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 – 09th September 2025

Health and Wellbeing Board Priorities Background and Overview

1. Purpose, Background and Overview

This paper provides an update on progress against the Health and Wellbeing Board's key priorities, Place transformation programmes, and wider system goals in Hillingdon. It focuses on delivery progress, performance outcomes, and next steps. The report consolidates the latest developments across three core areas:

- **Health and Wellbeing Board Metrics** – A summary of performance against agreed strategic indicators, highlighting areas of improvement and flagging metrics requiring further attention.
- **Integrated Neighbourhood Teams (INTs)** – Update on mobilisation across Hillingdon, covering infrastructure, workforce, and governance. Next steps include finalising operating models, embedding enabling workstreams, and aligning INT delivery with borough priorities.
- **Reactive Care Programme** – Current status and forward plan, including:
  - Development and phased launch of the Community Coordination Hub
  - Expansion of Urgent Community Response (UCR) services
  - Integration of rehabilitation and reablement services
  - Actions to reduce "No Criteria to Reside" delays and improve hospital discharge flow

In response to growing health needs, inequalities, and system pressures, we have established **five strategic priorities**, aligned with Core20PLUS5, NWL ICS priorities, the HHCP strategic plan, and the Council's wider policy framework. These are designed to strengthen prevention, reduce unplanned care, and target inequality at neighbourhood level:

1. **Start Well** – Improve early years outcomes, reduce childhood obesity, and promote school and life readiness.
2. **Live Well** – Prevent and delay long-term conditions (particularly hypertension), improve mental wellbeing, and strengthen early intervention and carer support.
3. **Age Well** – Scale proactive frailty management and improve end-of-life care to help people live independently for longer, avoiding unnecessary admissions and enabling earlier discharge.
4. **Healthy Places** – Address housing, environment, employment, and social isolation.
5. **Equity and Inclusion** – Focus resources where inequalities are greatest (Hayes, Yiewsley, West Drayton) through the Core20PLUS5 framework.
6. For Years 1–2, delivery will focus on **Live Well, Age Well, and Equity and Inclusion**, balancing ambition with manageable delivery risk.

To deliver the 5 Strategic Priorities, we are implementing a new 7 day Place Operating Model through 2 key transformation programmes for 25/26

1. Integrated Neighbourhoods :

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

- **Same Day Urgent Primary Care through 3 Neighbourhood Super hubs** to reduce demand pressure on Primary Care and the THH Urgent Treatment Centre and Emergency Department
- **Proactive Care** through risk stratification, case finding and enhanced case management to prevent the onset of non elective crises **for people with severe frailty** (9,840)
- **A Preventative and Anticipatory Care Programme** for those people with mild to moderate hypertension (

2. Reactive Care:

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

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

Key Metrics :

Tackle the short and long term root cause of population ill health, challenged UEC operational performance and ensure that we deliver the activity assumptions set out in the new hospital redevelopment plan.

1. Reduce UTC Attendances to a daily average of <= 180 by 2025
2. Reduce ED attendances to a daily average of <= 164 by 2025
3. Reduce non elective admissions to hospital by 10% over 2019/20 baseline
4. Increase the percentage of people on the carers register over 2021 census
5. Increase the proportion of people who use Reablement and who require no ongoing support over the 2024/25 baseline
6. Flatline permanent admissions to care homes based on 2025/26 baseline.
7. Enable THH to operate within a target bed base of <= 412 beds by reducing patients without criteria to reside to a daily average of <= 34 by 2025 and reducing discharge delays across all pathways to national norms by 2025
   - P1: <=2 days delay
   - P2: <=5 days delay
   - P3: <=7 days delay
8. Deliver a 30% reduction in associated non elective admissions/long term care for (hypertension) over the 2019/20 baseline by 2028 by:
   I. Increasing prevalence rates for hypertension amongst adults to 24% by 2028
   II. Ensuring that at least 80% of patients with diagnosed hypertension have their Blood Pressure under control by 2028

Executive Summary

2. High-Level Progress Summary (as of July 2025)

- **Neighbourhood Integration**: All three Integrated Neighbourhood Teams (INTs) now live, covering the borough; 50% of the severe frailty cohort already case managed, delivering a **36% reduction in non-elective admissions**. Remaining 50% by April 2026.
- **Prevention**: Hypertension prevalence recording increased to **13.8%** (up from 10% baseline), with **85% of diagnosed cases under control** – exceeding target. Short term target is 16% by March 2026. Flu and COVID immunisation uptake improved following provider changes and targeted outreach.
- **Reactive Care**: Design and mobilisation of the **Reactive Care Coordination Hub** underway for Dec 2025 go-live; **Lighthouse Mental Health Crisis model** expanded capacity and live from Sept 2025; **Take-Home-and-Settle** service launched in July supporting safer discharges.
- **Hospital Flow**: Weekday discharges improved (55/day vs 51 in June); weekend discharges rising modestly but still below requirement. Patients with **No Criteria to Reside** remains high (46 vs target ≤34), with a system taskforce and 8 week delivery plan now in place. New Choice Policy due Nov 2025.
- **Challenges**:
  - **ED attendances** remain significantly above target (196/day vs ≤164).
  - **UTC activity** at 189/day, above target (≤180).
  - **Patients with No Criteria to Reside still too high with Discharge Pathway 2 delays (42% of all Patients with NC2R)** above norm (6.5 days vs ≤5).
  - **Estates and funding constraints** risks delaying **Neighbourhood Super Hubs** and full SDUC rollout.
- **Next Steps**:
  - Launch Coordination Hub (Dec 2025).
  - Pilot Mobile Diagnostics for Care Home Residents and Frailty elderly cohort in Q3 2025/26
  - Implement NCR reduction taskforce and 8 week delivery plan (Sept 2025) and Choice Policy (Nov 2025).
  - Scale hypertension outreach to reach **16% prevalence by Mar 2026**.
  - Archus appointed to develop Neighbourhood Estates Business Case for Super Hubs
  - Embed integrated INT leadership by end 2025.
- A summary of metrics, actions and accountability is given overleaf:

Health and Wellbeing Priorities: Summary Progress to Date (July 2025)

Metric	Target	Actual (Jul '25)	RAG	Likely Cause	Summary Action to Remedy	Timeline to Resolution	Accountability
ED Attendances	≤164/day	196/day		High demand, limited UCR capacity, mental health crises at Front Door	Expand UCR including launch of Co-ordination hub, mobile diagnostics, Implement new Lighthouse diversion from Sept	Phased rollout from Q3 25/26	SRO Reactive Care
UTC Attendances	≤180/day	189/day		Reduction in SDUC funding , demand spill over into UTC	Revised Delivery Plan incorporating stronger front door diversion and capacity improvement	Phased rollout from Q3 25/26	SRO Neighbourhoods
Patients with No Criteria to Reside (NCR)	≤34/day	46/day		Discharge bottlenecks particularly P2, referral process delays across all Pathways, Family choice Delays	8 Week Delivery Plan developed running Sept through end Oct	Choice policy live Nov 25, 8 Week Delivery Plan Sept - Oct	SRO Reactive Care
NEL Admissions: Moderate Frailty	≤285/1,000	273/1,000		INT case management effective	Sustain INT scaling, expand anticipatory care	Full coverage by Apr 26	SRO Neighbourhoods
NEL Admissions: Severe Frailty	≤694/1,000	674/1,000		Early impact of frailty programme	Full rollout to 100% severe frailty cohort	By Apr 26	SRO Neighbourhoods
Unplanned Admissions from Care Homes	≤688/1,000	688/1,000		Variable care home capability, lack of community alternatives for Falls and Infection	Care Home Champion forum, UCP training, Expand UCR, access to mobile diagnostics including IVA	Phased rollout from Q3 25/26	SRO Reactive Care
Discharge Pathway Delays (P1)	≤2 days	1.23		• Discharge Process Bottlenecks esp time to Placement in P2 • Referral Process Delays across all Pathways: D2A, District Nursing • Family Choice Delays • Capacity Constraints	8 Week Delivery Plan developed running Sept through end Oct Integration of Rehabilitation and Reablement Jan 2026	Choice policy live Nov 25, 8 Week Delivery Plan Sept - Oct	SRO Reactive Care
Discharge Pathway Delays (P2)	≤5 days	6.53					
Discharge Pathway Delays (P3)	≤7 days	6.1					
Hypertension Prevalence	16% (Mar '26)	13.8%		Outreach scaling slower than required	Accelerate pharmacy/GP/INT outreach, Borough campaign	16% by Mar 26	SRO Neighbourhoods
Hypertension Control	≥80%	85%		Strong primary care management	Maintain and spread learning	Ongoing	SRO Neighbourhoods

Integrated Neighbourhood Teams – Proactive Care

3. Integrated Neighbourhood Teams – Proactive Care

Integrated Neighbourhood Teams (INTs) drive Hillingdon's **preventative and personalised care** agenda at the community level.

These teams unite GPs, community nurses, social care, mental health, therapists, and voluntary sector partners within three locality-based "neighbourhoods."

The proactive care program focuses on **keeping people healthy and independent**, managing long-term conditions (like frailty and hypertension) to **prevent crises and hospital admissions**.

Proactive Care – Strategic Intent

Establish three Integrated Neighbourhood Teams and hubs providing joined-up care closer to home. Focus on **frailty management** and **preventative interventions** (e.g. hypertension case finding) to reduce avoidable hospital use. Each INT coordinates GPs, community services, soial care, and VCS support to keep residents healthy and independent.

Key Achievements to Date

✓ **3 INTs launched**, covering the whole borough, with co-located teams

✓ **Severe frailty case management for ~50%** of identified cohort – achieved a **36% drop in emergency admissions** for those patients

✓ **Hypertension case-finding drive**: raised recorded prevalence from **10% to 13.8%** (highest in NWL), with **85% of known hypertensives under control** (above 80% target)

✓ **Community outreach pilot ("Living Well")**: 25% of attendees had undiagnosed high BP and were escalated for treatment

✓ **Infrastructure progress**: Business case drafted for 3 locality hubs; joint INT leadership roles being created across organisations

Upcoming Priorities

- Roll out **INT care hubs** (subject to funding) – expand same-day urgent care and diagnostics in communities by **mid-2026**
- Enrol **100% of severe frailty patients** in Enhanced Case Management by **Apr 2026** (up from ~50% now)
- **Merge community teams** (District Nursing, Care Home team) by **Nov 2025** to boost proactive capacity
- **Hypertension outreach**: monthly health check invites and borough-wide BP awareness events (starting **Sept 2025**) to reach **16% prevalence by 2026**
- **Strengthen patient engagement** via new Neighbourhood PPI forums (launch in **early 2026**)

Integrated Neighbourhood Teams – Proactive Care

Next 6–12 Months – Priorities

Frailty Case Management
By Q4 2025/26 (March–April 2026), every patient with severe frailty will have a care coordinator and a multidisciplinary plan. This will require recruiting extra matrons and therapists (enabled by the planned Care Home & CCT team integration by Nov 2025) and using the WSIC frailty data to identify and enrol patients. A new digital frailty dashboard is due early 2026, enabling INTs to track and support high-risk patients more effectively.

•Neighbourhood Care Hubs (pending funding)
Securing ICB capital funding through the Archus led business case is critical to progress. Interim South Hub sites will be identified by Sept 2025 to expand access ahead of full development. Once funding is approved (expected by end 2025), design and phased implementation will follow: All hubs will offer 7-day urgent primary care, diagnostics (ultrasound, X-ray), and outpatient clinics, improving local access.

•Hypertension & Prevention
A borough-wide campaign ("Know Your Numbers" week) launches Sept 2025 to promote blood pressure checks, supported by pharmacies, GP Confederation clinics, and community events. The target is to increase recorded prevalence from 13.8% to 16% by March 2026, on the way to 20%+ by 2027, while maintaining high levels of BP control (>80%). INTs will also expand anticipatory care for other conditions, such as a COPD case-finding pilot in early 2026 and embedding mental health practitioners in each INT to intervene early in anxiety/depression.

Aug 2025: Frailty Group Kickoff
ICB-led taskforce launched to implement the NWL Frailty specification in Hillingdon. Gaps analysis and project plan initiated.

Sept 2025: Hypertension Outreach Start
First batch of ~350 Health Check invitations sent via Blinx. Borough-wide BP awareness campaign plan completed.

Nov 2025: Integrated Team Merger Plan
Complete options appraisal to merge Care Home & Community Nursing teams into INTs, increasing frailty case management capacity.

Dec 2025: INT Hubs Business Case Decision
ICB expected to decide on funding for 3 Integrated Care Hubs. If approved, hub development project plan initiates (with target go-live in 2026).

Apr 2026: 100% Frailty Coverage
Goal for all ~10k severely frail residents to be under enhanced case management via INTs, doubling the current reach and sustaining reduced hospitalisation rates.

Reactive Care

4. Reactive Care Programme – Hillingdon

The Reactive Care programme is redesigning urgent and crisis care so residents receive the **right care, in the right place, at the right time** when health or social care needs escalate.
It brings together our **Integrated Urgent Response**, hospital avoidance services, and discharge support – creating a single pathway for unplanned care outside of the acute hospital.

The goal is a **24/7 community-based urgent care system** able to respond to crises within two hours, deliver short-term treatment and monitoring at home, and coordinate a smooth return to routine or planned care.

This transformation is vital to:

- Reduce pressure on A&E and 999
- Prevent unnecessary admissions
- Enable timely discharges
- Improve patient outcomes and system flow

Hillingdon's Reactive Care model has three components:

1. **Integrated Urgent Community Response**
2. **Supporting Discharge**
3. **Proactive support for reactive care** (bridging prevention with urgent response)

The intended outcome is a **single borough-wide Integrated Reactive Care Service**, consolidating previously separate teams (rapid response nursing, admission avoidance, discharge, and reablement) into **one coordinated system**.

Reactive Care – Strategic Intent

Integrate and strengthen urgent & emergency community services to manage crises outside hospital and support safe discharges. Establish a single **Community Coordination Hub** for 2-hour urgent response, linking rapid response, mental health crisis, and social care teams. Expand same-day urgent primary care capacity and implement 7-day services to improve hospital flow.

Key Achievements to Date

✓ **Coordination Hub model designed**: Multi-agency taskforce set high-level operating model, staff workshops begun

✓ **New "Lighthouse" mental health pathway approved:** Increase crisis alternative capacity from 4 to 8–10 patients, direct from A&E (Phase 1 live Sept 2025)

✓ **Community IV Antibiotics service launched (July 2025):** Providing 6–8 daily IV therapy slots in the community, reducing hospital visits

✓ **Direct GP-to-SDEC referrals implemented:** GPs can now refer patients straight to same-day emergency care without ED, adding ~5 extra cases/day

✓ **Hospital discharge improvements:** Weekday discharges up from 51 to 55 per day (July 25) after new initiatives; weekend discharge up modestly. "Home First" discharge teams restructured and Take-Home-and-Settle service in place.

Upcoming Priorities

◆ **Launch Hillingdon Coordination Hub pilot by Dec 2025**: single point for urgent community referrals, operating 8am–8pm, integrating health & social care rapid response

◆ **Winter resilience (Oct 2025–Mar 2026):** Execute surge plan – extend community urgent care hours, extra virtual ward capacity, close monitoring of admissions and discharges

◆ **Lighthouse Phase 2 (Q3 25/26):** pending evaluation, expand mental health hub to GP referrals further relieving ED

◆ **Embed 7-day discharge model:** By Q4 2025/26, fully implement weekend in-reach services (therapy, social care) to sustain higher discharge rates

◆ **Integrated rehab & reablement service:** Design by early 2026 a merged community rehab pathway (Health & Social Care) to reduce post-acute lengths of stay.

Reactive Care

Next 6–12 Months – Key Priorities

•Launch the Integrated Coordination Hub (Dec 2025):
Phase 1 will co-locate the Urgent Community Response, Rapid Response nursing, and therapy triage teams. Preparatory work is underway, with SOPs due in October, end-to-end testing in November, and go-live on 1 December. Phase 2 (by March 2026) will extend the Hub to include mental health and social care staff, enabling a 2-hour response for at least 70% of appropriate community crisis referrals.

•Strengthen Discharge and Flow (from Sept 2025):
A new multi-agency "NCR reduction taskforce" will review stranded patients daily to bring medically-fit numbers down towards the target of 34. The Council and Age UK have deployed staff to support families of self-funding patients with care home placements. The revised Choice Policy will be rolled out by November to speed up discharge decisions.

•Intermediate Care Integration (Q4 2025):
Finalise the joint operating model for rehabilitation and reablement, with pilot implementation planned for early 2026 and governance sign-off by year-end.

Sept 2025 – Coordination Hub Model Finalised

Coordination Hub design completed with multi-agency input; inclusion/exclusion criteria for 2-hour response agreed. Staff co-design workshop held (22 Aug) to refine workflows. Integrated operating model (covering urgent community response, social care crisis, mental health, and end-of-life) ready for sign-off.

Oct 2025 – UCR Pathways & Discharge Initiatives in Place

Urgent Community Response (UCR): New streamlined referral pathway launched. District Nursing 2-hour calls formally redirected to UCR. Rapid Response nurses trained to handle catheter issues and other urgent tasks now moved from hospital to community.
No Criteria to Reside: Hillingdon Hospital opens a dedicated "Discharge Ready" ward. Revised Choice Policy drafted to expedite complex discharges. Borough-led working group initiated focusing on sustaining <34 daily NCTR patients.

Dec 2025 – Coordination Hub Phase 1 Launch

Hillingdon Community Coordination Hub goes live (pilot). The hub operates 8am–8pm, 7 days a week, co-locating UCR rapid responders, therapists, palliative nurses, mental health crisis staff, and social workers. It provides a single point of coordination for urgent community referrals. Initial focus is on admission avoidance: meeting 2-hour response for ≥70% of calls and avoiding hospital conveyance for ≥65%. Pilot evaluation metrics are collected for Phase 2 planning.

Jan 2026 – Integrated Rehab & Reablement Service Established

Launch of an integrated Rehabilitation & Reablement service (Phase 1). Community health therapists and Council reablement officers begin working as one team, with a single referral route. Joint triage ensures patients get a coordinated care package upon hospital discharge or urgent referral. Initial operating procedures and joint KPIs are implemented.

Mar 2026 – Phase 2 Enhancements & Targets Achieved

Coordination Hub Phase 2: Hub expands to include Frailty Virtual Ward and enhanced mental health pathways. By end of Q4, the hub handles proactive frailty referrals and fully integrates the High Intensity User service. A Senior Clinical Decision-Maker rota is in place 8am–8pm to support hub triage.
No Criteria to Reside: Average "medically fit" inpatients (NCTR) consistently at or below 34 across Hillingdon Hospital. Weekend discharges have increased, closing the gap to weekdays. By end of 2025/26 the system aims for a marked reduction in delayed discharges and avoidable admissions.