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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 Labina Basit
Councillor Tony Burles
Councillor Becky Haggar OBE
Councillor Kelly Martin
Councillor Sital Punja (Opposition Lead)

Date: **TUESDAY, 20 JANUARY 2026**

Time: **6.30 PM**

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

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Contact: Nikki O'Halloran
Email: nohalloran@hillingdon.gov.uk

Lloyd White
Head of Democratic Services
London Borough of Hillingdon,
Phase II, Civic Centre, High Street, Uxbridge, UB8 1UW
www.hillingdon.gov.uk

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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

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Minutes

HEALTH AND SOCIAL CARE SELECT COMMITTEE

3 December 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), Labina Basit, Tony Burles, Kelly Martin, Sital Punja (Opposition Lead) and Peter Smallwood (In place of Becky Haggar) **Also Present**: Dr Richard Grocott Mason, CEO for the Heart, Lung and Critical Care Group, Royal Brompton and Harefield Hospitals - Guy's and St. Thomas' NHS Foundation Trust Sue Jeffers, Joint Lead Borough Director, North West London Integrated Care Board (NHS NWL ICB) Dr Ritu Prasad, Chair, The Confederation Hillingdon CIC Jason Seez, Joint Chief Infrastructure & Redevelopment Officer for Chelsea and Westminster NHS Foundation Trust & The Hillingdon Hospitals NHS Foundation Trust Keith Spencer, Managing Director, Hillingdon Health and Care Partners (HHCP) **LBH Officers Present**: Matt Davis (Director - Strategic & Operational Finance), Martyn Storey (Head of Finance - Adult Social Care), Sandra Taylor (Corporate Director of Adult Services and Health) and Nikki O'Halloran (Democratic, Civic and Ceremonial Manager)
37.	**APOLOGIES FOR ABSENCE** *(Agenda Item 1)* Apologies for absence had been received from Councillor Becky Haggar (Councillor Peter Smallwood was present as her substitute).
38.	**DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING** *(Agenda Item 2)* There were no declarations of interest in any matters coming before this meeting.
39.	**MINUTES OF THE MEETING HELD ON 11 NOVEMBER 2025** *(Agenda Item 3)* **RESOLVED: That the minutes of the meeting held on 11 November 2025 be agreed as a correct record.**
40.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 4)* **RESOLVED: That all items of business be considered in public.**
41.	**HEALTH UPDATES** *(Agenda Item 5)* The Chair welcomed those present to the meeting and noted that Councillor June Nelson had been replaced in the Committee by Councillor Labina Basit. He welcomed

Councillor Basit and thanked Councillor Nelson for her long-standing service to the Committee.

The Hillingdon Hospitals NHS Foundation Trust (THH)

Mr Jason Seez, Chief Infrastructure and Redevelopment Officer at THH, advised that he would be providing Members with an update on the Hillingdon Hospital redevelopment project as well as a general update. Insofar as the redevelopment was concerned, it was noted that the Government had undertaken a review of the New Hospitals Programme (NHP) and made an announcement in January regarding the priorities – Hillingdon had been the only London hospital that had been included in wave one. It was noted that THH's enabling and decamp work had slowed down during the review.

In April, the requirements had been confirmed and an agreement with NHP had now been signed with a requirement for the design to be in line with the Hospital 2.0 specifications. Although planning approval had previously been granted, the application was being refreshed to ensure compliance with Hospital 2.0 and stakeholders would be consulted as part of this process. It was anticipated that the contractor selection / onboarding process would be undertaken in 2026 – NHP would be selecting larger building companies to undertake this work. The Outline Business Case would be completed in 2026 and the Full Business Case (FBC) in 2028 with the new hospital build starting in 2028 and expected to be open by the end of 2032.

Knowing how long it took for things to happen, it was queried how the building work could start in 2028 when the FBC would submitted that same year. Mr Seez advised that it was a lengthy process to get things through the NHP, so THH had codesigned everything with NHP as the project had progressed. This meant that, when the FBC was submitted, NHP would already be cognisant of its contents and there should be no serious questions.

Concern was expressed that 2028 was very close to the next general election and that a change in government might impact the redevelopment project. Mr Seez recognised that the long term project management was at the mercy of political cycles and, as such, it would be important to start the construction before the next general election.

Members praised Mr Seez and his team for their hard work in getting Hillingdon Hospital into wave one but queried whether, as it had already taken many years to get to this stage, this new build was definitely going to happen. Mr Seez noted that it could feel like the process had gone back a stage as planning permission had already been agreed once and was now having to be resubmitted. He believed that the project would be making progress again by the summer of 2026 - the financial commitment from the Government had been received and, once the builder had been identified, the design would be finalised.

Members thanked Mr Seez for giving them a tour of the Hillingdon Hospital development work on 26 September 2025. During that visit, there had been some discussion about where staff would be parking for the duration of the development work. Mr Seez advised that there were plans for all services to move around and that staff parking would move off site, whilst retaining patient parking on site. It had been hoped that THH would be able to come to an agreement with Brunel University but this was not looking positive. The alternative would be for staff to park at a site in Moorcroft Lane.

Mr Seez advised that a CQC inspection had been undertaken in October to look at surgery and urgent care. The resultant report would be due out in the next few months and should show improvements. Hillingdon Hospital urgent and emergency care had been doing well nationally and in London. Concerns had previously been raised about the Trust's finances but Mr Seez reassured Members that the deficit was on plan and on track to deliver a balanced financial position. The staff survey had been undertaken and the responses were being collated. Performance, finances and workforce were all doing well with sustained improvements.

In the report, it had stated that THH had scored 4 for patient safety on the NHS oversight framework. Mr Seez explained that NHS England oversaw NHS Trust providers and had put together a simple rating across the country. The patient safety score had been affected most by the infection prevention and control performance from previous years. A comprehensive programme to address infection prevention and control was now in place at THH and performance had been returning to where it should be. It was recognised that this could impact avoidable deaths as well as patient choice. It was agreed that the Committee would like an update in the future on the progress that was being made.

Members queried why there had been an increase in falls at Hillingdon Hospital (from 33 to 47) and what action had been taken to mitigate this. Mr Seez advised that Hillingdon Hospital was an old high rise building and that he would provide a detailed breakdown for Members with the reasons, trends and a narrative.

Concern was expressed that there had been no consultation undertaken with regard to the closure of the Mount Vernon Minor Injuries Unit (MVMIU), except for a roundtable event, to which a select group of people had been invited to attend. Residents that had previously attended MVMIU were now having to attend Hillingdon Hospital and wait for ages to be seen. Mr Seez was unaware of the exact process but confirmed that it had gone to all partners. The waiting times at Hillingdon Hospital's Urgent Treatment Centre (UTC) were being monitored and numbers had increased but the performance was on par with what it had been before the closure of MVMIU. Mr Seez would forward additional information to the Democratic, Civic and Ceremonial Manager for circulation to Members of the Committee.

Patient experience data had shown that facilities such as the Pembroke Centre had not been meeting the needs of residents that had previously used MVMIU. It was questioned how Hillingdon Hospital would be able to perform to the same level as MVMIU. Dr Ritu Prasad, Chair of the Hillingdon Confederation, advised that patients were now able to get their dressings done at the extended access hub rather than going to MVMIU.

<u>Hillingdon Health and Care Partners (HHCP)</u>
Mr Keith Spencer, Managing Director at HHCP, advised that the place transformation programme was currently underway and that the focus had been on getting patients discharged as soon as possible and improving the Emergency Department (ED) performance. All metrics had been rooted in the Hillingdon Hospital redevelopment programme so that everything tied up.

Action was being taken to try to keep patients away from the ED with a target of 164 ED attendances per day. Hillingdon had been the only London borough to reduce activity in the previous week where attendances had been down 5% compared to the same time during the previous year. There had also been a 27% reduction in the

number of people with no criteria to reside. About one third of the patients attending Hillingdon's ED did not need to be there so action was being taken to redress this balance and re-educate these attendees. Work would be undertaken in January / February 2026 in each neighbourhood to promote the services that were available in the community and to be more assertive about individuals' personal responsibility for their own health. A social contract was needed and information circulated about what alternatives were available to residents.

The reactive care programme acted as a hinge between the neighbourhoods and the hospital. Work was underway to increase the number of referrals from 3,500 to 7,000 each year. Mr Spencer advised that the coordinated hub launch would take place this month and that the mobile diagnostics had gone live. The first xray had been undertaken in Northwood and a number of care homes had been seen in the previous week which had prevented these residents from having to attend hospital. This pilot would be focussing on the frail and would be able to do up to ten diagnostics each day. If the pilot was a success, it would be scaled up.

Members queried how the mobile diagnostics would be prioritised. Dr Prasad advised that this service would be covering all areas of the Borough and would be in the Heathrow Villages the following day. The service was based at the Pembroke Centre in Ruislip but would move around Hillingdon to wherever it was needed and the equipment was compact enough to be able to be transported on a motorbike. Mr Spencer advised that consideration could be given to including services such as ultrasound.

Work was currently underway to establish how many patients could be diverted from hospital to the hubs. A coordination hub would be created as part of the reactive care and provide an 'air traffic control' for Hillingdon's out of hospital care. Previously, if a resident in a care home had a fall, an ambulance would be called and they would be taken to the ED. The new system would provide a direct link between the London Ambulance Service, coordination hub and hospital at all times and better coordinate what were currently very individual services.

Ms Jeffers noted that a same day emergency pathway was already in place between GPs and the hospital. The GP referral pathways had already been worked through whereby GPs could undertake a clinical triage and send the patient to the most appropriate unit without the patient having to be reassessed.

All three Integrated Neighbourhood Teams were now operational and would be looking to improve frailty by around 50% over the next year and expand the hypertension case finding work (if 24% had been identified and 80% of these cases were controlled, there would be a 16% reduction in associated ED admissions).

IV antibiotics were now available at the Ruislip hub and mental health capacity had been expanded to deal with ten people per day from 17 December 2025. Dealing with 'no criteria to reside' had consumed a significant amount of senior time (as it deserved scrutiny) and the Hillingdon Health and Wellbeing Board had adopted children and young people as a priority at its meeting on the previous day.

Mr Spencer advised that a significant transformation programme was being mobilised during winter which attracted significant risks. However, the data showed that ED attendance had already reduced. Hillingdon (along with two other North West London (NWL) boroughs) had been chosen as one of 43 areas taking part in wave one of the

development of neighbourhood hubs. These hubs would be located at the Civic Centre in Uxbridge, the old Nestle factory in Hayes, and Ruislip and would help to shape what neighbourhoods and place should look like. This initiative was all about early implementation rather than money (a business case would be put together in relation to this as it would be part of a separate process). A real advantage for Hillingdon was that this work was being undertaken in line with the development of the new hospital but there was some concern that capital funding was not yet in place for this pilot.

Members were pleased that the locations of the neighbourhood hubs had been agreed and queried how Hillingdon would be affected by the merger of the ICBs in NWL and North Central London (NCL) as they controlled a lot of the funding and enabling. Would the Borough have enough freedom to do what was needed locally or would it be too remote to be heard? Ms Sue Jeffers, Joint Borough Director for NWL ICB, advised that the merger of the two ICBs was expected to be effective from 1 April 2026. The new body would be called the West and North ICB (WN ICB) and would be made up of the 13 local authorities from NWL and NCL. It would cover 50 neighbourhoods and 4.5m people.

The reorganisation would follow a national blueprint for ICBs which had been published around May 2025 and would reposition them as strategic commissioning bodies with a focus on issues such as reducing inequalities. Work would be undertaken over the next few months to establish how the new WN ICB would engage with its 13 local authorities and 50 neighbourhoods. Discussions would be undertaken with local authority, voluntary sector, health and social care colleagues.

The Pharmacy First service had been a great success and it was queried whether there would be any scope for mobile diagnostics to be included in the services provided. Ms Jeffers advised that Pharmacy First was available in all 52 pharmacies across the Borough and had dealt with 18,000 appointments between April and September 2025, dealing with a range of conditions including minor infections and urinary tract infections. The UTC at Hillingdon Hospital was linked and had successfully been redirecting patients to Pharmacy First services if the patient did not need to be at the hospital. Consideration could be given to how community pharmacy services could be further embedded into neighbourhoods and linked into wider neighbourhood services. Ms Jeffers was asked to provide the Committee with further information on lessons learned at a future meeting.

Dr Prasad advised that the introduction of Pharmacy First had had a positive impact on GPs in that the pharmacists were able to prescribe antibiotics for certain conditions which then freed the GPs up to deal with more complex cases. Although there had been some improvements, some patients were still struggling to get GP appointments which was partly as a result of it being difficult to change some patients' behaviours. GPs and pharmacists had a good relationship and it was hoped that further improvements would come over time as patients became more familiar with accessing alternative pathways.

Concern was expressed that the number of children's neurodiversity referrals remained high. With the funding coming to an end and the increase in numbers, Members queried how a backlog was going to be prevented in future. Ms Jeffers advised that the increase in the number of children and young people on neurodiverse pathways had been a national issue but no reason could be found as to why it was increasing. Schools and services were having to try to manage the issue and NWL had put £6.7m into community provider services to try to clear the backlog. In the meantime, funding

had been provided for a 'waiting well' programme and CNWL had been working on developing a sustainable solution (the SEND Executive Board would be keeping a close eye on this). The Committee had previously undertaken a review of CAMHS and would be receiving an update at a future meeting.

The flu season had started early and seemed to produce more prolonged cases, taking up to two weeks to go. Hillingdon had been coping better with this pressure than the rest of NWL and had higher vaccination rates than the rest of NWL.

Royal Brompton and Harefield Hospitals (RBH) - Guy's and St. Thomas' NHS Foundation Trust

Dr Richard Grocott Mason, CEO for the Heart, Lung and Critical Care Group at RBH, advised that Harefield Hospital did not have an ED and was part of the Guy's and St Thomas' group which fell under the South East London ICB. Since 2024, Harefield Hospital had had the busiest heart attack centre in the country, undertaking cardiac and thoracic surgery and providing heart and lung transplant services. It was quite a difficult environment at the moment and waiting times for cardiac surgery had still not recovered to pre Covid levels (Covid had significantly reduced London's cardiac surgery capacity). The transplant service had been thriving, with 62 heart and lung transplant operations undertaken in the previous year and 27 lung and 21 heart transplants already completed this year. Harefield Hospital had also become a new LifeArc Centre for rare respiratory diseases.

There had been an increase in the number of early diagnoses of lung cancer which had opened up more treatment options. This had put pressure on the hospital's ability to meet the 62-day target. Dr Grocott Mason noted that 18 months was not an appropriate period for treatment and that treatment should ideally be undertaken within four weeks but recognised that this timeframe could not be delivered for all patients.

Members queried whether the increase in waiting times had been solely as a result of the volume of patients. Dr Grocott Mason advised that it had been a mix of increased demand (there were 1,600 patients across London waiting for surgery, 800 of which were within the Guy's and St Thomas' group). If there were more resources available, services could be extended into the weekends. One third of the patients were waiting for non-elective surgery so two thirds could be dedicated to reducing waits.

Although Harefield Hospital might appear quiet from the outside, internally it had been particularly busy, especially the on-call service and critical care. However, there had been a reliance on staff with specialist skills and there were only so many overtime hours that staff could do.

The mortality rates at Harefield Hospital had been ten times more favourable than other hospitals. It was suggested that this might be because the hospital had a very big and very experienced thoracic team who dealt with one sixth of lung cancer treatments being undertaken.

In the past, Harefield Hospital had experienced some challenges in relation to building improvements and recruitment. Dr Grocott Mason advised that the recruitment and retention of staff had been good but that this would be an ongoing process to ensure that the hospital was fully staffed. Insofar as redevelopment, modernisation and investment were concerned, this continued to be a challenge. A number of plans and options had been identified but there were issues around securing public funding and the lack of capital investment in NHS estate had not been great.

	RESOLVED: That: **1. Mr Jason Seez additional information about the impact of the closure of MVMIU on the UTC to the Democratic, Civic and Ceremonial Manager for circulation to Members of the Committee;** **2. Mr Jason Seez provide the Committee with an update on the comprehensive programme that had been introduced at THH to address infection prevention and control;** **3. Mr Jason Seez provide Members with a detailed breakdown of the increase in falls with the reasons, trends and a narrative;** **4. Ms Sue Jeffers provide the Committee with further information on lessons learned from the implementation of the Pharmacy First service at a future meeting; and** **5. the discussion be noted.**
42.	**BUDGET AND SPENDING REPORT - SELECT COMMITTEE MONITORING** *(Agenda Item 6)* Ms Sandra Taylor, the Council's Corporate Director of Adult Social Care (ASC) and Health, noted that the Committee had previously asked for the ASC budget to be benchmarked against other local authorities. She advised that the use of resources report had been completed and included data from the Adult Social Care Outcomes Framework (ASCOF) which was out of date. An updated version of the report would be published the following week and would be reviewed for the Committee. It showed Hillingdon as providing very good value for money and low cost in comparison to other London boroughs, therefore demonstrating the Council's good use of limited resources. Since the Committee's meeting in September 2025, officers had undertaken a lot of work in relation to demand growth and inflation. There had been pressure on the placements budget so officers had spent 8-12 months going through this. However, Ms Taylor was confident that the older people's placements had started to stabilise and Hillingdon Hospital had managed to work through the elective backlog which had had a positive impact on older people's services. The increase in neuro diverse demand on health services had been reflected in social care. As a result of the inspection process, there had been some improvements to the number of direct payments being made which provided good value for money as well as giving residents the autonomy to make their own choices. Mr Martyn Storey, the Council's Head of Finance – Adult Social Care, advised that the volume of home care had reduced as the number of direct payments had increased. Mr Matt Davies, the Council's Director of Strategic and Operational Finance, advised that the Month 6 position showed a £5.1m overspend which the ASC team had been trying to mitigate by making savings to offset the overspend. The renegotiation of the social care contracts had been flagged as a red risk with a value of £1.7m as a result of increases in NI charges and the rising older people population. There had been challenges with regard to the Section 117 funding split with the North West London Integrated Care Board (NWL ICB) with Hillingdon receiving 37% of the funding (whereas other London boroughs received a fairer percentage ranging from 40% to 50%). Ms Taylor advised that the ICB determined how much the local authority would receive and Hillingdon had received the lowest percentage in NWL since 2019. As such, discussions were underway with the ICB to try to redress the balance.

Mr Davies noted that, if a service was looking to achieve a savings target, it could reduce costs or create additional income. Members were advised that the £5.1m overspend equated to around 2% of the budget. There were a number of outer London boroughs that had reported an overspend in the second quarter of this year including: Ealing (£2m), Brent (£1.2m), Kingston (£1m) and Havering (£6.57m). There were a lot of pressures being faced by local government as a result of local and national issues.

Whilst Members appreciated what other local authorities were doing and the issues that they faced, the Committee was only really concerned about what was happening in Hillingdon. The amazing service provided by ASC teams at Hillingdon could not be disputed. In the previous financial year, officers had talked to the Committee about the use of artificial intelligence (AI) in the transformation of ASC services. A realistic conversation was needed in relation to the analysis as the data modelling had been undertaken for forecasting but needed to include things like the variance from cost to budget and the associated narrative. Ms Taylor noted that AI had provided a fantastic resource and had been used on the Magic Notes pilot to make a difference by providing high quality recording and translations and putting the information directly onto the system. The full rollout had just started throughout children's and adult social care (Ms Taylor advised that she would arrange a demonstration for Members of the Committee). The new system managed quality and reduced the time needed from social workers to obtain / input the information, therefore delivering staff time savings.

This was the start of the digital journey with more initiatives like self service and tech-enabled care emerging. AskSARA (Self Assessment Rapid Access) had been introduced as a needs-based assessment tool, producing a report and making recommendations for potential aids and services that might be beneficial for that individual with their daily living activities. This work was largely about managing demand (which was relentless) rather than achieving savings, and helped residents to help themselves.

Ms Taylor advised that the amount of funding needed to meet the demand was based on the number of people using the services and the cost that the Council was charged for these services. As the price had outstripped the demand, the authority had opened The Burroughs, reducing the need to buy beds from private providers at a higher cost, and was in the process of developing the Civic's multi storey car park (the Lobster Pot) into a care home. Hillingdon had a busy care market (with around 1,200 beds) but the Council had been unable to access a lot of these.

Demand in all areas had been reviewed (as well as growth) and consideration was being given to ensuring that there was enough in the budget to cope with this. As so much work was being undertaken to get this right, Members would be holding the Corporate Director to account if the service area was overspent next year.

Members asked that future reports included calculations on the projections. Mr Davies advised that lessons had been learnt in relation to not delivering on the budget and changes could now only go into the budget setting if a two-page form had been completed. Growth and savings had been split into categories and it would be important to ensure that the process did not miss next year's pressures. The 2026/27 budget would be out for consultation before the end of December 2025 and Members would get the opportunity to comment on it at their next meeting on 20 January 2026. Members asked if it would be possible to provide them with a briefing session on the budget to talk through what the numbers meant.

	It was suggested that the fairer funding settlement would help to achieve the savings that were needed and that this needed to be discussed at a future meeting. Processes needed to be in place to help residents access services if they did not quite meet the thresholds, whilst also keeping the budgets in order. Ms Taylor noted that it was important for ASC to remember that they were dealing with real people. The resource allocation system recorded an individuals' needs which were then reviewed by the brokerage service that looked at cost versus allocation. The Council tried to work with set providers so that quality and cost could be controlled. There were parameters around costs whereby the Care Act stated that decisions could not be made on cost alone and decisions needed to meet individual needs whilst also delivering best value for money. The Council currently spent £184.33 per adult on social care (which was less than other local authorities) and was driven by an overarching need to recognise who needed to receive funding. Ms Taylor advised that the value for money provided by the Council had resulted from effective negotiation with providers. It was noted that Hillingdon had been ranked 90th out of 153 councils with regard to deprivation, despite having several wards that were amongst the most deprived in the country. Hillingdon had seen an increase in deprivation in some areas (level 2 in Uxbridge and the south of the Borough). As such, there needed to be a focus on these areas to ensure that these residents' needs were being met. Insofar as fairer funding was concerned, Ms Taylor advised that Hillingdon needed further funding to enable residents to live independently and reduce the pressure on other Council departments. In the past, it had been cheaper to outsource services than to provide them inhouse. Work was currently underway to review and manage the stability of the market. There would also be employer-related legislative changes introduced in the next year and the subsequent impact on costs would need to be monitored. The Council's own trading company needed to provide good care and lower costs. **RESOLVED: That:** **1. Ms Sandra Taylor arrange for Members of the Committee to receive a demonstration of the Magic Notes pilot;** **2. investigations be undertaken to establish whether it would be possible for Members to have a briefing session on the budget to talk through what the numbers meant; and** **3. the discussion be noted.**
43.	**CABINET FORWARD PLAN MONTHLY MONITORING** *(Agenda Item 7)* Consideration was given to the Cabinet Forward Plan. **RESOLVED: That the Cabinet Forward Plan be noted.**
44.	**WORK PROGRAMME** *(Agenda Item 8)* Consideration was given to the Committee's Work Programme. It was noted that the CAMHS update would be discussed at the meeting on 20 January 2026. The Democratic, Civic and Ceremonial Manager would circulate the recommendations from the Committee's previous CAMHS review to Members. It was agreed that the HHCP place based transformation update be moved from 20

	January 2026 to 17 February 2026. **RESOLVED: That:** **1. the Democratic, Civic and Ceremonial Manager circulate the recommendations from the Committee's CAMHS review to the Members;** **2. the HHCP place based transformation update be moved from 20 January 2026 to 17 February 2026; and** **3. the Work Programme, as amended, be noted.**
	The meeting, which commenced at 6.30 pm, closed at 8.47 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.

PUBLIC HEALTH IN HILLINGDON UPDATE

Committee name	Health and Social Care Select Committee
Officer reporting	Sharon Stoltz, Director of Public Health, London Borough of Hillingdon
Papers with report	Public Health Outcomes Framework – at a glance summary
Ward	All

HEADLINES

The report is provided to the Committee at its request. It provides an introduction to public health, an overview of the public health outcomes framework and how Hillingdon is performing against a range of indicators compared with England and regional averages together with a brief summary of some of the work being delivered by the Council's public health team.

RECOMMENDATIONS

That the Health and Social Care Select Committee:

1. **notes the content of the report.**
2. **makes any comments.**

SUPPORTING INFORMATION

What is Public Health?

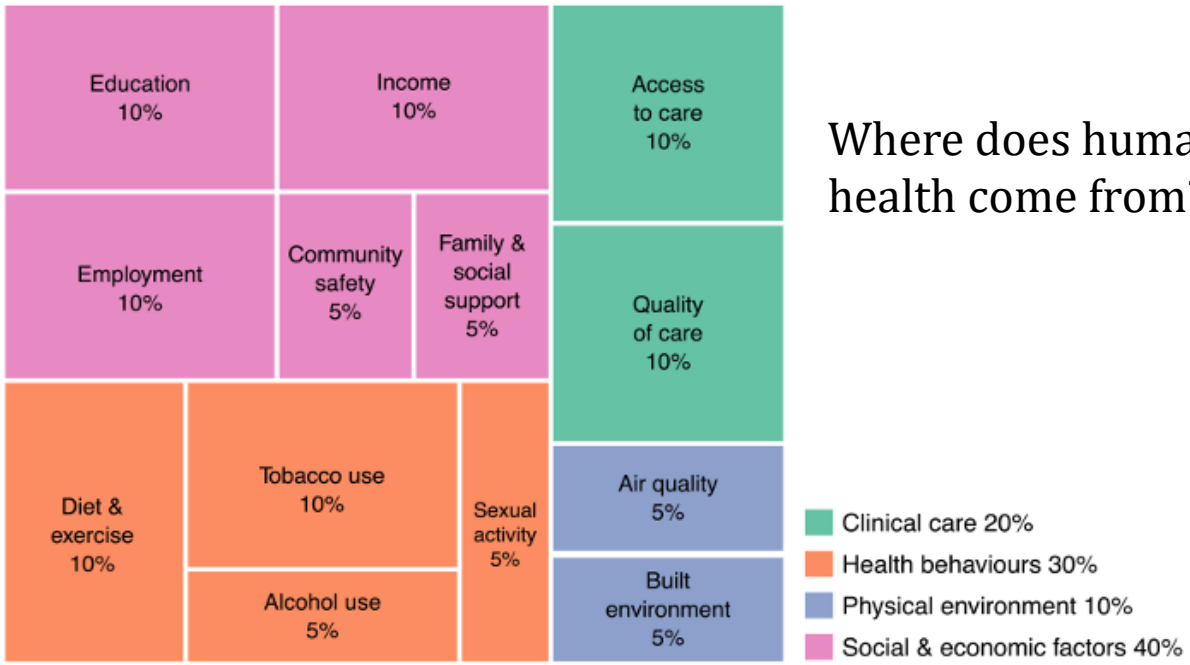
The Faculty of Public Health describes public health as the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society.

Public health is usually organised in four domains as illustrated below:

DOMAIN 1:	DOMAIN 2:	DOMAIN 3:	DOMAIN 4:
Improving the wider determinants of health	Health improvement	Health protection	Healthcare public health and preventing premature mortality
Objective: Improvements against wider factors that affect health and wellbeing, and health inequalities	Objective: People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities	Objective: The population's health is protected from major incidents and other threats, while reducing health inequalities	Objective: Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities

Improving the health of a local population requires a whole system response. Evidence from the World Health Organisation suggests that medical care accounts for only about 20% of health outcomes, while the remaining 80% is shaped by non-medical factors including behaviours such

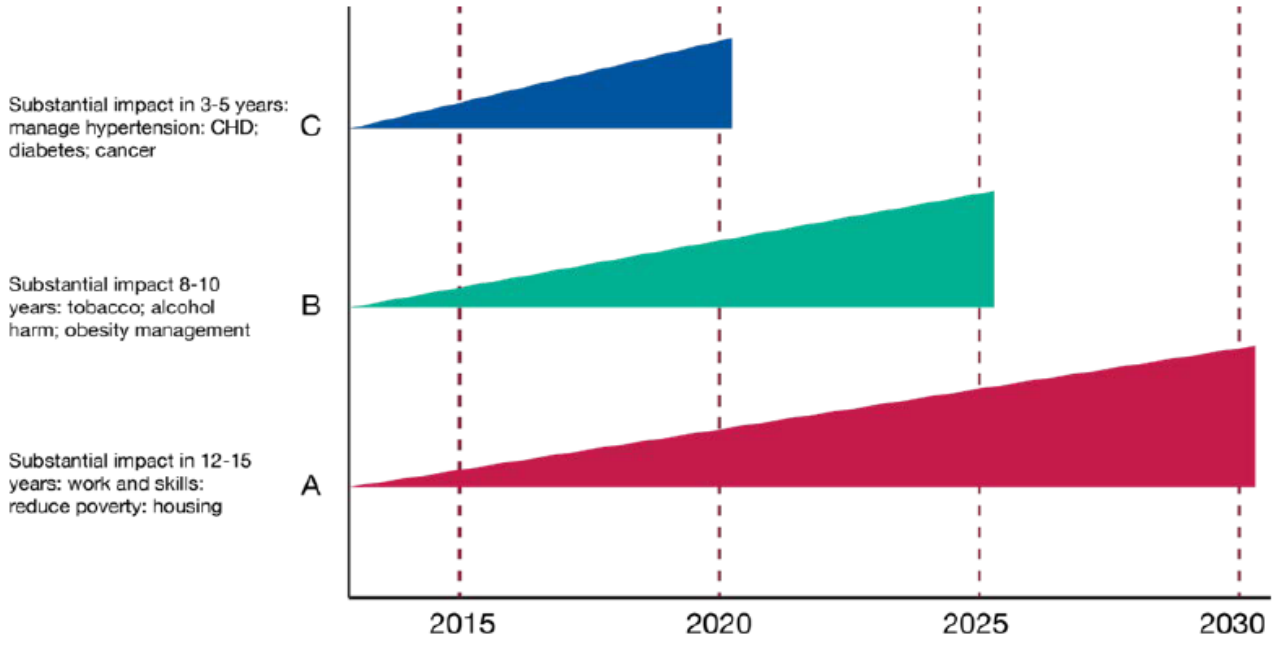
as diet, physical activity, smoking and alcohol use, alongside socio-economic conditions and the physical environment as illustrated below:



Source: Robert Wood Johnson Foundation 2014

This means that adopting positive habits – such as regular exercise, balanced nutrition, avoiding tobacco and moderating alcohol – can significantly reduce the risk of chronic diseases such as heart disease, diabetes and certain cancers, and even extend life expectancy. Conversely, unhealthy behaviours accelerate disease onset and premature mortality reinforcing the critical importance of individual life-style choices in shaping population health.

A systematic approach to prevention is needed over an extended period of time to deliver improvements in the health of a population at scale as illustrated below:



Local Authority Mandated Public Health Functions

The Health and Social Care Act 2012 and associated public health regulations set out the following mandated public health functions:

- 0-5 Child Public Health Services (health visiting, Healthy Start vitamins)
- National Child Measurement Programme (weighing and measuring of children in Reception class and year 6)
- NHS Health Checks (5 yearly screening of healthy adults aged 45 to 74 years)
- Sexual Health and Contraception Services
- Provision of specialist public health advice to NHS commissioners
- Protecting the health of the local population

There are also non-mandated functions but they are required to be delivered as conditions of the local authority public health grant:

- Stop Smoking Services
- Drug and Alcohol Services

These functions form part of the statutory responsibilities of the local authority Director of Public Health.

Developments and Achievements

Key developments and achievements of the Public Health Team over the last three years are summarised below:

- **Hillingdon Healthy Smiles** – a children's oral health improvement programme that aims to address persistent rates of decay among children by embedding good tooth-brushing habits, reducing exposure to sugary foods and drinks and reducing inequalities in access to dental care. The programme is targeted to children aged 0-5 years and delivered in partnership with the health visiting service, nurseries, schools, family hubs and children's centres. It is part of a wider health strategy addressing improvements in family nutrition and tackling excess weight in children.

- **School SuperZones** – the Public Health Team received £58,000 from the Greater London Authority for work across multiple council teams to deliver projects aimed at improving community safety, healthy eating and active travel. The council teams include Green Spaces, Trading Standards, Licensing, Active Travel, Education, Youth Services, Environmental Health and Community Safety. The initial project involved three schools but has since been incorporated into the Education Strategy, development of a new School Food Working Group and work to address the problem of serious youth violence.

- **Physical Activity Programmes** – the team has worked to expand the physical activity offer which has resulted in increased participation levels for children post-Covid. Discussions are underway to ensure the sustainability of these programmes by building them into the GLL contract.

- **'SORTED' Drugs and Alcohol Service for Children and Young People** – this is a service funded by Public Health and delivered as part of the Hillingdon Youth Offer. The service provides confidential advice, information and education for children, young people and parents/carers and is accessible to anyone who either lives in Hillingdon or attends a school in the Borough.

- **Support for Healthy Lifestyles** – provision of stop smoking services in partnership with the NHS and community pharmacies, exercise on referral programme, weight management programme for children and adults.

- **Tobacco Control** – we have successfully implemented a Tobacco Control Alliance with multi-agency representation including Trading Standards. Successes include more than 1.3 million illegal or counterfeit vaping devices seized at Heathrow Airport together with successful prosecution for illegal sales to under-aged children of vapes and cigarettes.

- **NHS Health Checks** – a review of the contract with GP Practices for delivery of NHS Health Checks to eligible adults aged between 45 and 75 years to improve the service offer and tackle variation of quality and uptake, for example by sharing best practice. The expected population health outcomes include improved uptake of screening and earlier detection of hypertension (high blood pressure), heart disease and stroke risk, diabetes and some types of dementia.

- **Population Health Management** – support to the production of the Joint Strategic Needs Assessment, Pharmaceutical Needs Assessment, development of data packs to inform public health and NHS commissioning and training on population health management to a range of professionals across the council and the Hillingdon Health and Care Partnership.

- **Delivery through the Integrated Neighbourhood Teams** – the Public Health Team provide support to strategic decision making and delivery of a range of programmes to improve health and wellbeing through the three Hillingdon Integrated Neighbourhood Teams. Some examples of the programmes being delivered include:
    a) Falls Prevention – strength and balance sessions held in libraries and other community settings to improve balance function, prevent falls and maintain independence. Support to Care Homes on falls prevention including delivery of training to staff.
    b) Social Isolation – working in partnership with Brunel University to support mainly older residents who are socially isolated and lonely
    c) Dementia Early Intervention programmes being delivered in libraries and leisure centres together with dementia awareness training to residents and professionals and establishment of a Dementia Action Alliance.
    d) Warm Welcome Centres – 10 centres have been set up across the Borough offering a range of activities together with community outreach
    e) Cancer Project – delivered in partnership with the NHS to improve the awareness of symptoms of cancer, the importance of cancer screening and early detection and wellbeing support
    f) Promoting the uptake of vaccinations – delivered in partnership with the NHS targeting older people together with sessions aimed at gypsy/travellers in Harefield. Work being planned to improve the uptake of childhood vaccinations.

Priorities for 2026

The new Director of Public Health in Hillingdon has only recently been appointed and so the priorities for improving and protecting the health of the people of Hillingdon are in the process of being developed but the focus is likely to include:

- Ensuring that the statutory responsibilities are being delivered

- A review of the commissioned services for stop smoking support, drugs and alcohol, sexual health and contraception to ensure quality and outcomes and value for money
- Embedding the new contract for delivery of NHS Health Checks
- Development of proposals for an integrated healthy lifestyles offer
- Development of proposals for improving the levels of physical activity and reducing sedentary behaviours to be integrated into the GLL contract

PERFORMANCE DATA

The Office for Health Improvement and Disparities (OHID) produce the Public Health Outcomes Framework which allows local authorities to benchmark their performance against a range of public health indicators. A summary of the Public Health Outcomes Framework for Hillingdon can be found as Appendix 1.

The health of the population in Hillingdon is generally good compared to England and Region averages. However, we know that there is significant variation in health outcomes within communities in Hillingdon and work is being undertaken to better understand the reasons for this.

RESIDENT BENEFIT

The report describes some of the activities being undertaken to improve the health and wellbeing of local residents.

FINANCIAL IMPLICATIONS

Each upper tier and unitary authority with responsibilities for public health receive an annual Local Authority Public Health Grant Allocation to fund local public health services. Hillingdon received a Public Health Grant Allocation of £21,007,294 for 2025/26. At the time of writing the allocations for 2026/27 have not been published.

LEGAL IMPLICATIONS

There are no direct legal implications arising from this report.

BACKGROUND PAPERS

NIL

APPENDICES

Public Health Outcomes Framework – at a glance summary.

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Office for Health Improvement & Disparities

Public Health Outcomes Framework - at a glance summary

Published 7 May 2025

Hillingdon

Key

Significance compared to goal / England average:

Significantly worse	Significantly lower	↑ Increasing / Getting worse	↑ Increasing / Getting better
Not significantly different	Significantly higher	↓ Decreasing / Getting worse	↓ Decreasing / Getting better
Significantly better	Significance not tested	↑ Increasing	↓ Decreasing
		→ No significant change	– Could not be calculated

Notes

- Indicators that are shaded blue rather than red/amber/green are presented in this way because it is not straightforward to determine for these indicators whether a high value is good or bad.
- The Change from previous column shows whether there has been a change in value compared to the previous data point. Statistically significant changes highlighted in this column have been calculated by comparing the confidence intervals for the respective time points. If the confidence intervals do not overlap, the change has been flagged as significant.
- Recent trend refers to the analysis done in the Fingertips tool which tests for a statistical trend. Changes in this column are calculated using a chi-squared statistical test for trend. This is currently only available for certain indicator types; full details are available in the tool.
- Increases or decreases are only shown if they are statistically significant. Where no arrow is shown, no comparison has been made. This may be due to the fact that the required data to make the comparison is not available for the time point, or that no confidence interval values are available for the indicator.

A. Overarching indicators

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
A01a - Healthy life expectancy at birth	All ages	Male	2021 - 23	66.0	63.9	61.5	Years	-	→
A01a - Healthy life expectancy at birth	All ages	Female	2021 - 23	66.6	64.0	61.9	Years	-	→
A01b - Life expectancy at birth	All ages	Male	2023	80.5	80.4	79.3	Years	-	→
A01b - Life expectancy at birth	All ages	Male	2021 - 23	79.4	79.8	79.1	Years	-	→
A01b - Life expectancy at birth	All ages	Female	2023	84.6	84.6	83.2	Years	-	→
A01b - Life expectancy at birth	All ages	Female	2021 - 23	83.9	84.1	83.1	Years	-	→
A01c - Disability free life expectancy at birth	All ages	Male	2018 - 20	65.7	64.4	62.4	Years	-	→
A01c - Disability free life expectancy at birth	All ages	Female	2018 - 20	63.8	63.3	60.9	Years	-	→
A02a - Inequality in life expectancy at birth	All ages	Male	2021 - 23	7.6 [b]	8.3 [b]	10.5 [b]	Years	-	→
A02a - Inequality in life expectancy at birth	All ages	Female	2021 - 23	6.3 [b]	5.6 [b]	8.3 [b]	Years	-	→
A02c - Inequality in healthy life expectancy at birth LA	All ages	Male	2009 - 13	10.7	-	-	Years	-	-
A02c - Inequality in healthy life expectancy at birth LA	All ages	Female	2009 - 13	14.1	-	-	Years	-	-
A01a - Healthy life expectancy at 65	65	Male	2021 - 23	11.3	10.5	10.1	Years	-	→
A01a - Healthy life expectancy at 65	65	Female	2021 - 23	11.8	10.8	11.2	Years	-	→
A01b - Life expectancy at 65	65	Male	2023	19.5	19.3	18.8	Years	-	→
A01b - Life expectancy at 65	65	Male	2021 - 23	18.7	18.9	18.7	Years	-	→
A01b - Life expectancy at 65	65	Female	2023	22.1	22.2	21.3	Years	-	→
A01b - Life expectancy at 65	65	Female	2021 - 23	21.6	21.8	21.1	Years	-	→
A01c - Disability-free life expectancy at 65	65	Male	2018 - 20	9.6	10.3	9.8	Years	-	→
A01c - Disability-free life expectancy at 65	65	Female	2018 - 20	10.2	10.2	9.9	Years	-	→
A02a - Inequality in life expectancy at 65	65	Male	2021 - 23	5.8 [b]	5.8 [b]	5.6 [b]	Years	-	→
A02a - Inequality in life expectancy at 65	65	Female	2021 - 23	4.5 [b]	4.1 [b]	5.0 [b]	Years	-	→

B. Wider determinants of health

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
B01b - Children in absolute low income families (under 16s)	<16 yrs	Persons	2022/23	11.4	12.3	15.6	%	↓	↓
B01b - Children in relative low income families (under 16s)	<16 yrs	Persons	2022/23	14.8	15.8	19.8	%	↓	↓
B02a - School readiness: percentage of children achieving a good level of development at the end of Reception	5 yrs	Persons	2023/24	66.5	70.0	67.7	%	–	→
B02a - School Readiness: percentage of children with free school meal status achieving a good level of development at the end of Reception	5 yrs	Persons	2023/24	52.3	58.3	51.5	%	–	→
B02b - School readiness: percentage of children achieving the expected level in the phonics screening check in Year 1	6 yrs	Persons	2023/24	81.6	82.0	80.2	%	↓	→
B02b - School readiness: percentage of children with free school meal status achieving the expected level in the phonics screening check in Year 1	6 yrs	Persons	2023/24	67.8	73.6	68.1	%	↓	→
B02c - School readiness: percentage of children achieving at least the expected level in communication and language skills at the end of Reception	5 yrs	Persons	2023/24	77.3	79.0	79.3	%	–	↓
B02d - School readiness: percentage of children achieving at least the expected level of development in communication and language and literacy skills at the end of Reception	5 yrs	Persons	2023/24	68.2	71.2	69.2	%	–	→
B03 - Pupil absence	5-15 yrs	Persons	2023/24	6.7	6.4	7.1	%	↑	↓
B04 - First time entrants to the youth justice system	10-17 yrs	Persons	2023	100.9	143.3	143.4	per 100,000	→	→
B05 - 16 to 17 year olds not in education, employment or training (NEET) or whose activity is not known	16-17 yrs	Persons	2023/24	3.7	3.4	5.4	%	→	↓
B06a - Adults with a learning disability who live in stable and appropriate accommodation	18-64 yrs	Persons	2023/24	81.7	79.4	81.6	%	→	→
B06b - Adults in contact with secondary mental health services who live in stable and appropriate accommodation	18-69 yrs	Persons	2020/21	67.0	61.0	58.0	%	–	→
B08a - Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate	16-64 yrs	Persons	2022/23	11.8	10.2	10.4	Percentage points	–	→
B08a - The percentage of the population with a physical or mental long term health condition in employment (aged 16 to 64)	16-64 yrs	Persons	2022/23	57.9	65.6	65.3	%	–	→
B08b - Gap in the employment rate between those who are in receipt of long term support for a learning disability (aged 18 to 64) and the overall employment rate	18-64 yrs	Persons	2022/23	65.6	70.5	70.9	Percentage points	–	→
B08b - The percentage of the population who are in receipt of long term support for a learning disability that are in paid employment (aged 18 to 64)	18-64 yrs	Persons	2022/23	4.1	5.3	4.8	%	→	→
B08c - Gap in the employment rate for those who are in contact with secondary mental health services (aged 18 to 69) and on the Care Plan Approach, and the overall employment rate	18-69 yrs	Persons	2020/21	71.9	68.5	66.1	Percentage points	–	→
B08c - The percentage of the population who are in contact with secondary mental health services and on the Care Plan Approach, that are in paid employment (aged 18 to 69)	18-69 yrs	Persons	2020/21	5.0	6.0	9.0	%	–	→
B08d - Percentage of people in employment	16-64 yrs	Persons	2023/24	72.7	74.5	75.7	%	→	→

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
B09a - Sickness absence: the percentage of employees who had at least one day off in the previous week	16+ yrs	Persons	2021 - 23	1.5	2.4	2.2	%	–	→
B09b - Sickness absence: the percentage of working days lost due to sickness absence	16+ yrs	Persons	2021 - 23	1.0	1.1	1.2	%	–	→
B10 - Killed and seriously injured (KSI) casualties on England's roads	All ages	Persons	2023	74.5	187.5 $	91.9 $	per billion vehicle miles	→	→
B11 - Domestic abuse related incidents and crimes	16+ yrs	Persons	2023/24	22.3 @	22.3	27.1	per 1,000	–	–
B12a - Violent crime - hospital admissions for violence (including sexual violence)	All ages	Persons	2021/22 - 23/24	37.0 ~	34.8	34.2	per 100,000	–	→
B12b - Violent crime - violence offences per 1,000 population	All ages	Persons	2023/24	26.7	28.5 [e]	32.7	per 1,000	↑	→
B12c - Violent crime - sexual offences per 1,000 population	All ages	Persons	2023/24	1.7	2.4 [e]	2.9	per 1,000	↑	↓
B13a - Reoffending levels: percentage of offenders who reoffend	All ages	Persons	2022/23	20.4	22.0	26.2	%	→	–
B13b - Reoffending levels: average number of reoffences per reoffender	All ages	Persons	2022/23	3.43	3.43	4.04	per re-offender	→	–
B13c - First time offenders	10+ yrs	Persons	2022	194	180	166	per 100,000	↓	→
B14a - The rate of complaints about noise	All ages	Persons	2023/24	5.0 $	14.9 $	5.9 $	per 1,000	→	↓
B14b - The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	All ages	Persons	2021	5.4 $	11.3 $	4.3 $	%	–	–
B14c - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time	All ages	Persons	2021	9.5 $	18.1 $	8.4 $	%	–	–
B15a - Homelessness: households owed a duty under the Homelessness Reduction Act	Not applicable	Not applicable	2023/24	25.3	17.9	13.4	per 1,000	↑	↑
B15c - Homelessness: households in temporary accommodation	Not applicable	Not applicable	2023/24	10.3	17.2	4.6	per 1,000	↑	↑
B16 - Utilisation of outdoor space for exercise or health reasons	16+ yrs	Persons	Mar 2015 - Feb 2016	14.9 ^	18.0	17.9	%	–	→
B17 - Fuel poverty (low income, low energy efficiency methodology)	Not applicable	Not applicable	2022	9.1	10.4	13.1	%	–	–
B18a - Social Isolation: percentage of adult social care users who have as much social contact as they would like	18+ yrs	Persons	2023/24	45.0	40.7	45.6	%	→	→
B18b - Social Isolation: percentage of adult carers who have as much social contact as they would like	18+ yrs	Persons	2023/24	21.2	29.8	30.0	%	–	→
B19 - Loneliness: Percentage of adults who feel lonely often or always	16+ yrs	Persons	2021/22 - 22/23	8.6	7.0	6.8	%	–	→
1.01i - Children in low income families (all dependent children under 20)	0-19 yrs	Persons	2016	16.3	19.3	17.0	%	↓	↑

C. Health improvement

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
C01 - Total prescribed LARC excluding injections rate / 1,000	All ages	Female	2023	23.8	33.6	43.5	per 1,000	→	↓
C02a - Under 18s conception rate / 1,000	<18 yrs	Female	2021	6.9	9.5	13.1	per 1,000	↓	→
C02b - Under 16s conception rate / 1,000	<16 yrs	Female	2021	1.1	1.5	2.1	per 1,000	→	→
C03a - Obesity in early pregnancy (previous method)	All ages	Female	2018/19	19.8	17.8	22.1	%	-	-
C03a - Obesity in early pregnancy	All ages	Female	2023/24	- [d]	20.9	26.2	%	-	-
C03c - Smoking in early pregnancy (previous method)	All ages	Female	2018/19	6.9	6.0	12.8	%	-	-
C03c - Smoking in early pregnancy	All ages	Female	2023/24	- [d]	12.7	13.6	%	-	-
C04 - Low birth weight of term babies	=37 weeks gestational age at birth	Persons	2022	3.5	3.4	2.9	%	→	→
C05a - Baby's first feed breastmilk	Newborn	Persons	2023/24	81.9	84.3	71.9	%	-	↑
C05b - Breastfeeding prevalence at 6 to 8 weeks - current method	6-8 weeks	Persons	2023/24	- x	- [f]	52.7 [f]	%	-	-
C06 - Smoking status at time of delivery	All ages	Female	2023/24	2.8	3.9	7.4	%	↓	→
C07 - Proportion of New Birth Visits (NBVs) completed within 14 days	<14 days	Persons	2023/24	- x	84.2 [f]	83.0 [f]	%	↓	-
C08a - Child development: percentage of children achieving a good level of development at 2 to 2 and a half years	2-2.5 yrs	Persons	2023/24	- [c]	74.7 [g]	80.4 [f]	%	-	-
C08b - Child development: percentage of children achieving the expected level in communication skills at 2 to 2 and a half years	2-2.5 yrs	Persons	2023/24	- [c]	81.0 [g]	86.6 [f]	%	-	-
C08c - Child development: percentage of children achieving the expected level in personal social skills at 2 to 2 and a half years	2-2.5 yrs	Persons	2023/24	- [c]	90.8 [g]	91.2 [f]	%	-	-
C09a - Reception prevalence of overweight (including obesity)	4-5 yrs	Persons	2023/24	18.7	20.9	22.1	%	→	→
C09b - Year 6 prevalence of overweight (including obesity)	10-11 yrs	Persons	2023/24	37.5	37.8	35.8	%	→	→
C10 - Percentage of physically active children and young people	5-16 yrs	Persons	2023/24	43.5	47.3	47.8	%	-	→
C11a - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 14 years)	<15 yrs	Persons	2023/24	71.8	59.1	72.7	per 10,000	→	→
C11a - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 4 years)	0-4 yrs	Persons	2023/24	84.1	75.7	93.2	per 10,000	→	→
C11b - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15 to 24 years)	15-24 yrs	Persons	2023/24	70.0	62.5	88.6	per 10,000	→	→
C12 - Percentage of looked after children whose emotional wellbeing is a cause for concern	5-16 yrs	Persons	2023/24	42.0	36.0	41.0	%	→	→
C14b - Emergency Hospital Admissions for Intentional Self-Harm	All ages	Persons	2023/24	61.4	51.7	117.0	per 100,000	↓	→
C15 - Percentage of adults meeting the '5-a-day' fruit and vegetable consumption recommendations (new method)	16+ yrs	Persons	2023/24	25.8	29.7	31.3	%	-	→
C15 - Proportion of the population meeting the recommended '5 a day' on a 'usual day' (adults) (old method)	16+ yrs	Persons	2019/20	49.3	55.8	55.4	%	-	→
C16 - Overweight (including obesity) prevalence in adults, (using adjusted self-reported height and weight)	18+ yrs	Persons	2023/24	63.0	57.8	64.5	%	-	→
C17a - Percentage of physically active adults	19+ yrs	Persons	2023/24	56.2	66.7	67.4	%	-	→
C17b - Percentage of physically inactive adults	19+ yrs	Persons	2023/24	30.9	22.7	22.0	%	-	→
C18 - Smoking Prevalence in adults (aged 18 and over) - current smokers (APS)	18+ yrs	Persons	2023	11.8	11.7	11.6	%	-	→
C19a - Successful completion of drug treatment: opiate users	18+ yrs	Persons	2023	7.7	5.2	5.1	%	→	→
C19b - Successful completion of drug treatment: non opiate users	18+ yrs	Persons	2023	28.2	28.0	29.5	%	→	→

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
C19c - Successful completion of alcohol treatment	18+ yrs	Persons	2023	37.8	33.7	34.2	%	→	↑
C19d - Deaths from drug misuse	All ages	Persons	2021 - 23	4.5	3.8	5.5	per 100,000	–	→
C20 - Adults with substance misuse treatment need who successfully engage in community based structured treatment following release from prison	18+ yrs	Persons	2023/24	36.1	40.5	53.3	%	↑	→
C21 - Admission episodes for alcohol-related conditions (Narrow)	All ages	Persons	2023/24	525	403	504	per 100,000	↑	→
C21 - Admission episodes for alcohol-related conditions (Narrow)	All ages	Male	2023/24	708	593	686	per 100,000	↑	→
C21 - Admission episodes for alcohol-related conditions (Narrow)	All ages	Female	2023/24	358	238	340	per 100,000	→	→
C22 - Estimated diabetes diagnosis rate	17+ yrs	Persons	2018	82.6	71.4	78.0	%	–	→
C23 - Percentage of cancers diagnosed at stages 1 and 2	All ages	Persons	2021	55.0	- [d]	54.4	%	→	→
C24a - Cancer screening coverage: breast cancer	53-70 yrs	Female	2024	64.2	61.5 [e]	69.9 [e]	%	→	↑
C24b - Cancer screening coverage: cervical cancer (aged 25 to 49 years old)	25-49 yrs	Female	2024	61.1	58.4 [e]	66.1 [e]	%	↓	→
C24c - Cancer screening coverage: cervical cancer (aged 50 to 64 years old)	50-64 yrs	Female	2024	73.3	70.7 [e]	74.3 [e]	%	↓	→
C24d - Cancer screening coverage: bowel cancer	60-74 yrs	Persons	2024	64.9	63.8 [e]	71.8 [e]	%	↑	→
C24e - Abdominal Aortic Aneurysm Screening Coverage	65	Male	2023/24	83.3	75.1 [e]	81.9 [e]	%	↑	→
C24m - Newborn Hearing Screening: Coverage	<1 yr	Persons	2023/24	99.6	98.8 [e]	99.0 [e]	%	↑	→
C24n - Newborn and Infant Physical Examination Screening Coverage	<1 yr	Persons	2023/24	95.6	95.3 [e]	96.1 [e]	%	–	↓
C26a - Cumulative percentage of the eligible population aged 40 to 74 offered an NHS Health Check	40-74 yrs	Persons	2019/20 - 23/24	72.9	84.4	69.1	%	–	↑
C26b - Cumulative percentage of the eligible population aged 40 to 74 offered an NHS Health Check who received an NHS Health Check	40-74 yrs	Persons	2019/20 - 23/24	45.7	44.9	40.6	%	–	↓
C26c - Cumulative percentage of the eligible population aged 40 to 74 who received an NHS Health check	40-74 yrs	Persons	2019/20 - 23/24	33.3	37.9	28.1	%	–	↑
C27 - Percentage reporting a long-term Musculoskeletal (MSK) problem	16+ yrs	Persons	2023	14.3	13.4	18.4	%	–	→
C28a - Self reported wellbeing: people with a low satisfaction score	16+ yrs	Persons	2022/23	6.1	5.8	5.6	%	–	→
C28b - Self reported wellbeing: people with a low worthwhile score	16+ yrs	Persons	2022/23	- &	4.5	4.4	%	–	–
C28c - Self reported wellbeing: people with a low happiness score	16+ yrs	Persons	2022/23	7.3	9.1	8.9	%	–	→
C28d - Self reported wellbeing: people with a high anxiety score	16+ yrs	Persons	2022/23	24.1	23.7	23.3	%	–	→
C29 - Emergency hospital admissions due to falls in people aged 65 and over	65+ yrs	Persons	2023/24	2107	2061	1984	per 100,000	→	→
C29 - Emergency hospital admissions due to falls in people aged 65 to 79	65-79 yrs	Persons	2023/24	1067	1051	955	per 100,000	→	→
C29 - Emergency hospital admissions due to falls in people aged 80 plus	80+ yrs	Persons	2023/24	5124	4990	4969	per 100,000	→	→

D. Health protection

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
D01 - Fraction of mortality attributable to particulate air pollution (new method)	30+ yrs	Persons	2023	5.8	6.2	5.2	%	–	–
D02a - Chlamydia detection rate per 100,000 aged 15 to 24	15-24 yrs	Female	2023	1277 *	2028 *	1962 *	per 100,000	–	→
D02a - Chlamydia detection rate per 100,000 aged 15 to 24	15-24 yrs	Male	2023	763	1397	1042	per 100,000	–	→
D02a - Chlamydia detection rate per 100,000 aged 15 to 24	15-24 yrs	Persons	2023	1008	1739	1546	per 100,000	–	→
D02b - New STI diagnoses (excluding chlamydia aged under 25) per 100,000	All ages	Persons	2023	497	1229	520	per 100,000	→	↑
D03a - Population vaccination coverage BCG: areas offering universal BCG only	1 yr	Persons	2021/22	- [a]	- x	- x	%	–	–
D03b - Population vaccination coverage: Hepatitis B (1 year old)	1 yr	Persons	2023/24	93.8	- [c]	- [c]	%	–	→
D03c - Population vaccination coverage: Dtap IPV Hib HepB (1 year old)	1 yr	Persons	2023/24	90.6 *	86.2 *	91.2 *	%	→	→
D03d - Population vaccination coverage: MenB (1 year)	1 yr	Persons	2023/24	91.1 *	85.5 *	90.6 *	%	→	→
D03e - Population vaccination coverage: Rotavirus (Rota) (1 year)	1 yr	Persons	2023/24	89.5 *	83.6 *	88.5 *	%	→	→
D03f - Population vaccination coverage: PCV	1 yr	Persons	2023/24	94.4 *	88.8 *	93.2 *	%	↑	→
D03g - Population vaccination coverage: Hepatitis B (2 years old)	2 yrs	Persons	2023/24	95.0	- [c]	- [c]	%	–	→
D03h - Population vaccination coverage: Dtap IPV Hib HepB (2 years old)	2 yrs	Persons	2023/24	89.0 *	87.7 *	92.4 *	%	↓	→
D03i - Population vaccination coverage: MenB booster (2 years)	2 yrs	Persons	2023/24	83.9 *	79.3 *	87.3 *	%	→	→
D03j - Population vaccination coverage: MMR for one dose (2 years old)	2 yrs	Persons	2023/24	87.3 *	81.8 *	88.9 *	%	→	→
D03k - Population vaccination coverage: PCV booster	2 yrs	Persons	2023/24	84.6 *	80.4 *	88.2 *	%	→	→
D03l - Population vaccination coverage: Flu (2 to 3 years old)	2-3 yrs	Persons	2023/24	39.8 *	37.2 [e] *	44.4 *	%	→	→
D03m - Population vaccination coverage: Hib and MenC booster (2 years old)	2 yrs	Persons	2023/24	87.6 *	81.2 *	88.6 *	%	↑	→
D04a - Population vaccination coverage: DTaP and IPV booster (5 years)	5 yrs	Persons	2023/24	82.0 *	72.8 *	82.7 *	%	↑	→
D04b - Population vaccination coverage: MMR for one dose (5 years old)	5 yrs	Persons	2023/24	88.9 *	85.2 *	91.9 *	%	→	→
D04c - Population vaccination coverage: MMR for two doses (5 years old)	5 yrs	Persons	2023/24	81.0 *	73.3 *	83.9 *	%	→	→
D04d - Population vaccination coverage: Flu (primary school aged children)	4-11 yrs	Persons	2023	36.7 *	45.8 [e] *	55.1 *	%	↓	↑
D04e - Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old)	12-13 yrs	Female	2023/24	39.6 *	61.6 *	72.9 *	%	→	↑
D04e - Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old)	12-13 yrs	Male	2023/24	39.1 *	57.0 *	67.7 *	%	→	↑
D04f - Population vaccination coverage: HPV vaccination coverage for two doses (13 to 14 years old)	13-14 yrs	Female	2022/23	45.2 *	52.9 *	62.9 *	%	↓	↓
D04f - Population vaccination coverage: HPV vaccination coverage for two doses (13 to 14 years old)	13-14 yrs	Male	2022/23	34.5 *	45.7 *	56.1 *	%	–	↓
D04g - Population vaccination coverage: Meningococcal ACWY conjugate vaccine (MenACWY) (14 to 15 years)	14-15 yrs	Persons	2023/24	35.3 *	64.1 *	73.0 *	%	↓	↓

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
D05 - Population vaccination coverage: Flu (at risk individuals)	6 months-64 yrs	Persons	2023/24	38.3 *	34.7 [e] *	41.4 *	%	↓	↓
D06a - Population vaccination coverage: Flu (aged 65 and over)	65+ yrs	Persons	2023/24	71.6 *	65.9 [e] *	77.8 *	%	→	↓
D06b - Population vaccination coverage: PPV	65+ yrs	Persons	2022/23	72.3 *	67.2 *	71.8 *	%	↑	→
D06c - Population vaccination coverage: Shingles vaccination coverage (71 years)	71	Persons	2022/23	43.6 *	40.8 *	48.3 *	%	↓	↓
D07 - HIV late diagnosis in people first diagnosed with HIV in the UK	15+ yrs	Persons	2021 - 23	48.8 *	41.1 *	43.5 *	%	-	→
D08a - Proportion of drug sensitive TB notifications who had completed a full course of treatment by 12 months	All ages	Persons	2022	78.9	83.2	82.8	%	→	→
D08b - TB incidence (three year average)	All ages	Persons	2021 - 23	21.9	18.1	8.0	per 100,000	-	→
D09 - NHS organisations with a board approved sustainable development management plan	Not applicable	Not applicable	2015/16	50.0	70.1	66.2	%	→	→
D10 - Adjusted antibiotic prescribing in primary care by the NHS	All ages	Persons	2023	0.85 *	0.68 *	0.88 *	per STAR-PU	-	↑

E. Healthcare and premature mortality

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
E01 - Infant mortality rate	<1 yr	Persons	2021 - 23	4.0	3.5	4.1	per 1,000	-	→
E02 - Percentage of 5 year olds with experience of visually obvious dental decay	5 yrs	Persons	2023/24	32.9	27.4	22.4	%	-	→
E03 - Under 75 mortality rate from causes considered preventable	<75 yrs	Persons	2023	132.0	129.0	153.0	per 100,000	-	→
E03 - Under 75 mortality rate from causes considered preventable	<75 yrs	Persons	2021 - 23	153.4	149.9	163.7	per 100,000	-	→
E04a - Under 75 mortality rate from cardiovascular disease	<75 yrs	Persons	2023	72.3	74.2	77.4	per 100,000	-	→
E04a - Under 75 mortality rate from cardiovascular disease	<75 yrs	Persons	2021 - 23	74.0	74.5	77.1	per 100,000	-	→
E04b - Under 75 mortality rate from cardiovascular disease considered preventable	<75 yrs	Persons	2021 - 23	30.2	29.9	30.5	per 100,000	-	→
E05a - Under 75 mortality rate from cancer	<75 yrs	Persons	2023	105.4	109.2	120.8	per 100,000	-	→
E05a - Under 75 mortality rate from cancer	<75 yrs	Persons	2021 - 23	116.2	109.5	121.6	per 100,000	-	→
E05b - Under 75 mortality rate from cancer considered preventable	<75 yrs	Persons	2021 - 23	42.2	42.6	49.5	per 100,000	-	→
E06a - Under 75 mortality rate from liver disease	<75 yrs	Persons	2023	23.1	18.7	21.9	per 100,000	-	→
E06a - Under 75 mortality rate from liver disease	<75 yrs	Persons	2021 - 23	24.4	18.5	21.5	per 100,000	-	→
E06b - Under 75 mortality rate from liver disease considered preventable	<75 yrs	Persons	2021 - 23	21.6	16.7	19.2	per 100,000	-	→
E07a - Under 75 mortality rate from respiratory disease	<75 yrs	Persons	2023	30.1	27.9	33.7	per 100,000	-	→
E07a - Under 75 mortality rate from respiratory disease	<75 yrs	Persons	2021 - 23	26.2	25.5	30.3	per 100,000	-	→
E07b - Under 75 mortality rate from respiratory disease considered preventable	<75 yrs	Persons	2021 - 23	13.5	14.5	18.0	per 100,000	-	→
E08 - Mortality rate from a range of specified communicable diseases, including influenza	All ages	Persons	2021 - 23	11.6	12.6	13.0	per 100,000	-	→
E09a - Premature mortality in adults with severe mental illness (SMI)	18-74 yrs	Persons	2021 - 23	139.8	106.6	110.8	per 100,000	-	→
E09b - Excess under 75 mortality rate in adults with severe mental illness (SMI)	18-74 yrs	Persons	2021 - 23	496.0	359.6	383.7	%	-	→
E10 - Suicide rate	10+ yrs	Persons	2021 - 23	9.5	7.0	10.7	per 100,000	-	→
E11 - Emergency readmissions within 30 days of discharge from hospital	All ages	Persons	2023/24	13.1	14.8	14.8	%	-	↑
E12a - Preventable sight loss: age related macular degeneration (AMD)	65+ yrs	Persons	2023/24	105.8	82.4 [e]	105.1	per 100,000	→	→
E12b - Preventable sight loss: glaucoma	40+ yrs	Persons	2023/24	18.9	18.6 [e]	14.3	per 100,000	→	→
E12c - Preventable sight loss: diabetic eye disease	12+ yrs	Persons	2023/24	2.2	3.5 [e]	3.0	per 100,000	→	→
E12d - Preventable sight loss: sight loss certifications	All ages	Persons	2023/24	39.2	36.1 [e]	43.5	per 100,000	→	→
E13 - Hip fractures in people aged 65 and over	65+ yrs	Persons	2023/24	474.0	474.8	547	per 100,000	→	→
E13 - Hip fractures in people aged 65 to 79	65-79 yrs	Persons	2023/24	160.2	210.9	237.8	per 100,000	→	→
E13 - Hip fractures in people aged 80 and over	80+ yrs	Persons	2023/24	1384	1240	1444	per 100,000	→	→
E14 - Winter mortality index	All ages	Persons	Aug 2021 - Jul 2022	12.3	10.3	8.1	%	-	↓
E14 - Winter mortality index (age 85 plus)	85+ yrs	Persons	Aug 2021 - Jul 2022	9.5	14.0	11.3	%	-	↓
E15 - Estimated dementia diagnosis rate (aged 65 and older)	65+ yrs	Persons	2024	66.5 *	67.0 *	64.8 *	per 100	→	→

Accompanying indicator value notes

symbols	Data note
*	Value compared to a goal (see below)
~	Should be treated with caution due to Frimley Health Foundation Trust not submitting any HES data for June 2022 to March 2023. In 2021/22, between 1% and 10% of hospital patients from this area were treated at Frimley Health Foundation Trust
$	Value is modelled or synthetic estimate
^	Value based on effective sample size <100
&	Value suppressed for disclosure control due to small count
x	Value suppressed due to incompleteness of source data
@	LAs are allocated the rate of the police force area within which they sit
[a]	Value not available as there is no universal TB programme in this area
[b]	Value based on provisional population data
[c]	Value missing in source data
[d]	Value not published for data quality reasons
[e]	Aggregated from all known lower geography values
[f]	Annual figure includes constituent area(s) with annual figure scaled up data from three quarters' data
[g]	Interpret this figure with caution as it is based on low coverage - see caveats in Data view > Definitions for details

Thresholds for indicators that are compared against a goal

Indicator Name	Green	Amber	Red
D02a - Chlamydia detection rate per 100,000 aged 15 to 24	>=3250	2400-3250	<2400
D03c - Population vaccination coverage: Dtap IPV Hib HepB (1 year old)	>= 95%	90-95%	< 90%
D03d - Population vaccination coverage: MenB (1 year)	>= 95%	90-95%	< 90%
D03e - Population vaccination coverage: Rotavirus (Rota) (1 year)	>= 95%	90-95%	< 90%
D03f - Population vaccination coverage: PCV	>= 95%	90-95%	< 90%
D03h - Population vaccination coverage: Dtap IPV Hib HepB (2 years old)	>= 95%	90-95%	< 90%
D03i - Population vaccination coverage: MenB booster (2 years)	>= 95%	90-95%	< 90%
D03j - Population vaccination coverage: MMR for one dose (2 years old)	>= 95%	90-95%	< 90%
D03k - Population vaccination coverage: PCV booster	>= 95%	90-95%	< 90%
D03l - Population vaccination coverage: Flu (2 to 3 years old)	>= 65%	40-65%	< 40%
D03m - Population vaccination coverage: Hib and MenC booster (2 years old)	>= 95%	90-95%	< 90%
D04a - Population vaccination coverage: DTaP and IPV booster (5 years)	>= 95%	90-95%	< 90%
D04b - Population vaccination coverage: MMR for one dose (5 years old)	>= 95%	90-95%	< 90%
D04c - Population vaccination coverage: MMR for two doses (5 years old)	>= 95%	90-95%	< 90%
D04d - Population vaccination coverage: Flu (primary school aged children)	>= 65%		<65%
D04e - Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old)	>= 90%	80-90%	< 80%
D04f - Population vaccination coverage: HPV vaccination coverage for two doses (13 to 14 years old)	>= 90%	80-90%	< 80%
D04g - Population vaccination coverage: Meningococcal ACWY conjugate vaccine (MenACWY) (14 to 15 years)	>= 90%	80-90%	< 80%
D05 - Population vaccination coverage: Flu (at risk individuals)	>= 55%		< 55%
D06a - Population vaccination coverage: Flu (aged 65 and over)	>= 75%		< 75%

Indicator Name	Green	Amber	Red
D06b - Population vaccination coverage: PPV	>= 75%	65-75%	< 65%
D06c - Population vaccination coverage: Shingles vaccination coverage (71 years)	>= 60%	50-60%	< 50%
D07 - HIV late diagnosis in people first diagnosed with HIV in the UK	< 25%	25-50%	>= 50%
D10 - Adjusted antibiotic prescribing in primary care by the NHS	<= mean England prescribing (2013/14)		> mean England prescribing (2013/14)
E15 - Estimated dementia diagnosis rate (aged 65 and older)	>= 66.7% (significantly)	Similar to 66.7%	< 66.7% (significantly)

BUDGET SETTING REPORT - SELECT COMMITTEE MONITORING

Committee name	Health and Social Care Select Committee
Corporate Director(s) responsible	Sandra Taylor, Corporate Director Adult Services and Health
Papers with report	n/a
Ward	All

RECOMMENDATIONS

That the Health and Social Care Select Committee:

1. **notes the draft revenue budget and Medium-Term Financial Strategy proposals for 2026/27 to 2030/31 relating to services within the Committee's remit.**
2. **considers and comments on the financial assumptions, savings proposals, growth pressures, service impacts and delivery risks within those proposals.**
3. **agrees specific feedback and recommendations to be submitted to Cabinet for consideration as part of the final budget proposals to be presented to Council in February 2026.**

HEADLINES

1. The Council published the Medium-Term Financial Strategy 2026/27 to 2030/31 on Tuesday 23rd December as part of the Cabinet agenda for that evening. This report sets out the growth and saving proposals within the remit of this committee from that report and should be read in conjunction with the Medium-Term Financial Strategy 2026/27 to 2030/31 cabinet paper.

Overview

2. Services within the remit of this committee are proposed to see a net budget change for 2026/27 of £14.7mm, rising to £39.6m by 2028/29, driven by savings proposals in 2026/27 of £3.3m and growth proposals of £17.9m. Whilst the revenue budget proposals are set out in the context of a three-year budget strategy, the Council's legal requirement is to set a balanced budget for 2026/27.

3. The below table sets out the overview of savings and growth proposals by directorate for the services within the remit of this committee.

Table 1: Budget Proposal Overview

Health & Social Care Select Committee Overview	2026/27 Annual Change *(£,000's)*	2027/28 Annual Change *(£,000's)*	2028/29 Annual Change *(£,000's)*	2026/27 Cumulative Change *(£,000's)*	2027/28 Cumulative Change *(£,000's)*	2028/29 Cumulative Change *(£,000's)*
Savings	(3,265)	(12)	(83)	(3,265)	(3,277)	(3,360)
Growth	17,947	10,725	14,307	17,947	28,672	42,979
Health & Social Care Select Committee Total	**14,682**	**10,713**	**14,224**	**14,682**	**25,395**	**39,619**

Savings Proposals

4. The below table sets out the line-by-line savings proposals for the services within the remit of this committee as set out in the above overview position.

Table 2: Savings Proposals

Health & Social Care Select Committee Savings	2026/27 Annual Change (£,000's)	2027/28 Annual Change (£,000's)	2028/29 Annual Change (£,000's)	2026/27 Cumulative Change (£,000's)	2027/28 Cumulative Change (£,000's)	2028/29 Cumulative Change (£,000's)
Telecare Review	(400)	-	-	(400)	(400)	(400)
Post 16 Policy change to offer Personal Transport Budgets	(387)	-	-	(387)	(387)	(387)
Creation of a SPV for Direct Care services	(736)	-	-	(736)	(736)	(736)
Passenger Assistant supplier switch (Pertemps to Operator)	(227)	(76)	(25)	(227)	(303)	(328)
Supported Living De-Commissioning	(253)	(84)	-	(253)	(337)	(337)
SEND Transport Demand 2026/27 to 2030/31	(1,262)	148	(58)	(1,262)	(1,114)	(1,172)
Direct Care & Business Delivery Total	**(3,265)**	**(12)**	**(83)**	**(3,265)**	**(3,277)**	**(3,360)**
Health and Social Care Select Committee Total	**(3,265)**	**(12)**	**(83)**	**(3,265)**	**(3,277)**	**(3,360)**

Growth Proposals

5. The below table sets out the line-by-line growth proposals for the services within the remit of this committee as set out in the above overview position.

Table 3: Growth Proposals

Health & Social Care Select Committee Growth	2026/27 Annual Change (£,000's)	2027/28 Annual Change (£,000's)	2028/29 Annual Change (£,000's)	2026/27 Cumulative Change (£,000's)	2027/28 Cumulative Change (£,000's)	2028/29 Cumulative Change (£,000's)
ASC Placements Demand 2026/27 - 2030/31	3,600	4,700	5,800	3,600	8,300	14,100
ASC Placements Inflation 2026/27 - 2030/31	6,900	7,100	8,300	6,900	14,000	22,300
ASC Placements Rebasing for 2025/26 Pressure	4,400	-	-	4,400	4,400	4,400
Placements Fee Renegotiation	1,739	-	-	1,739	1,739	1,739
ASC Placements Total	**16,639**	**11,800**	**14,100**	**16,639**	**28,439**	**42,539**
SEND Transport Inflation 2026/27 to 2030/31	127	25	207	127	152	359
Legal Costs for the development of the Lobster Pot Site for Care Provision	100	(100)	-	100	-	-
Direct Care & Business Delivery Total	**227**	**(75)**	**207**	**227**	**152**	**359**
Section 117 Funding split with ICB	1,081	(1,000)	-	1,081	81	81
Immediate Response Total	**1,081**	**(1,000)**	**-**	**1,081**	**81**	**81**
Health and Social Care Select Committee Total	**17,947**	**10,725**	**14,307**	**17,947**	**28,672**	**42,979**

Fees & Charges

6. For 2026/27, the Council has proposed to increase all discretionary Fees & Charges by 10% where appropriate and where the Council anticipates this will generate an overall benefit for the Council, taking into account possible elasticity of demand implications. Where fees and charges have been increased outside of this approach, the financial impact has been included

as a standalone saving proposal.

7. The saving generated from this approach for the services within this committee are set out in the table below, with the full details of the charges being levied included in Appendix F of the December Cabinet report.

Table 4: Fees & Charges Savings

Directorate	Service	Charge	2026/27 Forecast Income	2026/27 Saving
Adult Social Care & Health	Direct Care Provision	Mortuary	0	10
Total			0	10

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BUDGET & SPENDING REPORT – SELECT COMMITTEE MONITORING

Committee name	Health and Social Care Select Committee
Corporate Director(s) responsible	Sandra Taylor Corporate Director Adult Social Care & Health
Papers with report	None
Ward	All

RECOMMENDATION

That the Health and Social Care Select Committee notes the 2025/26 Month 7 budget monitoring position.

HEADLINES

This report provides an update on the 2025/26 Month 7 budget monitoring position relevant to the Select Committee. The Corporate Director, supported by their Finance Business Partners, will attend the meeting to provide further details and clarifications.

2025/26 MONTH 7 BUDGET MONITORING POSITION

At Month 7 service operating budgets within the Committee's remit are forecasting a net overspend of £4.7m against budget. This is a favourable movement of £0.2m from the restated Month 6 position.

The forecast overspend of £4.7m, is the result of adult social care placements forecasting a pressure of £7.2m offset by a £1.6m underspend against SEND Transport and further mitigations of £0.9m through reductions in staff forecasts and holding vacant posts. This position is driven by the ongoing and unrelenting growth in demand for the service since the pandemic, with all client groups reporting ongoing exceptional demand in 2025/26. To date, client numbers continue to grow above the budgeted position, particularly in Learning Disabilities and Mental Health services. The underspend in SEND Transport is driven by a more economical procurement of personal assistants and maximising efficiencies through the mix of delivery options. The movement against the prior month's forecast is primarily driven by improvements within the SEND Transport forecast.

Table 1 provides an overview of the Committee's Month 7 budget monitoring position. It includes adjustments for Earmarked Reserves, Provisions and Transformation Capitalisation.

Table 2 provides a detailed breakdown of the Committee's outturn by service area.

2025/26 SAVINGS

For the services within the remit of this Committee, the savings requirement for 2025/26 is £8.3m.

At Month 7, £3.8mm (46%) of the savings and interventions are being recorded as banked or on track for delivery, with a further £0.7m (9%) being at initial stages of delivery. £3.8m (45%) of the

savings are reported at risk in 2025/26, including £1.7m expected to slip into 2026/27.

Table 3 provides a detailed breakdown of the 2025/26 Month 7 savings position.

PERFORMANCE DATA

N/A

RESIDENT BENEFIT

Regular monitoring of financial performance ensures that spending and savings targets are met, which supports the efficient delivery of services to residents. By closely tracking expenditure and identifying variances, the council can take timely corrective actions to address overspending and mitigate risks. This also enhances public transparency and accountability, providing residents with confidence that their Council is managing finances prudently and prioritising their needs. Overall, regular monitoring supports safeguarding the Council's finances and the delivery of quality services to residents.

FINANCIAL IMPLICATIONS

This is primarily a finance report, and the implications are set out in the main body of the report above.

LEGAL IMPLICATIONS

There are no direct legal implications arising from regular monitoring of the council's finances by select committees.

Democratic Services advise that effective overview and scrutiny arrangements require access to the information under the committee's purview and, in accordance with the 2024 Statutory Scrutiny Guidance, such information includes finance and risk information from the Council, and its partners where relevant.

BACKGROUND PAPERS

NIL

APPENDICES

Appendix A – Tables 1-3

Appendix A – Tables 1-3

Table 1: 2025/26 Month 7 Budget Monitoring

		Approved Budget	Underlying Forecast	Earmarked Reserves	Provisions	Transformation Capitalisation	Forecast Outturn	Final Forecast Variance	Forecast Variance Month 6	Change in Variance
R3: Executive Director Adult Services and Health	A1: Staffing Costs	24,650	22,649	0	0	(80)	22,569	(2,080)	(1,627)	(453)
	A2: NonStaffing Costs	160,529	169,279	0	0	0	169,279	8,749	8,737	12
	A3: Grants Fees & Other Income	(84,287)	(84,952)	(1,253)	0	0	(86,205)	(1,920)	(2,141)	221
	Total Service Operating Budgets	100,892	106,976	(1,253)	0	(80)	105,643	4,749	4,969	(220)

Table 2: 2025/26 Month 7 Budget Monitoring by Service Area

		Approved Budget	Underlying Forecast	Earmarked Reserves	Provisions	Transformation Capitalisation	Forecast Outturn	Final Forecast Variance	Forecast Variance Month 6	Change in Variance
R31: OT Minor Adaptations and Community Equipment	A1: Staffing Costs	0	224	0	0	0	224	224	0	224
	A2: NonStaffing Costs	474	451	0	0	0	451	(23)	(23)	0
	A3: Grants Fees & Other Income	(332)	(286)	0	0	0	(286)	45	(79)	124
	Sub-Total	**142**	**389**	**0**	**0**	**0**	**389**	**246**	**(102)**	**348**
R32: Head of Direct Care Provision HSC	A1: Staffing Costs	7,980	7,527	0	0	0	7,527	(453)	(407)	(46)
	A2: NonStaffing Costs	1,517	1,681	0	0	0	1,681	163	111	52
	A3: Grants Fees & Other Income	(625)	(732)	0	0	0	(732)	(107)	(90)	(17)
	Sub-Total	**8,872**	**8,476**	**0**	**0**	**0**	**8,476**	**(397)**	**(386)**	**(11)**
R33: Head of Child & Family Development CFE	A1: Staffing Costs	138	607	0	0	0	607	469	477	(8)
	A2: NonStaffing Costs	5,018	5,329	0	0	0	5,329	311	328	(17)
	A3: Grants Fees & Other Income	(93)	(430)	(600)	0	0	(1,030)	(937)	(999)	62
	Sub-Total	**5,063**	**5,506**	**(600)**	**0**	**0**	**4,906**	**(157)**	**(194)**	**37**
R34: Head of Learning Disability and Mental Health Services	A1: Staffing Costs	0	35	0	0	0	35	35	37	(2)
	A2: NonStaffing Costs	336	452	0	0	0	452	116	108	8
	A3: Grants Fees & Other Income	0	0	0	0	0	-	0	0	0
	Sub-Total	**336**	**487**	**0**	**0**	**0**	**487**	**151**	**145**	**6**
R35: Head of Hospital and Localities Services	A1: Staffing Costs	325	0	0	0	0	-	(325)	(179)	(146)
	A2: NonStaffing Costs	860	935	0	0	0	935	75	75	0
	A3: Grants Fees & Other Income	0	(47)	0	0	0	(47)	(47)	0	(47)
	Sub-Total	**1,185**	**888**	**0**	**0**	**0**	**888**	**(297)**	**(104)**	**(193)**
R36: Director of Health and Public Health	A1: Staffing Costs	709	869	0	0	0	869	160	196	(36)
	A2: NonStaffing Costs	10,289	10,739	0	0	0	10,739	450	366	84
	A3: Grants Fees & Other Income	(22,437)	(22,394)	(653)	0	0	(23,047)	(610)	(562)	(48)
	Sub-Total	**(11,439)**	**(10,786)**	**(653)**	**0**	**0**	**(11,439)**	**0**	**0**	**0**
R37: Director Adult Services and Health	A1: Staffing Costs	41	140	0	0	(80)	60	20	31	(11)
	A2: NonStaffing Costs	1,129	1,624	0	0	0	1,624	494	495	(1)
	A3: Grants Fees & Other Income	(22,518)	(22,521)	0	0	0	(22,521)	(4)	(4)	0
	Sub-Total	**(21,348)**	**(20,757)**	**0**	**0**	**(80)**	**(20,837)**	**510**	**522**	**(12)**
R38: Head of Safeguarding Adults	A1: Staffing Costs	0	0	0	0	0	0	0	59	(59)
	A2: NonStaffing Costs	691	700	0	0	0	700	9	5	4
	A3: Grants Fees & Other Income	0	0	0	0	0	0	0	0	0
	Sub-Total	**691**	**700**	**0**	**0**	**0**	**700**	**9**	**64**	**(55)**
R39: ASC Placements	A1: Staffing Costs	45	44	0	0	0	44	(1)	(1)	0
	A2: NonStaffing Costs	126,224	133,697	0	0	0	133,697	7,473	7,294	179
	A3: Grants Fees & Other Income	(35,315)	(35,540)	0	0	0	(35,540)	(225)	(12)	(213)
	Sub-Total	**90,954**	**98,201**	**0**	**0**	**0**	**98,201**	**7,247**	**7,281**	**(34)**
R3A: A Head of Direct Care Provision CFE	A1: Staffing Costs	4,948	4,048	0	0	0	4,048	(900)	(755)	(145)
	A2: NonStaffing Costs	10,806	10,112	0	0	0	10,112	(693)	(396)	(297)
	A3: Grants Fees & Other Income	(320)	(370)	0	0	0	(370)	(50)	(46)	(4)
	Sub-Total	**15,434**	**13,790**	**0**	**0**	**0**	**13,790**	**(1,643)**	**(1,197)**	**(446)**
R3B: Immediate Response Service	A1: Staffing Costs	4,543	4,101	0	0	0	4,101	(442)	(398)	(44)
	A2: NonStaffing Costs	2,427	2,762	0	0	0	2,762	335	335	0
	A3: Grants Fees & Other Income	(2,400)	(2,624)	0	0	0	(2,624)	(224)	(349)	125
	Sub-Total	**4,570**	**4,239**	**0**	**0**	**0**	**4,239**	**(331)**	**(412)**	**81**
R3C: Sustained Support Service	A1: Staffing Costs	5,921	5,045	0	0	0	5,045	(876)	(692)	(184)
	A2: NonStaffing Costs	758	797	0	0	0	797	39	39	0
	A3: Grants Fees & Other Income	(247)	(8)	0	0	0	(8)	239	0	239
	Sub-Total	**6,432**	**5,834**	**0**	**0**	**0**	**5,834**	**(598)**	**(653)**	**55**
R30: Closed Codes Corporate Director Social Care	A1: Staffing Costs	0	9	0	0	0	9	9	5	4
	A2: NonStaffing Costs	0	0	0	0	0	0	0	0	0
	A3: Grants Fees & Other Income	0	0	0	0	0	0	0	0	0
	Sub-Total	**0**	**9**	**0**	**0**	**0**	**9**	**9**	**5**	**4**
R3: Executive Director Adult Services and Health	**A1: Staffing Costs**	**24,650**	**22,649**	**0**	**0**	**(80)**	**22,569**	**(2,080)**	**(1,627)**	**(453)**
	A2: NonStaffing Costs	**160,529**	**169,279**	**0**	**0**	**0**	**169,279**	**8,749**	**8,737**	**12**
	A3: Grants Fees & Other Income	**(84,287)**	**(84,952)**	**(1,253)**	**0**	**0**	**(86,205)**	**(1,920)**	**(2,141)**	**221**
	Sub-Total	**100,892**	**106,976**	**(1,253)**	**0**	**(80)**	**105,643**	**4,749**	**4,969**	**(220)**

Table 3: 2025/26 Month 7 Savings

Description	Total	RAG Rating 2025/26 & B/fwd savings						Total 2025/26
		B	G	A1	A2	R	W/O	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Mortuary - Provision of External Training	**(10)**	(10)						**(10)**
Review of Early Years Operating Model	**(130)**	(130)						**(130)**
Acquisition of Care home	**(550)**		(550)					**(550)**
AI Digitisation of Operational Social Work Practices	**(548)**	(548)						**(548)**
Care Diagnostic Equipment	**(150)**	(150)						**(150)**
Child and Family Support Service Staffing Review	**(182)**	(182)						**(182)**
Creation of a care company for temporary staff via an SPV	**(277)**			(277)				**(277)**
Implementation of Ask SARA	**(150)**		(150)					**(150)**
Increase MVF by 1%	**(146)**	(146)						**(146)**
Lease Income for Sexual Health Clinics	**(250)**			(250)				**(250)**
Post 16 Transport	**(624)**	(624)						**(624)**
Proposal to decant Lowdell Close Registered Care home due to safety concerns	**(200)**	(200)						**(200)**
Re-negotiation of Social Care contracts	**(1,739)**						(1,739)	**(1,739)**
Review and change in the catering services offer for Extra Care, Day Resources & Ea	**(217)**	(118)		(99)				**(217)**
Review of Early Years Operating Model (Additional) - Lease Income	**(93)**				(93)			**(93)**
Review of Early Years Operating Model (Additional) - Residual EY Budget	**(94)**	(94)						**(94)**
Review of third sector Carers contract value in Social Care	**(172)**	(172)						**(172)**
Review of third sector Information, Advice and Guidance contract value in Social Ca	**(170)**	(170)						**(170)**
Section 117 Funding split with ICB	**(2,031)**					(2,031)		**(2,031)**
Use of Disabled Facilities Grant	**(300)**	(300)						**(300)**
Vacant Post Review	**(283)**	(283)						**(283)**
	(8,316)	**(3,127)**	**(700)**	**(626)**	**(93)**	**(2,031)**	**(1,739)**	**(8,316)**

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SIX MONTH PERFORMANCE MONITORING REPORT

Committee name	Health and Social Care Select Committee
Officer reporting	Ian Kavanagh, Head of Business Intelligence
Papers with report	Appendix 1 – Six-month performance report 2025-26
Ward	All

HEADLINES

This six-monthly performance report monitors the value the council provides by benchmarking expenditure against key performance indicators. The analysis is based entirely on publicly available data to ensure a fair, transparent, and repeatable comparison with other local authorities.

The latest Adult Social Care Outcomes Framework (ASCOF) 2024–25 data was published in December 2025, after this performance report had been finalised. A short summary of this has been provided in the 'Performance Data' section below, but full analysis of this data will follow in the future performance report.

RECOMMENDATIONS

That the Health and Social Care Select Committee:

1. **notes the Six-month performance report for 2025/26, as attached in Appendix 1; and**
2. **makes any comments which will be presented to full Council in January alongside the Six-month performance report for information.**

Performance management is a critical function in local government, enabling councils to use data-driven insights to improve outcomes for residents. It supports accountability—both internally and externally—by demonstrating how public services respond to local needs and ensure value for money.

The Council's performance framework is aligned with the Hillingdon Council Strategy and incorporates a suite of reports accessible to services, senior management, the Corporate Management Team, and Cabinet – and then reported to select committees. This annual report draws on key performance indicators and monitoring data to assess progress against strategic objectives. Where applicable, it includes the most recent data available, including pre-2024/25 benchmarks.

Notably, the report integrates financial benchmarking from the 2024-25 local authority revenue expenditure and financing outturn report.

SUPPORTING INFORMATION

1. Performance management is about using data to drive evidence-based decision making to challenge current ways of working and service delivery models. It is an important tool for local government to take responsibility for its own performance and for the public and national

governments to hold local service providers to account, ensuring they respond to local needs and that public money is being spent wisely.

2. Performance management includes a range of processes and methods to identify shared goals and various measurements of progress towards these. Closely aligned to the concept of governance it ensures arrangements are in place so an authority's objectives can be achieved.

3. Within Hillingdon, performance is aligned to the Council Strategy, where a suite of performance reports is available to services, senior management teams, our Corporate Management Team, and the Leader and Cabinet. Monthly reports are presented to CMT and action logs completed.

4. This report uses key performance indicators and benchmarking data to show performance and value on key services for financial Year 2024/25 (or in some cases, the latest data available as well as pre-financial year 2024/25).

5. The 6-month performance report for 2025/26 presents a detailed and transparent benchmarking of how Hillingdon council is performing across its core service areas, with a clear emphasis on putting residents first. The report reflects a council that is actively responding to significant challenges—rising demand, financial pressures, and evolving community needs—while maintaining a strong commitment to service quality, accountability, and resident wellbeing.

6. **Hillingdon had the 4th lowest net expenditure in London per 100,000 residents.** Heathrow Airport's presence within the borough creates unique operational and financial pressures that many other London authorities do not face. Despite years of government underfunding and these unique challenges, Hillingdon continues to be recognised as a well-run council, consistently delivering strong value for money and maintaining one of the lowest net expenditure levels in London.

Adult Social Care and Health (ASC&H)

7. Hillingdon continues to deliver Adult Social Care in a financially sustainable and outcome-focused way. The borough has the 2nd lowest net expenditure on Adult Social Care among statistical neighbours, remaining below both the London and national averages. Despite this Hillingdon achieved a 'Good' Care Quality Commission (CQC) rating with an overall score of 73%. This score continues to see Hillingdon in the top quartile of inspected authorities.

8. Hillingdon's rate of people in residential and nursing placements was in line with the average of our statistical neighbours and London average. This is a positive indicator of our ability to support people in the least restrictive setting and to promote independence wherever possible with the success of our discharge-to-assess model, short-term intervention pathways, and community-based support services, which together help residents avoid unnecessary long-term care placements.

9. 58.4% of service users are satisfied with care (slightly below London average), but Quality of Life score is above London average. Hillingdon continues to deliver Adult Social Care services with a strong emphasis on personalisation, safety, and positive outcomes for both residents and carers. The borough's performance in key satisfaction measures reflects a service that is responsive, targeted, and committed to continuous improvement.

10. Hillingdon has the 5th lowest net expenditure on Public Health and Adult Obesity among neighbours but remains above London averages. Adult obesity (15.4%) is higher than England, London and NWL ICB, with highest prevalence in Hayes and Yiewsley. Hypertension prevalence has increased from 10% to 13.5%, reflecting the success of proactive case-finding, with 85% of diagnosed cases controlled—above target and national benchmarks.

PERFORMANCE DATA

The latest Adult Social Care Outcomes Framework (ASCOF) 2024–25 data was published in December 2025, after this performance report had been finalised. The summary below highlights the newly published results and compares them with the 2023–24 figures referenced on the slide "Adult Social Care and Health – Adult Social Care Satisfaction".

Please note that several ASCOF measures have changed in the latest return. A full analysis of all updated metrics will be undertaken using the new dataset.

1. Overall satisfaction of service users increased to 62% in 2024–25, up from 58.4% in 2023–24 and is now above the London average (60.7%).
2. Older people still at home 91 days after discharge from hospital into reablement/rehabilitation was 89.9% in 2023–24. This measure has been revised and now focuses on new clients aged 65 and over who were discharged from hospital into reablement and remained in the community at 12 weeks. The 2024–25 figure is 65.6%, which is above the London average (63.3%).
3. Older people offered reablement services following discharge from hospital was 2.4% in 2023–24. This measure has changed to include only those clients who received reablement. The 2024–25 figure is 1.6%, which is below the London average (7.1%).
4. Overall satisfaction of carers with social services is collected biennially and is therefore not available for 2024–25.
5. The measure "Carers who receive self-directed support" is no longer collected as part of the ASCOF return.

RESIDENT BENEFIT

This report enables residents, communities, and service users to understand how well services are performing, ensuring transparency, accountability, and continuous improvement in meeting local needs.

FINANCIAL IMPLICATIONS

There are no direct financial implications to the Council associated with the recommendations in this report.

LEGAL IMPLICATIONS

There are no direct legal Implications that arise out of the recommendations set out in this report.

BACKGROUND PAPERS

None

APPENDICES

Six-Month Performance Report, 2025/26

Hillingdon Council:
Health & Social Care Select Committee

Six-month performance report
First half 2025/2026 (April to October)

HILLINGDON
LONDON

Approach

The aim of this performance report is to assess the value the council provides by benchmarking our expenditure against key performance indicators across each directorate. The analysis is based entirely on publicly available data to ensure a fair, transparent, and repeatable comparison with other local authorities. As with all published datasets, the figures are only as accurate as the information submitted by each authority.

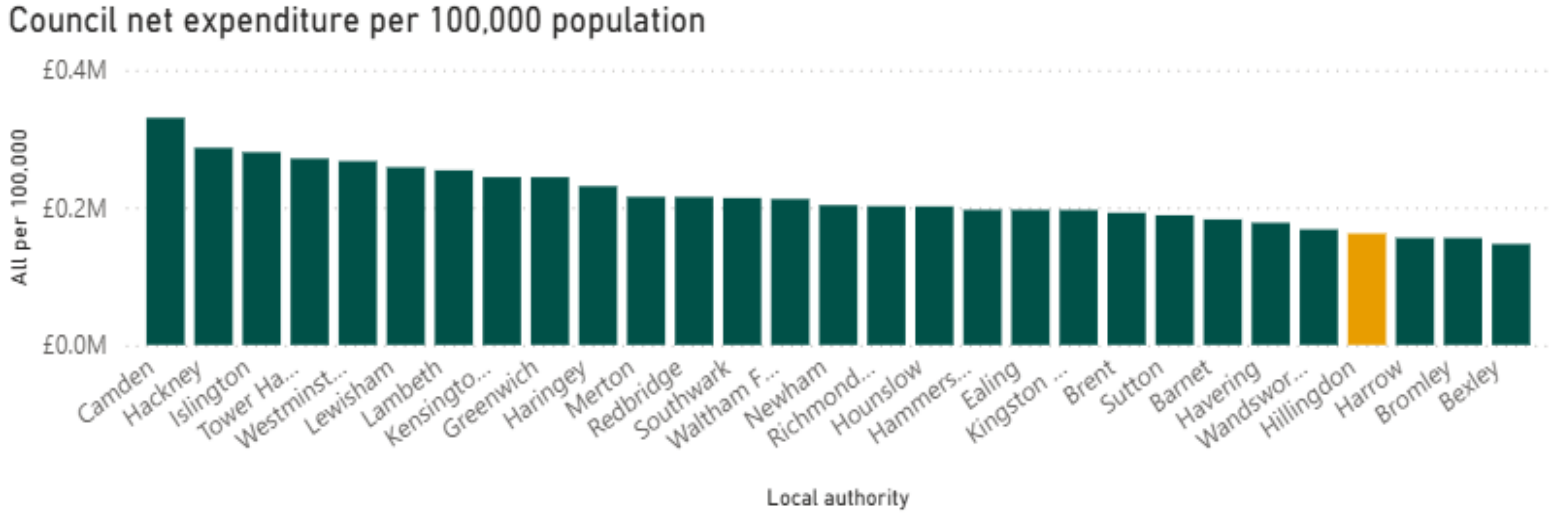
Because this report relies on published national datasets, it uses the most recent information available. For most measures, this is the 2024/25 financial year, although a small number of datasets cover slightly different periods. These variations are due to the time required for data cleansing and standardisation by both local authorities and the relevant national publishing bodies (e.g. DLUHC, DfE).

The report incorporates financial benchmarking from the 2024/25 Local Authority Revenue Expenditure and Financing Outturn to demonstrate how effectively Hillingdon deploys its resources to deliver positive outcomes for residents. To allow meaningful comparisons, expenditure figures have been standardised using published population data relevant to each service area—for example, using the 0–18 population when analysing Children's Services.

Where available, comparisons are made against statistical neighbour groups, recognising that different services have different socio-demographic comparators, such as Youth Justice having a different statistical neighbour set from Adult Social Care . Where statistical neighbour sets are not published, nearest neighbours have been used instead.

Executive Summary

- Hillingdon had the 4th lowest net expenditure in London per 100,000 residents.
- Heathrow Airport's presence within the borough creates unique operational and financial pressures that many other London authorities do not face.
- Despite years of government underfunding and these unique challenges, Hillingdon continues to be recognised as a well-run council, consistently delivering strong value for money and maintaining one of the lowest net expenditure levels in London.



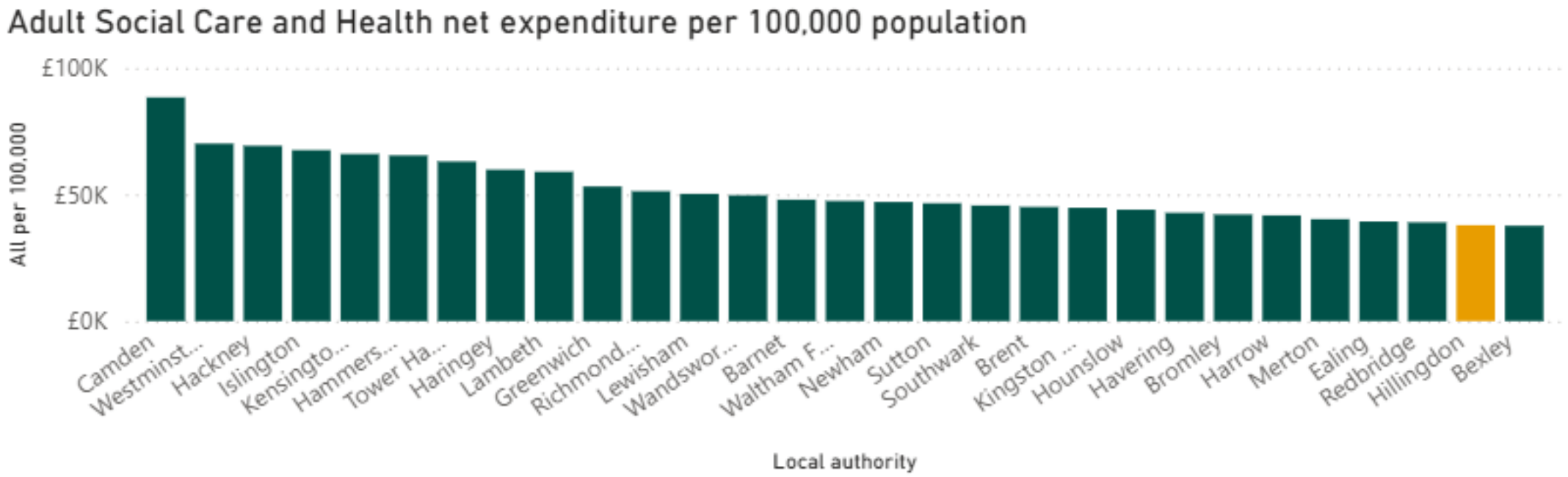
- Adult Social Care had the 2nd lowest expenditure of London boroughs per 100,000 residents.
- Achieved a 'Good' Care Quality Commission (CQC) rating with an overall score of 73%. This score continues to see Hillingdon in the top quartile of inspected authorities.
- Assessed across 5 key areas: safe, effective, caring, responsive and well-led.

- Resident Services had the 8th lowest expenditure of London boroughs for housing general fund and homelessness expenditure per 100,000 residents.
- Achieved a C2 (2nd highest) grade from the Regulator of Social Housing (RSH).
- Grading ranges from C1 to C4. Only 7 of 66 (10.6%) local authorities assessed achieved the C1 grade and most authorities (56%) received a C3 or C4 grade.

- Children's social care had the 3rd lowest expenditure of London boroughs per 100,000 children.
- Achieved an 'Outstanding' Ofsted rating in November 2023, the highest grade indicating a high quality, innovative service that consistently exceeds expectations where children achieve excellent outcomes.
- Only 15% of Councils Nationally are currently assessed at the highest standard.

Sandra Taylor
Corporate Director of Adult Social Care and Health

Adult Social Care and Health Summary



Hillingdon has the 2nd lowest net expenditure across all London councils for Adult Social Care and health, but despite this services were judged to be 'good' with an overall score of 73% in the last Care Quality Commission (CQC) inspection.

This score continues to see Hillingdon in the top quartile of inspected authorities. Authorities are assessed across 5 key areas: safe, effective, caring, responsive and well-led.

Adult Social Care and Health – **Adult Social Care Demand**

Comparators	Adult Social Care net expenditure	In Home Care	In Residential or Nursing placements	Hours of support given
Barnet	42499	467	241	8496
London	40965	407	241	6271
Sutton	40872	446	241	6485
Waltham Forest	39877	547	223	7285
Brent	38117	454	214	6958
Havering	37727	370	264	7310
Kingston upon Thames	37684	349	245	5305
Hounslow	37068	399	177	5592
Harrow	37049	445	232	4963
Bromley	36571	359	282	4551
Merton	34414	261	204	3480
Redbridge	33196	423	229	7578
Bexley	32992	425	241	6571
Hillingdon	32418	316	242	4517
Ealing	31547			
Enfield		275	264	5386

Understanding the data:

- **Adult Social Care net expenditure[1]** - Shows the 2024-25 expenditure. Value is in £000s, per 100,000.
- **In home care[4]** – Shows the number of residents receiving home care as at 30/06/24, as a rate per 100,000 population.
- **In residential or nursing placement[3]** - Shows the number of residents in residential or nursing placements as at 31/09/24, as a rate per 100,000 population.
- **Hours of support given[4]**- Shows the number of weekly hours of home care given as at 31/09/24, as a rate per 100,000 population.

Adult Social Care and Health – **Adult Social Care Demand**

Hillingdon has the 2nd lowest net expenditure on Adult Social Care among its statistical neighbours and remains below both London and national averages. It also reports the 2nd lowest number of home care clients and hours.

Hillingdon delivers Adult Social Care with a strong emphasis on value for money and effective demand management, ensuring high quality care in a financially sustainable way. Our home care provision is proportionate and well-managed, targeting support efficiently to help residents maintain independence while directing resources where they are most needed.

Hillingdon's rate of people in residential and nursing placements was in line with the average of our statistical neighbours and London average at 242 people per 100,000 compared to the average of 241.

This is a positive indicator of our ability to support people in the least restrictive setting and to promote independence wherever possible with the success of our discharge-to-assess model, short-term intervention pathways, and community-based support services, which together help residents avoid unnecessary long-term care placements.

Adult Social Care and Health – **Adult Social Care Satisfaction**

Comparator	Adult Social Care net expenditure	Social support for Carer net expenditure	ASC Complaints	Overall satisfaction of service users	Overall satisfaction of carers with social services	Older people still at home 91 days after discharge from hospital into reablement/rehabilitation	Older people offered reablement services following discharge from hospital	Carers who receive self-directed support
England	43087	256	4.74	65.4%	37%	83.8%	3.0%	89.7%
Barnet	42499	0	6.17	60.9%	29%	93.2%	3.9%	100.0%
London	40965	180	6.20	60.4%	33%	87.9%	4.3%	88.2%
Sutton	40872	-63	6.06	61.8%	35%	85.4%	6.3%	100.0%
Waltham Forest	39877	300	5.72	64.7%	46%	88.6%	5.7%	100.0%
Brent	38117	29	5.67	54.0%	31%	73.5%	2.2%	100.0%
Havering	37727	198	2.53	61.3%	29%	90.2%	4.9%	100.0%
Kingston upon Thames	37684	233		59.6%	42%	86.4%	3.4%	100.0%
Hounslow	37068	-183	6.35	62.1%	29%	89.0%	1.8%	16.4%
Harrow	37049	390	13.67	55.6%	22%	85.2%	2.9%	100.0%
Bromley	36571	0	6.86	60.3%	29%	95.2%	8.6%	66.7%
Merton	34414	346	7.32	58.9%	29%	88.5%	4.2%	100.0%
Redbridge	33196	369	6.85	64.5%	37%	92.2%	3.5%	100.0%
Bexley	32992	53	3.90	60.1%	38%	81.7%	4.4%	100.0%
Hillingdon	32418	128	5.16	58.4%	36%	89.9%	2.4%	100.0%
Ealing	31547	7	7.00	59.2%	28%	94.7%	2.6%	93.5%
Enfield			5.50	65.2%	36%	85.3%	1.9%	100.0%

Understanding the data:

- **Adult Social Care net expenditure[1]** - Shows the 2024-25 expenditure. Value is in £000s, per 100,000.
- **Social support of carer net expenditure[1]** - Shows the 2024-25 expenditure. Value is in £000s, per 100,000.
- **ASC complaints[6]** – 2024/25 complaints received as a rate per 100,000 population.
- **Overall satisfaction of service users[2]** - as per Adult Social Care Outcomes Framework (ASCOF) 23-24.
- **Overall satisfaction of carers with social services[2]** – percentage, as per ASCOF 23-24.
- **Older people still at home 91 days after discharge from hospital into reablement/rehabilitation[2]** – percentage as per ASCOF 23-24.
- **Older people offered reablement services following discharge from hospital[2]** – percentage, as per ASCOF 23-24.
- **Carers who receive self directed support[2]** – percentage, as per ASCOF 23-24.

Adult Social Care and Health – **Adult Social Care Satisfaction**

Hillingdon had the 6th lowest net expenditure for its social support to carers when compared to our statistical neighbours. Hillingdon's overall satisfaction is the 4th lowest out of our statistical neighbours for service users and 6th highest for carer satisfaction, using the latest published 2023/24 survey results. Hillingdon is 6th highest for those still at home 91 days after a hospital discharge and 4th lowest for the percentage of people offered reablement support after a hospital discharge. This shows how Hillingdon's discharge arrangement does not direct everyone to the reablement route but instead offers a short discharge to assess service options to support an early discharge while the council can assess the correct level of care for the resident. By targeting reablement support toward those who are most likely to benefit, this can secure better outcomes for residents. Hillingdon is also one of the councils operating with 100% self-directed support, meaning that people have choice and control over how their care and support needs are met..

Hillingdon continues to deliver Adult Social Care services with a strong emphasis on personalisation, safety, and positive outcomes for both residents and carers. The borough's performance in key satisfaction measures reflects a service that is responsive, targeted, and committed to continuous improvement.

Adult Social Care and Health – **Adult Social Care Satisfaction**

The 2023/24 Adult Social Care Survey, conducted between 8 January and 8 March 2024, gathered feedback from residents receiving care in the community, supported living, and residential or nursing settings. The survey achieved a return rate of 25.4%, with responses used to benchmark satisfaction and inform service development.

- **Satisfaction with care and support**: 58.4% of respondents reported being 'extremely' or 'very satisfied' with the care and support they receive. While slightly below the London average (60.5%), this reflects a stable and improving trend.
- **Quality of life score**: Hillingdon achieved a score of 19.1 out of 24, above the London average of 18.4. This composite score reflects residents' views on dignity, safety, nutrition, social participation, and control over daily life.
- **Safety and independence**: Hillingdon ranks 6th highest among statistical neighbours for the proportion of older people still at home 91 days after discharge, demonstrating the effectiveness of our discharge-to-assess model and short-term support pathways.
- **Reablement offer**: While Hillingdon is 4th lowest for the proportion of residents offered reablement, this reflects a targeted and outcome-focused approach. By prioritising those most likely to benefit, this ensure resources are used effectively and residents receive tailored support.
- **Carer support**: The borough continues to perform strongly in carer engagement, with 100% of carers receiving self-directed support, placing Hillingdon among the leading councils nationally for personalised care planning.

The survey also highlighted areas for further development, including social contact and loneliness. These insights are being actively addressed through the borough's Carers Strategy and wider wellbeing initiatives.

Reablement Service – Key performance highlights (2023/24)

- **Residents Supported**: Over 650 residents received reablement support across the first three quarters.
- **Independence outcomes**: 63% required no further care 90 days post-intervention.
- **Cost avoidance:** Achieved a total cost avoidance of £2.67 million, significantly exceeding the annual target of £500,000.

Adult Social Care and Health - **Public Health**

Comparators	Public Health net expenditure	Adult obesity net expenditure
Ealing	7801	67
Waltham Forest	7563	50
Kingston upon Thames	7063	69
Hounslow	6937	114
England	5987	52
Merton	5836	18
Redbridge	5803	85
Sutton	5655	49
Bromley	5546	32
Barnet	5444	22
Hillingdon	5434	48
Havering	5024	21
Harrow	4694	50
Bexley	4650	96
Brent	4650	96
London	2268	20

Comparators	Hypertension prevalence	Obesity prevalence - adults
North Connect PCN	16.0%	13.5%
England	15.2%	13.9%
Colne Union PCN	14.9%	19.2%
Celadine Health & Metrocare PCN	14.5%	12.4%
Long Lane First Care Group PCN	13.8%	17.0%
Hillingdon	13.5%	15.4%
South East London ICB	12.1%	12.5%
Hh Collaborative PCN	11.6%	16.8%
Synergy PCN	11.6%	14.3%
Unallocated (2 GPs)	11.5%	11.7%
South West London ICB	11.3%	10.4%
London	11.3%	11.9%
North West London ICB	11.2%	11.6%
North Central London ICB	10.9%	10.4%
North East London ICB	10.9%	13.8%

Understanding the data:

- **Public Health net expenditure[1]** - Shows the 2024-25 expenditure. Value is in £000s, per 100,000.
- **Adult obesity net expenditure[1]** - Shows the 2024-25 expenditure. Value is in £000s, per 100,000.
- **Hypertension prevalence[5]** – percentage of all ages with hypertension, registered with a GP in 2024/25.
- **Obesity prevalence – adults[5]** – percentage of adults aged 18+ , registered with a GP, with obesity in 2024/25.

Adult Social Care and Health - **Public Health**

Hillingdon's Health and Wellbeing Board identified five priorities for 2025-28:

1. Start Well: Improve early years outcomes, reduce child obesity, and promote readiness for school and life.
2. Live Well: Prevent and/or delay the onset of long-term conditions, particularly hypertension, improve mental wellbeing, and enhance access to early intervention and support for carers.
3. Age Well: Implement ‘at scale’ proactive frailty management, and better end-of-life care that enables people with multi-morbidity to maintain independence for as long as possible in order to avoid non-elective presentations, admission to long-term care and to promote early discharge.
4. Healthy Places: Tackle housing, environment, employment, and social isolation.
5. Equity and Inclusion: Target resources and interventions where inequalities are greatest using Core20PLUS5: specifically, Hayes, Yiewsley, and West Drayton.

For years 1 and 2 the focus priorities are 'live well', 'age well' and 'equity and inclusion'. Chronic conditions are rising - 48% of adults have one or more long-term conditions (LTCs), with hypertension, obesity, anxiety, depression, and diabetes the most common. Hillingdon’s adult population has grown 16% in seven years, with a rapidly ageing population; the 65+ group represents 14% of the population but accounts for 40% of health and social care usage.

Adult Social Care and Health **- Public Health**

Hillingdon had the 5th lowest net expenditure on both public health and adult obesity when compared to our nearest neighbours, but this was significantly more than the London average.

Obesity is a global and complex public health concern. It is associated with reduced life expectancy and is a risk factor for a range of chronic diseases, including cardiovascular disease, type 2 diabetes, at least 12 types of cancer, respiratory disease and can also impact on mental health. The risk and severity of these diseases increases with a higher body mass index (BMI). The proportion of adults in England living with obesity has seen large increases in the last four decades. Hillingdon's prevalence (15.4%) is higher than England (13.9%), London (11.9%) and North West London Integrated Care Board (ICB) (11.6%) rates. At GP practice level, the highest prevalence rates (20%+) can be seen in the south of the borough, specifically in Hayes and Yiewsley. The latest data on childhood obesity is due to be released in late 2025.

The current prevalence rate for hypertension in Hillingdon is 13.5% against a target of 16% by March 2026; it is estimated that about 30% of the population nationally have hypertension. Hillingdon's prevalence has improved from 10% since the start of roll out of the Hypertension Anticipatory Care Programme in neighbourhoods. The percentage (of the 13.5%) with their blood pressure under control is 85% - which is above target. Prevalence rates will increase as the programme progressively rolls out. At GP practice level, three out of five of the highest rates are in surgeries in the north of the borough.

Hillingdon's prevalence of hypertension is lower than England (15.2%), but significantly higher than London (11.3%) and North-West London ICB (11.2%).

Data Sources

Data Sources:

1. LA revenue expenditure and financing: 2024 - 2025
2. ASCOF 2023 – 2024
3. ADASS Bed based return 2024
4. ADASS Home Care return 2024
5. Disease Prevalence, Quality Outcomes Framework, NHS Digital
6. Local Government & Social Care Ombudsman

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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					Decision-Maker				Cabinet Member Lead & Officers				Status
Ref	**Business Item**	**Further information**	**Ward(s)**	NEW ITEM	**CABINET meeting**	**Cabinet Member**	**Shareholder Committee**	**Full COUNCIL**	**Cabinet Member(s) Responsible**	**Relevant Select Committee**	**Report Author**	**Corporate Director Responsible**	**Public or Private (with reason)**
JANUARY 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		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
97a	**The Hillingdon Care Company Ltd. (THCC) Reporting**	The Shareholder Committee, comprising relevant Cabinet Members, will receive relevant reports relating to the Council's care services and trading company.	N/A				15 January		Shareholder Committee Members	Health & Social Care	TBC	TBC	Private (3)
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
MARCH 2026													
109	**Healthier Food Advertising Policy**	Cabinet will consider a healthier food advertising policy for the Council. Such a policy encourages brands to swap out unhealthy foods and drinks for healthier ones, as part of efforts to prioritise our residents' health. Increasing evidence and research shows that exposure to advertising of food and drink high in fat, salt and/or sugar is linked to a strong preference for such products, more snacking, and eating more calories.	All	NEW ITEM	19 March				Cllr Jane Palmer - Health & Social Care	Health & Social Care	Priscilla Simpson / Dir. of Public Health	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		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

					Decision-Maker				Cabinet Member Lead & Officers				Status
Ref	**Business Item**	**Further information**	**Ward(s)**	NEW ITEM	**CABINET meeting**	**Cabinet Member**	**Shareholder Committee**	**Full COUNCIL**	**Cabinet Member(s) Responsible**	**Relevant Select Committee**	**Report Author**	**Corporate Director Responsible**	**Public or Private (with reason)**
97b	**The Hillingdon Care Company Ltd. (THCC) Reporting**	The Shareholder Committee, comprising relevant Cabinet Members, will receive relevant reports on the Council's care company.	N/A				19 March		**Shareholder Committee Members**	**Health & Social Care**	**TBC**	**TBC**	Private (3)
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
BOROUGH LOCAL ELECTIONS - 7 MAY 2026													
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 Eddie Lavery - 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

					Decision-Maker				Cabinet Member Lead & Officers				Status
Ref	**Business Item**	**Further information**	**Ward(s)**	NEW ITEM	**CABINET meeting**	**Cabinet Member**	**Shareholder Committee**	**Full COUNCIL**	**Cabinet Member(s) Responsible**	**Relevant Select Committee**	**Report Author**	**Corporate Director Responsible**	**Public or Private (with reason)**
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)
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 Eddie Lavery - 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													

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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 - CANCELLED~~	~~CR6~~
~~Tuesday 11 November 2025, 6.30pm~~	~~CR5~~
~~Wednesday 3 December 2025, 6.30pm~~	~~CR6~~
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 CANCELLED~~	~~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	January 20	February 17	March 26	CANCELLED April 21	May No meeting	June	July	August No meeting	September	October No meeting	November	December No meeting	January
Review A: ASC Early Intervention & Prevention													
Topic selection / scoping stage													
Witness / evidence / consultation stage													
Findings, conclusions and recommendations	Findings												
Final review report agreement		Final report											
Target Cabinet reporting			Cabinet (19th)										
Review B: Pharmacies													
Regular service & performance monitoring													
Bi-Annual Performance Monitoring	X					X					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
Mid-year budget / budget planning report (July/September)													
Cabinet's Budget Proposals For Next Financial Year (Jan)	X								X				X
Cabinet Member for Health and Social Care													
Cabinet Forward Plan Monthly Monitoring	X	X	X			X	X		X		X		X
One-off information items													
Autism Update													
Commissioning Model for delivery of health and social care services		X											
BCF Update		X											
Minor Injuries Unit Update													
Hospice and End of Life Services in the Borough													
Hillingdon Advice Partnership Update						X							
CAMHS Update		X											
HHCP Place Based Service Delivery		X											X
Health External Scrutiny													
Mount Vernon Cancer Centre Strategic Review Update													
Hillingdon Hospital Redevelopment Update													
Health Updates			X						X				
Public Health Update	X												
Quality Accounts (outside of meetings)				X									
Past review delivery													
Review of Children's Dental Services 2021/22 (outside of meetings)													
CAMHS Referral Pathway 2023/24		X											

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