Choose an item.

Department of Health & Social Care | Ministry of Housing, Communities & Local Government | NHS England

Better Care Fund 2026-27
Narrative return

Submission details

Adapt as necessary	**HWB area 1**
HWB	**Hillingdon**
ICB	**West and North London**

The Hillingdon Context: Place and People

The Place

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.

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. Hillingdon's geography is illustrated in **Appendix 1**.

The borough is also divided into three Integrated Neighbourhood Teams (INTs), and these are:

- **North Team (115,000 registered patients)**: covering Ruislip, Northwood, Harefield and Ickenham.
- **Southwest Team (96,000 registered patients)**: covering Uxbridge, Yiewsley and West Drayton.
- **Southeast Team (127,000 registered patients)**: covering Hayes and Harlington.

Appendix 1 provides more detail of the geographical coverage of the INTs.

The People

The current population is estimated by the Office of National Statistics (ONS) to be 329,185[1]. The 2021 census showed that Hillingdon had a population of 305,900 at that time, which suggests a nearly 8% increase over the last five years. In 2021 there were 41,178 people aged 65 and over (11,680 aged 80 and above). The ONS mid-year 2024 estimates suggest that the 65 and above population has increased to 43,198 (11,881 for those aged 80 and above). Projections suggest that this could increase to 53,082 (15,092 for those aged 80 and above) by 2035.

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.

Some key data headlines about Hillingdon's population reported in the 2025/26 plan still apply and include:

- 48% (127,264) of the 18+ population registered with a Hillingdon GP are living with one

[1] Mid-year estimate 2024.

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)[2].

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

- People aged 65 and above account for approximately 13% Hillingdon's resident population and are 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 have a greater risk to their health and wellbeing. Approximately 30% of carers (2021 census baseline) are on Hillingdon's Carers' Register, further indicating the importance of awareness raising.

Inequalities

Hillingdon has experienced an increase in levels of deprivation over the last seven years. **Appendix 1A** shows overall deprivation in Hillingdon according to the indices of multiple deprivation (IMD). Whilst this shows that there are no Lower-level Super Output Areas (LSOAs) in the top deprivation level (level 1) for overall indices, in 2025 there were 18 in level 2, which compares to 2 in 2019. For indices affecting older people there has been an increase in number of LSOAs in level 1 from 6 in 2019 to 12 in 2025 and those in level 2 from 14 in 2019 to 25 in 2025. All LSOAs in levels 1 and 2 of the IMD are in the south of the borough.

The Core20PLUS5 framework and the North West London Shared Needs Assessment highlight that:

- Overcrowding, homelessness and food insecurity are concentrated in parts of **Hayes, Yiewsley, and West Drayton.**
- Respiratory conditions, income, employment and education deprivation are key drivers of inequality in **Harefield**.
- These same areas see higher rates of diabetes, hypertension, asthma, obesity and mental health need
- Air pollution and environmental factors, particularly around Heathrow, contribute to respiratory and cardiovascular risk

[2] 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.

- People from South Asian and Black communities are disproportionately affected by certain conditions, including diabetes and hypertension

Q1. Please provide a short statement setting out the rationale for using BCF funding to maximise delivery of integrated and preventative care linked to the relevant areas of neighbourhood health and social care services.

BCF Funding Context

The use of BCF funding must be seen in the broader context of Hillingdon's draft *Joint Health and Wellbeing Strategy, 2026 – 2031*. Consultation on the strategy ended on 30 April 2026 and the Health and Wellbeing Board will be asked to approve the final version in June 2026. The Place-based partnership is responsible for delivering the strategy. The partnership is known as Hillingdon Health and Care Partners (HHCP) and comprises of The Confederation of Hillingdon GPs, Central and North West London Foundation Trust, The Hillingdon Hospitals Foundation Trust and 3ST, a third sector consortium. Hillingdon Council is closely aligned to the partnership.

The *Joint Health and Wellbeing Strategy* aligns with the ICB strategic aims of shifting care out of hospital, strengthening community-based support and enhancing place-based service delivery, which also reflects the direction of travel within the 10-year NHS Plan. Similar themes are reflected in the Council's *Adult Social Care and Health Plan, 2024 to 2030* that can be found using this link adult-social-care-and-health-plan-2024-27.

The draft *Joint Health and Wellbeing Strategy*, can be found using this link Joint Health and Wellbeing Strategy 2026 to 2031 | Hillingdon Council. One of the principles of this strategy is that we apply a life-course approach to our work, and this means a focus on four outcomes:

- **Best Start in Life** – Children are born healthy, families are well supported, and early development lays strong foundations for lifelong health and wellbeing.
- **Live Well** – Adults in Hillingdon are supported to live healthier lives, manage long-term conditions, maintain independence and stay emotionally well.
- **Age Well** – Older adults in Hillingdon are supported to live independently, safely and with dignity for as long as possible.
- **Healthy Places** – Places and communities support healthier, more connected lives.

BCF funding in 2026/27 does not contribute to the *Best Start in Life* outcome, although funding to support children's safeguarding is included.

A key component of the Joint Health and Wellbeing Strategy is implementation of a single place operating model designed to shift care from fragmented organisational delivery toward coordinated, population-based pathways. This represents further development of the operating model reflected in our 2025/26 BCF plan and is illustrated in **Appendix 2**. **Appendix 2A** summarises the role and functions of partner organisations in the delivery of the operating model. The model also supports the transition to a new Hillingdon Hospital footprint by strengthening community-based capacity and integrated pathway management across the system. The new hospital is scheduled to start receiving patients in 2032.

A population health management (PHM) approach and the Core20PLUS5 framework is assisting with focusing resources, including BCF funding, where it is needed most, which

includes the most deprived neighbourhoods, i.e., Southwest and Southeast. This informs the priorities for the three INTs as shown in table 1 below.

Table 1: Neighbourhood Priorities	
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. • Increasing hypertension diagnosis: Holding events where blood pressure checks can take place and self-care management advice provided, e.g., at Costa Ruislip, Ruislip Baptist Church and Piccadilly and Metropolitan line underground stations.
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, e.g., outreach to local Hayes Mosque and Heathrow Villages. • ***Healthy living test of concept*:** To reduce excess weight and improve access to services that support positive health behaviours.
Southwest Neighbourhood	• ***Increasing hypertension diagnosis*:** 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 between hospital and community. • ***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.

BCF funding in 2026/27 is integral to the delivery of model of care and addressing some of our high impact priorities, which are summarised below.

- **Proactive and Preventative Neighbourhood Care:** Identifying and supporting rising-risk adults before frailty develops, and those living with hypertension intervening early to prevent deterioration and avoid escalation. It is important to note that Hillingdon is a first wave Neighbourhood Health implementation site. See table 1 above for INT priorities.
- **Frailty, falls and community support for older adults:** Providing intensive support for people already living with moderate or severe frailty, maintaining independence and avoiding admissions.
- **No Criteria to Reside (NC2R) and Discharge Improvement:** Reducing length of stay to achieve a sustainable system to support the capacity of the new Hillingdon Hospital development.
- **Supporting the care market**: A stable care market is critical to the sustainability of Hillingdon's health and care system. 43% of BCF funding received by Hillingdon Council from the mandated BCF revenue income streams supports the care market, e.g., homecare and care home placements and helps to maximise independence in the least restrictive setting at a time of escalating costs.

A sample of relevant BCF funded services include:

- Neighbourhood-based services such as Same Day Urgent Care, diagnostics, Community Nursing and Integrated Therapy Services.

- Support for unpaid carers, such as the Carer Support Service contract and respite provision.

- Bed-based and home-based intermediate care services as part of the Borough-wide Reactive Care Service. Bed based services would include the Hawthorn Intermediate Care Unit. Home-based services supporting discharge pathway 1 would include the Bridging Care Service, which Hillingdon pioneered and was rolled out across Northwest London in 2025/26. Reablement and therapy services are also included.

- Sustainable long-term bed-based and home-based care provision.

- Community equipment, technology enabled care and major adaptations are funded via Disabled Facilities Grants.

BCF Funding Changes 2026/27

The 2026/27 BCF plan is essentially a roll forward of the agreed 2025/26 plan and the structure of the plan remains largely the same, i.e., aligned to the life-course approach, for this transitional year. This is shown below.

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

- ***Scheme 2: Age 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.

There are, however, some funding changes linked to lessons learned from 2025/26 and the full-year effect of reductions in ICB additional NHS contribution. Changes remain aligned to the HHCP priorities within the Integrated Neighbourhood Teams (Proactive Care) and Reactive Care (preventing crises). Changes include:

- *Senior clinical decision maker role:* This is GP-level cover from 8am to 8pm 7-days a week intended to support community teams, e.g., Urgent Community Response, Your Lifeline (advice line for people on the end-of-life pathway), Care Home Support Team, and Community Diagnostics, with the intention of preventing avoidable admissions and providing care closer to home. Support is also provided to the Frailty Assessment Unit at Hillingdon Hospital.

- *Out of borough coordinator role:* This post will be responsible for improving coordination for people whose discharge requires placement or agreement with other local authorities. It was a role previously undertaken by the ICB, which becomes a responsibility of Place following the creation of NHS West and North London.

- *Self-funder advice and guidance service pilot extension*: Intended to increase understanding amongst self-funders and their families about available options and reduce delayed days attributable by expediting take-up of options, funding has been identified to extend the pilot for 2026/27 to enable a full evaluation of impact to be undertaken.

- *Strengthening the housing and homelessness support*: This includes clinical support in A & E delivered through the North West London Homeless Health Enhanced Model role. This service is supported by a dedicated housing officer post whose role it is to address housing-related barriers to discharge. This was a pilot established in 2025/26 and funding will be extended for 2026/27. The post will be based within the Integrated Discharge Team to enhance opportunities for early involvement in discharge planning.

- *Technology enabled care (TEC) digitalisation*: DFG funding has been included to support the digital upgrade of existing TEC supplied to residents in the community in time for the digital switchover in January 2027.

A key funding challenge for 2026/27 has been the inflationary pressures faced by the Council from Adult Social Care providers and the mismatch with allocated funding available within the BCF. Adjustments have been made to the plan to alleviate inflationary pressures as far as is possible.

Intermediate Care Demand and Capacity

An intermediate care (IMC) demand and capacity analysis was undertaken by partners, and the results are reflected in the response to Q2.

Q2.	**Please provide a brief explanation of the rationale for how you have set out goals for the metrics of non-elective admissions (for those 65 years old and over) and delayed discharges. Please also set out how you will monitor and drive progress in preventing avoidable long-term care home admissions and improving outcomes from reablement, including through any locally agreed goals for long term admissions to residential care and nursing homes.**

a) Non-elective admissions to hospital for people aged 65+ per 100,000 population: The goals for this metric have set within the context of the ICB Neighbourhood Care Model and its multi-year strategy to drive the '*left shift'* in care spend from acute to community, which is backed by a 1% investment in the delivery of the model in 2026/27 and up to 5% additional investment in future years linked to performance improvements. A related target is a 30% reduction in the non-elective admissions for the top 2 – 5% of older people who are living with complex conditions such as frailty, dementia, serious mental illness and people at end of life.

The 2026/27 target has been arrived at by identifying the number of non-elective admissions associated with older people in the specialist segmentation within our Whole Systems Integrated Care (WSIC) database (1,274) and applying a 30% reduction, i.e., 382. This has then been deducted from the projected 2025/26 outturn. The latter has been obtained from the Department of Health and Social Care (DHSC)'s Better Care Database.

b) Average length of discharge delay for all acute adult patients*:* The 2026/27 goals for this metric have been established using the data within the DHSC's Better Care Database to establish baselines based on 2025/26 activity. An average 0.5% reduction has been applied to the average number of days between the Discharge Ready Date (DRD) and the actual date of discharge and a 0.5% increase in the proportion of adult patients discharged on their DRD.

The discharge reporting and management tool OPTICA that was introduced in Hillingdon in 2023/24 and extended across the North West London Integrated Care System in 2025/26, provides borough-based discharge pathway data that will be used to monitor performance against the target. OPTICA provides data discharge pathway data. There is a continuing focus to ensure that the data is as accurate as possible, and data reporting is monitored by the HHCP Programme Management Office (PMO) that provides centralised oversight, governance, support, and assurance of Place-based initiatives. The PMO is accountable to both the Finance and Performance and the Operational Oversight Committees (see **Appendix 3**).

Discharge pathway 1: In 2025/26 Hillingdon has consistently been amongst the top two performing boroughs in NWL with an average of 1.77 delayed days against an ICB target of 2 days.

Discharge Pathway 2: Hillingdon's 2025/26 average performance of 5.38 delayed days against an ICB target of 5 days is the fourth lowest in NWL but requires improvement to contribute to the broader NC2R reduction target. A key issue for the local system is that

approximately 50% of people on the P2 pathway in Hillingdon Hospital are not residents of the borough, which impacts on flow and capacity to accept new patients, 80% of which are Hillingdon residents. This is not, however, reflected in the Hillingdon P2 figures.

Discharge Pathway 3: With an average of 5.56 delayed days Hillingdon had the best performance of all the boroughs in NWL in 2025/26 against the ICB P3 target of 7 delayed days.

***c) Long-term admissions to residential and nursing care homes for people aged 65+ per 100,000 population*:** Hillingdon has a robust process in place for determining that an admission to a care home is the most appropriate and least restrictive option available to addressing the needs of our older residents. This entails seeking approval from a panel chaired at assistant director level.

This metric continues to be 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 2025/26 is 170. This is retained as the target for 2026/27 and reflects the increase in the older people population, especially the increase in those aged 80 and above. The data is based on Client Level Data and is reported by local authorities to NHS England on a quarterly basis. A key issue with this data is the time lag before comparative information is available. For example, the most recent comparative data is 2024/25 and 2025/26 will not be available until November 2026. Hillingdon's 2024/25 permanent admission rate per 100,000 65 + was 479.2, which was significantly lower than the England average of 592.5 but above the London average of 433.3 as well as the Outer London average of 418.7.

The data used to populate the numerical template is based on a rolling 12-month total. This means, for example, that the figure given for the quarter ending 30 June 2026 is based on the period July 2024 to June 2025. This gives like for like month so that seasonality is taken into consideration. The quarter ending 30 September 2026 is based on the period from October 2024 to September 2025.

Improving Reablement Outcomes

The effectiveness of reablement is an important contributor to maintaining people in their own homes for as long as possible and impacts on all three current national BCF metrics. Two measures within the Adult Social Care Outcomes Framework (ASCOF) identified to demonstrate and reflected within the draft *Joint Health and Wellbeing Strategy* this are:

- **ASCOF 2 a:** ***The proportion of people who received reablement during the year, who previously were not receiving services, where no further request was made for ongoing support*** – Nationally published data for 2024/25 showed that Hillingdon's score was 81.8% against a NWL average of 73%, an Outer London average of 76.1% and an all-England average of 77%, thus indicating a high level of performance that was further supported by the data for September 2025 that showed an increased performance of 84.6%.

- **ASCOF 2 d (i)**: ***The proportion of people aged 65 and over discharged from hospital into reablement and who remained in the community within 12 weeks of discharge*** – The nationally published data for 2024/25 showed that Hillingdon's score was 65.6% against a NWL average of 59.9%, an Outer London average of 63.7% and an average for England of 63.7%. Data shows that 93% of those who did not remain the community

were readmitted to hospital and the remainder were deceased. September 2025 data showed a slight reduction in Hillingdon's performance to 63.9%.

There is work in progress as part of the development of the Reactive Care Service to integrate, or more closely align, Reablement and Rehabilitation Services to increase efficiency through the deployment of staff with the most appropriate skill set to address need. The development of the Reactive Care Coordination HUB will facilitate this, including deployment for other services that might reduce the number of readmissions in respect of ASCOF 2d above, e.g., Urgent Community Response.

This work will progress during 2026/27 but will not be completed. The factors that national guidance[3] identify as needing to be in place to improve the effectiveness of reablement shown below are under consideration as part of the review process:

- High-quality, person-centred reablement delivery, i.e., focused on restoring skills, confidence and daily living independence.
- Therapy-informed practice.
- Strong transitions and community support.
- Skilled and consistent workforce.
- Clear pathway governance.
- Robust outcome recording.

Q3. Please provide a short explanation of the planned impact of BCF funding on achievement of goals.

a) Non-elective admissions to hospital for people aged 65+ per 100,000 population:

Proactive case management is key to supporting delivery of the target for this metric and is intended to direct people into appropriate support through the Reactive Care 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. Health and wellbeing coaches funded through the Additional Roles Reimbursement Scheme (ARRS) provide support at an INT level, including through social prescribing to address contributors to deterioration, such as social isolation and loneliness. From our IMC analysis we will be building our Urgent Care Response Service capacity using BCF funding to support 450 people a month within a 2-hour window from December 2026. In addition to Reablement and the Urgent Care Response Service, other BCF funded services that support delivery of this metric include:

- Integrated Therapies
- Integrated Nursing
- Senior Clinical Decision Maker
- Technology enabled care (TEC)
- Community equipment

Neighbourhood targets concerning non-elective admissions for people with moderate frailty and those with severe frailty and the work being done to identify and support people living with hypertension (high blood pressure) is intended to contribute to achieving the metric target. Unplanned admissions from care homes are a significant contributor to the over-

[3] Recommendations | Intermediate care including reablement | Guidance | NICE

arching BCF metric. The Care Home Support Service linked to INTs has a major role in preventing avoidable admission from care homes, including supporting people who have fallen and/or are at risk of falls. The funding of this service is outside of the BCF, however, a GP-led model delivering proactive and responsive care home support 7-days a week that includes mobile community diagnostics, support for urgent primary care and senior clinical decision making as a single coordinated service is in development partly funded through the BCF, i.e., senior clinical decision, diagnostics and same day urgent primary care caacpity.

The development of bed-based reablement provision will be explored during 2026/27 located within a care home acquired by the Council during 2025/26. Approximately 30% of the home-based reablement service capacity supported people from the community in 2025/26 and it is planned that this will be maintained during 2026/27. Crucial to supporting capacity is flow of people through the service once they have achieved their reablement potential and communication is key to this to address the myth about entitlement to six weeks' free care. Please also refer to *Improving Reablement Outcomes* which is addressed in response to Q2 above.

Not all schemes have a direct and quantifiable impact on the national metrics but instead have a more indirect influence. Key examples would be long-term care provision, i.e., long-term homecare and long-term care home placements, and support for regulated care providers through the Council's Quality Assurance Team. It is, however, important to emphasise that a sustainable, quality care market is a critical enabler to maintaining resident independence, preventing hospital admission and reducing discharge delays.

In addition, the Hillingdon plan includes some schemes that link back to the original intention of the BCF, which was to support implementation of new responsibilities under the Care Act and an example of this includes Adult Safeguarding. The role of the Quality Assurance Team referred to above also links to market management responsibilities under the Care Act.

***b) Average length of discharge delay for all acute adult patients**:*

There are a range of BCF funded services intended to reduce the number of *No Criteria Reside* (NC2R) patients as well as associated actions intended to improve the efficiency of this provision that will contribute to the delivery of the 2026/27 ambition for this metric. This is illustrated below:

Discharge Pathway 1

- *Creating one consistent D2A pathway* to reduce duplication and unnecessary handoffs across the therapy service provider (CNWL), the Bridging Care provider (Comfort Care Services) the Integrated Discharge Team and Adult Social Care. All these services and teams are BCF funded.

- *Improving discharge efficiency and patient flow* through clear booking rules, decision-making standards and governance.

- *Optimising therapy and bridging capacity* using a unified workforce model and structured daily coordination.

- *Strengthening continuity and outcomes* by standardising environmental safety checks and clear escalation processes.

- *Improving patient and family understanding* with clear information about the discharge journey.

Discharge Pathway 2

Hillingdon has a BCF funded 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 Intermediate Care Escalation (ICE) Hub, which is a single offer from the ICB for bed-based rehab to ensure consistent service delivery and a joint single point of access for pathway 2 patients. Funding for the Alderbourne Unit and the ICE Hub is external to the BCF.

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 that is funded outside of the BCF. Spot purchases to address additional demand against this category would be sourced through the ICE hub referred to above.

Within this supply context, the actions being taken to reduce the number of P2 delays include:

- Introduction of an out of borough coordinator post to liaise with out of Hillingdon local authorities and relevant ICBs.

- Earlier referral to Adult Social Care of people on P2 step-down provision who are likely to require a long-term placement.

- Transferring step-down provision for non-weight bearing patients to a local authority owned care home to maximise system flexibility.

- Increase social worker capacity to reduce length of stay in step-down provision from 42 to 28 days thereby increasing flow.

Discharge Pathway 3

A pilot information, advice and guidance service for self-funders delivered by Age UK was established in 2025/26 to support patients likely to be required to fund their own care as misunderstandings Adult Social Care funding contribution arrangements was a cause of delays on this pathway. Funded via the BCF, this pilot will continue into 2026/27, and an evaluation undertaken in Q3 to inform decisions about its continuation beyond 2027/28.

c) Long-term admissions to residential and nursing care homes for people aged 65+ per 100,000 population

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. The BCF funded services supporting this metric include Bridging Care, Reablement, long-term homecare and the use of assistive technology, e.g.,

TEC such as telecare and community equipment. Rehabilitation support is available through the Integrated Therapy 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. The BCF funds the Extra Care Team Manager post (scheme 2) that supports better management of the schemes and reduces impact on primary care, but the broader costs relating to these services is excluded.

It is important to note that an issue for Hillingdon is the 56% 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 Carers

Supporting unpaid carers is essential to the achievement of all three national metrics. Funding to support carers, including respite, is included in the NHS minimum contribution to Adult Social Care. In addition, the Council contracts with a third sector provider to deliver the one-stop Carer Support Service the scope of which includes information, advice and guidance as well as access to peer support and short break opportunities that do not require a Care Act assessment. This service support both adult and young carers and undertakes carers assessments on behalf of the Council. The scope of the service is illustrated below.

Not all schemes have a direct and quantifiable impact on the national metrics but instead have a more indirect influence. Key examples would be long-term care provision, i.e., long-term homecare and long-term care home placements, and support for care providers through the Council's Quality Assurance Team. It is, however, important to emphasise that a sustainable, quality care market is a critical enabler to maintaining resident independence, preventing hospital admission and reducing discharge delays.
In addition, the Hillingdon plan includes some schemes that link back to the original intention of the BCF, which was to support implementation of new responsibilities under the Care Act and an example of this includes Adult Safeguarding. The role of the Quality Assurance Team referred to above also links to market management responsibilities under the Care Act.

Q4. Please outline how ICBs and local authorities have confidence that the services funded through the BCF represent value for money, and how they will seek to raise the productivity of services.

Structured Approach to Considering Value for Money

Hillingdon applies the 3s framework to determining value for money summarised in table 2 below.

Table 2: 3 Es Value for Money Framework	
Dimension	**Key Question**
Economy	Are outputs bought at lowest reasonable cost?
Efficiency	Are resources converted into outputs effectively?
Effectiveness	Are desired outcomes achieved?

A review of BCF funded services undertaken across the NWL Integrated Care System in 2024/25 led to some rationalisation and simplification of schemes the full effect of which will take place in 2026/27; however, historic commissioning means that there is still a "*patchwork quilt*" of separate service lines across health and social care. A further review will be taking place in Q1 2026/27 that will be looking at costs and inputs compared to outputs and outcomes. A particular focus of the 2026/27 review will be on the scope for integration between reablement and rehabilitation, which will entail benchmarking with other boroughs within the West and North London ICB footprint but also other parts of London.

Performance of Key BCF Funded Services

Many of the BCF funded services are subject to block contracts and subject to monthly monitoring meetings. Examples would include Bridging Care, Reablement, Rehab, bed-based step-down and Urgent Community Response that are monitored via the PMO arrangements explained in response to Q2 above. This would also apply to Neighbourhood based services such as Same Day Urgent Care.

Opportunities to Improve Productivity

Examples of opportunities to improve productivity that Hillingdon Place is exploring include are summarised below.

- **Workforce flexibility**: The Hillingdon Workforce Passport has been developed to allow staff across partner organisations to take their skills and experience to a different setting and organisation without losing their cumulative terms and conditions with their substantive employer. It allows access to the clinical records of the host organisation and enables members of staff to work at another organisation within the agreement without having to go through pre-employment checks with the host employer, provided the duties being performed are similar.

- Linked to the review of reablement and rehabilitation it is also being explored whether there are tasks that are currently being undertaken by therapists that could be delivered by care workers, thus freeing up therapist capacity.

- **Digital and Technology Enabled Care**: A Digital and Data Steering Group has been established to enable neighbourhood transformation through better coordinated digital delivery at Place. Aspects of this work include linking up primary care and CNWL IT systems, i.e., Blinx PACO and System One, as well as linking into the Council's TEC offer to support people in the community.

- **Longer-term contracts**: Security and sustainability of third sector services have been supported through offering contracts of up to eight years and an example is the Carer Support Service led by Carers Trust Hillingdon and Ealing. This contract started in May 2025 for five years with the option to extend for up to three further years.

Strong Governance Arrangements to Monitor Efficiency, Resource Allocation and Improvement

See Q5 for the role of joint governance in monitoring efficiency, resource allocation and improvement.

Q5. Please outline your robust joint governance for managing the expenditure of BCF funding, including assessing impact of funding, value for money and continuous improvement.

Joint governance for managing the expenditure of BCF funding takes place at three levels as explained below.

a) Integrated Care System Executive Oversight

Strategic oversight across the 13 boroughs within the footprint of the newly formed West and North London Integrated Care Board is jointly provided by local authority chief executives, Directors of Adult Social Services from the respective boroughs and ICB executive leaders. This group will share accountability for BCF priorities, resource use and alignment with wider system goals.

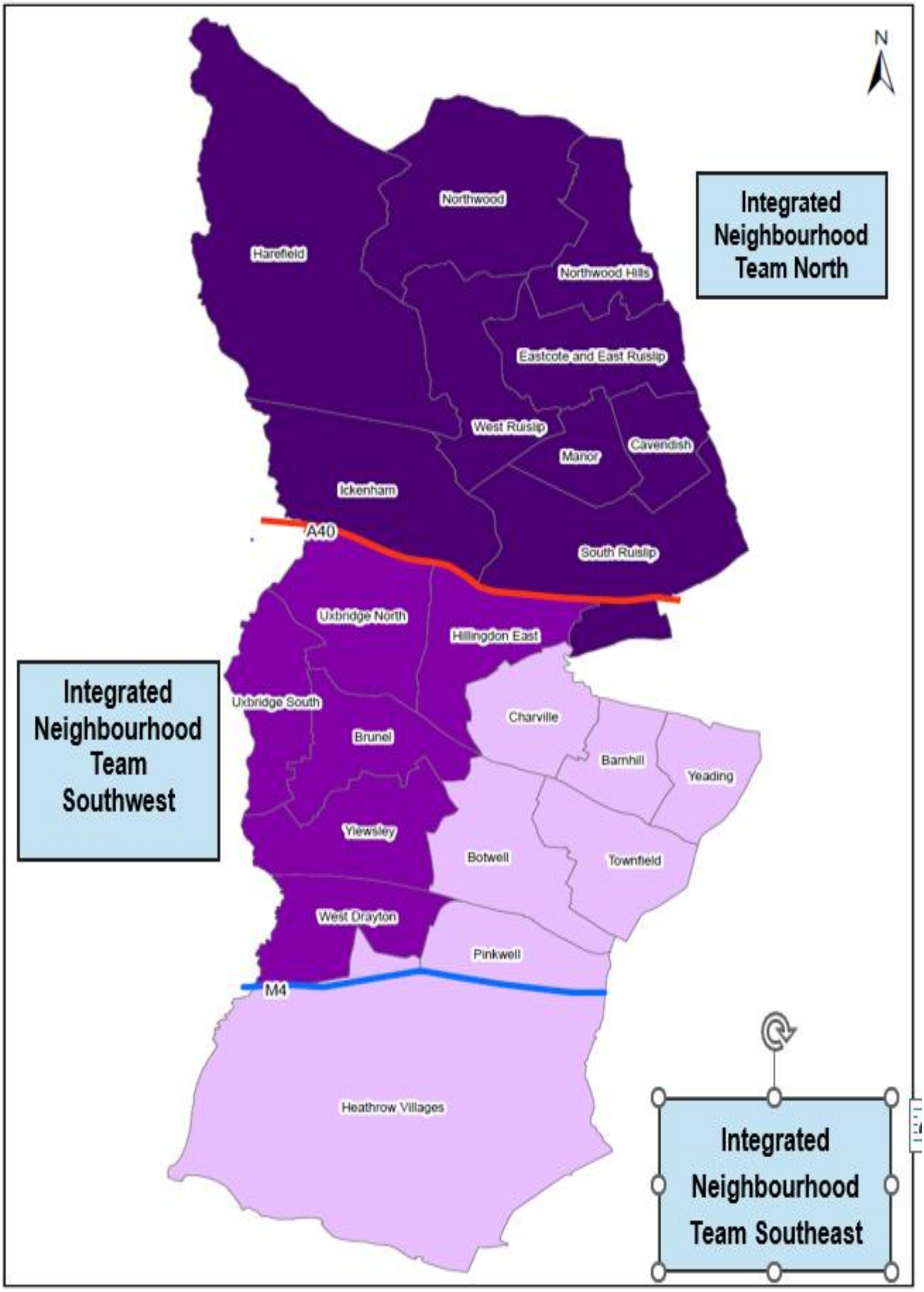
b) Integrated Care System Management and Operational Leads

A forum comprising of together ICB leads, Local Authority BCF leads and senior officers oversees delivery of the BCF plan, monitors progress, assesses scheme impact and coordinates shared planning and reporting timelines. At this level, ICB and Local Authority Finance teams jointly review expenditure, ensure alignment with the agreed financial framework and confirm that Section 75 agreements reflect approved budgets and commitments.

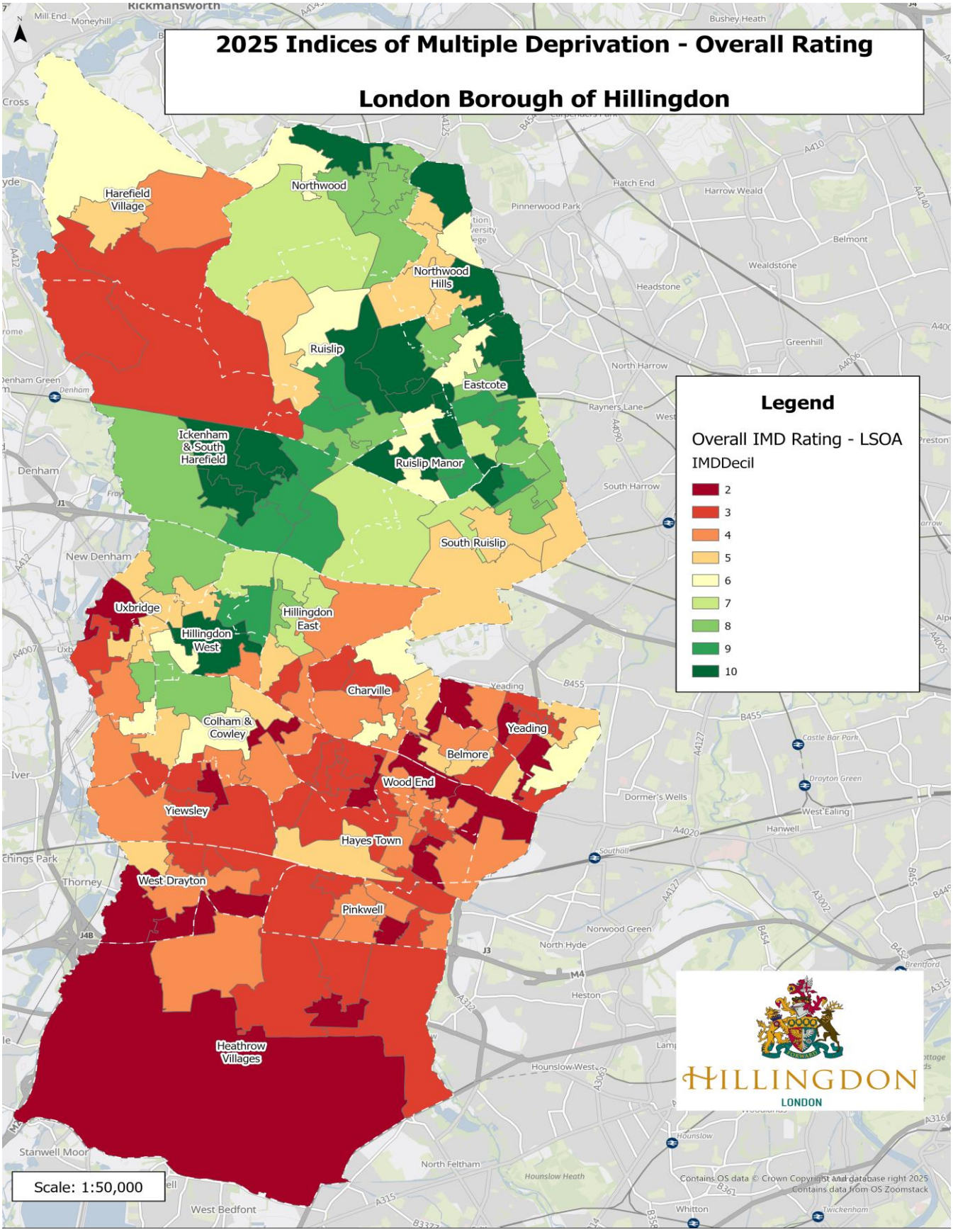
c) Place-based Governance

A summary of the Place-based governance structure can be found in **Appendix 3**. Oversight of BCF-related expenditure and performance is a function undertaken by the Finance and Performance Committee and supported by Business Intelligence and programme management capacity, the latter of which is funded via the BCF. The Committee, which meets monthly, has a key role in providing financial scrutiny to ensure that funding and investment decisions are robust and provide value for money. This approach ensures that BCF funding and targets are seen as an integral part of the Committee's broader financial oversight and performance management function for the Hillingdon Place and not separate from it. The Committee is chaired by the Chief Finance Officer of the Hillingdon Integrator, i.e., Central and North West London Foundation Trust (CNWL). It includes amongst its membership the Head of Adult Social Care Finance. Accountabilities are illustrated in **Appendix 3**. Input from the Operational Oversight Committee assists with shaping conclusions about value for money.

Quarterly reports showing performance against agreed system metrics reflected in the Joint Health and Wellbeing Strategy, including BCF, will continue to be considered by the Health and Wellbeing Board. This will include performance against planned spend of BCF income streams.


N
Integrated Neighbourhood Team North
Integrated Neighbourhood Team Southwest
Integrated Neighbourhood Team Southeast
Northwood
Harefield
Northwood Hills
Eastcote and East Ruislip
West Ruislip
Manor
Cavendish
Ickenham
A40
South Ruislip
Uxbridge North
Hillingdon East
Uxbridge South
Brunel
Charville
Barnhill
Yeading
Yiewsley
Botwell
Townfield
West Drayton
Pinkwell
M4
Heathrow Villages

Appendix 1A


2025 Indices of Multiple Deprivation - Overall Rating
London Borough of Hillingdon
Legend
Overall IMD Rating - LSOA
IMDDecil
2
3
4
5
6
7
8
9
10
Harefield Village
Northwood
Northwood Hills
Ruislip
Eastcote
Ickenham & South Harefield
Ruislip Manor
South Ruislip
Uxbridge
Hillingdon East
Hillingdon West
Charville
Yeading
Colham & Cowley
Belmore
Wood End
Yiewsley
Hayes Town
West Drayton
Pinkwell
Heathrow Villages
HILLINGDON
LONDON
Scale: 1:50,000
Contains OS data © Crown Copyright and database right 2025
Contains data from OS Zoomstack

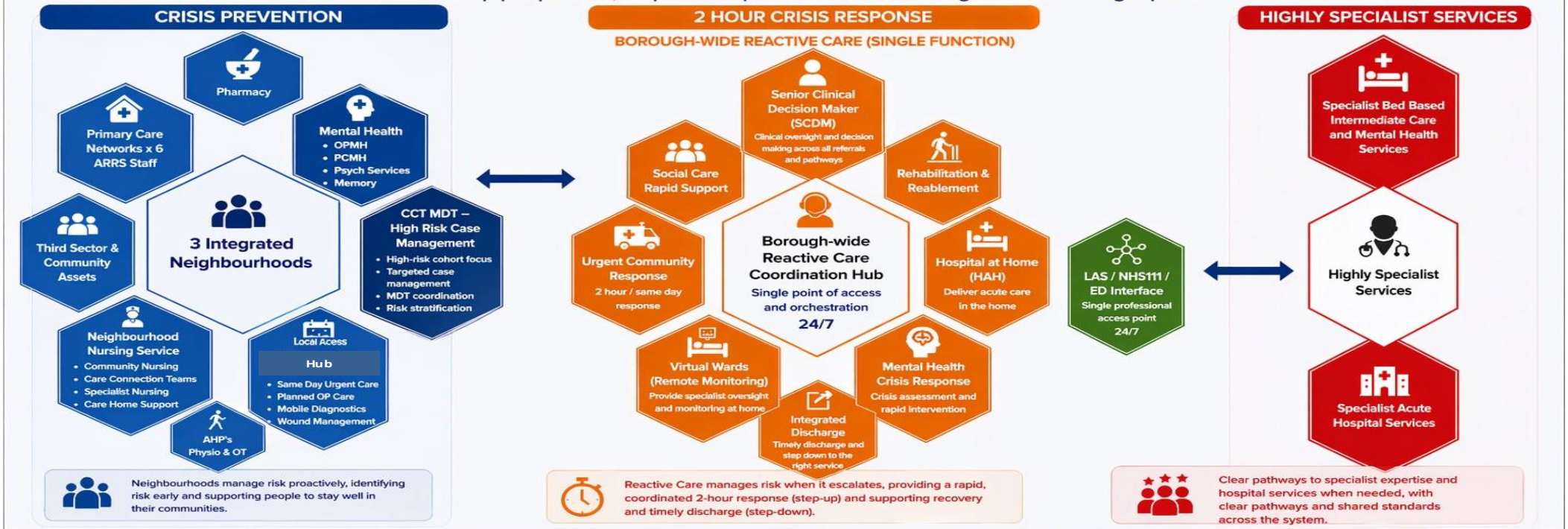
Choose an item.

Department of Health & Social Care | Ministry of Housing, Communities & Local Government | NHS England

Appendix 2

HILLINGDON PLACE OPERATING MODEL – THE SYSTEM IN ACTION

Integrated neighbourhoods and a single **borough-wide Reactive Care** function working together to keep people well, respond at speed and deliver the right care in the right place.



A Place-based operating model aligning the whole workforce into two integrated units: Neighbourhoods and Reactive Care, each operating under single leadership.

Neighbourhoods manage risk proactively; Reactive Care manages risk when it escalates.

The new operating model brings together 32 existing local health **and** care services into:

1. **3 Integrated Neighbourhoods delivering population-based care**
   Operating from 3 neighbourhood hubs, bringing together primary care, community health, mental health, social care and VCSE partners.
   Within Neighbourhoods, CCT MDTs are discrete teams providing structured case management for high-risk cohorts, coordinating care delivered by the wider neighbourhood team.
2. **A Single Borough wide Reactive Care Service**
3. **Reactive Care** provides a single borough-wide function for rapid escalation (step-up) and recovery (step-down), linking neighbourhoods to urgent and specialist care.

WORKING TOGETHER TO DELIVER BETTER OUTCOMES

- Prevent crisis and reduce avoidable hospital use
- Respond within 2 hours to urgent community need
- Support recovery at home and in the community
- Improve experience and outcomes for residents
- Make best use of resources and reduce variation
- Focus on prevention, early help and wellbeing

Together, neighbourhoods and Reactive Care deliver the four pillars of proactive care – from prevention and early help to escalation and recovery. Prevent • Identify Early • Respond Rapidly • Recover Well

Partner Roles and Functions

One shared operating model. Integrator enables. Lead Partners deliver. PBPB assures.

THE INTEGRATOR (CNWL) provides the **enabling infrastructure**, coordination **and performance framework** that makes consistent delivery of integrated neighbourhood and place-based services possible. This includes:

- **Driving collaboration** across all sectors through shared governance and delivery disciplines.
- **Aligning workforce planning and deployment** through a unified **Workforce Passport.**
- **Leading on data sharing, population health analytics, and performance management** to enable real-time system insight.
- **Supporting service transformation, left-shift initiatives, and continuous improvement** across all Lead Partner functions.

The Integrator ensures one shared operating model — not multiple interpretations of it.

Integrator role is delivered through a dedicated **Place Integrator Team,** hosted by CNWL led by the Place Managing Director but resourced collectively by Partners.

LEAD PARTNERS are accountable to the **Place-Based Partnership Board (PBPB)** for delivering and continuously improving their designated component of the Place Operating Model.

Each Lead Partner:

- **Accountable** for pathway outcomes, quality and KPIs agreed by the PBPB — operating within the shared model, not outside it.
- **Leads operational coordination** of staff from across partner organisations working in their functional area.
- **Hosts jointly appointed clinical and service leadership roles,** ensuring alignment and consistency across all providers.
- **Holds delegated authority for delivery:** not for re-designing their own model.

Lead Partners hold delegated authority for delivery: not for re-designing their own model.

A SINGLE OPERATING MODEL

One shared operating model – multiple accountable partners delivering as one system

Aligned leadership | Shared data and insight | Unified workforce | Consistent quality | Better outcomes for our population


Place Governance
Strong leadership • Clear accountability • Collective delivery
STRATEGIC LEADERSHIP
Integrated Care Board
Strategic Commissioner
CNWL Board of Directors
(Lead Provider)
Health and Wellbeing Board
Place Partner
Statutory/Sovereign Boards
Place Based Partnership Board
Shared Priorities • Joint Decisions • Better Outcomes
ASSURANCE AND OVERSIGHT
Finance and Performance Sub Group
Resource • Value • Impact
Operational Oversight Committee
Delivery • Integration • Risk
Clinical and Professional Senate
Quality • Safety • Assurance
ENGAGEMENT AND DELIVERY
Transformation Workstreams
• Neighbourhoods
• Reactive Care
• Children and YP
Neighbourhood Public and Patient Involvement Forum
Our Communities • Our Voice • Better Together
Enabling Programmes
• Digital
• Workforce
• Estate
• Communications
Working together for healthier people, stronger communities and a sustainable future