# Hillingdon Joint Health and Wellbeing Strategy 2026 – 2031

## Delivery Plan: Draft

# 1. Introduction: Your Guide to the Delivery Plan

This delivery plan turns the 2026–2031 strategy into practical action and shows how progress will be monitored.

**Purpose:** to connect what we want to improve for residents with the changes needed to deliver more joined-up care.

## Mobilise the new operating model

Neighbourhood teams • Reactive care • Hospital to community • Digital and data • Diagnostics • Workforce and culture

## Enable the life-course actions

Start Well • Live Well • Age Well • Healthy Places

The actions depend on the operating model being mobilised successfully.

**Supported by cross-cutting enablers:** workforce • digital and data • estates • finance • VCSE partnerships • co-production

## Scope

- For residents, carers, communities and health and care professionals.
- Covers actions, milestones, equalities, enablers, governance and impact.
- Runs alongside the strategy from 2026 to 2031.

## How the plan is structured

1. Introduction
2. Delivery Plan context
3. Place Operating Model mobilisation
4. Life-course approach delivery
5. Equalities and Human Rights Impact Assessment tracker
6. Cross-cutting enablers
7. Governance and assurance
8. Impact framework
9. Glossary

***In short:*** **the operating model is the delivery mechanism; the life-course actions are the outcomes we want to achieve.**

# 2. Delivery Plan Context

**Challenges and Resources**

Hillingdon faces many challenges and limited resources. **We cannot do everything all at once.** Priority in this delivery plan is therefore given to programmes that:

- Affect large population groups.
- Address the biggest drivers of avoidable hospital use.
- Have strong evidence of impact.
- Support the delivery model for a new Hillingdon Hospital.
- Align directly with our neighbourhood model, family hubs and the Reactive Care Service.
- Have measurable baselines and clear outcomes.

**Overarching Principle: Coproduction and Engagement**

We will ensure the resident, carer and community voice is heard in shaping our strategy and this delivery plan, including the design and monitoring of services.

## 3. Place Operating Model Mobilisation

| Workstream | Purpose | Key Milestones |
|---|---|---|
| 1. System Engine | A central function to coordinate the programme, track progress, manage risks and support partners to work together. | • ***Phase 1 (Oct 2026):*** Core capabilities of leadership, Programme Management Office, governance, finance, communications and benefits frameworks in place.<br>• ***Phase 2 (March 2027):*** Analytical capabilities and Population Health Management embedded.<br>• ***Phase 3 (March 2028):*** Mature system engine in place. |
| 2. Integrated Neighbourhood Teams | Three local, multi-agency teams who will deliver more joined-up support and care at home where appropriate. | • ***Phase 1 (Oct 2026):*** Case management for 5,000 high-complexity residents in place.<br>• ***Phase 2 (March 2027):*** Case management extended to 7,500 residents.<br>• ***Phase 3 (March 2028):*** Case management extended to 12,000 residents. |
| 3. Reactive Care | Urgent community response, discharge support, and care at home where appropriate. | • ***Phase 1 (Oct 2026):*** Establish initial operational capability for Reactive Care Coordination Hub covering 7-days a week (08:00 – 20:00) for physical health, Adult Social Care, mobile diagnostics Your LifeLine Palliative Integrated Care established.<br>• ***Phase 2 (March 2027):*** Mental health referrals integrated into the Reactive Care Coordination Hub. Wider range of mobile diagnostic services available.<br>• ***Phase 3 (Sept 2027):*** Hospital discharge coordination integrated into the hub, including rehabilitation.<br>• ***Phase 4 (March 2028):*** Reactive care model fully established. |

<table>
<tr><th>Workstream</th><th>Purpose</th><th>Key Milestones</th></tr>
<tr>
<td>4. Hospital to community</td>
<td>Shift clinically appropriate specialist care into Local Access Hubs in neighbourhood settings.
<table>
<tr><th colspan="2">The Seven Specialties</th></tr>
<tr><td>1. Geriatrics/frailty<br>2. Respiratory<br>3. Diabetes<br>4. Mental health</td><td>5. Muscular skeletal<br>6. Cardiology<br>7. Renal</td></tr>
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<td>
• Phase 1 (Nov 2026): Mobilise geriatrics/frailty specialty with consultant-led community clinics and shared care pathways.<br>
• Phase 2 (April 2027): Extend to respiratory, diabetes and mental health specialties.<br>
• Phase 3 (Oct 2027): Extend to musculoskeletal, cardiology and renal specialties.<br>
• Phase 4 (March 2028): All seven specialties fully established and working effectively.<br>
<u>Local Access Hubs</u><br>
• North: Became operational Nov 2025.<br>
• Southwest: Operational Dec 2027.<br>
• Southeast Hub: Operational by January 2029.
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<tr>
<td>5. Digital Integration</td>
<td>Improved sharing of information, dashboards and tools to help teams coordinate care through use of Blinx PACO as Place Operating Model digital platform.</td>
<td>
• Phase 1 (Oct 2026): Core Blinx PACO digital operating platform established, including onboarding of the 5% frailty/complexity population.<br>
• Phase 2 (Sept 2027): Shared patient record and operational workspace progressively deployed to support integrated MDT working and scaling of the 5% frailty/complexity pathway.<br>
• Phase 3 (March 2028): Place operational command and control, Population Health Management, risk stratification and AI-enabled capabilities fully established. Blinx PACO established as digital operating platform and working effectively.
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</table>

| Workstream | Purpose | Key Milestones |
|---|---|---|
| 6. Diagnostics and Community Intravenous Therapy (IV) | More tests and some treatments delivered in community settings or at home, where safe to do so. | • ***Phase 1 (Oct 2026):*** Expand Mobile X-ray Service to 7-days (08:00 – 20:00) and direct referral routes from multiple services.<br>• ***Phase 2 (March 2027):*** Start offering mobile ultrasound and heart scans.<br>• ***Phase 3 (March 2027):*** Community IV therapy for antibiotics and other treatments supporting admission avoidance and early discharge fully established.<br>• ***Phase 4 (March 2028):*** Mobile diagnostics and IV therapy fully established within the neighbourhoods. |
| 7. Workforce and Culture | Helping staff from different organisations work together more easily. | • ***Phase 1 (Jan 2027):*** Implement integrated management structure replacing traditional organizational silos with place-based leadership.<br>• ***Phase 2 March 2027 and beyond):*** Implement Workforce Passport enabling flexible staff deployment across organisations.<br>• ***Phase 3 (March 2027):*** Deliver organisational development programme to support integrated teams, collaborative behaviours, shared culture, and change management.<br>• ***Phase 4 (March 2028):*** Deliver system leadership development to cultivate leaders capable of cross-organisational integrated care leadership and continuous improvement. |

## 4. Delivering a Life-course Approach

### Start Well

| Priority: Improve maternal health and reduce maternity inequalities | | | |
|---|---|---|---|
| **Actions** | **Indicator** | **Target** | **Date** |
| 1. Provide targeted and culturally tailored maternity support in the most deprived neighbourhoods.<br>2. Strengthen smoking cessation in pregnancy via opt-out referral and neighbourhood-based support.<br>3. Improve access to antenatal education, healthy pregnancy pathways and early postnatal support.<br>4. Increase personalised maternity pathway access for Black, Asian and deprived women. (Core20PLUS5).<br>5. Attain '*UNICEF UK Baby Friendly'* accreditation status across relevant settings. | • Smoking at Time of Delivery (SATOD) (Hillingdon Baseline: 3.3 - 3.4%).<br>• Reduce neighbourhood variation in stillbirth and neonatal mortality.<br>• Increase the % of infants totally/exclusively breastfed at 6 to 8 weeks (2024/25 baseline 34%). | ≤ 3%<br>20%<br>70% | 2031<br>2031<br>2031 |

| Priority: Increase childhood Immunisation coverage | | | |
|---|---|---|---|
| **Actions** | **Indicator** | **Target** | **Date** |
| 1. Strengthen call/recall and outreach through INTs and primary care.<br>2. Target communities with lower uptake, particularly in Hayes, Yiewsley and West Drayton.<br>3. Expand vaccination delivery in community venues and Family Hubs. | • Increase routine vaccination coverage by age 5 in every neighbourhood..<br>• Reduce variation between neighbourhoods. | 89% to ≥ 95%<br>within ±2% | 2027<br>2027 |

| Priority:Improve early child development and school readiness | | | |
|---|---|---|---|
| **Actions** | **Indicator** | **Target** | **Date** |
| 1. Expand speech, language and communication (*SLC*) support in all neighbourhoods.<br>2. Strengthen Health Visitor (early years)/INT links to identify needs earlier.<br>3. Increase access to high-quality early education, especially for disadvantaged 2-year-olds.<br>4. Improve parental engagement through Family Hubs and schools. | • Increase the proportion of Children achieving a *Good Level of Development* (*GLD*) above the current baseline of 70%.<br>• Increase GLD for disadvantaged children.<br>• Reduce the 19% GLD inequality gap for disadvantaged children.<br>• Establish a borough-wide baseline for uptake of funded early education places and increase uptake of funded places for 2-year-olds. | >70%<br>≥ 51.9%<br>20%<br>10% | 2031<br>2031<br>2031<br>2031 |

| Priority: Childhood and Young People's Mental Health 5 - 16 | | | |
|---|---|---|---|
| **Actions** | **Indicator** | **Target** | **Date** |
| 1. Expand school-based mental health support, including Mental Health Support Teams (*MHSTs*) and early intervention practitioners working through schools and Family Hubs.<br>2. Strengthen joint working between schools, Child and Adolescent Mental Health Services (*CAMHS*), educational psychology and INTs for earlier identification and support.<br>3. Deliver community-based resilience and wellbeing programmes in high-need neighbourhoods.<br>4. Work with education providers to identify young and young adult carers and sign-post to appropriate support. | • Increase MHST and school based mental health support coverage.<br>• Reduce % of pupils reporting anxiety/behavioural difficulties in targeted schools.<br>• Reduce MH-linked persistent absence. | 44% to 60%<br>10%<br>5% | 2027<br>2028<br>2028 |

| Priority: Strengthen school attendance and engagement | | | |
|---|---|---|---|
| **Actions** | **Indicator** | **Target** | **Date** |
| 1. Strengthen multi-agency attendance pathways (schools, Early Help, youth, social care).<br>2. Target intensive support at persistently/severely absent pupils.<br>3. Improve health–education pathways for pupils with LTC, anxiety or neurodiversity. | • Reduce persistent absence (Hillingdon baseline 21.2%)<br>• Reduce fixed-term exclusions in highest-need schools (2025/26 baseline).<br>• Increase Early Help engagement for persistently absent pupils (2025/26 baseline) | 3%<br>20%<br>25% | 2028<br>2031<br>2031 |

| Priority:Reduce childhood obesity and improve physical activity | | | |
|---|---|---|---|
| **Actions** | **Indicator** | **Target** | **Date** |
| 1. Expand active travel, after-school sport and community programmes.<br>2. Strengthen school- and community-based healthy eating programmes.<br>3. Integrate school nursing, INTs and early years services to support earlier intervention. | • Reduce proportion of Year 6 who are overweight/obese.<br>• Increase physical activity (5–16-year-olds).<br>• Increase uptake of targeted healthy-eating programmes in high need neighbourhoods (2025/26 baseline). | 38.3% to 34%<br>43.5% to 50%<br>20% | 2031<br>2031<br>2031 |

| Priority: Early Intervention and Community Mental Health Mental Health Support 0 - 25 | | | |
|---|---|---|---|
| **Actions** | **Indicator** | **Target** | **Date** |
| 1. Expand neighbourhood-based CYP mental health support through schools, Family Hubs and VCSE partners by 2027.<br>2. Embed CYP MH practitioners within INTs by 2027.<br>3. Strengthen joint CAMHS/school/Early Help early intervention pathway by 2026. | • Increase proportion of young people accessing early intervention support (2025/26 baseline).<br>• Reduce CYP crisis presentations and emergency referrals (2025/26 baseline).<br>• Expand MHST and community MH community coverage.<br>• Increase health input into Education, Health and Care Plans (EHCP). | 10%<br>44% to 60%<br>10% | 2031<br>2027<br>2031 |

| Priority: Strengthen neurodevelopment (ND) pathways | | | |
|---|---|---|---|
| **Actions** | **Indicator** | **Target** | **Date** |
| 1. Develop a coordinated ND pathway across paediatrics, CAMHS, schools and Family Hubs.<br>2. Provide early pre-diagnostic support.<br>3. Improve transition from assessment to education and support plans. | • Reduce ND assessment waiting times (2025/26 baseline).<br>• Increase proportion of children receiving early pre-diagnostic support (2025/26 baseline).<br>• Reduce exclusions for CYP with ND needs (2025/26 baseline).<br>• Reduce the number of CYP with ND needs not in education, employment or training (NEET). | 20%<br>20%<br>20% | 2027<br>2031<br>2031<br>2031 |

| Priority: Improve support to families and joint SEND planning | | | |
|---|---|---|---|
| **Actions** | **Indicator** | **Target** | **Date** |
| 1. Expand Family Hub and VCSE parent-carer support.<br>2. Strengthen joint commissioning and planning across education, health and care.<br>3. Improve SEND navigation pathways for information access, assessment and support. | • Increase parent-carer satisfaction/participation in SEND and early help pathways (baseline to be established).<br>• Improve EHCP timeliness.<br>• Reduce repeat specialist referrals through stronger early support (2025/26 baseline). | 20%<br>≥60% within 20 weeks<br>15% | 2031<br>2031<br>2031 |

## Live Well

| Priority: Earlier detection and management of long-term conditions and rising risk frailty | | | |
|---|---|---|---|
| **Actions** | **Indicator** | **Target** | **Date** |
| 1. Use PHM and INT Multi-disciplinary Team (*MDTs*) meetings to identify rising-risk adults.<br>2. Deliver neighbourhood hypertension/cardiovascular disease (*CVD*) programmes.<br>3. Increase NHS Health Checks and targeted screening.<br>4. Strengthen diabetes and lifestyle change support.<br>5. Improve the identification of carers. | • Increase hypertension prevalence capture.<br>• Maintain blood pressure (BP) control in diagnosed cases.<br>• Provide proactive case management to rising risk adults.<br>• Increase percentage of carers registered on the carers register (2021 census baseline).<br>• Increase the proportion of adult carers saying they have as much social contact as they like from 2025/26 baseline. | 13.8% to 24%<br>≥85%<br>12,000<br>40%<br>21% to 19% | 2028<br>2028<br>2028<br>2030<br>2029 |

| Priority: Improving mental wellbeing through neighbourhood support | | | |
|---|---|---|---|
| **Actions** | **Indicator** | **Target** | **Date** |
| 1. Embed MH practitioners in all INTs.<br>2. Expand talking therapies, social prescribing and wellbeing support.<br>3. Increase community programmes to reduce loneliness and isolation. | • Increase talking-therapy access.<br>• Reduce MH presentations (2025/26 baseline).<br>• Reduce unplanned MH bed days (2025/26 baseline) | ≥25%<br>10%<br>10% | 2027<br>2031<br>2031 |

| Priority: Reduce health-harming behaviours | | | |
|---|---|---|---|
| **Actions** | **Indicator** | **Target** | **Date** |
| 1. Deliver targeted smoking cessation, weight management and physical activity programmes via INTs.<br>2. Strengthen nutrition, cooking and healthy-eating support in schools, Family Hubs and community settings.<br>3. Embed lifestyle interventions within proactive care and long-term condition pathways. | • Reduce adult smoking prevalence.<br>• Reduce adult obesity.<br>• Increase physically active adults.<br>• Increase identified adults on the Primary Care Network (*PCN*) Client Record Management (CRM) register lifestyle improvement with completion of holistic assessment, including 6 pillars of lifestyle medicine. | 11.8% to 9%<br>26.3% to 23%<br>55.8% to 62%<br>20% | 2031<br>2031<br>2031<br>2028 |

## Age Well

| Priority: Proactive frailty care and rapid support | | | |
|---|---|---|---|
| **Actions** | **Indicator** | **Target** | **Date** |
| 1. Identify and stratify people with severe frailty using the Frailty Index/Population Health Management (*PHM*) and INT MDTs.<br>2. Deliver proactive personalised care plans with wrap around care to all severely frail people (approx. 5,000, i.e., frail/complex).<br>3. Implement NWL Frailty Pathway.<br>4. Expand Urgent Community Response (*UCR*) and mobile diagnostics to provide same day alternatives to ED.<br>5. Use the Reactive Care Co-ordination Hub as the single referral point for urgent community support.<br>6. Implement and scale Hospital at Home to provide acute level care in familiar surroundings. | • Population with severe frailty to have a personalised care plan.<br>• Reduce Emergency Department attendances.<br>• Reduce frailty emergency admissions (2025/26 baseline).<br>• % of appropriate UCR referrals seen within 2 hours of referral.<br>• Scale up Hospital at Home capacity.<br>• Maintain rate of people 65 + permanently admitted to care homes per 100,000 at 2025/26 baseline. | 100%<br>164/day<br>10%<br>90%<br>410.3 (170 admissions) | 2026<br>2027<br>2028<br>2027<br>Annual |

| Priority:Improve falls prevention, rehabilitation, reablement and discharge | | | |
|---|---|---|---|
| **Actions** | **Indicator** | **Target** | **Date** |
| 1. Merge falls services into a single strengthened offer with a clear delineated pathway.<br>2. Deliver 7-day integrated reablement and rehabilitation with expanded capacity.<br>3. Implement the Place NC2R Improvement Plan to reduce discharge delays.<br>4. Redesign IDT with clear escalation and decision-making. | • Reduce falls-related emergency admissions.<br>• Increase % of P0/P1 discharges taking place same day/next day.<br>• Sustained number of NC2R patients throughout 2026 and beyond.<br>• Increase % of people discharged from hospital to reablement still in the community 12 weeks after discharge (2025/26 baseline) | 10%<br>≥65%<br>≤34<br>65% to 70% | 2031<br>2027<br>2026 & annual<br>2028 |

| Priority: Improve care home, dementia and end of life support | | | |
|---|---|---|---|
| **Actions** | **Indicator** | **Target** | **Date** |
| 1. Strengthen INT-led care home support with GP, therapy and pharmacy input.<br>2. Deploy UCR and rapid mobile diagnostics into care homes.<br>3. Increase dementia diagnosis and post-diagnostic support.<br>4. Review care home capacity including the balance between commissioned and directly provided services.<br>5. Implement Palliative Integrated Care Service (*PICS*) across Hillingdon. | • Reduce avoidable care home admissions (2025/26 baseline).<br>• Increase dementia diagnosis %.<br>• Increase post diagnostic dementia support. (2025/26 baseline).<br>• Increase deaths in usual place of residence. (2025/26 baseline). | 10%<br>≥66.7%<br>20%<br>10% | 2031<br>2027<br>2028<br>2031 |

## Healthy Places

| Priority: Improve housing stability and reduce homelessness | | | |
|---|---|---|---|
| **Actions** | **Indicator** | **Target** | **Date** |
| 1. Strengthen early identification of housing instability through joint work between Housing, INTs and Family Hubs.<br>2. Improve pathways for people facing homelessness, including hospital discharge.<br>3. Improve the standard of Council owned homes.<br>4. Target enforcement/support for unsafe private rented homes.<br>5. Maximise the number of disabled and older residents able to remain in their own homes by making best use of the Disabled Facilities Grant. | • Reduce households in temporary accommodation (1,700 baseline).<br>• Reduce the percentage of Council owned homes not meeting the Decent Homes Standard. | 10%<br>≤5% | 2028<br>2028 |

| Priority: Create safer, healthier neighbourhoods | | | |
|---|---|---|---|
| **Actions** | **Indicator** | **Target** | **Date** |
| 1. Strengthen the joint working between the Health and Wellbeing Board and the Safer Hillingdon Partnership.<br>2. Develop a *Health in All Policies* approach to embedding health and wellbeing concerns into council plans and strategies. | • Establish cross representation between the Health and Wellbeing Board and the Safer Hillingdon Partnership.<br>• Development of a Health in All Policies framework to be adopted by all partners. | Rep in place<br><br>Framework established | 2027<br><br>2027 |

| Priority: Reduce social isolation and improving community cohesion | | | |
|---|---|---|---|
| **Actions** | **Indicator** | **Target** | **Date** |
| 1. Support community-led connection programmes.<br>2. Use INTs and Family Hubs to connect residents into local groups.<br>3. Expand digital/social inclusion support for older adults and vulnerable groups. | • Reduce the proportion of adults reporting loneliness. | 24% to 20% | 2031 |

## 5. Equalities and Human Rights Impact Assessment Tracker

| Equality Group/Issue | Potential Impact | Required Action | Timescale |
|---|---|---|---|
| Children in deprived south of the borough. | Entrenched early years, school readiness, obesity, asthma and wellbeing inequalities. | • Family hubs mobilisation.<br>• Speech, language & communication support.<br>• Immunisation Outreach<br>• GLD gap monitoring by ward and ethnicity. | Mobilise by Mar 2027; monitor biennially to 2031. |
| Children and young people with SEND. | Long waits, fragmented pathways and harm to attainment and family wellbeing. | • Coordinated ND pathway.<br>• Pre-diagnostic support.<br>• Monitoring waits by ethnicity & deprivation. | Coordinated pathway by 2027; support and monitoring annually to 2031. |
| Older adults in deprived south of the borough. | Risk that Age Well benefits are not equitably distributed. | • Apply Core20PLUS5.<br>• Monitor frailty plans, hospital admissions and care home admissions by neighbourhood and deprivation. | From Oct 2026; annual monitoring to 2031. |
| People living with severe mental illness (SMI). | Lower detection and management of physical health risks. | • SMI-inclusive physical health checks.<br>• Track hypertension capture and BP control by SMI status.<br>• Strengthen mental health and INT links. | Physical health checks and INT links by Mar 2027; monitor biennially to 2031. |

| Equality Group/Issue | Potential Impact | Required Action | Timescale |
|---|---|---|---|
| Black and South Asian women. | Maternity inequalities and poorer birth outcomes. | • Targeted culturally tailored maternity support.<br>• Personalised pathways.<br>• Monitor SATOD, breastfeeding and neonatal outcomes. | From 2026/27; outcomes monitored biennially to 2031. |
| Unpaid carers. | Under identification.<br>Isolation and risk of carer breakdown (including male and young carers). | • Identification through INTs, GPs, MECC and Family Hubs.<br>• 40% registration target.<br>• Targeted outreach. | Identification routes and inclusive practice by Mar 2027.<br>40% registration target by Mar 2030.<br>Annual outreach programme. |
| LGBTQ+ residents. | Isolation, access barriers, and invisibility in service planning. | • Develop data and needs identification.<br>• Inclusive practice and training.<br>• Accessible community connection programmes. | Data identification Oct 2027. |
| Older and disabled residents. | Digital exclusion and TEC switchover risk. | • TEC digitalisation<br>• Digital inclusion support.<br>• Maintain non-digital access routes through INTs and Local Access Hubs. | TEC digitalisation by Jan 2027. |

## 6. Cross Cutting Enablers

| Enabler | Delivery Requirement |
|---|---|
| Workforce and organisational development | • Integrated leadership<br>• Workforce passport<br>• Shared training, cultural competence, staff wellbeing and retention. |
| Digital, data and PHM | • Data sharing<br>• Neighbourhood dashboards<br>• Risk stratification<br>• Digital inclusion |
| Estates and Super Hubs | • Neighbourhood Super Hub plans for Hayes, Ruislip and Uxbridge and alignment with the new hospital redevelopment. |
| Finance and pooled budgets | • Section 75 opportunities, resource alignment and transformation funding for priority models. |
| VCSE and community partnerships | • Collaboration with 3ST and wider VCSE partners, particularly prevention, mental health, support for carers and loneliness reduction. |

## 7. Governance and Assurance

| Governance Route | Role in Assurance Delivery |
|---|---|
| Health and Wellbeing Board | • Strategic leadership in determining priorities for addressing resident health and wellbeing needs, assurance on risks, impact and progress. |
| Executive Oversight Board | • Delivery oversight, alignment with ICB frameworks and escalation of delivery risks. |
| Operational Oversight Committee | • Expert operational clinical oversight. |
| Finance and Performance Committee | • Monitoring resources, outcomes, investment impact and benefits realisation. |
| Safeguarding Boards | • Discharge of statutory safeguarding functions relating to children and adults. |
| Quality and Safety Committee | • Quality and safety in health services oversight. |
| Place Integrator Team | • Programme reporting, risk and dependency management, assurance, benefits and continuous improvement. |
| Resident and community feedback routes | • Feedback through surveys, forums, Family Hubs, VCSE, Healthwatch and neighbourhood engagement. |

## 8. Impact Framework

| Impact Area | What should be evidenced |
|---|---|
| **Operating model mobilisation**: are we building and scaling the model? | • Delivery of mobilisation milestones. |
| **Place outcomes:** are we reducing demand, improving system flow and shifting care from hospital to community? | • Non-Elective Admissions – 20,180 per year<br>• Non-Elective Admissions ≥2 days – 9,827 per year<br>• ED Attendances – 40,600 per year<br>• UTC Attendances – 120 per day<br>• NC2R – ≤34 patients per day<br>• Average length of stay for adults staying ≥2 days – 8.5 days<br>• Outpatient activity – 300,911 per year<br>• Hypertension prevalence – 24%<br>• Hypertension target-to-treatment – 80%<br>• Permanent admissions to care homes – 170 per year |
| **Wider strategy outcomes**: are we supporting better resident health and reducing inequalities? | • Improvement in Core20PLUS5<br>• Improvements in *Best Start* and *Healthy Places'* measures.<br>• Improved resident and carer experience. |

## 9. Glossary

| Term | Meaning |
|---|---|
| 3ST | Third Sector Together |
| ASC | Adult Social Care |
| Blinx PACO | A digital platform to support shared working, patient records, workflows and dashboards. |
| CAMHS | Child and Adolescent Mental Health Services. |
| Core20PLUS5 | An NHS inequalities framework used to focus action on the most deprived populations and priority groups. |
| DFG | Disabled Facilities Grant |
| EHCP | Education, Health and care Plan |
| GLD | Good Level of Development |
| HHCP | Hillingdon Health and Care Partners |
| HWB | Health and Wellbeing Board |
| INT | Integrated Neighbourhood Team |
| NC2R | No criteria to reside |
| ND | Neurodevelopment |

| Term | Meaning |
| --- | --- |
| PHM | Population Health Management |
| PICS | Palliative Integrated Care |
| SMI | Severe Mental Illness |
| UCR | Urgent Community Response |
| VCSE | Voluntary, community and social enterprise sector |