NWL Integrated Care Board Hillingdon Place Summary 24/25

Appendix A

The ICB borough team working at Place is part of supporting implementation of NWL commissioning plans in Hillingdon, working with HHCP to implement priorities and support improving performance of Hillingdon Place partners for residents and patients. This report highlights some key deliverables. The ICB refreshed its Joint Forward Plan in 24/25 for this coming year and it was presented to the Hillingdon Health and Wellbeing Board in March 25. Hillingdon HHCP priorities are embedded in the Joint Forward Plan.

Performance slides 2 and 3. The performance targets as outlined on slides two and three are in the NWL ICB Operating Plan for 24/25 and are monitored by the Board on a monthly basis. The data largely relates to January 2025. It is pleasing to see that in Hillingdon the targets for people requiring health checks meet all the targets set.

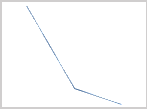
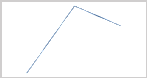
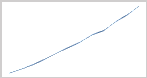
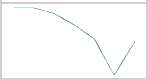
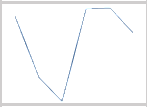
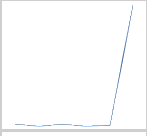
Estates slide 4. The work starting on the Northwood and Pinner site is a significant achievement as the first development of a health site in Hillingdon for a number of years. NWL ICB has developed an estates strategy which it has submitted to NHS England and is published on the ICB website. The Hillingdon team has actively contributed to the strategy, the slides pertaining to Hillingdon reflecting neighbourhood estates plans.

Slide 5 gives a brief update on progress on the improvement plan for our SEND CYP following the inspection in April 24.

Health Inequalities Transformation slides 6,7, and 8. This funding as in addition to ICB core commissioning funding supports meeting our obligations under improving health inequalities for people who are in the Core 20+5 cohorts. Really significant progress has been made in this area in Hillingdon in 24/25.

Access to general practice slides 9 & 10. This is a national and local priority. The NWL Primary Care Programme team asked the Primary Care Networks to carry out engagement with patients during the autumn. The total number of responses in Hillingdon was 13,988 and the total across NWL was over 100,000. The feedback from the Hillingdon engagement is outlined on slide 9. The ICB has included an access specification into the NWL enhanced service offer for 25/26. The new access service balances access and continuity of care.

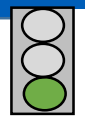
2. Summary — ICB Place Summary

Most Recent Month	NWL Metric Name	Measure	Goal (Increase or Decrease)	Target	Benchmark	NWL	Trend	Westminster	Kensington and Chelsea	Hammersmith and Fulham	Brent	Ealing	Hounslow	Harrow	Hillingdon
Dec-24	People with diabetes who have received nine care processes in the last 15 months	%	↑	70.0%		71.6%		66.5%	74.7%	66.2%	71.4%	73.8%	70.0%	71.3%	73.7%
Jan-25	Eligible female patients who have received a Cervical Cancer Screening within the last 3.5 years for ages 25-49.	%	↑	80.0%	London Average - 60.9%	55.9%		48.5%	53.5%	52.9%	49.8%	63.5%	61.1%	56.4%	62.5%
Jan-25	Children (17 or under) with asthma who have completed an asthma check	%	↑	60.0%		65.9%		65.0%	66.3%	58.4%	65.6%	70.4%	64.0%	64.6%	66.0%
Jan-25	People with severe mental illness (SMI) receiving a full physical health check	%	↑	60.0%		72.9%		70.1%	76.4%	65.2%	74.5%	72.6%	72.0%	75.5%	77.2%
Dec-24	People over age of 14 on a doctor's learning disability register who have had an annual health check(YTD)	%	↑	35.0%	London average - 7%	58.0%		65.0%	66.0%	51.0%	60.0%	58.0%	52.0%	56.0%	56.0%
Nov-24	Estimated diagnosis rate for people (aged 65 and over) with dementia	%	↑	66.7%	England Average - 62.2%	65.7%		59.9%	63.1%	63.3%	61.2%	67.6%	67.9%	69.7%	68.9%
Oct-24	Two hour Urgent community Response Rate	%	↑	90.0%	London average 82.7%	85.5%		77.6%	91.7%	87.5%	92.6%	85.7%	100.0%	71.1%	84.8%
Jan-25	Patients aged 79 years or under with hypertension who have a blood pressure reading of 140/90 mmHg or less	%	↑	44.7%	5% increase from previous year	59.8%		58.6%	62.8%	55.7%	58.4%	61.1%	61.3%	59.6%	59.8%
Jan-25	Patients aged 80 years and over with hypertension who have a blood pressure reading of 150/90 mmHg or less	%	↑	59.7%	5% increase from previous year	76.6%		73.4%	76.2%	72.7%	74.2%	78.0%	78.4%	76.8%	76.4%
Oct-24	Patients discharged to usual place or residence	%	↑	94.6%	Q2 NWL Target - Defined by BCF	92.7%		91.6%	92.0%	94.2%	94.7%	91.9%	92.8%	94.0%	90.7%

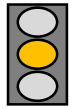
Data Source: NWL Borough Dashboard

3. Summary — Placed Based Partnership Performance Update – Hillingdon

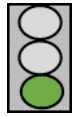
Hillingdon's performance overall is good with 8 metrics on green and 2 amber at year end.



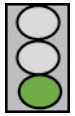
Diabetes – Hillingdon remains the top performing NWL Borough in people receiving the 9 care processes at 73.7%. PCN's are focusing on diabetes, making it a priority year-round. Pharmacists have been upskilled on managing diabetes patients, and have been reviewing diabetes patients on a regular basis as well as helping practices improve their recall process so patients are reviewed and followed up at the right time.



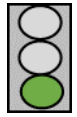
Cervical Cancer - Hillingdon's performance at 62.5% is the second highest within NW London. There is a NWL Cervical Screening Steering Group which the Borough Lead for Cancer attends. At this group, performance and best practice are shared. The RM Partners Cancer Primary Care Clinical Lead, Dr. Bushra Khawaja attended PCN meetings in Q3 sharing performance data and providing instruction on accessing data on screening dashboards, enabling practices to improve performance.



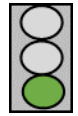
Children who have completed an Asthma Check - Various work is taking place across the HHCP system to improve the performance. For example, THH Paediatric Consultant and NWL CYP Asthma Network Lead working with PCN's on a 'Getting it right first time' campaign. There is also a new asthma template which practices to improve the quality of data captured. The NWL Paediatric Asthma Senior Delivery Project Manager is working on the asthma-friendly schools programme. 90% of Hillingdon's schools have signed up to the initiative with work ongoing to engage the final 10%.



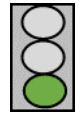
SMI Health Checks - The National target is 75% Hillingdon in February 2025 is above the target at 78.7%. The success of the Hillingdon SMI initiative is a collaborative effort involving the practices, Hillingdon Confederation and Hillingdon MIND. Both MIND and The Confederation have been actively assisting practices in reaching out to and supporting residents who may find it challenging to schedule and attend SMI checks.



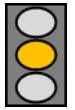
LD Health Checks - The cumulative NWL target for January 2025 is 71% the national cumulative target is 63% and Hillingdon actual performance is 66% this above the national target. The annual target is 75%. The CNWL LD team work with LD health champions, PCNs and the Local Authority to support with annual checks. Work continues with GP Practices who require more support.



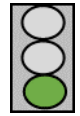
Dementia - % people diagnosed within 6 weeks of referral – National target 66.7%. The performance from Hillingdon for January 2025 is above the national target 68.1%.



Patients Discharged to Usual Place of Residence - This is a national BCF metric and the target for 2024/25 was 91.7%. The national report hasn't been updated since October at which point we were off trajectory and showing as red rated on slide 2, however the SUS data pack published by the national Better Care Team shows the average to end of February 2025 to be 92.25% thereby indicating that Hillingdon is on track to exceed the target.



Two-Hour Community Response Rate – The system changed to DocAbobe in September, which lead to some duplication for staff reporting on patients, the glitches are being worked through and checks that it is being used consistently with staff. In terms of resourcing of the team, demand and capacity is being investigated internally and through the reactive care transformation programme. During the last quarter there was a high level of staff winter sickness.

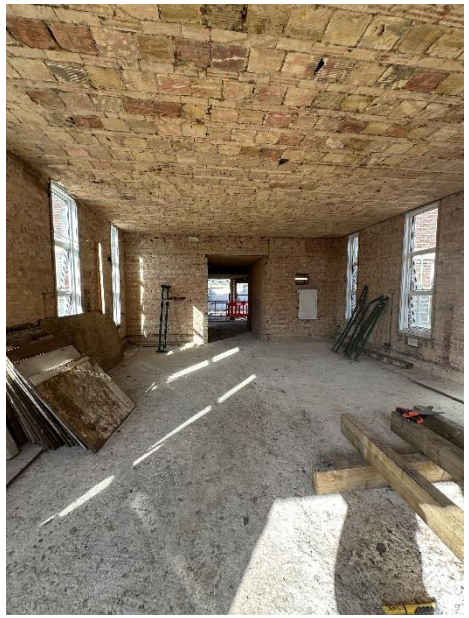


Hypertension – Performance remains high and rated green with several initiatives to support diagnosis and management of hypertension including community roadshows encompassing BP and AF checks. Tools and resources have been developed to increase knowledge and awareness about hypertension available in different languages. The Neighbourhood priorities across the borough include a focus on CVD with a number of projects underway to further support the detection and management of CVD in integrated teams. We are exploring opportunities to expand the Library BP Loan scheme to local spaces across the borough including local faith and community centres as well as supermarkets. This will support the prevention and management of hypertension, embedding and localising access to BP machines in local public spaces as the 'new norm'.

Estates – Northwood and Pinner

With the project given the go ahead by North West London ICB in December 2024, NHS property Services (NHS PS) commenced the works in January 2025 with the demolition of the old wings of the cottage hospital. The main rebuild and refurbishment of the cottage hospital will start in April 2025 with completion scheduled for May 2026.

Services will relocate into the new building in July 2026 from Northwood Health Centre and other locations. Services will include Carepoint Practice and Acre Surgery with PCN Services, community and mental health services provided by Central & North West London Trust (CNWL) and digital retinopathy services delivered by Health Intelligence.



SEND Improvement Plan Update

Following the SEND inspection of the Joint Area Partnership an improvement plan was put into place. Progress against the SEND Improvement Plan is developing well. Feedback from Department for Education is positive, with agreement that monitoring will now only be required on a half-yearly basis. There will be also be a review meeting in April with NHSE to report on progress against the plan.

The new Hillingdon Directory has gone live with education, social care and health partners supporting with promoting this widely. This contains information for families regarding all services available in Hillingdon for CYP with SEND and also has links to other websites and resources. Work has commenced on a co-produced guide for CYP and their families to be shared when a referral is made to CDC/CAMHS for an ASD or ADHD assessment to signpost to support if parents/carers suspect that their child may be neurodiverse.

The Designated Clinical Officer is working with the BI Leads for LBH, CNWL and ICB with regards to improving the scope of SEND data available and the ability to communicate this between our organisations. This is ongoing with further meetings scheduled.

6. Summary — Health Inequality Transformation Funding 24/25 for Hillingdon

NHS England has allocated recurrent Health Inequality Transformation (HIT) funding to every Integrated Care Board (ICB) to strengthen and accelerate strategic capabilities in identifying, understanding, and addressing health inequalities. In Hillingdon, the HIT funding allocation for FY 24/25 is £679,688. A business case for Hillingdon Place was approved in September 2024, with an assumption that funding will remain at this level for FYs 25/26 and 26/27. The Hillingdon HIT programme aims to reduce health disparities by enhancing service access, community engagement, and prevention initiatives, particularly for underserved populations. The funding has been allocated across two key areas:

- **Core20+5 Health Inequalities Schemes:**
- **Population Health Management (PHM) Infrastructure**

To ensure effective oversight, HHCP has established a HIT steering group within its governance structure. This group oversees that business case development meets the core HIT Core 20+5 requirements, monitors spending, and the impact of projects funded through HIT.

In addition to our internal evaluation at a Hillingdon level, the NWL Health Equity team has commissioned PPL to conduct an evaluation of all HIT schemes across NWL. This evaluation will:
- Assess the **impact of each scheme** on reducing health inequalities.
- Identify **cross-cutting themes** and shared learnings across interventions.
- Highlight effective and **impactful practices** in health equity.
- Provide evidence-based recommendations to inform future priorities and system-wide improvements.

Scheme progress update:

1. Children's Oral Health – Healthy Smiles Hillingdon: A targeted oral health programme focusing on children aged 2-4 olds living in deprived (Core 20 areas). Healthy Smiles Hillingdon by design is focused specifically on families whose economic, social, environmental circumstances or lifestyle place children at high risk of poor oral health or make it difficult for them to practice healthy diet, healthy lifestyle, maintain good oral hygiene and access dental services.

Key Achievements:

- 23 early years settings enrolled (target: 20), reaching up to 1,200 children by June 2025. With a focus on areas (West Drayton and Hayes) with the highest child populations and deprivation levels.
- Supervised tooth brushing launched, with staff training completed in 9 settings and 10 more scheduled. 6 settings has officially started supervised tooth brushing
- High parental consent rates indicate strong community support. Involving parents enhances their awareness and ability to support children's oral health at home.
- Culturally tailored resources are available to help reach diverse communities to improve parental consent rate.
- Integrated approach underway with early years settings, Family Hubs, and community initiatives.
- Provision of fluoride toothpaste, toothbrush packs, and dental check-up encouragement.

Next Steps:
- Expand programme borough-wide to all early years settings.
- Evaluation will be carried out by LB of Hillingdon Public Health Team.
- Strengthen links with NHS dental services for improved access.
- Integrate with wider child health initiatives (nutrition, early years development).

2. Community Champions: A volunteer-led initiative empowering local residents to support health improvement efforts.

Key Achievements:
- 9 Community Champions recruited, engaging 222 residents through workshops, events, and outreach.
- Health roadshows & screenings:
  - o Hypertension awareness event: 42 attendees, 34 blood pressure checks, 3 engaged in healthy eating discussions.
  - o Healthy Lungs project launched in Harefield, training champions to support COPD and asthma patients.
  - o Asthma workshops scheduled for schools and children's centres, fully launching in March.
- Mental health & social wellbeing:
  - o Partnered with The Proper Blokes Club to establish a men's walk-and-talk group, with a women's group launching soon.
  - o Community mental health first aid training scheduled for March (25 residents signed up).
- Developed a local service directory for improved signposting to health and social services.

Next Steps:
- Brunel University have been commissioned to evaluate the project. The aim is to evaluate the viability/feasibility of a model which uses the active support of volunteers as the health promotion champions. Final report to be available in November 2025.
- Strengthen partnerships with voluntary organisations to embed the model into wider service provision.
- Secure long-term funding and develop sustainability plans.
- Expand outreach efforts and integrate with existing NHS health and wellbeing initiatives.

3. CYP Mental Health & Emotional Wellbeing Early Intervention: A targeted programme to improve the mental and emotional health and wellbeing for Hillingdon's children and young people through early intervention that is targeted and person-centred, thus providing them the best opportunity to thrive into adulthood.

Key Achievements:
- Over 300 surveys completed to gather insights on young people's mental health challenges and service experiences.
- Engaged 60 young people from diverse backgrounds, including 30 from LGBTQIA+ communities.
- Healthwatch-led engagement identified gaps in support and barriers to access.
- Commissioned PPL to evaluate the early intervention model, aligning with the THRIVE approach.

Next Steps:
- Develop a Voluntary Sector Consortium to enhance service coordination and accessibility.
- Scale up early intervention and prevention models based on evaluation findings.
- Strengthen partnerships between health, education, and community sectors to ensure a more integrated approach.

4. Neighbourhood Directors:
The funding was used to pump prime three Neighbourhood Director roles. These roles play a pivotal role within the Neighbourhood Leadership Team, working in partnership with Health and Social Care to drive the development and growth of the Neighbourhood and its services.

Hillingdon has 3 INT which have each adopted localised strategies to target their own Core 20+5 groups. North INT has focussed its efforts on frailty and service design that targets their own significant older population. South East INT has identified areas of practice that target younger people and mental health, hypertension and excessive weight; whilst South West INT is targeting hypertension, atrial fibrillation and CVD. Each of these approaches is supported by a data-led PHM approach that reflects the INT-level C20+5 groups that have been identified.

These clinical priorities have been established over the last 6 months (the last INT director was in post in Autumn 2024) and early findings have proved to be encouraging. We know that Hillingdon has a sizable 'unseen' population who are hard to reach and have historically not engaged with core service offers. We are now seeing increased testing, prevalence and diagnosis across the Borough (especially in hypertension) as we engage with these hard-to-reach client groups and help drive community engage and tackle health inequalities. All programmes have been designed to help tackle these identified priorities and early trend data supports some of these early wins.

Each Neighbourhood Director has been critical in leading local infrastructure development with steering groups established for each localised INT that reflect both the primary care and wider health and care partners for these areas. Each INT has a team of clinical directors, transformation managers, public health leaders and local clinical experts to help define policy and deliver interventions specifically targeted to address locally identified inequalities. These areas are now well established and resilient with INTs being successful integrated as the 'new normal' for practice in both NHS and non-NHS services.

5. Building PHM Infrastructure

Population Health Management is recognised in both the NHS Forward Plan and the Hillingdon JSNA as the new means by which services should be co-designed, delivered and reviewed. PHM is a relatively new skillset for Hillingdon and as such, significant efforts have been made to on board this into the Borough and establish PHM as the core method of working.

The funding was for three roles: BI Analyst, Programme and Project Managers employed working across Hillingdon Place to support HHCP strategic transformation, leading on PHM Place programmes and responsibility for skills transfer and of PHM methodologies to staff.

The PHM infrastructure team has conducted a borough-wide, INT focussed review of available data sources to provide localised insights into the wider determinants of health. It is fair to say that these activities sit at the forefront of efforts to understand the health needs of our population, define changes that are required and aid in the development of novel or improved methods to tackle the wider determinants of health. Alongside this, the PHM team has also made significant inroads with population modelling, allowing for both the forecasting of future population needs (especially around aging with the recognition that Hillingdon is an aging Borough) and A&E utilisation (acting as a means of identifying these wider determinants of health).

The team is working with partners across HHCP to develop Population Health Management (PHM) capability and capacity and embed this approach to support addressing health inequalities in the Borough. This will enable improving population health by data-driven planning and delivery of proactive care to achieve maximum impact.

Finally, the PHM team is now established as a thought leader within the Borough that supports Neighbourhood directors and wider services with understanding health needs and developing the means to address them.

9. Summary — Patient Engagement on Access

- The Hillingdon 6 PCNs undertook a survey & hosted 2 focus group sessions that used the survey results as the basis for conversations with attendees
- The main themes raised were access to appointments and digital solutions - positive successes and areas of good practice were shared

Name of PCN	Celandine and Metrocare PCN	**Name of PCN**	Colne Union PCN	**Name of PCN**	HH Collab PCN	Name of PCN	Long Lane PCN	Name of PCN	North Connect PCN	Name of PCN	Synergy PCN
• Online systems like Blinx and NHS App are convenient for patients and allow ease of access to consultations and medical records • Patients appreciate the changes in telephone systems allowing the callback feature and also the ability to track their place in the queue which reduces uncertainty. • Appreciate services closer to home for example Phlebotomy now being delivered in GP practices rather than the hospital • The Community Roadshows were praised as beneficial for engaging patients and showcasing roles within PCNs • Benefits of having different roles within a primary care setting for example First Contact Physiotherapists • Being seen by different professionals other than the GP and Confederation services who have access to the patient notes • Accurx is useful for communicating with the practices including sending images and doesn't need log in details • Flexibility of appointment type i.e. telephone, face to face and online consultations • Triage processes work well especially to signpost to the right clinician and access for same day appointments • Digital workshops being provided to support knowledge and awareness of digital solutions		• Positive experience and support for same-day appointments • Online repeat prescribing is working really well • Different consultation types was useful but it depended on the situation as to which one is most appropriate • Experience of staff within the practices was generally really positive and patients welcome access to same day appointments • Positive to have availability of different professionals within primary care but signposting must ensure that they can deal with the patient's needs • An example was shared of good practice in Camden whereby they have more Voluntary Sector and Community grants through their local authority along with better day centre facilities		• Virtual appointments are great for convenience and accessibility • Multidisciplinary teams (MDTs) were highlighted for their benefits in specialized care, such as diabetes management and also for helping to reduce demands on GPs. • There was some examples where triage/signposting had worked well and patients had been directed to the appropriate professional • Telephone call-back system was praised by patients especially where you can select a convenient time for follow-up calls • Patients really valued the face to face appointments for certain conditions • Patients felt there was a good number of events, forums, and surveys to gather comprehensive insights from diverse patient groups • There has been more confidence in the telephone consultation process particularly for discussing test results and minor issues • There was praise for being able to access same day appointments		• A patient had a good experience of using PATCHS and then obtaining an appointment within 2 weeks to see a Physiotherapist • It is good to have a variety of appointment types but it has to be appropriate i.e. telephone and online solutions ok for minor issues • Noted the information that the number of appointments had increased year on year which patients appreciated • Additional accessible locations to treatment into community pharmacy and into the Confederation Hubs at the Civic Centre and Pembroke • Change to telephone systems has been a success with patients welcoming the callback functionality • Face to face appointments eases communication and overcome language barriers. • Patient education is an effective tool, both digital workshops and Social Prescribing prescribers offering 121 training has had a positive impact in patients adopting digital skills • Digital access has helped to cut telephone queues and streamline administration processes in practices • Signposting to different services and resources has enabled better self-management		• Patients reported being able to secure a same-day appoints for important issues and are seen with two-weeks for non urgent • Improved scheduling systems in some practices contribute to efficiency • Utilisation of different roles i.e. Pharmacists review medications and assist with blood/diabetic management, Physiotherapists help with MSK issues and Social Prescribing Link Workers addressing stressors like housing or social isolation • Better screening and continuity of care for chronic conditions like diabetes and CKD has improved outcomes • Longer follow-ups with chronic patients are beneficial • Patients favoured out of hours appointments especially for those balancing work • Sharing medical records with the hub facilities enhances the patient experience • Online booking allows for flexibility and patient choice • Text messages has improved efficiencies reducing DNAs		• New telephone system was praised • The NHS app is great for ordering medications • For pain control, test results or a general follow up, telephone consultations are good • One patient stated that they like it when the GP reaches out to them as they am unlikely to go to the GP unless they are really ill. This is due to work and commitments so they appreciate it when the practice reach out to suggest a check up or getting my BP done as otherwise they would not go. • Patients expressed that they could get same day appointments when required • Patient representatives like the idea of different professionals with special knowledge and are pleased to have local access to health care such as podiatrists

10. Summary — 25/26 Access Specification

- As NWL ICB had heard from our residents 2024/25 while they value their general practice services and the majority can get a GP appointment when they need to, the process of booking appointments is challenging. This was especially stressful when people were seeking care quickly. There is a risk that these people are deterred from seeking help from their GP and may turn to A&E or urgent treatment centres for help instead.
- In March 2025, the Government announced that they would also be looking to improve access and ensure patients can easily access general practice care through changes to the core contract.

- The NW London 25/26 access service specification objectives are to:
  - Improve access to general practice making use of learning derived from patient engagement and locally-led plans developed in 2024/25.
  - Support practices to make the changes needed to deliver improved access – taking the time to develop and refine processes and protocols, and to drive up staff and patient skills.
  - Move towards a more sophisticated way of demonstrating value in general practice services, moving away from a reliance on counting GP appointments as the only measure of success.
  - Empower patients to take greater responsibility for their own health and wellbeing, be actively involved in decision-making, and participate in shaping their local services.

- The model for this year aligns to a number of measures and quality markers to be tracked throughout the course of 2025/26, with a focus on:
  1. **Improved patient satisfaction** through improving processes for booking appointments, measured through waiting times and response rates.
  2. **Making best use of clinical time** through the development of local access plans, using a quality improvement approach, and better recording of clinical contacts.
  3. **Improved continuity** with a focus on identification and care for high risk patients who should be benefiting from consistent access to a named clinical team.
  4. **Patient empowerment** through increased opportunity to use the NHS app and PCN/practice led engagement events to help shape the local care offer.