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A

Health and Social Care Select Committee

Councillors on the Committee

Councillor Nick Denys (Chair)
Councillor Reeta Chamdal (Vice-Chair)
Councillor Tony Burles
Councillor Becky Haggar OBE
Councillor Kelly Martin
Councillor June Nelson
Councillor Sital Punja (Opposition Lead)

Date: **TUESDAY, 16 SEPTEMBER 2025**

Time: **6.30 PM**

Venue: **COMMITTEE ROOM 5 - CIVIC CENTRE**

Meeting Details: The public and press are welcome to attend and observe the meeting.

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Terms of Reference

Health & Social Care Select Committee

Portfolio(s)	Directorate	Service Areas
Cabinet Member for Health & Social Care	Adult Services & Health	Adult Social Work (incl. Direct Care and Business Delivery, Provider & Commissioned Care)
		Adult Safeguarding
		Hospital & Localities
		Adult Learning Disabilities & Mental Health
		Adult Social Services transport and travel
		Health & Public Health (incl. health partnerships, health inequalities & Health Control Unit at Heathrow)
		Health integration / Voluntary Sector
	Homes & Communities	The Council's Domestic Abuse services and support (cross-cutting)
		Services to asylum seekers

STATUTORY COMMITTEE	<u>Statutory Healthy Scrutiny</u> This Committee will also undertake the powers of health scrutiny conferred by the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. It will: • Work closely with the Health & Wellbeing Board & Local Healthwatch in respect of reviewing and scrutinising local health priorities and inequalities. • Respond to any relevant NHS consultations. <u>Duty of partners to attend and provide information</u> The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, imposes duties on 'responsible persons' to provide a local authority with such information about the planning, provision and operation of health services in the area of the authority as it may reasonably require to discharge its health scrutiny functions through the Health & Social Care Select Committee. All relevant NHS bodies and health service providers (including GP practices and other primary care providers and any private, independent or third sector providers delivering services under arrangements made by clinical commissioning groups, NHS England or the local authority) have a duty to provide such information.

	Additionally, Members and employees of a relevant NHS body or relevant health service provider have a duty to attend before a local authority when required by it (provided reasonable notice has been given) to answer questions the local authority believes are necessary to carry out its health scrutiny functions. Further guidance is available from the Department of Health on information requests and attendance of individuals at meetings considering health scrutiny.

Agenda

CHAIR'S ANNOUNCEMENTS

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Minutes

HEALTH AND SOCIAL CARE SELECT COMMITTEE

22 July 2025

Meeting held at Committee Room 6 - Civic Centre, High Street, Uxbridge UB8 1UW

	Committee Members Present: Councillors Nick Denys (Chair), Reeta Chamdal (Vice-Chair), Tony Burles, Becky Haggar, Kelly Martin, June Nelson and Barry Nelson-West (In place of Sital Punja) **Also Present**: Sean Bidewell, Assistant Director – Integration & Delivery / Acting Joint Borough Director, North West London Integrated Care Board (NWL ICB) Carleen Duffy, Your Voice in Health and Social Care (Healthwatch) Edmund Jahn, Chief Executive Officer, The Confederation Hillingdon CIC Lisa Taylor, Managing Director, Healthwatch Hillingdon **LBH Officers Present**: Nikki O'Halloran (Democratic, Civic and Ceremonial Manager)
12.	**APOLOGIES FOR ABSENCE** *(Agenda Item 1)* Apologies for absence had been received from Councillor Sital Punja (Councillor Barry Nelson-West was present as her substitute).
13.	**DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING** *(Agenda Item 2)* There were no declarations of interest in matters coming before this meeting.
14.	**MINUTES OF THE MEETING HELD ON 19 JUNE 2025** *(Agenda Item 3)* **RESOLVED: That the minutes of the meeting held on 19 June 2025 be agreed as a correct record.**
15.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 4)* **RESOLVED: That all items of business be considered in public.**
16.	**SINGLE MEETING REVIEW: GP COVERAGE IN HILLINGDON** *(Agenda Item 5)* The Chair welcomed those present to the meeting. Witnesses had provided a response to many of the key lines of enquiry highlighted in the scoping report in advance of this single meeting review – this information had been circulated to Members of the Committee on 15 July 2025. Mr Edmund Jahn, Chief Executive Officer at The Confederation Hillingdon CIC, advised that the Confederation represented 42 of the 44 GP practices in Hillingdon.

These practices were grouped into six Primary Care Networks (PCNs) which each had Clinical Directors who sat on the Confederation Board. The two practices that had not joined the PCNs were owned by the same person and the central primary care team worked closely with them to plug any gaps.

Members queried the value in being part of the PCN and why two would have opted out. Officers advised that they did not know why they had opted out but that, whilst the practices would provide appointments, the PCN offered additional support and signed up to single offer additional contracts. Mr Jahn advised that all PCNs employed pharmacists in practice teams which most independent GPs were unable to do. They also provided GPs with access to social prescribers and other specialist services such as physiotherapists, podiatrists and dieticians to help their patients. Ms Lisa Taylor, Managing Director at Healthwatch Hillingdon (HH), advised that Healthwatch Hillingdon had the ability to rank GPs based on patient satisfaction, and that they had made a recommendation in their recent report to review the utilisation of enhanced services to identify any inconsistencies. GPs could be ranked based on patient satisfaction and how well GPs were accessing enhanced services but this was inconsistent.

Action was being taken to try to introduce more personalised care for patients with complex needs as well as dealing with same day access for other patients. Pharmacy First consultation service enabled patients to be referred into community pharmacy for a minor illness or an urgent repeat medicine supply. It enabled community pharmacies to complete episodes of care for seven common conditions following defined clinical pathways: infected insect bites, impetigo, shingles, sinusitis, sore throat, urinary tract infections and ear infection.

Ms Taylor had undertaken a review of Pharmacy First and was currently writing up the findings and recommendations of the review. This would be shared with the Committee in due course.

Mr Sean Bidewell, Integration and Delivery at NWL ICB, advised that pharmacies had been alleviating pressure on GPs. Since May 2025, 58 of the 59 pharmacies in Hillingdon had been delivering support for some of the seven common conditions. 56 of the pharmacies also offered a hypertension case finding service and 53 provided a contraception service. Other services such as flu and covid vaccinations and smoking cessation support were also provided by some pharmacies. Between January and May 2025, there had been around 4k individuals with common conditions seen by pharmacies in Hillingdon and about 5½k patients seen in relation to their medicine supplies. Around 12k people had had their blood pressure monitored at a Hillingdon pharmacy during this same period.

Mr Jahn noted that the scoping document for this single meeting review had picked up on several themes regarding GP coverage in Hillingdon. GPs were nationally contracted with GP Directed Enhanced Service (DES), General Medical Services (GMS) or Alternative Provider Medical Services (APMS) contracts. GPs were also contracted by North West London Integrated Care Board (NWL ICB) for some services. Whilst the services provided could be commissioned, each practice was independent and would be able to deliver those services in their own way.

In Hillingdon, although practices could cover the majority of services required, they were able to pull together as PCNs to run clinics for things like diabetes. In addition, the Confederation provided services that were not provided by the practices or the PCNs. This tended to be at scale, for example, the integration of the care home

service in partnership with Central and North West London NHS Foundation Trust (CNWL). Specialist services such as women's clinics and warfarin monitoring were also undertaken by the Confederation and top up work was available if practice capacity dipped (GPs were able to refer patients to Confederation clinics to ensure that they met 100% of patient requirements).

GPs used to get quite a lot of support from the NHS / CCG in relation to issues such as workforce / training, technical / digital and estates but, over the last 3-4 years, this had moved to the ICB and diminished, with responsibility shifting to the providers themselves. Increasingly, collaboration was becoming the norm to maximise the services available to patients. Whilst GPs would have a Practice Manager, they would not have an HR Manager, Digital Manager, etc. However, they were able to receive this support from the Confederation.

Mr Jahn advised that the NWL ICB was a strategic commissioner which measured GPs against targets based on local contracting agreements. The PCNs organised who did what amongst the practices and a lot of contracting was undertaken locally by the Confederation to fulfil PCN decisions and meet strategic contracts and objectives.

It was noted that a major engagement exercise had been undertaken with regard to access plans with 5% of the Hillingdon population participating. Six access plans had been produced for the coming year which set out changes in delivery. The NWL ICB had identified what access improvements it would like to see which included a requirement for practices to answer 90% of calls within ten minutes.

Mr Jahn noted that there had been an increase in the overall number of GP appointments available but feedback on the patient experience was still not where the Confederation would like it to be. In terms of improving this, a lot of effort was being made, but more listening was needed across all practices. Members queried whether this increase in appointments was solely for GP appointments or whether it included appointments for things like nurse practitioners. Mr Bidewell advised that there had been an increase in activity but that he was not sure about the proportions (the national GP data set on activity could be broken down by face-to-face, telephone, etc). In 2022/23, there had been 1.7 million appointments with a 6% increase in 2023/24 and a 9% increase in 2024/25 (68% of these had been face-to-face which was an increase on the previous year). There had been an increase in the number of patients wanting a same day appointment (up from about 3k to 3½k).

Mr Bidewell advised that he was part of the Borough team based in the Civic Centre and worked with Hillingdon Health and Care Partners. The ICB had a strategic commissioning role and linked with partners for monitoring and managing. Locally, the team worked with partners to look at the local delivery of the strategic commissioning priorities. Although the ICB would continue at a NWL level centrally in some form, it was unclear what the changes being made to the organisational structure would mean for the Borough team.

The Integrated Neighbourhood Teams were working to bring care closer to patients including the PCNs and core services such as community nursing, musculoskeletal (MSK), adult social care, third sector and acute services. The Paediatric Clinics were a good example of this closer working in the community which saw teams from different organisations working together to improve patient experience and increase the number of patients seen. These clinics were being run from the Integrated Neighbourhood Hub. Practices were able to book appointments at the Hub through patient contact with

GPs. In future, neighbourhood working meant that patients should be able to be booked in to see the community nurse and the community nurse should be able to book the patient in to see their GP.

Ms Taylor advised that HH had recently published its report on GP access. The most common cause for residents to contact HH was in relation to getting a GP appointment – patient satisfaction had not improved even though there had been an increase in the total number of appointments available.

HH's research for the GP access report had started in 2024 but, as the survey had been put on hold whilst NWL ICB looked at same day access issues, discussions had been undertaken with groups such as carers, travellers and asylum seekers. Although 62% had been satisfied with GP contact there were concerns about issues such as booking appointments, telephone systems and continuity of care (these concerns were largely from people of working age).

The PATCHS system had been introduced to try to reduce phone waiting times by enabling patients to make an appointment request online. However, access times were limited and there had been some technical issues which meant that practice staff were having to call patients back. Furthermore, issues had been identified with regard to the telephone call back system which was not currently working properly and the use of multiple platforms for various elements of the NHS had been causing confusion for some patients (this was not helpful to those members of the public who were not technologically confident or competent). Mr Jahn advised that it had been recognised that patients were not able to specify a convenient time for a call back so might be busy and unable to answer when the call came. There were four Digital Transformation Managers that had been looking at this type of issue to help simplify it from the patient perspective.

Other concerns raised by residents in Hillingdon included data security, continuity of care and inconsistent follow ups. The reliance of some practices on locums had impacted on patient confidence in their GP as there was a lack of familiarity with their health history and they were having to repeat their story multiple times. There had also been some language barriers where interpreters were not always provided and people with hearing impairments were not being supported through the telephone system (there could be a confidentiality issue if patients were reliant on a third party to interpret for them).

Ms Taylor advised that patients would often be unaware of the role of each individual in a practice and sometimes felt that they were not being seen by the most appropriate person. They were also not always happy about giving personal information to reception staff even though they needed this to be able to triage.

Mr Jahn advised that there had been an increase in the number of GPs in Hillingdon and proactive action had been taken to increase the number of training practices in the Borough. Once full trained, trainee GPs at these practices tended to get their first job once fully qualified within the area that they had trained which had had a positive impact on numbers. In addition, use had been made of fellowships and supporting them with mentorships.

There had been an expansion of general practice capacity through the Additional Roles Reimbursement Scheme (ARRS) which enabled PCNs to claim reimbursement for the salaries of certain roles within the multidisciplinary team, selected to meet the needs of

the local population. This had resulted in two new GPs being recruit in the last year and 3-4 more GPs currently in the process of being recruited. However, Mr Jahn noted that around 25% of Hillingdon's GP were nearing or beyond retirement age (which was a high risk), with demand continuing to increase and many new GPs being portfolio based (working part time as a GP as a lifestyle choice or so that they could work somewhere else as well).

Members queried what action was being taken to provide a GP services across all of the Heathrow Villages (particularly Harmondsworth, Sipson and Longford) and what progress had been made to secure a site for a general practice in the area. Mr Bidewell advised that he did not know about the plans to secure land for a GP practice in Heathrow Villages so would ask Mr Keith Spencer (Managing Director at Hillingdon Health and Care Partners) and Ms Sue Jeffers (Borough Director at NWL ICB) to provide Members with an update. He was, however, aware that a contract had been put in place for the HESA Centre in Hayes to take on some of the patients in the Heathrow Villages. Ms Jeffers had also been reaching out to pharmacies to see what support could be provided for residents in this area.

There had been efforts to ensure that women were able to see a female GP (or other female professionals) if required. Members queried whether the same priority was given to men. Ms Taylor was unaware of any such requirement but suggested that the same focus ought to be given to men's health as women's as this appeared to be a gap in the system.

Members queried how patients from different practices were able to access the same services (for example, dressings) and where they would be provided, particularly if they were unable to use / access IT. Mr Jahn advised that healthcare was complex and that staff often tried to deal with that complexity behind the scenes but that this didn't always work. There were at least five patient digital systems in use by General Practice in Hillingdon (possibly six) that patients needed to interact with for different things (this should probably be a maximum of two). The computer systems tended to be siloed and patient were often passed between them. The NHS should be able to work as a single team without the patient having to intervene but the data governance needed to be sorted out. Mr Bidewell advised that this challenge was bigger than NWL ICB but that, locally, work was being undertaken to enable systems to talk to each other through Whole Systems Integrated Care (WSIC) dashboards which provided a linked integrated summary of patient's health and social care. This information could be used to case find and case manage patients who required more targeted and proactive care.

Members expressed concern that residents might get lost in the system between services and queried how GPs received communication about the actions taken by other clinicians. Mr Jahn advised that, in many ways, the last four years had seen better cooperation across practices and networks, and staff had been collaborating more than ever. First contact physiotherapists were employed in general practice with another tier in CNWL (MSK) and anther at the hospital. These siloes had still not be joined together and patients might be asked to complete similar forms for each of the services asking for very similar information. Ideally, as part of the 3-5 year plan being developed across and between local NHS providers (including GPs), there would be integrated physiotherapy teams collocated in each of the three Hubs.

In Hillingdon, a partnership had been established between the GP Confederation, local hospital, CNWL and others. This had been a significant step and was quite advanced,

with officers pushing and championing the joined up way of working to ensure that Hillingdon was in the first wave in 2026 for the formal introduction of neighbourhood working.

It was queried how the NHS planned its future provision. For example, a new GP surgery had been planned for inclusion in the St Andrews Park development but this had not happened. As a result, a large number of patients had had to join the Uxbridge practice list, making it one of the largest practices and putting it under greater pressure. Mr Jahn advised that this type of question would usually need to be answered by the commissioners. The Confederation had worked closely with the Council, NWL ICB and providers to recently put an integrated estates strategy in place but, during his seven years as Chief Executive Officer, he noted that the development of general practice had not followed a plan very closely. He noted that there were some gaps where some GP practices catered for four times as many patients for the same size practice as others and it was hoped that the strategic plan would address these inconsistencies (for example, more GP capacity was needed in Yiewsley / West Drayton).

Members queried who proactively decided where and when additional GP capacity was needed and how this was done in practice. Mr Jahn advised that commissioning would be involved. When the last GP in a practice retired, would the practice close and the patient list need to be redistributed? If a practice was needed, it would be referenced on the basis of the strategic plan. Freeing up capital allocation would be a Government decision and, although commissioners had not had it in their gift over the last ten years, they now had a reference document / plan. Closer working relations had been developed with the Council so there was a possibility of sharing estate (and the local authority had fewer restrictions so provided better options).

In terms of monitoring the quality of, and complaints about, GP services, the CQC inspected practices and was able to issue improvement notices if standards were not being achieved (the CQC had been very active in Hillingdon). Data about GPs was very visible, for example, the qualities and outcomes framework, and there were 188 measures included in NWL ES GP contracts alone. GPs would deal with complaints and incidents through their own governance processes so work was needed on this as it was fairly self-contained.

Members queried what additional services were being explored to take the pressure off GPs. Ms Taylor advised that a Children and Young People's Champion role had been appointed in one of the PCNs as a one year pilot to alleviate the impact of mental health presentations on GPs and get young people and their families to the right support as quickly as possible (there was a need to reduce the reliance on CAMHS by diverting to other services that were available and more appropriate). There were also plans to introduce additional roles such as practice nurses in some PCNs. As the neighbourhood population needs were analysed, action would be needed to ensure that services were tailored to meet those needs. Members asked that the Children and Young People's Champion be invited to attend a future meeting of the Health and Social Care Select Committee in about six months.

Members were asked to forward any additional questions that they might have for those present (or for Ms Jeffers or Mr Spencer) or suggested recommendations to the Democratic, Civic and Ceremonial Manager by Friday 1 August 2025.

The Chair noted that this would be Ms Taylor's last attendance at the Committee's meetings. He thanked her for her insightful contributions over the years and wished

	her well. Ms Carleen Duffy would be taking the service forward from 1 August 2025. **RESOLVED: That:** **1. Mr Keith Spencer and Ms Sue Jeffers be asked to provide the Committee with a written update on progress with regard to securing land for a GP practice and providing pharmaceutical services in Heathrow Villages;** **2. the newly appointed Children and Young People's Champion be invited to attend a future meeting in about six months;** **3. Members forward any additional questions that they might have for those present (or for Ms Jeffers or Mr Spencer) or suggested recommendations to the Democratic, Civic and Ceremonial Manager by Friday 1 August 2025; and** **4. the discussion be noted.**
17.	**CABINET FORWARD PLAN MONTHLY MONITORING** *(Agenda Item 6)* Consideration was given to the Cabinet Forward Plan. **RESOLVED: That the Cabinet Forward Plan be noted.**
18.	**WORK PROGRAMME** *(Agenda Item 7)* Members agreed to cancel the meeting scheduled for 21 April 2026 and move the health updates item to the meeting on 26 March 2025. The new Children and Young People's Champion that had been appointed to one of the Primary Care Networks would be invited to attend the meeting on either 20 January 2026 or 17 February 2026. It was agreed that the update on the implementation of recommendations from the review of the CAMHS referral pathway be moved to coincide with this attendance. **RESOLVED: That the Work Programme, as amended, be agreed.**
	The meeting, which commenced at 6.30 pm, closed at 8.07 pm.

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nikki O'Halloran on nohalloran@hillingdon.gov.uk. Circulation of these minutes is to Councillors, officers, the press and members of the public.

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Chelsea and Westminster Hospital NHS Foundation Trust
The Hillingdon Hospitals NHS Foundation Trust
Imperial College Healthcare NHS Trust
London North West University Healthcare NHS Trust

NWL Acute Provider Collaborative Board in Common (Public)
15/07/2025
Item number: 3.1
This report is: Public

Future of Minor Injuries Provision across The Hillingdon Hospitals NHS Foundation Trust (THHFT)

Author: Dr Alan McGlennan
Job title: Managing Director and Chief Medical Officer

Accountable director: Lesley Watts
Job title: Chief Executive Officer

Purpose of report

Purpose: Decision or approval

The THHFT Trust Standing committee recommends that the Board of THHFT approve the consolidation of minor injuries services into a single, clinically robust and financially sustainable model. This proposal involves bringing together the standalone Urgent Care Nurse Practitioner Service (UCNPS) at Mount Vernon Hospital (MVH) with the Urgent Treatment Centre (UTC) at Hillingdon Hospital (HH), with the aim of optimising resources and enhancing access, safety, and equity of care across the borough.

Report history

Outline committees or meetings where this item has been considered before being presented to this meeting.

CEO Cabinet 30/06/2025 Supported the case for change	**THHFT Trust Standing Committee** 03/07/2025 Supported the case for change and recommend the Board of THHFT approve

Executive summary and key messages

Strategic Rationale:

The Trust currently operates two minor injuries services with differing scopes and resilience. MVH UCNPS is a limited, appointment-only service, while HH UTC is a 24/7 walk-in facility with

broader clinical capabilities but workforce fragility. Consolidation addresses inequity, duplication, and inefficiency.

Key Benefits:

- Improved access for underserved populations
- Enhanced clinical safety and resilience
- Alignment with NHSE urgent care standards and Core20PLUS5 equity goals
- Supports NHS 10-Year Plan priorities: shifting care closer to communities, reducing health inequalities, and strengthening prevention-focused urgent care
- Recurrent savings of £1 million per annum

Workforce Impact:
All MVH staff will be offered redeployment to HH UTC, supported by a formal HR consultation. No redundancies are anticipated.

Financial Impact:
Consolidation eliminates premium agency costs and avoids capital investment at MVH. There is no expected change in Trust income or overall activity.

Engagement and Risk Mitigation:
Extensive engagement has been undertaken with stakeholders, including staff, community groups, and elected officials. A full Equality and Health Inequalities Impact Assessment (EQIA) and risk assessment have been completed.

The Board of THHFT is asked to:

- Approve the proposal to consolidate services
- Endorse implementation and communications plans
- Support staff consultation and transition planning

as recommended by the THHFT Trust Standing Committee

Strategic priorities

Tick all that apply

☒ Achieve recovery of our elective care, emergency care, and diagnostic capacity
☒ Support the ICS's mission to address health inequalities
☒ Attract, retain, develop the best staff in the NHS
☒ Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation
☒ Achieve a more rapid spread of innovation, research, and transformation

Impact assessment

Tick all that apply

- ☒ Equity
- ☒ Quality
- ☒ People (workforce, patients, families or careers)
- ☒ Operational performance
- ☒ Finance
- ☒ Communications and engagement
- ☒ Council of governors

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Future of Minor Injuries Provision across The Hillingdon Hospitals NHS Foundation Trust

1. Purpose of the Paper

To seek approval from the Board of The Hillingdon Hospitals NHS Foundation Trust (THHFT) to consolidate minor injuries services into a single, clinically robust and financially sustainable model. This proposal recommends the relocation of the existing Urgent Care Nurse Practitioner Service (UCNPS) at Mount Vernon Hospital (MVH) to the Urgent Treatment Centre (UTC) at Hillingdon Hospital (HH). Our aim is simple: by strengthening and focusing our expertise, we can provide a more robust 24/7 urgent care service to the 310,000 people living in our borough.

The relocation of the UCNPS to the UTC at Hillingdon Hospital is a necessary and strategic step to improve urgent care provision.

2. Recommendation

The Board is asked to:

- Approve the closure of the Mount Vernon UCNPS
- Support the transition of staff to the Hillingdon UTC
- Endorse implementation of a single-site urgent care model that is clinically sustainable, financially viable, and aligned with Trust and system-wide priorities

3. Executive Summary: Strategic Rationale

Hillingdon Hospital faces significant constraints. We are responding to financial pressures, growing patient demand, and widening health inequalities, and we now must make carefully considered and equitable decisions about how we deliver care. Reconfiguring and fully optimising our services is no longer optional — it is essential to sustain safe, high-quality, and equitable healthcare for our local community.

Rising costs for staffing, infrastructure, and clinical supplies have outpaced available resources. Continuing to operate services in their current form is financially unsustainable. Hillingdon UTC serves a diverse population, including communities with higher levels of deprivation and poorer health outcomes than other similar areas in London. By centralising our clinical expertise and resources we will ensure the urgent care service we provide is more sustainable and equitable for the future.

The Trust currently operates two minor injuries services with significantly different scope, resilience, and reach:

- **Mount Vernon UCNPS**: A stable but limited service that does not meet the national specification for Urgent Treatment Centres (NHSE, October 2023). Activity trends and demographic analysis indicate suboptimal allocation of clinical resources (appendix 3&4).
- **Hillingdon UTC**: A broader, 24/7 walk-in service providing access to diagnostics and integrated emergency care — but hampered by chronic staffing challenges and over-reliance on agency cover.

This dual-site arrangement is inequitable and operationally inefficient.

Consolidating services at Hillingdon UTC would:

- Improve access for underserved populations
- Deploy a more stable, substantive workforce
- Deliver recurrent cost savings of £1 million per annum
- Eliminate unnecessary duplication
- Align services with NHSE urgent care standards and Core20PLUS5 equity objectives
- Support NHS 10-Year Plan priorities: shifting care closer to communities, reducing health inequalities, and strengthening prevention-focused urgent care

MVH will continue to provide cancer, outpatient, surgical and elective services. This proposal concerns only the reconfiguration of one urgent care pathway.

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4. Case for Change

a. Background and context

The Trust currently operates two minor injuries services with significantly different scope, resilience, and reach:

- **Mount Vernon UCNPS**: Appointment-based (8am – 8pm), excludes children under two, limited diagnostics, and predominantly serving lower-need populations. Mainly accepts minor injuries and limited minor illness. Has contact with approximately 40 to 50 patients per day. This is a more limited, appointment-only service, operating 8am–8pm, excluding children under two and offering only partial diagnostic access (e.g., X-ray until 5pm). Staffed by Emergency Nurse Practitioners (ENPs).
- **Hillingdon UTC**: A broader, 24/7 walk-in service providing access to diagnostics and integrated emergency care. Accepts all minor injury and illnesses. The service sees between 170 and 200 patients per day, with a midpoint estimate of 185. It operates 24/7, accepts walk-in patients, and provides full diagnostics and paediatric care. Staffed by GPs and ENPs (appendix 1,2 & 5).

b. Clinical Safety and Quality

- Hillingdon UTC delivers a broader clinical offer, co-located with an Emergency Department but with significant workforce fragility. Our aim is to strengthen this pinnacle service, ensuring our most vulnerable patients have the right expertise at the right time, in the right setting is potentially life-saving.
- A fifth of patients that come to UCNPS have to be diverted somewhere else, either because they should see their GP or because they need more complex support than MVH can offer. At HH, if patients present with more complex requirements or needs more sophisticated diagnostics, then the UTC is co-located with the main Emergency Department and emergency acute care provision.
- 45% of attendances in UCNPS could have been cared for in a primary care settings. Of these, 15% were dressing changes or minor illnesses better suited to redirection to GPs or pharmacies. The remaining 30% of patients required no treatment at all following assessment.

c. Equity and Access

It is vital that equity and access are at the heart of this decision, particularly for communities who may be disproportionately affected. The consolidation presents an opportunity to improve equity of clinical care by ensuring all patients - particularly the most vulnerable - can access a wider range of diagnostics and medical expertise in a single well-equipped setting.

Estimated travel times to drive to Hillingdon UTC from key wards such as Ruislip, Uxbridge, Ruislip Manor, West Drayton and Hayes Town range between 5 to 15 minutes.

Resource consolidation aligns with Core20PLUS5 and local Health Inequality Reduction strategies.

d. Workforce Resilience

- MVH benefits from a substantive, low-turnover Emergency Nurse Practitioner workforce.
- HH UTC is currently reliant on premium cost temporary staff (bank and agency).

e. Financial Efficiency (see appendix 6)

- The MVH service is a nurse practitioner led model, which sees c 14,000 attendances a year, at an average unit cost of £116 (2024/25 national cost collection average unit cost). The direct nursing workforce costs are £0.9 million annually.
- The Hillingdon Hospital urgent treatment centre sees c67,000 attendances per year at an average unit cost of £117 (2024/25 national cost collection average unit cost). The service at HH sees a higher acuity of patients than the service at MVH. The HH UTC service has a number of vacancies and therefore is currently reliant on premium cost temporary staff. HH bank & agency costs were £1.0 million in 2024/25.
- The net saving of consolidating services would be £1.0m recurrent benefit due to the consolidation of staffing at the Hillingdon site.

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5. Current Service Comparison

a. Hospital and Primary Care UTC Services in Hillingdon

Feature	**Hillingdon Hospital UTC**	**Mount Vernon UCNPS**	**Primary Care Same-Day Hubs (e.g. Pembroke, Uxbridge Civic Centre)**
Access	Walk-in, 24/7	Appointment only, 8am–8pm	Appointment only, extended hours
Staff	GPs + ENPs (agency reliant)	ENPs (permanent)	GPs, Advanced Nurse Practitioners, nurses
Diagnostics	Full (X-ray, labs)	Limited (X-ray until 5pm)	Minimal (e.g., phlebotomy only)
Children under 2	Yes	No	Varies by site
Local population	Higher deprivation	More affluent	Borough-wide catchment via referral
Patients seen daily	170–200	~50	Varies, often 20–50 per hub
Booking	Walk-in + NHS 111	Phone triage or referral	GP or NHS 111 referral only
CQC rating	Requires Improvement	Good	Not registered as UTCs individually

This comparison underscores the unique strategic importance of Hillingdon UTC as the only full-spectrum walk-in urgent treatment facility in the borough.

6. Options Appraisal

Option 1: Status Quo

- Maintains inequality in service access
- Sustains operational inefficiencies and staffing risk

Option 2: Reinvestment in Mount Vernon

- Requires capital investment in estate, radiology, and workforce development
- Duplicates provision without addressing HH fragility
- No additional funding available to expand capacity

Option 3: Consolidate at Hillingdon (Recommended)

- Improves access and equity
- Enhances workforce stability and skill mix
- Eliminates duplication and reduces agency dependence
- Releases £1m of recurrent savings
- The preferred option is to consolidate services at the Hillingdon Hospital site.

---

7. Anticipated Impact of Option 3

a. Patients

- Hillingdon UTC will absorb redirected activity with improved service resilience
- Alternative pathways via GP, pharmacy, or NHS 111 remain available
- Consolidation provides the opportunity to deploy a permanent, multi-skilled team at Hillingdon, ensuring consistent quality and resilience.

b. Workforce

- Merging services allows redeployment of experienced staff to under-resourced areas. HH UTC has sufficient vacancies to enable this transition without risk of either redundancy or over-establishment and would reduce the reliance on bank and agency staff. There are 9.4 WTEs of Emergency Nurse Practitioners working at the MVH MIU who would be redeployed into vacant posts at the HH UTC under this proposal. This would be subject to an HR-led staff consultation.
- All MVH staff offered roles into vacancies at HH UTC

- Full HR consultation in line with organisational change policies
- Supports standardisation of workforce terms and conditions

c. Financial and Contractual Considerations

- Consolidation of services and transferring the patients to Hillingdon will save £1m per year and allow us to replace agency staff with substantive nursing professionals from MVH, improving the quality of care for all patients.
- There would be a part year effect of the savings in 2025/26 due to timing and also some non-recurrent costs of transition.

Any change in provision of urgent care at Mount Vernon will be accommodated for at the Hillingdon Hospital site. Therefore, there is no change in income or overall activity for the Trust as a whole. Activity will be reviewed with NWL ICB as part of the quarterly true-up process.

d. Equity and Strategic Alignment

- Delivers against Core20PLUS5 ambitions
- Supports borough-wide UEC redesign and Trust redevelopment goals
- Delivers urgent care that meets NHS standards

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8. Engagement and Communications

Our approach to engagement was to gather views, feedback, and insight from a range of stakeholders to help inform the future model of care and ensure it meets the needs of the local population. We are very grateful to everyone for their time, contributions and input to this process.

The Trust conducted targeted engagement with:

- Community groups and residents
- Healthwatch Hillingdon
- Staff and clinical teams
- Council of Governors
- Elected members including parliamentary and councillor representatives
- NHS Leadership, NHSE region, ICB leadership
- Primary care leadership including GP Federations
- Hillingdon London Borough Council

Messages have been consistent:

- MVH Hospital is not closing
- The proposal is clinically led, evidence-based and equity-driven
- Transparency and co-design remain central to implementation

In undertaking this engagement, we worked closely with key stakeholders and residents who shared a number of views in support and against the proposal which are detailed in (appendix 7). We ensured the proposals met the Department of Health and Social Care 5 key tests for service change. These tests are designed to ensure that service changes are safe, sustainable, and in line with quality and outcomes.

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9. Risk Summary and Mitigations

A full risk assessment has been completed. An Equality and Health Inequalities Impact Assessment (EQIA) has also been undertaken to ensure that the proposed service changes do not disproportionately affect any specific population group. The EQIA has informed both the engagement approach, and the mitigation strategies outlined below. A full risk assessment has been completed. Key mitigations include:

- Public communications: Clarity that only one service is affected; reassurance on continued access.
- Staff engagement: HR-led consultation and structured redeployment plan.
- Access continuity: Alternative services (GP, pharmacy, NHS 111) remain in place and signposted.

---

10. Conclusion

This proposal represents a clinically justified, financially prudent and strategically aligned change in minor injury provision. It enhances:

- Equity of access for underserved communities
- Clinical resilience and staff wellbeing
- Financial sustainability

It delivers on the Trust's obligations to deliver safe, equitable, and high-quality urgent care.

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11. Board Action Requested

The THHFT Board is asked to:

- **Approve the proposal to consolidate and strengthen the Mount Vernon UCNPS**
- **Endorse implementation plans and ongoing public/stakeholder communications**
- **Support consolidation of all urgent care services at Hillingdon UTC**
- **Support commencement of a staff consultation to enable redeployment**

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12. Next Steps if Approved

If the THHFT Board approves the proposal, the Trust will proceed with the following implementation actions:

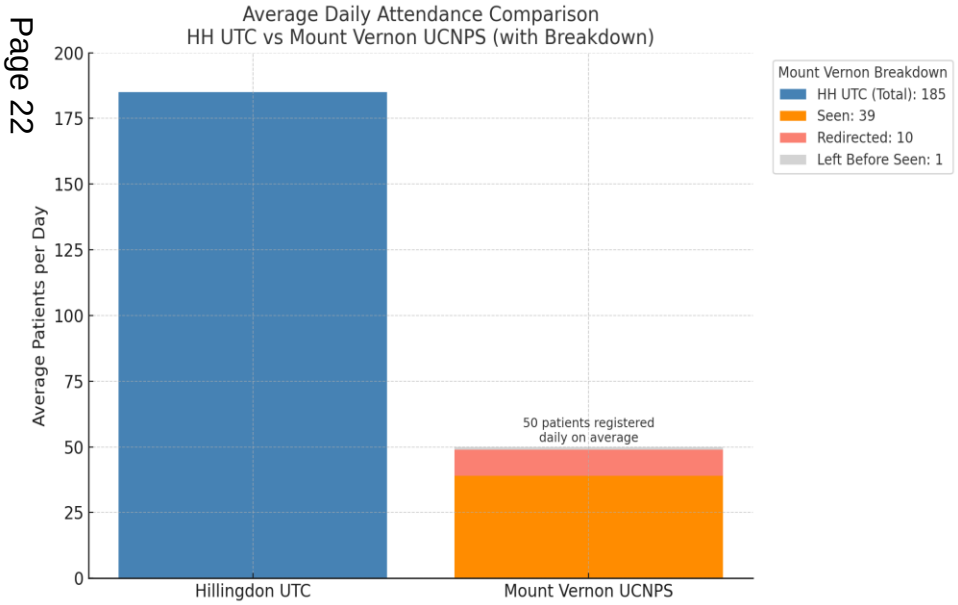
- Initiate formal staff consultation processes in line with HR policies and frameworks
- Develop and mobilise a detailed transition plan for service reconfiguration and workforce relocation
- Finalise and action internal and external communications, including updates to patients, public, and stakeholders
- Update service directories and pathways to reflect the change in provision (e.g. NHS 111, Directory of Services)
- Monitor and evaluate implementation impacts, reporting through appropriate governance structures
- Ensure ongoing visibility and responsiveness to patient experience and equity impacts during and after transition

Appendices

Appendix 1

This bar chart illustrates the comparative average daily attendance at the two minor injuries services within The Hillingdon Hospitals NHS Foundation Trust:

- **Hillingdon Hospital Urgent Treatment Centre (UTC)**: Sees between **170 and 200 patients per day**, with a midpoint estimate of **185**. It operates 24/7, accepts walk-in patients, and provides full diagnostics and paediatric care.
- **Mount Vernon Urgent Care Nurse Practitioner Service (UCNPS)**: Has **contact** with approximately **40 to 50 patients per day.** This is a more limited, appointment-only service, operating 8am–8pm, excluding children under two and offering only partial diagnostic access (e.g., X-ray until 5pm).



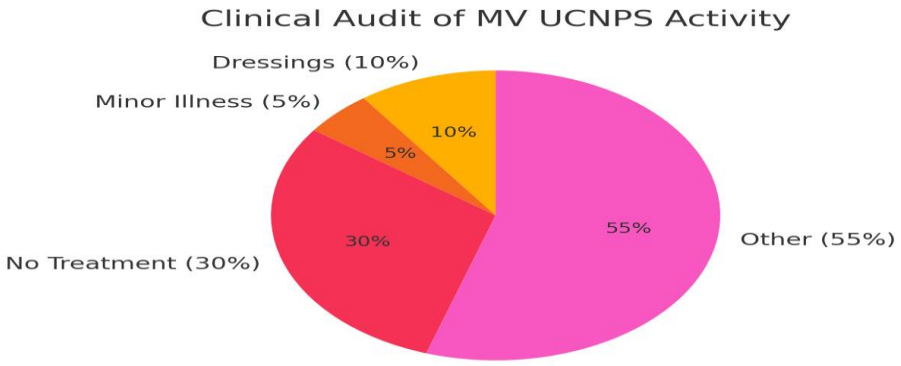
Appendix 2

Clinical Audit of MV UCNPS Activity

A recent clinical audit of patient presentations at Mount Vernon UCNPS found that:

- **10%** of attendances were for **dressing changes**, which are typically more appropriate for primary care settings.
- **5%** were minor illnesses better suited to redirection to **GPs or pharmacies**.
- **30%** of patients required **no treatment at all** following assessment.
- The remaining **55%** included a range of injuries suitable for urgent care, though not always requiring the MV-specific model.

This highlights opportunities for improved patient redirection and more efficient use of clinical time and resources.

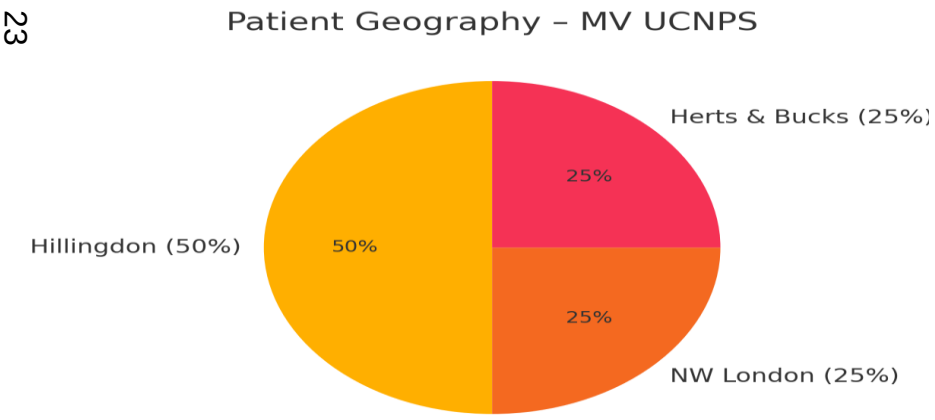


Appendix 3

Analysis of data shows that:

- 50% of patients using the Mount Vernon UCNPS live in the London Borough of Hillingdon.
- 25% are from the wider North West London area, reflecting cross-borough usage.
- The remaining 25% are from Hertfordshire and Buckinghamshire, likely due to geographic proximity.

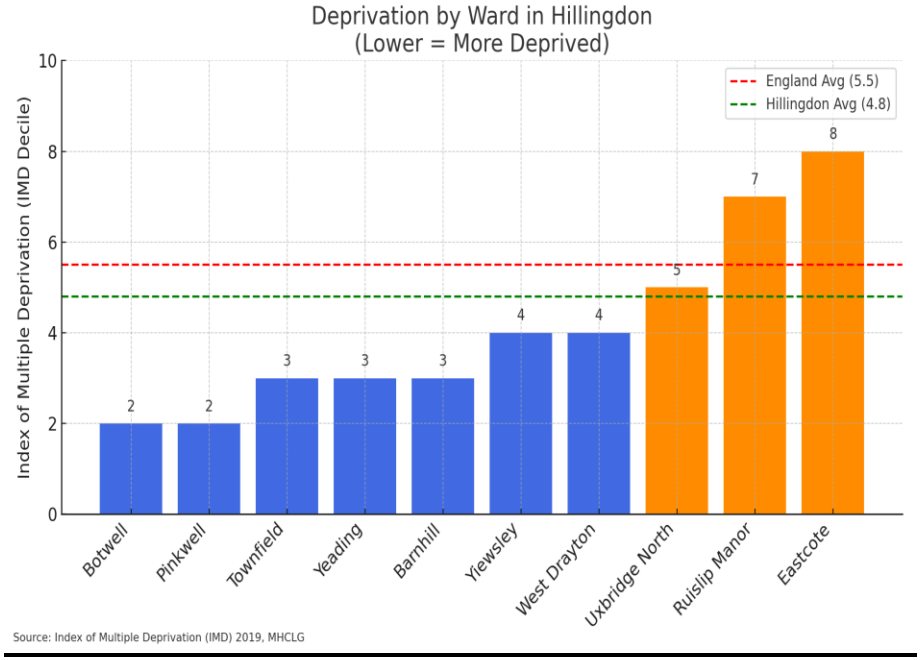
This broad, mixed catchment contrasts with the more deprived and higher-acuity population typically seen at Hillingdon Hospital UTC. It reinforces the case for focusing urgent treatment capacity where clinical need is greatest.



This chart shows the relative deprivation across selected wards in Hillingdon, based on the Index of Multiple Deprivation (IMD), where 1 = most deprived and 10 = least deprived.

- Highest deprivation is found in Botwell, Pinkwell, Townfield, Yeading, and Barnhill – all in the south of the borough and closer to Hillingdon Hospital.
- More affluent areas such as Eastcote and Ruislip Manor—located near Mount Vernon Hospital—score higher (less deprived).

This geographic disparity reinforces the strategic rationale for consolidating urgent care provision at Hillingdon Hospital, where both demand and clinical need are demonstrably higher.

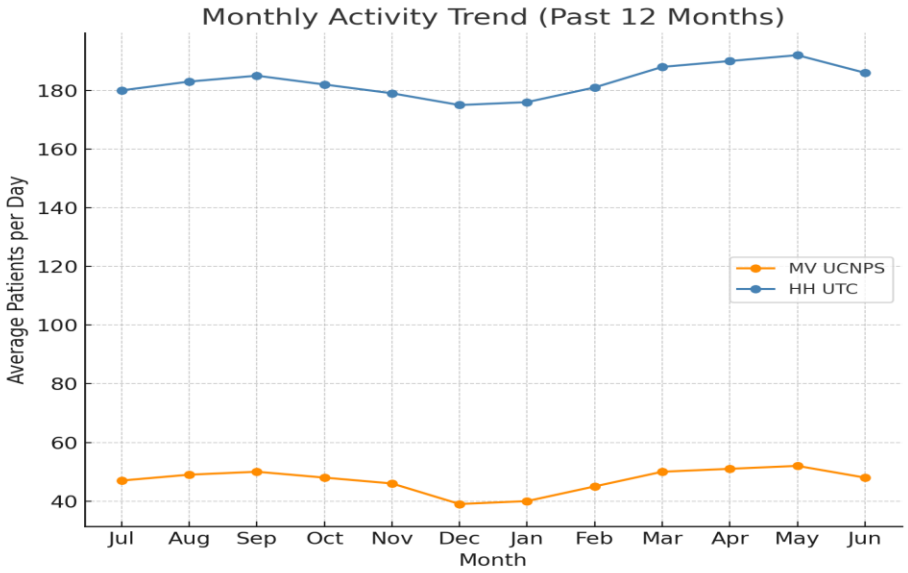


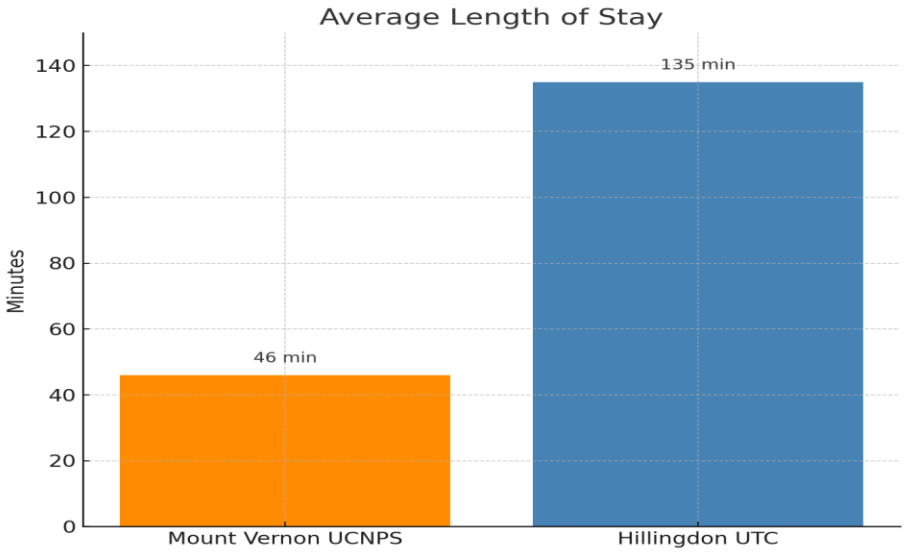
Appendix 4

Appendix 5

The first chart shows a stable pattern of daily activity across both sites. Mount Vernon UCNPS sees a consistent 45–50 patient contacts/day, with a seasonal dip in December–January. Hillingdon UTC consistently manages 175–190 patients/day, reflecting its broader clinical remit and walk-in model.

This stability demonstrates that the proposal is not driven by a sudden drop in demand, but by a strategic opportunity to streamline and improve care delivery.





Average Length of Stay

The second chart illustrates the significant difference in average patient journey time:

- Mount Vernon UCNPS: 46 minutes
- Hillingdon UTC: 135 minutes (2 hours 15 minutes)

This reflects:

- Greater complexity of cases at Hillingdon
- Broader scope of diagnostics and walk-in presentations
- A more pressured and high-demand clinical setting

These insights support the proposal to consolidate urgent care capacity at the site where clinical need is higher and resource reinforcement is most critical.

Appendix 6

This appendix outlines the financial analysis of the 3 options considered in this paper.

Option 1 – Status Quo

Based on 2024/25 expenditure, the direct nursing & non-pay costs are £1.0m for the MVH MIU service and £2.2m for the HH UTC service (excluding medical staffing costs), a total of £3.1m of direct nursing & non-pay costs across the 2 services.

Option 1: Status Quo

Description (24/25 Direct Costs)	MVH MIU (£000)	HH UTC (£000)	Total Direct Costs
Nursing staff costs	£903	£607	**£1,510**
Nursing agency & bank costs		£1,012	**£1,012**
Non-pay	£49	£548	**£597**
Total Cost	**£952**	**£2,167**	**£3,119**

Notes:

1. Excludes Medical & A&C staff

Option 2 – Reinvestment in MVH

This option includes the additional nursing staffing to open the MIU at Mount Vernon 24/7, but with no additional funding. The costs therefore increase by £0.9m compared to option 1 – status quo. This would also require significant capital investment to reinstate waiting room facilities lost during the pandemic; substantial changes to ENP training to enable minor illness and paediatric cover; a fundamental shift in primary care provision; and considerable effort and cost to recruit radiology staff. Importantly, this option would not improve the Hillingdon UTC service.

Option 2 - Reinvestment in MVH

Description (24/25 Direct Costs)	MVH MIU (£000)	HH UTC (£000)	Total Direct Costs
Nursing staff costs	£1,806	£607	**£2,413**
Nursing agency & bank costs		£1,012	**£1,012**
Non-pay	£49	£548	**£597**
Total Cost	**£1,855**	**£2,167**	**£4,022**
Movement From Option 1: Status Quo	**-£903**	**£0**	**-£903**

Notes:

1. Excludes Medical & A&C staff
2. Assumes no additional income

Option 3 – Consolidate at Hillingdon Hospital

In this option, the MIU staff are assumed to be redeployed to the HH UTC. Costs to run the HH UTC are expected to increase marginally (£60k) due to the increase in non-pay for the patients transferring to the service, but there is an overall saving of £1.0m due to the consolidation of the service and removal of premium bank and agency costs.

Option 3 - Consolidate at HH

Description (24/25 Direct Costs)	MVH MIU (£000)	HH UTC (£000)	Total Direct Costs
Nursing staff costs	£0	£1,510	**£1,510**
Nursing agency & bank costs		£0	**£0**
Non-pay	£0	£597	**£597**
Total Cost	**£0**	**£2,107**	**£2,107**
Movement From Option 1: Status Quo	**£952**	**£60**	**£1,012**

Notes:

1. Excludes Medical & A&C staff
2. Assumes no additional income
3. Figures are full year effect

Appendix 7

This appendix summaries stakeholder engagement and public/media interest in relation to the proposed changes to minor injuries provision at Mount Vernon Hospital and Hillingdon Hospital UTC. It includes positive feedback, concerns raised, and Trust actions in response.

Date	Stakeholder / Channel	Positive Feedback	Concerns / Queries	Actions / Response
Apr 2025 - June 2025	David Simmonds MP & Campaign		Concern about possible closure of MV UCNPS and impact on local access. Petition with over 12k signatories shows local support against the closure. The petition (c. 12,000 signatures) represents approximately 5% of the borough's estimated voting-age population (~240,000). While not a majority, it indicates significant local interest, particularly in affected areas.	Trust confirmed no plans to close hospital; ongoing engagement with MP.
May 2025	Council of Governors		Raised queries on whether it means MIU closing, what is the local offering for primary care concern	Agreed that there was a need for primary care offer to be clearly signposted and will bring to the attention to primary care providers.
May–Jun 2025	Community Groups Resident Associations	High levels of community engagement; shared interest in urgent care access.	Queries over perceived closure; confusion about MVH's future. More clarity needed on the Hillingdon primary care hubs	We have been engaging with local residents and Healthwatch Hillingdon on the proposal and are supporting more proactive signposting on the services available in the primary care hubs
Jun 2025	GP Federations, Hillingdon Health Partners Healthwatch Hillingdon	Supportive of consolidation and case for equity-driven service redesign.	Questions around diagnostics, transport and signposting for minor injuries.	Included letters of support for the proposal
Jun 2025	Elected Representatives	Interest reflects high public engagement and political accountability.	Concerns around visibility of community urgent care pathways.	The Trust is working with Hillingdon Health and Care Partners and Hillingdon Healthwatch, ICB on a stepped up proactive signposting on the hubs services- there is more work to be done to address the lack of awareness https://www.woodlanesurgery.nhs.uk/health-information/appointments/extended-access-hub/

For a number of years now, patients have increasingly reported to us long wait times to be seen in an overcrowded A&E department at the Hillingdon Hospital, drastically compromising patient safety and experience.

In the context of increased demand for urgent and emergency care, rising costs, workforce pressures, and the CQC reporting that Hillingdon's A&E department requires improvement, we must support quick and decisive action by the Hillingdon Hospitals NHS Trust to make the necessary improvements to ensure the sickest people, with the greatest need, receive high standards of care within the fastest amount of time.

We are assured by the Trust that the necessary Equalities Impact Assessments have been undertaken. However, whilst we accept the need for consolidating the Minor Injuries Unit at Mount Vernon to the Hillingdon site, we also acknowledge this change in service provision will be unpopular with residents in the north of the borough, and we have heard their concerns around the impact it may have on vulnerable residents.

Therefore, in mitigating any adverse impact of the proposed move, we strongly urge the Trust to work closely with their Health and Care Partners in Hillingdon to ensure residents requiring treatment for minor injuries and illnesses, in the north of the borough, are appropriately signposted to nearby alternative services, with clear communication about how and where those services can be accessed.

Healthwatch Hillingdon | 2 July 2025

Lynn Hill

Chair, Healthwatch Hillingdon

Hillingdon Health and Care Partners

On Behalf of Hillingdon Health and Care Partners

A decision to close the Minor Injuries Unit at Mount Vernon Hospital would align with the strategic shift in how Hillingdon Health and Care Partners plan to deliver urgent and emergency care across Hillingdon. Our local health and care system is evolving to deliver more **coordinated, neighbourhood-based care** that is **preventative, person-centred, and integrated across services** in line with the Governments recently published 10 Year Plan.

Rather than relying on fragmented, location-specific walk-in units, Hillingdon is implementing **three strategically located Neighbourhood Access Care Hubs (Super Hubs)**, one of which will be at the Pembroke Centre in Ruislip. These centres are designed to provide **same-day urgent care**, mobile diagnostics, and proactive support to patients closer to where they live—improving access, reducing duplication, and relieving unnecessary pressure on acute hospital settings.

Under the new model:

- Residents will benefit from **a 2-hour community crisis response** supported by integrated, multidisciplinary teams utilising mobile diagnostics
- Access to community based urgent care will be **more consistent**, with extended service hours, rapid assessment pathways, and seamless coordination with GPs, social care, and mental health services.
- The system aims to work together to **reduce pressure on the emergency department and the** Urgent Treatment Centre.

Maintaining a standalone Minor Injuries Unit at Mount Vernon would **duplicate services**, stretch limited clinical resources, and undermine efforts to consolidate care around fully integrated hubs that deliver **better outcomes and greater value for public investment**.

Furthermore, the transformation is in direct response to national policy imperatives from the **NHS Long Term Plan**, the **ICB Blueprint**, and the **London Neighbourhood Target Operating Model**, all of which call for the rationalisation of legacy services in favour of streamlined, integrated delivery at place and neighbourhood level.

Ultimately, the closure of the Minor Injuries Unit is not a loss of access but a **redesign of access**—part of a broader commitment to **safer, faster, and more equitable urgent care for all Hillingdon residents**.

Keith Spencer

Managing Director, Hillingdon Health and Care Partners

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GP COVERAGE IN HILLINGDON SINGLE MEETING REVIEW - DRAFT FINAL REPORT

Committee name	Health and Social Care Select Committee
Officer reporting	Nikki O'Halloran, Democratic Services
Papers with report	Appendix A – Draft Final Report
Ward	All

HEADLINES

To enable the Committee to review the draft final report of the GP coverage single meeting review.

RECOMMENDATION: That the Health and Social Care Select Committee considers the draft final report of the GP coverage single meeting review and agrees any amendments.

SUPPORTING INFORMATION

The Health and Social Care Select Committee undertook a single meeting review of GP coverage in Hillingdon at its meeting on 22 July 2025. Reflecting on the discussion from that meeting, the attached report and recommendations have been drafted for Members to review. Members are asked to provide feedback on the report and suggest possible revisions.

Implications on related Council policies

The role of the Select Committees is to make recommendations on service changes and improvements to the Cabinet, who are responsible for the Council's policy and direction.

How this report benefits Hillingdon residents

Select Committees directly engage residents in shaping policy and recommendations and the Committees seek to improve the way the Council provides services to residents.

Financial Implications

None at this stage.

Legal Implications

None at this stage.

BACKGROUND PAPERS

NIL.

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GP COVERAGE IN HILLINGDON

Cabinet Member & Portfolio	Councillor Jane Palmer, Cabinet Member for Health and Social Care
Responsible Officer	Sandra Taylor. Corporate Director of Adult Social Care and Health
Report Author & Directorate	Nikki O'Halloran, Central Services
Papers with report	None.

HEADLINES

Executive Summary

At its meeting on 19 June 2025, the Health and Social Care Select Committee confirmed that it would like to undertake a single meeting review of General Practitioner (GP) coverage in Hillingdon. The review aimed to consider the number and geographical location of GPs in the Borough as well as the adequacy of the provision in serving the local population now and into the future.

The report highlights the challenges faced by GP practices amid population growth and evolving healthcare demands, and outlines recommendations to improve service delivery and patient experience. The recommendations are based around meeting future demand, the expansion of the champions role, awareness raising, streamlining IT systems, improving online bookings and equality.

Putting Our Residents First	Putting our residents first: *Our People*
Financial Cost	There is no direct financial cost to the Council associated with the recommendations in this report.
Select Committee	Health and Social Care Select Committee
Ward(s) affected	All

RECOMMENDATIONS

That Cabinet welcomes the insight and findings of the Health and Social Care Select Committee and asks that:

1. **officers work with partners to identify where GP surgeries are likely to be needed by 2035;**
2. **Health and Wellbeing Board partners be asked to:**
    a. **investigate a reduction in the complexity and quantity of data governance and IT systems currently being used in Hillingdon to enable patient data to**

be easily passed between professionals;

b. subject to the outcome of the pilot, expand the provision of champions to other health related issues; and

c. increase awareness that the nature of community care is changing; and

3. The Confederation Hillingdon CIC be asked to:

a. investigate the possibility of increasing patients' use of online bookings systems, including being able to specify convenient call back times; and

b. ensure equality with regard to the ability to request to be seen by the same sex medical professionals at GP surgeries.

Reasons for recommendations

Health partners have provided the Health and Social Care Select Committee (and its predecessor, the External Services Select Committee) with regular updates on the challenges faced by GPs in Hillingdon. With population growth in the Borough expected to continue, it is important that action is taken to ensure that this does not compound the challenges already being faced by GPs.

The Committee looked at the work that has already been undertaken in the Borough and identified possible further improvements. These recommendations have been formulated to improve organisational resilience in providing GP services in the Borough.

Alternative options considered / risk management

Cabinet could choose to not approve or amend any of the recommendations.

SUPPORTING INFORMATION

Background

1. The system of GPs and primary care is the cornerstone of the NHS. They are often the first point of contact for anyone with a physical or mental health need and either treat patients or refer them on to the appropriate pathway for diagnosis and treatment. An NHS GP is a medical doctor who works in primary care and provides general healthcare services to patients within the NHS system. They are highly trained professionals who provide a broad range of services, from managing common illnesses to offering preventative care and coordinating more specialised treatments. At the end of September 2024, there were 38,421 FTE NHS GPs in England (according to data from NHS Digital).

2. NHS England has delegated its responsibilities for the direct commissioning of primary care services (primary medical, dental, ophthalmic and community pharmacy services) to Integrated Care Boards (ICBs). The responsibilities delegated are set out in the standard Delegation Agreement between NHS England and each ICB. This includes contractual management and supporting improvement and transformation of services[1].

3. In 2018, the average number of patients per fully qualified GP was higher in North West London (NWL) (2,696) than the London (2,497) and England (2,255) averages (these figures do not include other practice staff). NHS Digital states that there are 1,081 fully

[1] NHS England - https://www.england.nhs.uk/commissioning/primary-care/

qualified GPs and 234 GPs in training grades in NWL which is a reduction of 5.1% in fully qualified GPs and a 134% increase in GPs in training grades, giving an overall combined increase of 7.9%.

4. 42 of Hillingdon's 44 GP surgeries have been organised into six Primary Care Networks (PCNs) – there are no GPs in Ruislip Manor or Hillingdon West wards[2]. A PCN is a group of general practices and other health and care providers that come together to provide health and care services for their community. PCNs are a key aspect of the NHS Long Term Plan, allowing services to be developed locally in response to the needs of patients in their area.

5. In Hillingdon, GP hubs have been set up to support practices by providing same day appointments for patients who have an urgent need on the day. GP and ANP (Advanced Nurse Practitioner) appointments are available face-to-face and by telephone, depending on the patient's needs. GP practices may book patients into the hub if they need a same day appointment but the practice is unable to see them. Appointments are available for all ages but the hubs are not suitable for routine appointments (which should be booked with the patient's own GP).

The Health and Social Care Select Committee Review

6. Having received regular updates from partners on GP services in the Borough, the Health and Social Care Select Committee met on 22 July 2025 to undertake a single meeting review of GP coverage in Hillingdon. The Committee was able to question and solicit evidence from the following witnesses:
    - Sean Bidewell, Assistant Director – Integration & Delivery / Acting Joint Borough Director, North West London Integrated Care Board (NWL ICB)
    - Carleen Duffy, Your Voice in Health and Social Care (Healthwatch)
    - Edmund Jahn, Chief Executive Officer, The Confederation Hillingdon CIC
    - Lisa Taylor, Managing Director, Healthwatch Hillingdon

7. The discussions held during the meeting highlighted a number of matters as set out below:

Future Demand

8. Although there has been an increase in the overall number of GP appointments available, the feedback on patient experience is still not where partners would like it to be. In 2022/23, there were 1.7 million appointments with a 6% increase in 2023/24 and a 9% increase in 2024/25 (68% of these had been face-to-face, which was an increase on the previous year). There had also been an increase in the number of patients wanting a same day appointment (up from about 3k to 3½k). A lot of effort is being made by partners to try to improve this.

9. As the commissioner, the ICB is responsible for proactively deciding where and when additional GP capacity is needed and how this is done in practice. Given the increasing demand for GP appointments and the increasing average age of current GPs in Hillingdon, Members have concerns about the possibility that practices may close when the last GP in

[2] Draft Pharmaceutical Needs Assessment 2025 - https://www.hillingdon.gov.uk/media/16706/Draft-PNA-2025/pdf/s8Hillingdon_DRAFT_PNA_2025.pdf?m=1750254962493

a practice retires. If no action is taken to ensure continuity, their list would need to be redistributed to other practices that are already dealing with longer-than-average patient lists.

10. Although a new GP surgery had been planned for inclusion in the St Andrews Park development, this had not happened and a large number of patients had had to join the Uxbridge practice list, making that one of the largest practices in the Borough and putting it under greater pressure. The Confederation had worked closely with the Council, NWL ICB and providers to put an integrated estates strategy in place. However, the development of general practice had not followed the plan very closely and there are gaps where some GP practices cater for four times as many patients for the same size practice as others. It had been hoped that the strategic plan would address these inconsistencies (for example, more GP capacity is needed in Yiewsley / West Drayton).

11. It is recognised that this is not an easy challenge to resolve and that, if a practice is needed, it will be referenced on the basis of the strategic plan. However, partners need to look at predicting where the increasing population within Hillingdon will settle and where new major developments are likely to arise. Insofar as GP premises are concerned, although the current commissioners have not had it in their gift over the last ten years, they now have a reference document / plan.

12. Closer working relations have also developed between the Council and health partners so there is the possibility of sharing estate as the local authority has fewer restrictions (freeing up capital allocation is a Government decision and is hampered by significant restrictions). Although not in complete control, it is hoped that place partners will be able to put pressure on the centre by identifying where future GP capacity will need to be located.

IT Systems

13. There had been some confusion about how patients from different practices are able to access the same services (for example, dressings) and where they are provided, particularly if the patient is unable to use / access IT. Healthcare is complex and staff will often try to deal with this complexity behind the scenes but this doesn't always work. There are currently at least five patient digital systems in use by General Practice in Hillingdon that patients needed to interact with for different things (this should probably be a maximum of two). The computer systems tend to be siloed and patients often have to move from one system to another providing the same information multiple times.

14. Although it seems logical that the NHS should be able to work as a single team without the patient having to intervene, the data governance needs to be sorted out to enable this to happen. Members have been advised that this challenge is bigger than NWL ICB but that, locally, work is being undertaken to enable systems to talk to each other through Whole Systems Integrated Care (WSIC) dashboards which provide a linked integrated summary of patient's health and social care. This information could be used to case find and case manage patients who require more targeted and proactive care.

15. This issue is regularly brought to Members attention and there are continuing concerns that residents get lost in the system between services. With regard to the communication with GPs in relation to actions taken by other clinicians, the last four years have seen better cooperation across practices and networks, and staff have been collaborating more than

ever. First contact physiotherapists have been employed in general practice with another tier in CNWL (MSK) and another at the hospital. However, these siloes have still not been completely joined together and patients might be asked to complete similar forms for each of the services which ask for very similar information. Ideally, as part of the 3-5 year plan being developed across and between local NHS providers (including GPs), there will be integrated physiotherapy teams collocated in each of the three Hubs.

16. With the increasing integration of services, it is becoming even more important to ensure that the patients' journey around the NHS is as seamless and smooth as possible, with as little repetition as is necessary. This means reducing the number of systems, eradicating the duplication of information and minimising effort on the part of the patient as well as partners.

Champions

17. GPs are, by definition, general practitioners and are therefore not expert in everything health related. Consideration is regularly given to potential additional services that could be explored and implemented that would take the pressure off GPs. One such initiative is the creation of a Children and Young People's Champion role as a one year pilot in one of the PCNs. The aim of this role is to alleviate the impact of mental health presentations on GPs and get young people and their families to the right support as quickly as possible (there is also a need to reduce the reliance on CAMHS by diverting to other services that are available and more appropriate). There are also plans to introduce additional roles such as practice nurses in some PCNs.

18. As the neighbourhood population needs are analysed, action will be needed to ensure that services are tailored to meet those needs. Where patients need detailed and personalised support (and this is not available from GPs), a knowledgeable champion would be useful to help guide them. This is especially true for young people's mental health, as the Committee knows from its report on this subject. However, it is suggested that, subject to the outcome of the pilot, consideration be given to introducing champion roles for other issues that would benefit a large number of patients, for example, weight loss.

Awareness Raising

19. The way that health services are being delivered is changing. The Integrated Neighbourhood Teams are working to bring care closer to patients (including the PCNs) and core services (such as community nursing, musculoskeletal (MSK), adult social care, third sector and acute services). The Paediatric Clinics are a good example of this closer working in the community, which see teams from different organisations working together to improve patient experience and increase the number of patients seen. These clinics are being run from the Integrated Neighbourhood Hub and practices are able to book appointments at the Hub through patient contact with GPs. In future, neighbourhood working should enable patients to be booked in to see the community nurse and the community nurse should be able to book the patient in to see their GP.

20. Action is being taken to try to introduce more personalised care for patients with complex needs as well as dealing with same day access for other patients. The Pharmacy First consultation service enables patients to be referred into community pharmacy for a minor illness or an urgent repeat medicine supply. It enables community pharmacies to complete

episodes of care for seven common conditions following defined clinical pathways (infected insect bites, impetigo, shingles, sinusitis, sore throat, urinary tract infections and ear infection) thus circumventing the need to see a GP.

21. Patients are often unaware of the role of each individual in a practice (or the role of other organisations) so will sometimes feel that they are not being seen by the most appropriate person. It seems that residents have not really engaged with how community health care is changing and still see the GP as being the answer to all of their issues (rather than an alternative, and more appropriate, pathway that could help them). More effort is needed to ensure that residents understand that community health care goes beyond the GP.

Online Bookings

22. Healthwatch Hillingdon (HH) has recently published its report on GP access which highlights that the most common reason for residents to contact the organisation is in relation to getting a GP appointment. Seemingly, patient satisfaction has not improved even though there has been an increase in the total number of GP appointments available.

23. HH's research for the GP access report had started in 2024 but, as the survey had been put on hold whilst NWL ICB looked at same day access issues, discussions had been undertaken with groups such as carers, travellers and asylum seekers. Although 62% had been satisfied with GP contact there were concerns about issues such as booking appointments, telephone systems and continuity of care (these concerns were largely from people of working age).

24. The PATCHS system had been introduced to try to reduce phone waiting times by enabling patients to make an appointment request online. However, access times have been limited and there have been some technical issues resulting in practice staff having to call patients back. Furthermore, issues have been identified with regard to the telephone call back system (which is not currently working properly). Currently, the system does not allow patients to specify a convenient time for a call back so they might be busy and unable to answer their telephone when the call comes. Four Digital Transformation Managers have been looking at this type of issue to help simplify it from the patient perspective.

25. The Committee is mindful that it should be standard practice that residents can make all of their bookings online as this would alleviate pressure on the GP receptionists. Whilst the receptionist would still need to triage, this should be designed as simply as possible, for example, include a free text box (maximum 500 words) for the patient to explain what the appointment is for. This online triaging system would need to be simple because if it is too complicated, it will put people off.

26. To this end, the Committee would like The Confederation to investigate the ways in which patients' use of online bookings systems could be increased and include the ability for patients to specify convenient call back times.

Equality

27. Over a number of years, there has been a shift to ensure that GP practices make every effort to meet patients' preferences to see the doctor, nurse or other healthcare professional when they need an appointment (although there are some occasions when this might not be

possible). This has been publicised particularly for women who would like to see a female practitioner but greater effort is needed to publicise that this is also open to male patients who may want to see a male practitioner as some men may feel uncomfortable with a female.

28. It is suggested that future publicity about choices proactively advertises the ability for men to request a male practitioner.

Should Cabinet agree the recommendations contained within this report, it is proposed that the Chief Executive and / or the Corporate Director for Adult Social Care and Health write to the organisations concerned to raise the recommendations from the Committee, enabling them to be considered, taken forward and monitored accordingly.

Financial Implications

There are no direct financial implications arising from this report.

RESIDENT BENEFIT & CONSULTATION

The benefit or impact upon Hillingdon residents, service users and communities?

The recommendations in this report are designed with the purpose improving the resilience of GP practices in the Borough.

Consultation & Engagement carried out (or required)

Witness testimony from the Committee as outlined in this report.

CORPORATE CONSIDERATIONS

Corporate Finance

Corporate Finance has reviewed this report, confirming that there are no direct financial implications associated with the recommendations outlined above.

Legal

There are no legal implications arising from the recommendations in this report.

BACKGROUND PAPERS

NIL.

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CABINET FORWARD PLAN

Committee name	Health and Social Care Select Committee
Officer reporting	Nikki O'Halloran, Democratic Services
Papers with report	Appendix A – Latest Forward Plan
Ward	As shown on the Forward Plan

HEADLINES

To monitor the Cabinet's latest Forward Plan which sets out key decisions and other decisions to be taken by the Cabinet collectively and Cabinet Members individually over the coming year. The report sets out the actions available to the Committee.

RECOMMENDATION

That the Health and Social Care Select Committee notes the Cabinet Forward Plan.

SUPPORTING INFORMATION

The Cabinet Forward Plan is published monthly, usually around the first or second week of each month. It is a rolling document giving the required public notice of future key decisions to be taken. Should a later edition of the Forward Plan be published after this agenda has been circulated, Democratic Services will update the Committee on any new items or changes at the meeting.

As part of its Terms of Reference, each Select Committee should consider the Forward Plan and, if it deems necessary, comment as appropriate to the decision-maker on the items listed which relate to services within its remit. For reference, the Forward Plan helpfully details which Select Committee's remit covers the relevant future decision item listed.

The Select Committee's monitoring role of the Forward Plan can be undertaken in a variety of ways, including both pre-decision and post-decision scrutiny of the items listed. The provision of advance information on future items listed (potentially also draft reports) to the Committee in advance will often depend upon a variety of factors including timing or feasibility, and ultimately any such request would rest with the relevant Cabinet Member to decide. However, the 2019 Protocol on Overview & Scrutiny and Cabinet Relations (part of the Hillingdon Constitution) does provide guidance to Cabinet Members to:

- Actively support the provision of relevant Council information and other requests from the Committee as part of their work programme; and
- Where feasible, provide opportunities for committees to provide their input on forthcoming executive reports as set out in the Forward Plan to enable wider pre-decision scrutiny (in addition to those statutorily required to come before committees*, i.e. policy framework documents – see paragraph below*).

As mentioned above, there is both a constitutional and statutory requirement for Select Committees to provide comments on the Cabinet's draft budget and policy framework proposals after publication. These are automatically scheduled in advance to multi-year work programmes.

Therefore, in general, the Committee may consider the following actions on specific items listed on the Forward Plan:

	Committee action	When	How
1	**To provide specific comments to be included in a future Cabinet or Cabinet Member report on matters within its remit.**	As part of its pre-decision scrutiny role, this would be where the Committee wishes to provide its influence and views on a particular matter within the formal report to the Cabinet or Cabinet Member before the decision is made. This would usually be where the Committee has previously considered a draft report or the topic in detail, or where it considers it has sufficient information already to provide relevant comments to the decision-maker.	These would go within the standard section in every Cabinet or Cabinet Member report called "Select Committee comments". The Cabinet or Cabinet Member would then consider these as part of any decision they make.
2	**To request further information on future reports listed under its remit.**	As part of its pre-decision scrutiny role, this would be where the Committee wishes to discover more about a matter within its remit that is listed on the Forward Plan. Whilst such advance information can be requested from officers, the Committee should note that information may or may not be available in advance due to various factors, including timescales or the status of the drafting of the report itself and the formulation of final recommendation(s). Ultimately, the provision of any information in advance would be a matter for the Cabinet Member to decide.	This would be considered at a subsequent Select Committee meeting. Alternatively, information could be circulated outside the meeting if reporting timescales require this. Upon the provision of any information, the Select Committee may then decide to provide specific comments (as per 1 above).
3	**To request the Cabinet Member considers providing a draft of the report, if feasible, for the Select Committee to consider prior to it being considered formally for decision.**	As part of its pre-decision scrutiny role, this would be where the Committee wishes to provide an early steer or help shape a future report to Cabinet, e.g., on a policy matter. Whilst not the default position, Select Committees do occasionally receive draft versions of Cabinet reports prior to their formal consideration. The provision of such draft reports in advance may depend upon different factors, e.g., the timings required for that decision. Ultimately any request to see a draft report early would need the approval of the relevant Cabinet Member.	Democratic Services would contact the relevant Cabinet Member and Officer upon any such request. If agreed, the draft report would be considered at a subsequent Select Committee meeting to provide views and feedback to officers before they finalise it for the Cabinet or Cabinet Member. An opportunity to provide specific comments (as per 1 above) is also possible.
4	**To identify a forthcoming report that may merit a post-decision review at a later Select Committee meeting**	As part of its post-decision scrutiny and broader reviewing role, this would be where the Select Committee may wish to monitor the implementation of a certain Cabinet or Cabinet Member decision listed/taken at a later stage, i.e., to review its effectiveness after a period of 6 months. The Committee should note that this is different to the use of the post-decision scrutiny 'call-in' power which seeks to ask the Cabinet or Cabinet Member to formally re-consider a decision up to 5 working days after the decision notice has been issued. This is undertaken via the new Scrutiny Call-in App members of the relevant Select Committee.	The Committee would add the matter to its multi-year work programme after a suitable time has elapsed upon the decision expected to be made by the Cabinet or Cabinet Member. Relevant service areas may be best to advise on the most appropriate time to review the matter once the decision is made.

BACKGROUND PAPERS

- Protocol on Overview & Scrutiny and Cabinet relations adopted by Council 12 September 2019
- Scrutiny Call-in App

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Ref	Business Item	Further information	Ward(s)	NEW ITEM	Decision-Maker			Cabinet Member Lead & Officers				Status
					CABINET meeting	Cabinet Member	Full COUNCIL	Cabinet Member(s) Responsible	Relevant Select Committee	Report Author	Corporate Director Responsible	Public or Private (with reason)
AUGUST 2025 (no Cabinet meeting)												
13	**Award of Contracts: Statutory Advocacy and Best Interest Assessments**	Cabinet Members will consider procurement arrangements for statutory adult social care services, in particular in respect of advocacy which provides support to individuals in understanding and exercising their rights and making informed decisions and Best Interest Assessments which evaluate whether it is in the best interests of a person lacking capacity to be deprived of their liberty for their safety and well-being.	N/A			Aug-25		Cllr Ian Edwards - Leader of the Council / Cllr Jane Palmer - Health & Social Care	Health & Social Care	Graham Puckering / Sally Offin	Sandra Taylor	Private (3)
SEPTEMBER 2025												
8	**Telecare and Out of Hours Service**	Cabinet will receive a report on a review of the Telecare Service and will also consider procurement decisions on the related Out of Hours Service contract that support this.	N/A	NEW ITEM	18 September			Cllr Jane Palmer - Health & Social Care	Health & Social Care	Sarah Baker / Jan Major	Sandra Taylor	Public
23	**Annual Performance Report**	Cabinet will receive an annual report performance report, setting out how the Council is delivering on key service metrics and the Council Strategy.	All		18 September			All Cabinet Members	All	Ian Kavanagh	Matthew Wallbridge	Public
26	**Contracts for supported living for those with mental health support needs**	Cabinet will consider the relevant procurement decisions in respect of care and support services in supported living for those with mental health support needs.	All		18 September			Cllr Jane Palmer - Health & Social Care	Health & Social Care	Graham Puckering / Sally Offin	Sandra Taylor	Public
60	**Social Care Catering Services**	Cabinet will consider contracts for the award of Social Care Catering Services, within the Extra Care Services.	N/A		18 September			Cllr Jane Palmer - Health & Social Care	Health & Social Care	Tanya Bedoyian . Jan Major	Sandra Taylor	Private (3)

					Decision-Maker			Cabinet Member Lead & Officers				Status
Ref	**Business Item**	**Further information**	**Ward(s)**	**NEW ITEM**	**CABINET meeting**	**Cabinet Member**	**Full COUNCIL**	**Cabinet Member(s) Responsible**	**Relevant Select Committee**	**Report Author**	**Corporate Director Responsible**	**Public or Private (with reason)**
27	**Better Care Fund Section 75 Agreement**	Cabinet will be asked to agree the agreement under section 75 of the National Health Service Act, 2006, between the Council and North West London Integrated Care that will give legal effect to the financial and partnership arrangements under the 2025/26 Better Care Fund Plan. This plan aims to support the independence of residence and prevent escalation of health and care needs.	All		18 September			Cllr Jane Palmer - Health & Social Care	Health & Social Care	Gary Collier	Sandra Taylor	Public
SI	**Public Preview of matters to be considered in private**	A report to Cabinet to provide maximum transparency to residents on the private matters to be considered later in Part 2 of the Cabinet meeting and agenda.	TBC		18 September			TBC	TBC	Democratic Services		Public
73	**Rural Activities Garden Centre**	Following Cabinet's decision to close retail operations on 26 June, following further consultation and engagement with those in receipt of assessed social care services and those who attend the RAGC as volunteers on proposals to relocate services, under delegated authority the Cabinet Member will make a decision on the future of the RAGC site and relocation of service provision accordingly.	Colham & Cowley	NEW ITEM		September		Cllr Eddie Lavery - Community & Environment	Residents' Services / Health & Social Care	Steve Brown	Karrie Whelan	Public
OCTOBER 2025												
63	**Carers Strategy Update**	Cabinet will receive a progress report on the Carers Strategy and Delivery Plan and the priorities going forward.	N/A		23 October			Cllr Jane Palmer - Health & Social Care	Health & Social Care	Gary Collier	Sandra Taylor	Public
32	**The Annual Report Of Adult and Child Safeguarding Arrangements**	This report provides the Cabinet with a summary of the activity undertaken by the Safeguarding Children Partnership Board and the Safeguarding Adults Board to address the identified local priorities. The Cabinet will consider this report and approve the activity and the local priorities for the two boards.	N/A		23 October			Cllr Susan O'Brien - Children, Families & Education / Cllr Jane Palmer - Health & Social Care	Health & Social Care / Children, Families & Education	Alex Coman / Susan-Sidonia Gladish	Sandra Taylor	Public
SI	**Reports from Select Committees**	Reports, findings and recommendations for consideration by the Cabinet, when referred from the appropriate Committee.	All		23 October			TBC	TBC	Democratic Services		Public

					Decision-Maker			Cabinet Member Lead & Officers				Status
Ref	**Business Item**	**Further information**	**Ward(s)**	**NEW ITEM**	**CABINET meeting**	**Cabinet Member**	**Full COUNCIL**	**Cabinet Member(s) Responsible**	**Relevant Select Committee**	**Report Author**	**Corporate Director Responsible**	**Public or Private (with reason)**
SI	**Public Preview of matters to be considered in private**	A report to Cabinet to provide maximum transparency to residents on the private matters to be considered later in Part 2 of the Cabinet meeting and agenda.	TBC		23 October			**TBC**	**TBC**	**Democratic Services**	**TBC**	Public
NOVEMBER 2025												
SI	**Reports from Select Committees**	Reports, findings and recommendations for consideration by the Cabinet, when referred from the appropriate Committee.	All		20 November			**TBC**	**TBC**	**Democratic Services**		Public
SI	**Public Preview of matters to be considered in private**	A report to Cabinet to provide maximum transparency to residents on the private matters to be considered later in Part 2 of the Cabinet meeting and agenda.	TBC		20 November			**TBC**	**TBC**	**Democratic Services**	**TBC**	Public
DECEMBER 2025												
35	**Older People's Plan update**	Cabinet will receive its yearly progress update on the Older People's Plan and the work by the Council and partners to support older residents and their quality of life.	All		18 December			**Cllr Ian Edwards - Leader of the Council / Cllr Jane Palmer - Health & Social Care**	**Health & Social Care**	**John Wheatley**	**Sandra Taylor**	Public
SI	**Public Preview of matters to be considered in private**	A report to Cabinet to provide maximum transparency to residents on the private and confidential matters to be considered later in Part 2 of the Cabinet meeting and agenda.	TBC		18 December			**TBC**	**TBC**	**Democratic Services**		Public
SI	**Reports from Select Committees**	Reports, findings and recommendations for consideration by the Cabinet, when referred from the appropriate Committee.	All		18 December			**TBC**	**TBC**	**Democratic Services**		Public
SI	**2026/27 Budget and Future Medium-Term Financial Strategy (BUDGET FRAMEWORK)**	This report will set out the Medium Term Financial Strategy (MTFS), which includes the draft General Fund reserve budget and capital programme for 2026/27 for consultation, along with indicative projections for the following four years. This will also include the HRA rents for consideration and may include Council Tax Reduction Scheme proposals. Cabinet will also consider the outcome of consultation on proposed mid-year changes to fees and charges.	All		18 December		26 February 2026 - adoption	**Cllr Martin Goddard - Finance & Transformation**	**All**	**Andy Goodwin**		Public
JANUARY 2026												

					Decision-Maker			Cabinet Member Lead & Officers				Status
Ref	**Business Item**	**Further information**	**Ward(s)**	**NEW ITEM**	**CABINET meeting**	**Cabinet Member**	**Full COUNCIL**	**Cabinet Member(s) Responsible**	**Relevant Select Committee**	**Report Author**	**Corporate Director Responsible**	**Public or Private (with reason)**
SI	**Public Preview of matters to be considered in private**	A report to Cabinet to provide maximum transparency to residents on the private and confidential matters to be considered later in Part 2 of the Cabinet meeting and agenda.	TBC		15 January			**TBC**	**TBC**	**Democratic Services**		Public
SI	**Reports from Select Committees**	Reports, findings and recommendations for consideration by the Cabinet, when referred from the appropriate Committee.	All		15 January			**TBC**	**TBC**	**Democratic Services**		Public
FEBRUARY 2026												
SI	**Public Preview of matters to be considered in private**	A report to Cabinet to provide maximum transparency to residents on the private and confidential matters to be considered later in Part 2 of the Cabinet meeting and agenda.	TBC		19 February			**TBC**	**TBC**	**Democratic Services**		Public
SI	**Reports from Select Committees**	Reports, findings and recommendations for consideration by the Cabinet, when referred from the appropriate Committee.	All		19 February			**TBC**	**TBC**	**Democratic Services**		Public
	2026/27 Budget and Future Medium-Term Financial Strategy (BUDGET FRAMEWORK)	Following consultation, this report will set out the Medium Term Financial Strategy (MTFS), which includes the draft General Fund reserve budget and capital programme for 2026/27 for consultation, along with indicative projections for the following four years. This will also include the HRA rents for consideration and any proposals for the Council Tax Reduction Scheme.	All		19 February		26 February 2026 - adoption	**Cllr Ian Edwards - Leader of the Council / Cllr Martin Goddard - Finance & Transformation**	**All**	**Andy Goodwin**		Public
SI	**Members' Allowances 2026/27**	The Council is required to undertake an annual re-adoption of its Allowances Scheme and, in doing so give due regard to the recommendations made by the report of the Independent Panel on the Remuneration of Councillors in London.	All				26 February 2026	**N/A**	**N/A**	**Lloyd White**		Public
MARCH 2026												
SI	**Public Preview of matters to be considered in private**	A report to Cabinet to provide maximum transparency to residents on the private and confidential matters to be considered later in Part 2 of the Cabinet meeting and agenda.	TBC		19 March			**TBC**	**TBC**	**Democratic Services**		Public
SI	**Reports from Select Committees**	Reports, findings and recommendations for consideration by the Cabinet, when referred from the appropriate Committee.	All		19 March			**TBC**	**TBC**	**Democratic Services**		Public

Ref	Business Item	Further information	Ward(s)	NEW ITEM	Decision-Maker			Cabinet Member Lead & Officers				Status
					CABINET meeting	Cabinet Member	Full COUNCIL	Cabinet Member(s) Responsible	Relevant Select Committee	Report Author	Corporate Director Responsible	Public or Private (with reason)
APRIL 2026												
SI	**Public Preview of matters to be considered in private**	A report to Cabinet to provide maximum transparency to residents on the private and confidential matters to be considered later in Part 2 of the Cabinet meeting and agenda.	TBC		23 April			**TBC**	**TBC**	**Democratic Services**		Public
SI	**Reports from Select Committees**	Reports, findings and recommendations for consideration by the Cabinet, when referred from the appropriate Committee.	All		23 April			**TBC**	**TBC**	**Democratic Services**		Public
Schedule of Individual Cabinet Member Decisions that may be taken each month (standard items non key-decisions)												
SI	**Urgent Cabinet-level decisions & interim decision-making (including emergency decisions)**	The Leader of the Council has the necessary authority to make decisions that would otherwise be reserved to the Cabinet, in the absence of a Cabinet meeting or in urgent circumstances. Any such decisions will be published in the usual way and reported to a subsequent Cabinet meeting for ratification. The Leader may also take emergency decisions without notice, in particular in relation to the COVID-19 pandemic, which will be ratified at a later Cabinet meeting.	Various			Cabinet Member Decision - date TBC		**Cllr Ian Edwards - Leader of the Council**	**TBC**	**TBC**		Public / Private
SI	**Release of Capital Funds**	The release of all capital monies requires formal Member approval, unless otherwise determined either by the Cabinet or the Leader. Batches of monthly reports (as well as occasional individual reports) to determine the release of capital for any schemes already agreed in the capital budget and previously approved by Cabinet or Cabinet Members	TBC			Cabinet Member Decision - date TBC		**Cllr Martin Goddard - Finance & Transformation (in conjunction with relevant Cabinet Member)**	**All - TBC by decision made**	**various**		Public but some Private (1,2,3)
SI	**Petitions about matters under the control of the Cabinet**	Cabinet Members will consider a number of petitions received by local residents and organisations and decide on future action. These will be arranged as Petition Hearings.	TBC			Cabinet Member Decision - date TBC		**All**	**TBC**	**Democratic Services**		Public
SI	**To approve compensation payments**	To approve compensation payments in relation to any complaint to the Council in excess of £1000.	n/a			Cabinet Member Decision - date TBC		**All**	**TBC**	**various**		Private (1,2,3)

					Decision-Maker			Cabinet Member Lead & Officers				Status
Ref	**Business Item**	**Further information**	**Ward(s)**	**NEW ITEM**	**CABINET meeting**	**Cabinet Member**	**Full COUNCIL**	**Cabinet Member(s) Responsible**	**Relevant Select Committee**	**Report Author**	**Corporate Director Responsible**	**Public or Private (with reason)**
SI	**Acceptance of Tenders**	To accept quotations, tenders, contract extensions and contract variations valued between £50k and £500k in their Portfolio Area where funding is previously included in Council budgets.	n/a			Cabinet Member Decision - date TBC		**Cllr Ian Edwards - Leader of the Council OR Cllr Martin Goddard - Finance & Transformation / in conjunction with relevant Cabinet Member**	**TBC**	**various**		Private (3)
SI	**All Delegated Decisions by Cabinet to Cabinet Members, including tender and property decisions**	Where previously delegated by Cabinet, to make any necessary decisions, accept tenders, bids and authorise property decisions / transactions in accordance with the Procurement and Contract Standing Orders.	TBC			Cabinet Member Decision - date TBC		**All**	**TBC**	**various**		Public / Private (1,2,3)
SI	**External funding bids**	To authorise the making of bids for external funding where there is no requirement for a financial commitment from the Council.	n/a			Cabinet Member Decision - date TBC		**All**	**TBC**	**various**		Public
SI	**Response to key consultations that may impact upon the Borough**	A standard item to capture any emerging consultations from Government, the GLA or other public bodies and institutions that will impact upon the Borough. Where the deadline to respond cannot be met by the date of the Cabinet meeting, the Constitution allows the Cabinet Member to sign-off the response.	TBC			Cabinet Member Decision - date TBC		**All**	**TBC**	**various**		Public
SI = Standard Item that may be considered each month/regularly												

WORK PROGRAMME

Committee name	Health and Social Care Select Committee
Officer reporting	Nikki O'Halloran, Democratic Services
Papers with report	Appendix A – Work Programme
Ward	All

HEADLINES

To enable the Committee to note future meeting dates and to forward plan its work for the current municipal year.

RECOMMENDATION: That the Health and Social Care Select Committee considers its Work Programme for the year and agrees any amendments.

SUPPORTING INFORMATION

The meeting dates for the 2025/2026 municipal year were agreed by Council on 16 January 2025 and are as follows:

Meetings	Room
~~Thursday 19 June 2025, 6.30pm~~	~~CR5~~
~~Tuesday 22 July 2025, 6.30pm~~	~~CR6~~
Tuesday 16 September 2025, 6.30pm	CR5
Tuesday 7 October 2025, 6.30pm	CR6
Tuesday 11 November 2025, 6.30pm	CR5
Tuesday 20 January 2026, 6.30pm	CR5
Tuesday 17 February 2026, 6.30pm	CR5
Thursday 26 March 2026, 6.30pm	CR5
Tuesday 21 April 2026, 6.30pm	CR5

It has been agreed that a report be brought to each meeting for Members to keep track of progress on the spending / savings targets of the Cabinet Portfolio that the Committee covers (except those meetings in September and January when a budget related report is already scheduled for consideration).

Review Topics

The Committee has agreed to undertake a major review in relation to adult social care early intervention and prevention with the first witness session having taken place on 25 February 2025. Members agreed the terms of reference for this review at the meeting on 12 November 2024.

Implications on related Council policies

The role of the Select Committees is to make recommendations on service changes and improvements to the Cabinet, who are responsible for the Council's policy and direction.

How this report benefits Hillingdon residents

Select Committees directly engage residents in shaping policy and recommendations and the Committees seek to improve the way the Council provides services to residents.

Financial Implications

None at this stage.

Legal Implications

None at this stage.

BACKGROUND PAPERS

NIL.

MULTI-YEAR WORK PROGRAMME

2026/27

Health & Social Care Select Committee	September 16	October 7	November 11	December No meeting	January 20	February 17	March 26	April 21	May No meeting	June	July	August No meeting	September	October No meeting	November	December No meeting
Review A: ASC Early Intervention & Prevention																
Topic selection / scoping stage																
Witness / evidence / consultation stage		Witness Session														
Findings, conclusions and recommendations			Findings													
Final review report agreement					Final report											
Target Cabinet reporting						Cabinet										
Review B: Pharmacies																
Review C: GP Coverage	Final report	Cabinet														
Regular service & performance monitoring																
Annual Performance Monitoring			X										X			
Annual Report of Adult and Child Safeguarding Arrangements																
Older People's Plan Update (prior to Cabinet)																
Health & Social Care Budget & Spending Report	X		X			X	X	X		X	X				X	
Mid-year budget / budget planning report (July/September)	X															
Cabinet's Budget Proposals For Next Financial Year (Jan)					X								X			
Cabinet Member for Health and Social Care					X											
Cabinet Forward Plan Monthly Monitoring	X	X	X		X	X	X	X		X	X		X		X	
One-off information items																
Autism Update	X															
Carer Support Services - Cabinet report		X														
Commissioning Model for delivery of health and social care services			X													
BCF Update			X			X										
Minor Injuries Unit Update	X															
Hospice and End of Life Services in the Borough																
Hillingdon Advice Partnership Update										X						
CAMHS Update						X										
Updated Select Committee Remits					X											
Health External Scrutiny																
Mount Vernon Cancer Centre Strategic Review Update																
Hillingdon Hospital Redevelopment Update															X	
Health Updates			X				X								X	
Quality Accounts (outside of meetings)								X								
Past review delivery																
Review of Children's Dental Services 2021/22 (outside of meetings)		X														
Making the Council more autism friendly 2020/21	X															
CAMHS Referral Pathway 2023/24						X										

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