Equality and Human Rights Impact Assessment

Hillingdon Better Care Fund Plan, 2026/27

STEP A) Description of what is to be assessed and its relevance to equality

What is being assessed? Please tick ✓

Review of a service ☐ Staff restructure ☐ Decommissioning a service ☐

Changing a policy ☐ Tendering for a new service ☐ A strategy or plan ✓

Hillingdon Better Care Fund (BCF) Plan 2026-27: a joint health and social care plan submitted on behalf of the Hillingdon Health and Wellbeing Board, setting out how £76.3 million of pooled funding will be used to deliver integrated and preventative health and care services across the borough.

Who is accountable? E.g. Head of Service or Corporate Director

Sandra Taylor – Corporate Director, Adult Social Care and Health, Hillingdon Council. Keith Spencer – Managing Director, Hillingdon Health and Care Partners Sean Bidewell – Assistant Director of Place (Hillingdon), NHS West and North London

Date assessment completed and approved by accountable person

May 2026

Names and job titles of people carrying out the assessment

Gary Collier – Health and Social Care Integration Manager, Hillingdon Council

A.1) What are the main aims and intended benefits of what you are assessing?

The Hillingdon BCF Plan 2026-27 is a plan, agreed by the Health and Wellbeing Board, which pools £76,342,227 of NHS and local authority funding to support integrated, preventative health and care services across Hillingdon. The plan is structured around a life-course approach aligned to the draft *Joint Health and Wellbeing Strategy 2026-2031*. Its main aims are:

- Maximise independence and prevent unnecessary hospital admission or residential care for adults of working age (Scheme 1: Live Well).
- Support older adults aged 65+ to live independently, safely and with dignity (Scheme 2: Age Well).
- Promote recovery and independence following acute illness through active rehabilitation, reablement and discharge support (Scheme 3: Active Recovery).
- Provide effective infrastructure and enabling services to support integrated care delivery (Scheme 4: Infrastructure Enablers).

Key intended benefits include:

- A reduction in non-elective hospital admissions for people aged 65+ (target: approximately 32 fewer admissions per month vs 2025-26).
- Improvement in hospital discharge delays (target: average reduction in delayed days of 0.5%);
- Reduction in permanent care home admissions (target: 170 placements or fewer in 2026-27);
- Improved reablement outcomes; and
- A sustainable, quality care market that supports resident independence.

The plan also aims to address health inequalities, particularly in the more deprived south of the borough (Hayes, Yiewsley, West Drayton), and to progress Hillingdon as a first-wave Neighbourhood Health implementation site.

A.2) Who are the service users or staff affected by what you are assessing? What is their equality profile?

The BCF plan primarily affects Hillingdon residents who use health and social care services, with a particular focus on older adults, adults with long-term conditions, unpaid carers, and people being discharged from hospital. Key demographic data from the plan and supporting evidence:

Population Context

- Hillingdon's population is estimated at 329,185 (ONS mid-year 2024), an increase of approximately 8% since the 2021 Census.
- The 65+ population stands at approximately 43,198 (mid-year 2024 ONS estimates), projected to rise to 53,082 by 2035. Those aged 80+ number approximately 11,881, projected to rise to 15,092 by 2035.
- The 2021 Census showed 51.8% of Hillingdon's population identify as Black, Asian or from other minority ethnic groups — up from 2011. Diversity varies by ward: Harefield in the north is the least diverse; Belmont ward in the south-east is the most diverse.

Health and Care Need

- 48% (127,264) of adults registered with a Hillingdon GP are living with one or more long-term conditions — among the highest weighted average in North West London.
- The top five long-term conditions are hypertension (also known as high blood pressure), anxiety, depression, obesity and diabetes. Hypertension accounts for approximately 50% of unplanned hospital admissions in older adults and 20% in working-age adults.
- People aged 65+ account for 13% of the population but over 30% of GP and A&E activity and 40% of emergency hospital admissions.
- 4,400 residents (approx. 1.4%) account for 50% of all emergency hospital admissions.
- 22,465 unpaid carers were identified in the 2021 Census; nearly 29% provide 50+ hours of care per week, placing them at elevated risk to their health and wellbeing. In March 2026 approximately 30% (against 2021 baseline) were on Hillingdon's Carers Register.

Deprivation and Inequality

- Deprivation has increased over the past seven years. In 2025, 18 Lower Super Output Areas (LSOAs) fall within the second-highest deprivation level — compared to just 2 in 2019. All LSOAs in the top two deprivation levels are in the south of the borough.
- Overcrowding, homelessness and food insecurity are concentrated in Hayes, Yiewsley and West Drayton.
- People from South Asian and Black communities are disproportionately affected by diabetes and hypertension.
- Socio-economic deprivation and poor air quality around Heathrow contribute to respiratory and cardiovascular risk in adjacent communities.

Staff

The BCF plan includes workforce development initiatives (e.g., the Hillingdon Workforce Passport). Staff affected include community health staff, social workers, therapy staff, discharge teams and care providers across the NHS, local authority and voluntary sector. Staff data is not disaggregated by protected characteristic in the plan.

A.3) Who are the stakeholders in this assessment and what is their interest in it?

Stakeholders	Interest
Older residents (65+) and residents with long-term conditions.	That the plan delivers high-quality, timely, community-based care that supports independence and prevents unnecessary hospital admission or residential care placement.
Adults of working age with disabilities or	That care and support services enable

long-term conditions.	independent living, employment participation and social inclusion.
Unpaid carers (including young carers)	That adequate respite, information, assessment and support services are funded and accessible, reducing the health risk of caring.
Residents in deprived communities (particularly south Hillingdon)	That population health management and targeted outreach address health inequalities and ensure equitable access to services.
South Asian and Black communities	That culturally appropriate services address elevated risk of diabetes and hypertension.
Self-funders and their families	That impartial information and advice about care funding and options is available to support informed decision-making.
Hillingdon Council –Cabinet Member, Director of Adult Social Services.	To ensure value for money in service delivery; statutory compliance under the Care Act; transparent and fair commissioning; resident wellbeing.
NHS West and North London ICB	To fulfil statutory BCF conditions, maintain the NHS minimum contribution to adult social care, achieve national metrics, and deliver the ICB neighbourhood health strategy.
Hillingdon Health and Care Partners (HHCP) – including CNWL, Hillingdon Hospitals FT, Confederation of Hillingdon GPs, 3ST	To improve integrated care delivery, reduce hospital pressure, achieve system-wide targets and foster community-based pathways.
Care providers (homecare, care homes)	To ensure a sustainable, quality-assured care market through appropriate commissioning and Quality Assurance Team oversight.
Voluntary, community and social enterprise (VCSE) sector, including Carers Trust Hillingdon and Ealing	To deliver on contracted outcomes for carers support and social prescribing; continued funding security.
Council Cabinet and Council Leader	Democratic accountability; value for money; equitable service delivery for all residents.
Health and Wellbeing Board	Strategic oversight; approval of the joint plan; performance monitoring against the BCF national conditions.

A.4) Which protected characteristics or community issues are relevant to the assessment? ✓ in the box.

Age	✓	Sex	✓
Disability	✓	Sexual Orientation	✓
Gender reassignment	✓	Socio-economic status	✓
Marriage or civil partnership	X	Carers	✓
Pregnancy or maternity	X	Community Cohesion	✓
Race/Ethnicity	✓	Community Safety	X
Religion or belief	✓	Human Rights	✓

STEP B) Consideration of information; data, research, consultation, engagement

B.1) Consideration of information and data - what have you got and what is it telling you?

Age

- The plan is primarily focused on older adults (65+). People aged 65+ account for approximately 13% of Hillingdon's population but over 30% of GP and A&E attendances and 40% of emergency admissions. People aged 65+ are the primary population denominator for two of the three nationally determined BCF metrics for 2026/27.
- The residential care home admission rate for Hillingdon was 479.2 per 100,000 people aged 65+ in 2024-25 — below the England average (592.5) but above the London average (433.3). The 2026-27 target is to hold this to approximately 170 placements in the year.
- Non-elective admission rates for people aged 65+ averaged 1,921 per 100,000 in April 2025, with a planned reduction to approximately 1,847 per month in 2026-27.
- The 80+ population is projected to increase by 27% by 2035, creating future demand pressure. The plan explicitly responds to this growing older people population, presenting a strong positive impact for this age group.
- Adults of working age (18-64) are also in scope: BCF funded services include long-term domiciliary care and residential care for those aged 18-64 (Scheme 1: Live Well). Hypertension is identified as increasing in working-age adults.

- Children and young people (CYP) are not a primary BCF cohort, although the ICB's contribution to children's safeguarding (£69,237) is included. and CYP mental health is an Integrated Neighbourhood Team (INT) priority (Southwest neighbourhood), but funding to support this need is outside the BCF.

Disability

- The plan serves residents with a wide range of disabilities including frailty, dementia, serious mental illness, learning disabilities and physical impairment. Approximately 48% of the adult population registered with a Hillingdon GP have one or more long-term conditions.
- Disabled Facilities Grants (DFG: £6,341,993 total income in 2026-27) fund major home adaptations, enabling people with disabilities to remain in their own homes. An additional £1,944,243 of DFG underspend from 2025-26 is carried forward.
- Technology enabled care (TEC) and community equipment services (£3,359,822) support independent living for residents with disabilities.
- The plan funds Mental Health Discharge Social Worker and Approved Mental Health Professional posts, with the intention of reducing barriers to discharge for people with mental health needs.
- A Mental Health Service Manager post is also funded to increase management capacity to improve the response to increase demand for Adult Social care support from people with mental health needs.

Race and Ethnicity

- Hillingdon is a highly diverse borough: 51.8% of the population identify as Black, Asian or from other minority ethnic groups.
- The plan identifies that people from South Asian and Black communities are disproportionately affected by diabetes and hypertension — two of the top five long-term conditions driving health need in Hillingdon.
- Targeted outreach in the Southeast Integrated Neighbourhood Team (INT) includes community-focused cardiovascular health checks and visits to Hayes Mosque and Heathrow Villages, recognising the higher rates of diabetes and hypertension in these communities.
- Making Every Contact Count is a priority in the Southeast INT, aimed at reducing health inequalities affecting diverse communities.

Socio-economic Status

- Deprivation has increased significantly in Hillingdon: by 2025, 18 LSOAs are in the second-highest deprivation band (versus 2 in 2019). All highly deprived LSOAs are in the south of the borough.
- The Core20PLUS5 framework is being applied to focus BCF resources on the most deprived neighbourhoods — the Southwest and Southeast INTs.
- Overcrowding, food insecurity, homelessness and poor air quality are concentrated in Hayes, Yiewsley and West Drayton. The Homeless Health NWL Enhanced Model (£191,060) and a dedicated Housing Officer (discharge, £61,778) are funded specifically to address housing-related barriers to hospital discharge.
- The self-funder advice and guidance pilot (Age UK, extended into 2026-27)

addresses socio-economic barriers faced by residents who fund their own care but lack information and advice to make informed choices.

Carers

- 22,465 unpaid carers were recorded in the 2021 Census; 29% provide 50+ hours per week. The plan identifies carers as critical to the sustainability of all three BCF national metrics.
- £502,366 of NHS minimum contribution and £500,000 of Additional LA Contribution funds the Carer Support Service (Carers Trust Hillingdon and Ealing). This provides information, advice, peer support, short breaks and carer assessments.
- A long-term contract (5 years from May 2025, with option to extend by 3 years) provides stability for carer support services.
- Young carers are included in the Carer Support Service offer.

Sex/Gender

- Women form most unpaid carers nationally and are disproportionately represented in part-time care sector roles.
- Women live longer on average, meaning older women are likely to be the primary beneficiaries of older people's care services, including frailty management and residential care.
- The DFG programme and domiciliary care packages, which support independent living, will disproportionately benefit older women.

Religion or Belief and Community Cohesion

- The Southeast INT outreach specifically includes the Hayes Mosque, demonstrating culturally sensitive engagement with faith communities.
- Community-based diagnostics and health checks are being delivered in community venues, including faith venues, to reach underserved groups.
- Extra care housing schemes (4 schemes, 243 households) serve diverse communities and contribute to community cohesion.

Sexual Orientation and Gender Reassignment:

- The plan does not present data on the needs or access patterns of LGBTQ+ residents, which is a gap.

Human Rights

- The plan directly engages with Article 8 (right to respect for private and family life) by supporting residents to remain in their own homes rather than entering residential care.
- The Disabled Facilities Grant programme, reablement, TEC, homecare and community equipment services all support the right to independent living, consistent with the UN Convention on the Rights of Persons with Disabilities.
- Discharge pathway data shows Hillingdon performing well in 2025-26: average 1.77 delayed days on Pathway 1 (against ICB target of 2); best performance in NWL on Pathway 3 (5.56 days against a 7-day target). These figures indicate reasonable protection of patient rights relating to timely discharge, though the 50% of Pathway 2 patients who are non-Hillingdon residents creating flow difficulties is a system risk that is mitigated by the introduction of the Out of

Borough Coordinator post.

- Adult safeguarding is funded through the BCF (£465,491), upholding residents' rights to protection from abuse and neglect.

Consultation

B.2) Did you carry out any consultation or engagement as part of this assessment?

Please tick ✓ NO ☐ YES ✓

The BCF plan aligns to the priorities within the draft *Joint Health and Wellbeing Strategy, 2026 – 2031*, which has been subject to a public consultation that ended on 30 April 2026. The results of the consultation will be reported to the Health and Wellbeing Board in June 2026. Consultation included an online survey, discussions with community groups and established fora such as the Carers Forum, Assembly for People with Disabilities and the Older People's Assembly.

Partners will ensure that people with lived experience, including older people, people with disabilities, carers and representatives of diverse communities, are engaged in the monitoring and review of BCF-funded services throughout 2026-27.

B.3) Provide any other information to consider as part of the assessment

Legal Context

The Council and its partners have a public duty under Section 149 of the Equality Act 2010 to pay due regard to the need to: eliminate discrimination; advance equality of opportunity; and foster good relations between those who share protected characteristics and those who do not. This assessment fulfils that duty in respect of the BCF plan.

The plan also engages with duties under the Care Act, 2014 (including adult safeguarding, care market oversight and support for carers), the Health and Social Care Act 2012, and the NHS Act 2006, i.e., regularising funding and partnership arrangements within section 75 pooled budgets.

Financial Context

The total BCF pooled budget for 2026-27 is £76,342,227, comprising: DFG (£6,341,993); NHS Minimum Contribution (£27,927,934); Local Authority Better Care Grant (£9,212,761); Additional LA Contribution (£31,119,368, including £1,944,243 DFG underspend and LBH contribution to long-term care provision); and Additional ICB Contribution (£1,740,171). The NHS minimum planned spend on adult social care is £9,564,653 (the required minimum). The plan acknowledges inflationary pressures from Adult Social Care providers and notes that adjustments have been made to alleviate this as far as possible. It reflects adjustments that

have been made to accommodate the full year effect of the £1.5m reduction in the NHS additional contribution linked to the outcome of the BCF review undertaken in 2024/25.

National Policy Context

The BCF plan aligns with the government's 10-year NHS Plan direction to shift care from acute to community settings, and with the ICB's strategy to develop Neighbourhood Health. Hillingdon is a first-wave Neighbourhood Health implementation site. The plan also reflects the Core20PLUS5 framework, which targets NHS health inequalities reduction in the 20% most deprived populations, and specific conditions including: cardiovascular disease (including hypertension); severe mental illness; learning disability; and early cancer diagnosis.

Value for Money and Productivity

Hillingdon applies the 3Es framework (Economy, Efficiency, Effectiveness). A further value for money review is planned in Q1 2026-27, with particular focus on benchmarking reablement and rehabilitation integration with comparable NWL boroughs. Block contracts for key services (Bridging Care, Reablement, UCR, Hawthorn ICU) are monitored monthly through the HHCP Programme Management Office. Spend and performance of BCF funded services is also monitored by the HHCP Finance and Performance Committee and there are quarterly updates to the Health and Wellbeing Board.

C) Assessment

What did you find in B1? Who is affected? Is there, or likely to be, an impact on certain groups?

C.1) Describe any NEGATIVE impacts (actual or potential):

Equality Group	Impact and actions required
Age: Older people (aged 65+) — risk of delayed discharge	Discharge delays disproportionately affect older adults' recovery, dignity and independence, and may constitute a Human Rights concern (Article 8, ECHR). Mitigating actions: a) Development of a more integrated Reactive Care Service to increase efficiency of intermediate care provision. b) Linked to above, development of reablement bed capacity in a local authority-owned care home to increase system flexibility. c) OPTICA discharge tool providing real-time pathway data monitored by the HHCP Programme Management Office (PMO).

Age and Disability: Older (65 +) and disabled residents – digital switch over risks	The TEC digitalisation programme (£250,000 DFG) will upgrade existing telecare equipment ahead of the digital switchover in January 2027. Residents who rely on analogue telecare — often older people and people with disabilities — risk loss of service if not transitioned in time. This poses a Human Rights risk relating to personal safety and independence. Mitigating action: a) Dedicated DFG funding of £250,000 for TEC digitalisation.
Disability: People with mental health conditions — discharge pathway complexity	People with serious mental health conditions face challenges within discharge pathways, including risk of delayed discharge where specialist placement or agreement from other local authorities is required. The plan identifies that spot purchases for specialist placements (e.g., HIV, homeless, specialist 1:1) total £59,000. Mitigating actions: a) Mental Health Discharge Social Worker post funded (£54,132 additional ICB contribution). b) Additional Discharge AMHP post funded (£94,108 additional ICB contribution). c) Gap commissioning for spot-purchased specialist placements (£59,000 NHS minimum contribution).
Socio-economic status: People from deprived communities — access inequalities	Residents in south Hillingdon (Hayes, Yiewsley, West Drayton and Harefield) face significantly higher deprivation, compounded by overcrowding, food insecurity, poor air quality and higher rates of respiratory and cardiovascular conditions. Without targeted intervention, these residents may be less likely to access preventative services or early intervention, leading to worse health outcomes. Mitigating actions: a) Core20PLUS5 framework applied to prioritise BCF resources in deprived Southwest and Southeast INTs. b) Targeted community outreach for cardiovascular health (blood pressure checks) including Hayes Mosque and Heathrow Villages. c) Homeless Health NWL Enhanced Model and Housing Officer (Discharge) to address housing barriers. d) Same Day Urgent Care Hubs established in all three localities to ensure access without need for hospital attendance.
Ethnicity: health inequalities	South Asian and Black communities face disproportionate prevalence of diabetes and hypertension, which are key

(diabetes and hypertension)	drivers of emergency admissions and long-term care need. The plan identifies this but does not present detailed data on whether BCF services are accessed equitably by these groups. Mitigating actions: a) Targeted community outreach for blood pressure checks and diabetes management in areas of high South Asian and Black population. b) Making Every Contact Count initiative in Southeast INT specifically to increase disease prevalence identification. c) Partners to explore ethnicity-disaggregated service access data during 2026-27 to identify and address gaps.
Unpaid carers: carer breakdown risk	A 56% conversion rate from short-term to long-term residential care placements is identified as a concern, partly driven by carer need and breakdown. Many short-term placements are respite for carers. If carer support services are insufficient, carers face negative health and wellbeing impacts. Mitigating actions: a) Identification of people who may be carers recognised as a system priority. b) The Carer Support Service (contracted to Carers Trust Hillingdon and Ealing) provides information, peer support, short breaks and carer assessments. c) Long-term contract security (5 years with optional 3-year extension) provides continuity for carers. d) Respite and carer support included in NHS minimum contribution. e) Partners to monitor the short-term to long-term placement conversion rate and carer-breakdown triggers during 2026-27.
Sexual orientation: potential access gap	The plan does not contain data on the needs or access patterns of lesbian, gay, bisexual or transgender residents, or those undergoing gender reassignment, within BCF-funded services. This represents a potential gap in equalities monitoring. Mitigating actions: a) To explore with Healthwatch Hillingdon the scope for ascertaining the views of residents from LGBTQ+ communities concerning obstacles to accessing health and care services.

C.2) Describe any **POSITIVE** impacts

Equality Group	Impact and actions
Age: Older people (aged 65+)	Improved independence and reduced admissions through early identification of risk and proactive case management within the Neighbourhood Teams.
Disability	The DFG programme (£6.3m), home adaptations, TEC and community equipment provision have strong positive impacts for residents with disabilities, enabling independent living. • OT assessments (£260,000) and major adaptations (£2.3m) provide targeted support. • Reablement and Integrated Therapy Service support skill restoration and independent functioning.
Religion/belief and community cohesion	Community-based diagnostics and health checks are being delivered in community venues, including faith venues, to reach underserved groups.
Socio-economic status: (south Hillingdon)	Targeted investment through the Core20PLUS5 framework and INT priorities in the Southwest and Southeast directs preventative and early intervention resources to those most in need. This directly advances the equality of opportunity duty by addressing the health gap between deprived and less-deprived communities.
Socio-economic status:	The self-funder advice and guidance pilot is intended to address socio-economic barriers faced by residents who fund their own care but lack information and advice to make informed choices. This pilot has been extended for 2026/27.
Carers	The Carer Support Service, respite provision, carer assessments and short breaks directly advance the wellbeing of unpaid carers in Hillingdon, reducing risk of carer breakdown and supporting their own health and social participation.
Ethnicity	INT-level outreach including blood pressure checks at community venues and GP-led cardiovascular health initiatives address elevated cardiovascular risk in diverse communities. These represent direct positive action to reduce health disparities experienced by these groups.
Human Rights	The Palliative Integrated Care Service (£821,293) and Your Lifeline advice line for people on the end-of-life pathway are funded through the BCF, supporting people to die at home if that is their wish, with dignity and appropriate support —

	consistent with human rights principles. Urgent Community Response Service (target: 450 people per month within a 2-hour window from December 2026), and the Integrated Discharge Team together provide a positive system for safe, timely and person-centred discharge, consistent with the right to liberty and dignity.

D) Conclusions

The BCF 2026/27 plan is strongly aligned with advancing equality of opportunity, particularly through:

- Targeting deprived communities and high-risk populations.
- Investing in community-based preventative services.
- Supporting independence, carers, and least restrictive care options.

However, risks remain regarding:

- Access inequalities, particularly for deprived, minority and digitally excluded groups.
- Care market sustainability affecting vulnerable residents.
- Carer burden and system pressures.

These risks are being mitigated through:

- Population health management targeting (Core20PLUS5).
- Expansion of community and intermediate care services.
- Strengthened discharge and housing support.
- Continued investment in carer services.
- Ongoing monitoring via robust governance structures.

The actions arising from this assessment are as follows:

a) Develop ethnicity-disaggregated data on BCF service access and outcomes during 2026/27, where possible.

b) In partnership with Healthwatch Hillingdon, explore options for obtaining the views of LGBTQ + residents about service access challenges.

c) Monitor carer breakdown triggers and the short-term to long-term care home placement conversion rate.

d) Ensure that engagement with people with lived experience, including older people, people with disabilities, carers and diverse communities, is embedded in BCF monitoring and review.

e) Undertake a full evaluation of the self-funder advice and guidance pilot in Q3 2026/27.

f) Progress the TEC digitalisation programme to protect residents reliant on analogue telecare equipment ahead of the January 2027 switchover.

This assessment will be reviewed if there are significant changes to the plan during 2026-27, or if monitoring data reveals unexpected equality impacts. Quarterly performance reports against BCF metrics will be reviewed by the Health and Wellbeing Board and will include consideration of equality impacts.

18/05/26

Signed and dated:

Name and position: Gary Collier – Health and Social Care Integration Manager