Hillingdon Health and Care Partners

NHS North West London

Health and Wellbeing Board

Health and Wellbeing Strategic Priorities, Progress Update and Draft Dashboard

June 2025

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For discussion and approval

Health and Wellbeing Priorities Summary

Purpose

The Hillingdon Health and Wellbeing Board has a small number of strategic priorities for 2025–2028 developed at its meeting in March 2025. These aim to integrate current strategic plans and respond to worsening population health trends, increasing system health and social care pressures, and health inequalities. **The Board are asked to review the proposed priorities and amend this draft performance update and dashboard**

Strategic Context

- **Demographic Pressure**: Hillingdon's adult population has grown 16% in seven years, with a rapidly ageing population; the 65+ group represents 14% of the population but accounts for 40% of health and social care usage.
- **Chronic Conditions Rising**: 48% of adults have one or more long-term conditions (LTCs), with hypertension, obesity, anxiety, depression, and diabetes the most common.
- **High-Intensity Users**: A small group of 4,400 adults (1.6%) account for 50% of all non-elective admissions and admissions to long term care
- **Health Inequalities**: Deprivation in areas such as Hayes, Yiewsley, and West Drayton drives high levels of LTCs, emergency demand, and social care usage.

Key Challenges

- **Socioeconomic Risk: High child poverty (31%), food insecurity, overcrowding, and low post-housing income.**
- **Environmental Risk: Air pollution, particularly from Heathrow, increases cardiovascular and respiratory illness risk.**
- **Service Access Gaps: Inequalities in access to maternity care, mental health services, cancer screening, and hypertension management.**

We have therefore developed a set of 5 strategic priorities. These are aligned with Core20PLUS5, NWL ICS priorities, HHCP strategic plan, and LBH's broader policy framework and are focused on prevention, reducing unplanned care, and addressing inequality at neighbourhood level.

The Proposed Priorities are:

1. **Start Well:** Improve early years outcomes, reduce child obesity, and promote readiness for school and life **.**
2. ***Live Well: Prevent and/or delay the onset of Long Term Conditions particularly hypertension, improve mental wellbeing, and enhance access to early intervention and support for carers***
3. ***Age Well: Implement 'at scale' proactive frailty management, and better end-of-life care that enable people with multi morbidity to maintain independence for as long as possible in order to avoid non elective presentations, admission to long term care and to promote early discharge***
4. **Healthy Places:** Tackle housing, environment, employment, and social isolation.
5. ***Equity and Inclusion: Target resources and interventions where inequalities are greatest using Core20PLUS5: specifically Hayes, Yiewsley, and West Drayton***

For Years 1 and 2 our priorities will be focused on 'Live Well', 'Age Well' and 'Equity and Inclusion' (priorities 2, 3 and 5 italicised and set out above) in order to manage delivery risk

To deliver the Strategic Priorities, we are implementing a new 7 day Place Operating Model through 2 key transformation programmes for 25/26 (See Appendix 1 for full Place Operating Model)

1. Integrated Services focused on Preventing Crisis (Live Well/Equity):

Implement 3 co-located multi agency Integrated Neighbourhood Teams with 3 core functions:

- **Same Day Urgent Primary Care through 3 Neighbourhood Super hubs** for people with non complex needs to reduce demand pressure on Primary Care and the THH Urgent Treatment Centre and Emergency Department
- **Proactive Care** through risk stratification, case finding and enhanced case management to prevent the onset of non elective crises **for people with severe frailty** (9,840) **through enhanced multi disciplinary Care Connection Teams and the mobilisation of Neighbourhood assets**
- **A Preventative and Anticipatory Care Programme** for those people with mild to moderate hypertension (the major cause of population ill health across Hillingdon) to delay or prevent the onset of severe frailty and the associated increased risk of non elective presentation and/or long term care

2. Integrated Services focused on Responding to Crisis (Age Well/Equity)

Implement a new Borough wide Integrated Reactive Care Service to prevent unnecessary non elective episodes for patients with complex needs (moderate and severe Frailty) and to promote rapid recovery and prompt discharge after acute inpatient stay:

- **Implement a new Urgent Response Service**: a coordinated, community based urgent response service designed to support people who experience sudden deterioration in their health or social care needs close to their own home (frail elderly, people with acute functional decline, some mental health crises, and palliative (End of life) episodes)
- **Implement a new Active Recovery Service** to promote rapid recovery and discharge after acute inpatient stay reducing delays across all D2A pathways.

In order to :

Tackle the short and long term root cause of population ill health, challenged UEC operational performance and ensure that we deliver the activity assumptions set out in the new hospital redevelopment plan. The success of the proposed interventions set out opposite will be measured by the following key 'lead' metrics:

1. Reduce UTC Attendances to a daily average of <= 180 by 2025
2. Reduce ED attendances to a daily average of <= 164 by 2025
3. Reduce non elective admissions to hospital by 10% over 2019/20 baseline
4. Increase the percentage of people on the carers register over 2021 census
5. Increase the proportion of people who use Reablement and who require no ongoing support over the 2024/25 baseline
6. Flatline permanent admissions to care homes based on 2025/26 baseline.
7. Enable THH to operate within a target bed base of <= 412 beds by reducing patients without criteria to reside to a daily average of <= 34 by 2025 and reducing discharge delays across all pathways to national norms by 2025
8. Deliver a 30% reduction in associated non elective admissions/long term care for (hypertension) over the 2019/20 baseline by 2028 by:
   I. Increasing prevalence rates for hypertension amongst adults to 24% by 2028
   II. Ensuring that at least 80% of patients with diagnosed hypertension have their Blood Pressure under control by 2028

Progress against the Health and Wellbeing Implementation Plan Priorities: Neighbourhood Development…

We have made the following Progress in Neighbourhood Development

- ✓ 3 Integrated Neighbourhood Teams Implemented: North, South East and South West
- ✓ Service alignment agreed: Community and Mental Health Services now integrated at Neighbourhood Team level. Adult Social Care aligned.
- ✓ A Neighbourhood Leadership Team for each INT formed composed of jointly appointed Neighbourhood Director, Clinical Director (PCN CD) , Community Manager (CNWL) and Public Health Consultant (LBH)
- ✓ Each Neighbourhood is currently rolling out a series of **Preventative/Anticipatory Care Programmes** designed to increase prevalence and optimisation of Hypertension – the principal cause of population ill health in Hillingdon and designed **to progressively impact over the next 36 months**
- ✓ **Care Connection Teams** are now aligned to Neighbourhoods and are successfully case managing the top 2% (5,000) of people with severe frailty (multi morbidity) against a target of 9,700. **We need to progressively roll out Enhanced Case Management to the remaining Severe Frailty cohort (2%) by March 2026 through the greater identification and mobilisation of Neighbourhood assets**
- ✓ 2 out of 3 Interim **Same Day Urgent Care hubs** have been established. Roll out of the third is contingent on sourcing appropriate estate in the South West Neighbourhood. **We anticipate having an interim arrangement in place by September 2025 to increase daily SDUC capacity to 230 from 180. Current ICB proposals in relation to Access, however, pose a risk to this development.** Taken together with the proposals set out overleaf in relation to Reactive Care, this will enable us to further tackle the ED under performance against target set out opposite
- ✓ **Estates Super Hub** Option Appraisal Report completed and Neighbourhood Estates Business case in processes of development led by Archus and Northmores. This will provide alignment with hospital redevelopment programme. This will be completed and then progress through appropriate Place and NWL ICB governance in the **next 3-6 months**
- ✓ Proposals are being developed between THH and the Confederation to enable the incremental **'left shift' of appropriate transformed Outpatient services** from Hospital to Neighbourhood Based care commencing **from September 2025 onwards**

Our Current Performance against Key Metrics: (see slides 6 & 7 for detail)

- ✓ GP attendances have increased by 9% since 2022/23 (current average 3,500 per day) with same day GP attendances growing by an equivalent percentage
- ✓ Same Day Urgent Care Hubs have delivered a daily average of 180 attendances per day over the last 12 months against a target of 230. Full establishment of the third Super Hub (Hayes and Harlington) is required to reach the full target
- ✓ UTC daily average attendances are now below the new hospital target of 180 (12 month moving average of 167).
- ✗ Type 1 performance is challenged. ED attendances are significantly above their target <=164 average daily attendances by 32 attendances per day (an average 196 per day). Plans to tackle this are set out opposite and overleaf
- ✓ NEL Activity for patients under enhanced case management through Care Connection Teams has reduced by 36% post referral. ED attendances reduced by 41% for this cohort. The service, however, only currently covers 50% of people with severe frailty (9,840)
- ✓ Hillingdon has the second lowest admission rate in NWL for severe frailty: 643 per 1,000 pop
- ✗ The current prevalence rate for hypertension in Hillingdon is 13.8% against a target of 24% (It is estimated that about 30% of the population nationally have hypertension). This has improved from 10% since the start of roll out of the Hypertension Anticipatory Care Programme in Neighbourhoods. The percentage (of the 13.8%) with their Blood pressure under control is 85% -which is above target. Prevalence Rates will increase as the Programme progressively rolls out .

Progress against the Health and Wellbeing Implementation Plan Priorities: Reactive Care

We have made the following Progress in Reactive Care

Services focused on Responding to Crisis: Admission and ED Avoidance

- **We have undertaken a Demand, Capacity and Pathway Review** in relation to our Urgent Community Response Services. This includes services such as Rapid Response, Community Palliative Care, Emergency Social Care, Therapy Services, Mental Health. These services are intended to provide an urgent 2 hour crisis response in the event of a rapid deterioration in a persons physical and/or mental health to avoid a hospital episode.
- The Review has demonstrated that current services have neither the capacity (3,500 referrals annually against a requirement for 5,500 to 7,500), the skill base or the exit pathways back to Neighbourhood Care to deliver the level of response required in terms of ED/Admission avoidance.
- **We will therefore implement a new Urgent Response Service from September 2025.** It will bring together the existing Rapid Response Team, OTs, Respiratory Physiotherapists, Your Lifeline (EoL), and Social workers. It will deliver 21 new referrals per day compared to 7 new referrals per day for the existing service reducing ED attendance accordingly for this cohort
- It will have access to GP clinical supervision via Same Day Urgent Primary Care Hubs and consultant support through the Frailty Assessment Unit. There will be a single co-ordination Centre. This will enable us to tackle the current over use of ED by this cohort (+34 appointments above target per day). We are working with the ICB to access additional funding.
- In the meantime, we will fast track the implementation of a **new mobile IV Antibiotics Service (a key component of the future service)** by the end of June 2025 using funding from the Better Care Fund. This will benefit ED avoidance, free up Medical SDEC capacity and improve discharge.
- We have implemented an **End of Life Integrated Co-ordination hub** to better integrate out of hospital end of life care between Harlington Hospice and CNWL. Initial results are positive with our hospital admission rate now below the North West London average.
- We have implemented **a diversion scheme at THH for MH patients attending ED (average 9 per day) called the Lighthouse.** The impact has been disappointing (an average of 1 patient per day being seen). **As a result, we have decided to rethink the model and plan to move to a model akin to a Mental Health ED from the end of June 2025.**

Current Performance against Key Metrics: (see slides 6 & 7)

- × Type 1 performance is challenged. ED attendances are significantly above their target <=164 average daily attendances by 32 attendances per day (an average 196 per day)
- × Urgent Community Response: New Referrals per annum 3,635 (24/25), Demand 7,500 referrals per annum.
- × Lighthouse ED Diversion Attendances: April Average Actual 1 per day, Target 7 per day
- ✓ Hillingdon has the lowest hospital Admission Rate across North West London for people at the End of their Life: 2.03 admissions per 1,000 list size

Urgent and Emergency Care Flow In : Monthly Summary Performance Charts

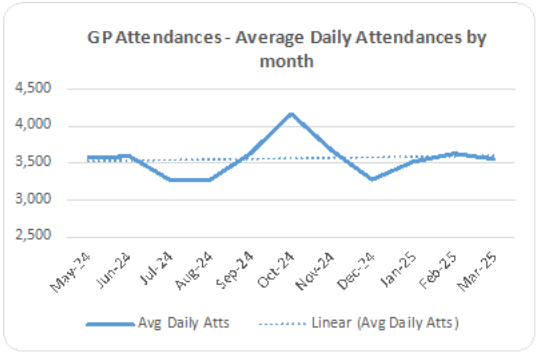
Integrated Performance Data Dashboard

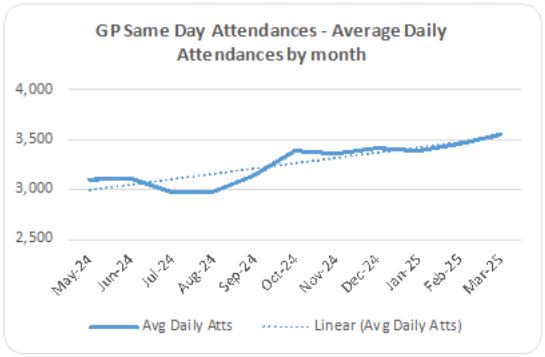
1. Hospital Build Ambitions - Summary Monthly View

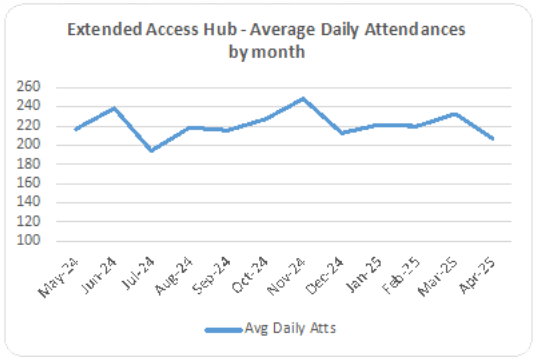
Data Source: *Combination of THH & ICB data, Monthly View*

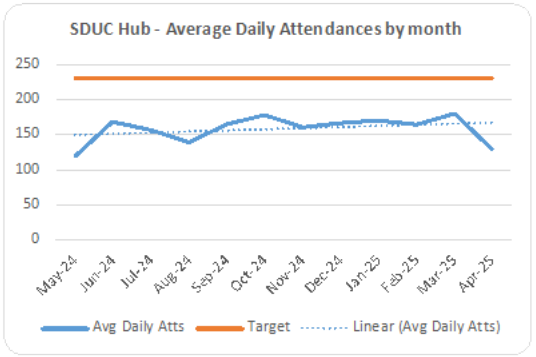
Key:
- Data not available
- Data to be confirmed\validated

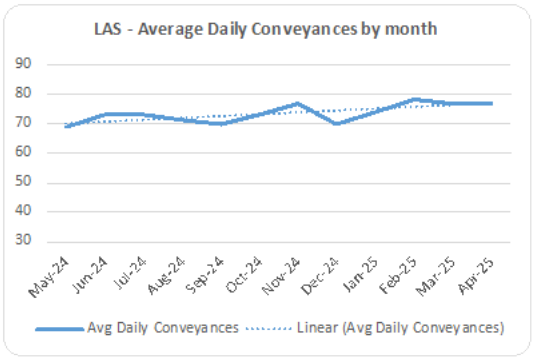
Metric Name	Measure	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	Average	Max	Min	Gap	Trend	Goal	Year 22/23	Change	Previous Year (23/24)	Change
Total GP Atts - Average Daily Attendances *(excl. same day)*	Number	-	3,563	3,585	3,269	3,271	3,631	4,155	3,662	3,274	3,510	3,627	3,554		3,552	4,155	3,254			↑	3,233	9.0%	3,474	2.2%
Same Day GP Atts - Average Daily Attendances	Number	-	3,097	3,119	2,969	2,981	3,147	3,389	3,355	3,413	3,382	3,457	3,555		3,204	3,457	2,921			↑	2,928	8.6%	3,103	3.1%
EAH - Average Daily Attendances	Number	-	217	239	195	219	216	228	248	213	221	220	233	207	217	248	157			↑				
SDUC Hub - Average Daily Attendances	Number	230	119	169	157	139	164	178	161	167	170	165	180	130	156	180	103	-74		↑	62	60.3%	78	50.0%
LAS Conveyances - Average Daily (incl. blue lights)	Number	-	69	73	73	71	70	73	77	70	74	78	77	77	73	78	69			↓	59	19.1%		100.0%
THH UTC - Average Daily Attendances	Number	**180**	174	172	168	150	159	159	175	174	165	164	170	172	**167**	175	150	-13		↓	225	-34.8%	210	-25.8%
THH Type 1 - Average Daily Attendances	Number	**164**	190	197	195	181	193	219	203	204	189	198	196	194	**196**	219	181	32		↓	201	-2.6%	186	5.0%
A&E Performance	%	**80%**	76%	71%	72%	72%	69%	70%	70%	70%	67%	67%	72%	69%	**71%**	79%	67%	-9%		↑	68%	4%	66%	7%

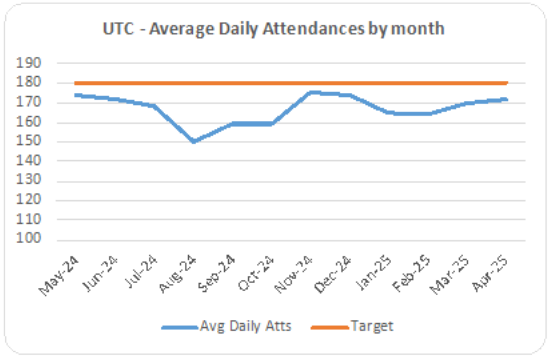


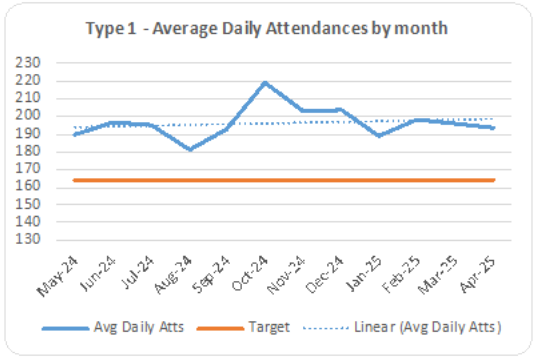












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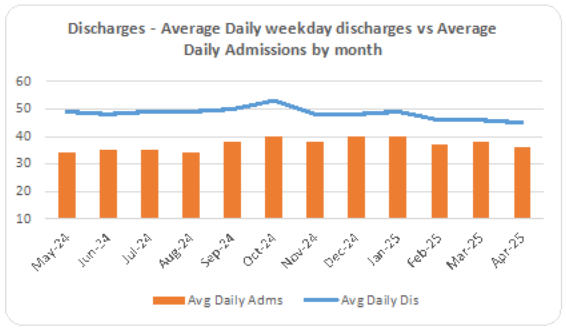
Urgent and Emergency Care Flow Out (Discharge): Monthly Summary Performance Charts

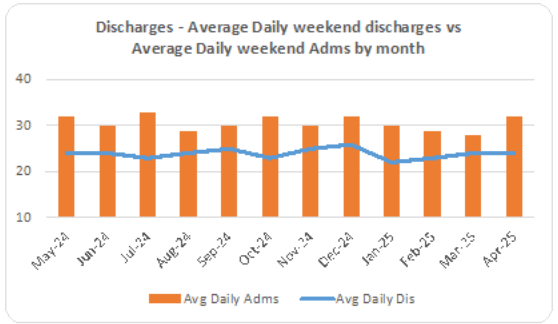
Integrated Performance Data Dashboard

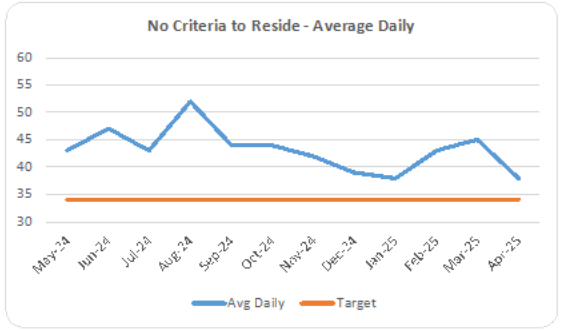
Key:
Data not available
Data to be confirmed\validated

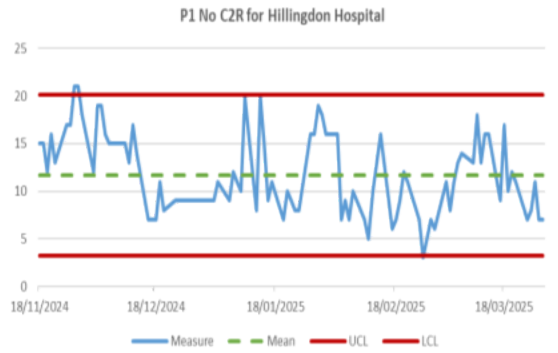
1. Hospital Build Ambitions - Summary Monthly View
Data Source: *Combination of THH & ICB data, Monthly View*

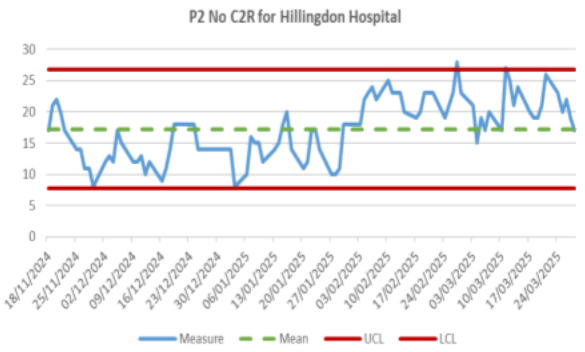
Metric Name	Measure	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	Average	Max	Min	Gap	Trend	Goal	Previous Year	Change
SDEC - Average Daily Atendances	Number	-	15	17	19	19	31	50	54	46	48	52	52	60	**33**	**54**	**15**	-		↑		
Emergency Admissions (weekday) - Average Daily Adms	Number	**54**	34	35	35	34	38	40	38	40	40	37	38	36	**38**	**47**	**34**	**-16**		↓	53	**-38.9%**
Emergency Admissions (weekend) - Average Daily Adms	Number	**23**	32	30	33	29	30	32	30	32	30	29	28	32	**32**	**41**	**29**	**9**		↓		
Discharges (weekday) - Average Daily Discharges	Number	**59**	49	48	49	49	50	53	48	48	49	46	46	45	**48**	**53**	**46**	**-11**		↑		
Discharges (weekend) - Average Daily Discharges	Number	**25**	24	24	23	24	25	23	25	26	22	23	24	24	**24**	**26**	**20**	**-1**		↑		
No Criteria to Reside	Number	**34**	43	47	43	52	44	44	42	39	38	43	45	38	**44**	**52**	**38**	**10**		↓		











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Progress against the Health and Wellbeing Implementation Plan : Reactive Care

We have made the following Progress in Reactive Care

Services focused on Responding to Crisis: Discharge

- The **average number of patients without Criteria to reside at THH** has steadily fallen over the last 12 months from an average of 54 in August 2024 to an average of 38 in April 2025. **This is still above our target of 34, however.**
- **Similarly, discharge delays across all D2A pathways** (P0, P1, P2 and P3) are below the NWL average and the targets set by the ICB . In particular, P1 pathway delays in Hillingdon and our total delay days, are the lowest in North West London.
- Nevertheless, THH has spent a significant period of time in 'black escalation' over recent months. There remain 2 significant interlinked challenges to be tackled in order to deliver better flow and hospital redevelopment targets**: <u>the growing number of P2 patients (awaiting in patient rehabilitation) with NCR and the low number of weekend discharges.</u>**
- **We have seen a gradual increase in the number of patients with NCR for Pathway 2 since February 2025.** On some days this amounts to 60% of the total number of Patients with NCR. We have therefore recently undertaken a root cause analysis.
- As a result of the P2 Deep dive, we have set a target to reduce the daily average number of P2 with NCR to <=14 from the current average of 22 by the end of June 2025 through:
  - Tackling overprescribing of care particularly IP Rehabilitation
  - Applying greater grip and control of existing processes and through more creative use of existing available resources
  - Increasing step down capacity where this is required
- These steps, properly executed, will take us below the target of 34 patients with NCR.
- In terms of discharge, slide 7 shows that on average, over the last 12 months, we have had a surplus of weekday discharges over admissions. This surplus is offset, however, by a significant deficit of discharges compared to admissions at weekends. **Over the next 4 months (by end of September 2025), we will work with the Trust to develop a clear and coherent plan to rectify this in the context of the roll out of our new 7 day place model**

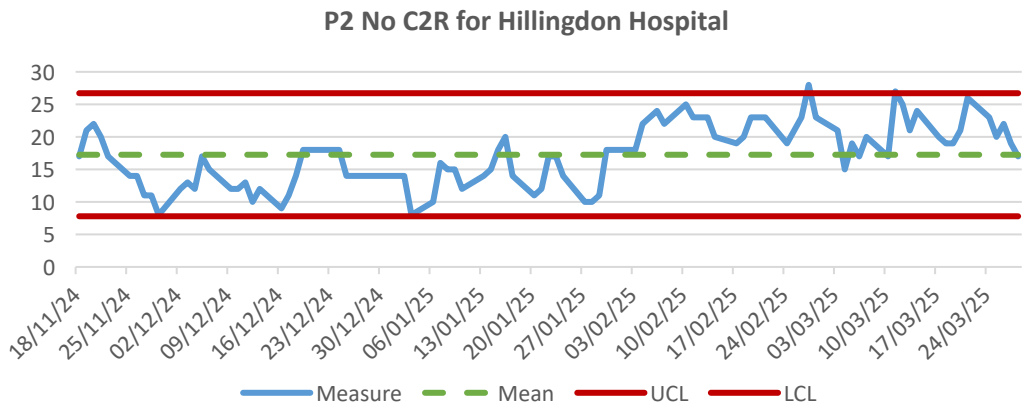
Current Performance against Key Metrics: (see slides 5 & 6)

× The average daily 'No Criteria to Reside' target is set at 34. Over the past few months, there have been significant reductions, with the average steadily decreasing. Aprils average was 38.

✓ Pathway Delay Days for Hillingdon compared to the NWL average are set out in the table below:

Pathway	Hillingdon Average	NWL Average
P0	0.23	0.26
P1	1.63	2.38
P2	4.43	4.65
P3	7.62	8.68
Total	**0.18**	**0.26**

✓ The growth in the **daily average number of P2 with NCR is set out clearly in the chart below**



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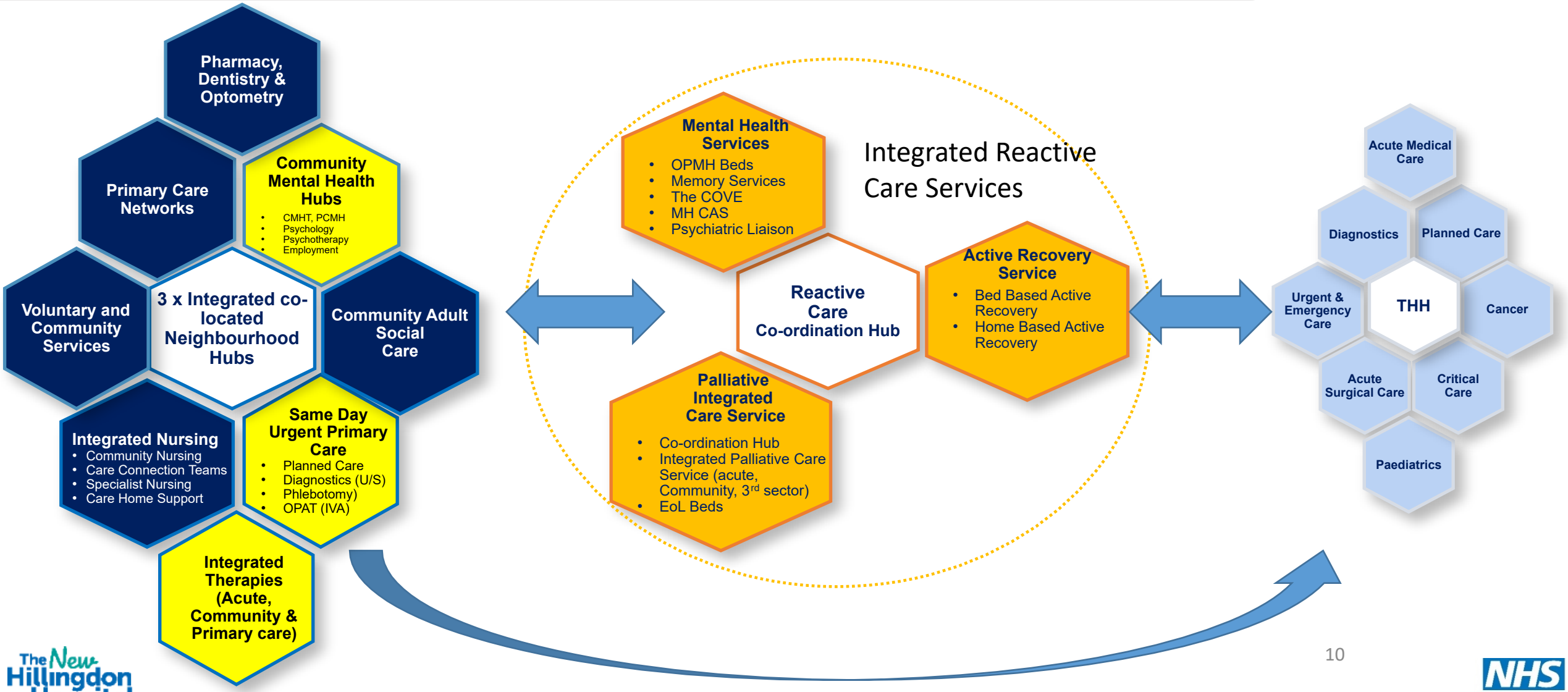
Appendix 1

Our New Place Target Operating Model looks like this….



The New Hillingdon Hospital

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