Hillingdon Health and Care Partners

NHS North West London

HHCP Transformation Update

Report for Health and Social Care Select Committee – February 2026

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Executive Summary

Purpose, Background and Overview

This report provides the Council's Overview and Scrutiny Committee with assurance on progress against the Hillingdon Health and Care Partnership (HHCP) transformation programme, delivered collectively by NHS organisations, the Council, primary care and voluntary sector partners. The programme is focused on improving outcomes for residents, reducing avoidable hospital use, and supporting the long-term sustainability of local health and care services in the context of rising demand and an ageing population.

The update focuses on two core areas of place-based delivery: **Integrated Neighbourhood Teams (INTs)** and **Reactive Care**, including urgent community response, discharge and reablement. The report supports Scrutiny's role in understanding progress, impact and risk across the local health and care system.

Evidence of Impact and Improvement

The place-based model is now demonstrating early signs of measurable, system-wide improvement:

- **Emergency demand is reducing:** A&E attendances decreased by **4.9%** between June–December 2025 compared with the same period in 2024, despite demographic growth and sustained winter pressures.
- **Hospital flow has improved materially**: Average daily **No Criteria to Reside (NC2R)** delays reduced by **34%**, from **50 to 33 per day below new hospital development targets**. By December 2025, fewer than **4% of Hillingdon hospital beds** were occupied by patients without a clinical need to remain, significantly outperforming the wider Northwest London and London averages (14% and 12% respectively).
- **Fewer frail residents are being admitted to hospital**: Emergency admissions among approximately **5,000 residents with severe frailty** reduced by **36%**, reflecting the impact of proactive neighbourhood case management and integrated community, primary care and social care support.
- **Earlier identification and better management of long-term conditions**: Hypertension prevalence has increased from **10% to around 14%**, with approximately **80% of patients achieving blood pressure control**, representing the strongest performance in Northwest London.

Taken together, these results demonstrate a system that is preventing crisis as well as responding to it, with care increasingly delivered earlier and closer to home.

What Is Driving the Improvement

The improvements set out above are linked to the deployment of specific interventions agreed through HHCP and implemented at pace.

- **Reductions in emergency admissions for people with frailty** reflect the roll-out of **Integrated Neighbourhood Teams**, with proactive case management, multidisciplinary working and earlier intervention helping to prevent escalation into crisis.
- **Reductions in Emergency Department demand** are being driven by the expansion of credible, same-day alternatives to hospital attendance, particularly for lower-acuity and mental health presentations. Expanded same-day urgent primary care, **Pharmacy First**, community IV therapy and **mobile diagnostics** are providing timely access to assessment and treatment in community settings, reducing the need for residents to default to A&E. In parallel, strengthened mental health crisis pathways, including the **Lighthouse service**, are diverting people experiencing mental health crisis away from Emergency Departments into more appropriate, therapeutic environments.
- **Sustained reductions in No Criteria to Reside (NC2R)** delays have been driven primarily by **improving end-to-end discharge processes and practice**, including clearer operational standards, daily multi-agency problem-solving, and a more consistent approach to identifying and addressing discharge barriers early. This has been strengthened by **Place Gold Command**, providing senior, cross-partner leadership oversight, a single agreed view of performance and actions, and a clear escalation route to resolve blockages at pace.

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Resident Impact – What This Means for People in Hillingdon

- For residents, these improvements translate into **fewer avoidable hospital visits, faster help when needs escalate, and more care delivered closer to home**. People living with frailty and multiple long-term conditions are increasingly being supported proactively by neighbourhood teams, reducing the likelihood of crisis admissions and helping residents remain independent for longer.
- When urgent health or care needs do arise, improved coordination across community health, mental health and social care services is enabling **quicker responses at home and smoother discharge from hospital**, reducing delays and disruption for residents and carers. Expanded access routes — including outreach general practice, Pharmacy First and community diagnostics — are making it easier for residents to receive timely care without defaulting to A&E.
- Targeted neighbourhood outreach, particularly in areas of higher deprivation, is also supporting **earlier identification and better management of long-term conditions**, helping to reduce health inequalities and improve outcomes over time.

Partnership Delivery and System Working

- Progress to date reflects **collective delivery through HHCP**, with NHS organisations, the Council, primary care and voluntary sector partners working together around neighbourhoods and shared outcomes. Neighbourhood teams, urgent community services, mental health crisis pathways, discharge arrangements and reablement operate as part of a single place-based system, with partners contributing their respective expertise, workforce and resources. Continued progress depends on maintaining this collaborative approach as changes are embedded into routine practice.

Priorities for the Next 3–6 Months

The next phase of delivery focuses on consolidation and embedding:

- **Scaling proactive frailty and anticipatory care** through neighbourhood teams, supported by shared population health dashboards.
- **Embedding improved discharge practice** and maintaining Place Gold Command oversight to sustain NC2R performance at or below **33–34 per day**.
- **Fully embedding Reactive Care**, including urgent community response, coordinated discharge and rehabilitation/reablement.
- **Sustaining and optimising the Lighthouse mental health crisis pathway**, with capacity expanded in Quarter 4 from **six to ten places per day**, and monitoring its impact on mental health-related Emergency Department attendances.
- **Developing the Neighbourhood Estate Hub business cases** and reviewing the impact of **mobile diagnostics**, with a view to informing decisions on **full roll-out in 2026/27**.
- **Targeted Heathrow Villages outreach**: between **March and May**, neighbourhood teams, working with **outreach general practice**, will deliver services from **local community facilities including Harmondsworth Parish Hall and the church**, including outreach GP appointments, health checks, hypertension case-finding and proactive follow-up for residents with long-term conditions.

Overall Assurance Statement

The HHCP transformation programme is demonstrating **clear, data-backed improvement** in resident outcomes and system performance, particularly in hospital flow, frailty admissions, mental health crisis response and access to care closer to home. The programme now enters a consolidation phase, where continued partnership working, disciplined operational practice and ongoing Scrutiny oversight will be important to ensure improvements are sustained, equitable and embedded across the local health and care system.

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4. Key Risks

As we enter Q4 2025/26, several system risks require active management to consolidate progress and maintain winter resilience.

Risk	Impact	Mitigation
High ED attendances	Increased pressure on A&E, overcrowding, missed targets	Strengthen same-day alternatives: Pharmacy First, **same-day urgent primary care**, UCR 2-hour response, GP-to-SDEC, **Coordination Hub triage and Lighthouse diversion**
NC2R relapses	Bed shortages, delayed discharges, ED backups	Embed improved end-to-end discharge practice, maintain **Place Gold Command oversight and escalation**, commission step-down/home care if required
Rising long-term condition demand	Increased avoidable admissions, higher pressure on INTs	Scale proactive care: hypertension, frailty, COPD, diabetes; strengthen anticipatory care
Winter pressures	System-wide strain from flu/COVID/norovirus	Full Winter Plan, surge protocols, expanded 7-day services, use of intermediate and contingency beds

5. Summary

As we enter the final quarter of 2025/26, the focus must now be on consolidating early progress and operationalising key changes made in Q3. While the transformation programme is showing early signs of impact—particularly in hospital flow, frailty management and access—sustained delivery through winter will require continued collective attention to system risks, workforce capacity, and the consistent embedding of new models across Neighbourhoods and Reactive Care.

By continuing to embed these changes through Q4 and into 2026, the system is on track to shift more care upstream, reduce pressure on acute services, and deliver more equitable, joined-up support across Hillingdon."

Purpose, Background and Overview

1. Purpose, Background and Overview

This paper provides the Committee with an update on the progress of the Hillingdon Health and Care Partnership (HHCP) Transformation Programme across three core areas:

Key Metrics – A summary of performance against agreed strategic indicators

Integrated Neighbourhood Teams (INTs) – Current status and forward implementation plan for Quarter 4 2025/26, including:

- Expand frailty case management toward full population cohort coverage (10,000) by April 2026, using the new WSIC frailty dashboard to monitor admissions, falls, and MDT follow-up.
- Review impact of Mobile Diagnostics on ED, Non-Elective admissions and planned care for people with frailty by March 2026
- Adopt and implement the Hypertension Strategy, intensify outreach in high-inequality areas, and continue toward the year end 16% prevalence target.
- Develop and implement INT-level performance dashboards to track activity, outcomes, and inequalities by January 2026
- Complete Integrated Neighbourhood Hub business cases by March 2026.

Reactive Care Programme – Current status and forward implementation plan for Quarter 4 2025/26, including:

- Fully mobilise Phase 1 of **the Coordination Hub (live Dec 2025),** providing single-call access (8am–8pm, 7 days/week) and begin planning for Phase 2 expansion.
- **Fully mobilise UCR staffing from January 2026 and align model with Virtual Wards** to enable up to 17 days of community-based care for frailty and heart failure to reduce inappropriate admissions and ED attendances to the new Hospital target
- **Expand Lighthouse capacity to 10 patients** following December review, with additional staffing and environmental adjustments.
- **Launch Integrated Rehabilitation & Reablement Service** in January , with NHS and Council staff delivering seamless post-discharge support.
- **Sustain NC2R inpatients at or below 34/day through daily multi-agency reviews,** operational discharge model, and system Gold oversight.

Place Transformation Programme AND Key Outcome Metrics

We are implementing a new 7 day Place Operating Model through 2 key transformation programmes for 25/26

1. Integrated Neighbourhoods :

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

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

2. Reactive Care:

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

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

Key Metrics :

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

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

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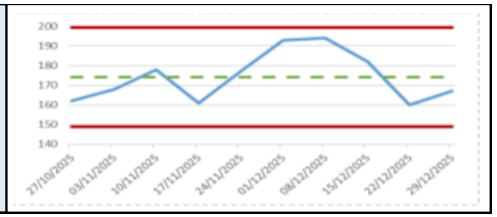
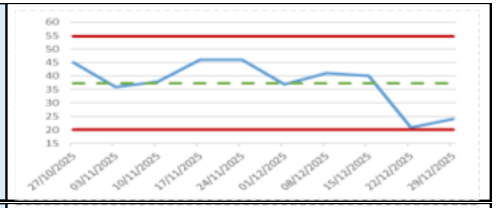
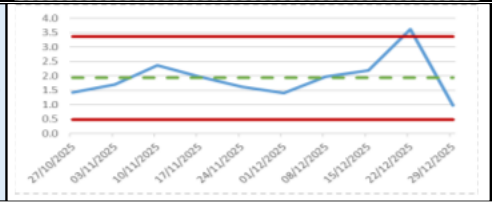
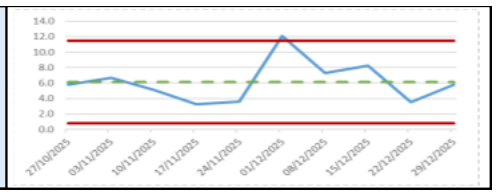
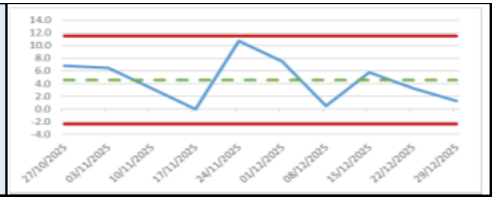
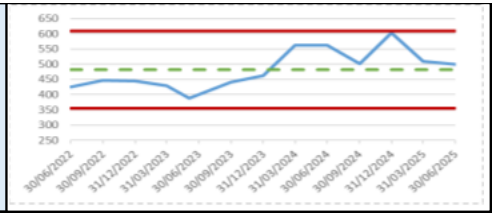
Neighbourhood Key Metrics

UTC Activity Reduction (Traffic light measured against 10 wk Avg)	Monthly Actual **220**	Target 180 10 wk Average 221 Trajectory 176	Graph Trendline for last 10 wks	The 10 week average is currently at 221 attendances per day with a December average of 220. This has remained pretty static compared to November activity levels and we continue to see lower levels of Type 1 activity suggesting more redirections to UTC.	Revised delivery plan incorporating stronger front door diversion & capacity improvement for community alternatives	Phased Rollout from Q3 25/26	SRO Neighbourhoods
Increase Hypertension Prevalence for 18+ population	YTD Actual **13.9%**	Target 16% Previous Year 13.2% Trajectory 16%	Yearly Trendline	Good progress has been made in scaling up from 10% baseline to 13.9%. 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	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	Hillingdon have one of the best outcomes for admission avoidance within NWL. Case management is effective. Launch of WSIC frailty radar to support case finding and management of frail patients	Sustain INT scaling of enhanced case management to 10,000 residents and expand anticipatory care to 16%.	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	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 of case management to 100% severe frailty cohort.	By April 2026	SRO Neighbourhoods

Reactive Care Key Metrics

						Narrative / Likely Cause	Actions to Remedy	Timeline	Accountability
A&E Activity Reduction (Traffic light measured against 10 wk Avg)		Monthly Actual **180**	Target 164 10 wk Average 174 Trajectory 187	Graph Trendline for last 10 wks		The 10 week average is currently 174 attendances per day with an December average of 180. Just to note the rolling 30 day average from beginning of January shows attendances at 176 per day. Type 1 attendances have decreased significantly in the last few months and more patients have been redirected to UTC & SDEC	Expansion of UCR along with the launch of the co-ordination hub, mobile diagnostics and the implementation of the new Lighthouse diversion from November 25.	Phased Rollout from Q3 25/26	SRO Reactive Care
No Criteria to Reside Reduction (Traffic light measured against 10 wk Avg)		Monthly Actual **33**	Target 34 10 wk Average 37 Trajectory	Graph Trendline for last 10 wks		Significant progress has been made in the reduction of No Criteria to Reside over the last month; with the monthly average currently sitting at 33, this is a 34% reduction from the average of 50 at the start of the NC2R Reduction programme in October	Sustain process improvements through continued oversight by Place Gold Command	Ongoing	SRO Reactive Care
Discharge Pathway Delays (P1) (Traffic light measured against		Monthly Actual **2.2**	Target 2 10 wk Average 1.9 Trajectory	Graph Trendline for last 10 wks		Overall we are meeting the discharge delay targets for P1 and P3 patients. But over 2 days off 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.	Integrated Bridging care and therapy D2A P1 services in place by December 2025	Phased Rollout from Q4 25/26	SRO Reactive Care
Discharge Pathway Delays (P2) (Traffic light measured against		Monthly Actual **6.1**	Target 5 10 wk Average 6.1 Trajectory	Graph Trendline for last 10 wks					
Discharge Pathway Delays (P3) (Traffic light measured against		Monthly Actual **3**	Target 7 10 wk Average 4.6 Trajectory	Graph Trendline for last 10 wks					
Reduce Rate of unplanned adms from Care Homes per 100k pop >65		Quarterly Actual **500**	Target 747.65 Yearly Average 529 Trajectory	Graph Trendline Quarters		Variable Care Home capability in managing pts who have behaviours that challenge and also recognising signs of deterioration. Not all CHs have routine Pharmacy input to ensure pts at highest risk have a medication review.	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 Q4 25/26	SRO Reactive Care

Integrated Neighbourhood Teams – Proactive Care

Integrated Neighbourhood Teams – Proactive Care

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

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

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

Key Achievements to Date

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

✓ **Community Nursing and Care Home Support Teams** successfully merged

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

✓ **Hypertension case-finding drive**: raised recorded prevalence from **10% to 13.9%** (highest in NWL), with **77% of known hypertensive patients under control**

✓ **Community Diagnostics have gone live;** this will initially be for X-rays and will provide both mobile and clinic based services for Frail/complex/housebound/Care Home patients.

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

✓ **Health Check drive**: Working with practices with low level health check uptake to case-find and proactive target patients. **350 patients** targeted to date

Upcoming Priorities Q4

- Expand frailty case management toward full population cohort coverage (10,000) by April 2026, using the new WSIC frailty dashboard to monitor admissions, falls, and MDT follow-up.
- Review impact of Mobile Diagnostics on ED, Non-Elective admissions and planned care for people with frailty by March 2026
- Adopt and implement the Hypertension Strategy, intensify outreach in high-inequality areas, and continue toward the year end 16% prevalence target.
- Strengthen mental health integration with a named practitioner in each INT and improved links to community mental health teams by March 2026
- Develop and implement INT-level performance dashboards to track activity, outcomes, and inequalities by January 2026
- Complete Integrated Neighbourhood Hub business cases for Hayes, Ruislip, and Uxbridge by March 2026.

Reactive Care

Reactive Care Programme:

The **Reactive Care Programme** is the redesign of Hillingdon's urgent and crisis care system to ensure residents receive the *right care, in the right place, at the right time* when health or social care needs escalate.

It brings together our **Integrated Urgent Response**, **hospital avoidance services**, and **discharge support**, creating a single, seamless pathway for unplanned care delivered outside the acute hospital. The goal is to establish a **7/7 community-based urgent care system** capable of responding to crises within two hours, providing short-term treatment and monitoring at home, and coordinating a safe, timely return to routine or planned care.

This transformation is vital to:

- Reduce pressure on A&E and 999 services
- Prevent unnecessary hospital admissions
- Enable faster, safer discharges reducing patients
- Improve patient experience, outcomes, and system flow

Hillingdon's Reactive Care model is built around three core components:

- Integrated Urgent Community Response
- Supporting Discharge
- Proactive Support for Reactive Care – bridging prevention with urgent response

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

Projects within the Reactive Care Programme include:

- Reactive Care Coordination Hub
- Urgent Community Response (UCR)
- Lighthouse Mental Health Crisis Pathway
- Integrated Rehabilitation and Reablement
- No Criteria to Reside (NC2R) Reduction Plan

Reactive Care – Strategic Intent

The **Reactive Care Programme** aims to create a single, integrated system for managing crises outside hospital and enabling faster, safer discharge.

It brings together urgent community, mental health and social care teams through a **Community Coordination Hub** providing a rapid two-hour response.

The programme introduces a **seven-day discharge and recovery model**, improving patient flow, reducing avoidable admissions, and supporting care closer to home.

Expected Outcome:
Reduce ED attendances by 30 per day
Reduce non elective admissions by 10%
Reduce Patients with NC2R to <=34 per day

Key Achievements to Date

- ✓ **The Coordination Hub** launched December 2025,
- ✓ **UCR now has daily Senior Clinical Decision Maker coverage days per week enabling UCR to hold highr risk patients**
- ✓ **Lighthouse capacity** has expanded to divert mental health demand from A&E
- ✓ **Mobile Diagnostics to Care Homes and People with Frailty went** live in November.
- ✓ **NC2R 8 week reduction plan concluded** having reduced NC2R by 35% to below the required target of <=34 daily average

Upcoming Priorities: Next 6 months

- Fully mobilise Phase 1 of the Coordination Hub (live Dec 2025), providing single-call access (8am–8pm, 7 days/week) and begin planning for Phase 2 expansion.
- Fully mobilise UCR staffing from January 2026 and align model with Virtual Wards to enable up to 17 days of community-based care for frailty and heart failure to reduce inappropriate admissions and ED attendances to the new Hospital target
- Expand Lighthouse capacity to 10 patients following December review, with additional staffing and environmental adjustments.
- Launch Integrated Rehabilitation & Reablement Service in January , with NHS and Council staff delivering seamless post-discharge support.
- Sustain NC2R inpatients at or below 34/day through daily multi-agency reviews, operational discharge model, and system Gold oversight.