Hillingdon Health and Care Partners

NHS North West London

Hillingdon Health and Social Care Select Committee

Hillingdon Place Integrated Performance Report and Service Update

Report for Hillingdon Health and Social Care Select Committee – 03rd December 2025

Health and Social Care Select Committee - Background and Overview – Summary of Priorities linked to Health and Wellbeing Board

1. Purpose, Background and Overview

This report provides the Health and Social Care Select Committee with an overview of progress against Health and Wellbeing Boards five strategic priorities and the major transformation programmes supporting them. It summarises delivery achievements, emerging performance trends, and risks to outcomes.

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

This update covers progress in three main areas:

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

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

2. Key Messages

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

Executive Summary

3. Executive Summary

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

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

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

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

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

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

4.1 Integrated Neighbourhood Teams: Purpose & Model

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

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

Neighbourhoods (Live Well & Age Well)

.4.2 Integrated Neighbourhood Delivery (Progress Update)

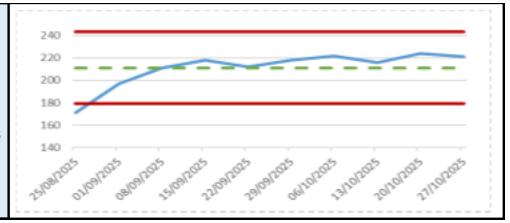
- **All INTs fully operational.** Multidisciplinary teams are now active across all three localities, providing a consistent neighbourhood model for prevention and coordinated care.
- **Frailty case management progressing well.** Around **50% of the severe frailty cohort (~1,000 residents)** is now under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

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

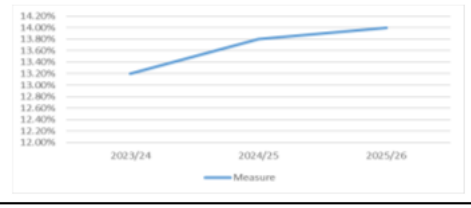
- **Primary Care Networks & Enhanced Services**
  PCNs continue to deliver the NWL Enhanced Services Single Offer, strengthening prevention and long-term condition management in primary care. Shifts from hospital to community settings (e.g. anticoagulation monitoring) and strong performance in diabetes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

Neighbourhoods (Live Well & Age Well)

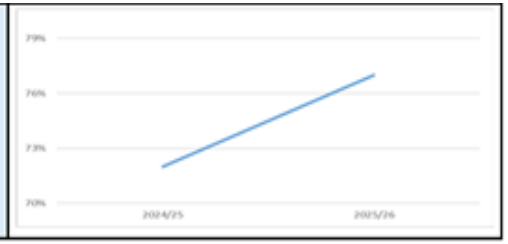
4.4 Neighbourhood Performance Metrics

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

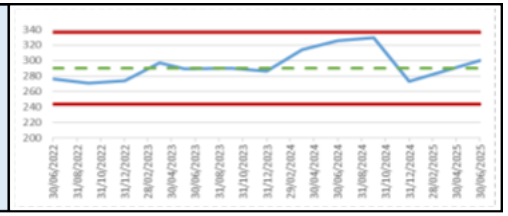
Narrative / Likely Cause	Actions to Remedy	Timeline	Accountability
The 10 week average is currently at 211 attendances per day with an October average of 220.	Revised delivery plan incorporating stronger front door diversion & capacity improvement.	Phased Rollout from Q3 25/26	SRO Neighbourhoods

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

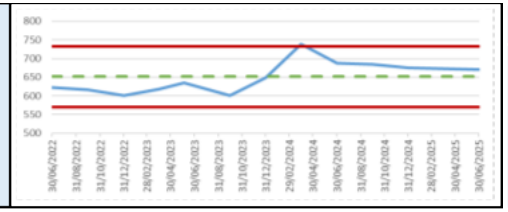
Narrative / Likely Cause	Actions to Remedy	Timeline	Accountability
Good progress has been made in scaling up from 10% baseline to 13.8%. However the scaling is slower than required to meet the 16% target by March 26.	In order to meet the trajectory, acceleration is needed in Pharmacy, General Practice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

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

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

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

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

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

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

Neighbourhoods (Live Well & Age Well)

4.5 Key Issues & Risks (Neighbourhoods)

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

Workforce Capacity & Capability

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

Variation in INT Maturity

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

Rising Demand Driven by Demographics & Long-Term Conditions

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

Inequalities Across Localities

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

4.6 Forward Plan (to March 2026)

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

Expand Frailty and Anticipatory Care Coverage

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

Implement the Hillingdon Hypertension Strategy

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

Neighbourhoods (Live Well & Age Well)

4.6 Forward Plan (to March 2026)

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

Strengthen Mental Health Integration

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

Introduce Neighbourhood Performance Dashboards

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

Progress Neighbourhood Estates (Hubs)

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

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

5.1 Reactive Care Purpose & Model

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

The programme has three core aims:

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

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

Reactive Care (Urgent & Crisis Response, Hospital Discharge)

5.2 Components of Reactive Care

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

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

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

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

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

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

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

Reactive Care (Urgent & Crisis Response, Hospital Discharge)

5.3 Reactive Care Performance Metrics

A&E Activity Reduction (Traffic light measured against 10 wk Avg)	Monthly Actual **170**	Target 164 10 wk Average 171 Trajectory 187	Graph Trendline for last 10 wks	**Narrative / Likely Cause**	**Actions to Remedy**	**Timeline**	**Accountability**
				10 week average is currently 171 per day with an October average of 170, seeing a month on month reduction from the winter peaks of 208 per day.	Expansion of UCR is to be expanded along with the launch of the co-ordination hub, mobile diagnostics and the implementation of the new Lighthouse diversion from Oct 25.	Phased Rollout from Q3 25/26	SRO Reactive Care
No Criteria to Reside Reduction (Traffic light measured against 10 wk Avg)	Monthly Actual **43**	Target 34 10 wk Average 45 Trajectory	Graph Trendline for last 10 wks	**Narrative / Likely Cause**	**Actions to Remedy**	**Timeline**	**Accountability**
				NC2R is an avg of 43 in month, with a 10 week avg of 45 (11 above the target). Drivers include: Discharge bottlenecks particularly P2, referral process delays across all Pathways, Family choice Delays.	8 week delivery plan has been developed and went live on the 13th October. Since the beginning of November we have seen averages of 35 per day compared to 43 during October	Choice policy live Nov 25, 8 Week Delivery Plan Sept - Oct	SRO Reactive Care
Discharge Pathway Delays (P1) (Traffic light measured against 10 wk Avg)	Monthly Actual **2.4**	Target 2 10 wk Average 1.6 Trajectory	Graph Trendline for last 10 wks	**Narrative / Likely Cause**	**Actions to Remedy**	**Timeline**	**Accountability**
Discharge Pathway Delays (P2) (Traffic light measured against 10 wk Avg)	Monthly Actual **11.1**	Target 5 10 wk Average 8.9 Trajectory	Graph Trendline for last 10 wks	Overall we are meeting the discharge delay targets for P1 and P3 patients. But not meeting the target for P2 patients. Bottlenecks especially in the time to place P2 patients, with referral process delays across all pathways (D2A, District Nursing, Family Choice delays, Capacity constraints) and longer than expected LOS in community led services.	8 week Delivery Plan has been developed and went live on the 13th October. Integrated Bridging care and therapy D2A P1 services in place by December 2025	Phased Rollout from Q3 25/26	SRO Reactive Care
Discharge Pathway Delays (P3) (Traffic light measured against 10 wk Avg)	Monthly Actual	Target 7 10 wk Average 5.3 Trajectory	Graph Trendline for last 10 wks				
Reduce Rate of unplanned adms from Care Homes per 100k pop >65	Quarterly Actual **500**	Target 747.65 Yearly Average 529 Trajectory	Graph Trendline Quarters	**Narrative / Likely Cause**	**Actions to Remedy**	**Timeline**	**Accountability**
				Variable Care Home capability in managing pts who have behaviours that challenge and also recognising signs of deterioration. Not all CHs have routine Pharmacy input to ensure pts at highest risk have a medication review.	Specialist dementia support from CNWL now available to support CH with pts who have behaviours that challenge, PCN pharmacies being trained to undertake SMRs for most complex frail pts in CHs. CH being digitally enabled so they can access UCPs.	Phased Rollout from Q3 25/26	SRO Reactive Care

Reactive Care (Urgent & Crisis Response, Hospital Discharge)

5.4 Issues & Risks (Reactive Care)

- **Winter Pressures & ED Demand**

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

- **Workforce Fragility**

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

- **Variation in Discharge Processes**

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

- **Scaling New Models**

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

5.5 Forward Plan (to March 2026)

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

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

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

2. Lighthouse Mental Health Crisis Expansion

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

Reactive Care (Urgent & Crisis Response, Hospital Discharge)

5.5 Forward Plan (to March 2026)

3. Launch of an Integrated Rehabilitation & Reablement Service

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

4. Sustain NC2R ≤34:

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

5. Expand UCR Capacity and Link to Virtual Wards

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

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

Best Start to Life (Children & Young People)

6.1 Purpose

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

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

6.2 Delivery Update

Recent progress in the Best Start in Life program include:

Child Health Hub Development

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

Integrated Paediatric Clinics

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

CYP Neighbourhood Dashboard

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

Mental Health Support Teams (MHSTs)

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

Best Start to Life (Children & Young People)

6.2 Delivery Update

Family Hubs Integration

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

Neurodevelopmental Pathways

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

6.3 Metrics & Performance (CYP Outcomes)

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

Neurodevelopmental Waiting Times

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

Mental Health Support Teams (MHSTs) in Schools

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

Early Years Outcomes

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

Service Utilisation and Preventative Reach

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

Best Start to Life (Children & Young People)

6.4 Forward Plan (up to March 2026)

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

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

Cross-Cutting System Risks & Mitigations

7.1 Cross-Cutting System Risks and Mitigations

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

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

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

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

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

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

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

Cross-Cutting System Risks & Mitigations

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

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

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

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

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

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

Appendices

Appendix 1: Investments Summary

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

Appendix 2: Neighbourhoods (Live Well & Age Well)

3.4 Neighbourhood Performance Metrics – PCN Enhanced Service Delivery

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

Enhanced service for diabetes

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

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

Continuity Audit

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

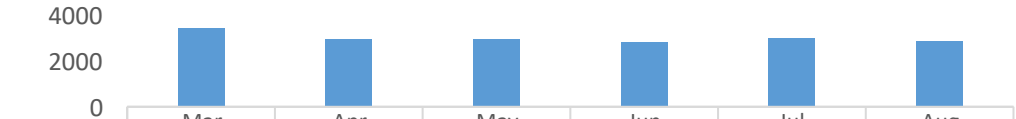
Appendix 3: Neighbourhoods (Live Well & Age Well)

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

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

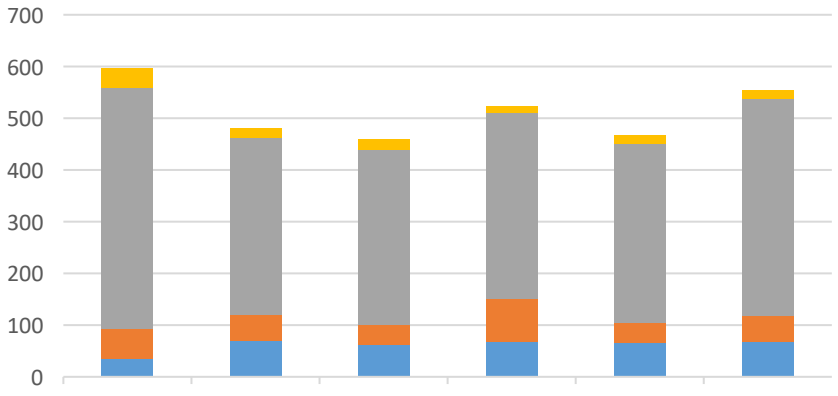
The most common condition is Acute sore throat, followed by uncomplicated UTI then Sinusitis

Pharmacy first consultations March- August 2025



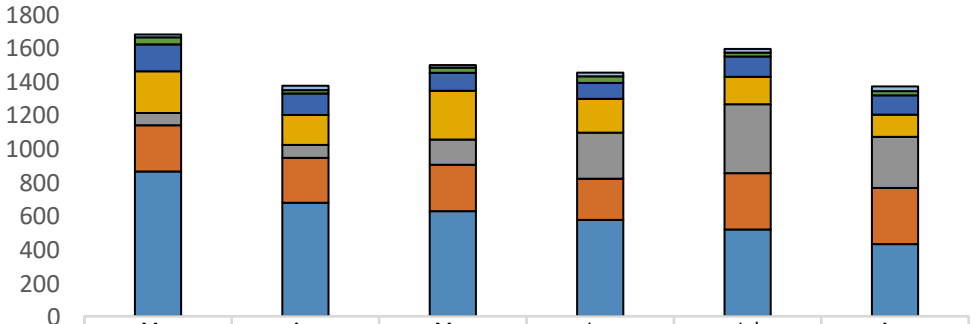
	Mar	Apr	May	Jun	Jul	Aug
Hillingdon	3419	2975	2973	2832	2980	2861

Pharmacy first referrals April- September 2025



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

Seven clinical conditions breakdown March- August 2025



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