

Minutes

HEALTH AND SOCIAL CARE SELECT COMMITTEE

26 March 2026



Meeting held at Committee Room 5 - Civic Centre

	<p>Committee Members Present: Councillors Nick Denys (Chair), Reeta Chamdal (Vice-Chair), Labina Basit, Tony Burles, Becky Haggart, Kelly Martin and Sital Punja (Opposition Lead)</p> <p>Also Present: Sean Bidewell, Assistant Director – Integration & Delivery / Acting Joint Borough Director, North West London Integrated Care Board (NWL ICB) Amanda Carey-McDermott, Chief Executive Officer, The Confederation Hillingdon CIC Dr Richard Grocott Mason, CEO for the Heart, Lung and Critical Care Group - HLCC, 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) Samreen Nawshin, Operations Manager, Healthwatch Hillingdon Vanessa Odlin, Managing Director for Hillingdon and Mental Health Services, Goodall Division, Central and North West London NHS Foundation Trust (CNWL) Keith Spencer, Managing Director, Hillingdon Health and Care Partners (HHCP) Lesley Watts, Chief Executive Officer, The Hillingdon Hospitals NHS Foundation Trust / Chelsea & Westminster Hospital NHS Foundation Trust</p> <p>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)</p>
64.	<p>APOLOGIES FOR ABSENCE (<i>Agenda Item 1</i>)</p> <p>There were no apologies for absence.</p>
65.	<p>DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING (<i>Agenda Item 2</i>)</p> <p>There were no declarations of interest in any matters coming before this meeting.</p>
66.	<p>MINUTES OF THE MEETING HELD ON 17 FEBRUARY 2026 (<i>Agenda Item 3</i>)</p> <p>RESOLVED: That the minutes of the meeting held on 17 February 2026 be agreed as a correct record.</p>
67.	<p>EXCLUSION OF PRESS AND PUBLIC (<i>Agenda Item 4</i>)</p> <p>RESOLVED: That all items of business be considered in public.</p>

68. **HEALTH UPDATES** (*Agenda Item 5*)

The Chair welcomed those present to the meeting.

Central and North West London NHS Foundation Trust (CNWL)

Ms Vanessa Odlin, Managing Director - Goodall Division at CNWL, advised that, in 2025, additional recurrent funding had been provided across all eight North West London boroughs to expand the Urgent Community Response (UCR) teams and establish a Hospital at Home function in each borough. It was anticipated that the UCR expansion would support patients in physical health crisis in under two hours to avoid Emergency Department (ED) attendance or admission and keep them at home for longer (this could be in relation to any physical health issue such as heart failure, palliative care pathway, etc). Hospital at Home would provide additional support for patients after UCR care (between days 3 and 17). Although there was no target, CNWL had been working to get as close to 100% of patients seen within two hours as possible (performance was currently at 70%-80%) and to reducing the number of non-elective ED admissions to support the new hospital targets.

The Lighthouse was located in a space close to the ED at Hillingdon hospital and provided a therapeutic environment to support patients experiencing a mental health crisis. Lighthouse staff were spending time in the ED with a pull across model and capacity had been expanded to be able to support between four and six patients at any time (an increase from 1-2 patients per day). Mr Sean Bidewell, Joint Lead Borough Director at North West London (NWL) Integrated Care Board (ICB), advised that the new model had come into effect around November 2025. The increase in the capacity had been driven by a 52% reduction in the average length of stay, reducing from 27 hours to around 13 hours (the performance target had been was to keep the average length of stay to below 24 hours). Most of the referrals had been picked up really quickly from the Urgent Treatment Centre, with 67% then returning home (some returning home with support) and 15% being admitted to a mental health hospital, with others being supported through initiatives such as the Crisis House.

With regard to Child and Adolescent Mental Health Services (CAMHS), Members were advised that non-recurrent funding had been provided by NWL ICB to the end of March 2026 and had reduced the waiting lists from 2,000 waiting for an assessment to around 400, with an average wait of around 6-9 months. As this was not sustainable, CNWL had transformed its assessment pathways to ensure that they were as efficient and safe as possible and developed a central triage point which would have a soft launch on 1 June 2026. It was anticipated that these changes would increase the number of children seen by around 50%.

The Mental Health Support Teams (MHSTs) worked with schools to support children with mental health concerns. This national model had been rolled out in waves, with additional Hillingdon teams being included in Wave 14. Around 64% of schools in Hillingdon were currently supported by the MHSTs (NHS England and the NWL ICB wanted 100% coverage by 2029).

The musculoskeletal physiotherapy team had been contacting patients on the waiting list to establish whether or not they still needed to be seen. This process had reduced the number of patients not attending their appointments (Did Not Attend (DNA)) to 7%.

Ms Amanda Carey-McDermott, Chief Executive Officer at The Confederation Hillingdon CIC, advised that Blinx Patient and Care Optimiser (PACO) software had been trialled

in Hillingdon to help the way that GPs worked. The software sat around existing IT systems already used by partners and enabled a single point of entry from different teams with the focus initially being on frailty (as there had already been joined up work in this area). Blinx had saved time and increased capacity as it meant that District Nurses only needed to input notes on one system for it to appear on all systems, but it could be used more extensively (such as automatic triangulation). There would be an opportunity to extend the system to other providers over the next six months but this would need investment from place (ideally from the ICB).

Ms Sue Jeffers, Joint Lead Borough Director at NWL ICB, advised that this was something that the ICB would be interested in supporting as digitisation as an enabler had been a key focus in their discussions. It was noted that the new ICB would be in place from 1 April 2026 and that workshops were currently being undertaken with place colleagues. The pilot would be helpful to inform any future investment decisions.

Ms Carey-McDermott noted that a new senior clinical decision maker was being trialled which was a GP working alongside Ms Odlin's team, 8am to 8pm, seven days a week. This had enabled quicker decision making and supported the mobile diagnostics initiative. The Committee would be interested in hearing how this trial progressed.

The Hillingdon Hospital NHS Foundation Trust (THH)

Ms Lesley Watts, Chief Executive at THH, advised that the number of patients attending Accident and Emergency (A&E) at Hillingdon had decreased and performance had improved, with 77.6% of patients being seen within four hours (which was better than the national average and London average). It was anticipated that funding had been secured for high intensity users whose attendances at A&E could be disruptive.

The National Oversight Framework (NOF) assessed NHS Trusts' operational performance, people management and financial standing based on objective data, with Hillingdon recently improving from NOF4 to NOF2 (partly because of its ambulance handover performance, which was one of the best in London). Hillingdon would be hitting its financial plan for the first time in 10 years, possibly with a small surplus, at the end of this financial year.

Although THH would achieve the referral to treatment target (60% within 18 weeks), improvements were still needed. Performance in relation to the two week wait for cancer appointments had been achieved but more work was needed to achieve the target to receive treatment in 62 days. Ms Watts would provide the Democratic, Civic and Ceremonial Manager with further information about the 62 day performance for each cancer speciality for circulation to the Committee.

On 1 April 2026, Hillingdon Hospital, Chelsea and Westminster Hospital (ChelWest), London North West Hospital and Imperial Hospital would be brought into one group with one Chief Executive, Mr Tim Orchard. THH already had a close relationship with these hospitals, particularly ChelWest where there had been staff and learning exchanges which had been positive for both organisations. The THH Chair had stepped down and been replaced by Mr Bob Alexander on an interim basis.

Work had continued in relation to the progression of the new hospital development. Ms Watts advised that the decant work continued with buildings being taken down and the site cleared. There had been an issue in relation to the basement so alternatives had been considered. This had more or less now been agreed but would alter the height of

the building so further discussions would be needed with the Council's planning team.

Ms Watts advised that corridor care was not an ideal situation as it was hard to pull back from once it had started. Hospitals were not the safest place in the world so consideration had been given to length of stay and getting staff to assess the risk to the patient in staying in hospital versus the risk in them being discharged. Other parts of the system had really stepped up but there was still lots to do. It would be important to respond quickly and deliver practical interventions in relation to intravenous antibiotics (at home or in nursing homes), falls and end of life care.

It was noted that there would be a resident doctor strike over the Easter period. Ms Watts advised that she did not know how many doctors would be on strike but there were currently no plans to cancel appointments. However, a priority list of appointments had been drawn up and consideration was being given to cancelling annual leave and study leave.

Healthwatch Hillingdon (HH)

Ms Samreen Nawshin, Operations Manager at HH, advised that Your Voice had taken over as provider for Healthwatch Hillingdon in August 2025 and had developed a number of workstreams. The organisation acted as a local watchdog and gathered feedback from local residents on their experiences.

As part of the patient experience programme, HH had spoken to 324 people between August and December 2025 about GPs and other health and social care partners (the patient experience report covering this period was available on the HH website at: <https://healthwatchhillingdon.org.uk/report/2026-03-24/patient-experience-report-q3-25-26>). The main issues raised in relation to GPs were: persistent telephone waits; challenges with filling in online forms; clarity around the appointment pathways; and a lack of awareness about the wider clinical team (often residents expected to speak to a GP when this was not always the most appropriate professional for them to speak to). Insofar as feedback on hospitals was concerned, the main issues raised were in relation to: positive feedback about the staff; waits at the ED; and more information and clarity in relation to timelines. HH had drafted a number of recommendations based on the feedback, whilst being mindful that this was based on a snapshot of feedback.

Ms Nawshin advised that, as part of its enter and view role, HH had undertaken a number of visits to care homes and supported housing. They had looked at good practice and had had constructive conversations with staff and residents. Feedback themes had included the physical environment, staff wellbeing and activities. Although there had been no big causes for concern, areas for improvement had been identified. A care home strategy would be developed by HH to highlight the good practices that had been gleaned during their visits which would then be shared with care providers.

Improvements had been made since the Parkside House Nursing Home had received its CQC inspection rating of 'Requires Improvement'. The HH report on this enter and view visit had been published online at: <https://healthwatchhillingdon.org.uk/report/2026-02-26/enter-view-parkfield-house-nursing-home>

HH had started its hospital discharge project on 24 March 2026 which aimed to learn about people's experience post-discharge and the transition back to their life outside of hospital, specifically in relation to communication.

It was queried how HH determined which issues it would investigate. Ms Nawshin advised that the small team at HH spoke to residents, the local scrutiny committee, partners and others to establish what they thought ought to be prioritised. Feedback and suggestions could be provided by the Committee on a rolling basis or as an annual activity. It was agreed that Ms Nawshin provide the Committee with its work programme for the year so that the Members could provide her with any relevant information that they might have.

HH had tried to raise awareness of the work that it undertook and would continue to do so with partners, but this could sometimes be a challenge. They had experienced some problems in getting cooperation from some GP practices as this was not a mandated function. There seemed to be a lack of awareness about the role of HH (an independent organisation looking at things from a resident's perspective) and a reluctance to fill in 'yet another survey' that potentially duplicated other surveys that the practice had already completed. In order to raise awareness of the role of HH, it was suggested that information be included in Hillingdon People and that they work with the Carers' Trust to access GP practices.

Royal Brompton and Harefield Hospitals (RBH)

Dr Richard Grocott Mason, Chief Executive Officer for the Heart, Lung and Critical Care Group at RBH - Guy's and St Thomas' NHS Foundation Trust, advised that the Trust dealt with patients by disease rather than by area so patients came in from all over the country. There had been a focus ensuring that no patient waited longer than 65 weeks for treatment and there were now no patients that had waited more than a year. However, there were concerns about the cardiac surgery waiting times.

The 62 day cancer performance had been a challenge. It would often take a long time to undertake lung cancer surgery as there could be delays in actions such as diagnostics before they were referred on to RBH. Although patient outcomes were good once they had had their surgery, early diagnosis was the lens to survival.

Dr Grocott Mason advised that there had been pressure on echo and sleep diagnostics. The number of referrals had doubled as an unintended consequence of these being criteria to get weight loss drugs on the NHS.

The BBC Radion 4 broadcast, "The battle for hearts and lungs: Transplants in trouble", highlighted the challenges in relation to heart and lung transplants. RBH had undertaken 71 in the year to date (in comparison to the 62 that had been undertaken in the same period in the previous year). There had been 42 lung transplants which had resulted in excellent outcomes.

About one third of cardiology surgery presented through the cardiac centre or via the ED but it was not possible to predict the level of transplants. There had been some bed closures over the last six months to facilitate a refurbishment but, even if there had been more beds, theatre capacity and critical care capacity could limit the number of transplants and being in hospital was not a safe place to be unless you needed to be in hospital.

Financially, the Trust would meet its plan overall but the changes to funding flows, patient choice and the money following the patient meant that funding was not quite as clear cut as it had previously been. RBH had also been in receipt of NHS capital funds. These had been used to purchase a robot for thoracic surgery and a modular extension building that would be in place from April 2027 to extend capacity in navigational

bronchoscopy.

The merger with Guys and St Thomas' had been a positive move and had enabled investment in technology, with there being little that appeared to have changed insofar as patients and staff were concerned. RBH continued to receive positive patient feedback and the staff survey continued to show Harefield as a place that staff would recommend to friends and family for treatment. Staff retention levels were also good as staff seemed to feel that they worked for Harefield Hospital rather than for the wider merged Trust. It was not difficult to recruit new staff generally but was more of a challenge in some scientific fields, especially where there had been a national shortage, e.g, physiotherapists and radiographers. Consideration needed to be given to finding a way to encourage more people into training for these roles. Ms Sue Jeffers, Joint Lead Borough Director at NWL ICB, advised that a survey had been undertaken in relation to hard to recruit roles about two years ago, with occupational therapists being identified as the most difficult role to recruit to. It was suggested that work be undertaken between the local health and social care partners and Brunel University to progress this.

It was recognised that the upcoming resident doctor strike would prove challenging for RBH with regard to dealing with non-elective surgery at that time. Managing demand for treatment at RBH could sometimes be tricky – if an acute hospital was under significant pressure, patients could go elsewhere.

North West London Integrated Care Board (NWL ICB)

Mr Sean Bidewell, Joint Lead Borough Director at NWL ICB, advised that the Committee had been provided with an update at its last meeting in February 2026. Members were advised that Hillingdon had achieved its discharges target of 34 patients per day (this had been 36 for the last 10 weeks and had been 50 per day before that).

To ensure that the new hospital metrics were met, it would be important for partners to reduce things like non-elective admissions and to achieve the target for average length of stay. There had been a lot of work undertaken with care homes to reduce ED attendance with senior clinical decision makers working alongside community diagnostics to prevent care home patients from going into hospital. This had resulted in a 25% reduction in attendance and a 33% reduction in non-elective admissions. The implementation of initiatives around intravenous antibiotics, falls and end of life care would be key to helping the hospital achieve its metrics for the new hospital. Universal care plans (UCPs) had been put in place for patients in care homes and consideration was now being given to increasing the number of patients in the community with a UCP. The next phase would be to secure and maintain these initiatives to ensure that the new hospital plans went forward.

Ms Sue Jeffers, Joint Lead Borough Director at NWL ICB, noted that the Committee had been provided with an update on Child and Adolescent Mental Health Services (CAMHS) at its previous meeting. Members were advised that a local GP had developed a mental health referral form with child psychologists for children and young people and that this had been rolled out in October 2025. The form had simplified the pathway to CAMHS which made it easier for GPs to engage with children and young people and their grown ups. As a result, there had been a 17% reduction in the number of GP referrals to CAMHS in December 2025 and a further 18% reduction in January 2026.

Members expressed concern that there had been a recent news item claiming that 75k children and young people in the UK were taking antidepressants. Ms Jeffers would look into this and provide the Committee with figures for Hillingdon.

The merger of the NWL ICB (8 boroughs) with the North Central London (NCL) ICB (5 boroughs) would collectively cover 4.5m residents and had proved to be a big challenge (it would be one of the largest ICBs in England). The merger would be effective from 1 April 2026 – the new Board was already in place. A consultation had been undertaken with staff and, although there would be no Borough team in place, there was a clear mandate for the ICB to engage with its 13 local authorities. It was anticipated that the two NWL and NCL Joint Health Overview and Scrutiny Committees that existed in the two ICB footprints would be merged and would need to hold the new ICB to account. It was unclear how this was going to work.

Concern was expressed that the ICBs consideration of 4.5m residents would dilute the needs of Hillingdon residents. It was thought that, if decision making was delegated to a local level, this would work well for Hillingdon but the ICB needed to trust that Hillingdon could deliver at place (the Joint Strategic Needs Assessment drilled down to where the needs were in Hillingdon rather than looking at Hillingdon as part of 13 boroughs). In NWL, population health management data was more developed and the whole system integrated care dashboard being used by partners was now being rolled out across London.

The National Neighbourhood Health Framework was published on 17 March 2026 and aimed to transform health and care services in England by moving care closer to communities. The document talked about neighbourhood teams (there were three in Hillingdon) working with social care to deliver population health needs and address disparities in health inequalities.

The medium term financial plan to 2029 included national metrics to reduce non-elective admissions of those with frailty by 10%, increase the number of people identified as at end of life by 10%, a diversion rate of 25% on outpatient referrals by March 2027 and to achieve the 82% target for ED waits by March 2027 (currently at 77.6%). Within this, the ICB and the local authority needed to agree shared financial principles including the Better Care Fund, neighbourhood footprints and the 2027/28 Joint Local Neighbourhood Health Plan.

On behalf of the Committee, the Chair thanked Mr Bidewell and Ms Jeffers for their contribution in Hillingdon over the years.

RESOLVED: That:

- 1. Ms Lesley Watts provide the Democratic, Civic and Ceremonial Manager with detailed information about the 62 day performance for each cancer speciality for circulation to the Committee;**
- 2. Ms Samreen Nawshin provide the Committee a copy of the Healthwatch Hillingdon annual work programme so that Members could provide her with any relevant information that they might have;**
- 3. Ms Sue Jeffers provide the Committee with figures for the number of children and young people in Hillingdon taking antidepressants; and**
- 4. the presentations and discussion be noted.**

69. **BUDGET AND SPENDING REPORT - SELECT COMMITTEE MONITORING**

(Agenda Item 6)

Mr Martyn Storey, the Council's Head of Strategy Finance – Adult Social Care, advised that this Committee was receiving the Month 10 report, whereas the timing of the Cabinet meeting had meant that the other Select Committees had received reports on Month 9.

Concern was expressed that a £6.5m overspend had been discovered early in the financial year and Member questioned whether the next financial year would start with more accurate figures. Mr Storey advised that officers were confident that the growth figures for the new year included demand and inflation and that 2025/26 had been rebased into 2026/27 to avoid these issues recurring. After 31 March 2026, officers would undertake a refresh in the commitments for adult social care placements which would then provide a clearer picture and a profile for the year. Mr Matt Davis, the Council's Director of Strategic and Operational Finance, noted that £18m of growth had been included for adult social care and that the cost pressures in this area were known. There would be pressures in 2026/27 in relation to fuel costs and Special Educational Needs transport but these should be covered by the provisions that had been put in place.

It was noted that the budget position was showing as £0.8m worse than it had been at Month 7 (which had been the last budget monitoring report received by the Committee). There were two reasons for this increase in spend: care home costs; and home to school transport.

Ms Sandra Taylor, the Council's Corporate Director of Adult Social Care and Health, advised that when individuals approached the Council to ask for support, an assessment was undertaken of their eligible needs which was then followed by a financial assessment (capacity assessments might also have to go to court). If the individual had savings of more than £23½k, they needed to pay for their own care. Most people had assets of more than this amount and would often go into a care home sooner than the Council would choose (when responsible for making the decision, the Council would usually put support in place to help residents to stay at home) and would pay for this care themselves. It was noted that the cost of a care home could range from £1,300 to £1,500 per week. The Council provided residents leaving hospital with a "Paying for Social Care" booklet that covered issues that would need to be considered – Ms Taylor would forward a copy of this booklet to the Democratic, Civic and Ceremonial Manager for circulation to the Committee.

There had been a small number of residents (4-6) identified that had been funding their own care home costs in homes that cost a lot more than the Council would pay. These residents had previously been unknown to the Council and had reduced their savings to a level that meant they now met the threshold for support from the Council. Sometimes it could take these residents a little while to work out what they needed to do to get support from the Council and for arrangements to be made to move the resident into a less expensive home that would usually be used by the local authority. Once the arrangements had been sorted out, the funding had to be backdated to the date that they became eligible and fees paid for the time that they had remained in the more expensive care home. It had been unusual to have this many residents in this situation at the same time.

Concern was expressed that the Council having to pick up the cost of a more

expensive care home placements appeared to be a loophole that could have a significant impact in the authority's resources. Ms Taylor advised that this was a national issue and, although it had been talked about as part of the fairer funding arrangements five years ago, this had not progressed any further. The authority's money needed to be spent wisely and fairly and, although the residents' best interests were always taken into account, finance was also a consideration.

The Council had been charging home to school transport costs for children with an Education and Health Care Plan (EHCP) to the Dedicated Schools Grant (DSG). Ms Taylor advised that personal transport budgets funded by the DSG had been available to those with an EHCP to ensure attendance at school. However, the Department of Education had advised that this should not be done unless the child or young person had home to school transport identified within their EHCP. Individual cases were being reviewed as some of this money would need to be returned to the DSG where transport had not been specified in the EHCPs. Members queried how many more cases still needed to be reviewed and the financial risk that this posed. Ms Taylor stated that her service area provided the transport but did not undertake the EHCPs so she would find out and pass this information on to the Democratic, Civic and Ceremonial Manager for circulation to the Committee.

It was noted that the next budget monitoring report to Cabinet in the new municipal year would not be until July 2026 which meant that it would not be presented to the Committee until September 2026 (a six month gap). Given that this would be a huge timescale, Mr Davis advised that officers would see what they could do to provide Members of the Committee with an update before then.

Ms Taylor advised that there were a significant number of contacts with adult social care but that the triage and early intervention that had been put in place had been effective in diverting residents and reducing the number of conversions. There had also been a shift from direct care to direct payments. This work needed to be built upon to help residents to help themselves, with initiatives such as AskSARA which enabled residents to undertake an online self-assessment to identify the equipment that they might need to help make everyday tasks easier. It was recognised that technology enhanced and enabled but would not replace, unless this had been specifically requested.

As greater use of technology had been part of the savings strategy, Members were keen to see the cost benefits as this was not explicitly visible – where had money been saved and how had this worked. It was agreed that a single meeting review on tech enabled care be held at the Health and Social Care Select Committee meeting on 21 July 2026.

Members queried what had happened to almost £4m in table 3 that was either in the red or had been written off. Ms Taylor advised that there had been an ongoing dispute with the North West London (NWL) Integrated Care Board (ICB) about their allocation of funding (other NWL boroughs had been experiencing the same issue) – although there should be a 50/50 split of costs after discharge, the Council paid 67% and the ICB paid 33%.

The Council had also been in the process of renegotiating the social care contracts when the increase in employers' National Insurance contributions had been announced. Effort continued to ensure that the Council received best value but this £2m had been written out as a difficult situation. The purchase of the care home had

	<p>not been completed until August 2025 and registration had only been completed the previous week so this had also been behind the curve in terms of providing savings.</p> <p>RESOLVED: That:</p> <ol style="list-style-type: none"> 1. Ms Sandra Taylor forward a copy of the Paying for Social Care booklet to the Democratic, Civic and Ceremonial Manager for circulation to the Committee; 2. Ms Sandra Taylor provide the Democratic, Civic and Ceremonial Manager with information about the number of EHCPs that still needed to be assessed to determine whether or not they were eligible for DSG payments and the financial risk that this posed for circulation to the Committee; 3. Mr Matt Davis provide Members of the Committee with an update on budget monitoring before its meeting in September 2026; 4. a single meeting review on tech enabled care be held at the Committee's meeting on 21 July 2026; and 5. the 2025/26 Month 10 budget monitoring position be noted.
70.	<p>CABINET FORWARD PLAN MONTHLY MONITORING (<i>Agenda Item 7</i>)</p> <p>Consideration was given to the Cabinet Forward Plan.</p> <p>RESOLVED: That the Cabinet Forward Plan be noted.</p>
71.	<p>WORK PROGRAMME (<i>Agenda Item 8</i>)</p> <p>Consideration was given to the Committee's Work Programme. It was agreed that:</p> <ol style="list-style-type: none"> 1. the Cabinet Member for Health and Social Care be invited to attend the meeting on 18 June 2026; and 2. a single meeting review be held at the meeting on 21 July 2026 to look at tech enabled care. <p>The Democratic, Civic and Ceremonial Manager would finalise the Committee's report on Adult Social Care Early Intervention and Prevention and circulate this to the Committee for their comments.</p> <p>The Chair thanked Members for their work on the Committee.</p> <p>RESOLVED: That:</p> <ol style="list-style-type: none"> 1. the Cabinet Member for Health and Social Care be invited to attend the meeting on 18 June 2026; 2. a single meeting review on tech enabled care be held on 21 July 2026; 3. the Democratic, Civic and Ceremonial Manager circulate the Committee's draft final report on Adult Social Care Early Intervention and Prevention for their comments; and 4. the Work Programme be agreed.
	<p>The meeting, which commenced at 6.30 pm, closed at 8.48 pm.</p>

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