DRAFT JOINT HEALTH AND WELLBEING STRATEGY, 2026 - 2031

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Papers with report	Appendix 1 – Draft Joint Health and Wellbeing Strategy, 2026 - 2031

HEADLINE INFORMATION

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

RECOMMENDATION

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

BACKGROUND

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

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

Summary of the Strategy

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

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

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

Engagement

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

Appendix 1.

Hillingdon Joint Health and Wellbeing Strategy 2026–2031

Executive Summary

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

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

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

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

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

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

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

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

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

What success will look like

By 2031 we will see:

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

Next Steps

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

1. Introduction and Purpose

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

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

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

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

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

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

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

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2. Strategic Vision

Our shared vision is:

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

This vision is underpinned by three core ambitions:

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

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3. Hillingdon – Place and People

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

The borough is home to:

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

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

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

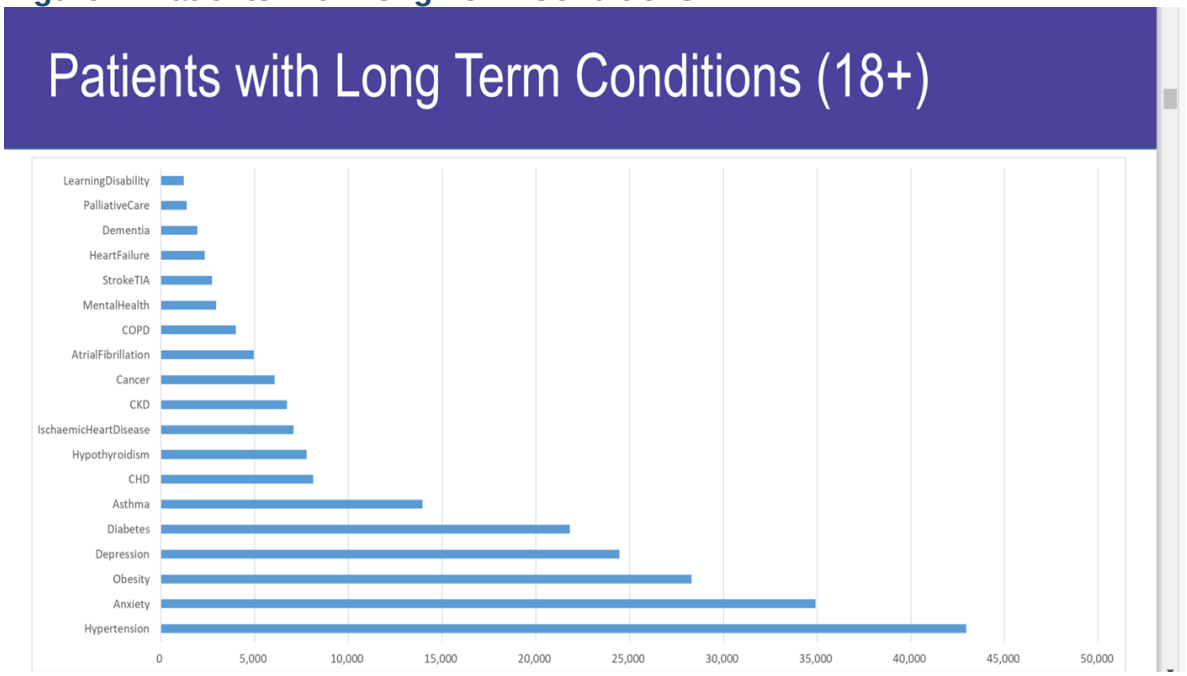
4. Population Needs and Case for Change

4.1 Rising Long-Term Conditions and Complexity

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

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

Figure 1: Patients with Long Term Conditions



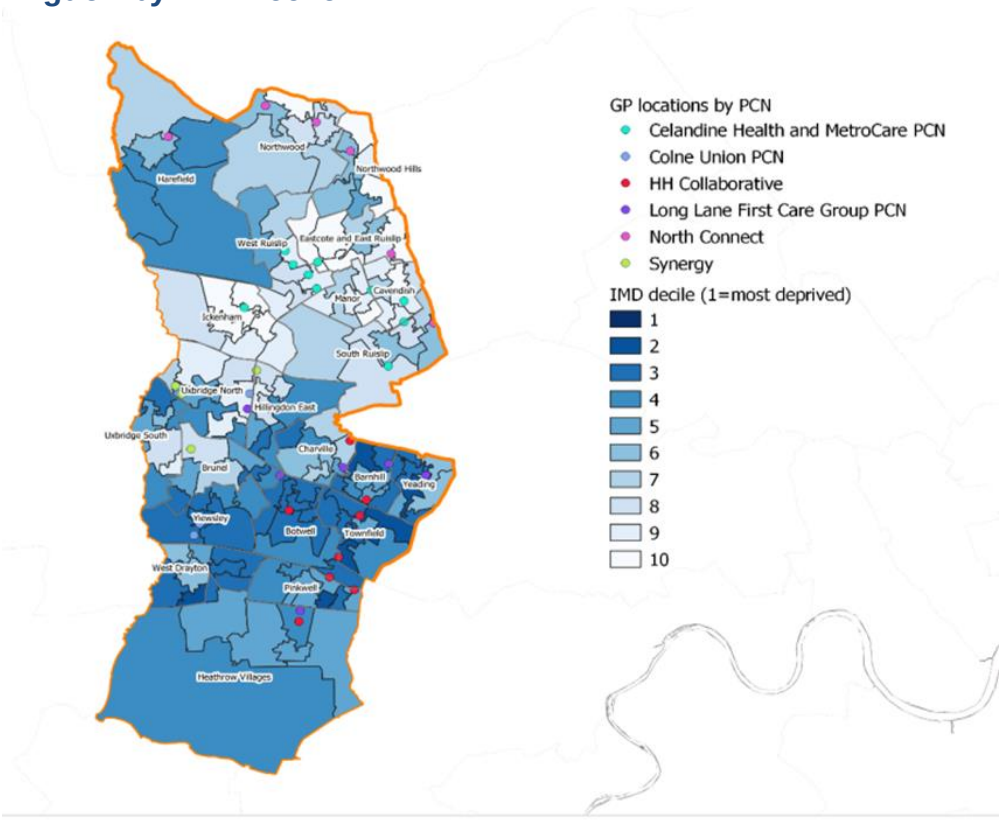
4.2 Inequalities and Wider Determinants

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

- Child poverty, overcrowding, homelessness and food insecurity are concentrated in parts of **Hayes, Yiewsley, and West Drayton.**
- Respiratory conditions, income, employment and education deprivation are key drivers of inequality in **Harefield**.
- These same areas see higher rates of diabetes, hypertension, asthma, obesity and mental health need
- Air pollution and environmental factors, particularly around Heathrow, contribute to respiratory and cardiovascular risk
- People from South Asian and Black communities are disproportionately affected by certain conditions, including diabetes and hypertension

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

Figure 2: Hillingdon by IMD Decile



4.3 Children and Young People

Children and families face multiple, interlinked challenges:

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

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

4.4 Ageing and Frailty

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

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

4.5 Fragmented Services and Workforce Pressures

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

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

4.6 New Hillingdon Hospital Redevelopment

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

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

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

4.7 Why We Must Change

These factors create a compelling case for change:

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

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

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5. Our Strategic Framework: Principles and Approach

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

5.1 Equity and Inclusion

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

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

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

5.2 Community Co-production and Voice

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

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

5.3 Life-Course Approach

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

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

5.4 Prevention and Early Intervention

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

5.5 Integrated Neighbourhood Delivery

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

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

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

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

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

5.6 Shared Leadership, Accountability and Resources

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

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6. Delivering Outcomes Across the Life Course

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

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

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

Priority BSIL1: Improve maternal health and reduce maternity inequalities

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

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

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

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

Priority BSIL2: Increase childhood immunisation coverage

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

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

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

Priority BSIL3: Improve early child development and school readiness

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

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

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

6.1.2 School Age (5–16)

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

Priority SA1: Improve emotional wellbeing and mental health

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

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

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

Priority SA2: Strengthen school attendance and engagement

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

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

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

Priority SA3: Reduce childhood obesity and improve physical activity

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

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

Delivery Measures:

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

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

Priority CM1: Expand early intervention and community mental health support

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

Actions:

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

Delivery Measures:

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

Priority CM2: Strengthen neurodevelopmental (ND) pathways

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

Actions:

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

Delivery Measures:

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

Priority CM3: Improve support to families and joint SEND planning

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

prevents escalation.

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

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

6.2 Live Well

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

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

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

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

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

Priority LW2: Improve mental wellbeing through neighbourhood support

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

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

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

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

Priority LW3: Reduce health-harming behaviours

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

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

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

6.3 Age Well

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

Priority AW1: Proactive frailty care and rapid support

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

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

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

Priority AW2: Improve falls, rehabilitation, reablement and discharge

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

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

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

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

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

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

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

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

6.4 Healthy Places

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

Priority HP1: Improve housing stability and reduce homelessness

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

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

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

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Priority HP2: Create safer, healthier neighbourhoods

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

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

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

Priority HP3: Reduce social isolation and improve community connection

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

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

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

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7. High-Impact Priorities

Given finite resources and the scale of challenge, Hillingdon will prioritise a small number of programmes that can deliver the greatest improvement in population health, reduce inequalities and relieve system pressure. These priorities have been selected because they:
- affect large population groups
- address the biggest drivers of avoidable hospital use
- have strong evidence of impact
- support the delivery model for the new Hillingdon Hospital
- align directly with our neighbourhood model, Family Hubs, and the Reactive Care Service
- have measurable baselines and clear outcomes

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

1. Proactive and Preventative Neighbourhood Care

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

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

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

2. Hypertension and Cardiovascular Risk Management

The highest-impact component of neighbourhood prevention.

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

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

3. Mental Health Early Intervention

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

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

4. Frailty, Falls and Community Support for Older Adults

Providing intensive support for people already living with moderate or severe frailty, maintaining independence and avoiding admissions.

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

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

5. NC2R and Discharge Improvement

A critical system priority enabling the new hospital model.

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

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

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

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

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

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

7. Family Hubs and Early Years

Preventing disadvantage from becoming entrenched and improving early childhood development.

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

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

8. The Hillingdon Place Operating Model

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

8.1 Overview

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

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

It is designed to:

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

8.2 Integrated Neighbourhood Teams (INTs)

The three Hillingdon Neighbourhoods are:

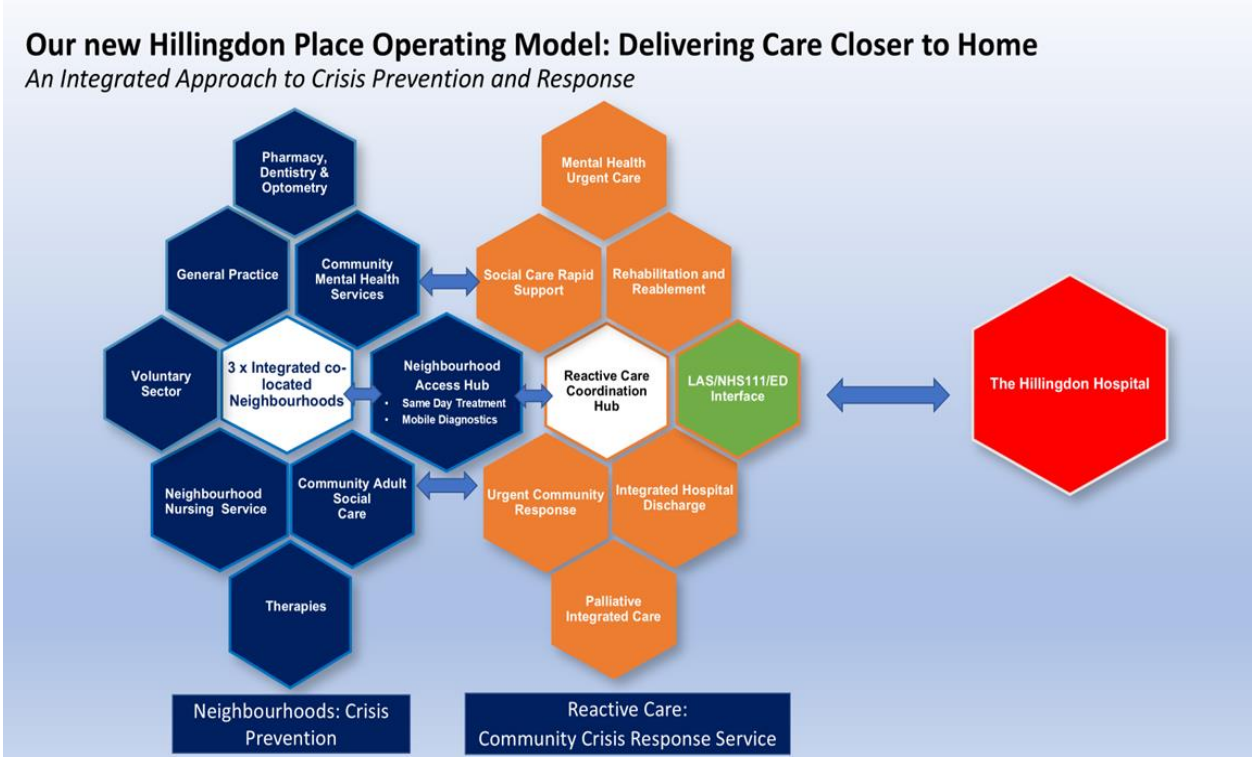
- **North:** Ruislip, Northwood, Harefield and Ickenham
- **South West:** Uxbridge, Yiewsley and West Drayton
- **South East:** Hayes and Harlington

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

Each INT will bring together:

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

Place Operating Model



Core functions include:

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

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

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

8.4 Borough-wide Reactive Care Service

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

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

This service is integral to achieving:

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

8.5 Children, Families and Family Hubs in the Place Model

Within the operating model:

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

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

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9. Enablers of Delivery

To deliver this strategy we will strengthen:

9.1 Workforce and Organisational Development

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

9.2 Digital, Data and Population Health Management

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

9.3 Estates and Super Hubs

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

9.4 Finance and Pooled Budgets

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

9.5 VCSE and Community Partnerships

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

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

10. Finance and Resources

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

10.1 How the Strategy Will Be Funded

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

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

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

10.2 Pooled Budgets and Joint Commissioning

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

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

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

10.3 Resourcing the Place Operating Model

Funding for the Place Operating Model will come from:

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

developments progress

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

10.4 Financial Oversight and Assurance

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

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

11. Governance, Accountability and Oversight

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

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

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12. Measuring Success and Monitoring Progress

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

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

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13. Implementation and Next Steps

Following approval of this strategy, partners will:

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