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Health and Wellbeing Board

Date: **TUESDAY, 2 DECEMBER 2025**

Time: **2.30 PM**

Venue: **COMMITTEE ROOM 5 - CIVIC CENTRE**

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To Members of the Board:

- Cabinet Member for Health and Social Care (Co-Chair)
- Hillingdon Health and Care Partners Managing Director (Co-Chair)
- Cabinet Member for Families, Education and Wellbeing (Vice Chair)
- LBH Chief Executive
- LBH Executive Director, Adult Services and Health
- LBH Executive Director, Children and Young People's Services
- LBH Director, Public Health
- NWL ICS - Hillingdon Board representative
- NWL ICS - nominated lead
- Central and North West London NHS Foundation Trust - nominated lead
- The Hillingdon Hospitals NHS Foundation Trust Chief Executive
- Healthwatch Hillingdon - nominated lead
- Royal Brompton and Harefield Hospitals - nominated lead
- Hillingdon GP Confederation - nominated lead

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Putting our residents first

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Agenda

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Hillingdon Health and Care Partners

NHS North West London

Hillingdon Health and Well-being Board

Integrated Health and Wellbeing Performance Report and Service Update

Report for Hillingdon Health and Well-being Board – 02nd December 2025

Agenda Item 5

Health and Wellbeing Board Priorities Background and Overview

1. Purpose, Background and Overview

This report provides the Health and Wellbeing Board with an overview of progress against its five strategic priorities and the major transformation programmes supporting them. It summarises delivery achievements, emerging performance trends, risks to outcomes, and the key areas where continued Board sponsorship is required.

Hillingdon's strategic priorities—**Best Start in Life, Live Well, Age Well, Healthy Places, and Equity & Inclusion**—are aligned with Core20PLUS5, NWL ICB priorities, and the Council's policy framework. The first two years of delivery focus on **Live Well, Age Well, and Equity & Inclusion**, reflecting the scale of need, the opportunity to reduce inequalities, and the significant impact these priorities have on urgent and unplanned care.

This update covers progress in three main areas:

1. **Integrated Neighbourhood Teams (INTs)** – delivering preventative, personalised care; early gains in hypertension control and frailty management; expansion of outreach and health checks.
2. **Reactive Care Programme** – strengthening urgent community response, improving flow, reducing "No Criteria to Reside" delays, and preparing for winter.
3. **Best Start in Life** – developing the Child Health Hub model, expanding school mental health support, and responding to high neurodevelopmental demand.

The report sets out current performance, highlights improvements in preventative care and hospital flow, and identifies areas requiring further acceleration to meet ambitions for 2026.

2. Key Messages

- ✓ **Emergency demand remains high.** A&E attendances average **171/day**, above the target of 164, meaning the system continues to operate under sustained pressure despite a reduction from last winter's peak.
- ✓ **There are early signs of improved hospital flow**, driven primarily by the 27% reduction in "No Criteria to Reside" (NC2R) delays (48 → 35). These improvements help stabilise bed capacity, but performance remains fragile and highly sensitive to winter pressures.
- ✓ **Neighbourhoods are now fully operational.** All three INTs are live borough-wide, providing the foundation for proactive community care.
- ✓ **Frailty management is reducing admissions.** Around **50%** of the severe frailty cohort is under enhanced case management, contributing to a **36% reduction** in emergency admissions for these residents.
- ✓ **Hypertension outcomes are strong.** Recorded prevalence has risen to **13.8%**, with **77%** of known patients achieving blood pressure control—highest in NWL.
- ✓ **Reactive Care model is maturing.** The Coordination Hub launches December 2025, UCR now has daily Senior Clinical Decision Maker coverage, Lighthouse capacity has expanded to divert mental health demand from A&E and Mobile Diagnostics to Care Homes and People with Frailty has gone live
- ✓ **Best Start in Life is progressing.** Child Health Hub development is underway and school Mental Health Support Team (MHST) coverage is increasing from 60% to around 80%.
- ✓ **Major challenges remain.** The main cross-cutting risks are high A&E demand, sustaining NC2R improvements, growth in long-term conditions, CYP neurodevelopmental demand, and winter pressures.

Executive Summary

3. Executive Summary

Hillingdon continues to make meaningful progress in delivering its Health and Wellbeing Strategy. Neighbourhood-based prevention, improved urgent community response, and stronger children's mental health support are beginning to shift demand away from acute settings and improve outcomes for residents. However, system pressures remain significant and will require sustained collective focus through winter.

- **Neighbourhoods (Live Well & Age Well).** All INTs are operational and delivering early impact. Frailty case management covers half of the cohort, reducing emergency admissions by 36% for those in scope. Hypertension case-finding has significantly expanded prevalence and 77% of patients now achieve blood pressure control. Next steps include full frailty coverage, expansion of anticipatory care, and integration with emerging Neighbourhood Local Access Hubs.

- **Reactive Care.** Flow is improving, with NC2R reductions and expanded urgent community services including UCR, Senior Clinical Decision Makers, community IV antibiotics and direct GP-to-SDEC access. The Coordination Hub will simplify referral routes and strengthen rapid response. The key risk remains winter demand and sustaining 7-day discharge processes.

- **Best Start in Life.** Work has commenced on a new Child Health Hub model aligned to the Family Hubs network. MHST expansion will extend support to ~80% of schools. Neurodevelopmental demand remains high, but additional funding will enable around half of the 2,000 waiting children to be assessed this year. The CYP dashboard will provide clearer oversight of outcomes and inequalities.

- **System Risks.** The main cross-cutting risks are high A&E demand, workforce constraints, sustaining NC2R improvements, growth in long-term conditions, CYP neurodevelopmental demand, and winter pressures. Mitigations include continued development of community alternatives to hospital care, joint workforce planning, strengthened discharge pathways, expanded prevention and anticipatory care, targeted CYP investment, and activation of the winter resilience plan.

- **Investments:** A number of targeted investments support delivery of the programme, including expansion of urgent community services, Lighthouse, neighbourhood prevention, and CYP backlog reduction. A full investment table is provided in Appendix 1

The Board is asked to note progress, endorse continued focus on preventative and urgent care priorities, and support actions required to sustain flow and improve outcomes for children and families.

4.1 Integrated Neighbourhood Teams: Purpose & Model

Integrated Neighbourhood Teams (INTs) are the core delivery model for Hillingdon's *Live Well* and *Age Well* priorities. Each Neighbourhood now brings together GPs, community services, social care, mental health and the voluntary sector into a single team focused on **prevention, early intervention and personalised care**. Neighbourhood working also aligns closely with Family Hubs and the Healthy Places agenda, ensuring joined-up support for families and communities.

The model aims to **keep residents healthier for longer**, reduce avoidable hospital use, and ensure coordinated support for people with long-term conditions and frailty. INTs provide proactive case management, anticipatory care and integrated support planning across partners.

Neighbourhoods (Live Well & Age Well)

.4.2 Integrated Neighbourhood Delivery (Progress Update)

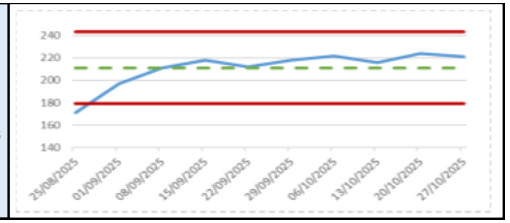
- **All INTs fully operational.** Multidisciplinary teams are now active across all three localities, providing a consistent neighbourhood model for prevention and coordinated care.
- **Frailty case management progressing well.** Around **50% of the severe frailty cohort (~1,000 residents)** is now under enhanced case management, contributing to a **36% reduction in emergency admissions** among these patients. Full coverage will be a key focus for 2026.
- **Hypertension and long-term conditions.** A borough-wide case-finding drive has increased recorded hypertension prevalence to **13.8%**, identifying thousands of residents previously not in care. **77%** of known hypertension patients now have controlled blood pressure—one of the strongest performances in NWL. Work is underway to expand anticipatory care for COPD and diabetes.
- **Targeted outreach reducing inequalities.** Community outreach in high-need areas is identifying significant undiagnosed risk and strengthening prevention, with rapid escalation to primary care and INT support.
- **NHS Health Checks.** Approximately **350 high-risk residents** have received proactive checks, improving early identification of cardiovascular risk factors.
- **Governance & infrastructure.** A Neighbourhoods Steering Board now oversees delivery and alignment. Work has begun on the **Integrated Neighbourhood Hub** business case to co-locate primary care, community and voluntary services in Hayes, Ruislip and Uxbridge.

4.3 Primary Care, Pharmacy and Dentistry (See Appendix 1 and 2 for Key Metrics)

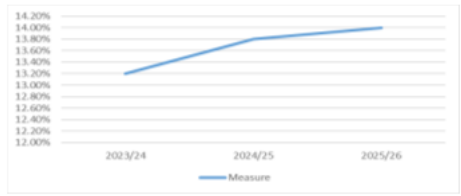
- **Primary Care Networks & Enhanced Services**
  PCNs continue to deliver the NWL Enhanced Services Single Offer, strengthening prevention and long-term condition management in primary care. Shifts from hospital to community settings (e.g. anticoagulation monitoring) and strong performance in diabetes and mental health are contributing to more consistent care across practices. £6.78m annual funding is secured to 2028, enabling continued alignment between PCNs and INTs.
- **Pharmacy First**
  Pharmacy First is now a major access route for minor illnesses (acute sore throat, uncomplicated UTIs, sinusitis and other minor infections). Between March–August 2025, **18,000+ consultations** took place, including **3,000 referrals** from NHS 111/GP/UTC. This has diverted low-acuity demand from GP practices and urgent care, supporting same-day access and relieving pressure on A&E. Ongoing Medicines Optimisation support ensures quality, safety and appropriate use of the service.
- **Dentistry (Access Expansion and Prevention):**
  - **Expanded NHS capacity.** Fourteen dental practices in high-need areas have increased appointment availability, improving access for residents who previously struggled to secure NHS dental care.
  - **Children's Oral Health Pilot.** Focused on the most deprived areas, the pilot is improving access to exams and fluoride treatments for children under 16, linking closely with Family Hubs.
  - **Inclusion Dental Pilot.** Provides longer, trauma-informed dental appointments for vulnerable groups, including people in temporary or emergency accommodation.
  - **24/7 urgent dental care via NHS 111.** Ensures residents with urgent dental needs can access appropriate care while avoiding unnecessary A&E attendance.

Neighbourhoods (Live Well & Age Well)

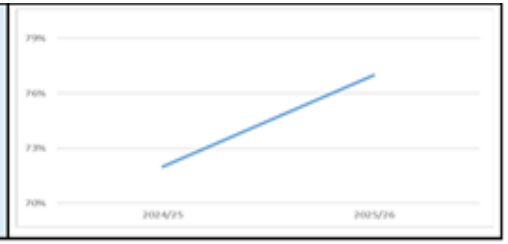
4.4 Neighbourhood Performance Metrics

UTC Activity Reduction (Traffic light measured against 10 wk Avg)	Monthly Actual **220**	Target 180 / 10 wk Average 211 / Trajectory 176	Graph Trendline for last 10 wks		

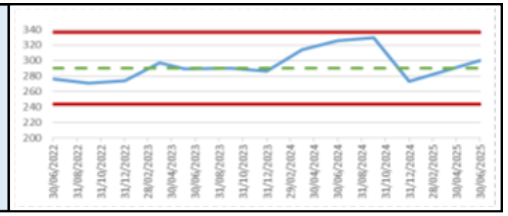
Narrative / Likely Cause	Actions to Remedy	Timeline	Accountability
The 10 week average is currently at 211 attendances per day with an October average of 220.	Revised delivery plan incorporating stronger front door diversion & capacity improvement.	Phased Rollout from Q3 25/26	SRO Neighbourhoods

Increase Hypertension Prevalence for 18+ population	YTD Actual **13.8%**	Target 16% / Previous Year 13.2% / Trajectory 16%	Yearly Trendline		

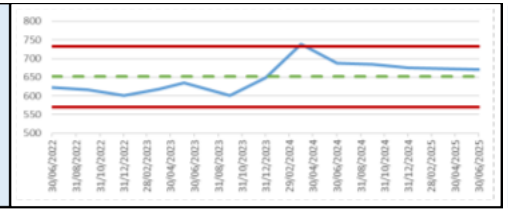
Narrative / Likely Cause	Actions to Remedy	Timeline	Accountability
Good progress has been made in scaling up from 10% baseline to 13.8%. However the scaling is slower than required to meet the 16% target by March 26.	In order to meet the trajectory, acceleration is needed in Pharmacy, General Practice and INT outreach with a borough campaign.	Accelerated rollout from Q3 25/26	SRO Neighbourhoods

Controlled Blood Pressure for 80% of Hypertensive cohort	YTD Actual **77%**	Target 80% / Previous Year 72% / Trajectory	Yearly Trendline		

Narrative / Likely Cause	Actions to Remedy	Timeline	Accountability
Good progress has been made towards achieving the 80% controlled blood pressure target, driven by strong primary care management. Although performance is improving, it remains just below the target, and as prevalence increases this level of optimisation will need continued focus to ensure we reach and sustain 80%	Strengthen and standardise optimisation approaches across all practices, including 24-hour BP monitoring and pharmacist-led medication reviews. Reinforce call-and-recall systems to ensure regular follow-up for patients with uncontrolled or borderline readings	Ongoing	SRO Neighbourhoods

Reduce NEL Adm Rate for patients with Moderate Frailty	Quarterly Actual **242**	Target 285 / Yearly Average 279 / Trajectory N\A	Graph Trendline Quarters		

Narrative / Likely Cause	Actions to Remedy	Timeline	Accountability
Hillingdon have one of the best outcomes within NWL. Case management is effective. Launch of WSIC frailty radar to support case finding and management of frail patients	Sustain INT scaling and expand anticipatory care.	Full coverage by Apr 26	SRO Neighbourhoods

Reduce NEL Adm Rate for patients with Severe Frailty	Quarterly Actual **671**	Target 694 / Yearly Average 675 / Trajectory N\A	Graph Trendline Quarters		

Narrative / Likely Cause	Actions to Remedy	Timeline	Accountability
Meeting the quarterly target and yearly average is almost on target. Which shows the early impact of the frailty programme. Currently supporting 50% case management to patients with severe frailty.	Full rollout to 100% severe frailty cohort.	By April 2026	SRO Neighbourhoods

Neighbourhoods (Live Well & Age Well)

4.5 Key Issues & Risks (Neighbourhoods)

Despite strong early progress, several risks could limit the scale and consistency of neighbourhood impact:

Workforce Capacity & Capability

Scaling preventative and proactive care depends on sufficient clinical and non-clinical workforce. Gaps remain in key roles (geriatricians, pharmacists, therapists, care coordinators). Without continued recruitment and skills development, INTs may struggle to expand frailty coverage, maintain quality, or keep pace with rising long-term condition demand.

Variation in INT Maturity

Not all INTs are operating at the same level of integration, shared processes or MDT coordination. This creates inconsistent resident experience and uneven delivery of prevention and anticipatory care. The Neighbourhoods Steering Board is addressing this through standardised operating models and planned investment in co-located Neighbourhood Hubs.

Rising Demand Driven by Demographics & Long-Term Conditions

The ageing population and increasing prevalence of long-term conditions continue to drive demand. As frailty case-finding expands towards 100% coverage, INT caseloads will grow substantially. Without matched capacity, there is a risk that proactive care becomes diluted, reducing its impact on avoidable admissions.

Inequalities Across Localities

Health outcomes vary significantly across Hillingdon, with areas such as Hayes & Harlington experiencing poorer health, lower life expectancy and higher prevalence of long-term conditions. Neighbourhood improvements may not reach these communities at the same pace unless metrics are monitored with an equity lens (e.g., frailty coverage, hypertension control, Health Checks). Targeted outreach and tailored interventions will be essential to avoid widening gaps.

4.6 Forward Plan (to March 2026)

Over the next two quarters, the Neighbourhoods programme will focus on consolidating early progress and expanding delivery to ensure consistent, preventative care across all localities:

Expand Frailty and Anticipatory Care Coverage

- Continue scaling frailty case management towards **full coverage by April 2026**, ensuring remaining high-risk residents have an identified care coordinator and shared care plan.
- Use the new **WSIC frailty dashboard** (launching early 2026) to identify gaps and monitor outcomes such as admissions, falls and MDT follow-up.
- Broaden anticipatory care beyond hypertension to include **COPD, diabetes, falls prevention and multimorbidity**, prioritising residents at moderate risk.

Implement the Hillingdon Hypertension Strategy

- Finalise and adopt the borough-wide Hypertension Strategy (due December 2025) to sustain progress on prevalence, intensify outreach in high-inequality areas, and support movement towards the **16% prevalence target**.
- Strengthen annual prevention campaigns (e.g., *Know Your Numbers*) and extend them into wider long-term condition awareness and early detection.

Neighbourhoods (Live Well & Age Well)

4.6 Forward Plan (to March 2026)

By March 2026, we aim to have a consistent neighbourhood operating model across all localities, with full frailty coverage, expanded anticipatory care and clearer outcome dashboards to track impact and inequalities. Specifically:

Strengthen Mental Health Integration

- Ensure each INT has a named **mental health practitioner** by Q4, improving early support for anxiety, depression and emerging cognitive issues.
- **Enhance links between INTs, primary care and community mental health teams** to reduce escalation to crisis pathways and improve access to brief interventions in neighbourhood settings.

Introduce Neighbourhood Performance Dashboards

- Develop and implement **INT-level performance dashboards** to provide near real-time insight into activity, outcomes, inequalities and variation between localities.
- Align with the emerging **Children & Young People dashboard**, enabling whole-life-course neighbourhood monitoring and supporting targeted resource allocation.

Progress Neighbourhood Estates (Hubs)

- Continue development of the Integrated Neighbourhood Hub business case, with decisions on the proposed “Super Hub” anticipated by March 2026.
- Use learning from the North Hillingdon Health Hub (launching November 2025) as the prototype for future hub design, co-location opportunities and community engagement.

These actions aim to strengthen the consistency and impact of neighbourhood delivery, embed proactive and preventative care, and support the long-term ambition to reduce avoidable hospital use and improve outcomes across Hillingdon’s communities.

5.1 Reactive Care Purpose & Model

The Reactive Care Programme strengthens urgent and crisis response in the community so that residents receive the **right care, at the right time, in the right place**, while reducing avoidable hospital use and supporting timely discharge. It brings together urgent community response, crisis support, and discharge pathways into a **single, coordinated model** with a simplified referral route via the new Coordination Hub.

The programme has three core aims:

- **Rapid Urgent Community Response (UCR):** Deliver fast, community-based interventions that stabilise health and social care crises and prevent avoidable A&E attendances or admissions.
- **Timely and Safe Discharge:** Improve discharge planning and post-discharge support, ensuring residents who no longer meet criteria to reside (NC2R) leave hospital promptly and safely.
- **Bridging Preventative and Reactive Care:** Strengthen the link between preventative care (INTs) and crisis response—ensuring early deterioration is managed proactively and repeat emergency use is reduced.

The intended outcome is a **joined-up reactive care system** that reduces avoidable ED attendances, shortens hospital stays, improves the resident experience and strengthens resilience through winter.

Reactive Care (Urgent & Crisis Response, Hospital Discharge)

5.2 Components of Reactive Care

1. Reactive Care Coordination Hub (Phase 1 – Dec 2025)
The Coordination Hub will act as the single point of access for urgent community referrals, enabling rapid triage and directing residents to the right service (UCR, crisis social care, mental health, therapy, reablement or discharge support). **Phase 2** in early 2026 will expand the Hub's remit to include proactive case management and end-of-life coordination. This will provide a simpler, more reliable route for GPs, London Ambulance Service and other referrers.

2. Urgent Community Response (UCR) & Senior Clinical Decision Makers
UCR provides a 2-hour response for urgent health and social care crises at home. Embedding **Senior Clinical Decision Makers (SCDMs)** from 8am–8pm seven days a week has strengthened decision-making for complex cases, enabling more people to be safely managed at home. Additional UCR staff capacity is being recruited for early 2026. This model reduces avoidable conveyance to ED and supports short-term stabilisation in the community.

3. Community IV Antibiotics
Since July 2025, 6–8 daily doses of IV antibiotics have been delivered in homes and community settings for conditions requiring intravenous treatment but not hospitalisation. This prevents unnecessary bed days and enables earlier discharge when clinically appropriate.

4. GP-to-SDEC Pathways
GPs can now refer suitable patients directly to Same Day Emergency Care (SDEC), bypassing the Emergency Department. This pathway ensures faster specialist review and avoids standard ED attendance for conditions that can be managed on the same day. For reactive care, this offers a reliable diversion route for patients who do not require full admission.

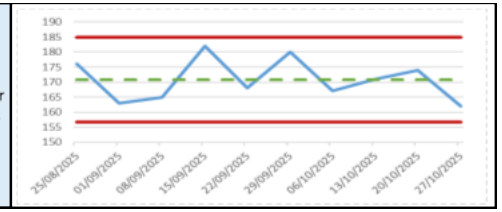
5. Mobile Diagnostics (X-ray)
A mobile X-ray pilot is providing diagnostics for housebound and frail residents, preventing the need for hospital radiology attendance. Early activity shows good uptake, and evaluation will determine the case for scaling the model. This strengthens both urgent response and INT-based case management.

6. Lighthouse Mental Health Crisis Service
The Lighthouse service provides an alternative to ED for residents experiencing mental health crisis. A new operating model went live in November 2025, increasing capacity from 4 to 6 patients at a time, with a further expansion to 10 patients planned following review. Lighthouse reduces psychiatric demand in ED and provides a calmer therapeutic setting with rapid access to follow-on support.

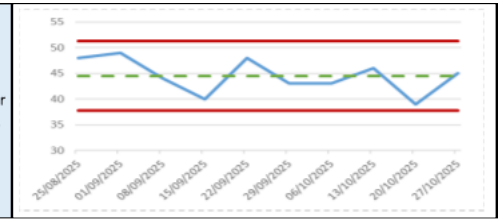
7. Discharge Pathways & NC2R Reduction
A joint NHS–Local Authority **NC2R Reduction Plan** has introduced daily multi-agency ward reviews, weekly Gold Command oversight, revised standard operating procedures and strengthened discharge pathways. This has contributed to a reduction in NC2R from **48 to 35**, improving flow and freeing bed capacity. Further work continues to operationalise changes and sustain progress made to date

Reactive Care (Urgent & Crisis Response, Hospital Discharge)

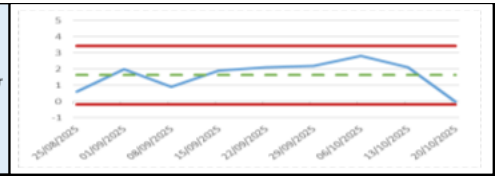
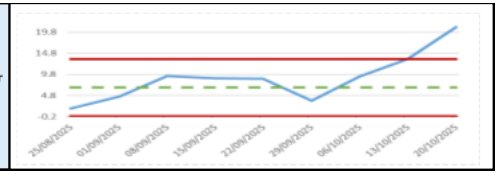
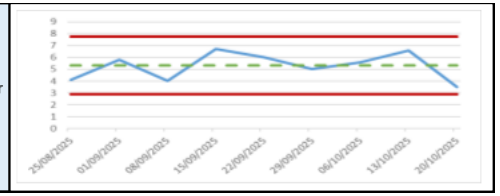
5.3 Reactive Care Performance Metrics

A&E Activity Reduction (Traffic light measured against 10 wk Avg)		Monthly Actual **170**	Target 164 10 wk Average 171 Trajectory 187	Graph Trendline for last 10 wks	

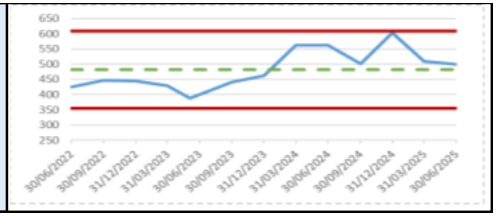
Narrative / Likely Cause	Actions to Remedy	Timeline	Accountability
10 week average is currently 171 per day with an October average of 170, seeing a month on month reduction from the winter peaks of 208 per day.	Expansion of UCR is to be expanded along with the launch of the co-ordination hub, mobile diagnostics and the implementation of the new Lighthouse diversion from Oct 25.	Phased Rollout from Q3 25/26	SRO Reactive Care

No Criteria to Reside Reduction (Traffic light measured against 10 wk Avg)		Monthly Actual **43**	Target 34 10 wk Average 45 Trajectory	Graph Trendline for last 10 wks	

Narrative / Likely Cause	Actions to Remedy	Timeline	Accountability
NC2R is an avg of 43 in month, with a 10 week avg of 45 (11 above the target). Drivers include: Discharge bottlenecks particularly P2, referral process delays across all Pathways, Family choice Delays.	8 week delivery plan has been developed and went live on the 13th October. Since the beginning of November we have seen averages of 35 per day compared to 43 during October	Choice policy live Nov 25, 8 Week Delivery Plan Sept - Oct	SRO Reactive Care

Discharge Pathway Delays (P1) (Traffic light measured against 10 wk Avg)		Monthly Actual **2.4**	Target 2 10 wk Average 1.6 Trajectory	Graph Trendline for last 10 wks	
Discharge Pathway Delays (P2) (Traffic light measured against 10 wk Avg)		Monthly Actual **11.1**	Target 5 10 wk Average 8.9 Trajectory	Graph Trendline for last 10 wks	
Discharge Pathway Delays (P3) (Traffic light measured against 10 wk Avg)		Monthly Actual	Target 7 10 wk Average 5.3 Trajectory	Graph Trendline for last 10 wks	

Narrative / Likely Cause	Actions to Remedy	Timeline	Accountability
Overall we are meeting the discharge delay targets for P1 and P3 patients. But not meeting the target for P2 patients. Bottlenecks especially in the time to place P2 patients, with referral process delays across all pathways (D2A, District Nursing, Family Choice delays, Capacity constraints) and longer than expected LOS in community led services.	8 week Delivery Plan has been developed and went live on the 13th October. Integrated Bridging care and therapy D2A P1 services in place by December 2025	Phased Rollout from Q3 25/26	SRO Reactive Care

Reduce Rate of unplanned adms from Care Homes per 100k pop >65		Quarterly Actual **500**	Target 747.65 Yearly Average 529 Trajectory	Graph Trendline Quarters	

Narrative / Likely Cause	Actions to Remedy	Timeline	Accountability
Variable Care Home capability in managing pts who have behaviours that challenge and also recognising signs of deterioration. Not all CHs have routine Pharmacy input to ensure pts at highest risk have a medication review.	Specialist dementia support from CNWL now available to support CH with pts who have behaviours that challenge, PCN pharmacies being trained to undertake SMRs for most complex frail pts in CHs. CH being digitally enabled so they can access UCPs.	Phased Rollout from Q3 25/26	SRO Reactive Care

Reactive Care (Urgent & Crisis Response, Hospital Discharge)

5.4 Issues & Risks (Reactive Care)

- **Winter Pressures & ED Demand**

  High A&E attendances continue to place pressure on flow and reactive services. Winter surges may reverse recent gains unless community capacity and same-day alternatives remain consistently available.

- **Workforce Fragility**

  UCR, therapy, discharge teams and Lighthouse all rely on skilled staff. Any gaps—particularly in SCDMs, therapists or assessors—risk slower response times and reduced community capacity.

- **Variation in Discharge Processes**

  The system remains over-reliant on senior escalation rather than routine operational practice, leaving performance vulnerable as we move into winter. Interim senior leadership for the Integrated Discharge Team and a rapid multi-agency redesign of the discharge operating model to be implemented to ensure the improvements made to date can be stabilised, embedded and sustained through winter and beyond.

- **Scaling New Models**

  Mobile diagnostics, community IV and the Coordination Hub are early in implementation. Their full impact will depend on adoption by referrers, reliable staffing and integration across INTs and acute services.

5.5 Forward Plan (to March 2026)

Over the coming months, the Reactive Care programme will focus on fully mobilising new services, strengthening discharge pathways and expanding community alternatives to hospital. Key actions include:

1. Full Mobilisation of the Coordination Hub (Dec 2025)

- Phase 1 of the Coordination Hub will go live in December, providing **single-call access** for urgent community referrals (8am–8pm, 7 days a week).
- The Hub will coordinate UCR, crisis response and discharge support in real time, simplifying access for GPs, LAS and hospital teams.
- Planning for **Phase 2** (early 2026) will include frailty pathways, end-of-life rapid response and mental health integration, moving towards a future **24/7 model**.
- A performance update (e.g., call volumes, referral patterns, ED diversions) will be reported back to the Board once the Hub has been operational for several months.

2. Lighthouse Mental Health Crisis Expansion

- Following the December service review, capacity will increase to **10 patients at any time** to divert more people in mental health crisis away from A&E.
- CNWL will provide additional staffing and any required environmental adjustments.
- The expected impact includes fewer psychiatric breaches in ED and faster access to therapeutic support, with outcome data reported to the Board in Q4.

Reactive Care (Urgent & Crisis Response, Hospital Discharge)

5.5 Forward Plan (to March 2026)

3. Launch of an Integrated Rehabilitation & Reablement Service

- Phase 1 goes live in early December, combining Council reablement workers and NHS community therapists into a single multidisciplinary team.
- This integrated model will support faster discharge for Pathway 1 and 2 patients, ensuring seamless personal care and rehabilitation at home.
- Work through Q4 will refine the operating model, governance and weekend capacity, with the aim of enabling consistent 7-day discharges.
- Further expansion (including community rehab beds) will be explored to address Pathway 2 delays.

4. Sustain NC2R ≤34:

- Work aggressively to sustain NC2R (medically fit) inpatients at or below 34 per day through winter and beyond. This involves Interim IDT Leadership, operationalising the daily multi-agency discharge huddles, weekly system reviews, Place Gold Command, reviewing functioning of IDT, and escalating any issue early.
- By end of Q4, the aim is that Hillingdon will have a new baseline for delays significantly lower than the pre-plan baseline (e.g., ~30 instead of 48).
- Achieving this may also require commissioning of any additional step-down beds or use of spot-purchase home care if needed during winter.
- The Board's oversight in keeping this a priority will help maintain cross-partner focus

5. Expand UCR Capacity and Link to Virtual Wards

- Additional UCR staffing from January 2026 will increase 2-hour response capacity and support a strengthened **Hospital at Home** function for up to 17 days of community-based care.
- The model will be increasingly aligned with **Virtual Ward pathways**—particularly frailty and heart failure—creating community "virtual beds" managed jointly by UCR and INTs.
- By March 2026, the Coordination Hub should begin triaging appropriate patients directly into these virtual ward slots.

These actions will strengthen community-based urgent care during the winter period, support sustained reductions in NC2R delays, and reduce avoidable pressure on A&E and hospital beds. By Q4, the Board should expect to see improvements in patient flow, community recovery times and overall system resilience.

Best Start to Life (Children & Young People)

6.1 Purpose

The Best Start in Life programme aims to ensure every child in Hillingdon has the foundations for a healthy, safe and positive start. The programme focuses on:

- **Early identification and intervention:** Detecting developmental, health and wellbeing needs as early as possible (during pregnancy, infancy and early childhood) and providing timely support through the Healthy Child Programme and early years checks.
- **Integrated children's services:** Bringing together health, social care, education and voluntary services around the child and family, supported by Family Hubs and the emerging Child Health Hub model, enabling families to access multiple services in a coordinated way.
- **Preventing ill-health:** Tackling risk factors early by promoting healthy weight, good oral health, high vaccination coverage and positive mental wellbeing to reduce future problems.
- **Reducing inequalities:** Targeting support to the most vulnerable children and communities, particularly those facing deprivation or at higher risk of poor outcomes. This aligns with Core20PLUS5 priorities, which highlight immunisation, obesity, mental health, oral health and asthma as key focus areas.
- Through these priorities, Hillingdon aims to improve early years outcomes such as school readiness, healthy weight in Reception and Year 6, and longer-term health and wellbeing across the life course.

6.2 Delivery Update

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Recent progress in the Best Start in Life program include:

Child Health Hub Development

A multi-agency group met in November 2025 to begin designing **Child Health Hubs** aligned with the neighbourhood model. These hubs will provide a single, integrated point of access for paediatric clinics, developmental assessments and family support linked to Family Hubs. Partners have agreed a joint strategy and will now define the hub model and identify a prototype site.

Integrated Paediatric Clinics

Integrated paediatric clinics delivered over 130 clinics in 2024/25, supporting more than 800 children. Clinics cover common conditions such as CMPA, constipation and neonatal issues. The delivery model provides consistent access to specialist advice for children under five and supports earlier identification of developmental needs.

CYP Neighbourhood Dashboard

Work is underway on a **Children & Young People dashboard** to provide a consolidated view of key metrics by neighbourhood, including immunisations, A&E attendances for under-fives, developmental checks, school readiness, oral health and obesity. The dashboard will support improved outcome monitoring, transparency and targeted action where inequalities persist. Full development and launch are expected in 2026.

Mental Health Support Teams (MHSTs)

Hillingdon has been selected for the **Wave 14 expansion** of MHSTs, which will extend provision to an estimated **~80% of schools** from January 2026 (up from ~60%). MHSTs provide early support for children with mild-to-moderate mental health needs and play a vital role in reducing escalation into specialist CAMHS service

Best Start to Life (Children & Young People)

6.2 Delivery Update

Family Hubs Integration

Child Health Hub planning is being aligned with the Family Hub network to avoid duplication and ensure parents receive joined-up support. Family Hubs already provide parenting programmes, health visitor clinics and early years support. The work now focuses on linking new paediatric pathways to existing community assets for maximum reach.

Neurodevelopmental Pathways

Demand for neurodevelopmental assessment has increased significantly, and Hillingdon currently has just under **2,000 children** awaiting assessment. Additional NWL investment for 2025/26 will enable around **50%** of these children to be assessed. CNWL is redesigning pathways—using digital tools and streamlined clinical processes—to increase productivity and reduce waiting times.

6.3 Metrics & Performance (CYP Outcomes)

Key outcome measures for Best Start in Life are being consolidated into the new Children & Young People (CYP) dashboard. Current headline metrics include :

Neurodevelopmental Waiting Times

- As of October 2025, **~1,980 children** are waiting for a neurodevelopmental assessment.
- Additional NWL investment is expected to **halve the waiting list by mid-2026** (towards ~1,000).
- A major aim is to reduce the **maximum waiting time to under 12 months** by year-end, monitored through monthly assessment activity and throughput.

Mental Health Support Teams (MHSTs) in Schools

- MHSTs currently cover ~60% of schools.
- With the Wave 14 expansion starting January 2026, coverage is projected to reach ~80% of schools by Q4.
- Performance will track: number of schools supported, pupils reached, and uptake of interventions (individual support, groups, workshops).

Early Years Outcomes

- Two priority indicators—school readiness and children's oral health—show room for improvement and are central to Best Start priorities.
- Data for school readiness, immunisations, dental access and oral health prevalence will be incorporated into the CYP dashboard.
- The Children's Oral Health pilot is expected to improve the % of under-5s attending a dentist annually, particularly in high-need areas.
- Childhood obesity (Reception and Year 6) will be monitored as a key long-term prevention measure.

Service Utilisation and Preventative Reach

- The dashboard will monitor uptake of Health Visitor reviews (new birth visit, 2–2½ year checks), immunisation coverage (including MMR), and A&E attendances for under-5s.
- These metrics provide insight into access, prevention, and parental support.
- The intention is to introduce an overall Best Start RAG rating in future reports to show progress and highlight areas requiring targeted action

Best Start to Life (Children & Young People)

6.4 Forward Plan (up to March 2026)

Upcoming priorities for Best Start in Life focus on strengthening early years services, improving children's health outcomes and embedding integrated models of support across Hillingdon.

- **Launch CYP Dashboard:** Finalise and roll out the **Children & Young People Neighbourhood Dashboard** by the next Board meeting. This will provide a baseline and regular reporting on key metrics (health and development indicators), enabling the Board to track progress in real time. It will also highlight any locality-based disparities so resources can be targeted accordingly.
- **Prototype Child Health Hub:** By Q4 2025/26, aim to **establish a prototype Child Health Hub** in one locality. This could involve co-locating a few services (e.g. a paediatrician or paediatric nurse practitioner working alongside a Family Hub team on specific days). The learnings from this prototype will inform the wider rollout. The prototype will focus on integrative care for issues like asthma, obesity, and developmental concerns in a community setting, testing the hub model in practice.
- **Enhance Community Paediatrics & Support Services:** Utilising recent investments:
    - Bring the **new Special School Nursing post** on board permanently (recruitment by early 2026) to support children with medical needs in special schools.
    - Deploy the **Wave 14 MHST** effectively in Jan 2026, ensuring it quickly engages with its allocated schools and starts caseloads (the goal is to start seeing students within weeks of launch, given existing demand).
    - Continue **neurodevelopmental assessments** through late 2025 and into 2026 to hit the target of 50% backlog reduction. By spring 2026, evaluate the outcome – e.g. how much the wait times have improved – and develop a sustainability plan for 2026/27.
- **Stronger Links with Family Hubs and Early Years:** Formalise pathways between **maternity/early years services and Family Hubs**. For example, when health visitors identify families in need, ensure warm handovers to parenting support at Family Hubs, and vice versa. In Q3–Q4, a plan will be developed to integrate health visiting data and Family Hub outreach efforts so that no families "drop off" after initial contacts. Also, tie the oral health and nutrition initiatives into the Family Hub network for broader reach. By having health, education, and social care speak with one voice in Family Hubs, the support for families (especially in the crucial 0-5 age range) will be more comprehensive.
- **Upcoming Initiatives:** Hillingdon is preparing for **Wave 15+ of MHST** (to eventually reach 100% schools), and exploring participation in any new national pilots (e.g. early language development programs). Additionally, discussions are underway about improving transitions for young people (e.g. moving from children to adult mental health services, or preparing those with long-term conditions for adult care). Plans to strengthen transition support by 17-18 years old will be considered as part of the "Start Well" to "Live Well" continuum. The Board will be updated on these in subsequent reports.

Cross-Cutting System Risks & Mitigations

7.1 Cross-Cutting System Risks and Mitigations

This section summarizes **system-wide risks** that span multiple programmes (Neighbourhoods, Reactive Care, Best Start) and their mitigation strategies:

High ED Attendances: Emergency Department visits remain above target, risking overcrowding and missed performance standards.

- **Impact:** Strains hospital resources, increases wait times, and could lead to poorer outcomes if patients aren't seen timely.
- **Likelihood:** High, given underlying demand and winter season.
- **Mitigation:** Strengthen alternatives to ED – e.g. *Front Door Diversion* strategies such as **GP direct-to-SDEC pathways** and **Pharmacy First referrals** to handle minor cases. The **UCR 2-hour crisis response** and **Lighthouse** mental health diversion reduce unnecessary A&E arrivals. Continued public messaging to use 111 and community services for non-critical needs (including 24/7 urgent dental care via 111) also supports this. The new Coordination Hub will play a role by directing referrers to appropriate community options, further easing ED burden.

NC2R (No Criteria to Reside) Relapses: After intensive effort, NC2R (delayed discharges) numbers have dropped to ~35, but could rise again without sustained focus.

- **Impact:** High – rising NC2R leads to bed shortages, and ED backups (when wards are full).
- **Likelihood:** Moderate; risk increases if winter capacity is strained or if processes slip.
- **Mitigation: Embed the discharge improvement measures** as business-as-usual: daily multi-agency discharge huddles, a and strict escalation according to the **NC2R SOP**. The Place "Gold" command structure will continue oversight through winter to quickly resolve blockages. In addition, new community capacity (through integrated reablement and bridging care) coming online in Dec 2025 will help absorb more discharges promptly. Maintaining NC2R ≤34 is a key success criterion, and any upward trend will trigger a rapid response by the system resilience group

Workforce Constraints: Across the system, recruiting and retaining skilled staff is a concern.

- **Impact:** If key roles are unfilled (e.g. community nurses, care coordinators, GPs, therapists, psychologists), it hampers service delivery and innovation uptake. Burnout is also a risk with the current pressures.
- **Likelihood:** High in certain areas (national shortages in nursing, therapy, social care).
- **Mitigation:** A multifaceted approach – **targeted recruitment drives** (for example, NWL has funded 4 additional specialist nurses for palliative care to fill critical gaps), cross-skilling existing staff (training pharmacists and paramedics to take on expanded roles in UCR and care homes). The integration of teams also offers opportunity to better **utilise the collective workforce** – e.g., having PCN pharmacists assist with care home medication reviews, or mental health practitioners working within INTs, to spread expertise.

Cross-Cutting System Risks & Mitigations

Long-Term Condition Growth: The population is experiencing growing prevalence of chronic conditions (diabetes, heart disease, COPD, etc.), which could drive future unplanned care demand.

- **Impact:** Medium to long-term – without action, more people will present in crisis with preventable complications (strokes, heart attacks, decompensated COPD).
- **Likelihood:** High, given demographic and national trends.
- **Mitigation: Prevention and early intervention** are our main tools. The Neighbourhoods programme directly addresses this through hypertension and frailty initiatives (already showing success in reducing admissions), and the NWL Enhanced Services focus on Cardiovascular-Renal-Metabolic diseases will further help manage risk factors in primary care. Continued investment in wellness services (smoking cessation, weight management) and community engagement in healthy lifestyles (leveraging Healthy Places and Equity work) is crucial. Essentially, mitigating this risk means **continuing the "left shift" of care** – moving care into community and preventative settings – which is exactly the strategy of Live Well and Age Well interventions.

CYP Neurodevelopmental Demand: The **surge in demand for children's assessments** (autism/ADHD) remains a risk.

- **Impact:** High for those families – long waits can worsen child outcomes and parental confidence in the system. Also impacts schools managing unmet needs.
- **Likelihood:** Currently very high (referrals quadrupled nationally).
- **Mitigation:** The immediate mitigation is the **additional funding to cut the backlog by 50%**, which is being executed now. For sustained mitigation, the **pathway redesign with digital tools** is key to increase throughput with existing resources. Also, exploring early support for children with possible neurodevelopmental issues *before* diagnosis (so needs are met without waiting for formal diagnosis) can reduce urgency – for example, parenting programs or school adjustments available based on need. The ICB and CNWL will monitor if referral rates continue at the new high; if so, they may need to commission additional permanent capacity or partner with independent providers to keep waits within acceptable limits.

Winter Pressures: The winter period (Q3–Q4) brings heightened risk of simultaneous demand surges – flu, COVID-19, norovirus, and weather-related illness among frail elderly.

- **Impact:** Could spike both community and acute demand beyond planned levels, testing all services.
- **Likelihood:** High from Dec through Feb.
- **Mitigation:** A comprehensive **Winter Plan** is in place. This includes: expanding vaccination uptake (flu and COVID campaigns) to reduce illness incidence; ensuring **full use of intermediate care beds** and possibly opening contingency beds; the Reactive Care Hub coordinating closely with London Ambulance Service for any surge (e.g. redirecting appropriate 999 calls to UCR); **weekend working expansions** (the End of Life care investment provided for weekend specialist cover, which can help manage palliative patients who might otherwise call 999); and **emergency respite schemes** via social care for times of extreme cold or workforce shortages. Additionally, the **ED front-door in-reach by community teams** is being strengthened (e.g. a community matron or palliative nurse in ED to pull patients out to community care faster). These combined actions are designed to mitigate the worst impacts of winter. The Board should note that if an exceptionally severe winter occurs, regional resources may be called upon as well.

Appendices

Appendix 1: Investments Summary

Investment Area	New Funding / Initiatives (2025/26)	Expected Outcomes and Impact
Urgent Community Response & "Hospital at Home"	Additional **recurrent funding** for UCR expansion. Launch of a new Hospital at Home model (from Jan 2026) supporting patients for up to 17 days after urgent crisis	➢ **Increased UCR capacity** to reach patients within 2h and manage more cases at home (avoiding A&E/admissions). ➢ **Hospital at Home** will provide acute-level care in domiciliary settings for 3–17 days, reducing length of hospital stay and readmissions.
"Lighthouse" Mental Health Crisis Hub	Service model enhancement behind A&E – capacity raised from 4 to **6 patients** (Nov 2025), with further expansion to **8–10 patients** from 17 Dec 2025	➢ More **mental health patients diverted from A&E** to a therapeutic setting, cutting A&E waits and crowding. ➢ Patients in crisis receive timely specialist care, improving outcomes and experience.
MHST in Schools (Wave 14)	Funding and approval for an **additional MHST** team in Hillingdon starting Jan 2026 (previous coverage ~60% of schools).	➢ **Expanded mental health support in schools** to ~80% coverage, allowing earlier help for children with mild/moderate issues. ➢ Expected reduction in severe cases over time and reduced CAMHS waiting lists due to early intervention.
Children's Neurodevelopmental Assessments	**Non-recurrent funding** in Oct 2025 to tackle backlog – will cover ~**50% of ~2,000 waiting children**. Plus pathway redesign (digital tools) by CNWL to improve efficiency.	➢ **~1,000 extra children assessed** in 2025/26, halving the waiting list and significantly shortening wait times (many from 2 years to <1 year). ➢ **Modernised assessment process** (e.g. some virtual elements) enabling sustained higher throughput and a more manageable service going forward.
SEND – Special School Nursing	**Recurrent funding** for 1 additional special school nurse post (bank staff in place as of Oct 2025 while permanent hire is made).	➢ **Improved medical support in special schools** – lower caseload per nurse, allowing more timely interventions for children with complex needs. ➢ Enhanced training and capacity in schools, potentially reducing emergency incidents and supporting inclusion.
Community Dental Services (Access & Prevention)	**Expanded NHS Dental Capacity:** Commissioned 14 practices in high-need areas for extra appointments. **Children's Oral Health Pilot:** Launched Oct 2025 in Family Hub areas. **Inclusion Dental Pilot:** New service for vulnerable groups (homeless, refugees). **24/7 Urgent Dental Access:** via NHS 111 for emergencies.	➢ **More routine dental slots** for residents in underserved communities, reducing waiting times for NHS dental care. ➢ **Improved oral health in children**: increased dental attendance among under-16s in pilot areas, early prevention of tooth decay. ➢ **Dental care for vulnerable individuals** leading to fewer dental issues escalating to A&E or acute pain situations. ➢ 24/7 urgent access ensures emergencies get prompt treatment and reassure patients to avoid A&E for dental needs.
End of Life Care (Community)	**£1.7 million recurrent investment** into community specialist palliative care and hospice support. Includes hiring **4 additional specialist nurses**, funding extra Hospice@Home capacity, weekend coverage, and developing ED in-reach model.	➢ **Expanded palliative care team** to support patients at home, aiming to prevent unnecessary end-of-life hospital admissions and to honour patient preferences. ➢ **Sustainability of local Hospice** services ensured, preserving this critical resource for the community. ➢ **7-day service coverage** in palliative care, meaning symptom crises can be managed out-of-hours, and potential to support patients in A&E so they can be discharged to home or hospice sooner.

Appendix 2: Neighbourhoods (Live Well & Age Well)

3.4 Neighbourhood Performance Metrics – PCN Enhanced Service Delivery

Primary Care Network/ Borough	DIABETES LEVEL 1						NON DIABETIC HYPERGLYCAEMIA			
		CURRENT ACHIEVEMENT						CURRENT ACHIEVEMENT		
	Diabetes Register (Aug-25)	% 9 Key Care Process in last 15m	% HbA1c, BP, Non HDL Cholesterol	% Diagnosed in last 2 years HbA1c <= 48 in last 15m	% Mental Health Screening in last 15m	% Care Plans completed in last 15m	Non Diabetic Hyperglycaemia Register (Aug-25)	% patients with NDH diagnosis in last 5 years who go onto develop T2DM	% Starting NHS Diabetes Prevention Programme in last 15m	% Annual Review in last 15m
50% TARGET ACHIEVEMENT		55.0%	29.0%	40.0%	60.0%	50.0%		<40.0%	3.5%	50.0%
100% TARGET ACHIEVEMENT		65.0%	35.0%	50.0%	70.0%	60.0%		<30.0%	5.5%	60.0%
HILLINGDON	23,960	69.3%	36.6%	38.8%	82.1%	77.6%	35,816	3.0%	5.9%	66.9%
CELANDINE HEALTH AND METROCARE PCN	3,773	67.2%	37.6%	34.3%	82.4%	78.2%	6,997	2.2%	7.2%	62.9%
COLNE UNION PCN	3,427	69.1%	33.9%	41.4%	78.6%	69.0%	6,098	3.0%	5.7%	70.2%
HH COLLABORATIVE	7,011	71.2%	34.3%	39.6%	81.6%	78.5%	8,475	3.4%	5.6%	66.4%
LONG LANE FIRST CARE GROUP PCN	3,461	72.0%	37.6%	35.5%	87.4%	86.6%	4,753	3.4%	5.9%	68.1%
NORTH CONNECT	3,782	67.5%	42.1%	42.6%	77.7%	76.6%	5,556	3.4%	6.2%	62.2%
SYNERGY	2,506	66.9%	35.9%	37.9%	87.2%	75.1%	3,937	2.6%	4.8%	74.2%

Enhanced service for diabetes

- As of Month 5, 3 PCNs have achieved all bar 1 of the performance metrics for Diabetes L1.
- 5 PCNs have met the performance metrics for the NDH service – excellent performance so far for 25/26.

					Continuity Audit: Review of a 10% sample of the identified population (Nov-25 - Jan-26) *Continuity flag for at least 2% of the patient list is in place*				
	Borough	PCN Code	PCN Name		Date subm	RAG	Notes	Continuity flag (≥2%)	Jan-26
	HILLINGD	U35513	CELADINE HEALTH & METROCARE PCN					1.40%	
		U36510	COLNE UNION PCN					0.40%	
		U51498	HH COLLABORATIVE PCN					1.70%	
		U91930	LONG LANE FIRST CARE GROUP PCN					2.60%	
		U07392	NORTH CONNECT PCN					2.10%	
		U51930	SYNERGY PCN					1.90%	

Continuity Audit

- Date of extraction: 01/09/2025
- As of Month 6, 2 PCNs demonstrate to be meeting the 2% metric target.

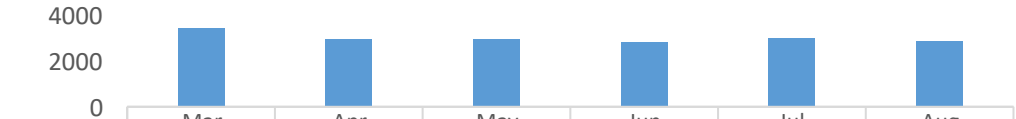
Appendix 3: Neighbourhoods (Live Well & Age Well)

3.4 Neighbourhood Performance Metrics – Pharmacy First Delivery (first 6 months of 2025/26)

The data shows that in a 6mth period over 18,000 Pharmacy 1st consultations took place, with over 3,000 referrals taking place (17% conversion rate). The majority of which were for minor illness.

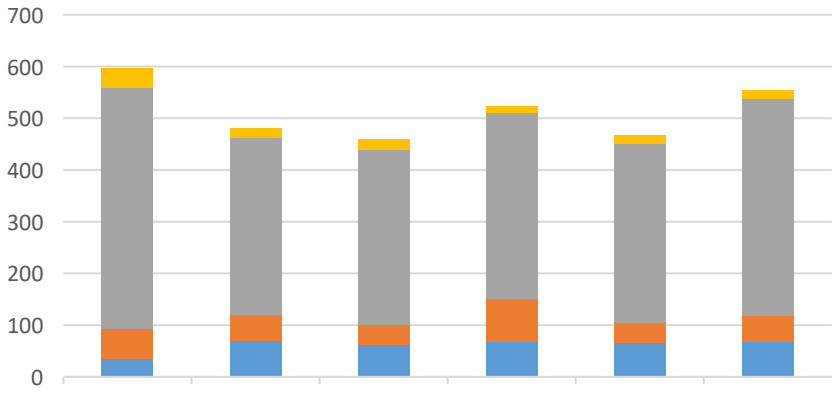
The most common condition is Acute sore throat, followed by uncomplicated UTI then Sinusitis

Pharmacy first consultations March- August 2025



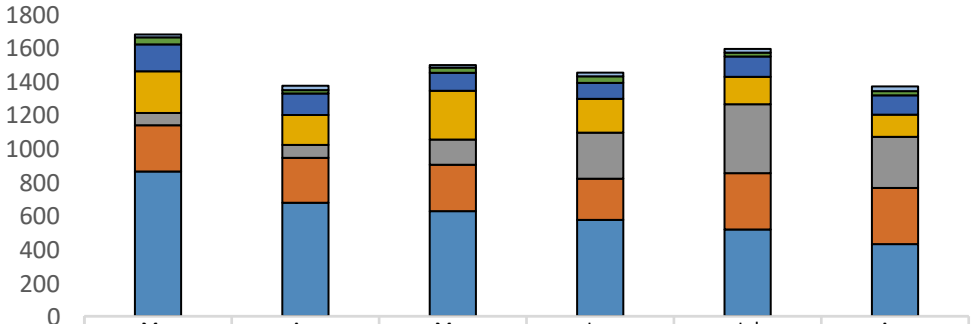
	Mar	Apr	May	Jun	Jul	Aug
Hillingdon	3419	2975	2973	2832	2980	2861

Pharmacy first referrals April- September 2025



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Referrals from THH	37	19	21	13	17	16
Minor Illness Referal	467	342	338	359	346	420
Clinical Pathways Consultation	58	49	37	83	40	50
Urgent Medicine Supply	34	70	63	68	65	68

Seven clinical conditions breakdown March- August 2025



	Mar	Apr	May	Jun	Jul	Aug
Shingles	17	26	15	22	22	28
Impetigo	42	20	31	39	23	25
Acute Otitis Media	160	128	107	95	121	115
Sinusitis	248	178	290	201	163	132
Infected Insect Bites	73	77	150	274	410	304
Uncomplicated UTI	275	267	276	245	335	334
Acute Sore Throat	861	675	625	573	516	429

DRAFT JOINT HEALTH AND WELLBEING STRATEGY, 2026 - 2031

Relevant Board Member(s)	Keith Spencer – Co-chair/Managing Director, Hillingdon Health and Care Partners Sandra Taylor – Corporate Director, Adult Social Care and Health
Organisation	London Borough of Hillingdon
Report author	Sharon Stoltz – Adult Social Care and Health Directorate, LBH Gary Collier - Adult Social Care and Health Directorate, LBH Keith Spencer – Hillingdon Health and Care Partners
Papers with report	Appendix 1 – Draft Joint Health and Wellbeing Strategy, 2026 - 2031

HEADLINE INFORMATION

Summary	This report presents the draft Joint Health & Wellbeing Strategy 2026–2031 for review and approval for public engagement. The strategy has been developed by Hillingdon Health and Care Partnership (HHCP) on behalf of the Health and Wellbeing Board and reflects extensive input from system partners.
Contribution to plans and strategies	The Health and Wellbeing Strategy is the overarching strategy that sets out partner ambitions to support the health and wellbeing needs of the Hillingdon Place.
Financial Cost	There are no direct cost implications from this report.
Ward(s) affected	All

RECOMMENDATION

That the Health and Wellbeing Board approves the draft Joint Health and Wellbeing Strategy for public and stakeholder engagement.

BACKGROUND

1. The Board has a statutory duty under the Health and Social Care Act, 2012 to produce a Joint Health & Wellbeing Strategy. This draft attached as **Appendix 1** is intended to replace the 2022 – 2025 Health and Wellbeing Strategy and represents the first fully integrated, life-course strategy for Hillingdon and aligns local ambitions with the North West London Integrated Care Strategy and the Hillingdon Place Operating Model.

2. The strategy responds to rising demand, widening inequalities and the requirements associated with the new Hillingdon Hospital. It is also the primary document for borough-wide resident and stakeholder engagement.

Summary of the Strategy

3. The strategy sets a shared vision for a **fairer, healthier, more integrated Hillingdon** and is structured around the four life-course outcomes:
   - Best Start in Life
   - Live Well
   - Age Well
   - Healthy Places

4. Each life-course section sets out a small number of priorities; clear outcome measures and the actions partners will take collectively. Seven high-impact programmes are identified, including neighbourhood proactive care, hypertension detection, mental health early intervention, frailty and falls, and reducing No Criteria to Reside.

5. Delivery is underpinned by Hillingdon's **Place Operating Model**, centred on:
   - Three Integrated Neighbourhood Teams, supported by Local Access Hubs
   - Family Hubs
   - A Borough-wide Reactive Care Service
   - The new Hillingdon Hospital, linked seamlessly into community provision

Engagement

6. This draft will form the basis of the public and partner engagement process, running January–February 2026. Engagement will be delivered through neighbourhood workshops, Family Hubs, community groups, online tools and targeted outreach in areas with the greatest inequalities. A plain-English version and translated summaries will be produced.

Hillingdon Joint Health and Wellbeing Strategy 2026–2031

Executive Summary

Hillingdon's Joint Health and Wellbeing Strategy sets out our shared ambition to improve health, reduce inequalities and support all residents to live well from childhood through to older age. It has been developed by Hillingdon Health and Care Partnership (HHCP) on behalf of the Health and Wellbeing Board, bringing together the Council, the NHS, Primary Care, Family Hubs, the voluntary and community sector and wider partners.

Hillingdon faces significant and growing challenges. Demand for urgent and emergency care is rising, mental health (MH) needs have increased, long-term conditions are more common, and too many residents experience poor health earlier in life. Inequalities are particularly concentrated in parts of Hayes, Yiewsley and West Drayton, where outcomes are consistently worse across childhood development, long-term conditions, and economic resilience. At the same time, the delivery of the new Hillingdon Hospital requires sustained improvement in discharge, a reduction in avoidable admissions, and a shift towards more proactive and preventative care delivered in the community.

To meet these challenges, partners in Hillingdon have agreed a shared vision:

to create a fairer, healthier borough where people of all ages can live well, stay well and age well.

The strategy is structured around the life course—**Best Start in Life, Live Well, Age Well and Healthy Places—**reflecting our ambition to focus on prevention and early intervention at every stage. Within each life-course stage we identify a small number of priorities, the outcomes we aim to achieve, and the actions partners will take together. These priorities have been chosen because they will have the biggest impact on improving outcomes, reducing inequalities and supporting the sustainability of the new hospital.

Delivering this strategy requires services to be organised differently**. Hillingdon's Place Operating Model** sets out how partners will work together to deliver care through:

- **Three Integrated Neighbourhood Teams** (INTs) aligned to primary care and supported by Local Access Hubs providing urgent, planned, community and diagnostic care closer to home.
- **Family Hubs** delivering integrated early years, parenting, SEND and CYP mental health support aligned to neighbourhoods.
- **A Borough-wide Reactive Care Service** providing urgent community response, Hospital at Home, integrated discharge and mobile diagnostics.
- **A new Hillingdon Hospital,** delivering modern acute and specialist services linked seamlessly to community-based care.

This integrated neighbourhood model will enable earlier intervention, reduce avoidable hospital attendances and admissions, shorten length of stay, support safe discharge and strengthen independence and wellbeing in the community.

This draft strategy is also being used as the primary vehicle for engagement with residents, service users, carers and voluntary and community partners. Their insights will help shape the final version of the strategy before approval by the Health and Wellbeing Board.

What success will look like

By 2031 we will see:

- ✓ More children achieving a good level of development and improved school readiness
- ✓ Reduced inequalities in early childhood outcomes, immunisation, obesity, dental health and long-term conditions.
- ✓ Earlier detection and better management of hypertension, diabetes and frailty
- ✓ Improved emotional wellbeing and mental health support for children, young people and adults.
- ✓ Fewer avoidable emergency attendances and unplanned admissions to hospital
- ✓ Faster, safer discharge and sustained performance on “No Criteria to Reside”
- ✓ More older adults supported to remain independent at home
- ✓ Stronger neighbourhoods, improved housing stability and reduced homelessness
- ✓ A clearer, more consistent experience of joined-up local services

Next Steps

Feedback from residents, partners and elected members will shape the final strategy. **Their feedback will directly inform the final priorities, delivery plans and outcomes framework**. A detailed Place Delivery Plan and outcomes framework will be developed to support implementation, with oversight from the Health and Wellbeing Board and HHCP.

1. Introduction and Purpose

The **Health and Wellbeing Board** has a statutory responsibility to produce a Joint Health and Wellbeing Strategy for Hillingdon. This strategy sets the overarching framework for improving health and wellbeing across the borough between 2026 and 2031.

It has been developed by **Hillingdon Health and Care Partnership (HHCP**), the borough’s Place-Based Partnership within the North West London Integrated Care System. HHCP brings together the Council, NHS organisations, Primary Care Networks, Family Hubs, the voluntary and community sector, schools, housing and wider local partners to plan and deliver integrated care. The strategy aligns with the North West London Integrated Care Strategy and reflects the shared priorities of partners across Hillingdon.

This document is intentionally published in **draft form** to act as the primary vehicle for engagement with residents, service users, carers, community organisations and frontline staff. Over the coming months, we will use this draft to test our priorities, assess whether the proposed outcomes reflect local experiences, and gather feedback on the Place Operating Model and the changes it proposes. Engagement will take place through neighbourhood-based workshops, Family Hubs, community organisations, online surveys and targeted outreach in areas experiencing the greatest inequalities.

To support broad and inclusive participation, **a plain English and accessible version will also be produced,** along with **a shorter public-facing summary** for wider engagement. Translated versions of the public summary will be available in the most commonly spoken community languages in Hillingdon to ensure meaningful participation from residents whose first language is not English.

Feedback gathered through this engagement programme will directly shape the final Joint Health and Wellbeing Strategy. The refined strategy, together with a summary of consultation

findings, will be presented to the Health and Wellbeing Board for approval in March 2026. A full Equality Impact Assessment (EQIA) will be undertaken alongside the consultation process and completed before the final strategy is presented for approval.

The strategy is structured around a clear life-course framework—**Best Start in Life, Live Well, Age Well and Healthy Places**—reflecting our shared ambition to focus on prevention, intervene early and address inequalities at every stage of life. It begins with our vision, an assessment of population needs and the case for change, before setting out the key outcomes and priorities for each life-course stage. The strategy then describes how these outcomes will be delivered through Hillingdon's **Place Operating Model**, including **Integrated Neighbourhood Teams, Local Access Hubs, Family Hubs and the Borough-wide Reactive Care Service**, supported by enabling work on workforce, digital, estates, data and community partnerships. Finally, the strategy outlines the financial framework, governance arrangements and performance approach that will support delivery and provide accountability through the Health and Wellbeing Board.

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2. Strategic Vision

Our shared vision is:

By 2031, residents in Hillingdon will live healthy, happy lives connected to their communities and be enabled to reach their full potential.

This vision is underpinned by three core ambitions:

1. **A Fairer Hillingdon** – where the gap in health outcomes between our most and least advantaged communities is narrowed, and where those facing the greatest barriers receive the greatest support.
2. **A Preventative Hillingdon** – where we focus on early help, prevention and proactive care, delaying or avoiding the need for hospital and long-term care wherever possible.
3. **An Integrated Hillingdon** – where services are organised around people and communities rather than organisational boundaries, and care is coordinated through integrated neighbourhood teams and family hubs.

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3. Hillingdon – Place and People

Hillingdon is the second largest London borough by area, spanning around 42 square miles. It includes a mix of suburban, urban and semi-rural environments, with significant transport infrastructure and Heathrow Airport in the south, and more affluent suburbs to the north of the A40.

The borough is home to:

- **Diverse communities**, with around half of residents from Black, Asian or minority ethnic backgrounds.
- **Pockets of significant deprivation** in the south of the borough (Hayes, Yiewsley, West Drayton, Harefield) alongside more affluent areas in the north.
- **A growing population of older adults**, with rising frailty and care needs.
- **A younger population in parts of Hayes and West Drayton**, with higher birth rates, child poverty and housing pressures.

Understanding this diversity – by **locality, ward, neighbourhood and population group using**

population health management tools – is central to this strategy. The Place Operating Model and Integrated Neighbourhood Teams are intentionally structured to align with this geography.

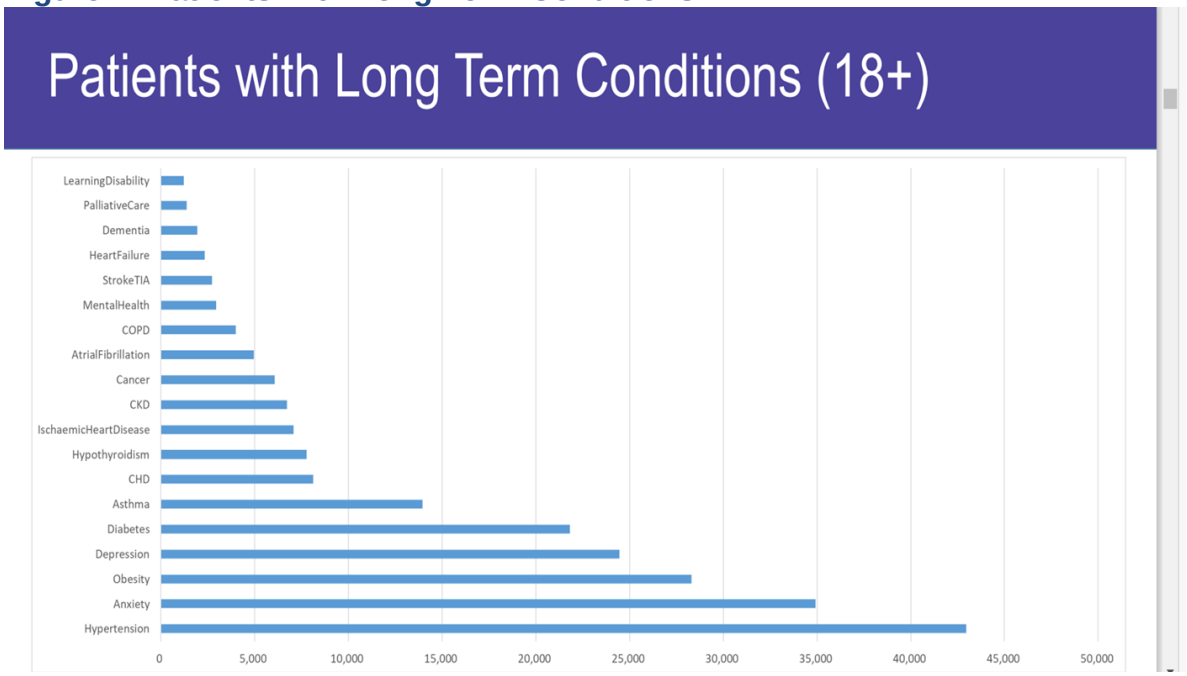
4. Population Needs and Case for Change

4.1 Rising Long-Term Conditions and Complexity

Nearly 48% of adults in Hillingdon now live with one or more long-term conditions (LTCs), such as hypertension, diabetes, obesity, chronic respiratory disease, anxiety and depression. The number of people living with multiple LTCs has doubled since 2017. LTCs are more common and more severe in our most deprived communities, contributing to earlier onset of illness and shorter healthy life expectancy.

A small cohort of approximately 4,400 adults (around 1.6% of the adult population) account for 50% of all non-elective episodes at The Hillingdon Hospital. These are often people with multiple LTCs, frailty, mental health issues and complex social needs.

Figure 1: Patients with Long Term Conditions



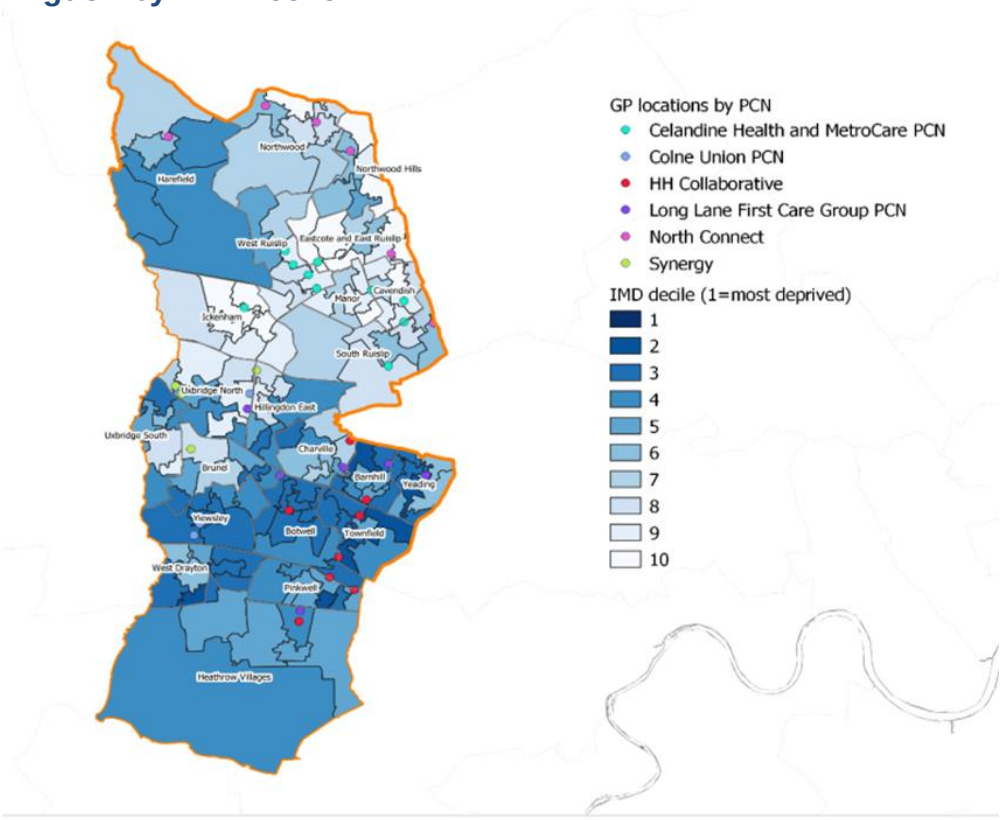
4.2 Inequalities and Wider Determinants

The **Core20PLUS5** framework and the NWL Shared Needs Assessment highlight that:

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

The strategy therefore emphasises action in these neighbourhoods and for these groups, aligning with the **"Core20"** and **"PLUS"** elements of Core20PLUS5.

Figure 2: Hillingdon by IMD Decile



4.3 Children and Young People

Children and families face multiple, interlinked challenges:

- Higher rates of child poverty and overcrowding in the south of the borough
- Variation in outcomes such as school readiness, childhood obesity and oral health
- Asthma as a leading cause of unplanned paediatric admissions
- Growing demand for support with emotional wellbeing, mental health and neurodevelopmental needs
- Increased complexity of Special Educational Needs and Disabilities (SEND)

Without earlier and more integrated support, these challenges persist into adulthood and drive long-term demand on health, care, education and criminal justice systems.

4.4 Ageing and Frailty

The population aged 65+ and 80+ is projected to grow significantly by 2031. Older residents account for a disproportionate share of healthcare and social care use, particularly unplanned hospital care and long-term care home placements.

Frailty, falls, dementia and social isolation are key drivers of hospital admissions, delayed discharges, and demand for long-term care. Many older residents could remain independent for longer with earlier identification and tailored support delivered in neighbourhoods.

4.5 Fragmented Services and Workforce Pressures

Historic commissioning has created a “patchwork quilt” of around 170 separate service lines across health and care. Services often operate with different referral routes, hours and criteria, making navigation difficult and contributing to duplication and gaps.

At the same time, Hillingdon has an ageing primary care and community nursing workforce, shortages in key roles, difficulties with recruitment and retention, and limited flexibility in how staff are deployed across organisational boundaries.

4.6 New Hillingdon Hospital Redevelopment

The new hospital offers a major opportunity but comes with clear assumptions:

- Reduced reliance on inpatient beds
- Shorter length of stay
- Fewer avoidable admissions
- Lower ED attendances and sustained improvements in flow

Without a fundamental shift in how care is delivered at Place and neighbourhood level, these assumptions will not be met, and the system will not be sustainable.

4.7 Why We Must Change

These factors create a compelling case for change:

- **To improve outcomes and quality of life**
- **To reduce inequalities**
- **To ensure financial and operational sustainability**
- **To enable the successful delivery of the new hospital model**

This strategy, and the new Place Operating Model, set out our collective response.

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5. Our Strategic Framework: Principles and Approach

Six principles shape this strategy and our new Place Operating Model.

5.1 Equity and Inclusion

We will use **population health management** (PHM) and the **Core20PLUS5** framework to focus resources where they are needed most, including:

- The most deprived neighbourhoods: **Hayes, Yiewsley, West Drayton and Harefield**
- Marginalised groups (e.g. people with severe mental illness, people experiencing homelessness, some migrant communities, people with multiple disadvantage)
- People with particular clinical risks (e.g. hypertension, respiratory disease, cancer, perinatal mental health)

We will work actively with communities to understand barriers to access and co-design solutions.

5.2 Community Co-production and Voice

Residents, carers and communities will be involved in shaping services through:
- Co-produced service redesign within neighbourhoods
- Patient and carer forums linked to each Integrated Neighbourhood
- Engagement via Family Hubs, schools, VCSE organisations and community groups
- Collaboration with Healthwatch Hillingdon

We will prioritise the voice of seldom-heard groups and those with lived experience of inequality and disadvantage.

5.3 Life-Course Approach

We will structure our work across four outcomes:
- **Best Start in Life** – supporting pregnancy, early years, childhood and youth
- **Live Well** – supporting adults of working age
- **Age Well** – supporting older adults and those approaching the end of life
- **Healthy Places** – addressing the physical and social environments that shape health

This ensures continuity of support over time and coordinated action across sectors.

5.4 Prevention and Early Intervention

We will move from reactive to proactive models of care by:
- Investing in early years and Family Hubs
- Using population data to identify people at rising risk
- Providing anticipatory and proactive support for frailty and long-term conditions
- Strengthening mental health early intervention and community support
- Preventing crises that result in emergency admissions or long-term care placement

5.5 Integrated Neighbourhood Delivery

Care in Hillingdon will be organised around three Integrated Neighbourhoods, each served by a co-located Integrated Neighbourhood Team (INT) and supported by a Local Access Hub providing proactive, multidisciplinary urgent, planned, community and diagnostic services closer to home.

The three Hillingdon Neighbourhoods are:
- **North:** covering Ruislip, Northwood, Harefield and Ickenham
- **South West:** covering Uxbridge, Yiewsley and West Drayton
- **South East:** covering Hayes and Harlington

Together, these Neighbourhoods will form the foundation of our population-based model of care, enabling earlier intervention, improved access and more integrated support across local communities.

Each INT will bring together:
- GPs and primary care teams
- Community nursing
- Adult social care
- Community mental health services

- Allied health professionals and therapies
- Mobile diagnostic teams
- Selected acute outpatient services
- Voluntary and community sector partners
- Family Hubs, paediatrics and children's services (through strong operational links)

5.6 Shared Leadership, Accountability and Resources

We will:
- Develop integrated leadership for INTs and the Reactive Care Service
- Progress pooled budgets and shared risk arrangements where appropriate (e.g. through Section 75 agreements)
- Establish a clear Place governance architecture with the HWB at its apex
- Use shared data, dashboards and outcomes frameworks to identify, risk stratify and monitor progress

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6. Delivering Outcomes Across the Life Course

Improving outcomes requires a coordinated, prevention-focused approach across the life course. By organising care through our Integrated Neighbourhood Teams (INTs) incorporating Local Access Hubs, Family Hubs and the Borough-wide Reactive Care Service, we will improve health, independence and wellbeing for all residents. **The following priorities set out the key actions and measurable improvements we will deliver.**

6.1 Best Start in Life
6.1.1 Early Years (0–5)

Ambition: Children are born healthy, families are well supported, and early development lays strong foundations for lifelong health and wellbeing. Family Hubs provide the central early years offer & work in close partnership with INTs, ensuring that families—particularly those with higher or more complex needs receive seamless, coordinated support from pregnancy through early years.

Priority BSIL1: Improve maternal health and reduce maternity inequalities

Why this matters: Maternal health and smoking in pregnancy are major determinants of lifelong outcomes, with clear inequalities across neighbourhoods.

Actions:
1. Provide targeted and culturally tailored maternity support in the most deprived neighbourhoods.
2. Strengthen smoking cessation in pregnancy via opt-out referral and neighbourhood-based support.
3. Improve access to antenatal education, healthy pregnancy pathways and early postnatal support.

Delivery Measures:
- Reduce Smoking at time of delivery (SATOD) to ≤3% (Hillingdon Baseline: 3.3-3.4%)

- Reduce neighbourhood variation in stillbirth and neonatal mortality by 20% by 2030. (Hillingdon Baseline 3.9 per 1,000)
- Increase personalised maternity pathway access for Black, Asian and deprived women. (Core20PLUS5)
- Increase the % of infants totally or partially breastfed at 6-8 weeks (target tbc)

Priority BSIL2: Increase childhood immunisation coverage

Why this matters: Vaccination saves lives and protects against avoidable childhood illness; uptake remains below the 95% WHO standard in some neighbourhoods.

Actions:
1. Strengthen call/recall and outreach through INTs and primary care
2. Target communities with lower uptake, particularly in Hayes, Yiewsley and West Drayton
3. Expand vaccination delivery in community venues and Family Hubs.

Delivery Measures:
- Increase routine vaccination coverage from 89% to ≥95% by age 5 in every neighbourhood by 2027
- Reduce variation between neighbourhoods to within ±2% by 2027

Priority BSIL3: Improve early child development and school readiness

Why this matters: Early development predicts lifelong health, wellbeing and educational attainment; clear developmental gaps exist between disadvantaged and other children.

Actions:
1. Expand speech, language and communication (SLC) support in all neighbourhoods.
2. Strengthen HV–early years–INT links to identify needs earlier.
3. Increase access to high-quality early education, especially for disadvantaged 2-year-olds.
4. Improve parental engagement through Family Hubs and schools.

Delivery Measures:
- Increase the proportion of Children achieving a Good Level of Development (GLD) above the current baseline of 70% and increase GLD for disadvantaged children above 51.9%. by 2030
- Reduce the 19 percentage point GLD inequality gap for disadvantaged children by 20% by 2030.
- Establish a Borough wide baseline for uptake of funded early education places and Increase uptake of 2-year-old funded places by 10pp by 2030.

6.1.2 School Age (5–16)

Ambition: Children and young people are healthy, resilient and engaged in education. Young and young adult carers are identified and supported.

Priority SA1: Improve emotional wellbeing and mental health

Why this matters: Emotional wellbeing underpins attendance, behaviour, attainment and safeguarding.

Actions:
1. Expand school-based mental health support, including Mental Health Support Teams (MHSTs) and early intervention practitioners working through schools and Family Hubs.
2. Strengthen joint working between schools, CAMHS, educational psychology and INTs for earlier identification and support
3. Deliver community-based resilience and wellbeing programmes in high-need neighbourhoods.
4. Work with education providers to identify young and young adult carers and sign-post to appropriate support.

Delivery Measures:
- Increase MHST and school based mental health support coverage from 44% → 60% by 2027.
- Reduce % of pupils reporting anxiety/behavioural difficulties by 10% in targeted schools by 2028
- Reduce MH-linked persistent absence by 5percentage points by 2028.

Priority SA2: Strengthen school attendance and engagement

Why this matters: Attendance is the strongest predictor of attainment, safeguarding risk and long-term outcomes.

Actions:
1. Strengthen multi-agency attendance pathways (schools, Early Help, youth, social care).
2. Target intensive support at persistently/severely absent pupils.
3. Improve health–education pathways for pupils with LTHC, anxiety or neurodiversity.

Delivery Measures:
- Reduce persistent absence by 3pp by 2028. Hillingdon Baseline above the national rate (21.2%)
- Reduce fixed-term exclusions in highest-need schools by 20% by 2030 (following establishment of a baseline in 2025/26).
- Increase Early Help engagement for persistently absent pupils by 25% by 2030. (following establishment of a baseline in 2025/26)

Priority SA3: Reduce childhood obesity and improve physical activity

Why this matters: Obesity at 11 predicts adult health outcomes; rates are highest in deprived neighbourhoods.

Actions:
1. Expand active travel, after-school sport and community programmes.
2. Strengthen school- and community-based healthy eating programmes.
3. Integrate school nursing, INTs and early years services to support earlier intervention.

Delivery Measures:

- Reduce proportion of Year 6 who are overweight/obese from 38.3% → 34% by 2030.
- Increase physical activity (5–16-year-olds) from 43.5% → 50% by 2030.
- Increase uptake of targeted healthy-eating programmes in high need neighbourhoods by 20% by 2030 following establishment of a baseline in 2025/26

6.1.3 Children and Young People's Mental Health & SEND (0–25)

Priority CM1: Expand early intervention and community mental health support

Why this matters: Demand continues to rise; early support prevents crisis and improves educational engagement.

Actions:

1. Expand neighbourhood-based CYP mental health support through schools, Family Hubs and VCSE partners by 2027
2. Embed CYP MH practitioners within INTs by 2027
3. Strengthen joint CAMHS–school–Early Help early intervention pathway by 2026

Delivery Measures:

- Increase proportion of young people accessing early intervention support (baseline to be established 2025/26).
- Reduce CYP crisis presentations and emergency referrals by 10% by 2030.
- Expand MHST and community MH community coverage from 44% to 60% by 2027.
- Increase health input into Education, Health and Care Plan (EHCP) annual reviews by 25% by 2030.

Priority CM2: Strengthen neurodevelopmental (ND) pathways

Why this matters: Demand for ASD/ADHD support is high; families report long waits and fragmented support.

Actions:

1. Develop a coordinated ND pathway across paediatrics, CAMHS, schools and Family Hubs.
2. Provide early pre-diagnostic support.
3. Improve transition from assessment to education and support plans.

Delivery Measures:

- Reduce ND assessment waiting times (baseline to be established 2025/26) by 2027
- Increase proportion of children receiving early pre-diagnostic support by 20% by 2030 (baseline to be established 2025/26)
- Reduce exclusions for CYP with ND needs by 20% by 2030.
- Reduce the number of CYP with ND needs not in education, employment or training (NEET) by 20% by 2030.

Priority CM3: Improve support to families and joint SEND planning

Why this matters: Parents-Carers report difficulty navigating services; strong early support

prevents escalation.

Actions:
1. Expand Family Hub and VCSE parent-carer support.
2. Strengthen joint commissioning and planning across education, health and care.
3. Improve SEND navigation pathways for information access, assessment and support

Delivery Measures:
- Increase parent-carer satisfaction/participation in SEND and early help pathways by 20% by 2030. (Baseline to be established)
- Improve EHCP timeliness to ≥60% within 20 weeks by 2030.
- Reduce repeat specialist referrals by 15% by 2030 through stronger early support. (Baseline to be established 2025/26)

6.2 Live Well

Ambition: Adults in Hillingdon are supported to live healthier lives, manage long-term conditions, maintain independence and stay emotionally well. Integrated Neighbourhood Teams (INTs) are the key vehicle for delivering this ambition, bringing together primary care, community health, mental health, social care, the voluntary sector and public health to provide proactive, personalised and community-based support. Adult carers are identified, listened to and supported.

Priority LW1: Earlier detection and management of long-term conditions & rising-risk frailty

Why this matters: LTCs and early frailty are major drivers of preventable admissions. Adults aged 45–70 with multimorbidity, obesity, hypertension, diabetes or early frailty indicators are at the greatest risk of deterioration. INTs provide the local platform for early identification, proactive case management and coordinated support.

Actions:
1. Use PHM and INT Multi-disciplinary Team (MDTs) meetings to identify rising-risk adults.
2. Deliver neighbourhood hypertension/Cardiovascular disease (CVD) programmes.
3. Increase NHS Health Checks and targeted screening.
4. Strengthen diabetes and lifestyle change support.
5. 40% of carers (2021 census baseline) are registered on the carers' register by 2030.
6. Increase proportion of adult carers saying they have as much social contact as they like from 2025/26 baseline.

Delivery Measures:
- Increase hypertension prevalence capture 13.8% → 16% by 2026, towards 24% by 2028.
- Maintain BP control in ≥85% of diagnosed cases by 2028
- Provide proactive case management to 5,000 rising-risk adults by 2027.
- Reduce CVD NEL admissions by 30% by 2030.

Priority LW2: Improve mental wellbeing through neighbourhood support

Why this matters: Mental health needs are rising, with increasing levels of anxiety, depression

and isolation. Hillingdon experiences high crisis presentations and unplanned mental-health bed days. Earlier, neighbourhood-based support prevents escalation and reduces pressure on acute service.

Actions:
1. Embed MH practitioners in all INTs.
2. Expand talking therapies, social prescribing and wellbeing support.
3. Increase community programmes to reduce loneliness and isolation.

Delivery Measures:
- Increase talking-therapy access to ≥25% by 2027.
- Reduce MH crisis presentations by 10% by 2030.
- Reduce unplanned MH bed days by 10% by 2030.

Priority LW3: Reduce health-harming behaviours

Why this matters: Smoking, inactivity, obesity and poor diet are major contributors to long-term conditions and health inequalities. Tackling these behaviours is essential to reducing preventable illness and emergency demand.

Actions:
1. Deliver targeted smoking cessation, weight management and physical activity programmes via INTs.
2. Strengthen nutrition, cooking and healthy-eating support in schools, Family Hubs and community settings.
3. Embed lifestyle interventions within proactive care and long-term condition pathways.

Delivery Measures:
- Reduce adult smoking prevalence from 11.8% → 9% by 2030.
- Reduce adult obesity 26.3% → 23% by 2030.
- Increase physically active adults 55.8% → 62% by 2030.
- Increase by 20% identified adults on the PCN CRM register lifestyle improvement with completion of holistic assessment, including 6 pillars of lifestyle medicine by 2028.

6.3 Age Well

Ambition: Older adults in Hillingdon are supported to live independently, safely and with dignity for as long as possible. INTs and the Reactive Care Service are the primary vehicles for delivering this ambition, enabling proactive frailty care, urgent community response, safe discharge, integrated rehabilitation and coordinated end-of-life support.

Priority AW1: Proactive frailty care and rapid support

Why this matters: Frailty is a major driver of avoidable admissions, ED attendance & long-term care. Early Neighbourhood proactive support reduces deterioration & helps people stay independent.

Actions:
1. Identify and stratify people with severe frailty using the Frailty Index/PHM and INT MDTs.
2. Deliver proactive personalised care plans with wrap around care to all severely frail people (~5,000).
3. Implement NWL Frailty Pathway
4. Expand UCR and mobile diagnostics to provide same day alternatives to ED
5. Use the Reactive Care Co-ordination Hub as the single referral point for urgent community support
6. Implement and scale Hospital at Home to provide acute level care in familiar surroundings

Delivery Measures:
- 100% of people with severe frailty to have a personalised care plan by 2027.
- Reduce ED attendances to 164/day by 2026
- Reduce frailty NEL admissions by 10% by 2028.
- 90% of appropriate UCR referrals seen within 2 hours by 2026.
- Implement Hospital at Home by 2026 and scaled to ≥10 patients/day by 2027.
- Maintain rate of people 65 + permanently admitted to care homes per 100,000 at 2025/26 baseline.

Priority AW2: Improve falls, rehabilitation, reablement and discharge

Why this matters: Falls, deconditioning and delayed discharge are key drivers of avoidable harm for older adults. Strengthening Home First, delivering 7-day integrated reablement/rehabilitation and reducing NC2R are essential to maintaining independence, reducing long-term care need and enabling the new Hillingdon Hospital model to function safely

Actions:
1. Merge falls services into a single strengthened offer with a clear delineated pathway.
2. Deliver 7-day integrated reablement and rehabilitation with expanded capacity.
3. Implement the Place 'No Criteria to Reside (NC2R)' Improvement Plan to reduce discharge delays.
4. Redesign IDT with clear escalation and decision-making.

Delivery Measures:
- Reduce falls related non elective admissions by 10% by 2030.
- ≥65% P0/P1 same/next-day discharge by 2026.
- Sustain NC2R at ≤34 throughout 2026 and beyond.
- ≥85% patients discharged from hospital to reablement who remain in the community within 12 weeks of discharge.

Priority AW3: Improve care home, dementia and end-of-life support

Why this matters: Care Home Residents, people with dementia and those nearing end of life have complex needs. Good neighbourhood-based support improves outcomes and aligns care with people's wishes.

Actions:
1. Strengthen INT-led care home support with GP, therapy and pharmacy input.
2. Deploy UCR and rapid mobile diagnostics into care homes.

3. Increase dementia diagnosis and post-diagnostic support.
4. Review care home capacity including the balance between commissioned and directly provided services.
5. Implement Palliative Integrated Care Service (PICS) across Hillingdon.

Delivery Measures:
- Reduce avoidable care home admissions by 10% by 2030.
- Increase dementia diagnosis to ≥66.7% by 2027.
- Increase post-diagnostic support by 20% by 2028.
- Increase deaths in usual place of residence by 10% by 2030.
- Reduce length of stay at Hillingdon Hospital for patients at the end of their life to below the NWL average by 2026

6.4 Healthy Places

Ambition: Places and communities support healthier, more connected lives.

Priority HP1: Improve housing stability and reduce homelessness

Why this matters: Housing insecurity and temporary accommodation undermine mental and physical health, disrupt education, and increase demand on services.

Actions:
1. Strengthen joint Housing–INT–Family Hub early identification.
2. Improve pathways for people facing homelessness, including hospital discharge.
3. Target enforcement/support for unsafe private rented homes.

Delivery Measures:
- Reduce households in temporary accommodation by 10% by 2028. Baseline 1,700 households

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Priority HP2: Create safer, healthier neighbourhoods

Why this matters: Safety and the physical environment influence wellbeing, confidence, activity levels and community cohesion.

Actions:
1. Strengthen the joint working between the Health and Wellbeing Board and the Safer Hillingdon Partnership.
2. Develop a Health in All Policies approach to embedding health and wellbeing concerns into council plans and strategies.

Delivery Measures:
- Cross representation between the Health and Wellbeing Board and the Safer Hillingdon Partnership.
- Development of a Health in All Policies framework to be adopted by all partners.

Priority HP3: Reduce social isolation and improve community connection

Why this matters: Loneliness is strongly associated with poor mental and physical health and increased use of urgent and emergency care.

Actions:

1. Support community-led connection programmes.
2. Use INTs and Family Hubs to connect residents into local groups.
3. Expand digital/social inclusion support for older adults and vulnerable groups.

Delivery Measures:

- Reduce the proportion of Adults reporting loneliness from ~24% → 20% by 2030.Baseline: 23-25% (ONS/PHOF indicators).

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7. High-Impact Priorities

Given finite resources and the scale of challenge, Hillingdon will prioritise a small number of programmes that can deliver the greatest improvement in population health, reduce inequalities and relieve system pressure. These priorities have been selected because they:

- affect large population groups
- address the biggest drivers of avoidable hospital use
- have strong evidence of impact
- support the delivery model for the new Hillingdon Hospital
- align directly with our neighbourhood model, Family Hubs, and the Reactive Care Service
- have measurable baselines and clear outcomes

Together, these programmes will drive the most significant improvements across the life course.

1. Proactive and Preventative Neighbourhood Care

Identifying and supporting rising-risk adults before frailty develops, intervening early to prevent deterioration and avoid escalation.

Delivered through INTs using PHM, risk stratification, proactive case management, early long-term condition support and targeted outreach.

Examples of impact: reduced crisis activity; fewer avoidable admissions; reduced progression to moderate/severe frailty**.**

2. Hypertension and Cardiovascular Risk Management

The highest-impact component of neighbourhood prevention.

A focused programme to improve detection, diagnosis and control of hypertension and cardiovascular risk — the largest preventable drivers of stroke, heart disease and unplanned bed days.

Examples of impact: hypertension detection ↑; blood pressure control ≥85%; reduced CVD admissions.

3. Mental Health Early Intervention

Preventing escalation, crisis presentations and avoidable hospital use by strengthening early support for children, young people and adults.

Delivered through schools, Family Hubs, INTs and community mental health services. Examples of impact: improved access to early help; reduced crisis and ED presentations; improved resilience.

4. 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.

Includes frailty identification for those with established frailty, personalised care plans, falls prevention, UCR, mobile diagnostics and Hospital at Home.

Examples of impact: falls-related admissions ↓; improved independence; fewer care home admissions.

5. NC2R and Discharge Improvement

A critical system priority enabling the new hospital model.

Focuses on Home First, improving P0–P3 pathways, redesigning the IDT, delivering 7-day rehabilitation and reablement, and ensuring rapid community response through the Reactive Care Service.

Examples of impact: NC2R ≤34 sustained; improved flow; reduced length of stay.

6. Healthy Childhood: Immunisation, Healthy Weight and Early Prevention

Addressing the strongest drivers of early inequality and future long-term health.

Delivered through Family Hubs, health visiting, schools and INTs, focusing on immunisation, healthy weight, early physical activity.

Examples of impact: immunisation coverage ≥95%; reduced obesity;

7. Family Hubs and Early Years

Preventing disadvantage from becoming entrenched and improving early childhood development.

Integrating early help, perinatal mental health, health visiting, SEND early intervention and VCSE support through the Family Hub network.

Examples of impact: improved GLD; reduced inequalities in school readiness; stronger parental support.

8. The Hillingdon Place Operating Model

This section sets out how we will deliver the strategy through our integrated Place Operating Model.

8.1 Overview

The **Hillingdon Place Operating Model** consolidates and integrates existing services into a coherent system of:

- **Three co-located Integrated Neighbourhood Teams** (INTs) supported by Local Access Hubs, bringing together primary care, community health, adult social care, mental health, therapies, diagnostics and the voluntary sector.
- **A network of Family Hubs** providing early years support, parenting, SEND pathways and early help.
- **A Borough-wide Reactive Care Service** providing rapid community response, integrated discharge, rehabilitation, bridging support and Hospital at Home.
- **A new Hillingdon Hospital working** seamlessly with neighbourhood teams, so residents receive the right care in the right place.
- **Shared leadership**, integrated workforce and pooled budgets where appropriate

It is designed to:

- Reduce fragmentation and duplication
- Enable multidisciplinary working around populations of c.100,000
- Deliver both proactive (prevention, long-term conditions, frailty) and reactive (urgent care, discharge) functions
- Support the activity and flow assumptions underpinning the new hospital

8.2 Integrated Neighbourhood Teams (INTs)

The three Hillingdon Neighbourhoods are:

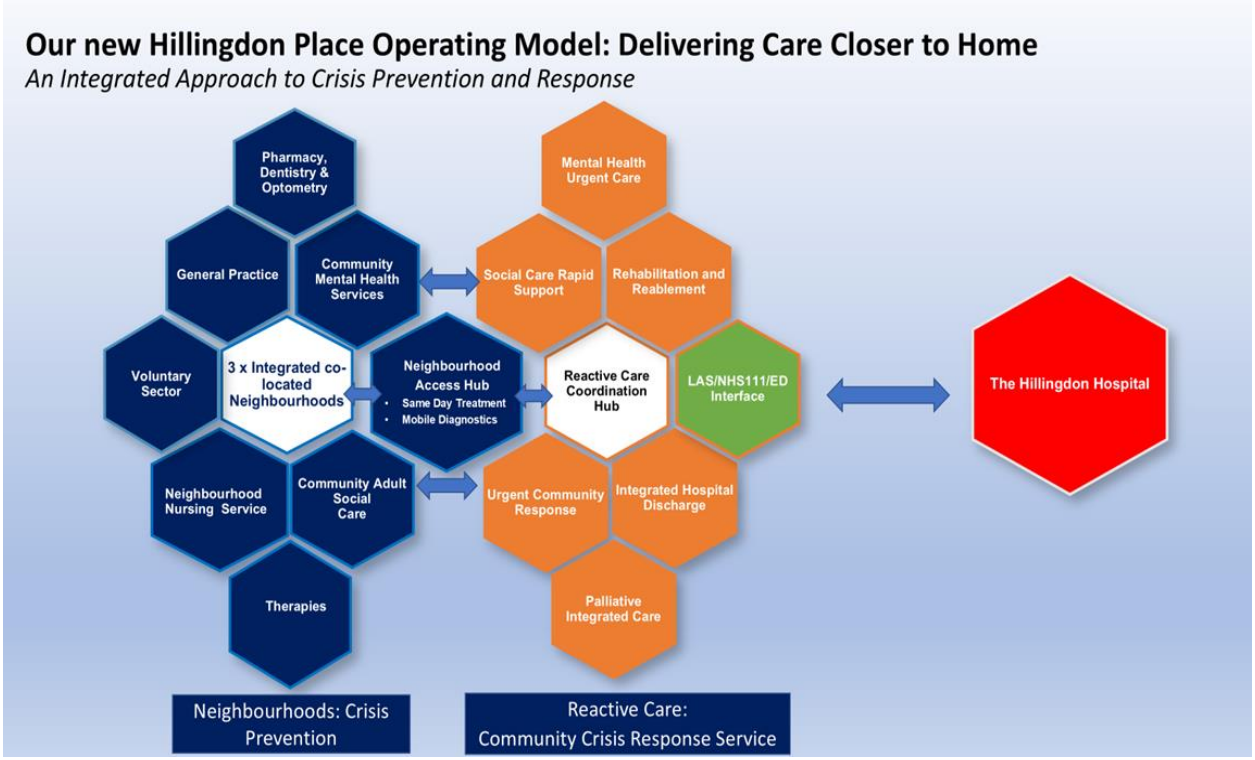
- **North:** Ruislip, Northwood, Harefield and Ickenham
- **South West:** Uxbridge, Yiewsley and West Drayton
- **South East:** Hayes and Harlington

Together, these Neighbourhoods will form the foundation of our population-based model of care, enabling earlier intervention, improved access and more integrated support across local communities.

Each INT will bring together:

- GPs and primary care teams
- Community nursing
- Adult social care
- Community mental health services
- Allied health professionals and therapies
- Mobile diagnostic teams including Xray, Ultrasound
- Selected acute outpatient services
- Voluntary and community sector partners
- Family Hubs and children’s services (through strong operational links)

Place Operating Model



Core functions include:

- Same Day Urgent Primary Care delivered
- Proactive Care for high-risk and rising-risk populations, including people with frailty and multiple LTCs
- Preventative and Anticipatory Care, including for hypertension and other key risks
- Interface with Family Hubs around families with complex needs or safeguarding concerns

The INTs and local access hubs will be co-located in modern fit for purpose accommodation and will be designed as highly accessible, multi-agency spaces that support:

- Reduced demand on ED and UTC
- Earlier diagnosis
- Better access to planned and urgent care in the community

8.4 Borough-wide Reactive Care Service

The **Reactive Care Service** is a high-intensity, mobile multidisciplinary service that:

- Provides a 2-Hour Urgent Community Response, in line with national standards.
- Supports safe and timely discharge from hospital, including bridging arrangements.
- Integrates nursing, therapies, social care, mental health and palliative care in a single response model.
- Coordinates activity via a Reactive Care Coordination Hub, which acts as the operational point of contact for ED, wards, GPs, LAS, NHS 111 and care homes.

This service is integral to achieving:

- Sustained NC2R at or below 34
- Reduced length of stay and fewer delayed transfers
- Reduced readmissions and improved patient experience

8.5 Children, Families and Family Hubs in the Place Model

Within the operating model:

- Family Hubs are formally linked to INTs and local neighbourhood governance
- CYP mental health and SEND teams are connected into INT meetings, planning and pathways
- Schools, Early Help, youth services and VCSE organisations are recognised as key neighbourhood partners
- Safeguarding arrangements are embedded within neighbourhood governance structures

This ensures that Better Start in Life outcomes are not treated separately from the integrated Place model but are a core component.

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9. Enablers of Delivery

To deliver this strategy we will strengthen:

9.1 Workforce and Organisational Development

- Develop integrated leadership roles across partners.
- Implement a "*workforce passport*" approach to enable flexible deployment across organisations.
- Provide shared training on population health, trauma-informed practice, equality, cultural competence and neighbourhood working.
- Support staff wellbeing and retention.
- Develop an integrated accommodation schedule for the three neighbourhood super hubs.

9.2 Digital, Data and Population Health Management

- Improve data sharing between partners, aligned to PHM goals
- Develop neighbourhood dashboards for INTs and HWB oversight
- Use the Whole System Integrated Care (WSIC) database and other tools to identify high-risk and rising-risk cohorts
- Support residents' digital inclusion where appropriate

9.3 Estates and Super Hubs

- Develop and implement estates plans for the three Neighbourhood Super Hubs (Hayes, Ruislip, Uxbridge)
- Maximise use of existing public estate and co-location opportunities
- Align estates plans with the new hospital redevelopment and other capital programmes

9.4 Finance and Pooled Budgets

- Explore and implement appropriate Section 75 agreements to support pooled budgets and shared risk
- Align Place resources to the strategic priorities in this strategy
- Use transformation and BCF resources to pump-prime integrated models such as the Reactive Care Service

9.5 VCSE and Community Partnerships

- Strengthen collaboration with 3ST and wider VCSE partners
- Support community-led projects, especially in Core20 neighbourhoods

- Recognise and fund the VCSE sector as a key delivery partner, particularly in prevention, mental health, carers' support and loneliness reduction

10. Finance and Resources

Delivering this strategy requires coordinated investment and budgetary alignment across the Council, NHS partners, Primary Care and the voluntary and community sector. Hillingdon Health and Care Partnership (HHCP), as the Place-Based Partnership, will oversee the financial framework that ensures resources are aligned to our shared priorities.

10.1 How the Strategy Will Be Funded

Delivery will be supported through a blend of **existing and new funding streams**, including:

- Existing NWL ICB budgets (with specific new investment into End of Life, Urgent Community Response, Hospital at Home, the Lighthouse,)
- Local Authority budgets (Public Health, Children's Services, Adult Social Care, Housing)
- Better Care Fund
- Primary Care (ARRS and enhanced services)
- Voluntary and community sector grants
- Capital investment linked to the new Hillingdon Hospital and development of Local Access Hubs

HHCP will coordinate these resources to reduce duplication, maximise value and ensure investment is focused on prevention, neighbourhood delivery and reducing inequalities.

10.2 Pooled Budgets and Joint Commissioning

To support integrated delivery, Hillingdon will explore the expansion of pooled budgets and joint commissioning through Section 75 agreements across key areas such as:

- Integrated Neighbourhood Teams
- Reactive Care and discharge pathways
- Early years and Family Hubs
- Community mental health and prevention
- Intermediate care, rehabilitation and reablement

This will enable shared accountability, clearer governance and more efficient use of local resources.

10.3 Resourcing the Place Operating Model

Funding for the Place Operating Model will come from:

- Core service realignment, bringing together existing community, primary care, mental health and social care resources at neighbourhood level
- BCF and transformation funding to support Reactive Care, Home First, 7-day reablement and intermediate care
- Public health, early years and children's services budgets aligned to Family Hubs and neighbourhood working
- Capital and estates solutions for Local Access Hubs using licence-to-occupy, space swaps and flexible use of section 106/Community Interest Levy (CIL) while longer-term hub

developments progress

This approach ensures the Operating Model is deliverable within current resources, with targeted investment for system change.

10.4 Financial Oversight and Assurance

Oversight will be delivered through:
- HHCP Finance and Performance Committee
- Joint Commissioning arrangements and Section 75 governance
- Regular assurance to the Health and Wellbeing Board and NWL ICB

A shared monitoring framework will track spend, outcomes and the impact of investment on reducing inequalities.

11. Governance, Accountability and Oversight

The Health and Wellbeing Board will:
- Provide strategic oversight and stewardship of this strategy
- Receive regular updates on progress, risks and impact
- Hold partners collectively to account for delivery

Supporting arrangements at Place will include:
- A Place Executive / Partnership Board to oversee operational delivery and alignment with ICS frameworks.
- A Finance & Performance Committee to monitor resource use and outcomes.
- A Quality & Safety Committee to ensure quality, safety and safeguarding.
- Children's and adults' safeguarding arrangements will be aligned and clearly embedded within the governance structure.

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12. Measuring Success and Monitoring Progress

A balanced Outcomes and Performance Framework will be agreed, including:
- System metrics – ED attendances, admissions, length of stay, NC2R, discharge delays
- Population health metrics – prevalence and control of hypertension, diabetes, frailty, mental health conditions
- Children & Families metrics – school readiness, obesity, dental decay, children's asthma admissions, CYP MH outcomes
- Experience metrics – patient, carer and staff experience measures
- Inequalities metrics – outcomes in Core20 localities and for priority groups

The Health and Wellbeing Board will receive regular **assurance reports** using a shared dashboard, with deep dives on key priorities. Where baselines are not currently available, these will be confirmed as part of the development of the Place Outcomes Framework by Q4 2025/26."

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13. Implementation and Next Steps

Following approval of this strategy, partners will:

- Develop detailed delivery plans for each outcome domain and high-impact priority
- A detailed delivery timeline will be developed alongside the final strategy.
- Refresh or align organisational plans and commissioning intentions to this strategy
- Agree implementation milestones for the Place Operating Model, including INTs, Super Hubs and Reactive Care
- Finalise the outcomes framework and dashboard for HWB oversight

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