when leaving school and preparing for adulthood. • The Hillingdon Supported Employment Forum has continued to meet and is attended by local special schools, colleges, training providers, PCF, the voluntary sector and the DWP – approximately 20 organisations.	**R**	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.**	**R**

What has been achieved since 2022/23	Plan for Year 3: 2024/25
• 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.	1. **ACTION:** 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.

In the first two years of the strategy new projects have been developed to progress the priority areas of the JLHWBS and demonstrate the importance of working together as a Health and Care Partnership committed to design new more efficient, effective and sustainable approaches to improve outcomes for Hillingdon's residents, neighbourhoods and communities.

For Hillingdon the funding allocation for 2022/23 was £615,127k, for 2023/24 was £666,100k and for 2024/25 increases to £679,688.

The NHSE funded Health Inequalities projects are supporting the borough delivery of the inequality's agenda. The following priority projects have been agreed for local delivery over a three-year period:

1. **Core20PLUS priorities:**
- 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

2. **Developing PHM Capacity and capability infrastructure:**
- Building specialist capacity (3 posts) as a shared resource to progress HHCP priorities and enable the INTs to agree a data and insight informed strategy to tackle complex health and care challenges. The team recruited are a programme manager, project manager and BI analyst

3. **Invest Integrated Neighbourhood Team Leadership:**
- Recruited three Clinical Directors to lead and provide support for the INTs.

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

The Board were advised of the governance and reporting arrangements for the new Population Health Management Team that are being hosted by the PH team, reporting to the Director of Public Health in the report to the Board in July 2024.

The role of the team of three PHM specialists is to accelerate our priority projects. The team are funded for a fixed 2-year period and will be prioritising the work of the Integrated Neighbourhood Teams and wider HHCP projects.

Since recruitment the team has:
- Started to review and refine the population health management framework and develop a framework for this systematic framework to tackle health risks and inequalities and

integrate PHM across the HHCP, building capacity in local teams; INTs, local authority, Hillingdon ICB, the GP Confed, and to extend to CNWL and THH.
- Completed a strategic review of the project and designed a two-year change management programme.

The Plan for Year 3: 2024/25 will be to:

- To establish a Programme Management Board and agree quarterly Key Performance Indicators.
- Agree scope of the six priority areas have been identified to support the delivery of PHM across the Programme life: Embedding, Upskilling, Behaviour Change, Combined Data Strategy, Continuous Improvement & Story of Change:
  - Embedding – Strategic review of internal documents, process and definitions across HHCP. Will agree on common approaches, definition and training of PHM to ensure a) long-term engagement with PHM and b) minimise organisational friction.
  - Upskilling – Training programme, delivered primary in support of new INTs, to begin in Oct 24 and run to 2026. Ancillary skill training for Health Economics to also begin in 25 to support additional beneficial skills to PHM.
  - Behaviour Change – Baselining underway, with quarterly reporting to be utilised to allow for tracking of PHM acceptance and allow for rapid response to programme feedback.
  - Combined Data Strategy – Develop and implement a Combined Data Strategy to facilitate access to both raw data and data products across the HHCP, mitigating impact of cross-organisation data sharing and to build out enhanced data insight across the entirety of the HHCP. Data usage will also address and link interventions to outcomes and allow us to better reinforce what works and to target groups that are not having an impact in line with what we would expect from the general Hillingdon Population.
  - Continuous Improvement – Board to be established in 25 and meeting monthly to allow for rapid actioning of received feedback and to drive pace of change. This will not only be focussed on operational changes but also feedback into service design to address existing change and reinforcing what works.
  - Story of Change – First stakeholder engagements underway in 24, to be expanded in 25 to allow for wider engagement with community and ensure range of insights and feedback captured.
- The ‘Upskilling Programme’ is currently being piloted by the Public Health Team and a training programme across HHCP will commence in October 2024.
- Build a new dashboard that includes service insights that will enable identification of Hillingdon neighbourhoods, community and population groups that are affected by health inequalities and feed this insight into the INTs.
- To support, and act as a critical enabling factor and support the onboarding and remit of the newly established INTs. PHM will not only allow for more efficient service design and development but also allows for better insight into the challenges faced by residents.
- A Health Inequalities Board will be established in Q4 24/25 to support the wider mission of addressing and improving outcomes for all Hillingdon residents and tackling disparity in outcomes. This will include representatives from across HHCP and will be chaired and organised by the PHM project team. This will reinforce the work being done with the INTs and allow for strategic, borough-wide insights, initiatives and change.

4. Planning for the New JLH&WBS – timetable for development:

The current JLHWBS three-year cycle will end in 2025 and the update of the JSNA is planned.

It is important that the new JH&WBS is informed by the revised JSNA and reflects the current and emerging health and care priorities in the borough, including health and care needs that effect different neighbourhoods and communities.

The Board is asked to delegate responsibility for the update of the JLHWBS to the Director of Public Health, supported by the LBH PH Team, and wider HHCP partners when required. The DPH will develop a timetable of action and activities that will result in a new strategy being agreed by the Board by September 2025. This timetable will be developed concurrently with the JSNA and will include an effective engagement and consultation plan that maximises community events, creates meaningful opportunities to discuss health experiences and health needs with residents, and when drafted create an opportunity for residents to review the final draft. The aim is that we try to co-produce this plan with those for whom health and care improvements are being addressed.

5. Financial Implications

None applicable

6. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

6.1. 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.

6.2. Consultation Carried Out or Required

Engagement with officers leading workstreams has informed this report.

BACKGROUND PAPERS

None.