2023/25 Better Care Fund Narrative Plan

Health and Wellbeing Board (s)

Hillingdon

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

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

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

How have you gone about involving these stakeholders?

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

As with the development of the 2022/23 BCF, the involvement of care home and homecare providers has been through their respective forums. A series of transformation workshops to agree the priorities outlined in schemes 1, 3 and 6 in section 1 below took place in Q4 2022/23 and all stakeholders were involved in the workshops.

1. Executive Summary

This should include:

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

1.1 Priorities for 2023/25.

Strategic Priorities

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

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

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

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

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

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

Scheme Specific Priorities

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

- Scheme 1: Neighbourhood development
- Scheme 2: Supporting carers
- Scheme 3: Reactive care
- Scheme 4: Improving care market management and development
- Scheme 5: Integrated care and support for people with learning disabilities

The priorities for 2023/25 by scheme are:

Scheme 1

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

- Integration of community nursing at Neighbourhood level.

- Integration of therapies at Neighbourhood level.

- Implementation of three Same Day Urgent Primary Care Hubs.

- Alignment of Adult Social Care staff to Neighbourhoods.

- Development and implementation of a third sector Neighbourhood offer.

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

- Improve dementia diagnosis rates.

Scheme 2

- Consulting on the draft all-age 2023 – 2025 Joint Carers Strategy.
- Completing restoration of carer leads in GP surgeries.
- Establishing carer registers in 100% of GP practices that are members of The Hillingdon [GP] Confederation.
- Reviewing the carers assessment process for parent carers and young carers.
- Retendering the Carer Support Services contract.
- Explore options for increasing the percentage of adult carers supported by the Council having needs met via Direct Payments.
- Supporting schools to develop their own support provision for young carers.
- Refresh the Memorandum of Understanding between health and care partners on an integrated approach to identifying and assessing carer need in Hillingdon.

Scheme 3

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

Scheme 4

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

Scheme 5

- Continuing the development of crisis pathways for people with learning disabilities and/or autistic people.
- Reviewing integration options for the LBH Learning Disabilities and CNWL Learning Disabilities Health Teams.

- Completing the All-age autism strategy, 2023 - 2026.

Key – LBH: London Borough of Hillingdon, also referred to as the '*Council*'.

1.2 Key changes since previous BCF plan.

The main change since the 2022/23 plan is the development of a new operating model, which is explored in more detail in section 3: *National Condition 1: Overall BCF plan and approach to integration.* The 2022/23 BCF scheme focusing on aspects of service transformation for children and young people has been removed from the 2023/25 plan, although the work will continue outside of the BCF framework. It is intended that partnership and financial arrangements will be reflected within the BCF section 75 agreement but outside of the pooled budget.

The plan enhances support to expedite discharge of people with mental health needs and discussions are in progress that could result in its scope being broadened in 2024/25 to include broader aspects of Adult Mental Health. Discussions in progress also include the possibility of a local NHS provider becoming a signatory to the section 75 agreement. Expansion of the scope of the BCF and inclusion of an NHS provider as a signatory to the section 75 are dependent on the outcome of a review of Hillindon's BCF schemes that will be undertaken in 2023/24. The review will take into consideration where consistency with other boroughs within North West London is appropriate whilst ensuring that the specific needs of Hillingdon's residents are addressed.

To avoid repetition, changes pertinent to national conditions are described in sections 4, 5 and 6 as appropriate.

2. Governance

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

2.1 BCF schemes and transformation workstream alignment

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

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

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

2.2 2023/25 governance arrangements

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

Under current governance arrangements, there is a transformation board with an executive lead from one of the health and care partners or the Council for all workstreams, e.g., workstream 1 is led by the chief executive from The Confederation, workstream 2 by the managing director for HHCP, workstream 4 by the Managing Director (Goodall Division) of CNWL. Workstream 3, which as previously stated is outside of the BCF, is led by Hillingdon Hospital's Chief Operating Officer.

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

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

The HWB considers a performance report on the delivery of the priorities within the Joint Health and Wellbeing Strategy as a standing item at each of its meetings. The March and June 2023 reports to the Board can be accessed via the following links London Borough of Hillingdon - Agenda for Health and Wellbeing Board on Tuesday, 13th June, 2023, 2.30 pm London Borough of Hillingdon - Agenda for Health and Wellbeing Board on Tuesday, 7th March, 2023, 2.30 pm

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

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

- Joint priorities for 2023/25
- Approaches to joint/collaborative commissioning.

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

3.1 Overview

About Hillingdon

Hillingdon is the second largest of London's 32 boroughs covering an area of 42 square miles over half of which is a mosaic of countryside including canals, rivers, parks and woodland, interspersed with historic towns and villages. It shares borders with Hertfordshire, Buckinghamshire, Slough, Surrey, Hounslow, Ealing, and Harrow. There are three localities in Hillingdon and these are North Hillingdon, Uxbridge and West Drayton and Hayes and Harlington. **Annex B** illustrates Hillingdon's geography, including wards.

The far south of Hillingdon is dominated by Heathrow Airport and the transportation infrastructure and hospitality services that support it. The Hayes area together with Yiewsley and West Drayton are more urban in nature. Uxbridge provides a metropolitan shopping centre and tube line terminus and is home to Brunel University. The borough is dissected by the key road links of the A40 just north of Uxbridge and the M4 in the far south in Hayes (see **Annex B**).

The recent census showed that in 2021 Hillingdon had a population of 305,900, which represents a 11.7% increase since the 2011 census and, importantly, a 17.4% increase in the 65 + population. The census also showed that Hillingdon's population is increasingly diverse with the percentage of people identifying themselves within the Black, Asian and other minority ethnic groups rising to 51.8% since 2011. Harefield ward in the north of the borough is the least diverse and Belmont ward in the south east the most.

Hillingdon includes more affluent areas (within the top 20% nationally), primarily located in wards to the north of the A40 as well as areas of deprivation (within the lowest 20% nationally). Ickenham ward in the north of the borough is the least deprived and Heathrow Villages ward in the south is the most.

Other key health and wellbeing characteristics of the borough include:

- 6% of the Hillingdon population who have multi-morbidity or are at the end of their life account for 65% of all Hillingdon GP appointments, 66% of all emergency admissions, 74% of all acute occupied bed days, 70% of all ASC resource and have average lengths of stay of twice as long as other population cohorts.

- People at end of life have an average of 613 emergency admissions per 1,000 population compared to a population average of 59 per 1,000.

- People with long-term conditions have an average of 91 emergency admissions per 1,000 population.

- 33% of Hillingdon GP appointments are for '*healthy*' people, i.e., those requiring episodic care but who have no other underlying health condition, but 'overflow' demand for same day primary care for this population group is a significant contributor to attendance at the Urgent Treatment Centre and Hillingdon Hospital's Emergency Department.

- 72% of people attending Hillingdon Hospital's Emergency Department do not need the service of an emergency care clinician.

- 87% of the Hillingdon GP registered population who have more than one long term condition identify as being in the White and Asian or Asian British ethnic groups.

- The most prevalent long term conditions in Hillingdon are hypertension, anxiety/depression and obesity.

- The prevalence of long-term conditions is highest amongst the three most deprived Neighbourhoods, i.e., Colne, Hayes and Harlington Collaborative and Long Lane. See **Annex C** for Neighbourhood geography and alignment with Primary Care Networks. See also under *Evolving Operating Model* below for more detail).

Joint Health and Wellbeing Strategy

Hillingdon enjoys many characteristics that makes taking a joint approach to meeting the health and wellbeing needs of our population less of a challenge than for some other areas. We have a single local authority, one acute hospital trust with two sites in the borough, a GP confederation that includes 43 of the borough's 45 practices, a single community health and community mental health provider and an established consortium of the five larger third sector organisations in the borough.

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

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

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

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

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

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

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

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

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

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

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

Borough-based Partnership and the BCF

HHCP is the borough-based partnership that serves as the delivery vehicle for integration across health services and the BCF provides the legal framework for delivering the place-based priorities set out in the Joint Health and Wellbeing Strategy that are dependent on integration between health and social care and/or closer working locally between the NHS and the Council for delivery. The BCF section 75 is identified as enabling delivery of a place-based health and care budget as reflected in the Government's health and care integration white paper '*Joining up care for people, places and populations: The government's proposals for health and care integration'* (DHSC Feb 2022) and discussions are in progress to develop this further in 2023/24. This will be within the context of the review of current BCF schemes referred to in section 1.2: *Key changes since previous BCF plan.*

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

Evolving Operating Model

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

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

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

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

3.2 Joint Priorities for 2023 – 2025

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

3.3 Approaches to joint/collaborative commissioning

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

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

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

- Commissioning jointly with the local authority avoids the NHS paying a premium that can impact on the supply and overall cost of care for the local system;

- Local residents want locally based care and support solutions and longer lengths of stay in hospital are more likely to occur where only out of borough care solutions are offered or where these are the only ones available.

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

The Council has long undertaken the brokerage function to access independent sector provided services on behalf of the NHS NWL in respect of people with learning disabilities in receipt of Continuing Healthcare funding, children and young people and also people subject to s117 of the Mental Health Act. The role of the brokerage team in supporting hospital discharge is addressed in section 5: *National Condition 3: Delivering National BCF Objective 2.*

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

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

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

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

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

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

Changes relevant to BCF national objectives 1 and 2 are addressed in sections 4 and 5 and unpaid carers in section 6.

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

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

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

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

In-line with (but pre-dating) the Fuller Stocktake, neighbourhoods have been established in Hillingdon as the building block of place based care building to deliver improvements to meet the needs of residents by multi-disciplinary teams arranged arounds groups of general practices that form six primary care networks.

The Integrated Neighbourhood Teams are focused on maintaining whole population health and wellbeing with three core functions and these are:

- Same Day Urgent Primary Care for people with non-complex needs.
- Proactive Care for at risk population cohorts with an emphasis on Frailty in the first instance.
- Preventative care for a range of population health Joint Strategic Needs Assessment (JSNA) priorities but with an initial emphasis on hypertension, anxiety/depression and obesity.

To deliver these functions there are a range of neighbourhood-based models of care in place and these include:

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

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

Overview: Data Analysis

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

Care Connection Teams

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

operating at Neighbourhood level will have a single integrated leadership structure operating across provider.

As shown in section 1: *Executive Summary*, a priority for the period of the plan is to create an Active Recovery Service (see also **Annex E**) that includes vertically integrated Rapid Response and place-based community therapy services. The intention is to improve efficiency and effectiveness through single line management arrangements. The Reablement Service is delivered by an independent sector provider under a contract with the Council and it is intended that its operation will align with the Active Recovery Service.

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

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

Same Day Urgent Primary Care Hubs

The intention is to open three hubs in the borough that will provide urgent care for people with non-complex needs and include diagnostics, such as bloods, x-ray, electro-cardiogram (ECG) and swabs. Joint work between The Confederation and the Council means that the intention is to open two hubs in 2023/24, one in the north of the borough and the other in the south. This is with the aim to divert 18% and 28% respectively of the non-complex cases attending the Emergency Department and Urgent Treatment Centre (UTC) at Hillingdon Hospital. The funding for the hubs is not included within the BCF.

Care Home Support Team

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

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

High Intensity User (HIU) Service

This service is delivered by H4All and was launched to reduce the attendances and admittances to Hillingdon Hospital of the top 50 patients. The team deliver a holistic model of support that utilises health coaching, integrative counselling, and social prescribing for these patients who do not fit into traditional systems of support. The service won the Health Service Journal (HSJ) *Urgent and Emergency Care Initiative of the Year 2021 Award* and is a partnership with the Hillingdon Hospital, London Ambulance Service, Police, housing, substance misuse and mental health services. The funding for this service is included in the BCF within the Integrated Care Programme (see scheme 1).

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

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

- *Self-help through access to information and advice* **–** As part of the implementation of its obligations under the Care Act, the Council has developed an online directory the functionality of which has evolved over time.

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

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

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

  A separate arrangement is in place to support people who wish to make complaints against NHS bodies. The contract for this provision will be retendered in 2023/24 and additional capacity will be built into Care Act

advocacy provision to reflect the expectation of increased demand arising from the Adult Social Care funding reforms that are to be implemented from October 2025.

- *Strong partnership with the voluntary and community sector* – The H4All consortium has a highly active role within HHCP and is commissioned by NHS NWL to deliver the Wellbeing Service, which has staff attached to PCNs. The Wellbeing Service, the funding for which is included within the BCF, supports people with long-term conditions who are at risk of escalating needs via multi-disciplinary work undertaken by the CCTs and works with them taking a strengths or asset-based approach to make best use of the positive attributes that a person already has. The Patient Activation Measure (PAM) tool is used to identify how motivated a person is to manage their long-term condition at the start of a period of person and whether this has improved at the end. Social prescribing is a tool available to the service to address identified need.

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

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

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

Please see section 8: *Equality and health inequalities*.

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

Unpaid Carers

Section 6: *Supporting unpaid carers*, details how unpaid carers are supported, including development of carer leads and carer registers in GP practices and referrals to the Carer Support Service, which delivers a one stop shop model of support for carers of all ages in Hillingdon.

Housing Adaptations

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

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

- Learning from 2022/23, such as
  - Where number of referrals did and did not meet expectations.
  - Unmet demand, i.e., where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected).
  - Patterns of referrals and impact of work to reduce demand on bedded services, e.g., admissions avoidance and improved care in community settings, plus evidence of under-utilisation or over-prescription of existing intermediate care services.
- Approach to estimating demand, assumptions made and gaps in provision identified:
  - Where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
- How have estimates of capacity and demand (including gaps in capacity) been taken on board and reflected in wider BCF plans?

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

4.6.1 Learning from 2022/23.

The focus of intermediate care resource in Hillingdon is more on supporting people out of hospital than preventing them from getting there in the first instance, hence the drive to move towards the new service model described in section 3.1: *Overview*, which is intended to support our residents in the community to stay healthier and fitter.

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

2023/24 demand has been obtained by using 2022/23 actuals and applying a 2% uplift to reflect demographic pressure.

Social support – Activity within scope is demand on the H4All Wellbeing Service (see section 4.3) operating at Neighbourhood level and 2022/23 actuals are given. Demand has remained at a similar level for the last two years and capacity is in place to meet this.

Urgent community response – Activity is based on demand for the Rapid Response Service in 2022/23. 2023/24 capacity assumes a maximum caseload of 30 per week, a 97% utilisation rate, and an average 3 day duration of service provision.

Reablement at home - Activity based on caseload capacity of 18 per day and 98% utilisation and a duration of service of 25.5 days. Demand and capacity analysis does identify gaps for some months.

Rehabilitation at home – Activity is based on 2022/23 community referrals for Community Adult Rehabilitation Service (CARS) + 20% to reflect the increase in activity seen in 2023/24. Capacity is broadly in line with demand, although there are gaps in some months. Mitigation would be through flexing other community health services provided by CNWL such as Rapid Response, the provision of Reablement, community equipment and/or homecare for people eligible for adult social care support from the Council.

Rehabilitation in a bedded setting – This would be delivered in the Hawthorn Intermediate Care Unit (HICU). The demand for active rehabilitation is not recorded as HICU capacity is committed to supporting discharge from Hillingdon Hospitals. The Alderbourne Rehabilitation Unit (ARU) is a 20-bed level unit providing multidisciplinary rehabilitation for people with neurological and other complex conditions. The specialist nature of this service means that it has not been considered as part of demand and capacity analysis.

Reablement in a bedded setting – See also 4.6.3 below. The gap between demand and supply would be met via spot purchase, subject to a caveat about availability and this is related to the receptiveness of providers to accept placements.

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

Reablement in a bedded setting – Three beds in a residential care home block contract were converted for use as step-up provision primarily for respite. This did not prove to be successful as the supply was not appropriate to address presenting need, which has been people living with dementia and having nursing needs. Funding has been included within the BCF for a block contract with a nursing provider for one bed.

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

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

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

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

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

Further examples of services within the BCF that support the objective include the Reablement Service in scheme 3: *Reactive care* and integrated homecare in scheme 4: *Market management and development*, the dementia resource centre referred to in scheme 2: *Supporting carers* and the range of community services delivered by CNWL referred to in section 5 below regarding delivery of BCF objective 2.

Health inequalities grant funding has been provided for PHM infrastructure but this sits outside of the BCF. Further explanation is provided in section 8.2: *Inequalities addressed through BCF plan and BCF funded services and changes from 2022/23 plan.*

The provision of blood pressure monitors is funded for 2023/24 from health inequalities grant funding but this also sits outside of the BCF.

Support for unpaid carers has critical role to delivering national objective 1 and is addressed in section 6: *Supporting unpaid carers*.

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

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

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

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

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

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

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

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

Falls-related injuries constitute one of the main causes of hospital admission from care homes. PHM funded falls training in 2022/23 enabled the CNWL falls service to deliver training to care homes in the borough supporting the 65 and over population. This is being evaluated to determine whether it should be continued in 2023/24.

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

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

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

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

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

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

in line with the Government's hospital discharge and community support guidance.

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

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

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

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

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

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

Please see section 5.6.

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

The following summarises how the discharge funding will be used:

- Additional Bridging Care Service capacity.
- Additional Homefirst/D2A Rehabilitation Service capacity
- Discharge-related homecare.
- Discharge-related residential placements.
- Discharge-related nursing placements.
- Block short-term nursing placements.
- Block short-term dementia nursing beds.
- Additional hospital social work capacity (7-day).
- Additional brokerage capacity (7-day).
- Pathway 3 bed manager post.

- Out of borough discharge liaison social worker post (2024/25).
- Specialist Autism Discharge Social Worker post (2024/25).
- Forensic Mental Health Social Worker post (2024/25).
- Housing Discharge Support Officer post (2024/25).

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

Through integrating active recovery services (see **Annex E**) it is intended to reduce the average length of stay in Medicine and Rehabilitation at THH initially for **the 21+ day long length of stay cohort by 5.2 days** and then the **7+ cohort by 1.7 days** in order to deliver a stepped 44 bed reduction of **15 beds by end of Q1 2023** and **29 beds by September 2023.** This would result in a minimum cost reduction of £4m.

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

Our BCF plan also includes provision to improve Mental Health-related discharges and the following provision has been included funded via NHS additional voluntary contribution linked to the capitalisation of community equipment:

- Hospital Discharge Approved Mental Health Professional (AMHP).
- Mental Health Hospital Discharge Social Worker.
- Mental Health Hospital Discharge Floating Support Service pilot.

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

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

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

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

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

5.3.1 Learning from 2022/23

The range of pathway 1 services, i.e., Bridging Care, Reablement and Community Adult Rehabilitation Service have worked well together to support timely discharge from Hillingdon Hospital. This has ensured that 7+, 14+ and 21+ length of stay figures are consistently low when compared with other NWL boroughs and the London average.

Capacity Tracker is showing an average care home occupancy rate of 95% in Hillingdon; however, there are homes that cater only for self-funders as well as those for niche markets, e.g., nuns and retired actors, and these factors taken into consideration with the homes designated by CQC as '*requires improvement'* mean that the occupancy rate for placements available to the statutory sector is probably closer to 97%. The consequent competition for limited supply as well as issues with securing a permanent workforce, contribute to making providers reluctant to accept people with more complex needs. A lack of local supply has necessitated a search for placements further afield. These are contributory factors leading to longer delays with a small number of people on pathway 3.

The option to secure short-term beds care home settings to support pathway 3 has to be balanced against the impact that this has on the availability of beds for long-term placements. Taking into particular consideration Hillingdon's high care home bed occupancy rate, removing supply will impact on the ability of partners to move people out of short-term beds, which will have consequences for hospital length of stay.

The development of Hillingdon's Market Sustainability and Fair Cost of Care plan has identified the following factors that impact on supply of care home beds and ongoing homecare provision:

- True cost of care is not addressed by rates paid by the statutory sector.

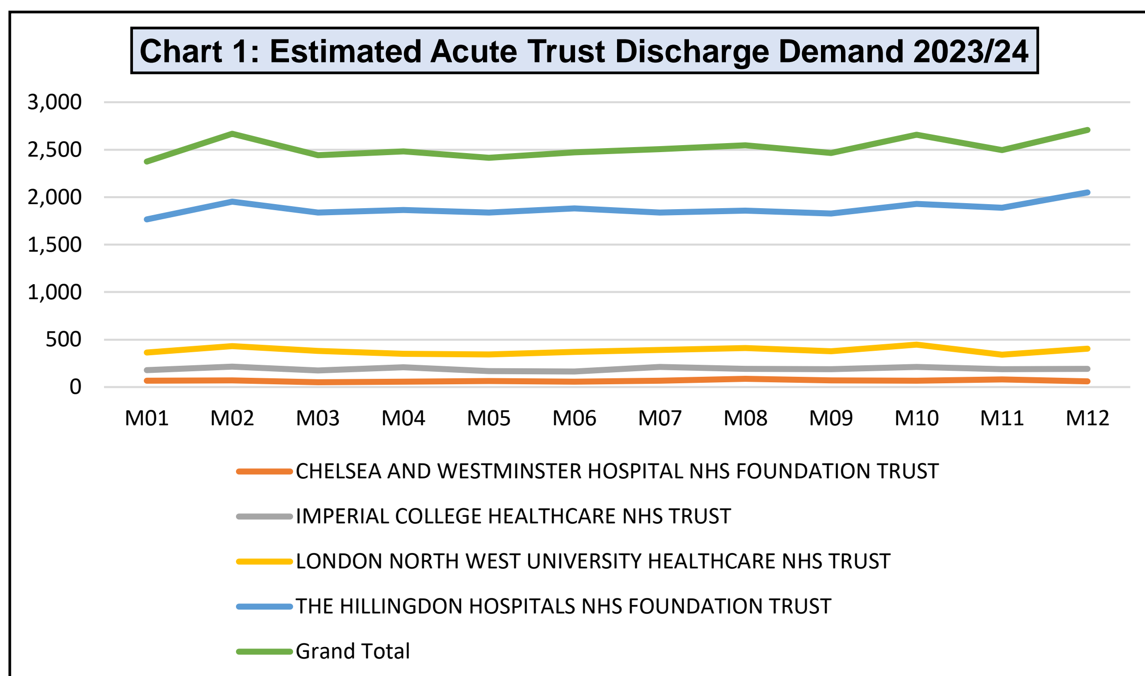
- Difficulty with securing and retaining permanent staff, i.e., 39% of care home staff were agency in September 2022.

Hillingdon's Market Sustainability and Fair Cost of Care Plan can be accessed via the following link Market sustainability and fair cost of care - Hillingdon Council A combination of the transition to a fair cost of care as well as inflationary pressures faced by providers poses particular challenges to commissioners as available funding will not meet the full estimated cost. It is the Council's intention to make 50% of the Fair Cost of Care Fund available to regulated providers in 2023/24 and 50% in 2024/25.

Limited supply within the local care home market is another factor taken into consideration in the multi-agency discharge meetings when discussing with patients and their families the most appropriate discharge pathway.

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

Chart 1 below summarises projected acute trust discharge demand. Demand is based on 2022/23 actuals with a 2% uplift to account for demographic pressure.



Hillingdon Hospitals account for 75% of Hillingdon's discharge demand, London North West University Healthcare Trust 15%, Imperial College 8% and the Chelsea and Westminster.

Pathway 0 – The *Hospital Discharge and Community Support Guidance* (DHSC July 2022) suggests that 50% of discharges should be on this pathway. Hillingdon Hospital's experience is that on average this pathway accounts for approximately 80% of discharges. The demand figures in tab 4 of the planning template includes all discharges on this pathway. However, the vast majority of people will not require any type of intervention. As shown in the planning template, '*social support'* for this pathway comprises of short-term post discharge assistance to older people provided by Age UK and it is assumed that available capacity meets actual demand.

Pathway 1 – Up to 40% of people accessing the Bridging Care Service proceed to be assisted by the Reablement Service. Discharge from Reablement for those requiring ongoing care is dependent on the capacity of homecare providers. Under homecare commissioning arrangements in Hillingdon there are two lead providers, one covering the north of the borough and the other the south, and these are supported by a framework of 10 other providers. It is assumed that these arrangements will provide sufficient capacity to facilitate flow through short-term

services. This is, however, subject to workforce-related constraints, i.e., recruitment and retention.

Pathway 2 – This pathway accounts for approximately 4% of discharges in Hillingdon and demand and capacity data included is for rehabilitation in a bedded setting. This refers to the Hawthorn Intermediate Care Unit (HICU), which is a 22-bed unit. Capacity reflects an average 21 day length of stay and an average 95% occupancy. Demand and capacity analysis does identify gaps for some months. Mitigation would be via spot purchase of nursing care home placements, with active rehabilitation being provided through in-reach by the Community Adult Rehabilitation Service. Spot placements would again be subject to availability.

Pathway 3 - In 2022/23 there were 207 short-term placements and of these nearly 84% (173) were for older people. 2023/24 has seen referrals to the Council's Brokerage Team at approximately four a week, which would suggest a level of demand equivalent to 2022/23.

2023/24 capacity reflects a 10 bed block contract that was established in April 2023 and assumes additional block arrangements for 5 beds coming into effect from September 2023 and applying the formula within the template guidance (see below for rationale). The block enables people likely to require long-term placements to be discharged from hospital whilst this need is confirmed. Where this is confirmed the necessary onward spot placements are then arranged. Capacity figures do not take into consideration spot purchases where there is insufficient capacity within the block or where the block cannot meet need, i.e., people with more challenging behaviours. A dedicated bed management resource funded via the ICB discharge fund is intended to improve flow through the block beds and other short-term placements, subject to the limiting factor of market supply for move-on.

Partners are exploring alternative ways of managing demand from people on the non-weight bearing pathway to reduce demand on block provision. Additional scrutiny of referrals is also being implemented to ensure that pathway 3 is the most appropriate route, e.g., whether need could be met within extra care housing. This work and increased block capacity should enable the system to address the expected spike in demand between December 2023 and March 2024 as illustrated in chart 1 above and the demand and capacity worksheet (tab 4) within the BCF planning template.

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

Key changes include:

- ***Pathway 1*** - A temporary increase in the weekly hours being delivered by the Bridging Care Service introduced in 2021/22 has been made permanent. This raises core hour capacity to 560 hours a week from 460 and recognises the increased acuity of people being assessed as no longer meeting the criteria to reside in hospital. It is recognised that this will need to be kept under continued review.

- ***Pathway 3*** – The Council was intending to undertake a tender for a block contract for 10 short-term nursing beds for a period of up to 6 years to secure

longer-term supply on behalf of health and care partners. Demand and capacity analysis applying the formula in the guidance has identified an additional 5 beds are necessary to meet the expected demand over a period of up to 6 years.

Securing the provision of 15 beds through a tender process should ensure that the Council and its health and care partners have sufficient capacity to provide appropriate care to most individuals in need of short-term nursing care who do not need to be in hospital.

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

- Discharge to usual place of residence.

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

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

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

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

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

- Rapid Response
- Community Adult Rehab
- Community Homesafe
- Community Matrons
- District Nursing
- Tissue Viability Service
- Twilight Service

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

- Hawthorn Intermediate Care Unit (HICU)

Pathways 2 and 3 provision funded via the NHS minimum contribution to social care, the NHS additional contribution and local authority discharge fund include:

- Parkfield House step-down beds

Section 5.2.2 describes the services funded via the discharge fund that will contribute to the delivery of national objective 2.

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

5.5.1 Discharge to usual place of residence.

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

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

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

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

HICM Change 1: Discharge planning.

Current Position

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

Update on 2022/23 Self-assessment.

Identified Actions	Update
Implementation of the medical admissions proforma called Redcoat.	Completed and will standardise record keeping.

Completion of patient discharge passport following consideration by the Hospital's Patient Forum.	Completed. A standardised discharge booklet now in place following collaboration with the NHS NWL.
Continued roll out of SAFER patient flow bundle, including criteria-led discharge.	This is a priority for 2023/24.
Explore scope for re-establishing the '*red bag'* scheme.	Partners agreed not to proceed in response to feedback from care home providers and lack of dedicated resource.
Developing a discharge checklist for the Hospital Emergency Department.	Completed
Developing a standardised discharge checklist for all adult inpatient wards.	This will take place in 2023/24 as part of the implementation of the Cerner patient record system.

Current status against maturity matrix: ***Mature***.

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

Current Position

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

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

Update on 2022/23 Self-assessment.

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

Current status against maturity matrix: ***Mature***.

HICM Change 3: Multi-disciplinary working.

Current Position

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

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

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

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

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

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

Current status against maturity matrix: ***Exemplary***.

HICM Change 4: Home First.

Current Position

The existence of the CCS Bridging Care Service that has been funded by the NHS via its voluntary contribution to the BCF since 2018/19 supports timely pathway 1 discharges. This service provides an onward referral route to the Reablement Service or long-term packages of care where a person does not have reablement potential.

A delirium pathway support service pilot has been established to increase discharges on pathway 1 and reduce discharges on pathways 2 and 3. The pilot started in March 2023 and is being delivered by CCS.

P2 support is provided via HICU or in step-down bedded provision pending access to active rehab via HICU. Ward assessments are being undertaken for people on pathway 3 only, who represent the lowest number of hospital discharges.

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

Current status against maturity matrix: ***Exemplary***.

HICM Change 5: Flexible working patterns.

Current Position

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

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

Current status against maturity matrix: ***Established***. The difficulty faced by care providers in being able to accept new referrals or restarts of packages of care regardless of the day of the week consistently prevents progress to the '***mature***' category.

HICM Change 6: Trusted assessment.

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

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

Current status against maturity matrix: ***Mature***.

HICM Change 7: Engagement and choice.

Current Position

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

Current status against maturity matrix: ***Plans in place***. Once the new NWL choice framework is in place it will enable Hillingdon to progress to '***Established'*** with the goal of achieving '***Exemplary'*** in 2024/25.

HICM Change 8: Improved discharge to care homes.

Current Position

A key route for Hillingdon's health and care system to engage with care home providers continues to be through the monthly care home managers' forum that is chaired by the Council. Discharge is a regular item for which the health and care

system's Head of Integrated Care attends. As previously stated, the Council's Brokerage Team is responsible for brokering short-term placements for people being discharged from hospital and the process also features regularly as part of the discussion about discharge.

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

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

Update on 2022/23 Self-assessment.

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

Current status against maturity matrix: ***Mature***. Support from the Care Home Support Team and Quality Assurance Team has facilitated care homes in Hillingdon from being towards the top in the league table of those in North West London with residents being admitted to hospital to being in a significantly lower position.

HICM Change 9: Housing and Related Services.

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

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

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

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

- **Information and advice:** Funding from the NHS minimum contribution supports the online information and directory of services platform '*Market Place*' and well as the online services coordinator post that has responsibility for its development and promotion. Core grant provision to voluntary and community organisations, e.g., Centre for ADHD and Autism Support (CAAS).

- **Preventing, reducing or delaying needs:** Funding addressing these responsibilities includes core grant to VCS organisations (scheme 5); DFGs to fund telecare (scheme 1) and community equipment (scheme 3); the Bridging Care and reablement services shown in scheme 3, which are funded from a combination of minimum and additional NHS contribution; the dementia resource centre in scheme 2, which is funded via NHS minimum contribution; and extra care team manager post funded from NHS minimum contribution to social care.

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

  Key - *PLD*: People with learning disabilities

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

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

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

6. Supporting Unpaid Carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers. This should include how funding for carers breaks and implementation of

Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

6.1 Overview

The importance of supporting carers continues to be recognised by all health and care partners as being critical to the sustainability of the local health and care system. The 2021 census showed that the number of people identifying themselves as carers reduced from 25,905 in 2011 to 22,465 in 2021. The age breakdown of carers in Hillingdon is shown in the table below.

Age Breakdown of Carers in Hillingdon	
Carer Age Group	**Number**
5 – 18	660
19 – 24	1,215
25 – 64	16,625
65 +	3,965
TOTAL	**22,465**

The reduction in the number of people identifying as unpaid carers reflected a national pattern that the Office of National Statistics (ONS) has attributed to possibly being related to the census taking place during covid lock-down conditions and changes to the carer-related question from that asked in the 2011 census. It highlights the issue of '*hidden carers', i.e.,* people who are providing unpaid care to another person but do not recognise themselves as carers.

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

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

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

The draft Joint Carers Strategy can be accessed via the following link Carers strategy 2023 to 2028 - Hillingdon Council

6.2 Delivering Outcomes for Carers

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

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

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

The main offer of support to young and adult (including parent) carers in the borough comes through the Carer Support Service contract between the Council and Carers' Trust Hillingdon (CTH), which is the lead organisation for the Hillingdon Carers' Partnership. The latter is a consortium of local VCS organisations that has been created to support carers in the borough. In addition to Carers' Trust, the consortium includes the Alzheimer's Society, Harlington Hospice (including their homecare arm called Harlington Care) and Hillingdon Mind. During 2022/23 this contract provided support to 6,307 adult carers and 1,064 young carers.

The funding for this service is included in the BCF from the Council and ICB's respective additional voluntary contributions. The scope of this contract is summarised below and addresses key aspects of the Council's Care Act responsibilities to carers:

- Information, advice and support to access health and wellbeing and universal services

- Home-based short break provision for carers who would satisfy the national eligibility criteria.

- Development of recreational activities that provide short break opportunities for carers.

- Counselling and emotional support.

- Undertaking triage carer assessments under a trusted assessor model. The purpose of the triage assessment is to enable a carer to identify whether they are likely to meet the National Eligibility for Carers, therefore necessitating a

full carer’s assessment as a precursor to receiving financial support from the Council.

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

6.3 Unpaid Carers and the Care Act

Carers Assessments

Carers are routinely identified by Adult Social Care through the Care Act assessment of need process and a carer assessment offered. There were 851 carers’ assessments undertaken in 2022/23, which includes 286 triage assessments completed by Carers’ Trust (see above). This compares to 897 assessments in 2021/22 and 299 triage assessments undertaken by Carers’ Trust. Our experience is that many carers decline the offer. The reasons for declining an assessment include people who consider that the assessed care package for the person they are caring for sufficiently addresses their needs; people not identifying themselves as carers and those who feel that the services available through Carers’ Trust meets their needs.

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

Respite Services and the BCF

The Carer Support Service contract includes a replacement care aspect. £83k is also being contributed from the ICB’s minimum contribution to social care is funding respite provision. A further contribution of £174k is made from this funding stream to secure provision of respite placements for carers of people with learning disabilities.

6.4 Carer Engagement

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

7. Disabled Facilities Grant (DFG) and Wider Services

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

7.1 Overview

Hillingdon is a unitary authority and therefore incorporates housing responsibilities contained within the Housing Grants, Construction and Regeneration Act, 1996,

i.e., DFGs. The re-housing and homelessness provisions of the Housing Act, 1996, also fall within the Council's sphere of responsibility. The content of this section has been agreed with the Council's DFG lead and approved by the Strategic Housing Board (see section 2.2: *2023/25 governance arrangements*).

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

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

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

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

- ***Telecare:*** DFG funding is used to purchase telecare equipment and there are currently 7,470 residents in receipt of equipment that ranges from the simple lifeline system to a range of sensors and detectors. 6,323 users of the service are people aged 75 and over to whom it is currently available free of charge. The Council's telecare offer also includes access to a responder service (including out of hours) for people who may not have relatives or friends who can assist in the event of a call going through the lifeline service, known as TeleCareLine. 3,834 people subscribe to this service that is delivered by an independent sector provider via the Reablement Service. The operating model for the telecare service is under review and the intention is that it will be subject to a competitive tender during 2023/24 for implementation in 2024/25.

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

- ***Extra care:*** There are 234 apartments in the Council's four extra care schemes. One of the two consulting rooms within the 88 apartment scheme called Grassy Meadow Court provides a base for the 6 Care Home Matrons employed by the Care Home Support Service. The matrons also have to the

treatment room at Park View Court to accommodate additional staff. It is intended that during 2023/24 the treatment room at Triscott House extra care scheme will be used by HHCP to deliver physiotherapy to residents of Hayes as part of the drive to reduce elective care waiting lists.

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

Hillingdon DFG allocation for both 2023/24 and 2024/25 is £5,111k for each year. The Council's Cabinet approved budget for 2023/24 includes provision of £2,261k for major adaptions and discretionary grants (including the Hospital Discharge Grant) described in more detail below. £2,850k was agreed for the capitalisation of social care equipment, including community equipment and telecare mentioned above.

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

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

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

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

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

  - *Safe and Warm Grant*: Up to £5,000 for replacement boilers, draught proofing to doors, windows and loft insulation, solid wall and flat roof insulation and security measures. The grant is available to people aged 60 and above.

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

8. Equality and health inequalities

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

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

8.1 Overview

People with Protected Characteristics

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

- Older people
- People with learning disabilities
- People with mental health needs
- Autistic people

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

Health Inequalities

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

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

The main causes of death in Hillingdon in 2020 (the most recent year for which data is available) was cancer which accounted for 23% of all deaths in 2020 (25% in males and 21% in females) and circulatory diseases which also caused 23% of all deaths (23% in males and 22% in females). Levels of obesity in school reception age children, Year 6 and the 18 years and over population are significantly higher than the average for England and London and are concentrated in the less affluent areas in the south of the borough.

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

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

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

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

- *Embedding PHM as an approach to system working* – NHS England Health Inequalities funding in 2022/23 provided the resource for two additional posts to proactively build capacity and capability within HHCP to embed PHM as a system of working. This funding was included in the BCF in 2022/23 but is sitting outside of it for 2023/24 pending the outcome of the review of BCF schemes referred to in section 1.2: *Key changes since previous BCF plan*. The postholders will be employed by CNWL with recurring funding and will operate under the direction of the Director of Public Health.

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

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

- Falling is one of the major causes of hospital admissions from care homes and PHM funding in the BCF in 2022/23 enabled CNWL to deliver falls prevention training to care home staff on a train the trainer basis. This is being evaluated to determine whether it should be extended into 2023/24.

- *Developing a whole systems approach to addressing obesity* – Obesity is an established risk factor for many chronic conditions including diabetes, arthritis and heart failure. 36% of Hillingdon's population live in the Hayes and Harlington locality, which has the highest obesity prevalence in the borough for both the 18 and above population and Year 6. The highest proportion of Hillingdon's Black, Asian and minority ethnic population also live in this locality. PHM funding in the BCF in 2022/23 supported the development of community champions. This is among the 2022/23 schemes being evaluated to determine appropriateness to continue into 2023/24 and beyond.

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

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

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

- *Delivery of health checks for people with learning disabilities (PLD) to national target:* In 2022/23 81% of people with learning disabilities on GP registers aged 14 and above received an annual health check against the national target during the period of the plan. The BCF funded services that will contribute to the delivery of this priority include:
  - Integrated care programme (scheme 1)
  - Care Connection Teams (scheme 1)
  - Social care staffing (scheme 5)
  - Supported living (scheme 5)

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

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

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

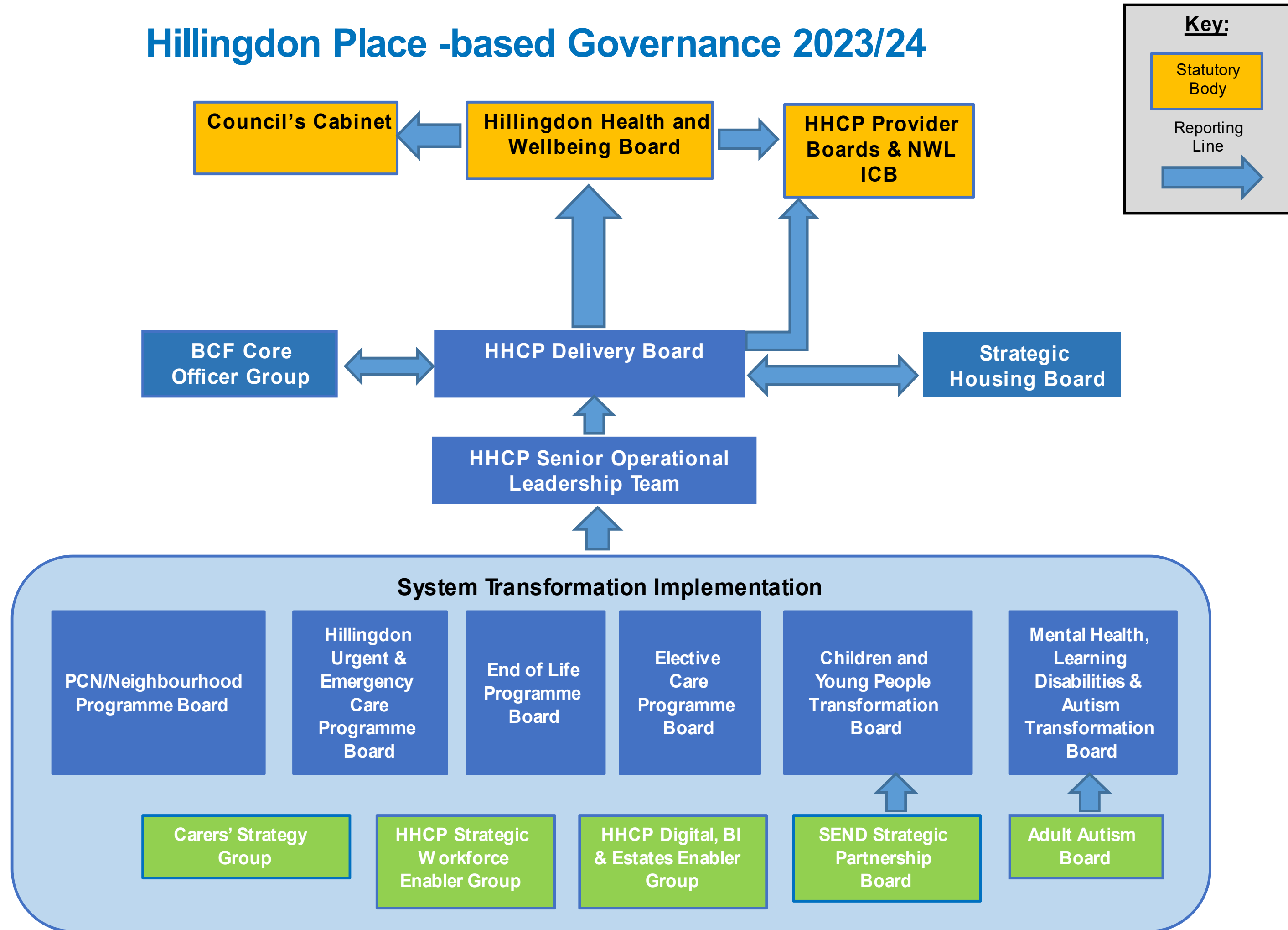
- *Supporting adults with mental health needs:* Sections 5.2.2 and 5.2.3 describe the increased infrastructure and funding source to expedite discharge from hospital of adults with mental health needs over the lifetime of the plan. This will be supplemented in 2024/25 by additional social worker review capacity funded from the uplift to the NHS minimum contribution.

- *Supporting autistic people:* Section 5.2.2 identifies the intention to create a specialist social worker post to support discharge from hospital of autistic people in 2024/25 from the Council's discharge fund. This will enhance the health and care system response to increasing numbers of people being admitted to hospital who are autistic.

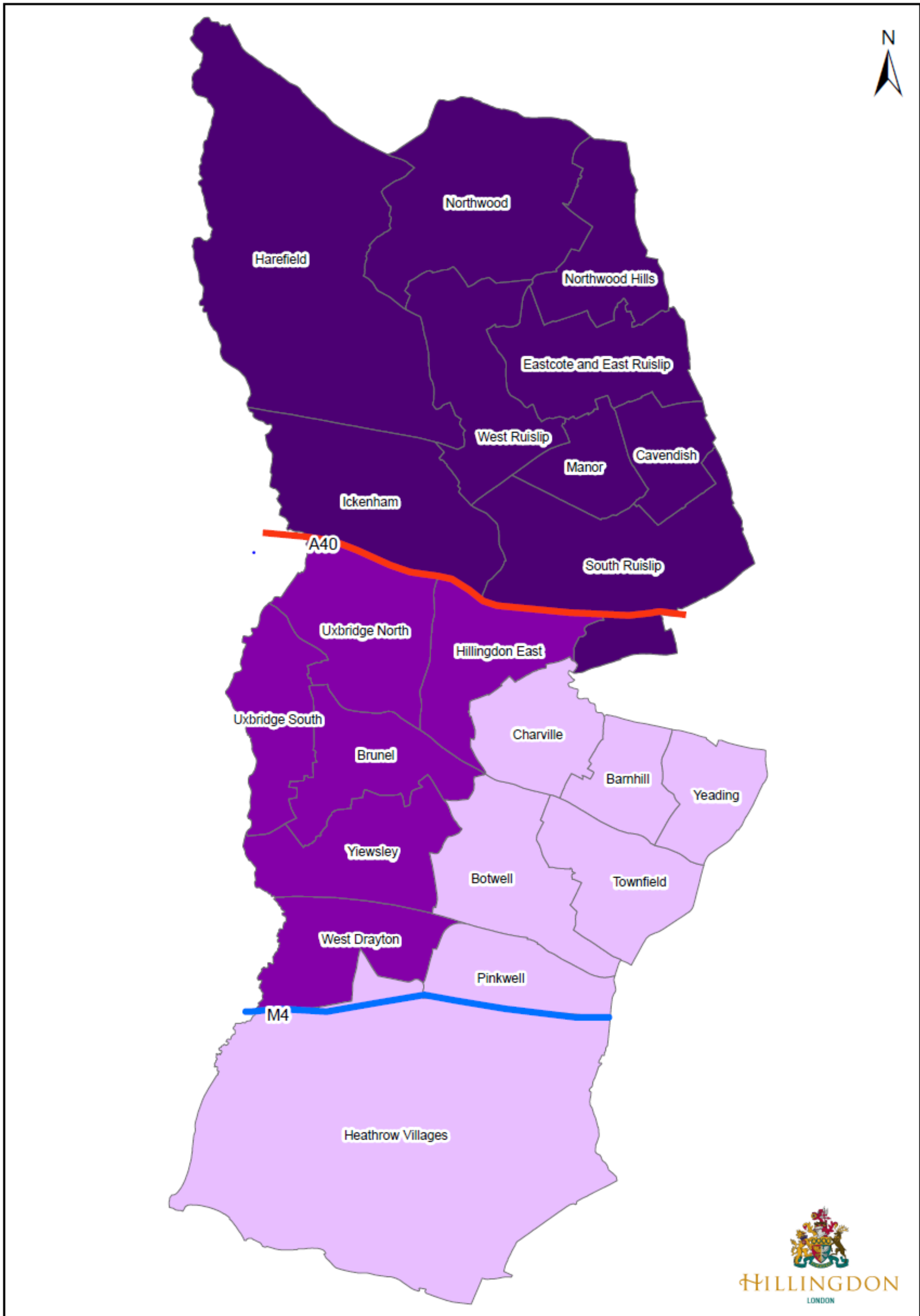
Safeguarding Children

A contribution to funding staff within the Multi-agency Safeguarding Hub (MASH) contained within the ICB minimum health contribution to the BCF is intended to protect the health, wellbeing and human rights of children and young people subject to, or at risk of, abuse.

Annex A



Hillingdon Geography and Wards



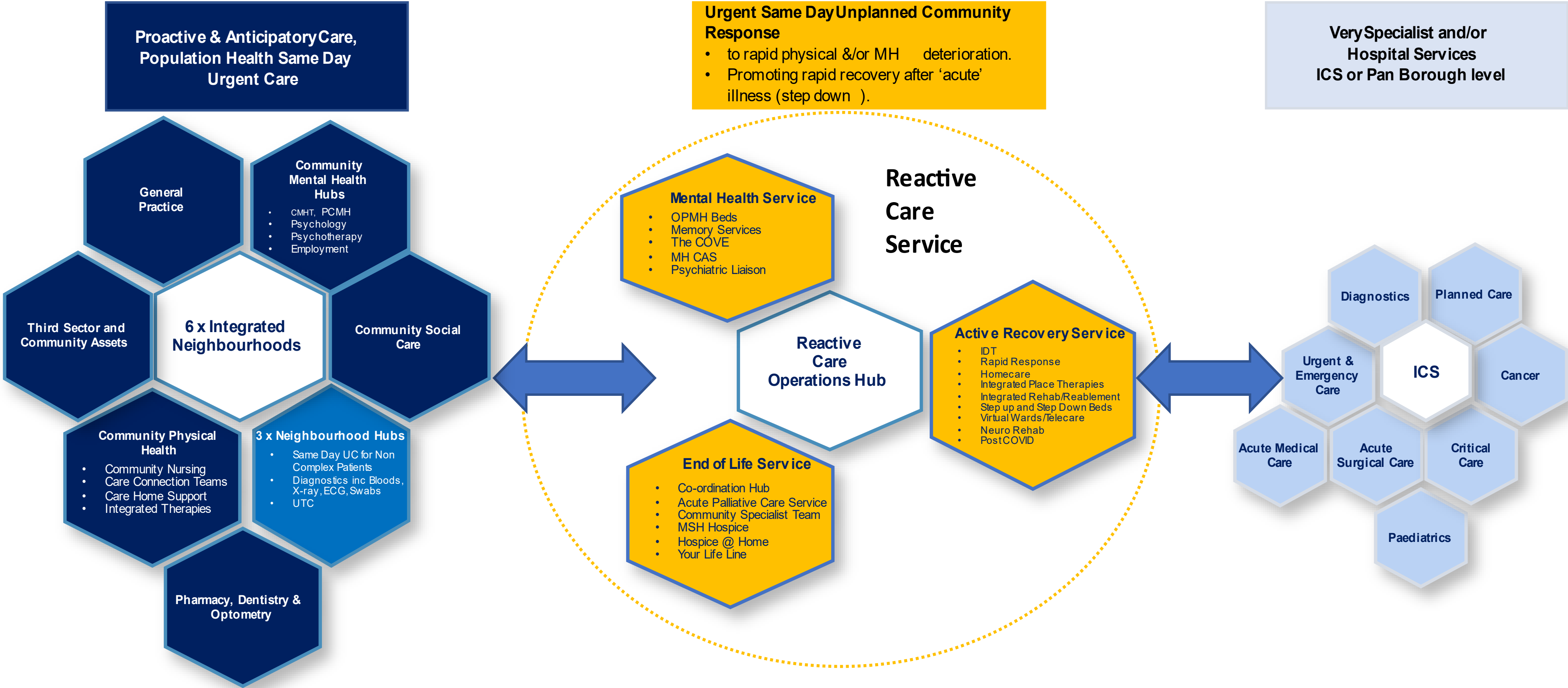
Integrated Neighbourhood Teams and Primary Care Networks

Annex D

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

Annex E

Future State Operating Model



1

Annex F

End of Life Coordination Hub Operating Model

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