Integration and Better Care Fund

Better Care Fund 2025-26 HWB submission

Narrative Plan

	HWB Area
HWB	**Hillingdon**
ICB	**NHS Northwest London**

Section 1: Overview of BCF Plan

1.1 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. There are three Integrated Neighbourhood Teams (INTS) in the borough and their boundaries broadly align with the localities. **Appendix 1** 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 **Appendix 1**).

The current population is estimated by the Office of National Statistics to be 319,018. The 2021 census showed that Hillingdon had a population of 305,900 at that time, 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 southeast 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.

Some key data headlines about Hillingdon include:

- 48% (127,264) of the 18+ population registered with a Hillingdon GP are living with one or more long-term health conditions, which makes Hillingdon comparable with Harrow for having the highest weighted average percentage of people with long-term conditions in Northwest London (NWL)[1].

- The top five long-term health conditions in the borough are hypertension, anxiety, depression, obesity and diabetes. Hypertension accounts for approximately 50% of all

[1] NHS North West London's Whole Systems Integrated Care (WSIC) database. Weighted average means that the calculation is based on data 'weighted' to its importance as a contributing factor.

unplanned hospital admissions in older adults and 20% in adults of working age, which is increasing year on year. It is common to see people affected by more than one of these five conditions at the same time.

- Data shows that people aged 65 and above account for approximately 13% of the resident Hillingdon population, and as higher health and care services users their activity makes up over 30% of GP and unplanned and urgent acute (Accident and Emergency) attendances and 40% of emergency hospital admissions.

- 4,400 residents (approximately 1.4% of the population in 2023) account for 50% of all emergency admissions to hospital.

- Nearly 29% of the 22,465 unpaid carers (2021 census) provide 50 or more hours of care a week and therefore a greater risk to their health and wellbeing.

1.2 Priorities for 2025/26

Hillingdon's key priorities for 2025/26 are:

- Continuing to embed a Population Health Management (PHM) approach across the health and care system.

- Further developing three INTs and the neighbourhood working approach to deliver care and support closer to home.

- Establishing fewer, larger integrated teams aligned to the INTs that cover seven days and have a single leader.

- Expanding a targeted care coordination programme within the INTs that utilises digital innovation and focuses on risk stratification and early intervention, particularly for the 4,400 people who are high users of health services.

- Reviewing the technology enabled care (TEC) offer and exploring alignment with the INTs to maximise opportunities for need escalation prevention.

- Implementing a single borough-wide Reactive Care Service that maximises the '*Homefirst*' approach and delivers community-based urgent responses.

- Implementing the outcomes of competitive tenders for third sector provided preventative services, e.g., information, advice and guidance, support for carers, and early intervention support for adults with mental health needs.

- Implementing the outcomes of the Northwest London Integrated Care System (ICS) BCF review to achieve greater alignment of approaches across the sector. This is intended to ensure that national BCF objectives are met within an equitable and sustainable joint system approach, except where divergence is appropriate to address place-based needs.

1.3 Key changes since previous BCF plan.

In the context of the ICS BCF review Hillingdon has amalgamated schemes using common definitions agreed across the sector and aligned against four '*buckets*' that have aims linked to the national BCF objectives. The buckets and related aims are shown below:

- ***Scheme 1: Living Well.*** Aim: Maximising independence and preventing unnecessary admission to hospital and residential care - Adults of working age.

- ***Scheme 2: Ageing Well*****.** Aim: Maximising independence and preventing unnecessary admission to hospital and residential care - People aged 65 +.

- ***Scheme 3: Active Recovery*****.** Aim: Promoting recovery and independence after acute illness.

- ***Scheme 4: Infrastructure Enablers*****.** Aim: Providing effective foundations for operational service delivery.

The online services coordinator post previously funded from the minimum contribution to Adult Social Care (ASC) has been deleted as the functions of the post are being addressed outside of the BCF.

1.4 Description of approach to development of plan and joint system governance to support plan delivery.

There are two dimensions to Hillingdon's approach to plan development and governance and these are at an ICS and place-based health and care system level.

ICS

A sector-wide working group arose from the BCF review and has been maintained. This enables a consistent approach to be taken across the sector and ensures alignment with BCF national conditions and dissemination of best practice. This collaborative approach should contribute to ensuring that BCF initiatives across the sector remain sustainable, effective and aligned with the broader system goals of enabling our residents to maintain independence in the community, avoid admission to hospital and return to their usual place of residence at the earliest opportunity following an acute hospital admission.

Hillingdon Place

Appendix 2 summarises Hillingdon's place-based governance arrangements. These have streamlined since the 2023/25 plan submission. In view of the limited time available prior to submission, engagement in the development of the plan will be undertaken at director and executive level as set out in the appendix. The BCF Core Officer that includes the Director of Adult Social Care, ICB Borough Director (Hillingdon) and the Managing Director of the borough-based partnership, Hillingdon Health and Care Partners (HHCP) meets monthly and has oversight over delivery. Accountabilities are illustrated in the appendix.

It should be noted that the HHCP Managing Director is co-chair of the Hillingdon Health and Wellbeing Board and that a refresh of the statutory joint health and wellbeing strategy will

take place during 2025/26, which will lead to a streamlining of priorities and supporting metrics. An updated performance and governance structure will evolve accordingly during 2025/26.

Hillingdon is a unitary authority and therefore incorporates housing responsibilities contained within the Housing Grants, Construction and Regeneration Act, 1996, i.e., DFGs. The rehousing and homelessness provisions of the Housing Act, 1996, also fall within the Council's sphere of responsibility. The Corporate Director of Homes and Communities has overall responsibility for these areas and has been engaged in the relevant aspects of this submission.

1.5 Alignment with plans for improving flow in urgent and emergency care services.

The BCF plan and the services funded through associated income streams are seen as an integral part of place-based plans for improving flow in urgent and emergency care services. **Appendix 3** shows the simplified operating model that is in the process of implementation,

1.6 Priorities for developing intermediate care (and other short-term care).

Discharge Pathway 1

A priority for 2025/26 is to maintain services that have proved successful in supporting flow from acute care, such as the Bridging Care Service, which Hillingdon has had in place since 2018 and has now been rolled out across the sector. The onward pathway for approximately 50% of people supported by the Bridging Care Service is to Reablement and a priority for this service in 2025/26 is to maintain increased utilisation from community to stop or minimise the need for ongoing care (see 2.2. and 2.3). In Hillingdon both services are delivered by the same provider and work closely with the Home-based Activity Recovery Service delivered by the community health provider to ensure access to therapies.

The Home-based Activity Recovery Service includes community-based therapy provision and most people supported by the Bridging Care Service also have therapy input. A key role for this Home-based Activity Recovery Service is to also prevent admission and support continued independence in a community setting.

There is an intention to undertake a sector-wide review of reablement and rehabilitation during 2025/26 to identify the most cost-effective delivery models and scope for replication where appropriate. The need for this review was a conclusion from the NWL BCF review previously mentioned.

Discharge Pathway 2

The ICB is implementing a single offer for bed-based rehab to ensure consistent service delivery and a joint single point of access for pathway 2 patients, i.e., the Intermediate Care Escalation (ICE) Hub. Hillingdon has the 22 bed Hawthorn Intermediate Care Unit (HICU) within its Bed-based Active Recovery Service which manages to support local need. Demand that cannot be met via HICU or, for neuro-rehab, at the Alderbourne Unit on the main Hillingdon Hospital site, is sourced through the ICE hub.

There is a block contract in place with an independent sector bed for five nursing care home beds for people who are non-weight bearing, which has been commissioned by the Council with funding across a range of BCF income streams. Additional capacity is provided via a block contract with Harlington Hospice for beds located at Michael Sobell House Hospice that can be flexed to support people on P2. This capacity is reflected under the '*Other short-term bedded care (pathway 2)*' category within the IMC demand and capacity template. Spot purchases to address additional demand against this category would be sourced through the ICE hub referred to above.

Discharge Pathway 3

The Council has block contracts in place with two providers for ten step-down assessment beds. This capacity is reflected in the '*Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)*' category in the IMC demand and capacity template. Funding changes have resulted in the block being reduced by one bed from May 2025. Additional capacity would be spot purchased as reflected in the template and delays pending this supply being sourced will need to be monitored. Flexibility using the discharge fund aspect of the NHS minimum contribution has been built into the plan for 2025/26 for an additional block contract for step-down care home beds to be put in place for the winter if required. This funding is included within the Additional Discharge Support scheme activity within the '*Active Recovery'* scheme shown in the expenditure tab of the planning template.

Section 2: National Condition 2: Implementing the objectives of the BCF

2.1 A joint system approach for meeting BCF objectives which reflects local learning and national best practice and delivers value for money.

The local health and care system approach to meeting BCF objectives is through the place-based governance structure referred to in section 1.3 and **Appendix 2**. This is integral to the broader system transformation agenda and BCF funding streams contribute to delivery. Key themes include:

- Role of INTS is the core mechanism for supporting the shift to preventative and proactive community-based care. The intended role and outcomes from the INTS are shown in **Appendix 3A**.
- Integration/alignment of staff teams with a single leadership.
- Flexible opportunities for staff to work across providers via workforce passports.
- Collaborative approaches to supporting the regulated care market.

The NWL BCF working group also referred to in section 1.3 provides an opportunity to consider good practice examples and extent to which it is appropriate to roll out across the sector to ensure consistency of provision. Joint approaches across the ICS and working in

partnership with the West London Commissioning Alliance creates opportunities to manage the regulated care market effectively to ensure value for money.

At Place level partners are taking a one public estate approach to the development of an integrated health and care hub within each of the INTs, which will include a broader range of services than the three Same Day Urgent Care Hubs with the aim of bringing care and support closer to where residents live. Services to be included in the new hubs include Integrated Community Nursing, diagnostics, acute outpatients, health and wellbeing coaches funded through the Additional Roles Reimbursement Scheme (ARRS), community mental health hubs and integrated muscular skeletal physiotherapy services.

2.2 Any changes to shift planned expenditure away from discharge and step-down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.

Recent data shows that only 46% of ambulance conveyances to Hillingdon Hospital result in an admission, which suggests that the needs of the other 54% of people could have been addressed in a different way. A deep dive into urgent community response provision in the borough and the relationship with intermediate care service capacity is currently in progress and due to complete early in 2025/26. For this reason, flexibility has been built into the discharge fund aspect of the NHS minimum contribution to fund additional capacity to support admission avoidance and/or provide discharge support and this is reflected in the expenditure tab of the planning template. This flexibility has been permitted by the removal of the ring-fence from the discharge funding.

2.3 Goals for performance against the three national metrics which align with NHS operational plans and local authority social care plans, including intermediate care demand and capacity plans.

a) Emergency admissions to hospital for people aged 65+ per 100,000 population: A 1% reduction has been applied to the projected outturn figures for 2024/25. This reflects an increase in the older people population and an increase in the number of falls-related admissions.

Data shows that people aged 65 and above account for approximately 13% of the resident Hillingdon population, but, as more intensive users of health and care services, their activity makes up over 30% of GP and unplanned and urgent acute (Accident and Emergency) attendances and 40% of emergency hospital admissions. Proactive case management for the rising risk group, i.e., those people with one or more complex long-term conditions, is intended to direct people into appropriate support through the Home-based Active Recovery Service, including Reablement, and direction to the voluntary, community and social enterprise (VCSE) sector. In addition, three Same Day Urgent Care Hubs in Hillingdon's three localities are now in place with the intention of supporting people with non-urgent health issues and diverting people from A & E. These are seeing approximately 154 a month, which is slightly above the target (150).

Health and wellbeing coaches funded through the ARRS referred to in section 2.1 above provide support at an INT level, including through social prescribing to address contributors

to deterioration, such as social isolation and loneliness. Demand and capacity for this support is reflected in tab 3.2 of the IMC demand and capacity template under '*social support (including VCS)'* and assumes an increase in the number of people being supported through this route during 2025/26.

In addition to proactive case management at neighbourhood level, there is a Frailty Assessment Unit (FAU) at Hillingdon Hospital that identifies people living with frailty who are most at risk of falling. Case management is provided by the INTs and direct support delivered by the Urgent Response Service (Rapid Response) for people with the most complex needs. Capacity of this service is an issue currently being explored to possibly be addressed through the discharge funding within the NHS minimum contribution.

As previously stated, we have seen an increase in falls-related admissions during 2024/25, Hillingdon's approach to this issue is two-fold, i.e., seeking to prevent falls from occurring in the first instance and then preventing recurrence where a person has fallen. Hillingdon has a range of services in place to support people at risk of falling. 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 INTs. 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.

Falls-related injuries constitute one of the main causes of hospital admission from care homes and 2024/25 has seen an increase in A & E attendances and admissions from care homes. It should be noted that Hillingdon has the second highest number of care home beds in NWL after Ealing and there is a support model in place. Clinical support to care homes is provided by the Care Home Support Team, who also work closely with the Council's Quality Assurance Team, which is funded via the BCF and supports regulated care providers based in the borough. An action for 2025/26 is to review the model of support for care homes, which aligns to a broader review being undertaken across the ICS.

In 2024/25 London Ambulance Service (LAS) data was analysed to identify the top 14 care homes for LAS call outs and conveyances to hospital. This led to visits to the care homes by CNWL to explore whether staff had attended falls training, if they had falls champions and what their pathways were for people who had experienced falls. Action plans were developed with the care homes and follow-up visits will take place in 2025/26, which will include an additional focus supporting the homes with their ability to access and input into universal care plans.

b) Average length of discharge delay for all acute adult patients*:* An improvement target of 1% against the projected 2024/25 outturn has been applied and this will be delivered through a comprehensive approach that includes a combination of bridging care and reablement services, complex care beds, care home training and support to facilitate local placements, community equipment and integrated community nursing. This provision is funded via the BCF.

There is an intention to reduce average length of stay in Medicine and Rehabilitation Wards at Hillingdon Hospital for people with a 21+ day length of stay by 5.2 days and those with a stay of 7+ days by 1.7 days to meet the bed optimisation assumptions for the new hospital

equivalent to 15 beds by end of Q1 2025 and 29 beds by September 2026. In addition to the above services, other contributors to delivery of reduced lengths of stay would include:

- Implementation of a Community Urgent and Emergency Care Service linked to the three super Neighbourhood Hubs previously mentioned.
- Implementation of an Integrated Active Recovery Service.
- Expansion of the Palliative Integrated Care Hub.
- Full implementation of an acute to hospice pathway.

***c) Long-term admissions to residential and nursing care homes for people aged 65+ per 100,000 population*:** This metric is considered as a proxy measure for the effectiveness of the local health and care system in supporting Hillingdon's residents to live in the community in a non-institutional setting. The projected total number of placements for 2024/25 is 189 and a 10% reduction ambition to 170 has been applied. This would be supported by maintaining the discharged to usual place of residence metric at 92.6% (although this is an all 18 + metric). This would also be supported by the Adult Social Care Outcomes Framework (ASCOF) measure 2A: *Outcome of short-term services: sequel to service being no ongoing provision* at 89.1% (2023/24), which is a reablement service measure. The projected outturn for 2024/25 is 78% but this reduction in headline performance should be seen in the context of the 61% increase in referrals to the Reablement Service from the community. The expectation is that the average number of people referred per month will be maintained at the higher rate seen in 2024/25, i.e., 40.

Improved performance would be achieved by strengthening community-based support and timely interventions resulting from 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 are key to this. Bridging Care, Reablement, homecare and the use of assistive technology, e.g., technology enabled care (TEC) such as telecare would be key services funded via the BCF that would be major components of Hillingdon's approach. Rehabilitation support is available through the Home-based Active Recovery Service.

The provision of Disabled Facilities Grants (DFGs) to fund or contribute to the funding of major adaptations with the support of the Council's in-house Home Improvement Agency is a means of extending the time that a person can remain in their own home. Section 2.4 below expands on this further.

It is, however, recognised that it will be necessary for some people to move to a more supportive environment and alternative provision is available through four extra care housing schemes for rent that have a capacity for 243 households, i.e., Cottesmore House, Grassy Meadow Court, Park View Court and Triscott House.

It is important to note that an issue for Hillingdon is the 79% conversion rate of short-term placements to long-term. Many of these short-term placements are providing respite to enable unpaid carers to take a break from their caring role. Key to reducing this conversion rate is support for unpaid carers.

Supporting Unpaid Carers and Contribution to Target Delivery

Support for unpaid carers is critical to the delivery of targets for all three metrics. This support takes the form of respite provision following a carers assessment, the funding for which is reflected in the BCF and access to information, advice and support through the Carer Support Service contract. The funding for this contract is included in the local authority additional contribution. A small amount of additional funding for the contract is also included within the minimum NHS contribution to Adult Social Care. The identification of carer leads in primary care assists with practices being '*carer aware'* and this contributes to more carers being identified for health checks to ensure that their wellbeing needs are supported. This is an area where there remains work to do to maximise consistency in approach across the borough.

2.4 Demonstrating a "*home first*" approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care.

The Hillingdon place-based operating model shown in **Appendix 2** demonstrates a '*homefirst*' approach through the creation of a borough-wide Reactive Care Service comprising of the following:

- An Active Recovery Service that includes home-based and bed-based intermediate care provision.
- A Palliative Integrated Care Service (PICS).
- Mental Health Services, including crisis prevention provision such as The Coves Café and The Retreat crisis recovery house.

Additional mental health social work capacity to support the hospital process funded via the BCF is intended to reduce bottlenecks. Posts include an additional mental health discharge social worker, and a discharge Approve Mental Health Professional (AMHP). To provide post discharge support to people with mental health needs a pilot floating support service specifically aimed at people leaving hospital is in place and funded via the BCF. This is provided by one of the Council's providers of supported living services for people with mental health needs. The contract for this pilot ends in November 2025 and an evaluation of impact will be undertaken early in 2025/26.

Disabled Facilities Grants

The use of DFGs supports residents to remain independent in their own homes through adaptations that enable them to remain in familiar surroundings to prevent or delay the upheaval of moving to a more restrictive setting. Using flexibilities under the Regulatory Reform (Housing Assistance) (England and Wales) Order, 2002 the Council can make available other 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.

2.5 How 2024-25 capacity and demand actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26).

The discharge reporting and management tool OPTICA was introduced in 2023/24 and during 2024/25 there has been an ongoing process of rolling this out across the ICS. This has been used as the basis for determining demand for 2025/26. However, this is still a relatively new tool and there is still an element of under-reporting and/or misallocation of discharge demand that can give the impression of surplus capacity that might not be accurate. As there are still issues relating to data accuracy, local knowledge based on 2024/25 activity has been used to determine projected 2025/26 demand.

A feature of 2024/25 was a 61% increase in community referrals to the Reablement Service that impacted on the length of stay within the Bridging Care Service. This was addressed by an increase of 250 hours per week for the Reablement Service and 50 hours per week for the Bridging Care Service and this additional capacity has been built into capacity plans for 2025/26 on the assumption that the level of referrals from community, which will help to maximise the independence of our residents and prevent hospital admission, will continue throughout the year. The additional capacity in 2024/25 was funded from the ICB Discharge Fund and in 2025/26 will be funded from a combination of the NHS minimum to ASC, the NHS additional contribution and the LA Better Care Grant. The Reablement Service has been operating at approximately 95% utilisation and a reduction of 50 hours a week will be implemented in May 2025 to maximise use of available capacity. A local IMC demand and capacity exercise is in progress the outcome of which will be reported in the Quarter 1 reporting template. This includes any implications for the funding alignment set out in the expenditure tab of the planning template. Changes have not been made to the IMC demand and capacity template to reflect the reduction in hours for the Reablement Service on the assumption that demand can be met by the under-utilisation. This, however, will be kept under review.

The approach to addressing increased demand for the Bridging Care Service (short-term domiciliary care (pathway 1) in the IMC demand and capacity template) would be through a combination of the following:

- Additional funded hours from the discharge fund aspect of the NHS minimum contribution; and/or

- The accelerated transfer of people into long-term care of people supported by the Reablement Service who have achieved their reablement goals to increase flow between services; and/or

- Prioritisation of Reablement referrals through the hospital discharge pathway above those from the community.

A similar approach would be taken to managing demand for the Reablement Service.

The services to be funded from discharge funds (local authority and ICB) support hospital discharge during 2025/26 are summarised below.

Local Authority Discharge Funding

- Discharge-related placements
- Discharge-related homecare
- Additional Reablement capacity
- Block nursing dementia step-down
- Deep clean & house clearance contract
- Social Work 7-day Discharge
- Additional Brokerage Capacity

ICB Discharge Funding

- Block nursing dementia step-down
- Homebased Active Recovery Service, i.e., therapy provision.
- Rehab Beds, Furness Ward, Willesden
- Gap commissioning, i.e., health-related provision not otherwise addressed
- Mildmay HIV Rehab Unit
- Additional Discharge Support

As result of an in-year reduction in the ICB additional contribution to the BCF, the step-down nursing bed block contract capacity will be reduced to 14 beds from 15 in 2024/25. The mitigation will be an increase in spot purchases, and this is reflected in the IMC demand and capacity template.

Demand and capacity in respect of social support (including VCS) in the IMC demand and capacity template is addressed in section 2.3 (a) above.

2.6 How capacity plans consider therapy capacity for rehabilitation and reablement interventions.

Hillingdon has seven-day therapy provision in place. Additional weekend therapy capacity is being funded via the discharge fund aspect of the NHS minimum contribution for the first six months of 2025/26. 2024/25 data suggests that this has not had added significant value and has been identified as a saving from Q3 in the context of reduced ICB funding. This is subject to the outcome of local IMC demand and capacity work currently in progress.

Section 3: Local priorities and duties

3.1 Developing and delivering plans in compliance with wider legal duties.

a) Having due regard to promoting equality and reducing inequalities, in accordance with the Equality Act 2010 public sector equality duty.

People with Protected Characteristics

The people with protected characteristics most affected by the 2025/26 BCF plan are:

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

The long-established Hillingdon practice reported in previous plans of considering being an unpaid carer as a protected characteristic continues for the 2025/26 plan.

Equality Impact Assessments

Equality impact assessments are completed as appropriate. Specific impact assessments will be completed to reflect changes to services arising from funding reductions.

Embedding a PHM Approach to System Working

Hillingdon continues to embed a Population Health Management (PHM) approach across the health and care system. This entails using data to understand what factors are driving poor outcomes in different population groups with the intention of designing proactive models of care that improve health and wellbeing and manage demand on health and care services.

Falls and Frailty

Hillingdon's approach to addressing falls and frailty in the context of the growing older people population is addressed in more detail in section 2.3 above.

Tackling Hypertension (aka high blood pressure)

Hillingdon continues to lead on several initiatives to support diagnosis and management of hypertension including community roadshows encompassing blood pressure and atrial fibrillation checks, facilitator led workshops and engagement with partners about wider determinants of health.

Health Checks for People with Learning Disabilities

Close working between Primary Care and the supported living schemes funded by the Council as well as Social Work Teams is contributing to Hillingdon's performance against the national metric of ensuring 75% of people aged 14 and over on GP learning disability

registers receive an annual health check in the year to 31 March 2025. For January 2025 the cumulative performance was 66% against the national target of 63% and the NWL target of 71%.

Supporting Adults with Mental Health Needs

Hillingdon's cumulative performance to February 2025 of 78.7% of people living with serious mental illness on GP registers receiving physical health checks was above the national annual target of 75%.

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.

b) Engaging or consulting with people affected by the proposals. For ICBs, trusts and foundation trusts this includes their involvement duties under the NHS Act 2006.

The short timescale for completion of the plan exacerbated by the changing NHS financial landscape nationally and across the NWL, has limited the scope for engagement and consultation with residents. This would be necessary where financial circumstances led to the decommissioning of services.

c) For ICBs: To have regard to the need to reduce inequalities in access to NHS services and the outcomes achieved by NHS services.

The NHSE/I Core20PLUS5 approach to drive targeted action in health inequalities improvement is progressing in Hillingdon and is informing priorities. In addition to the information set out in section 3.1 (a), this can be seen in the different priorities of the three Integrated Neighbourhood Teams as shown below.

Neighbourhood	Priorities
North Neighbourhood	• ***Respiratory:*** To develop a 'One Stop Respiratory Clinic' for patients led by a respiratory consultant, community specialist respiratory nurse and primary care spirometry service to improve patient care. • ***Older people's mental health/dementia:*** To improve the management of older people with low to moderate mental health needs, including dementia, in primary care.
Southeast Neighbourhood	• **Making Every Contact Count across INT partners:** To increase prevalence identification, support early intervention, and align with the "*Make Every Contact Count*" initiative to enhance community health outcomes. • **Targeted outreach to increase point of care testing (POCT) and health education promoting**

	cardiovascular health and lifestyle: Undertaking a data-driven approach to target underserved communities, ensuring equitable access to blood pressure and other cardiovascular health checks to address health inequalities. • **Healthy living test of concept:** To reduce excess weight and improve access to services that support positive health behaviours. • **Establish a pool of volunteers to support POCT:** To grow a volunteer workforce from within existing NHS services to support point of care testing.
Southwest Neighbourhood	• **Hypertension:** To improve outcomes for hypertensive patients and identify those at risk early. • **Digital transfer of care:** To deliver a pilot between Hillingdon Hospital and INT practices to demonstrate the benefits of adopting a standardised transfer of care process. • **Children & young people (CYP) mental health:** Implementing an initiative to enhance services and pathways for CYP by addressing system-wide challenges, including reducing inappropriate Children and Adolescent Mental Health Service (CAMHS) referrals and improving early intervention. This is outside of the BCF.

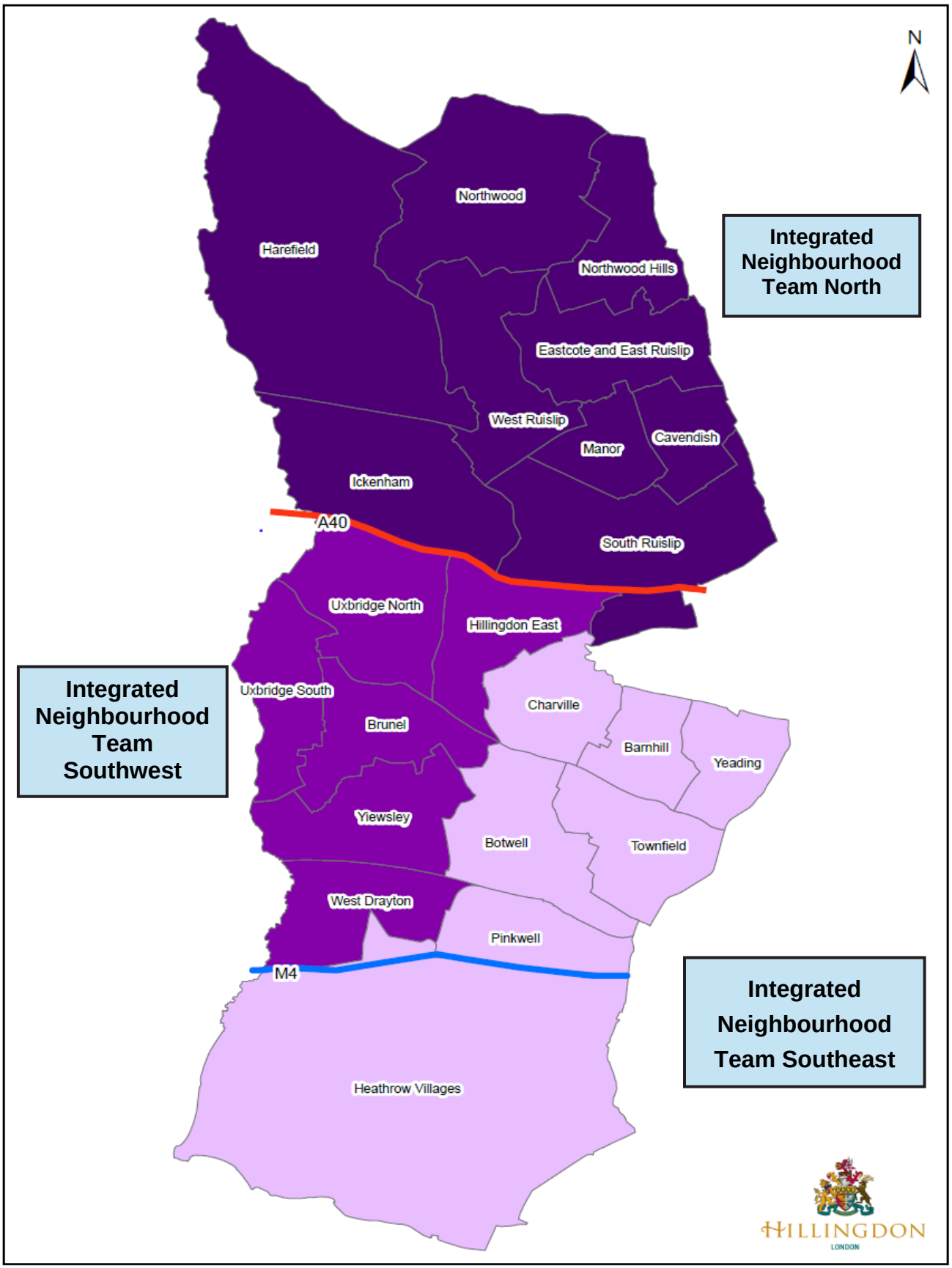
d) For ICBs: To have regard to the duty to support and involve unpaid carers in line with the Health and Care Act 2022.

A funding contribution to the Carers Support Service contract is reflected in the minimum NHS contribution to Adult Social Care. Feedback from carers is sought through existing carer engagement structures such as the carer forums chaired by Carers Trust Hillingdon and Ealing and the Carers Strategy Group that is chaired by the Council.

Both the local acute trust and CNWL as community health and community mental health provider have their own patient and carer engagement strategies that link into place-based strategy. For CNWL a key priority is extending the 'Triangle of Care' and 'think carer' approach across services beyond mental health where they are more established.

For The Hillingdon Hospitals, in response to feedback from carers a nationally recognised campaign to support carers to remain with the people they care for whilst they are in hospital called '*John's campaign'* has been implemented across Hillingdon Hospitals' wards and open visiting has been implemented in two wards and there are plans to extend to all wards.

Appendix 1: Hillingdon Geography and Wards



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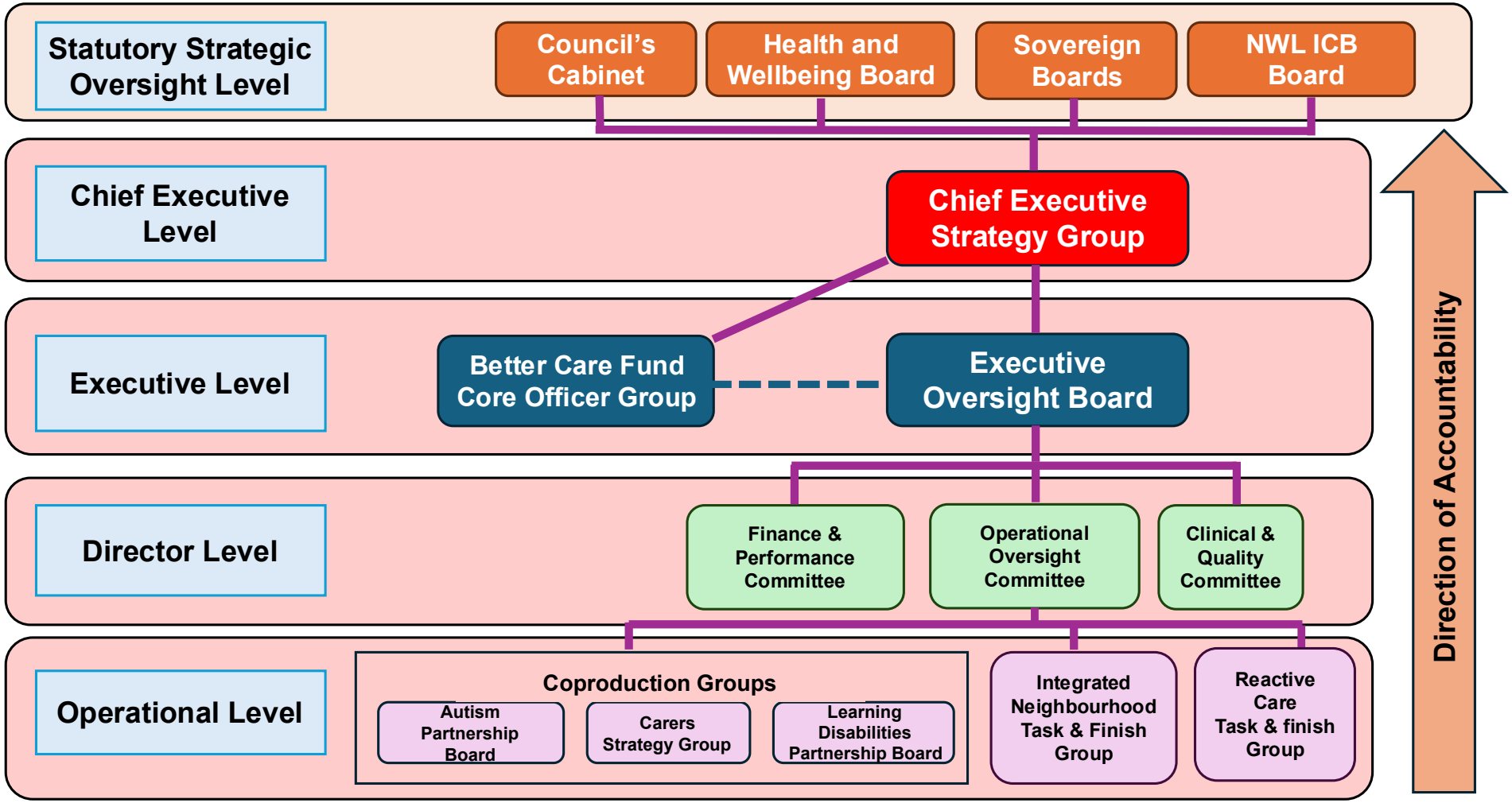
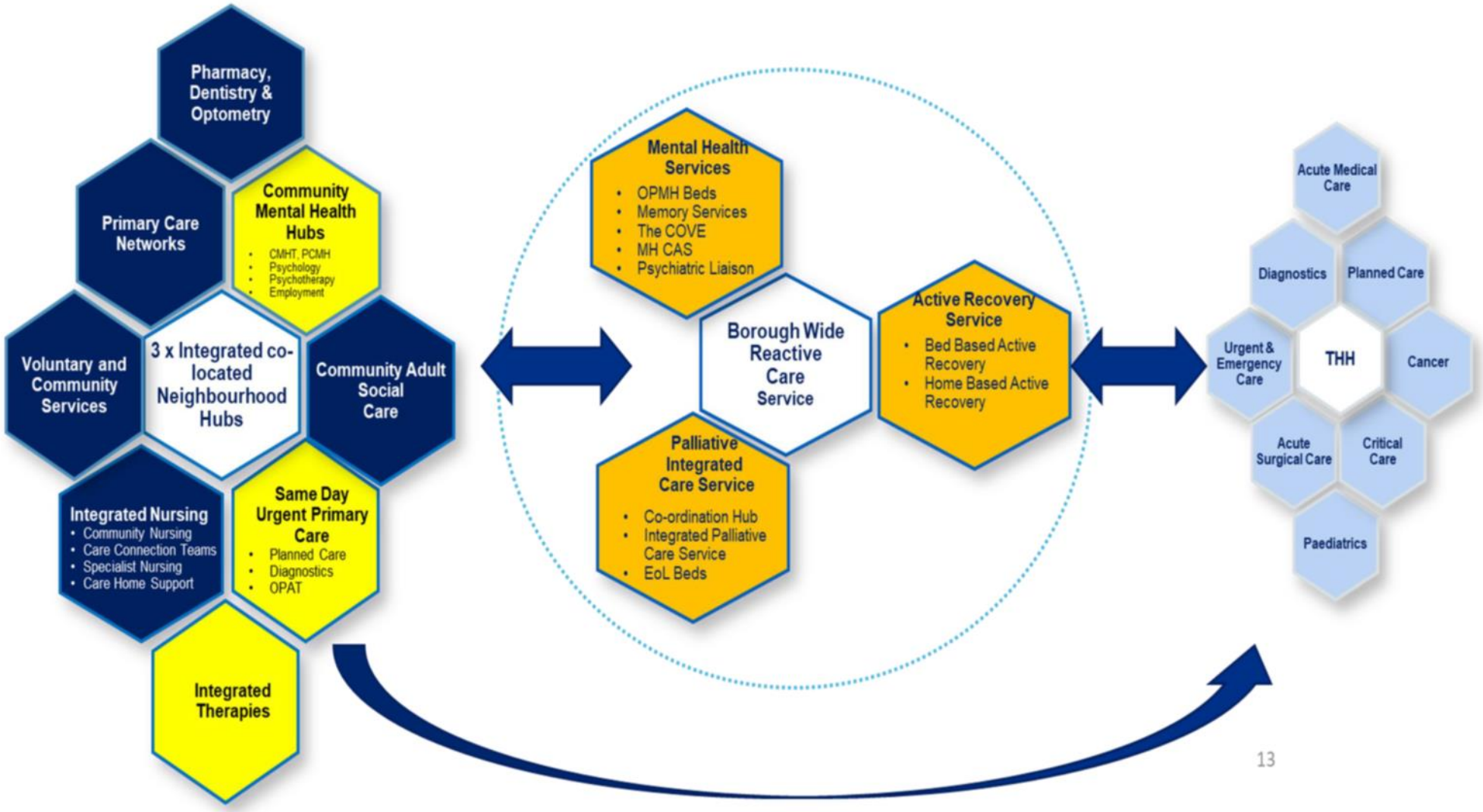
Integration and Better Care Fund

Appendix 2: Hillingdon Place-based Governance Structure



Appendix 3 - Hillingdon Place-based Operating Model



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Appendix 3A: Integrated Neighbourhood Working and Intended Outcomes

Integrated Neighbourhood Teams

Neighbourhood Working
Aimed at providing a demonstrable improvement in experience for residents and staff.

Preventative Care
Delaying the onset of long-term conditions (LTCs) and/or frailty and supports self-management of early stage LTCs.

Proactive Care
To reduce exacerbations and escalations of residents with LTCs and/or frail and elderly people.

Reactive Care
Enabling urgent needs to be better managed in the community – or when inpatient admission is required, expediting discharge

Integrated Neighbourhood Teams: Expected Outcomes

Residents experiencing integrated and coordinated care as a result of staff working as part of a multi-disciplinary team, i.e., ''no wrong front door'' approach and residents not bouncing between services.

Improvements in key public health measures, e.g., levels of obesity, child tooth decay, etc.

Corresponding reduction in utilisation of both planned and emergency care.

Improvements in vaccination and screening uptake, reducing variation between ethnic groups and between deprivation levels.

Reduction in A & E attendances and emergency hospital admissions, particularly for frequent users and frail and elderly people.

Reduction in admissions to permanent care home beds.

Improvements in LTC prevalence recording and management, particularly with cardio, renal and metabolic conditions.

Reduction in A & E attendances and emergency hospital admissions.

Reduction in hospital bed days lost to discharge delays.

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