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Health and Wellbeing Board

Date: **WEDNESDAY, 18 MARCH 2026**

Time: **2.30 PM**

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

Meeting Details: The public and press are welcome to attend and observe the meeting.

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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

Published: Tuesday, 10 March 2026

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Putting our residents first

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Agenda

CHAIR'S ANNOUNCEMENTS

Health and Wellbeing Board Reports - Part I (Public)

Health and Wellbeing Board Reports - Part II (Private and Not for Publication)

That the reports in Part 2 of this agenda be declared not for publication because they involve the disclosure of information in accordance with Section 100(A) and Part 1 of Schedule 12 (A) to the Local Government Act 1972 (as amended), in that they contain exempt information and that the public interest in withholding the information outweighs the public interest in disclosing it.

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Minutes

HEALTH AND WELLBEING BOARD

2 December 2025

Meeting held at Committee Room 5 - Civic Centre

	Board Members Present: Councillor Jane Palmer, Keith Spencer, Sean Bidewell, Amanda Carey-McDermott, Claire Eves (In place of Vanessa Odlin), Dr Richard Grocott Mason, Dr Alan McGlennan (In place of Lesley Watts), Derval Russell, Sharon Stoltz, Sandra Taylor and Tony Zaman **Officers Present:** Gary Collier (Health and Social Care Integration Manager) and Nikki O'Halloran (Democratic, Civic and Ceremonial Manager)
58.	**APOLOGIES FOR ABSENCE** *(Agenda Item 1)* Apologies for absence had been received from Councillor Susan O'Brien, Professor Ian Goodman, Ms Julie Kelly, Ms Samreen Nawshin, Ms Vanessa Odlin (Ms Claire Eves was present as her substitute) and Ms Lesley Watts (Dr Alan McGlennan was present as her substitute). The Co-Chair noted that this would be Ms Derval Russell's last attendance and, on behalf of the Health and Wellbeing Board members, thanked her for her contribution over the years.
59.	**DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING** *(Agenda Item 2)* There were no declarations of interest in matters coming before this meeting.
60.	**TO APPROVE THE MINUTES OF THE MEETING ON 9 SEPTEMBER 2025** *(Agenda Item 3)* **RESOLVED: That the minutes of the meeting held on 9 September 2025 be agreed as a correct record.**
61.	**TO CONFIRM THAT THE ITEMS OF BUSINESS MARKED PART I WILL BE CONSIDERED IN PUBLIC AND THAT THE ITEMS MARKED PART II WILL BE CONSIDERED IN PRIVATE** *(Agenda Item 4)* It was confirmed that Agenda Items 5 to 11 would be considered in public and Agenda Items 12 to 14 would be considered in private.
62.	**INTEGRATED HEALTH AND WELLBEING PERFORMANCE REPORT AND SERVICE UPDATE** *(Agenda Item 5)* Mr Sean Bidewell, Joint Borough Director at North West London Integrated Care Board (NWL ICB), noted that the report tracked Hillingdon's progress against five priorities with a particular focus on live well, age well and early intervention. Mr Gary Collier, the Council's Health and Social Care Integration Manager, advised that it was intended

that the report considered at the next Board meeting would include updates on the metrics. Mr Keith Spencer, the Co-Chair and Managing Director at Hillingdon Health and Care Partners, noted that partners now had a better understanding of the metrics with targets like 'no criteria to reside' being included in the New Hospital Programme (NHP). Dr Alan McGlennan, Chief Medical Officer at The Hillingdon Hospitals NHS Foundation Trust, advised that the work being undertaken by partners had aligned with the development plans for the new hospital and had contributed towards about 60% of the documents that had fed into the NHP. The only thing that had been missing had been what it meant to residents. Partners were clear about what they were trying to do but residents were not clear about public health, what hubs provided or how services would be delivered. This needed to be explained to residents and they needed to be advised of the part that they were required to play in keeping themselves healthy.

It was suggested that there needed to be a focus on the application of the transformation work (as if it hadn't happened). For example, what was the impact of the intervention, had it stopped people from going to see a GP, etc. It was clear that more work was needed to improve residents' health literacy and explain and simplify the terminology and options alongside the transformation work. Residents would often receive multiple notifications which could make it difficult to navigate the system.

The challenges being faced in Hillingdon included the implementation of sustainable improvements, the growth in health conditions and winter pressures. The work already undertaken had shown early signs of improvement in the flow and all three integrated neighbourhoods were fully operational. A business case would be developed to satisfy a number of masters by the end of March 2026 for the neighbourhood hubs, which had been attracting a lot of local and political interest. Although Hillingdon had been selected to participate in the national neighbourhood programme, this did not come with any associated funding so consideration was being given to how this would be funded.

The outcomes in relation to hypertension had been strong with more than 70% of blood pressures (BPs) being under control (which was one of the best performances in London). It was noted that a Boroughwide campaign was being developed in relation to hypertension which would run from February 2026 on the back of the British Heart Foundation's Heart Month and would link into the pan-London Healthy Hearts Scheme. Consideration needed to be given to what happened after individuals' BP had been taken as it was not just about numbers. GPs wanted to know residents' results when they took their own BP even if the results were positive. About one third of people who had their BP taken would need an onward referral and information needed to be available and handed out in relation to self care / self management and small changes that could be made to one's lifestyle. It would also be useful to encourage those who were able to, to monitor their own BP at home, as well as provide them with information about the risk factors and when it would be appropriate to go to a clinician. It was noted that BP monitors were freely available for residents to use in libraries across the Borough so they did not need to buy their own machine if they could not afford one.

A single Integrated Neighbourhood Team (INT) delivery team had been put together to deliver the live well and age well priorities in the community. Frailty case management had also been progressing well, resulting in a 36% reduction in emergency admissions amongst the 350 high risk residents. The frailty work would be fully expanded by April 2026.

The Primary Care Network (PCN) had been delivering services and the Pharmacy First initiative had proved to be very successful, providing an access route to support minor

	illnesses. Further work would be needed in relation to dental access and strengthening mental health integration. Partners had a clear and joined up view of the challenges and how to address them and exciting work had been planned in relation to rehabilitation and reablement. A number of reactive care schemes had been developed to strengthen the urgent and crisis response in the community and bring everything together. The Council had started to deliver patients straight from the hospital front door to the reablement services. However, improvements were needed to ensure that the therapies that were needed were available in the community. The next steps would need the integration of teams into the discharge processes. It was hoped that the coordination hub would be launched in December 2025. A six-month mobile diagnostics pilot had started and plans were afoot to increase capacity at the Lighthouse mental health service from six to ten. At Hillingdon Hospital, work had been undertaken on the discharge pathway for those patients with 'no criteria to reside', putting the right escalation processes in place to help at times of pressure, reducing to 35 in the first three weeks. Delayed discharges had been sustained at 34 per day, the Best Start In Life had been initiated to reduce inequalities and new dashboards for children and young people's services were due to be launched next year with links to Early Years and Family Hubs. It was clear that, rather than building upon existing services, partners needed to simplify the processes and make them more linear and easier to understand. It was agreed that partners needed to have a conversation about transformation capacity, capability and execution, particularly in light of the changes at the ICB. **RESOLVED: That:** **1. the Board notes progress, endorses continued focus on preventative and urgent care priorities, and supports actions required to sustain flow and improve outcomes for children and families; and** **2. partners have a conversation about transformation capacity, capability and execution.**
63.	**DRAFT JOINT HEALTH & WELLBEING BOARD STRATEGY 2026-2031** *(Agenda Item 6)* Mr Keith Spencer, Co-Chair and Managing Director at Hillingdon Health and Care Partners, advised that the current Joint Health and Wellbeing Strategy had come to an end. The Board had agreed the priorities that it wanted to include in the newest iteration of the Strategy earlier in the municipal year and the document focussed on interventions which had demonstrated progress. The 'what' and 'how' had been set out in the report (what needed to be improved and how this would be done). Each section set out the priorities and identified seven high impact programmes to deliver these priorities. Consideration had been given to what was known to work (or was likely to work) and delivery thereof would mean that partners would need to work differently. Links had been drawn with the Family Hub as well as between the Family Hub and neighbourhoods, promoting independence and wellbeing. Mr Spencer advised that he would like a plain English version of the Strategy available for the public consultation which would take place in January and February 2026 and be brought back to the Board's March 2026 meeting. The metrics had been collected

	as part of the performance report and it would be important to ensure that the new hospital was set in the right place in the system. There had been some resistance to including additional priorities. Although children and young people were thought to be important, the addition of another priority would need to be resourced and would need the Council to lead on it. The Director of Children and Young People's Services should be attending the Health and Wellbeing Board meetings and it had been identified that stronger relationships were needed between CNWL and the Council's Children's Services. Although there was a Safer Children's Partnership (SCP), there seemed to be a focus on public health issues and the priorities set out in the Strategy did not really sit with the SCP. As such, it was suggested that further conversations were needed to ensure that these areas aligned. Lots of children and young people witnessed domestic abuse in the home and the frequency of incidents was not decreasing. This had an impact on their mental and physical health. The issue needed to be discussed with the relevant partners around the table. It would be important for partners to reflect and for residents to take responsibility for what they did and look at what partners could reasonably be expected to do. It was noted that the Board's next meeting had been scheduled for 3 March 2026. To ensure that there was enough time to be able to report back on the results of the consultation after resident engagement, it was agreed that the meeting be moved to 24 March 2026. It was noted that, if partners delivered on everything set out in the Strategy, there would definitely be improvements in residents' health and a reduction in the pressure on partners. The Board queried what the expectation was of residents and how they should be looking after themselves. It was also asked if partners would be sufficiently brave to be more equal in their approach and initiate a social contract which set out the expectations of residents. **RESOLVED: That:** **1. the draft Joint Health and Wellbeing Strategy be approved for public and stakeholder engagement; and** **2. the Health and Wellbeing Board meeting scheduled for 3 March 2026 be moved to 24 March 2026.**
64.	**CHILDHOOD OBESITY UPDATE** *(Agenda Item 7)* Ms Sharon Stoltz, the Council's Director of Public Health, advised that the report provided the Board with an update and detailed the reasons why managing children's healthy weight was so important. A table had been included which set out the long term conditions that could be attributed to obesity including hypertension, diabetes, gout and ovarian cancer. The drive to tackle obesity needed to be top of the agenda but there didn't appear to be a clear strategic direction to tackle excess weight in Hillingdon. It was noted that children did not make decisions about what food they ate or what activity they undertook (these were decisions made by the adults in their lives) so a whole system strategic vision, approach and delivery plan was needed which could be led by Public Health. It was agreed that a report on the delivery plan would need to be included on a future agenda.

	It was noted that the document provided information on a collection of projects rather than a strategy. Action would be needed to transform this into a strategy and engagement activities would need to be undertaken to keep residents on board. It would be important for partners to remember how diverse Hillingdon's population was and to consider how best to engage with them. The report included a diagram which illustrated the inequality in the Borough. It was thought that, if residents' expectations were managed, there could be improvements in the inequalities. It was thought that the neighbourhood work linked with the Family Hub and Integrated Neighbourhood Teams would also help to achieve this. Some issues lent themselves better to an integrated approach and obesity was one of these issues. A different approach was needed as not all approaches would work for everything. It was about engaging with people and work needed to be undertaken with the family and extended family of the child. However, although it was recognised that there would not be improvements in adult obesity for a generation, there would be incremental changes over time. It was noted that some might say that there should be a focus on excess weight rather than hypertension. It was agreed that Hillingdon's Director of Public Health develop a strategy for reducing excess weight as part of the Health and Wellbeing Strategy and delivery plan. **RESOLVED: That:** **1. Hillingdon's Director of Public Health be asked to develop a strategy for reducing excess weight as part of the Health and Wellbeing Strategy and delivery plan; and** **2. the report be noted.**
65.	**HILLINGDON HEALTH PROTECTION COMMITTEE** *(Agenda Item 8)* Ms Sharon Stoltz, the Council's Director of Public Health, advised that Hillingdon used to have a Health Protection Board and suggested that it be reestablished as a Committee rather than a Board and be chaired by the Director of Public Health. Health protection issues could not be resolved just by talking about them. There were residents in Hillingdon that were vulnerable to infectious diseases and it would be important to be in a position to respond to the next pandemic. Work was already underway with Hounslow on the emergency response plans in London but a group was needed to identify and address local risks. To do this, there would need to be a change of governance arrangements so that the Committee could report to the Health and Wellbeing Board through an annual report (unless a significant issue arose during the course of the year whereby interim reports could be brought to the Board). Subject to this aligning with provisions in the Council's Constitution, it was agreed that the Health Protection Committee be established as per the report. **RESOLVED: That:** **1. the establishment of a Health Protection Committee for Hillingdon be approved;** **2. the Board's comments on the proposed Terms of Reference and membership be noted; and** **3. the Board agrees to receive an Annual Health Protection Report, prepared by the Director of Public Health, to document health protection system activities**

	over the previous year and set out priorities for the different areas of health protection for the next 12 months.
66.	**OCCUPATIONAL THERAPY SERVICE UPDATE** *(Agenda Item 9)* As there were no officers in attendance to present the report, it was agreed to defer this item to the next meeting. **RESOLVED: That the item be deferred to the March 2026 meeting.**
67.	**REPORTS REFERRED FROM CABINET / HEALTH AND SOCIAL CARE SELECT COMMITTEE GP COVERAGE IN HILLINGDON SINGLE MEETING REVIEW** *(Agenda Item 10)* It was noted that the Health and Social Care Select Committee had undertaken a single meeting review of GP coverage in Hillingdon at its meeting in July 2025. The final report had been considered at Cabinet in November 2025 when the Health and Wellbeing Board had been asked to monitor the implementation of the resolutions. It was suggested that some of the resolutions needed a little more definition but noted that action had already been taken in relation to all patients having the option of being able to book a GP appointment online. It was also noted that, although it enabled patients to request a call back, the telephony system was not used by all practices and did not allow for patients to specify in/convenient call back times. It was agreed that any updates on the implementation of resolutions would be included in the regular integrated health and wellbeing performance report considered by the Board at each meeting. **RESOLVED: That:** **1. clarification be provided in relation to the expectation for each resolution; and** **2. updates on the implementation of resolutions from the single meeting review of GP coverage be included in the performance report considered by the Board.**
68.	**BOARD PLANNER & FUTURE AGENDA ITEMS** *(Agenda Item 11)* Consideration was given to the Board planner. It was noted that the Health and Wellbeing Strategy would be brought to the next meeting on 24 March 2026 for approval. The Childhood Obesity Update item that had been deferred from this agenda and an update on the ICB reconfiguration would also be brought to the next meeting on 24 March 2026. **RESOLVED: That the Board planner be noted.**
69.	**TO APPROVE PART II MINUTES OF THE MEETING ON 9 SEPTEMBER 2025** *(Agenda Item 12)* **RESOLVED: That the confidential minutes of the Health and Wellbeing Board meeting led on 9 September 2025 be agreed as a correct record.**
70.	**UPDATE ON ICB CHANGES** *(Agenda Item 13)* Consideration was given to the confidential report.

	RESOLVED: That the report and discussion be noted.
71.	**UPDATE ON CURRENT AND EMERGING ISSUES AND ANY OTHER BUSINESS THE CHAIRMAN CONSIDERS TO BE URGENT** *(Agenda Item 14)* There were no current or emerging issues to discuss.
	The meeting, which commenced at 2.30 pm, closed at 4.28 pm.

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nikki O'Halloran on nohalloran@hillingdon.gov.uk. Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.

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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 – 18th March 2026

Executive Summary

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, and reducing "No Criteria to Reside" delays.
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 and beyond.

2. Overall Position

The system is stabilising and showing measurable improvement, particularly in discharge performance, frailty management and mental health crisis flow. However, **performance remains above operational targets for ED attendances and bed days**, and the scale of change required to lock in sustainable improvement has not yet been fully delivered.

Progress made since Q3 demonstrates that the direction of travel is right. The priority for the final quarter is to **protect these gains through winter, translate early programme impact into consistent operational performance, and accelerate delivery where gaps remain**.

3. What Has Improved

- **Winter Resilience:**
  When reviewing the impact of the Acute ED this winter compared to last winter (September to February), we can see that overall attendances at THH ED have reduced by 4.6%, ED waits over 12hrs have reduced by over 35% and The All Types A&E 4hr % has improved by 8.5%, we are now one of the highest performers within NWL. The grip, control and measures that have been put into place has helped support in times of escalated needs.
- **Flow and discharge:**
  No Criteria to Reside (NC2R) has reduced materially from pre-intervention levels (~50/day) to a 10 week average of ~36/day. Daily multi-agency grip and Gold oversight are

Executive Summary

- **Mental health crisis response:**
  The redesigned **Lighthouse** model has reduced length of stay by **52%**, increasing throughput and relieving pressure on ED, with most service users now returning home with support rather than being admitted.
- **Community alternatives to hospital:**
  The Reactive Care Coordination Hub is live and simplifying access to urgent community response, while **mobile diagnostics** are demonstrating strong early uptake and evidence of avoided hospital attendances.

4. Where Performance Remains Off-Track

- **Emergency demand:**
  ED attendances remain above the operational hospital target (January average ~176/day vs target 164/day), despite improvement against last year and the redevelopment baseline.
- **Bed days and Length of Stay:**
  While Non-Elective admissions volumes are trending down and remain below the redevelopment baseline, **bed days remain materially above target**, driven primarily by Length of Stay >1 day activity. This remains the most significant gap.
- **Pathway 2 discharges:**
  P2 delays persist, particularly for non-Hillingdon residents (around 50% of delayed P2 patients), limiting the system's ability to sustain NC2R performance without continued senior grip.

5. Key Risks Requiring Board Oversight

- **Workforce fragility:** Delivery remains dependent on scarce roles across UCR, discharge, therapy and Lighthouse services. Any slippage risks reduced responsiveness and throughput.
- **Scaling new models:** Mobile diagnostics, the Coordination Hub and community IV antibiotics are early in implementation; their full impact depends on adoption, staffing stability and integration with neighbourhood teams.

6. Priorities for the Next Three Months (Q1 2026)

The focus for Q4 25/26 through Q1 26/27 is **consolidation and acceleration**, not new initiatives:

1. **Sustain NC2R at ≤34/day**: Embed discharge processes as business-as-usual, maintain daily multi-agency grip, and deliver a small but consistent surplus in P2 discharges, including improved management of out-of-borough patients.
2. **Translate frailty into bed-day reduction**: Scale the frailty operating model, formalise the SOP, and move from coverage to quantified impact on admissions and Length of Stay.
3. **Fully mobilise Reactive Care**: Embed the Coordination Hub, align UCR with Virtual Wards and INTs.
4. **Strengthen community alternatives to ED**: Increase utilisation of mobile diagnostics, GP-to-SDEC pathways and Pharmacy First to reduce avoidable attendances.

Neighbourhoods (Live Well & Age Well)

7.1 Integrated Neighbourhood Teams: Purpose & Model

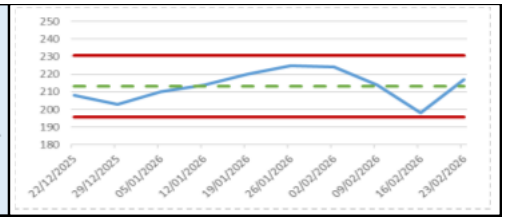
Integrated Neighbourhood Teams (INTs) are the core delivery model for Hillingdon's *Live Well* and *Age Well* priorities. Each Neighbourhood now brings together GPs, community services, social care, mental health and the voluntary sector into a single team focused on **prevention, early intervention 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.

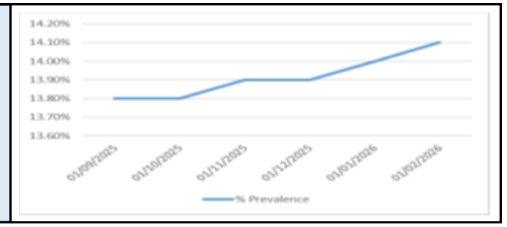
7.2 Integrated Neighbourhood Delivery Update

- **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.** Frailty case management now covers approximately 50% of the severe frailty cohort, with early evidence of reduced emergency admissions. This is a critical foundation for reducing future bed-day demand. Early work has commenced to develop a consistent borough-wide frailty operating model starting with a single-neighbourhood pilot and scaling up across all neighbourhoods by April 2026.
- **National Neighbourhood Implementation Programme (NHIP)** – Hillingdon is currently participating in the National Neighbourhood Implementation Programme, with delivery progressing well. As part of the pilot, a frailty cohort has been identified within the North Neighbourhood, focusing on patients classified as moderately and severely frail. Interventions are scheduled to commence from the end of February 2026, with outcome measures to be reported from March 2026 onwards.
- **Hypertension and long-term conditions.** Prevalence has increased to 14.1%, with optimisation levels remaining stable at 78–80%. While progress is positive, there is a recognised challenge of reaching the 16% target by March 2026. To accelerate improvement, the Healthy Heart campaign has been launched alongside a standardised practice approach to strengthen data coding and proactively identify high-risk cohorts. Targeted recalls, community engagement events, and outreach activities — including mosque -based sessions — are underway to widen reach and drive further uptake.
- **Hospital to Community** – The Community Pathway Programme is progressing well, with Phase One pathways (heart failure, cardiac rehab and community headache) advancing through business case development, quality impact assessments and planning for enhanced primary care diagnostics. The programme is also identifying pathways that could be more effectively delivered in community or primary care settings, supporting improved access, earlier intervention and care closer to home.
- **Integrated Neighbourhood Hub** The Estates workstream is progressing development of the three Neighbourhood Hubs (Nestlé (Hayes, SE Neighbourhood), Pembroke (North neighbourhood) and Uxbridge/Civic (SW neighbourhood)), with strengthened delivery support through WSP's onboarding to lead the Schedule of Accommodation alongside Assura and C&W. Workstreams and governance are being integrated to support business case development, with next steps including the procurement of legal, finance and design advisors to enable parallel progression of the Pembroke and Civic hubs alongside the Nestlé Hub.

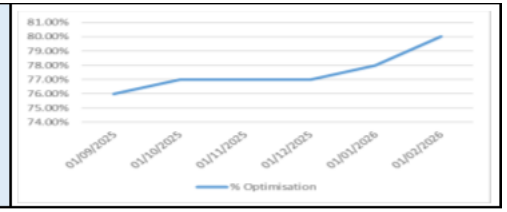
Neighbourhoods (Live Well & Age Well)

UTC Activity Reduction (Traffic light measured against 10 wk Avg)	Monthly Actual **212**	Target 180 / 10 wk Average 213 / Trajectory 176	Graph Trendline for last 10 wks		

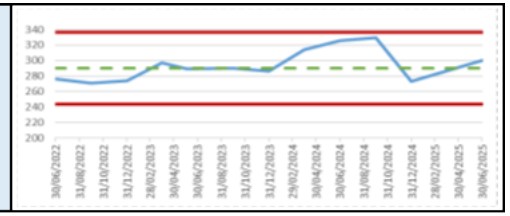
Narrative / Likely Cause	Actions to Remedy	Timeline	Accountability
The 10 week rolling average is currently at 213 attendances per day with a February monthly average of 212, this is against a target of 180 per day. We continue to see lower levels of Type 1 activity suggesting more redirections to UTC.	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 **14.1%**	Target 16% / Previous Year 13.2% / Trajectory 16%	Yearly Trendline		

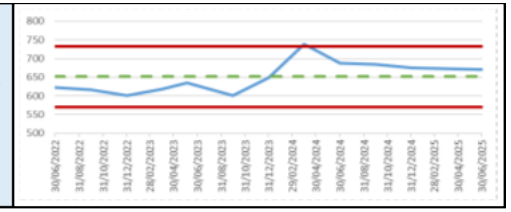
Narrative / Likely Cause	Actions to Remedy	Timeline	Accountability
Hypertension prevalence continues to increase gradually and is currently 14.1% for February, against a target of 16% by March 2026. At present, 14 practices within the Borough are achieving the 16% prevalence target.	Strengthen and standardise 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	Accelerated rollout from Q3 25/26	SRO Neighbourhoods

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

Narrative / Likely Cause	Actions to Remedy	Timeline	Accountability
Hypertension optimisation is currently 80% across the Borough, meeting the target. Performance has improved gradually over recent months, with a 4% increase recorded since September 2025.	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	As part of the NNIP pilot, a frailty cohort has been identified within the North Neighbourhood, focusing on patients classified as moderately and severely frail. Interventions are scheduled to commence from the end of February 2026	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)

7.3 Forward Plan (Q4 2025/26, Q1 2026/27)

Over the next quarter, the Neighbourhoods programme will focus on strengthening consistency, expanding proactive care, and improving delivery across all localities. These actions will strengthen preventative, proactive neighbourhood delivery and support the long term goal of reducing avoidable hospital use and improving outcomes across Hillingdon.

Expand Frailty & Anticipatory Care

- Implement a consistent neighbourhood frailty operating model with clear SOPs and a Frailty Steering Board. Increase MDT activity to progress towards full frailty coverage.
- Broaden anticipatory care beyond hypertension to include COPD, diabetes, falls prevention and multi-morbidity, prioritising moderate-risk residents.

Deliver the Hillingdon Hypertension Strategy

- Finalise and adopt the borough-wide strategy by March 2026, with targeted outreach in high-inequality areas.
- Standardise practice-level data coding, undertake retrospective reviews and use WSIC searches to identify high-risk cohorts.
- Deliver February/March health literacy and community engagement events to support progress towards the 16% prevalence target.

Strengthen Mental Health Integration

- Ensure every INT has a named mental health practitioner to support early identification of anxiety, depression and cognitive concerns.
- Improve links between INTs, primary care and community mental health teams to reduce escalation to crisis pathways.

Introduce Neighbourhood Performance Dashboards

- Develop INT-level dashboards to provide near real-time insight into activity, outcomes, inequalities and variation.
- Align with the emerging CYP dashboard to support whole-life-course monitoring.

Progress Neighbourhood Estates (Hubs)

- Advance feasibility, design work and the Schedule of Accommodation for the three Neighbourhood Hubs (Nestlé, Pembroke, Uxbridge/Civic Centre).
- Progress the Outline Business Case, aligning with hospital redevelopment, left-shift priorities, workforce and digital enablers

7.4 Key Issues & Risks (Neighbourhoods)

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

Workforce gaps: Capacity remains fragile across key roles (geriatricians, pharmacists, therapists, care coordinators), limiting the pace and consistency of preventative and proactive care.
Variation in INT maturity: Differences in integration, MDT functioning and shared processes lead to uneven delivery and inconsistent resident experience. Standardised operating models and the development of Neighbourhood Hubs will help close this gap.
Growing demand from ageing and long-term conditions: As frailty case-finding scales toward full coverage, INT caseloads will rise. Without matched capacity, proactive care may dilute and reduce impact on avoidable admissions.
Local inequalities: Health outcomes vary significantly across neighbourhoods, with some areas (e.g., Hayes & Harlington) facing higher need. Without an equity-focused approach to metrics and outreach, improvements may not be realised evenly.

Reactive Care (Urgent & Crisis Response, Hospital Discharge)

8.1 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 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.

8.2 Reactive Care Delivery Update

1. Reactive Care Coordination Hub (Phase 1 – Dec 2025)

Phase 1 of the Reactive Care Coordination Hub went live in December, providing single-call access for urgent community referrals (8am–8pm, 7 days). The Hub now acts as the single point of access for urgent referrals, crisis response and discharge support, simplifying pathways for GPs, LAS and hospital teams. Senior Clinical Decision Makers (SCDMs) were embedded in Phase 1, strengthening real-time decision-making and supporting safe management at home. Improved pathways now operate with CCTs, X-ray Diagnostics and SDAH. ASC is now embedded into daily handovers/MDTs and strengthen links between the ICC Hub, SCDMs and wellbeing support. Phase 2 will expand to include frailty, mental health and end-of-life coordination. Currently, exploring opportunities to maximise impact by widening the referral criteria to include high-risk patients within Frailty services.

2. Community IV Antibiotics

The service continues to deliver 6–8 daily doses (with 25% utilisation) of IV antibiotics 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.

3. 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, with 115 referrals received (30.4% care home support team, 63.5% GP, 4.3% SCDM, 0.9% Michael Sobell, 0.9% other).

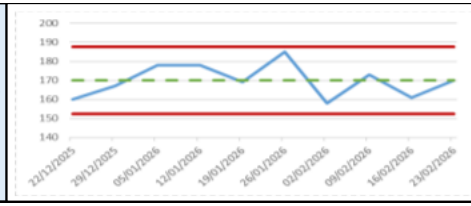
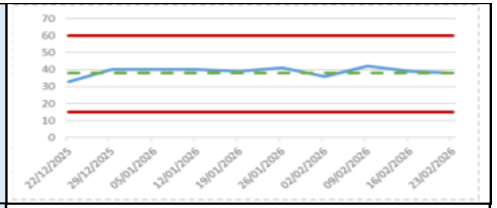
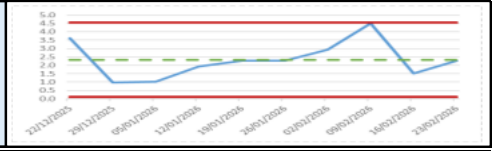
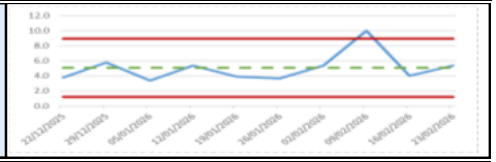
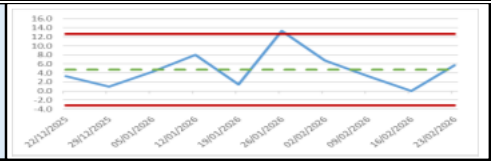
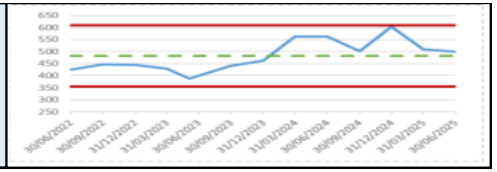
4. Lighthouse Mental Health Crisis Service

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 that went live in mid February. The average LoS has reduced by **52% (from 27 hours to 13 hours as of January 2026).** This reduction enables substantially higher throughput. **67% of service users** now return home with support, rather than being admitted, clear evidence of improved system flow with the majority of referrals coming from A&E and UTC.

5. Discharge Pathways & No Criteria 2 Reside (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 pre intervention levels of **~50 per day to the latest 10 week average of ~36 per day, representing a 28% reduction (positive improvement)**, improving flow and freeing bed capacity. Further work continues to operationalise changes, sustain progress made to date and embed continued delivery to achieve the target of <=34.

6. Discharge to Assess (D2A) Pathway 1 (P1) Integration: Commenced in October 2025 to support seven-day discharge and increase same-day discharge capacity, the service continues to show high utilisation (92% in Dec → 94% in Jan). Length of stay is improving (9.3 → 7.8 days) but remains above the ≤5-day KPI, driven primarily by reablement waits and family-related delays. To address this, the service is restructuring the daily D2A coordination call, launching daily Therapy–care provider joint case reviews, piloting the new Patient Discharge P1 leaflet, and establishing regular touchpoints between care providers, Therapy, and the acute trust to unblock delays and improve flow.

Reactive Care (Urgent & Crisis Response, Hospital Discharge)

						Narrative / Likely Cause	Actions to Remedy	Timeline	Accountability
A&E Activity Reduction (Traffic light measured against 10 wk Avg)		Monthly Actual **165**	Target 164 / 10 wk Average 170 / Trajectory 187	Graph Trendline for last 10 wks		The 10-week rolling average is currently 170 attendances per day, with a February average of 165. Type 1 attendances have decreased significantly in recent months, with a greater proportion of patients being appropriately redirected to UTC and SDEC services.	Work is currently underway to progress UCR and the expansion of the coordination hub. The Mobile Diagnostics trial is ongoing, with a significant number of patients benefiting from the service. In addition, the new Lighthouse service has been operational since November 2025.	Phased Rollout from Q3 25/26	SRO Reactive Care
NEL Admissions Reduction (Traffic light measured against 10 wk Avg)		Monthly Actual **38**	Target 29 / 10 wk Average 39 / Trajectory	Graph Trendline for last 10 wks		The 10-week rolling average currently stands at 39 NEL admissions per day, against a target of 29. This figure has remained relatively stable over recent months. While there has been an overall reduction in NEL activity over time, and NEL admissions with a length of stay (LoS) of 0 days continue to decline, further improvement is required in reducing admissions with a LoS greater than 0 days.	Since the beginning of November we have seen averages of 35 per day dropping again to 33 per day in December		SRO Reactive Care
No Criteria to Reside Reduction (Traffic light measured against 10 wk Avg)		Monthly Actual **40**	Target 34 / 10 wk Average 36 / Trajectory	Graph Trendline for last 10 wks		Significant progress has been made in reducing the number of patients recorded as having No Criteria to Reside over recent months. The 10-week rolling average currently stands at 36, with a February monthly average of 40. This represents an increase of four compared to December and places performance three above the target of 34.			SRO Reactive Care
Discharge Pathway Delays (P1) (Traffic light measured against 10 wk Avg)		Monthly Actual **2.2**	Target 2 / 10 wk Average 2.3 / Trajectory	Graph Trendline for last 10 wks		Overall we are meeting the discharge delay target for P3 and close to the target for P1 patients. But currently just over a day on the target for P2 patients. Key contributors to delay include discharge process bottlenecks—particularly time to placement within the P2 pathway—referral process delays across all pathways (including D2A and District Nursing), family choice-related delays, and broader capacity constraints.	P2 - IDT THH team to identify specific capacity to manage out of borough patients. P2 patients who require care home placement to be referred to ASC before MO to avoid delays for most complex pts.	Choice Policy Live. Integrated services to be in place by April 26	SRO Reactive Care
Discharge Pathway Delays (P2) (Traffic light measured against 10 wk Avg)		Monthly Actual **6.1**	Target 5 / 10 wk Average 5.1 / Trajectory	Graph Trendline for last 10 wks					
Discharge Pathway Delays (P3) (Traffic light measured against 10 wk Avg)		Monthly Actual **3**	Target 7 / 10 wk Average 4.7 / Trajectory	Graph Trendline for last 10 wks					
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		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.	Structured medicine and UCP reviews on-going. SCDM to support Care Home at weekends. Roll out of recognising signs of deterioration training to take place in Q4.	Phased Rollout from Q3 25/26	SRO Reactive Care

Reactive Care (Urgent & Crisis Response, Hospital Discharge)

8.2 Forward Plan (to Q1 2026/27)

The programme has made strong early progress, but further focused work is essential to secure long-term impact and address areas that remain off-track. The Forward Plan details the actions needed over the coming months to strengthen delivery, sustain improvements and expand community-led alternatives.

Key actions include:

1. Full Mobilisation of the Coordination Hub
- Planning for **Phase 2** (Q1 2026/27) will include frailty pathways, end-of-life rapid response and mental health integration, moving towards a future **24/7 model**.
- Additional UCR staffing 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.

2. Launch of an Integrated Rehabilitation & Reablement Service
- 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.

3. 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).

4. Mobile Diagnostics (X-ray)
- Continue to monitor and evaluate the diagnostics pilot and develop options for expansion. By the end of March 2026, produce a business case to inform future commissioning decisions.

8.3 Issues & Risks (Reactive Care)

- **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.

Best Start to Life (Children & Young People)

9.1 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.

9.2 Delivery Update

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 by the end of Q1 2026/27.

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)

9.3 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 .

9.4 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)

9.5 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

10.1 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 ~37, 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, Occupational therapists), 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), with Occupational therapists being noted as our top hard to recruit job, from the workforce survey we carried out.
- **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.

Appendices – Key Project Highlights

Lighthouse (Feb position)

The overarching aim of the programme is to:

The revised Lighthouse model, launched in **November 2025**, aims to:

- Improve crisis response capacity and flow for adults presenting in mental health crisis.
- Reduce avoidable admissions by enabling safe discharge home with support.
- Increase system throughput through reduced Length of Stay (LoS) and improved operational processes.

Delivery Progress to Date (January)

- Referrals increasing **from 11 patients to 25 patients per day**, with the first week post go live recording the highest referral rate since service launch.
- Daily activity has increased from **1.5 patients/day to 4 patients/day**
- Average LoS has reduced by **52% (from 27 hours to 13 hours as of January 2026**). This reduction enables substantially higher throughput.
- The service is currently managing around 4 patients per day against a target capacity of 6 (approximately 67% utilisation). Although utilisation has not yet reached the December target of 6 patients per day, the redesigned model has already delivered a step-change in throughput. This improvement is driven by a 52% reduction in length of stay, with service users now typically supported and discharged within one day, compared to 2–3 days previously.
- 67% of service users now return home with support, rather than being admitted, clear evidence of improved system flow with the majority of referrals coming from A&E and UTC.

The increase in activity from 1-2 to ~4 patients per day is therefore the result of greater operational efficiency, not an increase in presentations. As key operational enablers continue to embed (including staffing consultation outcomes, senior skill-mix enhancement, consultant and pharmacy cover, and strengthened A&E handover processes), the Lighthouse is well-positioned to scale up utilisation toward its full 10-patient daily capacity.

Core Delivery Model to Accelerate Improvement by March 2026

- Maintain LoS at ~1 day to safeguard high throughput.
- Integrate senior clinical oversight (consultant, pharmacy, advanced practitioners).
- Strengthen MDT decision making to support safe discharge home.
- Conclude staff consultation and permanently recruit to the staffing model
- Complete the planned service review for the Lighthouse model, which was intended to take place following its November launch. Findings of the review to determine the feasibility of scaling capacity to the proposed 10 patients per day.
- Strengthened A&E and UTC handover processes

Mobile Diagnostics (Feb Position)

The overarching aim of the programme is to:

To deliver and evaluate a 6-month Community Diagnostics pilot providing mobile and community-based diagnostic provision for frail, housebound, and care-home patients, with the objective of reducing hospital conveyances, improving patient experience, and informing future commissioning

Delivery Progress to Date

- **Strong early uptake and patient benefit demonstrated**: Since go-live on **15 November**, the Community Diagnostics Service has received **115 referrals by the end of January**. Patient case studies continue to evidence the benefits for frail, housebound and care-home residents, highlighting potenitaly avoided hospital conveyances and improved experience.
- **Significant potential to reduce avoidable acute demand**: January activity shows clear impact on system flow and avoidable hospital use (n = 80 recorded outcomes):
    - **68 patients** would otherwise have required *hospital attendance with transport*
    - **8 patients** would have had an outpatient hospital appointment
    - **4 patients** would have been taken to *A&E*
    - **17 patients** would have had *no X-ray performed*, potentially delaying diagnosis
    - **17** either recorded as other or not recorded

  This demonstrates strong potential for reducing unnecessary hospital-based activity and supporting earlier decision-making in the community.
- **Diagnostics delivered across a wide clinical range**: Chest X-rays account for **52%** of all examinations (42 cases).
- **Engagement across multiple community pathways**: Referrals have been received from **Direct GPs (63%), CHST (30%), SCDM (6%)**. This reflects the service gaining traction across the wider community provider network.

Core Delivery Model to Accelerate Improvement by March 2026

- **Expand the service to support additional pathways**, e.g. HICU (Hillingdon Integrated Care Unit), where frail patients frequently require diagnostics that currently trigger hospital attendance. Explore integration with virtual wards, reablement teams, and rapid response services to widen eligibility and streamline referral routes.
- **Improve awareness and increase referral volumes**: Despite growing uptake, utilisation is currently ~40%, indicating. A need for further promotion across the system. Development of simple referral guidance and prompts within primary/community systems (e.g., EMIS templates, CHST decision trees).
- **To support the future commissioning case**, a dedicated workshop with HomeMed, the BI Lead and PHM Lead has been held to improve data capture and ensure a robust evidence base for the future business case.

No Criteria to Reside (NC2R) (Feb Position)

The overarching aim of the programme is to:

To ensure that patients who no longer require acute hospital care are discharged promptly, safely, and to the most appropriate setting, thereby improving patient outcomes and optimising system flow. The programme seeks to:

- Maximise acute bed availability for patients with clinical need
- Reduce avoidable Length of Stay (LoS)
- Strengthen discharge pathways and system co-ordination across hospital, community and social care services
- Enhance overall system efficiency and resilience, particularly in managing demand pressures

Delivery Progress to Date

- NC2R 8 week reduction plan concluded Jan 26 having shown reductions of patients with NC2R by 35% to below the required target of <=34 (daily average achieved in December), with the number being slightly above in January (37)
- Went from a daily average of around 50 to 33 in December 25, less than 4% of Hillingdon's beds were occupied by patients without a clinical need to remain – compared to the North West London average of 14% and a London wide average of 12%
- Daily multi-agency reviews are taking place, supported by an established operational discharge model
- System Gold Oversight in place
- We have seen an increase in P2 patients delayed, with the volume of out of borough (Non Hillingdon patients) accounting for around 50% of this.
- Whilst we are delivering strong in day grip, a structured flow constraint prevents sustained improvement.

Core Delivery Model to Accelerate Improvement by March 2026

- Sustain NC2R inpatients at or below 34/day through the continuing multi-agency reviews, operational discharge model and system Gold oversight.
- Ensure we are delivering small, consistent surplus in P2 discharges and improve visibility and coordination, especially for non-Hillingdon patients.
- Gold are reviewing and looking at the structure of the IDT team and how this can be aligned/revised in order to sustain the current deliverables and provide on average an additional 1 NC2R discharge or provide an additional 5-7 resolutions per week for P2 patients.

Hypertension (Feb Position)

The overarching aim of the programme is to:

- Increase diagnosed/recorded prevalence (from 10% baseline → 14%, moving toward 16% by March 2026).
- Improve BP optimisation (currently 78–80%, highest in NWL).
- Reduce the medium term burden of cardiovascular emergencies (stroke, heart failure, hypertensive crises).
- Prioritise inequality hotspots through targeted coding, outreach and population health analytics .

Delivery Progress to Date

- Hillingdon prevalence has increased by 0.01% to 14% and remains the highest in NWL . Optimisation has increased from 77%. to 78%.
- Although an extra 394 new cases have been diagnosed since September 2025, approx. 6,700 more patients will need to be diagnosed to meet the 16% target.
- ALL PCN's are above 76% Optimisation & 24/42 practices are at 80% Optimisation. 14 practices have achieved 16% + Prevalence (increased from 13).
- Healthy Heart Campaign live on social media and system wide websites
- Dates secured to deliver Standardised practice-webinars/Masterclass/Webcast

While prevalence has increased to 14%, with optimisation levels remaining stable at 78–80%, there is a recognised challenge of reaching the 16% target by March 2026. Within Hillingdon, ~90% of practices have reached or contributed significantly to the 14% borough-wide prevalence figure, but a cluster of practices lag behind (largely in more diverse, higher deprivation areas) and hard to reach groups remain under diagnosed.

The next 8–12 weeks will focus on high-impact PHM-driven case finding, community-based BP testing, optimised recall pathways, and strengthened partnership working with community and voluntary sector organisations. Without this accelerated model, current projections indicate the borough will fall short of the March 2026 target.

Core delivery model to accelerate improvement by March 2026, will include:

- **Coding & data clean up**: Practices standardise coding, retrospectively review records, and use WSIC searches to proactively identify high-risk cohorts.
- **Targeted recalls**: Prioritise high risk residents (ethnic minorities, deprived wards, older adults, patients with co-morbidity).
- **Community outreach**: Mosques, local events, high footfall settings and out of hours engagement campaigns (recognising that many residents in Hillingdon work shift patterns), a health literacy engagement event is planned for February 2026, aligned with Healthy Heart Month.
- **Healthy Heart Campaign**: Engagement, BP testing pop ups, awareness work and signposting.
- **Hypertension Strategy**: Develop a borough-wide Hypertension Strategy.
- Work with PCN CDs to address the challenge of guaranteed workforce to deliver engagement events

Discharge to Assess (D2A) Pathway 1 (P1) Integration (Feb Position)

Purpose (Phase 1 objectives)

Create one consistent D2A pathway to reduce duplication and unnecessary handoffs across Therapy, Care Providers, IDT and ASC.
Improve discharge efficiency and patient flow through clear booking rules, decision- making standards and governance.
Optimise therapy and bridging capacity using a unified workforce model and structured daily coordination.
Strengthen continuity and outcomes by standardising environmental/safety checks and clear escalation processes.
Improve patient and family understanding with a clear, transparent assessment and discharge journey.

Progress to date:

- **Service Review & Baseline:** Completed a rapid review of Pathway 1 services, establishing a clear baseline to target improvement.
- **Integrated Pathway Model:** Finalised end-to-end Pathway 1 process maps, clarifying roles, handoffs, dependencies and system touchpoints to support smoother workflows.
- **SOP Consolidation:** Developed a consolidated draft SOP including a single referral pathway, clear RACI framework, escalation rules, double-handed care criteria, therapy booking standards and D2A call expectations.
- **Digital Enablement:** Validated the System C onboarding flow (UAT in progress), implemented Entra ID single sign-on with MFA, and progressed external user onboarding.
- **Operational Improvements:** Restructured the D2A daily call and introduced a daily Therapy–Care Provider case review (live from w/c 9 Feb 2026) to accelerate decision- making.
- Bridging Service (Dec–Jan 2025/26): Utilisation remained high (92% in Dec to 94% in Jan), with LOS improving but above KPI (9.3 days in Dec to 7.8 days in Jan; discharges ≤5 days 18% to 30%, ≤7 days 31% to 48.4%).

Key drivers of LOS/variability (Dec–Jan): High waits for Reablement (65% in Dec to 47% in Jan), sharp increase in family -related delays (23% to 48.5%), stable provider delays (3–4%), and self-funders <2%. Some longer stays during Dec–Jan resulted in patients being discharged with no ongoing package required.

To address this, the service is restructuring the daily D2A coordination call, launching daily Therapy–care provider joint case reviews, piloting the new Patient Discharge P1 leaflet, and establishing regular touchpoints between care providers, Therapy, and the acute trust to unblock delays and improve flow.

Next Steps

- **Process:** Embed revised D2A call structure; ensure consistent data brought to calls
- **Workforce:** Clarify single-workforce development opportunities (joint visits, joint case review and triage)
- **Digital:** Support training backlog, ensure new GDPR module deployment
- Piloting the new Patient Discharge P1 leaflet, and establishing a regular care provider / Therapy / acute trust touchpoint to unblock delays and improve flow.

Integrated Response Coordination Hub (Feb position)

Purpose

The Integrated Response Coordination Hub will provide a single coordination point for out-of-hospital patients in crisis, ensuring right care, right time, right place decisions, rapid response, and safer transitions between proactive, planned and urgent care to reduce unnecessary acute activity

Achievements Phase 1

- **Implemented Senior Clinical Decision Maker (SCDM)** – 8-8pm 7days – supporting UCR/YLL/CCTs/CHST/FAU from 3rd November
- SCDM – **refer to diagnostic service** for x-rays from the above services
- SCDM – **part of the daily handover** and works with UCR clinician of the day (COD)
- Improved referral and **communication to Adult Social Care**
- Agreed **Wellbeing support** to be able to **accept referral earlier**
- **Direct stepdown to CCTs** and other specialist services for appropriate patients.
- **Direct links** into **SDUC** and **Phlebotomy service**
- **Comms posters created** for SCDM and Mobile Diagnostics

Phase 1 Still to be embedded by April 26

- **Developing YLL and DNs reporting** on SystemOne to include 2hr response
- **Implemented ASC worker** into daily handover and MDTs –went live 28th January
- **Implement SCDM supporting FAU and Podiatry** – pathway being developed
- Implementing **earlier identification** of **Wellbeing Support** – met with Paula Aubrey 29/01 – f/up 23/02 to agree process and start date
- New process for **NWL ICC Coordination hub to refer to SCDM** for onward care if appropriate – Grace Harman presenting to NWL ICC signed off 12/02- need to agree go-live
- Improved shared information **UCP care planning** and better coordination of **care-SCDM trained and updated UCPs**
- **Performance framework** and **metrics** agreed with **automated reports** set up
- **Increased utilisation** for SCDM and Mobile Diagnostics – posters created, and webinars organised
- **IT scope requirements** documents created –presented at HHCP IT & Digital Data Steering group 10th Feb. Prioritisation and mapping exercise to be done.
- Conduct **workforce mapping** on services with identified functions/skills current capacity and identified gaps

Phase 2 From April to June 26

- Extend **wider than UCR to include EOL, Frailty and mental health** and align with the Neighbourhood model being developed
- Agree and **Implement core team** for Coordination hub
- **Set up infrastructure**, systems, process, workforce and training
- **Working with ED/Virtual Wards** to prevent admission
- **Align with Bridging/D2A** improvement being developed

Hillingdon Children & Young People (CYP) Transformation Board

Purpose of the meeting
The Board met to **reset and clarify the strategic governance for Children and Young People (CYP)** across Hillingdon, ensuring clear leadership, system-wide coordination, and stronger alignment with neighbourhoods, commissioning, and the Health & Wellbeing Strategy.

Key themes and discussion

1. Need for a single strategic CYP forum
- Strong consensus that CYP work is currently **fragmented across multiple meetings and partnerships**, leading to duplication and lack of strategic direction.
- Agreement that a **focused CYP strategic group** is needed to provide leadership, coordination, and parity of esteem with adult priorities.

2. Strategic vs operational separation
- Clear agreement that the CYP strategic group should **not replace operational or contractual forums**, particularly those managing the CNWL–Local Authority collaborative agreement.
- Proposal to keep **contractual and delivery detail** in separate operational groups, with escalation into the strategic forum where required.

3. Governance and system alignment
- Extensive discussion on how the group should sit within existing structures (Executive Oversight Board, Health & Wellbeing Board, HHCP).
- Emerging preference to **embed CYP within existing governance routes**, ensuring visibility through integrated performance reporting rather than creating parallel structures.

4. Neighbourhoods and integration
- Strong emphasis on ensuring CYP is **embedded within neighbourhood and integrated team models**, which are currently perceived as adult-focused.
- Recognition that CYP services (family hubs, child health hubs, therapies, mental health) need clearer system-level visibility and coordination.

5. Voice of children, young people and families
- Consensus that CYP and family voices must be **systematically included**, rather than ad-hoc.
- Existing mechanisms (Healthwatch, Family Hub Parent Groups, engagement forums) should be **better coordinated and linked into strategic decision-making**.
- Action taken to clarify how Healthwatch and other engagement routes feed into CYP governance.

6. Outcomes, data and performance
- Agreement that a **shared outcomes framework and dashboard** is essential to track impact across prevention, early intervention, and specialist services.
- Recognition that data sharing and consistency remain challenging but are critical for accountability and reporting to the Health & Wellbeing Board.

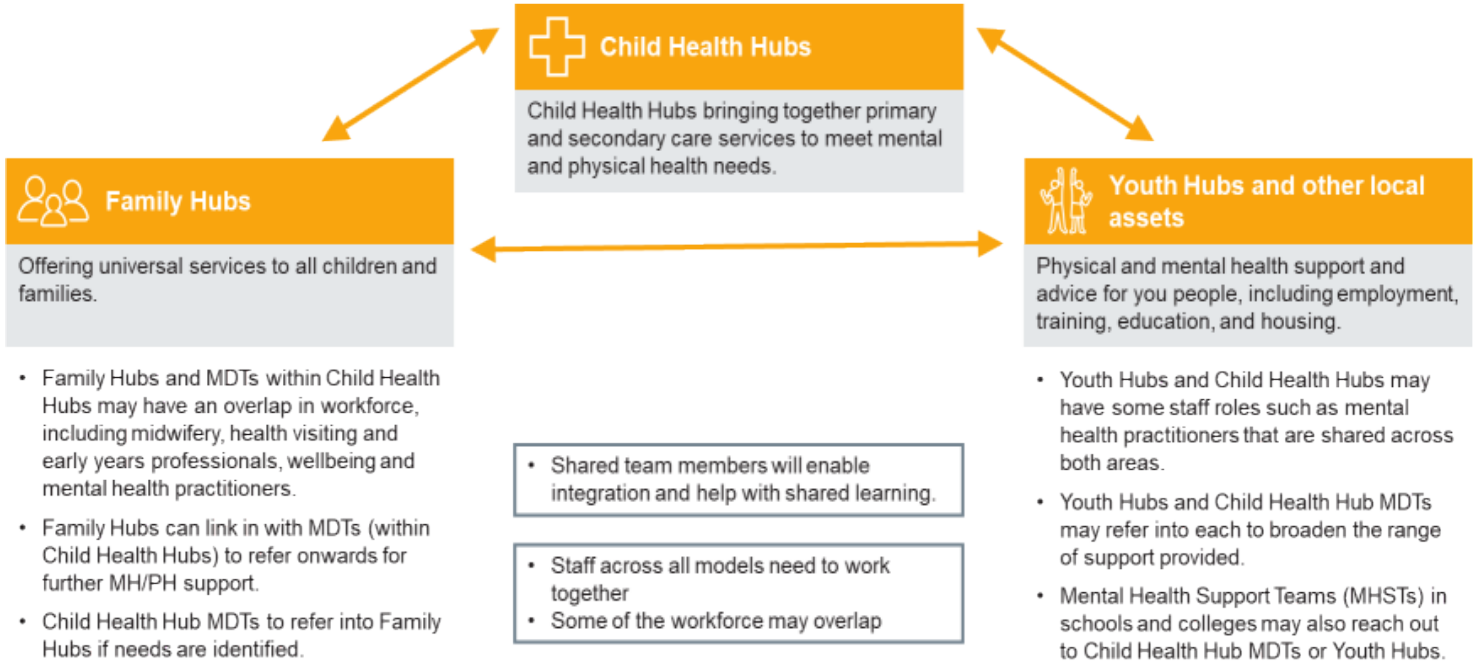
7. Health & Wellbeing Strategy influence
- The draft Health & Wellbeing Strategy was discussed, with recognition that CYP priorities (particularly prevention and early intervention) must be **clearly reflected and measurable**.
- Opportunity identified to influence final sign-off through integrated reporting and verbal updates.

Child Health Hubs – Overview and Next Steps

Child Health Hub Expansion – Mobilisation Summary

- **Approve & design**: Secure governance approvals and finalise the CHH service specification (Q1 2026)
- **Mobilise workforce**: Recruit programme and clinical resources and agree GP and paediatrician capacity
- **Enable delivery**: Finalise contracts, funding, data capture, and reporting infrastructure
- **Phased rollout**: Launch hubs in cohorts from Q1 to Q3 Apr 2026 to Sep 2027, supported by comms and engagement
- Evaluate & sustain: Evaluate impact and use findings to inform outcomes, scaling, and long-term funding

Integration of neighbourhood services for children and families



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OCCUPATIONAL THERAPY SERVICE UPDATE

Relevant Board Member(s)	Julie Kelly – Corporate Director, Children's Services
Organisation	London Borough of Hillingdon
Report author	Gary Binstead – Head of Commissioning
Papers with report	None

HEADLINE INFORMATION

Summary	This report is to brief the Board on the challenges of the delivery of Occupational Therapy (OT) statutory contacts for children with SEND, as outlined in their Education, Health, and Care Plans (EHCPs).
Contribution to plans and strategies	The delivery of therapies outlined in a child's EHCP is part of a statutory duty related to the SEND code of practice, and CNWL are jointly commissioned to deliver these therapeutic interventions on behalf of Hillingdon Council and the ICB.
Financial Cost	£2,739,345 overall contract value for therapies (LBH & ICB)
Ward(s) affected	All

RECOMMENDATION

That the Health and Wellbeing Board note the content of the report.

INFORMATION

1. This report relates to the number of children who did not receive their full number of statutory contact hours for OT during the last academic year (2024 / 25), setting out a recovery plan with approximate timescales. The information below sets out the number of children affected.

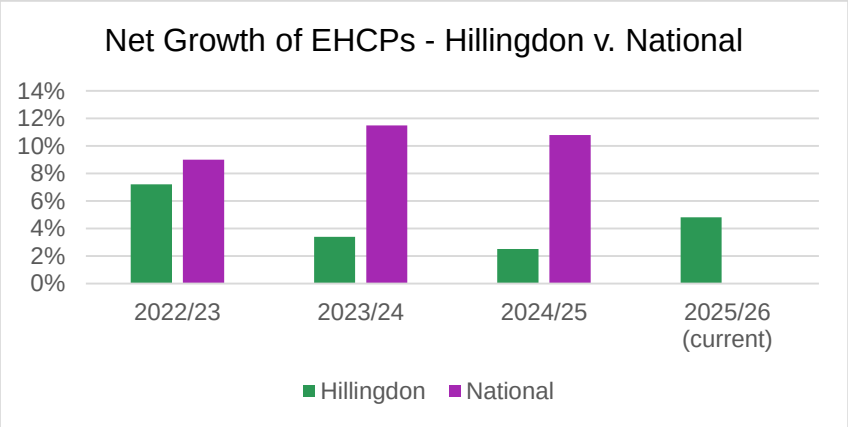
2. In the academic year 2024 / 25, approximately 400 children and young people did not receive their full allocation of OT contacts as set out in their EHCP, although more than half of all contacts were delivered as expected, and only a handful of children and young people did not receive any contacts.

3. This matter is being brought to the Board's attention because of the potential risk if the service is unable to meet the current demand and sets out how the CNWL service will recover from the current backlog.

Context

4. The number of EHCPs in Hillingdon have been growing significantly over the years like many

Local Authorities are experiencing. More recently, the growth has slowed compared to previous trends due to robust annual reviews, more opportunities for young people to be supported into employment and a range of other factors.



5. Not all children will have therapy input in their EHCPs but many children do. A number of children have personal budgets in place for therapy or have a private provider due to specific needs. The rest of the children with OT in their EHCPs will have their therapy delivered by CNWL as part of the commissioning arrangements.

Background

6. This issue was highlighted to CNWL during the last academic year, and CNWL have been working closely with the Head of Commissioning in the Council to agree a plan to recover from the backlog.

7. There is a national shortage of OTs due to a range of factors which are impacting service delivery across many regions, and CNWL has not been immune to the recruitment and retention challenges in the country. This has impacted the current workforce, and in turn, the capacity to deliver all statutory contacts.

8. These pressures have been evident through a reduced workforce due to maternity leave, recruitment challenges and other factors, and has reduced the OT capacity for a prolonged period of time, despite CNWL efforts to recruit to the appropriate staffing levels.

9. As a result, there are a number of children and young people who have not received their statutory number of contacts during the last academic year as outlined above, and work is underway to correct this as set out below.

Recovery Plan

10. Where a child or young person has been identified for not receiving any contacts, plans have been put in place to recover these through separate commissioning arrangements in conjunction with families, and some of these have been delivered already.

11. The therapy needs of all the other affected children are being assessed, and plans are being developed to ensure their individual needs are met appropriately. This will include input from children, families, therapists, and schools. Once these assessments are complete, appropriate therapy will be provided as agreed.

12. CNWL are planning to commission additional capacity from the independent therapy market, in order to ensure that the appropriate level of therapy is provided to all children as outlined in their EHCP and also keep pace with the increased demand for assessments. These discussions are well developed, and CNWL are aiming to have additional capacity commissioned before the end of December.

13. It is expected that the appropriate OT provision will have been delivered by the end of the Spring term at the end of March for the children impacted during the 2024 / 25 academic year.

14. Reassuringly, all the scheduled OT statutory contacts are forecast to be delivered by the end of the Autumn term at the end of December as planned, showing a marked improvement due to additional capacity.

15. Discussions will continue between all organisations involved, and the recovery plan will remain under review. Plans will be updated as necessary to ensure the appropriate levels of therapeutic input are delivered to all children and young people as outlined in their EHCPs.

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BOARD PLANNER & FUTURE AGENDA ITEMS

Relevant Board Member(s)	Councillor Jane Palmer Keith Spencer
Organisation	London Borough of Hillingdon Hillingdon Health and Care Partners
Report author	Nikki O'Halloran, Democratic Services
Papers with report	Appendix 1 - Board Planner 2026/2027

1. HEADLINE INFORMATION

Summary	To consider the Board's business for the forthcoming cycle of meetings.
Contribution to plans and strategies	Joint Health & Wellbeing Strategy
Financial Cost	None
Relevant Select Committee	N/A
Ward(s) affected	N/A

2. RECOMMENDATION

That the Health and Wellbeing Board considers and provides input on the 2026/2027 Board Planner, attached at Appendix 1.

3. INFORMATION

Supporting Information

Reporting to the Board

The draft Board Planner for 2026/2027, attached at Appendix 1, is presented for consideration and development in order to schedule future reports to be considered by the Board. Members may also wish to consider any standing items (regular reports) and on what frequency they are presented.

The Board Planner is flexible so it can be updated at each meeting or between meetings, subject to the Co-Chairs' approval.

Board agendas and reports will follow legal rules around their publication. As such, they can usually only be considered if they are received by the deadlines set. Any late report (issued after the agenda has been published) can only be considered if a valid reason for its urgency is agreed by the Co-Chairs.

Advance reminders for reports will be issued by Democratic Services but report authors should note the report deadlines detailed within the attached Board Planner. Reports should be presented in the name of the relevant Board member.

With the Co-Chairs, Democratic Services will review the nature of reports presented to the Board in order to ensure consistency and adequate consideration of legal, financial and other implications. It is proposed that all reports follow the in-house "cabinet style" with clear recommendations as well as the inclusion of corporate finance and legal comments.

The agenda and minutes for the Board will be published on the Council's website, alongside other Council Committees.

Board meeting dates

The Board meeting dates for 2026/2027 were considered and ratified by Council at its meeting on 22 January 2026 as part of the authority's Programme of Meetings for the new municipal year. The proposed dates and report deadlines for the 2026/2027 meetings have been attached to this report as Appendix 1.

Financial Implications

There are no financial implications arising from the recommendations in this report.

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

Consultation Carried Out or Required

Consultation with the Chairs of the Board and relevant officers.

5. CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

There are no financial implications arising from the recommendations in this report.

Hillingdon Council Legal comments

Consideration of business by the Board supports its responsibilities under the Health and Social Care Act 2012.

6. BACKGROUND PAPERS

NIL.

APPENDIX 1

BOARD PLANNER 2026/2027

9 Jun 2026 2.30pm Committee Room 5	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Thursday 28 May 2026 **Agenda Published:** 1 June 2026
	Board Planner & Future Agenda Items	LBH	
	PART II - Update on current and emerging issues and any other business the Co-Chair considers to be urgent	All	

8 Sep 2026 2.30pm Committee Room 5	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Thursday 27 August 2026 **Agenda Published:** 31 August 2026
	Board Planner & Future Agenda Items	LBH	
	PART II - Update on current and emerging issues and any other business the Co-Chair considers to be urgent	All	

1 Dec 2026 2.30pm Committee Room 5	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Thursday 19 November 2026 **Agenda Published:** 23 November 2026
	Board Planner & Future Agenda Items	LBH	
	PART II - Update on current and emerging issues and any other business the Co-Chair considers to be urgent	All	

9 Mar 2027 2.30pm Committee Room 6	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Thursday 25 February 2027 **Agenda Published:** 1 March 2027
	Board Planner & Future Agenda Items	LBH	
	PART II - Update on current and emerging issues and any other business the Co-Chair considers to be urgent	All	

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