Appendix D

Hillingdon – Health & Wellbeing Narrative (For NWL Annual Report, and Hillingdon Health Select Committee)

1. Overall Health & Wellbeing focus for the borough

Hillingdon's draft Joint Health and Wellbeing Strategy sets out a clear, life-course approach to improving outcomes and reducing inequalities, structured around *Best Start in Life, Live Well, Age Well* and *Healthy Places*. The focus is on prevention, early intervention and integrated neighbourhood delivery, recognising rising long-term conditions, frailty, mental health need and the wider determinants of health impacting local communities, including environmental and access challenges. This aligns closely with the North West London Integrated Care Strategy and the shift towards proactive, place-based care, aligning with NWL ICB priorities and 2025/26 delivery.

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

What has improved:

- **Flow and discharge:**
  No Criteria to Reside (NC2R) has reduced materially from pre-intervention levels **(~50/day) to an average of ~37/day** in January, achieving the ≤34 target in December.
- **Frailty and preventative care:**
  Frailty case management now covers approximately **50% of the severe frailty cohort**, with early evidence of reduced emergency admissions. This is a critical foundation for reducing future bed-day demand.
- **Mental health crisis response:**
  The redesigned **Lighthouse** model has reduced length of stay by **52%**, increasing throughput and relieving pressure on ED, with most service users now returning home with support rather than being admitted.
- **Community alternatives to hospital:**
  The Reactive Care Coordination Hub is live and simplifying access to urgent community response, while **mobile diagnostics** are demonstrating strong early uptake and evidence of avoided hospital attendances.

2. Integrated Neighbourhood Teams (INTs)

The development of INTs directly supports NWL ICB priorities, including the establishment of neighbourhood teams, reducing inequalities through population health management, proactive care and prevention and improving access to high-quality community services.

By embedding proactive care within neighbourhood and primary care-led models, Hillingdon has supported earlier engagement, personalised care planning and better coordination between services. This contributes to wider system goals to reduce non-elective activity, improve quality of life for residents and make best use of finite health and care resources.

All three INTs fully operational embedding the care connection teams into the wider INT. Multidisciplinary teams are now active across all three neighbourhoods, providing a consistent neighbourhood model for prevention, proactive and coordinated care. (Combining the W&NL ICB model of Local Care Network and Integrated Neighbourhood team together into the neighbourhood)

- **Frailty case management progressing well.** Early work has commenced to develop a consistent borough-wide frailty operating model starting with a single-neighbourhood pilot and scaling up across all neighbourhoods by April 2026.
- **NNHIP** – Hillingdon is currently participating in the National Neighbourhood Implementation Programme, with delivery progressing well. As part of the pilot, a frailty cohort has been identified within the North Neighbourhood, focusing on patients classified as moderately and severely frail. Interventions are scheduled to commence from the end of February 2026, with outcome measures to be reported from March 2026 onwards
- **Hypertension and long-term conditions. Prevalence has increased to 14%,** the highest in NWL with **optimisation levels remaining stable at 78–80%** also the highest in NWL. Targeted recalls, community engagement events, and outreach activities — including mosque-based sessions — are underway to widen reach and drive further uptake.
- **Hospital to Community (left shift)** – The hospital redevelopment Community Pathway Programme is progressing well, with Phase One pathways (heart failure, cardiac rehab and community headache) advancing through business case development, quality impact assessments and planning for enhanced primary care diagnostics. The programme is also identifying pathways that could be more effectively delivered in community or primary care settings, supporting improved access, earlier intervention and care closer to home.
- **Enablers: Integrated Neighbourhood Hub;** the Estates workstream is progressing development of the three Neighbourhood Hubs, work streams and governance are being integrated to support business case development, including the procurement of legal, finance and design advisors. **Digital;** Hillingdon NNIP has been shortlisted to lead the digital and data workstream in the national programme. **Workforce;** The Hillingdon workforce Passport has been presented to the national NNIP programme and the DHSC, and may be a case study in the forthcoming NHSE 10 year workforce plan.

3. Borough-wide Integrated Reactive Care and Urgent Response

The integrated model enables rapid assessment, intervention and short-term support in people's own homes or community settings, helping to prevent unnecessary attendance at urgent treatment centres or emergency departments.

Reactive and urgent response services also play a critical role in supporting timely discharge from hospital, working alongside acute, community and social care partners to reduce delays

and improve transitions of care. This delivery supports NWL ICB priorities to optimise system flow, reduce non-elective admissions and improve discharge outcomes.

Components of Reactive Care

- **Reactive Care Coordination Hub (Phase 1 – Dec 2025)**
  Phase 1 of the Reactive Care Coordination Hub went live in December, providing single-call access for urgent community referrals (8am–8pm, 7 days). The Hub now acts as the single point of access for urgent referrals, crisis response and discharge support, and simplifying pathways for GPs, LAS and hospital teams. Senior Clinical Decision Makers (SCDMs) were embedded in Phase 1, strengthening real-time decision-making and supporting safe management at home. Improved pathways now operate with the Care Connection Teams in neighbourhoods, mobile X-ray Diagnostics and Same Day Access Hubs. Adult Social Care is now embedded into daily handovers/MDTs and strengthen links between the ICC Hub, SCDMs and wellbeing support. Phase 2 will expand to include frailty, mental health and end-of-life coordination.
- **Community IV Antibiotics**
  The service continues to deliver **6–8 daily doses** (with 25% utilisation) of IV antibiotics in homes and community settings for conditions requiring intravenous treatment but not hospitalisation. This prevents unnecessary bed days and enables earlier discharge when clinically appropriate.
- **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. **GP referrals to SDEC units** has risen from 123 in April 2025 to 211 in November 2025 **over 90% increase in year**.
- **Mobile Diagnostics (X-ray)**
  A mobile X-ray pilot is providing diagnostics for housebound and frail residents, preventing the need for hospital radiology attendance. Early activity shows good uptake, with **115 referrals received** (30.4% care homes, 63.5% GP, 4.3% Senior Clinical Decision Maker in the Reactive Care Coordination Hub, 0.9% hospice, 0.9% other). For the four residents and their families in the hospice the quality improvement and positive impact of mobile diagnostics in the hospice has been significant and the CQC has identified it as a quality innovation.
- **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 a review due to take place in February). The Lighthouse reduces psychiatric demand in ED and provides a calmer therapeutic setting with rapid access to follow-on support. Phase 2 is being planned to add GP to Lighthouse pathway.

4. Children and Young People's Mental Health and Wellbeing

Improving outcomes for children and young people is a core priority within Hillingdon's Health and Wellbeing Strategy under *Best Start in Life*. During 2025/26, delivery has aligned closely with NWL ICB priorities to improve access to community-based mental health support and early intervention for children and young people.

System-wide focus has been placed on strengthening pathways between education, primary care, community services and specialist mental health provision, supporting earlier identification of need and reducing reliance on crisis-based responses.

Hillingdon Thrive Together! is a new website which has been launched in Hillingdon which brings together all early intervention services in one place. It includes:

- Service directories with clear descriptions of what each service offers.
- Referral processes for each service, making it easier to guide families.
- Self-care tools, videos, and resources for children, young people, parents/carers, and professionals.

Our aim is that the Thrive Framework will help:

- Signpost families confidently to appropriate services and resources.
- Reduce unnecessary CAMHS referrals by offering alternative support options.
- Empower families with tools to manage wellbeing while waiting for specialist help.

In the SW Neighbourhood we have implemented a Childrens Champion/CYP Co-ordinator who works directly with children, young people and their families/carers to discuss and agree the choice of service they may wish to access. Referrals are from GPs who have referred the CYP to CAMHS and the family is waiting for an appointment. The champion has been in post since September and has made significant progress in reducing CAMHS referrals and GP appointments for CYPMH. Since September 136 children and young people supported.

- Average **30% improvement in CYP ONS4 wellbeing scores**
- Average +2.41-point improvement in ONS Life Satisfaction, equating to an indicative **£0.69m wellbeing value over 12 months** (HM Treasury Green Book WELLBY methodology)
- **77 successful referrals** from SW neighbourhood GP Practices
- Positive qualitative feedback from families, with parents reporting increased confidence, clarity and feeling listened to.
- Release of **over 22 hours of GP practice**