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A

Health and Social Care Select Committee

Councillors on the Committee

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

Date: **WEDNESDAY, 3 DECEMBER 2025**

Time: **6.30 PM**

Venue: **COMMITTEE ROOM 6 - CIVIC CENTRE, HIGH STREET, UXBRIDGE UB8 1UW**

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

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Terms of Reference

Health & Social Care Select Committee

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

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

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

Agenda

CHAIR'S ANNOUNCEMENTS

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Minutes

HEALTH AND SOCIAL CARE SELECT COMMITTEE

11 November 2025

Meeting held at Committee Room 5 - Civic Centre

	Committee Members Present: Councillors Nick Denys (Chair), Reeta Chamdal (Vice-Chair), Tony Burles, Becky Haggar, Kelly Martin and Sital Punja (Opposition Lead) **Also Present**: Linda Andrew, Chief Executive, Carers Trust Hillingdon & Ealing (lead provider) Evelyn Cecil, Assistant Chief Executive Officer & Head of Mental Health Services, Hillingdon Mind Rachel Irving, Lead Therapist, Give Space Madhuri Kotecha, Senior Dementia Support Worker, Alzheimer's Society Becci Morris, Lead Therapist, Give Space Angela Stango, Chief Executive, Hillingdon Mind Jane Wheeler, Chief Executive, Harlington Hospice **LBH Officers Present**: Gary Collier (Health and Social Care Integration Manager), Ian Kavanagh (Head of Business Intellligence), Sandra Taylor (Corporate Director of Adult Services and Health) and Nikki O'Halloran (Democratic, Civic and Ceremonial Manager)
29.	**APOLOGIES FOR ABSENCE** *(Agenda Item 1)* Apologies for absence had been received from Councillor June Nelson.
30.	**DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING** *(Agenda Item 2)* There were no declarations of interest in matters coming before this meeting.
31.	**MINUTES OF THE MEETING HELD ON 16 SEPTEMBER 2025** *(Agenda Item 3)* **RESOLVED: That the minutes of the meeting held on 16 September 2025 be agreed as a correct record.**
32.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 4)* **RESOLVED: That all items of business be considered in public.**
33.	**REVIEW OF ADULT SOCIAL CARE EARLY INTERVENTION AND PREVENTION - 4TH WITNESS SESSION** *(Agenda Item 5)* The Chair welcomed those present to the meeting. Mr Gary Collier, the Council's Health and Social Care Integration Manager, advised that this was the fourth and final witness sessions for the major review of Adult Social Care early intervention and prevention (EIP). The Carers Support Services had been a critical part of the offer

insofar as the contracts that had been put in place in relation to prevention.

Ms Linda Andrew, Chief Executive of Carers Trust Hillingdon and Ealing (CTHE), advised that she had been in post for about nine weeks. CTHE provided a single point of access for carers, with 70% of the Board, volunteers and trustees having lived experience. The Team provided a highly specialised support service and built strong relationships to deliver seamless referrals and coordinated wrap around care. A two tier assessment was undertaken to ensure streamlined access:

- Tier 1 was in relation to statutory requirements; and
- Tier 2 was in relation to anything triggered by Tier 1.

Ms Andrew advised that there were 6,156 adult carers, 1,343 young carers and 536 young adult carers (aged 18-25) in Hillingdon. In 2024/25, 1,017 new carers and 345 young and young adult carers had been registered and £1,671,540 had been secured in carer related benefits, increasing the household income for carers and contributing to the local economy. Over an eight year period, around £1.7m had been secured in grant funding through strong partnership working to meet carers' needs. It was noted that carers cafes were in place across the Borough and that further work was needed in relation to hard to reach carers, particularly in Ruislip, Northwood and Pinner. Around 40 families from the traveller community were currently being supported – undertaking visits with them had helped to overcome these families' mistrust of services.

Members queried how the partners identified where they would undertake outreach work. Consideration was given to the unmet need and it had been identified that a greater presence was needed in the north of the Borough. Community groups from across Hillingdon approached the partners to hold sessions where they could talk about caring and the carers' role and the toll it took. It was noted that the Somaliland community had been particularly hard to reach as these residents did not tend to ask for help and did not recognise themselves as carers.

The effectiveness of the services that were provided were measured through a range of things including key performance indicators (KPIs), the amount of money secured in grant funding, compliments and complaints and stakeholder feedback.

The partnership had been experiencing challenges in relation to funding opportunities as an increasing number of organisations were competing for the same money and some eligibility requirements had changed (e.g., City Bridge Foundation). Members queried how partners worked collaboratively to ensure that they did not miss out on funding opportunities. Ms Andrew advised that discussions had already been undertaken between CTHE and HM regarding funding for 2028 to identify alignments, share information and source smaller pots of funding but the grant funders seemed to look differently at services that were deemed to be a statutory responsibility.

Ms Stango noted that this was a challenging time for funding in the third sector with some grants being reduced to as little as £10k which would not pay for a post and made it difficult when the organisations were trying to deliver something meaningful (Hillingdon Community Trust had reduced its grants to a maximum of £10k). Their approach needed to be flexible to work around the barriers and able to identify new carers.

There had also been challenges with providing support for the increasing number adult and young carers with their own mental health needs but it was hoped that better use

of technology (such as a pilot to develop enhanced digital services) would help. Ms Andrew advised that partners continued to look for improvements and, to this end, had reintroduced strategic development days.

Members queried how better use of technology would help to support carers when this was a largely people-based area. Ms Andrew advised that digital services would not be able to replace staff but that the pilot would help partners to engage with young adults who were more digitally enabled. Although they were not an emergency service, carers worked 24/7 so the use of technology would enable partners to provide additional support, enhancing rather than replacing what already existed.

Ms Angela Stango, Chief Executive at Hillingdon Mind (HM), noted that HM provided online counselling sessions over Zoom. The organisation had been working with Brunel University to research and develop an adaptation for Zoom that would make it feel more like a face-to-face meeting (which was the preferred method of communication). Members asked that HM provide the Committee with an update on this as it developed.

Ms Stango advised that HM's collaboration with CTHE stretched back a long way and that it had started with the provision of a drop in café for people with mental health issues. They had then secured £106k in lottery funding which had enabled them to provide additional services. The priority for carers seemed to be the ability to offload to a counsellor. These counsellors tended to work 25 hours each week and had an expert knowledge of mental health. Carers could also be provided with mental health first aid training to help them to look after themselves and work was underway with the Recovery College to deliver specific training for any carer on conditions such as schizophrenia, bipolar disorder and stress.

Ms Evelyn Cecil, Deputy Chief Executive at HM, advised that the organisation had supported more than 250 carers with their mental health in the previous year and had provided practical support to complement CTHE services and develop group activities.

Ms Rachel Irving, Lead Therapist at Give Space (GS), advised that GS was relatively new to the partnership. The organisation had been established as a Community Interest Company in 2020 and offered drama and movement therapy to young and adult carers. They went into schools to offer wellbeing workshops and provided case management support to observe emerging patterns as well as providing wellbeing workshops for the carers of those with Alzheimer's. Ms Becci Morris, Lead Therapist at GS, noted that working with young people in schools enabled them to address the real issues that these carers were facing. Their work brought carers together in groups which reduced their feelings of isolation and also reduced the stigma of being a carer. GS was able to liaise with schools and develop long and short term interventions (rather than taking a 'one size fits all' approach) and provided sessions during the summer and half term holidays.

The focus of carers was often on the person that they cared for rather than themselves. GS worked with small groups (they had worked with ages ranging from four to 97) and used drama therapy to help them to develop strategies to look after their own wellbeing. GS worked with multiple schools and colleges that had the highest number of young carers therein, and therefore the greatest need.

Give Space provided mental health and wellbeing support in schools and CTHE had also developed relationships with the schools. CTHE held monthly case management

meetings with GS to identify where the greatest need was.

Partners had been using a shared case management system (Charitylog) which stored information such as service user details, interactions, communications, workflows and outcomes.

Ms Jane Wheeler, Chief Executive at Harlington Hospice (HH), noted that HH had been involved in the partnership for a long time. They dealt with similar psychological safety and personalisation issues as the other partners and what was right for the carer was right for productivity. HH received statutory funding which had been focussed in the areas of most need. Carers' knowing that they had access to planned and urgent support, kept them going.

Ms Madhuri Kotecha, Senior Dementia Support Worker at Alzheimer's Society (AS), noted that referrals were made to AS after someone had been diagnosed with dementia and support was then provided to the carer for as long as they needed it. Although AS worked closely with HH with regard to respite, they also provided care.

Members queried how partners knew what carers wanted and how they delivered what was needed. Ms Andrew advised that partners always listened to the carers and wellbeing services were tailored to meet their needs (e.g., gardening or arts and crafts activities). CTHE provided carers with help to complete forms (e.g., Universal Credit application forms) and worked to ensure that young carers had a consistent social life (e.g., some had recently been taken on a camping trip).

It was important to ask carers "what matters to you?" rather than "what do you want?", which was more task orientated. Having listened to carers, it was important to ensure that the action being taken was working effectively. Partners needed to be flexible and not make assumptions about what carers needed. GS used creativity to explore feelings which tended to be less direct / confrontational.

Given that some were as young as eight years old, Members asked how young carers were identified as it was not something that they would necessarily recognise in themselves. Ms Andrew advised that these carers would often be identified by the schools as this was now a requirements of the Ofsted inspections. They also held carers awards and identified carers champions.

Members queried whether carers were more or less likely to be identified in stronger family units. Ms Wheeler advised that this was not an easy question to answer as strong family units manifested themselves in different ways and some of them preferred not to seek outside support.

Insofar as respite was concerned, the hours provided at Harlington Hospice were split between urgent and planned respite, with the urgent hours often being underused and therefore repurposed for planned respite. Generally, urgent respite could be organised within 24 hours.

Ms Stango advised that there had been an increase in the number of neurodiverse residents and mental health services had been overwhelmed by the increase in demand. As the NHS had been unable to meet this demand, HM had been dealing with increasingly complex cases and had been looking to recruit mental health social workers to deal with these complex needs.

Since the pandemic, people were not attending groups in the same way that they had before. There were also more people going to work now which meant that there had been an impact on the number of people that were able to volunteer their time. Conversely, this also meant that there were more people coming through to care work now.

Members queried how well partners were doing with regard to carers' assessments and the time it took to put a support package in place. Mr Collier advised that he would forward this information on to the Democratic, Civic and Ceremonial Manager for circulation to the Committee.

Ms Sandra Taylor, the Council's Corporate Director of Adult Social Care and Health, advised that the Council was pressed to the limit and would not be able to manage demand for adult social care if it had not had the support of the third sector and early intervention. She noted that these organisations needed to be provided with as much support as possible to prevent demand for adult social care services.

In terms of recommendations, it was suggested that collaborative working was a priority to ensure that families had a seamless experience. Finding appropriate venues for the various events and clubs was not always easy so support there would also be useful. It was suggested that a recommendation be included in the final report in relation to transformative interventions with a focus on positive outcomes and that consideration be given to whether there could be links with (or opportunities for) looked after children.

The Carers Support Contract was likely to evolve over the next eight years with partners continuing to be responsive to the needs of carers. The partners would welcome any additional support that was available to increase minimum grants or to help them be creative. It was suggested that consideration be given to the partnership working with Council departments such as the Library Service to facilitate creativity.

It was recognised that there had been a decrease in third sector funding. It was suggested that thought needed to be given to how the partnership could be helped with their business support structure, perhaps through initiatives like providing them with administrative support.

The partners were trying to engage with a range of communities, deal with a number of barriers and work with faith group leaders. As these communities and leaders seemed to be a common thread across a number of different topics, it was suggested that they be invited to attend a future meeting.

Ms Taylor noted that Hillingdon's core early intervention offer was vast. The 0-19 family service hubs were linked to the third sector and driven by Public Health. It was agreed that the Committee look at Public Health at a future meeting as this covered all third sector interventions across the board.

It was agreed that some draft recommendations be put together and tested with the Committee.

RESOLVED: That:

1. **Hillingdon Mind provide the Members with an update at a future meeting on the work being undertaken with Brunel University on the use of Zoom for counselling;**

	2. **Mr Gary Collier forward information about carers' assessments and putting support packages in place to the Democratic, Civic and Ceremonial Manager for circulation to the Committee;** 3. **community representatives and faith group leaders be invited to attend a future meeting to talk about engagement;** 4. **the topic of Public Health be considered at a future meeting; and** 5. **the discussion be noted.**
34.	**ANNUAL PERFORMANCE REPORT 2024/25** *(Agenda Item 6)* Mr Ian Kavanagh, the Council's Head of Business Intelligence, advised that it had appeared that the Council had not previously had the highest levels of transparency with regard to performance. Moving forward, the Committee would receive performance update reports every six months. Ms Sandra Taylor, the Council's Corporate Director of Adult Social Care and Health, noted that the information included in the report had been gathered from a range of sources including surveys, Association of Directors of Adult Social Services and the Adult Social Care Outcomes Framework. Some of the data included had been from 2023/24 whilst other data was more recent. The survey results could be a little tricky (new data was expected in December 2025) and the staff turnover had proved to be way below the London average (lower was better). Demand for social care services seemed to be relentless with increases in learning disability mental health services and older adults needing nursing dementia support. Although the contracts were being stabilised and the number of older people being supported was flattening, the number of people being supported with complex mental health needs was significant. Safeguarding referrals were also still very high but the number converting to Section 42 enquiries had been steady and reasonable, indicating that partners had been referring correctly. Artificial Intelligence tools were being used to help manage demand and Power BI dashboards had been created to provide insights into the data. It was noted that learning disability (LD) mental health clients started using social care services from a young age and for the duration of their life which then proved quite costly. There were currently around 5½k active services in adult social care being received by about 3½k individuals (which was quite stable). There tended to be lower numbers receiving home care and higher numbers receiving direct payments whereby they were able to choose their own care (home care and reablement would always be the local authority's first choice wherever possible). Investigations were currently underway to identify the reason as to why there was such a high number of LD clients in the Borough compared to other authorities. Members were advised that after triage was undertaken, there were around 1,000 assessments completed each month (with a 28 day target). Whilst most of these did not need to be provided with any adult social care services, they might be referred to third sector partners for additional support. Where services were needed, reablement was often the most appropriate intervention. Ms Taylor noted that reablement was a very effective tool for cost avoidance and had been funded through the discharge grant work that had been undertaken with the NHS. Reablement was classed as intermediate care and around 30% of referrals came from the community (e.g., GPs, self, referral, etc) so it was free to these individuals until 'aim

	achieved'. Ms Taylor advised that she was the Senior Responsible Officer for the reactive care programme on the Hillingdon Health and Care Partners partnership which aimed to prevent hospital admission. This was particularly important in relation to residents in care homes as, once admitted, older frail people tended to need to spend longer in hospital and would then need longer periods of rehabilitation (this would be helped by the introduction of mobile diagnostics). It was noted that direct payments were self-directed support. Officers made assessments and individuals might then be given a personal budget allocated for their care needs. They might then choose to have their care delivered by an agency that the Council did not use or appoint a Personal Assistant that would meet their needs. They were provided with a monthly pre-paid card (plus contingency) and were offered advice and support with regard to things like HMRC and payroll. The carer element was needed for those not able to arrange these things for themselves. Members were pleased with the format of the report but noted that it had stated "The council demonstrated robust governance structures and clear accountability mechanisms, ensuring transparency and responsiveness in service provision." This was contrary to the information that the Committee had received at a previous meeting in relation to accountability and governance. This information had stated that the structures were adequate but not fully mature or fully embedded and therefore consistent performance data and embedding of learning from reviews needed improvement. If this performance management tool had been developed to help the local authority take responsibility for its performance, then it would be important to reflect this. Ms Taylor acknowledged that this needed to be as clear as possible and would ensure that it was corrected. **RESOLVED: That:** **1. the Annual Performance Report for 2024/25 be noted; and** **2. the Committee's comments be drafted and presented to full Council in November alongside the Annual Performance Report for information.**
35.	**CABINET FORWARD PLAN MONTHLY MONITORING** *(Agenda Item 7)* Consideration was given to the Cabinet Forward Plan. **RESOLVED: That the Cabinet Forward Plan be noted.**
36.	**WORK PROGRAMME** *(Agenda Item 8)* Consideration was given to the Committee's Work Programme. **RESOLVED: That the Work Programme be noted**
	The meeting, which commenced at 6.30 pm, closed at 8.11 pm.

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

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HEALTH UPDATES

Committee name	Health and Social Care Select Committee
Officer reporting	Nikki O'Halloran, Democratic Services
Papers with report	Appendix A1 – The Hillingdon Hospitals NHS Foundation Trust Appendix A2 – The Hillingdon Hospitals NHS Foundation Trust Appendix B – Central and North West London NHS Foundation Trust Appendix C – Royal Brompton and Harefield Hospitals, Guy's and St Thomas's NHS Foundation Trust Appendix D – North West London Integrated Care Board
Ward	n/a

HEADLINES

To enable the Committee to receive updates and review the work being undertaken with regard to the provision of health services within the Borough.

RECOMMENDATION: That the Health and Social Care Select Committee notes the presentations.

SUPPORTING INFORMATION

Hillingdon Health and Care Partners (HHCP)

Hillingdon Health and Care Partners (HHCP) is the 'Place Based' alliance of health and care organisations that seeks, through collaboration and co-design, to make significant improvements to the quality and cost of care in Hillingdon. HHCP is made up of Hillingdon Hospitals NHS Foundation Trust, Central and North West London NHS Foundation Trust (CNWL), H4All (a partnership of voluntary sector health care providers) and Hillingdon's Confederation (which brings together all of Hillingdon's GPs). HHCP works together closely with the London Borough of Hillingdon and North West London Integrated Care Board (NWL ICB) to deliver 3 key strategic aims:

- Improving the outcomes for our population - delivering Hillingdon's Joint Health and Wellbeing Strategy
- Delivery of sustainable, person-centred, joined up models of care aligned to the new hospital plans and activity assumptions
- Delivering the NWL Integrated Care System (ICS) priorities through local care models building from a population health management approach

Shared delivery models are through 6 integrated Neighbourhood Teams and a range of joined up Borough wide teams across health and care.

The Hillingdon Hospitals NHS Foundation Trust (THH)

The Hillingdon Hospitals supplies services from two sites; Hillingdon Hospital and Mount Vernon Hospital and has an annual turnover of around £320 million, employing approximately 3,700 staff. We are proud to deliver services for our local borough of Hillingdon, and to those living in the surrounding areas of Ealing, Harrow, Buckinghamshire and Hertfordshire, giving us a total catchment population of over 350,000. Hillingdon Hospital is the only acute hospital in the

London Borough of Hillingdon and offers a wide range of services, including accident and emergency (A&E), inpatient care, day surgery, outpatient clinics and maternity services. The Trust's services at Mount Vernon Hospital include routine day surgery, an Urgent Care Nurse Practitioner service and outpatient clinics. The Trust hosts several other organisations that supply health services at the Mount Vernon site including East & North Hertfordshire NHS Trust's Cancer Centre.

Royal Brompton and Harefield Hospitals (RBH)

The Royal Brompton & Harefield Hospitals merged with Guy's and St Thomas's NHS Foundation Trust (GSTT) in February 2021 and, from April 2022, joined with the cardiorespiratory services at GSTT to form a new Heart & Lung & Critical Care Group across the three sites. At the same time, the Evelina Children's Hospital took over the running of the paediatric services at Royal Brompton.

The merger of the two NHS foundation trusts was approved by the Boards and Councils of Governors of both organisations in December 2020 and came into effect on 1 February 2021. This merger saw the creation of a newly expanded Guy's and St Thomas' NHS Foundation Trust, with Royal Brompton and Harefield forming a new Clinical Group within the Trust.

Since 2017, Guy's and St Thomas' and Royal Brompton & Harefield NHS Foundation Trusts have been working together, and with colleagues across King's Health Partners, to develop plans to transform care for adults and children with heart and lung disease. This merger is a key step towards achieving these ambitions. To begin with, the merger will mean clinicians and teams working more closely together, building on the partnership work over the last three years, but generally providing services to the same patients and in the same places as they do now.

Subject to the necessary public consultation, children's services will move from the Royal Brompton Hospital site to an expanded Evelina London Children's Hospital at St Thomas' in around four to five years' time. Subsequently, and again subject to consultation, the Trust hopes to build a new centre for heart and lung services at St Thomas', which will be the home to adult heart and lung services from across the new Trust and potentially other partners as well. There are no plans to move services from Harefield Hospital, but these services will be an integral part of the integration across the new Trust.

Central and North West London NHS Foundation Trust (CNWL)

CNWL is a large and diverse organisation, providing health care services for people with a wide range of physical and mental health needs. The Trust employs approximately 7,000 staff who provide integrated healthcare (more than 300 different health services) across 150 sites and in many other community settings. Types of services include:

- **Physical health:** Community treatment for physical conditions that do not require general hospital treatment or conditions that require long-term care. This includes district nursing, health visitors, stroke care and support for people in recovery.
- **Mental health:** Community and hospital treatment for children, adults and older people with mental health problems. Services range from counselling support for mild conditions to rehabilitation treatment for long and enduring mental health problems.
- **Learning disabilities:** Assessment and treatment for people with learning disabilities who also have complex mental health needs and/or challenging behaviour. Services are provided in the community or hospital.
- **Eating disorders:** Admission to hospital or appointment sessions are provided to support men and women with an eating disorder.

- **Addictions:** Community drug and alcohol treatment services are provided, as well as hospital admission when it is needed. Specialist services to address problem gambling, compulsive behaviour and club drug problems are also available.
- **Sexual health:** Appointment and walk-in services are available for anyone who needs them. This includes contraceptive choices, treatment of sexually transmitted infections and HIV testing and treatment.
- **Prison and offender care:** Full healthcare services, including primary healthcare, addictions and mental health support, are provided in a number of prisons. Mental health support is also provided in the community for people who have offended in the past or people at risk of offending.

North West London Integrated Care System (NWL ICS)

In response to the NHS long term plan, which suggested that the number of CCGs will be significantly reduced to align with the number of emerging Integrated Care Systems (ICSs), North West London (NWL) CCGs launched a case for change for commissioning reform on 29 May 2019. The case for change recognised that there were questions on how the CCGs respond to the configuration issues raised by the long term plan which required exploration and resolution. Following the engagement period, the recommendation to governing bodies was to proceed to a formal merger of CCGs from 1 April 2021, using 2020/21 as a transition year to focus on the following:

- System financial recovery
- Development of integrated care at PCN, borough and ICS level
- Building closer working relationships with the local authorities
- The development of a single operating structure across the commissioning system, and meet the expectations of NHSE that the CCG would operate in 2020/21 under a single operating framework, with the associated reduction in management costs and streamlined governance
- To work with providers to develop alternative reimbursement structures from 2020/21 to support delivery of ICP/ICS

On 1 April 2021, the eight Clinical Commissioning Groups in North West London (NWL) became one organisation, and the ICS then came into being in 2022.

Healthwatch Hillingdon

Healthwatch Hillingdon is a health watchdog run by and for local people. It is independent of the NHS and the local Council. Healthwatch Hillingdon aims to help residents get the best out of their health and social care services such as doctors, dentists, hospitals and mental health services and gives them a voice so that they can influence and challenge how health and care services are provided throughout Hillingdon. Healthwatch Hillingdon can also provide residents with information about local health and care services, and support individuals if they need help to resolve a complaint about their NHS treatment or social care.

Healthwatch Hillingdon is one of 152 community focused local Healthwatch. Together, they form the Healthwatch network, working closely to ensure consumers' views are represented locally and nationally led by Healthwatch England.

Healthwatch Hillingdon is all about local voices being able to influence the delivery and design of local services. Not just people who use them, but anyone who might need to in the future. By making sure the views and experiences of all people who use services are gathered, analysed and acted upon, Healthwatch can help make services better now and in the future.

To make sure that the voices of children and young people are heard, Healthwatch Hillingdon created Young Healthwatch Hillingdon (YHwH). YHwH is made up of volunteers who represent the views of children and young people living, working or studying in Hillingdon. They do this by:

- Sharing and promoting information about health issues and services that affect children and young people through events, social media updates and reports.
- Speaking to children and young people and gathering their views about what health issues and services are important to them.
- Working with health and social care services representatives to try to shape and improve services for children and young people.

Witnesses

Representatives from the following organisations have been invited to attend the meeting:

1. The Hillingdon Hospitals NHS Foundation Trust (THH)
2. Central and North West London NHS Foundation Trust (CNWL)
3. Royal Brompton & Harefield Hospitals, Guy's and St Thomas' NHS Foundation Trust (RBH)
4. Hillingdon Health and Care Partners (HHCP)
5. Integrated Care Board (ICB)
6. Healthwatch Hillingdon (HH)
7. The Confederation Hillingdon CIC

Hillingdon Hospital Redevelopment update

November 2025

Introduction

Members of the Health and Social Care Select Committee received an update on the redevelopment of Hillingdon Hospital in June 2025.

This included information on new national guidance for new hospitals being built, how we are preparing our current hospital site for construction, the Target Operating Model, and the process to appoint a contractor.

This paper provides an update on the progress we have made over the last five months.

Stage one of the design process completed

Since August 2025, we have been working closely with the New Hospital Programme (NHP) on the first stage of the revised design for the New Hillingdon Hospital.

We now have an agreed feasibility stage design for our New Hospital. This includes where each department will be located and how services will be organised to ensure staff and patients receive the best care and experience possible.

This was agreed by our Redevelopment Programme Board in October 2025.

Stage two of the design process

NHP have approved progression to the next stage of the design process

This will involve detailed planning for all hospital areas including every corridor, ward, theatre, staff and patient space plus every other part of our new hospital.

Our current latest design is based on the NHP's Hospital 2.0 principles which is a standardised blueprint now mandated by NHS England and the Department of Health and Social Care. To comply with this, our New Hospital will look different from our previous design, and an updated planning application will be submitted to Hillingdon Council next year.

Target Operating Model

A draft of the Target Operating Model has been developed in line with the New Hospital Programme guidance.

This covers a range of areas including patient safety, transformation strategy, future models of care, workforce, digital, and operational command functions.

It incorporates extensive engagement with clinical, operational, and external stakeholders.

Work also continues on the enabling strategies – workforce, digital, estates and facilities – which will support the Target Operating Model.

Preparing our current site for construction

Work continues to prepare the current hospital site to start building the New Hillingdon Hospital.

To make sure that we are ready to start construction in 2028, there will be a series of temporary service relocations and moves which are crucial to this major site redevelopment.

Building works are being carried out across the Trust to support our work to prepare our site for construction. This includes:

Currently we are completing:

- Refurbishment of the Furze building
- Building clinical accommodation within one of the existing Hillingdon Hospital courtyards.
- Refurbishment of the ground floor of the Medical Block at Mount Vernon Hospital.

Timelines

The Trust continues to work with the New Hospital Programme to develop a detailed programme of works. The draft milestones are below:

Contractor selection and onboarding	2026
Outline business case submission	2026
Full business case submission	2028
Construction begins	2028
New hospital welcomes first patients	2032

Stakeholder communication and engagement

A detailed plan is in place to ensure that we continue to involve a range of stakeholders including patients, residents and the wider community in this project.

We are also working with partners including Hillingdon Council and Hillingdon Health and Care partners to ensure that patients receive the right care in the right place when the new hospital opens.

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Chief Executive Officer's Report – The Hillingdon Hospitals NHS Foundation Trust

Accountable director: Lesley Watts
Job title: Chief Executive Officer

Executive summary and key messages

1. Key messages

1.1 ED performance top performer in London

We have seen sustained improvements in our Urgent and Emergency Care (UEC) performance, placing us as the second best in London for UEC performance. Performance across all domains (UEC, cancer, diagnostics and elective recovery) remains a focus for all of us. This is not just a set of targets- it represents the experience of our patients, the safety and quality of care we deliver, and the confidence our community place in us. The improvement in UEC performance has been recognised by NHS England London region and we would like to thank the tremendous efforts of our staff who have worked to support this sustained improvement.

1.2 NHS Oversight Framework

NHS England has introduced a new Oversight Framework that publicly ranks NHS trusts across areas such as quality, safety, access, workforce, and efficiency. Our Trust has been placed in Segment 4 (out of 5). Factors that have influenced this rating include:

- A national rule that limits ratings for trusts reporting a financial deficit in Quarter 1, which automatically caps our overall rating regardless of clinical performance.
- Higher-than-expected rates of C. difficile and E. coli infections, which have impacted our patient safety score.
- Challenges in timely access to services, including referral-to-treatment (RTT) times, cancer diagnostic pathways, and long waits in emergency care.

Segment ratings are reviewed quarterly, and we are actively working to improve across all areas.

By domain (1 – high, 4 – low) the trust is scored as follows:

- access to services – 3
- effectiveness and experience of care - 2
- patient safety - 4
- people and workforce - 3
- finance and productivity - 2

1.3 Urgent Care Nurse Practitioner Service, Mount Vernon Hospital

The Urgent Care Nurse Practitioner Service at Mount Vernon Hospital has been reconfigured into the Urgent Treatment Centre at Hillingdon Hospital. The last patients were seen at the Urgent Care Nurse Practitioner Service on Friday 26 September. By bringing services together, we are building a more resilient model of care that will improve patient experience and ensure we can provide the right care in the right place.

This change is an important step in strengthening our urgent care services and ensuring we continue to deliver high quality, safe and responsive care for our communities.

1.4 Inclusion and Diversity at Hillingdon

As part of National Inclusion Week, our colleagues across Hillingdon shared their personal reflections on what inclusion means to them. Their stories remind us that inclusion isn't abstract—it's lived every day through respect, openness, and the value we place on one another.

We're also proud to have worked with *The New York Times* to shine a light on our international workforce and their stories. Our diversity is not just something we recognise—it's what makes us stronger, more connected, and better able to care for our community. Together, we continue to build a culture where every voice is heard and every contribution matters.

1.5 Preparing for winter and supporting our staff

We are preparing for 2025/26 winter with an operational plan that sets out the Trust's approach to performance, incorporating outputs of a whole-system approach, to detailing what needs to be in place to support our services, patients and staff through what is going to be another challenging winter period of seasonal pressures.

The plan builds on learning from the previous year, integrates updated Integrated Care Board and NHS England requirements, and outlines the Trust-wide actions taken to ensure safe, effective, and timely care during the most operationally challenging period of the year. Our winter preparations will require a Trust-wide proactive approach focusing on our clinical pathways.

2. Quality and Safety

2.1 In August 2025, there were 47 recorded inpatient falls. This is an increase on the 33 reported in July, but remains within expected limits. The rate of reported falls per 1000 bed days, both for August and the year to date, remains below the Trust threshold of 4.6.

2.2. August saw the Trust receive 36 formal complaints, down from 44 complaints in July. The complaints are based on patient/service user attendance/activity within the hospital and therefore reflect on the volume of formal complaints.

2.3 There were zero recorded 78+ week waits and for the first time there were zero 65+ week waiters. 52+ week waiters has increased significantly. This is driven by ENT and data quality.

3. Operational performance

3.1 The UEC improvement programme continues with 5 key areas of focus: Front Door, ED, Admissions, Discharges and Medical SDEC. All type performance exceeded the national target and operating plan delivering 81.8% against the 4-hour standard for August, the second month to hit the target.

3.2 The front door flow has improved to reduce crowding in ED, streaming only 22% of all attends to ED.

3.3 Delays in LAS handover at 30 minutes reduced significantly, with performance at 97.9% for 30 mins and 83.3% for 15 mins.

4. Financial performance

4.1. Year to Date (YTD) Deficit

The year-to-date position for the first three months of the year was a £1.5m deficit, £1.5m adverse against the breakeven plan, this includes £1.5m expected variance to plan due to the phasing of delivery for the Trust's cost improvement plans.

4.2 Income Performance

The Trust's income position is largely in line with our plan. Elective Recovery Fund (ERF) activity is capped in 2025/26 and other activity is blocked. The YTD ERF over performance as at Month 3 is valued at £1.2m, however due to the cap this is not recognised within the position.

4.3 Pay Costs and Use of Temporary Staffing

The Trust has continued to see the trend of reducing temporary staffing spend, with agency costs representing 1.4% of the total pay costs. As well as reducing pay costs due to delayed recruitment and reduced temporary cover.

Pay costs remain over budget for Medical and HCA staffing groups, however this has reduced in Month 3 which is believed to be a result of the pay control panels, and the first month of this financial year without bank holidays.

4.4 Forecast

As at Month 3 the Trust is forecasting to deliver its plan, therefore there is a need to recover the £1.5m YTD deficit.

4.4 Cash and Better Payments Practice Code (BPPC)

Following funding received for 2024/25 activities, The Trust is in a stronger cash position at the start of this year. There is however a need to catch up on payments owed to suppliers. In the short term this will result in reduced performance for the BPPC as older invoices are reported as paid. This performance measure will improve later in the year.

5. People

5.1 Launching Great Big Thank You Week and Cheer Awards

We are launching a Great Big Thank You Week to celebrate our staff. This will be a week-long occasion at the start of December, packed with exciting events to celebrate the hard work and dedication of our staff and volunteers. We will also be hosting new Cheer Awards to recognise our staff with a number of awards and a celebration event.

5.2 New public-nominated CARES Award

Our CARES Awards are now open for public nomination, allowing patients and visitors to easily tell us if they have had a good experience and want our staff to be recognised for doing a good job. Nominations are accepted online, with staff recognised in a monthly recognition breakfast celebration with the Executive Team at the Trust.

5.3 Health, wellbeing and staff inclusion information event

Colleagues were invited to a Health and Wellbeing Event in September, with information and guidance from our Wellbeing Team, Freedom to Speak Up Guardian, Stop Smoking clinic and Health and Safety Team.

6. Equity, diversity and inclusion (EDI) update

6.1 National Inclusion Week

During National Inclusion Week, the Trust paid tribute to the wealth and expertise of our diverse team at our Trust by sharing the individual stories of staff reminding us of the role of inclusion in the work place and why it matters.

6.2 South Asian Heritage Month

We marked South Asian Heritage Month (from July to August) across the Trust with a celebration of diverse cultures, histories and identities. Our events included:

- **Flavours of Home** – an online culinary showcase with staff presenting a favourite South Asian dish, showing how it was made and reflecting on the story behind it.
- **Traditional Dress Day** – staff were invited to come to work wearing traditional South Asian dress to represent their South Asian heritage.
- **South Asian Menus in our restaurants** - South Asian-inspired dishes were available on our menus during the month of celebration.
- **Stories of Connection: a culture share webinar** - Staff from different South Asian backgrounds shared short stories about identity, heritage. Followed by a live Q&A and discussion.

7. Trust highlights

7.1 Summer event for our young cancer patients

Our Paediatric Oncology Team at Hillingdon Hospital hosted a heart-warming summer party for patients and families. The event was held in the facilities at Hewens College.

7.2 Hip patients benefit from our improvement work

Teamwork, excellent care, close monitoring and good data have helped drive significant improvements in our hip fracture care, making us second best in London and seventh in England. In addition, length-of-stay for our hip fracture patients is now below national average.

7.3 ‘Pharmacy First’ pilot exceeds expectations

We have led a London-first pilot to redirect patients from an Urgent Treatment Centre (UTC) pathway to our community pharmacists. The pilot measured the feasibility and effectiveness of a Pharmacy First referral pathway from a UTC setting.

The pilot involved staff leading a successful re-direction of patients with minor illness from urgent and emergency care services to community pharmacists. The pilot

has already exceeded our expectations, demonstrating the potential to release UTC capacity, reduce pressure and waiting times, and improve access to timely care.

7.4 Additional translation tool supports better patient care

A new translation tool, CardMedic, is being used in our hospitals. It can help patients and staff overcome communication barriers, providing instant access to thousands of clinically interpreted interactions in over 50 languages and multiple accessible formats. This includes sign language, Easy Read, and Read Aloud, helping to create more inclusive and effective care.

7.5 Day of hernia surgery using Da Vinci surgical robot

Surgery teams cleared a High-Intensity Theatre List of seven hernias in a day, using the Trust's Da Vinci surgical robot. The success of the day reduced waiting lists of similar surgical cases through maximum efficiency in theatre and rapid throughput.

7.6 Laser prostate procedure is another first

Urology surgeons, anaesthetists, nurses, operating department practitioners and other colleagues performed a Thulium Laser Enucleation of the Prostate (ThuLEP), a minimally invasive process to treat an enlarged prostate. This can give the patient significant and lasting relief from symptoms.

The procedure, using the laser instead of making an incision to remove obstructive tissue, reduces the risk of bleeding with lower risk of complications. It was a first for our Trust and was carried out in the theatres at Hillingdon Hospital.

7.7 Annual Members' Meeting

Our Annual Members Meeting was held on Wednesday 16 July 2025, where Foundation Trust members, partners, stakeholders and members of the public were invited to attend. During the evening the presenters reflected on the past year and presented how the Trust is working to improve care and support our communities.

7.8 Formal opening of our Jubilee Rehabilitation Garden

Patients, staff and guests were invited to the Jubilee Rehabilitation Garden for its formal opening ceremony. The garden, created next to the Jubilee Building at Hillingdon Hospital, is the work of garden designer Tom Stuart-Smith, assisted by a team of Trust volunteers who helped with the planting and ongoing maintenance.

8. Updates from the Council of Governors (COG)

8.1 The Council of Governors (CoG) formally convened in public on 16 July 2025 as part of the Annual General Meeting. During the session, the CoG received the Annual Report and Accounts, the Auditor's Annual Report, and a summary of our performance and innovation throughout the 2024/25 financial year.

8.2. The Council of Governors (CoG) attended a well-received briefing on the Dementia pathway, which was positively received by attendees.

8.3 In September 2025 the CoG approved the extension to the terms of office for Non-Executive Director - Nick Gash. Nick will continue his tenure on the Hillingdon and

Imperial Board until 13 October 2028, ensuring continuity and ongoing expertise for both Trusts.

8.4 The CoG and Hillingdon board approved a one year extension to those governors who were offered a two year term in the 2023 election process. This extension aligns all governor terms of office to 3 years and ensure continuity as the NWL APC establishes a formal group structure with the appointment on a single accountable officer.

8.5 We would like to extend our sincere thanks to all our governors for their continued commitment and contributions. Recognition and celebrating success.

9. Recognition and celebrating success

9.1 London Maternity and Neonatal Excellence Awards 2025

Dr Tristan Bate, Consultant Neonatologist and Clinical Lead in the Trust, was nominated for the London Maternity Neonatal and Excellence Awards 2025 in the 'Compassionate leadership award' category. This award honours individuals who have demonstrated exceptional leadership in education, research, and training, inspiring the next generation and fostering a culture of kindness, inclusion, and continuous improvement.

9.2 Radiologist Allan Andi rated a top tutor

Dr Allan Andi has been recognised at the 2025 Imperial College School of Medicine Education Awards as one of three recipients of the Excellence in Tutoring Award. Nominated by students across the entire school, the award acknowledges tutors who have provided exceptional support, advice, and guidance throughout the academic year.

Hillingdon Health and Social Care Committee

CNWL Update – December 2025

Community Services Month

Building on the successes of last years events, we are proud that November is Community Services Month again in CNWL. The month celebrates the fantastic work that our physical health community services do across our organisation and culminates in our Hillingdon open day at Southlands Art Centre on 27th November. The event is open to the public and aims to showcase and raise awareness of our services.

Neighbourhood Developments

CNWL is working with our partners to bring together services in neighbourhoods which can focus on delivering local care to our populations. To promote integrated working we have been realigning our nursing and mental health services around neighbourhoods. Hillingdon is seen as a leading example of partnership and neighbourhood working an we were really pleased to host two visits from national representatives recently. In November the Minister of State for Care, Stephen Kinnock MP and local MP Danny Beales visited and similarly back in September The Right Honourable Baron Lord Victor Adebowale, CBE, NHS Confederation Chair also visited.

From a children's viewpoint we are actively engaged in London Borough of Hillingdon's work on Family Hubs, and how our children's services can support this offer. We are also working with the health system on Child Health Hubs which focus more on a medical offer for complex cases and bringing a multidisciplinary approach to the provision of their care.

Urgent Emergency Care – Additional Funding

We are pleased to have secured additional funding from NWL ICB to support our crisis pathways for physical and mental health. Our new model for Urgent Community Response (UCR) is currently being mobilised for January and will see additional UCR capacity to support patients in a physical health crisis in under two hours to avoid A&E attendance or admission. Furthermore, this expanded model will provide ongoing support, where appropriate, between 3 and 17 days through our new Hospital at Home model.

Furthermore, funding is expanding our model in Hillingdon Hospital (THH) A&E. The Lighthouse is collocated behind THH A&E and aims to provide a therapeutic environment to support patients experiencing a mental health crisis. CNWL and THH have worked together to develop a new model which increases capacity in The Lighthouse. From 17th November capacity has increased so it can support 4 patients at any one time, to 6, and will further expand to 8-10 patients from 17th December. This will reduce the number of patients in A&E experiencing a mental health crisis, and the length of time they are waiting.

Children's Neurodevelopmental Diagnosis

Nationally there has been a significant increase in the number of children being referred for a neurodevelopmental assessment. A recent study by The Nuffield Trust has shown four time as many children are now being referred than there was three years ago. Like many areas nationally, Hillingdon has struggled for capacity to see this volume of children and we currently have just under 2,000 children waiting for a neurodevelopmental assessment for up to two years. NWL ICB have responded in October by providing additional non-recurrent funding in 2025/26 that will enable 50% of the children waiting to be assessed. Schemes to action this have been and are being mobilised. From a longer-term viewpoint, we are

transforming our pathways to ensure we have a safe but optimal process for assessing children which maximises latest digital technology to improve productivity. This includes the roll out of ambient voice technology which helps reduce clinical administrative work which is reinvested into clinical care.

We are also ensuring families referred to ourselves for assessment are signposted to the new ICB wide CAAS (Centre for ADHD and Autism) service which provides families with support pre, and post diagnosis including education, peer support and group sessions.

MHST (Mental Health Support Teams) – Wave 14 Rollout

Our MHST teams work with schools to support children with mental health concerns. We are really pleased to have received additional resources through Wave 14 of the national rollout in Hillingdon which will mean a new MHST team in January further supporting more schools across the borough. We are working with universities who support these schemes through trainees and in the process of implementing.

SEND (Special School Nursing)

Recurrent funding for the additional nurse to support The Eden Academy has been identified by NWL ICB. As of early October 2025, there has been Bank support provided whilst we recruit to the permanent post.

Royal Brompton and Harefield Hospitals

Briefing Report for the Health and Social Care Select Committee
November 2025

Elective activity

Cardiac Surgery

The total number of patients at Royal Brompton and Harefield Hospitals who have been waiting for more than a year for their cardiac surgery has decreased since the last report and all sites will meet both the 65-week wait target by 21st December 2025 and the 52-week target by 31st March 2026. Work continues to improve Theatre productivity, particularly the reduction of cancellation rates and improved scheduling processes. Any patients waiting over 6 weeks are closely monitored via our ORTUS platform. This platform remotely monitors a patient's condition and flags any deterioration to the clinical teams who then review the patient.

Cardiology

Both Harefield and Royal Brompton hospitals will achieve the target of zero patients waiting over 65 weeks by 21st December 2025 and are now working towards clearing all patients waiting 52 weeks by 31st March 2026. Within the Heart, Lung and Critical Care Clinical Group meeting the 52-week target is going to be the most challenging for Cardiology (Inherited Cardiac Conditions) and the Vascular Service, the later of which is delivered at St Thomas' hospital. During this financial year, GSTT took over the Lewisham and Greenwich NHS Trust vascular service and hence their long waiting patients. Additional outpatient, diagnostic and procedure capacity has been created to accommodate these long waiting patients and the patient pathways are currently under review.

There are currently 618 cardiology patients at Harefield Hospital and 539 patients at the Royal Brompton hospital awaiting a Cath lab procedure. The breakdown of these procedures is below:

Procedure Type	RBH	HH
Angio	94	78
Devices	96	49
Ablation	223	409
TAVI (transcatheter aortic valve insertion)	11	6
Other structural	115	76
Total	539	618

Over the last 6-9 months, Harefield Hospital has seen a significant increase in the number of patients waiting for an ablation procedure. This is due to increased referrals into the Electrophysiology (EP) Service and despite an increased number of ablation procedures being performed in the cath labs (due to efficiency gains), the waiting list continues to grow. To address this issue, HLCC is looking at this service across all hospital sites as well as reviewing the patient pathways. In addition, weekend EP cath lab lists are also being undertaken.

Diagnostics

Hospitals are measured against a DM01 standard which covers 15 diagnostic tests and 95% of all patients should receive their diagnostic test within 6 weeks of referral.

Brompton and Harefield Hospitals are performing well against this standard for most modalities. MRI and CT performance remains static on both sites with 95% of patients being seen within 6 weeks in both modalities.

Due to staffing constraints at both sites and the provision of support to the St Thomas's site, the overall DM01 performance for Echo remains a concern. The position has slightly worsened since the last report with 80% of patients having their scan within 6 weeks. With recruitment of staff into current vacancies, this position with improve and performance will return to previous levels.

The DM01 performance for sleep studies has seen an overall improvement. The Brompton site has seen a significant improvement; however, Harefield capacity remains challenging. Actions continue to be taken to improve performance. The planned trajectory is that the backlog will be significantly reduced by 31st January with Harefield will achieve compliance by the end of February 2026.

Cancer (Lung)

In April 2025 Royal Brompton and Harefield Hospitals reported that there was an overall reduction in the number of patients waiting thoracic surgery. This trend has continued over the last 7 months and there are currently 114 patients on the waiting list. Fifty of these patients have breached the 62-day target which is a 6% improvement since April 2025. Unfortunately, many of the referrals into our service are received after the 62-day target has already breached at the patient's local hospital.

The Trust is currently focusing on reducing the diagnostic component of the patient's pathway which will further reduce the number of patients breaching the 62-day target. Currently, patients referred to us wait 3 - 4 weeks for their surgery which is significantly better than 1 year ago when patients were waiting up to 8 weeks for their surgery.

It should be noted that our outcomes for thoracic surgery remain excellent. Recent data regarding surgical outcomes indicates that Royal Brompton and Harefield Hospitals have a mortality rate of 0.32% for patients 30 days post-surgery or less, which is almost ten times more favorable than the national average of 2.80%.

This year, the thoracic surgeons across our hospital sites have also commenced robotic surgery and this is likely to increase with plans for further robots to be introduced.

Transplant Activity

In 2024/25, Harefield performed 36 heart transplants and 26 lung transplants. This was the highest number of heart transplants carried out by a transplant centre in the UK.

This year to date, Harefield Hospital has performed 26 lung transplants, 21 heart transplants and 26 mechanical circulatory support (MCS) devices. At this point in the last financial year, a total of 12 lungs and 16 heart transplants had been performed so the activity this year well exceeds that of last year.

In the summer Harefield Hospital celebrated 30 years of Mechanical Circulatory Support (MCS) and the event was marked by staff and patients.

Harefield Clinical Strategy and Future Developments

The Harefield Clinical Strategy document has been finalised and endorsed by the Board.

The vision for Harefield Hospital is:

To be international leaders in the management of advanced heart and lung disease, whether acute or non-acute, delivered at scale through the most complete repertoire of treatment modalities, supported and aligned with cutting edge science.

The ambition is utilise the space, clinical expertise and academic links to create a fully integrated life sciences campus on the Harefield hospital site in partnership with pharma and MedTech.

The next step is to prepare an implementation plan outlining the various phases of the project and to develop the necessary Estates and Workforce strategies.

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Hillingdon Health and Care Partners

NHS North West London

Hillingdon Health and Social Care Select Committee

Hillingdon Place Integrated Performance Report and Service Update

Report for Hillingdon Health and Social Care Select Committee – 03rd December 2025

Health and Social Care Select Committee - Background and Overview – Summary of Priorities linked to Health and Wellbeing Board

1. Purpose, Background and Overview

This report provides the Health and Social Care Select Committee with an overview of progress against Health and Wellbeing Boards five strategic priorities and the major transformation programmes supporting them. It summarises delivery achievements, emerging performance trends, and risks to outcomes.

Hillingdon's strategic priorities—**Best Start in Life, Live Well, Age Well, Healthy Places, and Equity & Inclusion**—are aligned with Core20PLUS5, NWL ICB priorities, and the Council's policy framework. The first two years of delivery focus on **Live Well, Age Well, and Equity & Inclusion**, reflecting the scale of need, the opportunity to reduce inequalities, and the significant impact these priorities have on urgent and unplanned care.

This update covers progress in three main areas:

1. **Integrated Neighbourhood Teams (INTs)** – delivering preventative, personalised care; early gains in hypertension control and frailty management; expansion of outreach and health checks.
2. **Reactive Care Programme** – strengthening urgent community response, improving flow, reducing "No Criteria to Reside" delays, and preparing for winter.
3. **Best Start in Life** – developing the Child Health Hub model, expanding school mental health support, and responding to high neurodevelopmental demand.

The report sets out current performance, highlights improvements in preventative care and hospital flow, and identifies areas requiring further acceleration to meet ambitions for 2026.

2. Key Messages

- ✓ **Emergency demand remains high.** A&E attendances average **171/day**, above the target of 164, meaning the system continues to operate under sustained pressure despite a reduction from last winter's peak.
- ✓ **There are early signs of improved hospital flow**, driven primarily by the 27% reduction in "No Criteria to Reside" (NC2R) delays (48 → 35). These improvements help stabilise bed capacity, but performance remains fragile and highly sensitive to winter pressures.
- ✓ **Neighbourhoods are now fully operational.** All three INTs are live borough-wide, providing the foundation for proactive community care.
- ✓ **Frailty management is reducing admissions.** Around **50%** of the severe frailty cohort is under enhanced case management, contributing to a **36% reduction** in emergency admissions for these residents.
- ✓ **Hypertension outcomes are strong.** Recorded prevalence has risen to **13.8%**, with **77%** of known patients achieving blood pressure control—highest in NWL.
- ✓ **Reactive Care model is maturing.** The Coordination Hub launches December 2025, UCR now has daily Senior Clinical Decision Maker coverage, Lighthouse capacity has expanded to divert mental health demand from A&E and Mobile Diagnostics to Care Homes and People with Frailty has gone live
- ✓ **Best Start in Life is progressing.** Child Health Hub development is underway and school Mental Health Support Team (MHST) coverage is increasing from 60% to around 80%.
- ✓ **Major challenges remain.** The main cross-cutting risks are high A&E demand, sustaining NC2R improvements, growth in long-term conditions, CYP neurodevelopmental demand, and winter pressures.

Executive Summary

3. Executive Summary

Hillingdon continues to make meaningful progress in delivering its Health and Wellbeing Strategy. Neighbourhood-based prevention, improved urgent community response, and stronger children's mental health support are beginning to shift demand away from acute settings and improve outcomes for residents. However, system pressures remain significant and will require sustained collective focus through winter.

- **Neighbourhoods (Live Well & Age Well).** All INTs are operational and delivering early impact. Frailty case management covers half of the cohort, reducing emergency admissions by 36% for those in scope. Hypertension case-finding has significantly expanded prevalence and 77% of patients now achieve blood pressure control. Next steps include full frailty coverage, expansion of anticipatory care, and integration with emerging Neighbourhood Local Access Hubs.

- **Reactive Care.** Flow is improving, with NC2R reductions and expanded urgent community services including UCR, Senior Clinical Decision Makers, community IV antibiotics and direct GP-to-SDEC access. The Coordination Hub will simplify referral routes and strengthen rapid response. The key risk remains winter demand and sustaining 7-day discharge processes.

- **Best Start in Life.** Work has commenced on a new Child Health Hub model aligned to the Family Hubs network. MHST expansion will extend support to ~80% of schools. Neurodevelopmental demand remains high, but additional funding will enable around half of the 2,000 waiting children to be assessed this year. The CYP dashboard will provide clearer oversight of outcomes and inequalities.

- **System Risks.** The main cross-cutting risks are high A&E demand, workforce constraints, sustaining NC2R improvements, growth in long-term conditions, CYP neurodevelopmental demand, and winter pressures. Mitigations include continued development of community alternatives to hospital care, joint workforce planning, strengthened discharge pathways, expanded prevention and anticipatory care, targeted CYP investment, and activation of the winter resilience plan.

- **Investments:** A number of targeted investments support delivery of the programme, including expansion of urgent community services, Lighthouse, neighbourhood prevention, and CYP backlog reduction. A full investment table is provided in Appendix 1

4.1 Integrated Neighbourhood Teams: Purpose & Model

Integrated Neighbourhood Teams (INTs) are the core delivery model for Hillingdon's *Live Well* and *Age Well* priorities. Each Neighbourhood now brings together GPs, community services, social care, mental health and the voluntary sector into a single team focused on **prevention, early intervention and personalised care**. Neighbourhood working also aligns closely with Family Hubs and the Healthy Places agenda, ensuring joined-up support for families and communities.

The model aims to **keep residents healthier for longer**, reduce avoidable hospital use, and ensure coordinated support for people with long-term conditions and frailty. INTs provide proactive case management, anticipatory care and integrated support planning across partners.

Neighbourhoods (Live Well & Age Well)

.4.2 Integrated Neighbourhood Delivery (Progress Update)

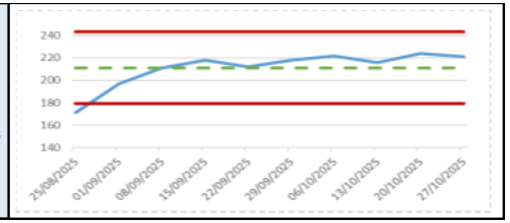
- **All INTs fully operational.** Multidisciplinary teams are now active across all three localities, providing a consistent neighbourhood model for prevention and coordinated care.
- **Frailty case management progressing well.** Around **50% of the severe frailty cohort (~1,000 residents)** is now under enhanced case management, contributing to a **36% reduction in emergency admissions** among these patients. Full coverage will be a key focus for 2026.
- **Hypertension and long-term conditions.** A borough-wide case-finding drive has increased recorded hypertension prevalence to **13.8%**, identifying thousands of residents previously not in care. **77%** of known hypertension patients now have controlled blood pressure—one of the strongest performances in NWL. Work is underway to expand anticipatory care for COPD and diabetes.
- **Targeted outreach reducing inequalities.** Community outreach in high-need areas is identifying significant undiagnosed risk and strengthening prevention, with rapid escalation to primary care and INT support.
- **NHS Health Checks.** Approximately **350 high-risk residents** have received proactive checks, improving early identification of cardiovascular risk factors.
- **Governance & infrastructure.** A Neighbourhoods Steering Board now oversees delivery and alignment. Work has begun on the **Integrated Neighbourhood Hub** business case to co-locate primary care, community and voluntary services in Hayes, Ruislip and Uxbridge.

4.3 Primary Care, Pharmacy and Dentistry (See Appendix 1 and 2 for Key Metrics)

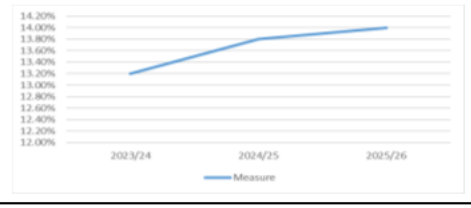
- **Primary Care Networks & Enhanced Services**
  PCNs continue to deliver the NWL Enhanced Services Single Offer, strengthening prevention and long-term condition management in primary care. Shifts from hospital to community settings (e.g. anticoagulation monitoring) and strong performance in diabetes and mental health are contributing to more consistent care across practices. £6.78m annual funding is secured to 2028, enabling continued alignment between PCNs and INTs.
- **Pharmacy First**
  Pharmacy First is now a major access route for minor illnesses (acute sore throat, uncomplicated UTIs, sinusitis and other minor infections). Between March–August 2025, **18,000+ consultations** took place, including **3,000 referrals** from NHS 111/GP/UTC. This has diverted low-acuity demand from GP practices and urgent care, supporting same-day access and relieving pressure on A&E. Ongoing Medicines Optimisation support ensures quality, safety and appropriate use of the service.
- **Dentistry (Access Expansion and Prevention):**
  - **Expanded NHS capacity.** Fourteen dental practices in high-need areas have increased appointment availability, improving access for residents who previously struggled to secure NHS dental care.
  - **Children's Oral Health Pilot.** Focused on the most deprived areas, the pilot is improving access to exams and fluoride treatments for children under 16, linking closely with Family Hubs.
  - **Inclusion Dental Pilot.** Provides longer, trauma-informed dental appointments for vulnerable groups, including people in temporary or emergency accommodation.
  - **24/7 urgent dental care via NHS 111.** Ensures residents with urgent dental needs can access appropriate care while avoiding unnecessary A&E attendance.

Neighbourhoods (Live Well & Age Well)

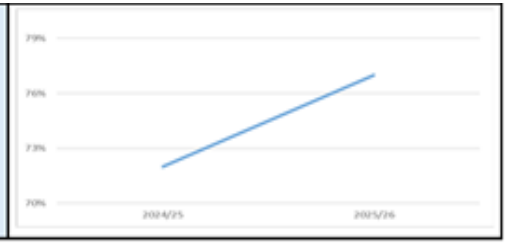
4.4 Neighbourhood Performance Metrics

UTC Activity Reduction (Traffic light measured against 10 wk Avg)	Monthly Actual **220**	Target 180 / 10 wk Average 211 / Trajectory 176	Graph Trendline for last 10 wks		

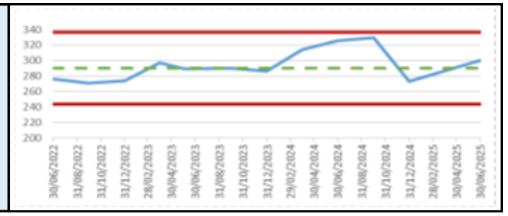
Narrative / Likely Cause	Actions to Remedy	Timeline	Accountability
The 10 week average is currently at 211 attendances per day with an October average of 220.	Revised delivery plan incorporating stronger front door diversion & capacity improvement.	Phased Rollout from Q3 25/26	SRO Neighbourhoods

Increase Hypertension Prevalence for 18+ population	YTD Actual **13.8%**	Target 16% / Previous Year 13.2% / Trajectory 16%	Yearly Trendline		

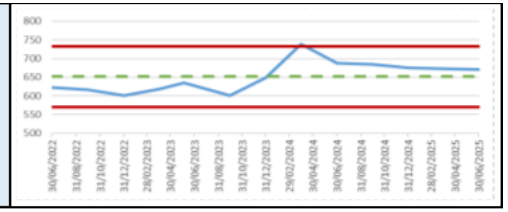
Narrative / Likely Cause	Actions to Remedy	Timeline	Accountability
Good progress has been made in scaling up from 10% baseline to 13.8%. However the scaling is slower than required to meet the 16% target by March 26.	In order to meet the trajectory, acceleration is needed in Pharmacy, General Practice and INT outreach with a borough campaign.	Accelerated rollout from Q3 25/26	SRO Neighbourhoods

Controlled Blood Pressure for 80% of Hypertensive cohort	YTD Actual **77%**	Target 80% / Previous Year 72% / Trajectory	Yearly Trendline		

Narrative / Likely Cause	Actions to Remedy	Timeline	Accountability
Good progress has been made towards achieving the 80% controlled blood pressure target, driven by strong primary care management. Although performance is improving, it remains just below the target, and as prevalence increases this level of optimisation will need continued focus to ensure we reach and sustain 80%	Strengthen and standardise optimisation approaches across all practices, including 24-hour BP monitoring and pharmacist-led medication reviews. Reinforce call-and-recall systems to ensure regular follow-up for patients with uncontrolled or borderline readings	Ongoing	SRO Neighbourhoods

Reduce NEL Adm Rate for patients with Moderate Frailty	Quarterly Actual **242**	Target 285 / Yearly Average 279 / Trajectory N\A	Graph Trendline Quarters		

Narrative / Likely Cause	Actions to Remedy	Timeline	Accountability
Hillingdon have one of the best outcomes within NWL. Case management is effective. Launch of WSIC frailty radar to support case finding and management of frail patients	Sustain INT scaling and expand anticipatory care.	Full coverage by Apr 26	SRO Neighbourhoods

Reduce NEL Adm Rate for patients with Severe Frailty	Quarterly Actual **671**	Target 694 / Yearly Average 675 / Trajectory N\A	Graph Trendline Quarters		

Narrative / Likely Cause	Actions to Remedy	Timeline	Accountability
Meeting the quarterly target and yearly average is almost on target. Which shows the early impact of the frailty programme. Currently supporting 50% case management to patients with severe frailty.	Full rollout to 100% severe frailty cohort.	By April 2026	SRO Neighbourhoods

Neighbourhoods (Live Well & Age Well)

4.5 Key Issues & Risks (Neighbourhoods)

Despite strong early progress, several risks could limit the scale and consistency of neighbourhood impact:

Workforce Capacity & Capability

Scaling preventative and proactive care depends on sufficient clinical and non-clinical workforce. Gaps remain in key roles (geriatricians, pharmacists, therapists, care coordinators). Without continued recruitment and skills development, INTs may struggle to expand frailty coverage, maintain quality, or keep pace with rising long-term condition demand.

Variation in INT Maturity

Not all INTs are operating at the same level of integration, shared processes or MDT coordination. This creates inconsistent resident experience and uneven delivery of prevention and anticipatory care. The Neighbourhoods Steering Board is addressing this through standardised operating models and planned investment in co-located Neighbourhood Hubs.

Rising Demand Driven by Demographics & Long-Term Conditions

The ageing population and increasing prevalence of long-term conditions continue to drive demand. As frailty case-finding expands towards 100% coverage, INT caseloads will grow substantially. Without matched capacity, there is a risk that proactive care becomes diluted, reducing its impact on avoidable admissions.

Inequalities Across Localities

Health outcomes vary significantly across Hillingdon, with areas such as Hayes & Harlington experiencing poorer health, lower life expectancy and higher prevalence of long-term conditions. Neighbourhood improvements may not reach these communities at the same pace unless metrics are monitored with an equity lens (e.g., frailty coverage, hypertension control, Health Checks). Targeted outreach and tailored interventions will be essential to avoid widening gaps.

4.6 Forward Plan (to March 2026)

Over the next two quarters, the Neighbourhoods programme will focus on consolidating early progress and expanding delivery to ensure consistent, preventative care across all localities:

Expand Frailty and Anticipatory Care Coverage

- Continue scaling frailty case management towards **full coverage by April 2026**, ensuring remaining high-risk residents have an identified care coordinator and shared care plan.
- Use the new **WSIC frailty dashboard** (launching early 2026) to identify gaps and monitor outcomes such as admissions, falls and MDT follow-up.
- Broaden anticipatory care beyond hypertension to include **COPD, diabetes, falls prevention and multimorbidity**, prioritising residents at moderate risk.

Implement the Hillingdon Hypertension Strategy

- Finalise and adopt the borough-wide Hypertension Strategy (due December 2025) to sustain progress on prevalence, intensify outreach in high-inequality areas, and support movement towards the **16% prevalence target**.
- Strengthen annual prevention campaigns (e.g., *Know Your Numbers*) and extend them into wider long-term condition awareness and early detection.

Neighbourhoods (Live Well & Age Well)

4.6 Forward Plan (to March 2026)

By March 2026, we aim to have a consistent neighbourhood operating model across all localities, with full frailty coverage, expanded anticipatory care and clearer outcome dashboards to track impact and inequalities. Specifically:

Strengthen Mental Health Integration

- Ensure each INT has a named **mental health practitioner** by Q4, improving early support for anxiety, depression and emerging cognitive issues.
- **Enhance links between INTs, primary care and community mental health teams** to reduce escalation to crisis pathways and improve access to brief interventions in neighbourhood settings.

Introduce Neighbourhood Performance Dashboards

- Develop and implement **INT-level performance dashboards** to provide near real-time insight into activity, outcomes, inequalities and variation between localities.
- Align with the emerging **Children & Young People dashboard**, enabling whole-life-course neighbourhood monitoring and supporting targeted resource allocation.

Progress Neighbourhood Estates (Hubs)

- Continue development of the Integrated Neighbourhood Hub business case, with decisions on the proposed “Super Hub” anticipated by March 2026.
- Use learning from the North Hillingdon Health Hub (launching November 2025) as the prototype for future hub design, co-location opportunities and community engagement.

These actions aim to strengthen the consistency and impact of neighbourhood delivery, embed proactive and preventative care, and support the long-term ambition to reduce avoidable hospital use and improve outcomes across Hillingdon’s communities.

5.1 Reactive Care Purpose & Model

The Reactive Care Programme strengthens urgent and crisis response in the community so that residents receive the **right care, at the right time, in the right place**, while reducing avoidable hospital use and supporting timely discharge. It brings together urgent community response, crisis support, and discharge pathways into a **single, coordinated model** with a simplified referral route via the new Coordination Hub.

The programme has three core aims:

- **Rapid Urgent Community Response (UCR):** Deliver fast, community-based interventions that stabilise health and social care crises and prevent avoidable A&E attendances or admissions.
- **Timely and Safe Discharge:** Improve discharge planning and post-discharge support, ensuring residents who no longer meet criteria to reside (NC2R) leave hospital promptly and safely.
- **Bridging Preventative and Reactive Care:** Strengthen the link between preventative care (INTs) and crisis response—ensuring early deterioration is managed proactively and repeat emergency use is reduced.

The intended outcome is a **joined-up reactive care system** that reduces avoidable ED attendances, shortens hospital stays, improves the resident experience and strengthens resilience through winter.

Reactive Care (Urgent & Crisis Response, Hospital Discharge)

5.2 Components of Reactive Care

1. Reactive Care Coordination Hub (Phase 1 – Dec 2025)
The Coordination Hub will act as the single point of access for urgent community referrals, enabling rapid triage and directing residents to the right service (UCR, crisis social care, mental health, therapy, reablement or discharge support). **Phase 2** in early 2026 will expand the Hub's remit to include proactive case management and end-of-life coordination. This will provide a simpler, more reliable route for GPs, London Ambulance Service and other referrers.

2. Urgent Community Response (UCR) & Senior Clinical Decision Makers
UCR provides a 2-hour response for urgent health and social care crises at home. Embedding **Senior Clinical Decision Makers (SCDMs)** from 8am–8pm seven days a week has strengthened decision-making for complex cases, enabling more people to be safely managed at home. Additional UCR staff capacity is being recruited for early 2026. This model reduces avoidable conveyance to ED and supports short-term stabilisation in the community.

3. Community IV Antibiotics
Since July 2025, 6–8 daily doses of IV antibiotics have been delivered in homes and community settings for conditions requiring intravenous treatment but not hospitalisation. This prevents unnecessary bed days and enables earlier discharge when clinically appropriate.

4. GP-to-SDEC Pathways
GPs can now refer suitable patients directly to Same Day Emergency Care (SDEC), bypassing the Emergency Department. This pathway ensures faster specialist review and avoids standard ED attendance for conditions that can be managed on the same day. For reactive care, this offers a reliable diversion route for patients who do not require full admission.

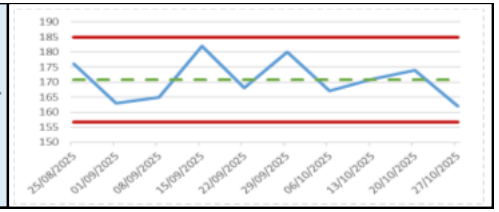
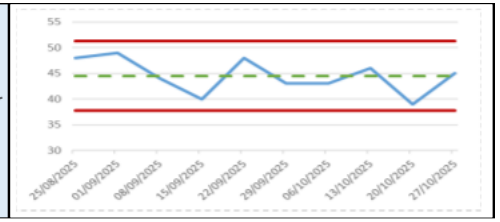
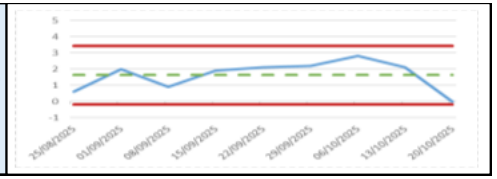
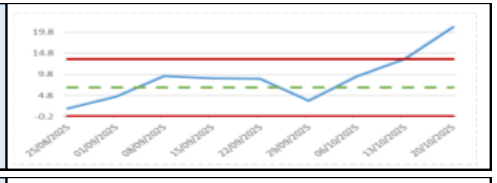
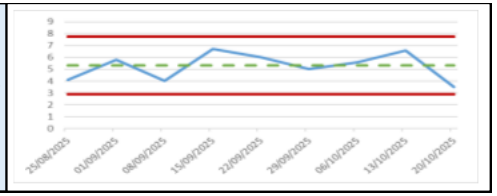
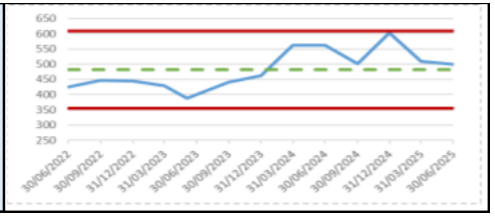
5. Mobile Diagnostics (X-ray)
A mobile X-ray pilot is providing diagnostics for housebound and frail residents, preventing the need for hospital radiology attendance. Early activity shows good uptake, and evaluation will determine the case for scaling the model. This strengthens both urgent response and INT-based case management.

6. Lighthouse Mental Health Crisis Service
The Lighthouse service provides an alternative to ED for residents experiencing mental health crisis. A new operating model went live in November 2025, increasing capacity from 4 to 6 patients at a time, with a further expansion to 10 patients planned following review. Lighthouse reduces psychiatric demand in ED and provides a calmer therapeutic setting with rapid access to follow-on support.

7. Discharge Pathways & NC2R Reduction
A joint NHS–Local Authority **NC2R Reduction Plan** has introduced daily multi-agency ward reviews, weekly Gold Command oversight, revised standard operating procedures and strengthened discharge pathways. This has contributed to a reduction in NC2R from **48 to 35**, improving flow and freeing bed capacity. Further work continues to operationalise changes and sustain progress made to date

Reactive Care (Urgent & Crisis Response, Hospital Discharge)

5.3 Reactive Care Performance Metrics

						Narrative / Likely Cause	Actions to Remedy	Timeline	Accountability
A&E Activity Reduction (Traffic light measured against 10 wk Avg)		Monthly Actual **170**	Target 164 10 wk Average 171 Trajectory 187	Graph Trendline for last 10 wks		10 week average is currently 171 per day with an October average of 170, seeing a month on month reduction from the winter peaks of 208 per day.	Expansion of UCR is to be expanded along with the launch of the co-ordination hub, mobile diagnostics and the implementation of the new Lighthouse diversion from Oct 25.	Phased Rollout from Q3 25/26	SRO Reactive Care
No Criteria to Reside Reduction (Traffic light measured against 10 wk Avg)		Monthly Actual **43**	Target 34 10 wk Average 45 Trajectory	Graph Trendline for last 10 wks		NC2R is an avg of 43 in month, with a 10 week avg of 45 (11 above the target). Drivers include: Discharge bottlenecks particularly P2, referral process delays across all Pathways, Family choice Delays.	8 week delivery plan has been developed and went live on the 13th October. Since the beginning of November we have seen averages of 35 per day compared to 43 during October	Choice policy live Nov 25, 8 Week Delivery Plan Sept - Oct	SRO Reactive Care
Discharge Pathway Delays (P1) (Traffic light measured against 10 wk Avg)		Monthly Actual **2.4**	Target 2 10 wk Average 1.6 Trajectory	Graph Trendline for last 10 wks		Overall we are meeting the discharge delay targets for P1 and P3 patients. But not meeting the target for P2 patients. Bottlenecks especially in the time to place P2 patients, with referral process delays across all pathways (D2A, District Nursing, Family Choice delays, Capacity constraints) and longer than expected LOS in community led services.	8 week Delivery Plan has been developed and went live on the 13th October. Integrated Bridging care and therapy D2A P1 services in place by December 2025	Phased Rollout from Q3 25/26	SRO Reactive Care
Discharge Pathway Delays (P2) (Traffic light measured against 10 wk Avg)		Monthly Actual **11.1**	Target 5 10 wk Average 8.9 Trajectory	Graph Trendline for last 10 wks					
Discharge Pathway Delays (P3) (Traffic light measured against 10 wk Avg)		Monthly Actual	Target 7 10 wk Average 5.3 Trajectory	Graph Trendline for last 10 wks					
Reduce Rate of unplanned adms from Care Homes per 100k pop >65		Quarterly Actual **500**	Target 747.65 Yearly Average 529 Trajectory	Graph Trendline Quarters		Variable Care Home capability in managing pts who have behaviours that challenge and also recognising signs of deterioration. Not all CHs have routine Pharmacy input to ensure pts at highest risk have a medication review.	Specialist dementia support from CNWL now available to support CH with pts who have behaviours that challenge, PCN pharmacies being trained to undertake SMRs for most complex frail pts in CHs. CH being digitally enabled so they can access UCPs.	Phased Rollout from Q3 25/26	SRO Reactive Care

Reactive Care (Urgent & Crisis Response, Hospital Discharge)

5.4 Issues & Risks (Reactive Care)

- **Winter Pressures & ED Demand**

  High A&E attendances continue to place pressure on flow and reactive services. Winter surges may reverse recent gains unless community capacity and same-day alternatives remain consistently available.

- **Workforce Fragility**

  UCR, therapy, discharge teams and Lighthouse all rely on skilled staff. Any gaps—particularly in SCDMs, therapists or assessors—risk slower response times and reduced community capacity.

- **Variation in Discharge Processes**

  The system remains over-reliant on senior escalation rather than routine operational practice, leaving performance vulnerable as we move into winter. Interim senior leadership for the Integrated Discharge Team and a rapid multi-agency redesign of the discharge operating model to be implemented to ensure the improvements made to date can be stabilised, embedded and sustained through winter and beyond.

- **Scaling New Models**

  Mobile diagnostics, community IV and the Coordination Hub are early in implementation. Their full impact will depend on adoption by referrers, reliable staffing and integration across INTs and acute services.

5.5 Forward Plan (to March 2026)

Over the coming months, the Reactive Care programme will focus on fully mobilising new services, strengthening discharge pathways and expanding community alternatives to hospital. Key actions include:

1. Full Mobilisation of the Coordination Hub (Dec 2025)

- Phase 1 of the Coordination Hub will go live in December, providing **single-call access** for urgent community referrals (8am–8pm, 7 days a week).
- The Hub will coordinate UCR, crisis response and discharge support in real time, simplifying access for GPs, LAS and hospital teams.
- Planning for **Phase 2** (early 2026) will include frailty pathways, end-of-life rapid response and mental health integration, moving towards a future **24/7 model**.
- A performance update (e.g., call volumes, referral patterns, ED diversions) will be reported back to the Board once the Hub has been operational for several months.

2. Lighthouse Mental Health Crisis Expansion

- Following the December service review, capacity will increase to **10 patients at any time** to divert more people in mental health crisis away from A&E.
- CNWL will provide additional staffing and any required environmental adjustments.
- The expected impact includes fewer psychiatric breaches in ED and faster access to therapeutic support, with outcome data reported to the Board in Q4.

Reactive Care (Urgent & Crisis Response, Hospital Discharge)

5.5 Forward Plan (to March 2026)

3. Launch of an Integrated Rehabilitation & Reablement Service

- Phase 1 goes live in early December, combining Council reablement workers and NHS community therapists into a single multidisciplinary team.
- This integrated model will support faster discharge for Pathway 1 and 2 patients, ensuring seamless personal care and rehabilitation at home.
- Work through Q4 will refine the operating model, governance and weekend capacity, with the aim of enabling consistent 7-day discharges.
- Further expansion (including community rehab beds) will be explored to address Pathway 2 delays.

4. Sustain NC2R ≤34:

- Work aggressively to sustain NC2R (medically fit) inpatients at or below 34 per day through winter and beyond. This involves Interim IDT Leadership, operationalising the daily multi-agency discharge huddles, weekly system reviews, Place Gold Command, reviewing functioning of IDT, and escalating any issue early.
- By end of Q4, the aim is that Hillingdon will have a new baseline for delays significantly lower than the pre-plan baseline (e.g., ~30 instead of 48).
- Achieving this may also require commissioning of any additional step-down beds or use of spot-purchase home care if needed during winter.
- The Board's oversight in keeping this a priority will help maintain cross-partner focus

5. Expand UCR Capacity and Link to Virtual Wards

- Additional UCR staffing from January 2026 will increase 2-hour response capacity and support a strengthened **Hospital at Home** function for up to 17 days of community-based care.
- The model will be increasingly aligned with **Virtual Ward pathways**—particularly frailty and heart failure—creating community "virtual beds" managed jointly by UCR and INTs.
- By March 2026, the Coordination Hub should begin triaging appropriate patients directly into these virtual ward slots.

These actions will strengthen community-based urgent care during the winter period, support sustained reductions in NC2R delays, and reduce avoidable pressure on A&E and hospital beds. By Q4, the Board should expect to see improvements in patient flow, community recovery times and overall system resilience.

Best Start to Life (Children & Young People)

6.1 Purpose

The Best Start in Life programme aims to ensure every child in Hillingdon has the foundations for a healthy, safe and positive start. The programme focuses on:

- **Early identification and intervention:** Detecting developmental, health and wellbeing needs as early as possible (during pregnancy, infancy and early childhood) and providing timely support through the Healthy Child Programme and early years checks.
- **Integrated children's services:** Bringing together health, social care, education and voluntary services around the child and family, supported by Family Hubs and the emerging Child Health Hub model, enabling families to access multiple services in a coordinated way.
- **Preventing ill-health:** Tackling risk factors early by promoting healthy weight, good oral health, high vaccination coverage and positive mental wellbeing to reduce future problems.
- **Reducing inequalities:** Targeting support to the most vulnerable children and communities, particularly those facing deprivation or at higher risk of poor outcomes. This aligns with Core20PLUS5 priorities, which highlight immunisation, obesity, mental health, oral health and asthma as key focus areas.
- Through these priorities, Hillingdon aims to improve early years outcomes such as school readiness, healthy weight in Reception and Year 6, and longer-term health and wellbeing across the life course.

6.2 Delivery Update

Recent progress in the Best Start in Life program include:

Child Health Hub Development

A multi-agency group met in November 2025 to begin designing **Child Health Hubs** aligned with the neighbourhood model. These hubs will provide a single, integrated point of access for paediatric clinics, developmental assessments and family support linked to Family Hubs. Partners have agreed a joint strategy and will now define the hub model and identify a prototype site.

Integrated Paediatric Clinics

Integrated paediatric clinics delivered over 130 clinics in 2024/25, supporting more than 800 children. Clinics cover common conditions such as CMPA, constipation and neonatal issues. The delivery model provides consistent access to specialist advice for children under five and supports earlier identification of developmental needs.

CYP Neighbourhood Dashboard

Work is underway on a **Children & Young People dashboard** to provide a consolidated view of key metrics by neighbourhood, including immunisations, A&E attendances for under-fives, developmental checks, school readiness, oral health and obesity. The dashboard will support improved outcome monitoring, transparency and targeted action where inequalities persist. Full development and launch are expected in 2026.

Mental Health Support Teams (MHSTs)

Hillingdon has been selected for the **Wave 14 expansion** of MHSTs, which will extend provision to an estimated **~80% of schools** from January 2026 (up from ~60%). MHSTs provide early support for children with mild-to-moderate mental health needs and play a vital role in reducing escalation into specialist CAMHS service

Best Start to Life (Children & Young People)

6.2 Delivery Update

Family Hubs Integration

Child Health Hub planning is being aligned with the Family Hub network to avoid duplication and ensure parents receive joined-up support. Family Hubs already provide parenting programmes, health visitor clinics and early years support. The work now focuses on linking new paediatric pathways to existing community assets for maximum reach.

Neurodevelopmental Pathways

Demand for neurodevelopmental assessment has increased significantly, and Hillingdon currently has just under **2,000 children** awaiting assessment. Additional NWL investment for 2025/26 will enable around **50%** of these children to be assessed. CNWL is redesigning pathways—using digital tools and streamlined clinical processes—to increase productivity and reduce waiting times.

6.3 Metrics & Performance (CYP Outcomes)

Key outcome measures for Best Start in Life are being consolidated into the new Children & Young People (CYP) dashboard. Current headline metrics include :

Neurodevelopmental Waiting Times

- As of October 2025, **~1,980 children** are waiting for a neurodevelopmental assessment.
- Additional NWL investment is expected to **halve the waiting list by mid-2026** (towards ~1,000).
- A major aim is to reduce the **maximum waiting time to under 12 months** by year-end, monitored through monthly assessment activity and throughput.

Mental Health Support Teams (MHSTs) in Schools

- MHSTs currently cover ~60% of schools.
- With the Wave 14 expansion starting January 2026, coverage is projected to reach ~80% of schools by Q4.
- Performance will track: number of schools supported, pupils reached, and uptake of interventions (individual support, groups, workshops).

Early Years Outcomes

- Two priority indicators—school readiness and children's oral health—show room for improvement and are central to Best Start priorities.
- Data for school readiness, immunisations, dental access and oral health prevalence will be incorporated into the CYP dashboard.
- The Children's Oral Health pilot is expected to improve the % of under-5s attending a dentist annually, particularly in high-need areas.
- Childhood obesity (Reception and Year 6) will be monitored as a key long-term prevention measure.

Service Utilisation and Preventative Reach

- The dashboard will monitor uptake of Health Visitor reviews (new birth visit, 2–2½ year checks), immunisation coverage (including MMR), and A&E attendances for under-5s.
- These metrics provide insight into access, prevention, and parental support.
- The intention is to introduce an overall Best Start RAG rating in future reports to show progress and highlight areas requiring targeted action

Best Start to Life (Children & Young People)

6.4 Forward Plan (up to March 2026)

Upcoming priorities for Best Start in Life focus on strengthening early years services, improving children's health outcomes and embedding integrated models of support across Hillingdon.

- **Launch CYP Dashboard:** Finalise and roll out the **Children & Young People Neighbourhood Dashboard** by the next Board meeting. This will provide a baseline and regular reporting on key metrics (health and development indicators), enabling the Board to track progress in real time. It will also highlight any locality-based disparities so resources can be targeted accordingly.
- **Prototype Child Health Hub:** By Q4 2025/26, aim to **establish a prototype Child Health Hub** in one locality. This could involve co-locating a few services (e.g. a paediatrician or paediatric nurse practitioner working alongside a Family Hub team on specific days). The learnings from this prototype will inform the wider rollout. The prototype will focus on integrative care for issues like asthma, obesity, and developmental concerns in a community setting, testing the hub model in practice.
- **Enhance Community Paediatrics & Support Services:** Utilising recent investments:
    - Bring the **new Special School Nursing post** on board permanently (recruitment by early 2026) to support children with medical needs in special schools.
    - Deploy the **Wave 14 MHST** effectively in Jan 2026, ensuring it quickly engages with its allocated schools and starts caseloads (the goal is to start seeing students within weeks of launch, given existing demand).
    - Continue **neurodevelopmental assessments** through late 2025 and into 2026 to hit the target of 50% backlog reduction. By spring 2026, evaluate the outcome – e.g. how much the wait times have improved – and develop a sustainability plan for 2026/27.
- **Stronger Links with Family Hubs and Early Years:** Formalise pathways between **maternity/early years services and Family Hubs**. For example, when health visitors identify families in need, ensure warm handovers to parenting support at Family Hubs, and vice versa. In Q3–Q4, a plan will be developed to integrate health visiting data and Family Hub outreach efforts so that no families "drop off" after initial contacts. Also, tie the oral health and nutrition initiatives into the Family Hub network for broader reach. By having health, education, and social care speak with one voice in Family Hubs, the support for families (especially in the crucial 0-5 age range) will be more comprehensive.
- **Upcoming Initiatives:** Hillingdon is preparing for **Wave 15+ of MHST** (to eventually reach 100% schools), and exploring participation in any new national pilots (e.g. early language development programs). Additionally, discussions are underway about improving transitions for young people (e.g. moving from children to adult mental health services, or preparing those with long-term conditions for adult care). Plans to strengthen transition support by 17-18 years old will be considered as part of the "Start Well" to "Live Well" continuum. The Board will be updated on these in subsequent reports.

Cross-Cutting System Risks & Mitigations

7.1 Cross-Cutting System Risks and Mitigations

This section summarizes **system-wide risks** that span multiple programmes (Neighbourhoods, Reactive Care, Best Start) and their mitigation strategies:

High ED Attendances: Emergency Department visits remain above target, risking overcrowding and missed performance standards.

- **Impact:** Strains hospital resources, increases wait times, and could lead to poorer outcomes if patients aren't seen timely.
- **Likelihood:** High, given underlying demand and winter season.
- **Mitigation:** Strengthen alternatives to ED – e.g. *Front Door Diversion* strategies such as **GP direct-to-SDEC pathways** and **Pharmacy First referrals** to handle minor cases. The **UCR 2-hour crisis response** and **Lighthouse** mental health diversion reduce unnecessary A&E arrivals. Continued public messaging to use 111 and community services for non-critical needs (including 24/7 urgent dental care via 111) also supports this. The new Coordination Hub will play a role by directing referrers to appropriate community options, further easing ED burden.

NC2R (No Criteria to Reside) Relapses: After intensive effort, NC2R (delayed discharges) numbers have dropped to ~35, but could rise again without sustained focus.

- **Impact:** High – rising NC2R leads to bed shortages, and ED backups (when wards are full).
- **Likelihood:** Moderate; risk increases if winter capacity is strained or if processes slip.
- **Mitigation: Embed the discharge improvement measures** as business-as-usual: daily multi-agency discharge huddles, a and strict escalation according to the **NC2R SOP**. The Place "Gold" command structure will continue oversight through winter to quickly resolve blockages. In addition, new community capacity (through integrated reablement and bridging care) coming online in Dec 2025 will help absorb more discharges promptly. Maintaining NC2R ≤34 is a key success criterion, and any upward trend will trigger a rapid response by the system resilience group

Workforce Constraints: Across the system, recruiting and retaining skilled staff is a concern.

- **Impact:** If key roles are unfilled (e.g. community nurses, care coordinators, GPs, therapists, psychologists), it hampers service delivery and innovation uptake. Burnout is also a risk with the current pressures.
- **Likelihood:** High in certain areas (national shortages in nursing, therapy, social care).
- **Mitigation:** A multifaceted approach – **targeted recruitment drives** (for example, NWL has funded 4 additional specialist nurses for palliative care to fill critical gaps), cross-skilling existing staff (training pharmacists and paramedics to take on expanded roles in UCR and care homes). The integration of teams also offers opportunity to better **utilise the collective workforce** – e.g., having PCN pharmacists assist with care home medication reviews, or mental health practitioners working within INTs, to spread expertise.

Cross-Cutting System Risks & Mitigations

Long-Term Condition Growth: The population is experiencing growing prevalence of chronic conditions (diabetes, heart disease, COPD, etc.), which could drive future unplanned care demand.

- **Impact:** Medium to long-term – without action, more people will present in crisis with preventable complications (strokes, heart attacks, decompensated COPD).
- **Likelihood:** High, given demographic and national trends.
- **Mitigation: Prevention and early intervention** are our main tools. The Neighbourhoods programme directly addresses this through hypertension and frailty initiatives (already showing success in reducing admissions), and the NWL Enhanced Services focus on Cardiovascular-Renal-Metabolic diseases will further help manage risk factors in primary care. Continued investment in wellness services (smoking cessation, weight management) and community engagement in healthy lifestyles (leveraging Healthy Places and Equity work) is crucial. Essentially, mitigating this risk means **continuing the "left shift" of care** – moving care into community and preventative settings – which is exactly the strategy of Live Well and Age Well interventions.

CYP Neurodevelopmental Demand: The **surge in demand for children's assessments** (autism/ADHD) remains a risk.

- **Impact:** High for those families – long waits can worsen child outcomes and parental confidence in the system. Also impacts schools managing unmet needs.
- **Likelihood:** Currently very high (referrals quadrupled nationally).
- **Mitigation:** The immediate mitigation is the **additional funding to cut the backlog by 50%**, which is being executed now. For sustained mitigation, the **pathway redesign with digital tools** is key to increase throughput with existing resources. Also, exploring early support for children with possible neurodevelopmental issues *before* diagnosis (so needs are met without waiting for formal diagnosis) can reduce urgency – for example, parenting programs or school adjustments available based on need. The ICB and CNWL will monitor if referral rates continue at the new high; if so, they may need to commission additional permanent capacity or partner with independent providers to keep waits within acceptable limits.

Winter Pressures: The winter period (Q3–Q4) brings heightened risk of simultaneous demand surges – flu, COVID-19, norovirus, and weather-related illness among frail elderly.

- **Impact:** Could spike both community and acute demand beyond planned levels, testing all services.
- **Likelihood:** High from Dec through Feb.
- **Mitigation:** A comprehensive **Winter Plan** is in place. This includes: expanding vaccination uptake (flu and COVID campaigns) to reduce illness incidence; ensuring **full use of intermediate care beds** and possibly opening contingency beds; the Reactive Care Hub coordinating closely with London Ambulance Service for any surge (e.g. redirecting appropriate 999 calls to UCR); **weekend working expansions** (the End of Life care investment provided for weekend specialist cover, which can help manage palliative patients who might otherwise call 999); and **emergency respite schemes** via social care for times of extreme cold or workforce shortages. Additionally, the **ED front-door in-reach by community teams** is being strengthened (e.g. a community matron or palliative nurse in ED to pull patients out to community care faster). These combined actions are designed to mitigate the worst impacts of winter. The Board should note that if an exceptionally severe winter occurs, regional resources may be called upon as well.

Appendices

Appendix 1: Investments Summary

Investment Area	**New Funding / Initiatives** (2025/26)	Expected Outcomes and Impact
Urgent Community Response & "Hospital at Home"	Additional **recurrent funding** for UCR expansion. Launch of a new Hospital at Home model (from Jan 2026) supporting patients for up to 17 days after urgent crisis	➢ **Increased UCR capacity** to reach patients within 2h and manage more cases at home (avoiding A&E/admissions). ➢ **Hospital at Home** will provide acute-level care in domiciliary settings for 3–17 days, reducing length of hospital stay and readmissions.
"Lighthouse" Mental Health Crisis Hub	Service model enhancement behind A&E – capacity raised from 4 to **6 patients** (Nov 2025), with further expansion to **8–10 patients** from 17 Dec 2025	➢ More **mental health patients diverted from A&E** to a therapeutic setting, cutting A&E waits and crowding. ➢ Patients in crisis receive timely specialist care, improving outcomes and experience.
MHST in Schools (Wave 14)	Funding and approval for an **additional MHST** team in Hillingdon starting Jan 2026 (previous coverage ~60% of schools).	➢ **Expanded mental health support in schools** to ~80% coverage, allowing earlier help for children with mild/moderate issues. ➢ Expected reduction in severe cases over time and reduced CAMHS waiting lists due to early intervention.
Children's Neurodevelopmental Assessments	**Non-recurrent funding** in Oct 2025 to tackle backlog – will cover ~**50% of ~2,000 waiting children**. Plus pathway redesign (digital tools) by CNWL to improve efficiency.	➢ **~1,000 extra children assessed** in 2025/26, halving the waiting list and significantly shortening wait times (many from 2 years to <1 year). ➢ **Modernised assessment process** (e.g. some virtual elements) enabling sustained higher throughput and a more manageable service going forward.
SEND – Special School Nursing	**Recurrent funding** for 1 additional special school nurse post (bank staff in place as of Oct 2025 while permanent hire is made).	➢ **Improved medical support in special schools** – lower caseload per nurse, allowing more timely interventions for children with complex needs. ➢ Enhanced training and capacity in schools, potentially reducing emergency incidents and supporting inclusion.
Community Dental Services (Access & Prevention)	**Expanded NHS Dental Capacity:** Commissioned 14 practices in high-need areas for extra appointments. **Children's Oral Health Pilot:** Launched Oct 2025 in Family Hub areas. **Inclusion Dental Pilot:** New service for vulnerable groups (homeless, refugees). **24/7 Urgent Dental Access:** via NHS 111 for emergencies.	➢ **More routine dental slots** for residents in underserved communities, reducing waiting times for NHS dental care. ➢ **Improved oral health in children**: increased dental attendance among under-16s in pilot areas, early prevention of tooth decay. ➢ **Dental care for vulnerable individuals** leading to fewer dental issues escalating to A&E or acute pain situations. ➢ 24/7 urgent access ensures emergencies get prompt treatment and reassure patients to avoid A&E for dental needs.
End of Life Care (Community)	**£1.7 million recurrent investment** into community specialist palliative care and hospice support. Includes hiring **4 additional specialist nurses**, funding extra Hospice@Home capacity, weekend coverage, and developing ED in-reach model.	➢ **Expanded palliative care team** to support patients at home, aiming to prevent unnecessary end-of-life hospital admissions and to honour patient preferences. ➢ **Sustainability of local Hospice** services ensured, preserving this critical resource for the community. ➢ **7-day service coverage** in palliative care, meaning symptom crises can be managed out-of-hours, and potential to support patients in A&E so they can be discharged to home or hospice sooner.

Appendix 2: Neighbourhoods (Live Well & Age Well)

3.4 Neighbourhood Performance Metrics – PCN Enhanced Service Delivery

Primary Care Network/ Borough	DIABETES LEVEL 1						NON DIABETIC HYPERGLYCAEMIA			
		CURRENT ACHIEVEMENT						CURRENT ACHIEVEMENT		
	Diabetes Register (Aug-25)	% 9 Key Care Process in last 15m	% HbA1c, BP, Non HDL Cholesterol	% Diagnosed in last 2 years HbA1c <= 48 in last 15m	% Mental Health Screening in last 15m	% Care Plans completed in last 15m	Non Diabetic Hyperglycaemia Register (Aug-25)	% patients with NDH diagnosis in last 5 years who go onto develop T2DM	% Starting NHS Diabetes Prevention Programme in last 15m	% Annual Review in last 15m
50% TARGET ACHIEVEMENT		55.0%	29.0%	40.0%	60.0%	50.0%		<40.0%	3.5%	50.0%
100% TARGET ACHIEVEMENT		65.0%	35.0%	50.0%	70.0%	60.0%		<30.0%	5.5%	60.0%
HILLINGDON	23,960	69.3%	36.6%	38.8%	82.1%	77.6%	35,816	3.0%	5.9%	66.9%
CELANDINE HEALTH AND METROCARE PCN	3,773	67.2%	37.6%	34.3%	82.4%	78.2%	6,997	2.2%	7.2%	62.9%
COLNE UNION PCN	3,427	69.1%	33.9%	41.4%	78.6%	69.0%	6,098	3.0%	5.7%	70.2%
HH COLLABORATIVE	7,011	71.2%	34.3%	39.6%	81.6%	78.5%	8,475	3.4%	5.6%	66.4%
LONG LANE FIRST CARE GROUP PCN	3,461	72.0%	37.6%	35.5%	87.4%	86.6%	4,753	3.4%	5.9%	68.1%
NORTH CONNECT	3,782	67.5%	42.1%	42.6%	77.7%	76.6%	5,556	3.4%	6.2%	62.2%
SYNERGY	2,506	66.9%	35.9%	37.9%	87.2%	75.1%	3,937	2.6%	4.8%	74.2%

Enhanced service for diabetes

- As of Month 5, 3 PCNs have achieved all bar 1 of the performance metrics for Diabetes L1.
- 5 PCNs have met the performance metrics for the NDH service – excellent performance so far for 25/26.

					Continuity Audit: Review of a 10% sample of the identified population (Nov-25 - Jan-26) *Continuity flag for at least 2% of the patient list is in place*				
	Borough	PCN Code	PCN Name		Date subm	RAG	Notes	Continuity flag (≥2%)	Jan-26
	HILLINGD	U35513	CELADINE HEALTH & METROCARE PCN					1.40%	
		U36510	COLNE UNION PCN					0.40%	
		U51498	HH COLLABORATIVE PCN					1.70%	
		U91930	LONG LANE FIRST CARE GROUP PCN					2.60%	
		U07392	NORTH CONNECT PCN					2.10%	
		U51930	SYNERGY PCN					1.90%	

Continuity Audit

- Date of extraction: 01/09/2025
- As of Month 6, 2 PCNs demonstrate to be meeting the 2% metric target.

Appendix 3: Neighbourhoods (Live Well & Age Well)

3.4 Neighbourhood Performance Metrics – Pharmacy First Delivery (first 6 months of 2025/26)

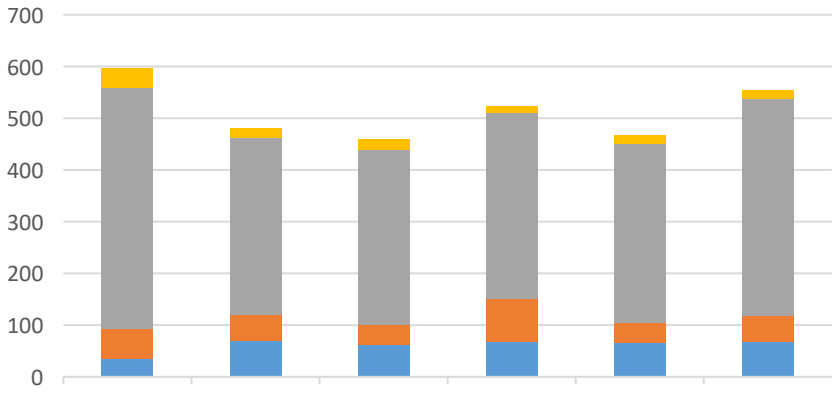
The data shows that in a 6mth period over 18,000 Pharmacy 1st consultations took place, with over 3,000 referrals taking place (17% conversion rate). The majority of which were for minor illness.

The most common condition is Acute sore throat, followed by uncomplicated UTI then Sinusitis

Pharmacy first consultations March- August 2025

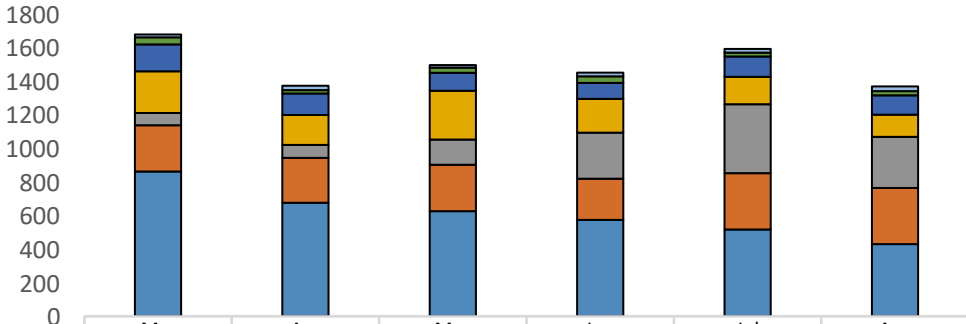
	Mar	Apr	May	Jun	Jul	Aug
Hillingdon	3419	2975	2973	2832	2980	2861

Pharmacy first referrals April- September 2025



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Referrals from THH	37	19	21	13	17	16
Minor Illness Referal	467	342	338	359	346	420
Clinical Pathways Consultation	58	49	37	83	40	50
Urgent Medicine Supply	34	70	63	68	65	68

Seven clinical conditions breakdown March- August 2025



	Mar	Apr	May	Jun	Jul	Aug
Shingles	17	26	15	22	22	28
Impetigo	42	20	31	39	23	25
Acute Otitis Media	160	128	107	95	121	115
Sinusitis	248	178	290	201	163	132
Infected Insect Bites	73	77	150	274	410	304
Uncomplicated UTI	275	267	276	245	335	334
Acute Sore Throat	861	675	625	573	516	429

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	Appendix 1 – GL Use of Resources 2024-25 Appendix 2 – ASC Placement Trends
Ward	All

RECOMMENDATIONS

That the Health and Social Care Select Committee notes the:

1. **2025/26 Month 6 budget monitoring position;**
2. **information on value for money benchmarking from the 2024/25 Use of Resources return; and**
3. **information on financial modelling for ASC placements.**

HEADLINES

This report provides an update on the 2025/26 Month 6 budget monitoring position relevant to the Select Committee.

It also provides information as requested by the Committee on value for money benchmarking and forecasting., as well as a review of growth over the last 3 years in the high cost/high demand areas of ASC.

Corporate Directors, supported by their Finance Business Partners, will attend the meeting to provide further details and clarifications.

2025/26 MONTH 6 BUDGET MONITORING POSITION

At Month 6 service operating budgets within the Committee's remit are forecasting a net overspend of £9.8m against budget.

Table 1 below provides an overview of the Committee's Month 6 budget monitoring position. It includes adjustments for Earmarked Reserves, Provisions and Transformation Capitalisation.

Table 1: ***2025/26 Month 6 Budget Monitoring***

Directorate		Approved Budget £'000	*Underlying Forecast* *£'000*	*Earmarked Reserves* *£'000*	*Provisions* *£'000*	*Transformation Capitalisation* *£'000*	Forecast Outturn £'000	*Variance* *£'000*	*Month 5* *£'000*	Movement £'000
Adults & Health	Expenditure	185,409	192,799	0	0	(80)	192,719	7,310	11,443	(4,133)
	Income	(84,206)	(85,161)	(1,286)	0	0	(86,447)	(2,241)	(1,462)	(779)
		101,203	**107,638**	**(1,286)**	**0**	**(80)**	**106,272**	**5,069**	**9,981**	**(4,912)**
Total Service Operating Budgets		**101,203**	**107,638**	**(1,286)**	**0**	**(80)**	**106,272**	**5,069**	**9,981**	**(4,912)**

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

Table 2: ***2025/26 Month 6 Budget Monitoring by Service Area***

		Approved Budget	Contingency Released	Revised Budget	Underlying Forecast	Earmarked Reserves	Provisions	Transformation Capitalisation	Forecast Outturn	Final Forecast Variance	Forecast Variance Prior Month	Change in Variance
R31: OT Minor Adaptations and Community Equipment	**A1: Staffing Costs**	0	0	0	0	0	0	0	0	0	224	(224)
	A2: NonStaffing Costs	474	0	474	451	0	0	0	451	(23)	(23)	0
	A3: Grants Fees & Other Income	(332)	0	(332)	(411)	0	0	0	(411)	(79)	7	(86)
	Sub-Total	**142**	**0**	**142**	**40**	**0**	**0**	**0**	**40**	**(102)**	**208**	**(310)**
R32: Head of Direct Care Provision HSC	**A1: Staffing Costs**	8,210	0	8,210	7,803	0	0	0	7,803	(407)	(392)	(15)
	A2: NonStaffing Costs	1,517	0	1,517	1,628	0	0	0	1,628	111	162	(51)
	A3: Grants Fees & Other Income	(637)	0	(637)	(727)	0	0	0	(727)	(90)	(90)	0
	Sub-Total	**9,090**	**0**	**9,090**	**8,704**	**0**	**0**	**0**	**8,704**	**(386)**	**(320)**	**(66)**
R33: Head of Child & Family Development CFE	**A1: Staffing Costs**	138	0	138	615	0	0	0	615	477	136	341
	A2: NonStaffing Costs	5,018	0	5,018	5,346	0	0	0	5,346	328	(212)	540
	A3: Grants Fees & Other Income	0	0	0	(399)	(600)	0	0	(999)	(999)	(467)	(532)
	Sub-Total	**5,156**	**0**	**5,156**	**5,562**	**(600)**	**0**	**0**	**4,962**	**(194)**	**(543)**	**349**
R34: Head of Learning Disability and Mental Health Services	**A1: Staffing Costs**	0	0	0	37	0	0	0	37	37	40	(3)
	A2: NonStaffing Costs	336	0	336	444	0	0	0	444	108	102	6
	A3: Grants Fees & Other Income	0	0	0	0	0	0	0	0	0	0	0
	Sub-Total	**336**	**0**	**336**	**481**	**0**	**0**	**0**	**481**	**145**	**142**	**3**
R35: Head of Hospital and Localities Services	**A1: Staffing Costs**	325	0	325	146	0	0	0	146	(179)	77	(256)
	A2: NonStaffing Costs	860	0	860	935	0	0	0	935	75	57	18
	A3: Grants Fees & Other Income	0	0	0	0	0	0	0	0	0	0	0
	Sub-Total	**1,185**	**0**	**1,185**	**1,081**	**0**	**0**	**0**	**1,081**	**(104)**	**134**	**(238)**
R36: Director of Health and Public Health	**A1: Staffing Costs**	709	0	709	905	0	0	0	905	196	193	3
	A2: NonStaffing Costs	10,289	0	10,289	10,655	0	0	0	10,655	366	262	104
	A3: Grants Fees & Other Income	(22,437)	0	(22,437)	(22,213)	(686)	0	0	(22,899)	(462)	(455)	(7)
	Sub-Total	**(11,439)**	**0**	**(11,439)**	**(10,653)**	**(686)**	**0**	**0**	**(11,339)**	**100**	**0**	**100**
R37: Director Adult Services and Health	**A1: Staffing Costs**	41	0	41	152	0	0	(80)	72	31	(647)	678
	A2: NonStaffing Costs	(4,490)	5,619	1,129	1,624	0	0	0	1,624	495	5,855	(5,360)
	A3: Grants Fees & Other Income	(22,518)	0	(22,518)	(22,522)	0	0	0	(22,522)	(4)	(3)	(1)
	Sub-Total	**(26,967)**	**5,619**	**(21,348)**	**(20,746)**	**0**	**0**	**(80)**	**(20,826)**	**522**	**5,205**	**(4,683)**
R38: Head of Safeguarding Adults	**A1: Staffing Costs**	0	0	0	59	0	0	0	59	59	52	7
	A2: NonStaffing Costs	691	0	691	696	0	0	0	696	5	2	3
	A3: Grants Fees & Other Income	0	0	0	0	0	0	0	0	0	0	0
	Sub-Total	**691**	**0**	**691**	**755**	**0**	**0**	**0**	**755**	**64**	**54**	**10**
R39: ASC Placements	**A1: Staffing Costs**	45	0	45	44	0	0	0	44	(1)	(1)	0
	A2: NonStaffing Costs	126,224	0	126,224	133,518	0	0	0	133,518	7,294	6,753	541
	A3: Grants Fees & Other Income	(35,315)	0	(35,315)	(35,327)	0	0	0	(35,327)	(12)	(2)	(10)
	Sub-Total	**90,954**	**0**	**90,954**	**98,235**	**0**	**0**	**0**	**98,235**	**7,281**	**6,750**	**531**
R3A: A Head of Direct Care Provision CFE	**A1: Staffing Costs**	4,948	0	4,948	4,193	0	0	0	4,193	(755)	(427)	(328)
	A2: NonStaffing Costs	10,806	0	10,806	10,410	0	0	0	10,410	(396)	72	(468)
	A3: Grants Fees & Other Income	(320)	0	(320)	(366)	0	0	0	(366)	(46)	(103)	57
	Sub-Total	**15,434**	**0**	**15,434**	**14,237**	**0**	**0**	**0**	**14,237**	**(1,197)**	**(458)**	**(739)**
R3B: Immediate Response Service	**A1: Staffing Costs**	4,543	0	4,543	4,145	0	0	0	4,145	(398)	(543)	145
	A2: NonStaffing Costs	2,427	0	2,427	2,762	0	0	0	2,762	335	335	0
	A3: Grants Fees & Other Income	(2,400)	0	(2,400)	(2,749)	0	0	0	(2,749)	(349)	(349)	0
	Sub-Total	**4,570**	**0**	**4,570**	**4,158**	**0**	**0**	**0**	**4,158**	**(412)**	**(557)**	**145**
R3C: Sustained Support Service	**A1: Staffing Costs**	5,921	0	5,921	5,229	0	0	0	5,229	(692)	(673)	(19)
	A2: NonStaffing Costs	758	0	758	797	0	0	0	797	39	39	0
	A3: Grants Fees & Other Income	(247)	0	(247)	(247)	0	0	0	(247)	0	0	0
	Sub-Total	**6,432**	**0**	**6,432**	**5,779**	**0**	**0**	**0**	**5,779**	**(653)**	**(634)**	**(19)**
R3: Executive Director Adult Services and Health	**A1: Staffing Costs**	**24,880**	**0**	**24,880**	**23,333**	**0**	**0**	**(80)**	**23,253**	**(1,627)**	**(1,961)**	**334**
	A2: NonStaffing Costs	**154,910**	**5,619**	**160,529**	**169,266**	**0**	**0**	**0**	**169,266**	**8,737**	**13,404**	**(4,667)**
	A3: Grants Fees & Other Income	**(84,206)**	**0**	**(84,206)**	**(84,961)**	**(1,286)**	**0**	**0**	**(86,247)**	**(2,041)**	**(1,462)**	**(579)**
	Sub-Total	**95,584**	**5,619**	**101,203**	**107,638**	**(1,286)**	**0**	**(80)**	**106,272**	**5,069**	**9,981**	**(4,912)**

Budget of £5.6m has been vired from corporate contingencies to address an underlying shortfall in the ASC placements budget brought forward from 2024/25. An overspend of £5.1m is forecast at Month 6, with ASC placements reporting a pressure of £7.3m, offset by a £1.2m underspend in SEND Transport and further mitigations of £1.3m through reductions in staff forecasts and holding vacant posts. The underspend in SEND Transport is driven by more economical procurement of personal assistants and maximising efficiencies in the mix of delivery options.

The savings requirement for 2025/26 is £8.3m. This is shown in table 3 below.

Table 3: ***2025/26 Month 6 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)**	**(3,770)**	**0**	**(8,316)**

PERFORMANCE DATA

Please see attached appendix on recently published ASC Use of Resources report for 24/25.

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

1. Use of resources report 2024/25.
2. Growth modelling in high cost/high demand areas.

Adult Social Care Use of Resources Narrative Report, 2024/25

for: Hillingdon

compared with: Greater London (ADASS Region)

Written by LGA Research from Local Government Association

LG Inform

Summary Report for Hillingdon, 2024/25

Introduction

This report looks at a variety of the latest cost and activity metrics to help review and understand the use of resources in adult social care in Hillingdon. If you would like further support with Adult Social Care finances, please contact your PCH Regional Care and Health Improvement Adviser (CHIA).

This LG Inform report includes data from both the Adult Social Care Activity Report, and the Adult Social Care Finance Report, which from 2024/25, are published as two separate reports, and can be found on the gov.uk website and not NHS Digital as before. These were previously combined into a single Activity and Finance publication. The key change in 2024/25 is that the activity data is now reported as 'official statistics in development' using Client Level Data (CLD) submissions from councils, where previously the aggregations came from the Short and Long Term (SALT) collection, which is now discontinued. The advice from the Department of Health and Social Care (DHSC) is that only CLD-derived long-term support statistics are comparable over time (previously sourced from SALT tables LTS001a/b/c). Fortunately, these are the key activity statistics used in the use of resources approach, and are therefore reliable to continue to use for ratio and trend analysis. All other activity metrics in the publication, some of which are used in the more detailed Single LA view LG Inform report, are not comparable over time. As a consequence, new LG Inform metrics have been set up and used in the detailed report as appropriate, but will only display data for 2024/25 and beyond.

About Partners in Care and Health

The **Local Government Association** and **Association of Directors of Adult Social Services** are **Partners in Care and Health** (PCH) working with well-respected organisations. PCH helps councils to improve the way they deliver adult social care and public health services and helps Government understand the challenges faced by the sector. The programme is a trusted network for developing and sharing best practice, developing tools and techniques, providing support and building connections. It is funded by the Department of Health and Social Care and is offered to councils without charge. You can find out more about PCH by visiting the website here.

How to use this report

The report will default to the lead authority area of the user, but you can change the area by simply changing the lead area in the menu at the top of the report. There are numerous comparison groups to choose from. The lead area can also be an ADASS region for a regional view, but the comparison group must also be changed to 'ADASS regions'. **Please make sure you click the 'apply' button to refresh the report when changing the area or comparison group.**

The report contains the latest publicly available data and will automatically update with each new release of published data. Please be mindful that ASCOF is published (and made available in LG inform) **3 months later** than the adult social care activity and finance data. During this window, the latest published ASCOF data will relate to the previous year. For each chart, the averages for England and your chosen comparison group are included.

Users are able to export the full report as a PDF or a word version. Alternatively, you can export the link to share with colleagues or use in local reports. You can also download specific components of the report by clicking on the horizontal lines in the icon in the top right of the block.

Interpreting the data

Throughout this report, metrics are shown as 'per adult' and 'per client'. Where the metric is 'per adult' it is based on adults of the relevant age group living in the local authority, using the latest mid-year population estimates. 'Per client' metrics are based on adults receiving care at any point during the year.

'90th percentile' and '10th percentile' are used to describe a more representative upper and lower range of values, instead of 'minimum' and 'maximum' that would otherwise include outliers in the data. These percentiles ignore the lowest and highest ten percent of councils.

Where average, rank or quartile metrics are shown over time, these are based on all current 153 English single tier and county councils.

We encourage councils to use this report to help with their understanding of the topic and to consider the similarities and differences in the trends shown in the published data. When comparing councils with one another, please bear the following in mind:

- Data recording is not fully consistent across England, so two figures from two different councils are not necessarily fully comparable.
- No one metric alone gives a complete picture of a council's situation.
- The metrics are the starting point of a conversation about the topic. There is a potential for metrics to be used to arrive at misleading conclusions without knowing local contexts. Further analysis and research will be required.
- In most cases, there is no assumed polarity to the metrics. For example, it is not necessarily the case that a low figure for a metric is 'good' and a high figure 'bad'. The needs and priorities of councils can vary significantly, so this needs to be considered when interpreting the figures.

To understand more about individual metrics, you can click on any metric hyperlink to reveal the source information and help text about that metric.

Feedback

The LGA are committed to improving the reports available on the LGInform platform, and would welcome feedback from users on content and functionality of the specific reports. Equally, if you would like to see new content, please get in touch with us via email to PCHdata@local.gov.uk.

Other resources relating to Use of Resources

The 13-step approach sets out the questions underpinning the Use of Resources approach. It is designed to promote informed self-assessment and improvement, taking into account local conditions and bringing in challenge at each step. It helps councils to identify areas for further exploration, where spend and/or performance is significantly different to regional or national averages. You can also make use of the other LG Inform reports below:

- Use of Resources Narrative Report includes the key spending headlines for your area compared to the national position and the previous year (this report). This report provides analysis of the key data and so may be the most useful report for DASSs and other senior officers.
- ASC Use of Resources single LA view report uses data from NHS England's Adult Social Care Activity and Finance Reference Tables to examine the relationship between spending and activity for a selected area and comparison group. This is the most detailed single council view report, but does not include the analysis in the narrative report.
- ASC Use of Resources report - single LA view (abridged view) is a shorter single council view with some comparison with the previous year.
- Use of Resources Time Series Report that includes all core measures from the Use of Resources approach for the last five years to help councils in reviewing a longer period.

Other LGA resources available

Please visit the Partners In Care & Health Data Resources section of our website here to find out what other LG Inform reports and data tools are available to support you. The website also provides some useful links to external data resources. Alternatively, you can explore the LG inform Adult Social Care themed reports here. Access to some of the reports will require a login. It is free to sign up.

Overview of Hillingdon

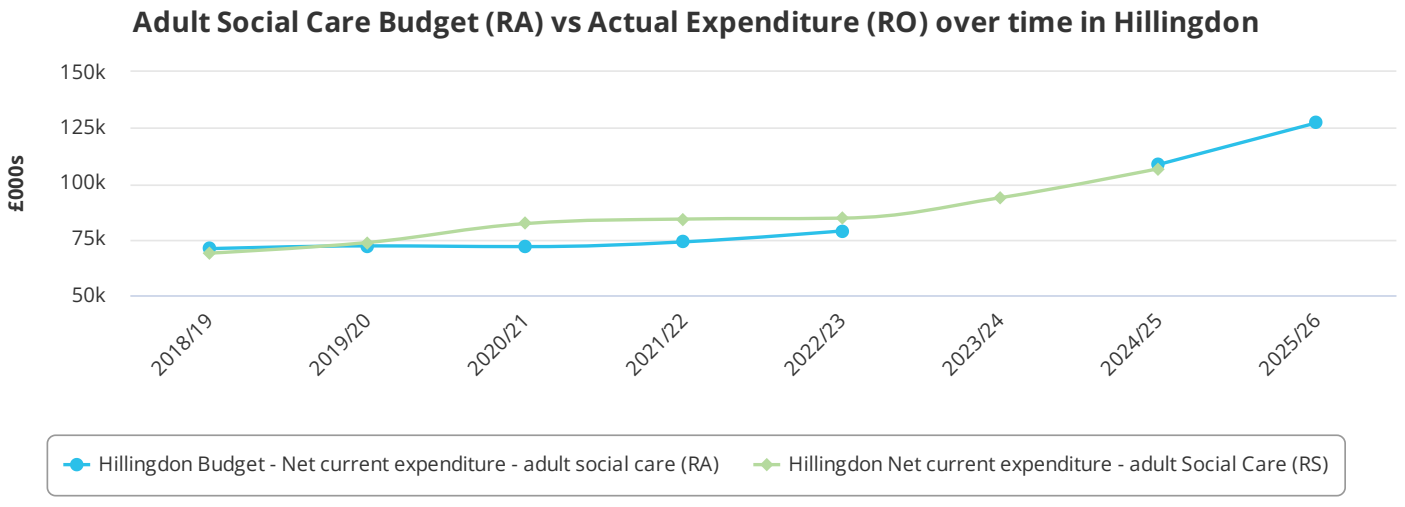
Hillingdon is a London borough authority in the London region of England. The latest Office for National Statistics (ONS) mid-year population estimates for 2024 show the total population to be 329,185, of which there are 253,661 adults aged 18+. The Indices of Multiple Deprivation (IMD) statistics can also provide some local context. These statistics are published every 4 to 5 years with the latest data published in 2025. In terms of overall deprivation, Hillingdon was ranked 90 out of the 153 single tier and county councils existing in England in 2025 (1 being the most deprived). 12.0% of neighbourhoods in the authority are within the 30% most deprived Lower Super Output Areas (LSOAs) in England.

Hillingdon has a higher proportion of younger adults, and a higher proportion of older adults compared to England overall (as per the latest mid-year population estimates). 83% of the adult population was aged 18 to 64 years old, and 17% were aged 65 and over (compared with 76% and 24% respectively for England).

In terms of diversity, at the time of the last Census (2021), 32.2% of the usual adult resident population identified as Asian or Asian British, 7.1% Black, Black British, Caribbean or African, 2.9% Mixed or Multiple ethnic groups, 51.8% as White, and 6.0% as Other ethnic groups.

Budgeted vs Actual Expenditure in Adult Social Care

This report primarily focusses on the detailed expenditure from the Adult Social Care Finance Return(ASC-FR). However, it is also useful to look at how this fits into the councils' overall expenditure and budget positions reported in the Revenue Outturn (RO) and the Revenue Accounts (RA) to the Ministry for Housing, Communities and Local Government (MHCLG). **Note that the actual spend data is sourced from the 'RS' table which is a summary table of the RO return.** The following chart presents a time series of the budgeted net current expenditure for the year (blue line) compared with the actual expenditure (green line).



Source:
Metric ID: 1765, Budgeted Revenue Accounts, Budget - Net current expenditure - adult social care (RA) , **Data updated:** 19 Jun 2025
Metric ID: 4093, Revenue Outturn Summary (RS), Net current expenditure - adult Social Care (RS) , **Data updated:** 21 Oct 2025

The proportion of council expenditure accounted for by Adult Social Care

This table shows the proportion of the council's net revenue expenditure in Hillingdon (London borough Authority), which is spent on Adult Social Care over time, compared to the national average, and the average for your chosen comparison group.

Note that unitary councils (including Metropolitan and London boroughs) are responsible for a wider range of services than County Councils, so this will significantly impact on the proportion of net revenue expenditure which is accounted for by Adult Social Care. Caution should be exercised when comparing with other councils. To account for authority type, averages for different comparison groups have been included in the table to provide more meaningful comparisons.

Adult Social Care as % of Council's Net Revenue Expenditure over time in Hillingdon

	Net current expenditure on adult social care as a % of net revenue expenditure (RS)						
	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Area	%	%	%	%	%	%	%
Hillingdon	36.55	36.32	36.18	42.11	44.92	42.80	41.87
Mean for All English Single tier and County from 2018/19	39.37	39.72	43.72	43.13	43.52	46.35	47.19
Mean for Greater London (ADASS Region)	38.03	37.57	40.07	39.61	42.12	42.35	42.40
Mean for All English county local authorities	48.32	48.60	55.81	54.02	52.79	55.34	56.06
Mean for All English unitary authorities	38.33	38.42	42.15	42.43	42.69	46.46	47.06
Mean for All English metropolitan boroughs	36.14	37.99	41.26	40.40	40.45	44.56	46.21
Mean for All London Boroughs (excl City)	39.09	38.59	41.19	40.62	43.27	43.48	43.70

Source:
Metric ID: 11123, Revenue Outturn Summary (RS), Proportion of Net Revenue Expenditure accounted for by Adults' Social Care (RS) , **Data updated:** 21 Oct 2025

Overall spending on Adult Social Care

- In Hillingdon, the total spend on Adult Social Care in 2024/25 expressed as the spend per adult in the local population was £503.87 per adult. This was less than the overall spend per adult for England of £632.97; a difference of -20.4% from the national level.
- Overall spending will likely be affected by the relative proportion of older people in the overall population. In Hillingdon, 13.1% of the population are aged 65, which is lower than England overall (18.7%), and higher than the average for the London region (12.3%).
- Overall spending will also likely be affected by the level of deprivation. Hillingdon is ranked 90 among all English single-tier and county councils on the Index of Multiple Deprivation (where a rank of 1 indicates a high level of deprivation). Hillingdon is less deprived than the average for Greater London (ADASS Region).
- Compared with 2023/24, overall spending per adult increased by 6.2% from its previous level of £474.47. For comparison, across England spending per adult increased by 7.3% from £590.00 in 2023/24.
- Looking at spending broken down by age group tends to provide more useful insights as it accounts for any differences in the circumstances of younger adults and older people.

Spending on Younger Adults

- Looking at spend specifically on short and long term support for younger adults, Hillingdon spent £295.39 per younger adult in 2024/25. This was less than the overall spend per younger adult for England of £332.50: a difference of -11.2% from the national level. Compared to other councils, Hillingdon is ranked 107th (1 is the highest spend per younger adult).
- The 90th percentile authority across England (that is, the authority with the 10th lowest spend per younger adult) was £253.67 per younger adult.
- Compared with 2023/24, spending per younger adult increased by 9.9% from its previous level of £268.83. For comparison, across England spending per adult increased by 10.0% from £302.28 in 2023/24.
- Hillingdon supported 0.75% of its younger adult population with long term support in 2024/25, which was less than the 0.88% of younger adults supported in England. Compared to other councils, Hillingdon is ranked 119th (1 is the highest proportion of the younger adults supported).
- Compared with 2023/24, the actual number of younger adults with long term support in Hillingdon increased by 5.4% to 1,570 from its previous level of 1,490. For context, the ONS population estimates for younger adults in Hillingdon increased by 2.7% over the same period.
- Hillingdon spent £39,598.09 on long and short term support per younger adult supported in 2024/25, an increase of 7.1% from its previous level of £36,988.59. For comparison, the spend per younger adult supported for England overall was £37,692.34, which was 6.4% higher than the previous year.
- High spending per adult is not necessarily a sign of poor value for money, and conversely low spending per adult is not necessarily positive. If a council has relatively few people in long term support (because they are being supported in other ways), then the costs per adult supported will be higher because the council is focusing on those with the most complex needs. Therefore packages are likely to be more expensive.
- Spending per adult may also be influenced by the type and extent of support used, such as direct payments, or reliance on care homes.
- In 2023/24, the percentage of younger adults with direct payments in Hillingdon was 25.5% compared to 37.1% nationally.
- In terms of new care home admissions in 2023/24, there were 21.7 admissions per 100,000 younger adults for Hillingdon, compared to 15.2 nationally. Compared to other councils, Hillingdon is ranked 133rd (1 is the fewest number of admissions per 100,000 younger adults). In 2022/23 these rates were 21.8 for Hillingdon and 14.6 nationally.
- For all permanent residential and nursing care provision throughout 2024/25 in Hillingdon, 3.2% of younger adults were supported in nursing care during the year, and 10.2% in residential care. Combined, 13.4% of younger adults accessed long term support in a care home, which is lower than the national average of 14.0%. Compared to other councils, Hillingdon is ranked 73rd (1 is the highest percentage of younger adults in a care home). The remaining 86.6% of younger adults were supported in the community.
- In Hillingdon, £16,337,000 was spent in 2024/25 on permanent residential and nursing care placement for younger adults. This is 26.9% of the total spend on long term support for younger adults, which is lower than the national position of 29.4%. In terms of package costs, £77,795 was spent on average for each younger adult supported in permanent residential or nursing care in Hillingdon, which is higher than the national average of £77,594.
- Another factor to consider is the proportion of younger adults with learning disabilities who live in their own home or with family. For 2023/24, this was 81.7% for Hillingdon and 81.6% nationally.

Spending on Older Adults

- Looking at spend specifically on short and long term support for older adults, Hillingdon spent £1,084.43 per older adult in 2024/25. This was less than the spend per older adult for England of £1,167.50; a difference of -7.1%. Compared to other councils, Hillingdon is ranked 111th (1 is the highest spend per older adult).
- Compared with 2023/24 spending per older adult changed by 13.1% from its previous level of £958.95. For comparison, across England spending per older adult changed by 6.9% from £1,092.09 in 2023/24.
- Hillingdon supported 5.39% of its older adult population with long-term care in 2024/25, which was greater than the England average of 5.25%. Compared to other councils, Hillingdon is ranked 83rd (1 is the highest proportion of older adults supported).
- Compared with 2023/24, the actual number of older adults with long term support in Hillingdon decreased by -5.3% to 2,330 (from its previous level of 2,460). For context, the ONS population estimates for older adults in Hillingdon increased by 1.7% over the same period.
- All councils should be seeing if they can do more to provide information and advice, and signposting to other services to help older people to live independently for as long as possible. Councils may benefit from comparing their performance with the targets set out by the Institute of Public Care in Six Steps to Managing Demand in Adult Social Care (Mar 2017). Further advice is available in New Developments in Adult Social Care (Jan 2019).
- Hillingdon spent £20,105.15 on long and short term care per older adult supported in 2024/25, an increase of 21.4% from its previous level of £16,560.16. For comparison, the spend per older adult supported for England overall was £22,258.30, which was 5.7% higher than the previous year.
- Spending per adult may also be influenced by the type and extent of support used, such as direct payments, or reliance on care homes.
- In 2023/24, the percentage of older adults with direct payments in Hillingdon was 11.9% compared to 14.3% nationally.
- In terms of new care home admissions in 2023/24, there were 907.9 admissions per 100,000 adults aged 65+ for Hillingdon, compared to 566.0 nationally. Compared to other councils, Hillingdon is ranked 147th (1 is the fewest number of admissions per 100,000 older adults). In 2022/23 these rates were 629.3 for Hillingdon and 560.8 nationally.
- For all permanent residential and nursing care provision throughout 2024/25 in Hillingdon,18.2% older adults were supported in nursing care, and 13.1% in residential care. Combined, 31.3% of older adults accessed long term support in a care home, which is lower than the national average of 38.8%. Compared to other councils, Hillingdon is ranked 115 (1 is the highest percentage of older adults in a care home). The remaining 68.7% of older adults were supported in the community.
- In Hillingdon, £26,505,000 was spent on permanent residential or nursing care for older adults. This is 61.4% of the total spend on long term support for older adults, which is lower than the national position of 62.8%. In terms of package costs, £36,308 was spent on average for each older adult supported in a care home in Hillingdon, which is higher than the national average of £33,813.

Other (non-age specific) expenditure

- The breakdown of spending rates by age group ignores 'other expenditure', which is reported by councils as 'non-age specific expenditure'. This is not broken down between younger adults and older people, or between long and short term care. It is clear from the figures published that there is some inconsistency in the way that this is reported by councils.
- Hillingdon spent £74.11 on non-age specific expenditure per adult in 2024/25. This was less than the spend per adult for England of £103.01 for the same period; a difference of -28.1% from the national level.
- Compared with the previous year, non-age specific expenditure per adult changed by -15.0% from its previous level of £87.18 in 2023/24. For comparison, across England spending per adult changed by 1.0% from £101.99 in 2023/24.
- Councils may want to reflect on the different components that make up other non-age specific expenditure, particularly in relation to 'social care activities' and 'commissioning and service delivery' which make up the greatest proportion of spend in this area and mostly account for staffing. Equally, councils may want to consider spending on specific cohorts such as **carers, asylum seekers,** and people dealing with **social isolation** or **substance misuse**. Lower level support and preventative services may also be bolstered through investment in **Assistive Equipment and Technology** and **Information and Early Intervention**. Spend in all of these areas may help to reduce or delay the needs of people and reduce the pressure on long term support activities and costs. This data can be found in Table T46 of the published activity and finance tables referenced in the introduction.

Spending funded by income from the NHS

- There are some issues about the way that DHSC collect both finance and activity data. The spending figures above do not include adult social care spending that is funded by the NHS. Step 13 in the Use of Resources approach provides further information about the position for Hillingdon.
- Gross current expenditure for Hillingdon in 2024/25 was £127,813,000 which was greater than the 2023/24 figure of £117,426,000. This expenditure does not include spending funded by income from the NHS. Revised expenditure for Hillingdon in 2024/25, which includes NHS income, was £157,324,000 and greater than the 2023/24 figure of £147,605,000.
- Overall, total income from the NHS in Hillingdon in 2024/25 was £27,824,000, of which income from the Better Care Fund was £13,153,000. In 2024/25, total income from the NHS accounted for 18% of revised gross current expenditure in Hillingdon, which is greater than 13% for England overall. Compared to all other English single tier and county councils, Hillingdon is ranked 20th in terms of the proportion of NHS-funded expenditure (where a rank of 1 is the highest proportion of NHS Funding).
- This translates to Hillingdon receiving £110 in NHS Income per adult aged 18+ in the population, compared to £95 per adult for England overall. Compared to all other English single tier and county councils, Hillingdon is ranked 48th in terms of NHS Income per head (where a rank of 1 is the highest level of funding per head).
- Looking at the proportion of revised gross expenditure which is funded by NHS Income, in Hillingdon, 8% was funded specifically from Better Care Fund Income, and a further 9% from other NHS sources in 2024/25. These figures in 2023/24 were 8% for Better Care Fund income and 11% for other NHS income respectively.
- Taking this income into account for the rates of expenditure, Hillingdon spent £620.21 in revised expenditure per adult in 2024/25. This was less than the overall revised spend per adult for England of £740.47; a difference of -16.2% from the national level.
- Compared with 2023/24, revised spending per adult changed by 4.0% from its previous level of £596.41. For comparison, across England revised spending per adult changed by 6.6% from £694.92 in 2023/24.
- Hillingdon spent £40,339 in revised expenditure per adult supported in 2024/25. This was greater than the overall revised spend per adult for England of £38,689; a difference of 4.3% from the national level.
- Compared with 2023/24, revised spending per adult supported changed by 8.0% from its previous level of £37,368. For comparison, across England revised spending per adult supported changed by 4.2% from £37,123 in 2023/24.
- Councils should check they have received all of the NHS Income they are entitled to from their BCF plans.

Spending funded by income from service user contributions

- Hillingdon reported financing 12.1% of its revised expenditure from service user contributions in 2024/25, compared with 13.6% nationally.
- Compared with the previous year, service user contributions as a percentage of revised total expenditure decreased compared to its previous level of 12.4% in 2023/24. For comparison, service user contributions nationally increased as a proportion compared with 12.9% in 2023/24.
- The level of income collected from service user contributions will be influenced by local charging policies and income collection procedures, but also by the use of care homes in an area. Councils who make significant use of care homes to support older people will normally have a much higher proportion of income from clients because almost every older person in a care home pays a significant amount towards the cost of their care.
- All councils should review regularly their income collection policies and procedures.

Supporting tables and charts

The following tables summarise some of the key activity and spend metrics per head of population and per adult supported, shown over a seven year period in Hillingdon. The charts show a comparison with England and your chosen comparator group.

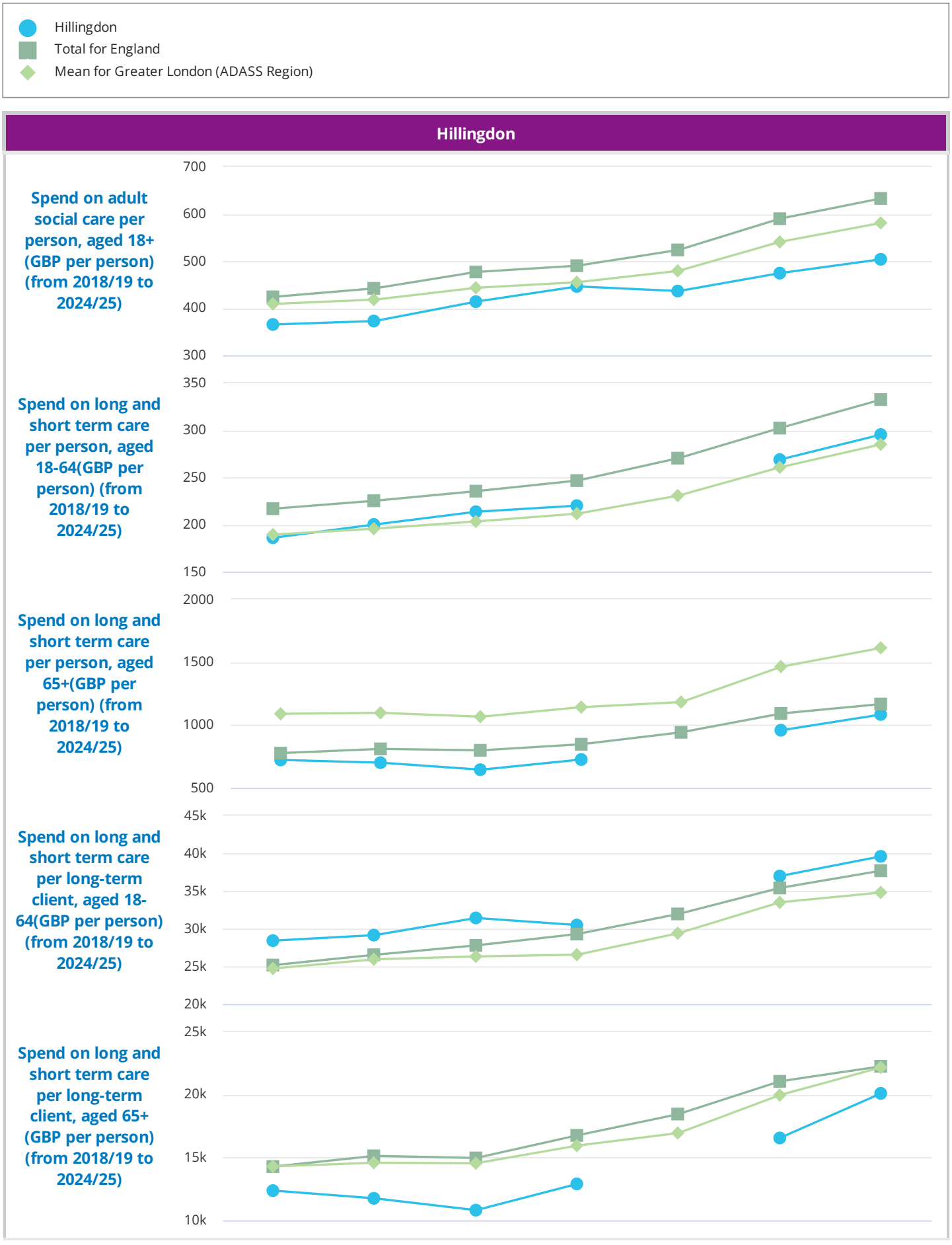
Adults supported during the year over time in Hillingdon

	Hillingdon						
	Count						
Metric type	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
Clients in long-term support	3,565	3,730	3,755	3,715	3,790	3,950	3,900
Clients in long-term support as % of population aged 18+	1.55	1.60	1.60	1.59	1.58	1.60	1.54
Clients accessing LT care during the year aged 18-64	1,250	1,325	1,315	1,390	1,425	1,490	1,570
Long-term care clients as % of the population, aged 18-64	0.65	0.69	0.68	0.72	0.72	0.73	0.75
Clients accessing LT care during the year aged 65+	2,315	2,405	2,440	2,325	2,365	2,460	2,330
Long-term care clients as % of the population, aged 65+	5.84	5.96	5.96	5.63	5.65	5.79	5.39
% Clients in residential or nursing care - 18-64	16	15	14	14	13	13	13
% Clients in residential or nursing care - 65+	26	26	23	25	25	27	31

Spend per head & per adult supported over time in Hillingdon

	Hillingdon						
	GBP per person						
Metric type	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Spend on long and short term care per person, aged 18-64	185.99	200.03	213.53	220.00	Missing	268.83	295.39
Spend on long and short term care per person, aged 65+	722.45	700.66	644.85	725.85	Missing	958.95	1,084.43
Spend on long and short term care per long-term client, aged 18-64	28,424.00	29,155.47	31,429.66	30,488.49	Missing	36,988.59	39,598.09
Spend on long and short term care per long-term client, aged 65+	12,370.63	11,757.17	10,815.16	12,903.66	Missing	16,560.16	20,105.15
Spend on adult social care per person, aged 18+	365.59	372.90	414.01	446.29	436.49	474.47	503.87
Spend on non age specific adult social care per person, aged 18+	87.41	86.34	125.20	136.92	Missing	87.18	74.11

Spend per adult and per person supported over time in Hillingdon with comparisons



% of the population supported over time in Hillingdon with comparisons

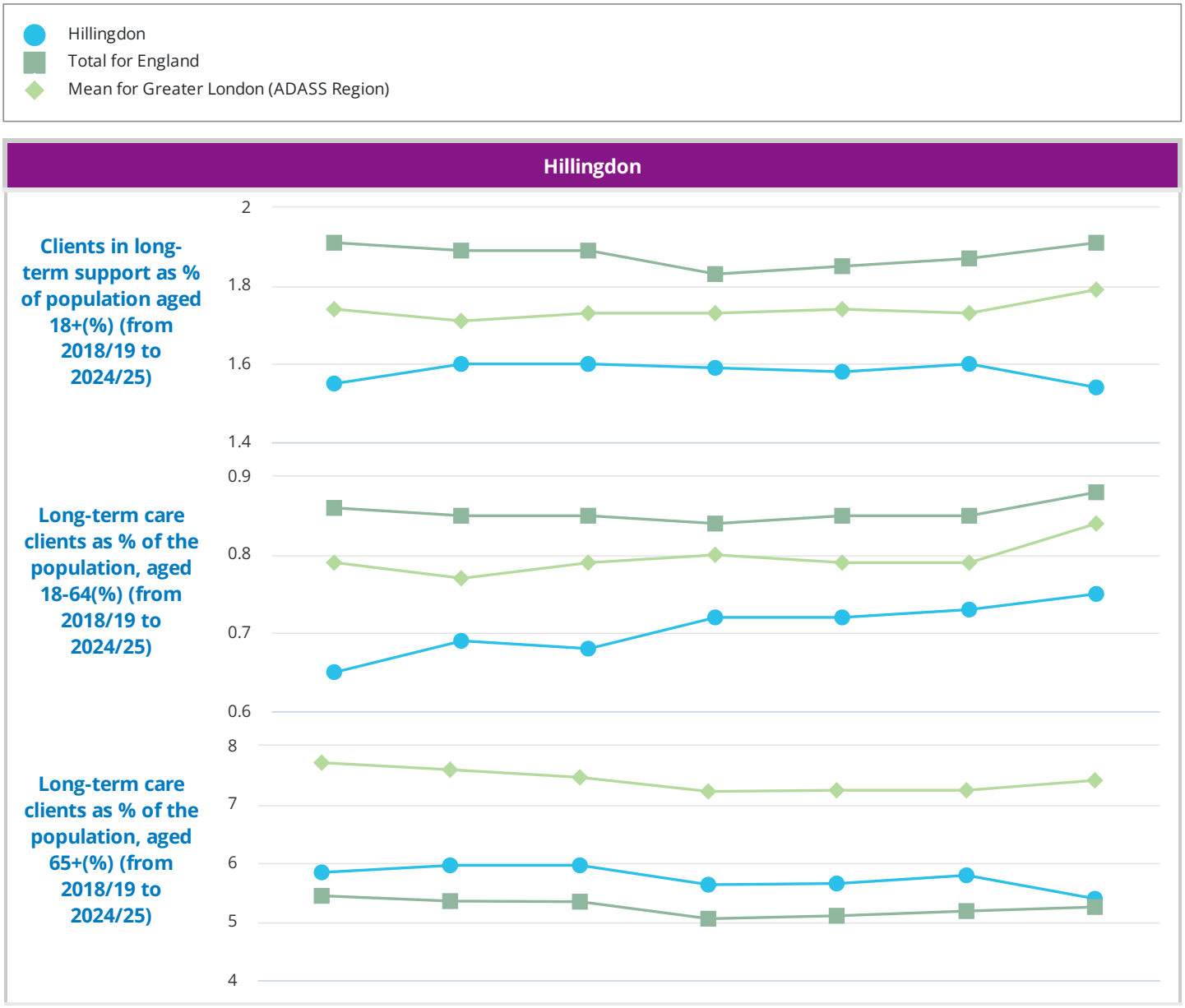


Table of key Use of Resources metrics at area level compared to previous year (£,000s)

Metric type	Hillingdon		
	2023/24	2024/25	
	Raw value	Raw value	% difference from 2023/24
Total expenditure (including capital) on adult social care	148,392	157,564	6.2
Total adult social care capital charges	787	240	-69.5
Revised spend on adult social care	147,605	157,324	6.6
Income from NHS excl. Better Care Fund	16,337	14,671	-10.2
Income from Better Care Fund	12,479	13,153	5.4
Adult social care income from joint arrangements	0	0	0.0
Adult social care income from other sources	1,363	1,687	23.8
Gross Current Expenditure on adult social care	117,426	127,813	8.8
Adult social care income from client contributions	18,313	18,971	3.6
Gross Current Expenditure on short term care for clients aged 18 to 64	850	1,418	66.8
Gross Current Expenditure on short term care for clients aged 65+	3,660	3,687	0.7
Gross Current Expenditure on long term care for clients aged 18 to 64	54,263	60,751	12.0
Gross Current Expenditure on long term care for clients aged 65+	37,078	43,158	16.4
Gross Current Expenditure on non age specific adult social care	21,575	18,798	-12.9

Table of key Use of Resources metrics for England compared to previous year (£,000s)

Metric type	England		
	2023/24	2024/25	
	Raw value	Raw value	% difference from 2023/24
Total expenditure (including capital) on adult social care	32,005,204	34,548,264	7.9
Total adult social care capital charges	126,957	163,204	28.6
Revised spend on adult social care	31,878,247	34,385,060	7.9
Income from NHS excl. Better Care Fund	1,777,096	1,829,065	2.9
Income from Better Care Fund	2,458,804	2,563,091	4.2
Adult social care income from joint arrangements	121,603	143,939	18.4
Adult social care income from other sources	455,769	455,800	0.0
Gross Current Expenditure on adult social care	27,064,975	29,393,167	8.6
Adult social care income from client contributions	4,107,840	4,676,133	13.8
Gross Current Expenditure on short term care for clients aged 18 to 64	215,351	248,998	15.6
Gross Current Expenditure on short term care for clients aged 65+	767,926	804,990	4.8
Gross Current Expenditure on long term care for clients aged 18 to 64	10,390,148	11,540,034	11.1
Gross Current Expenditure on long term care for clients aged 65+	11,012,976	12,015,457	9.1
Gross Current Expenditure on non age specific adult social care	4,678,572	4,783,687	2.2

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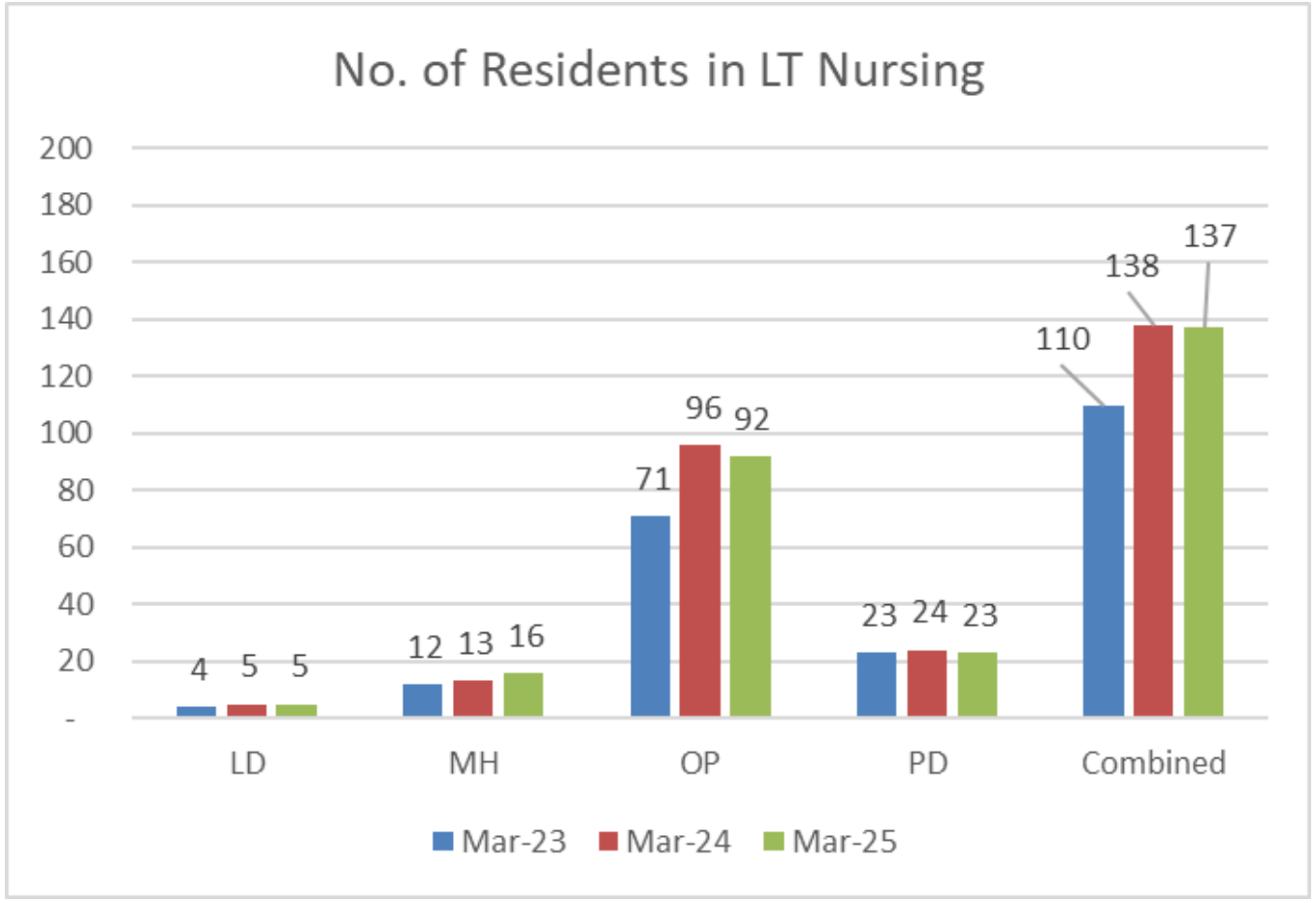
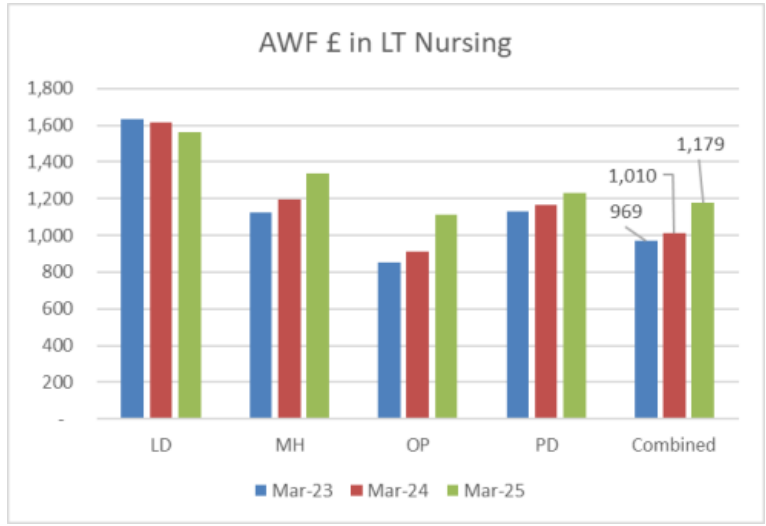
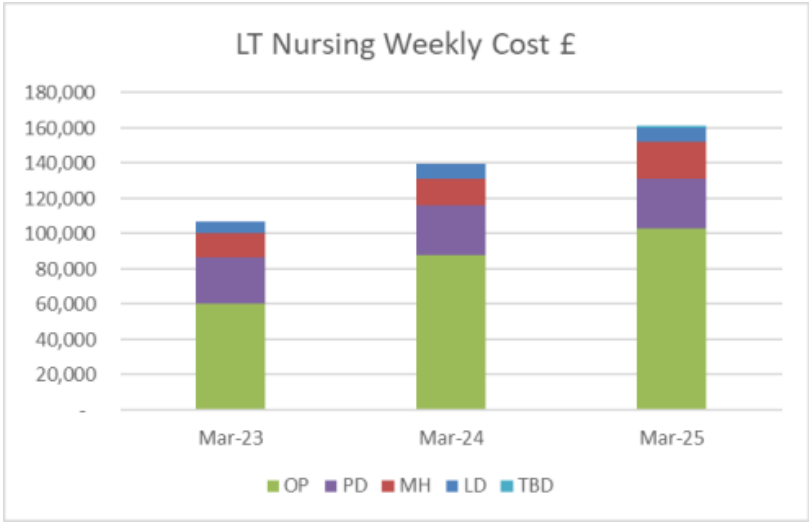
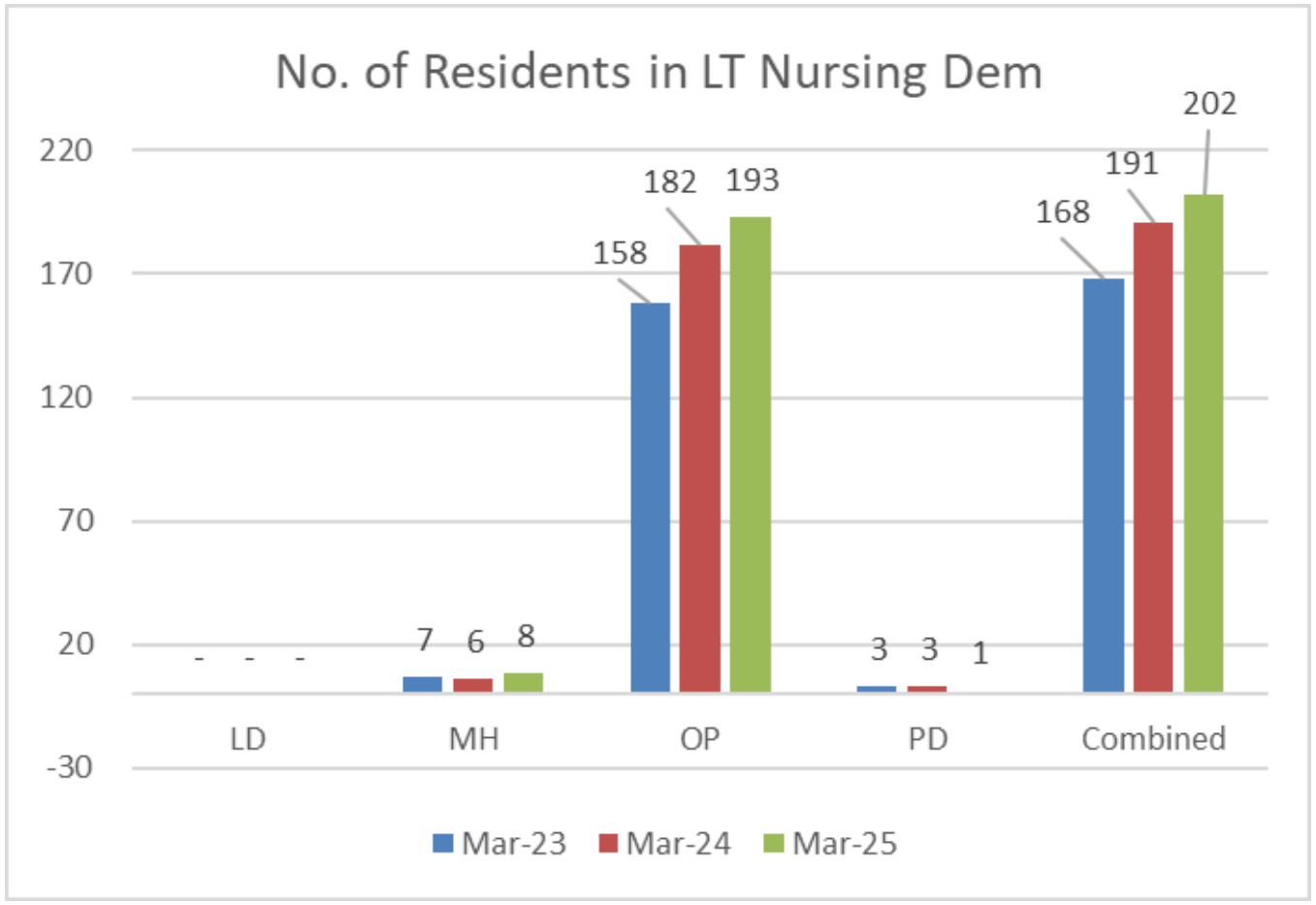
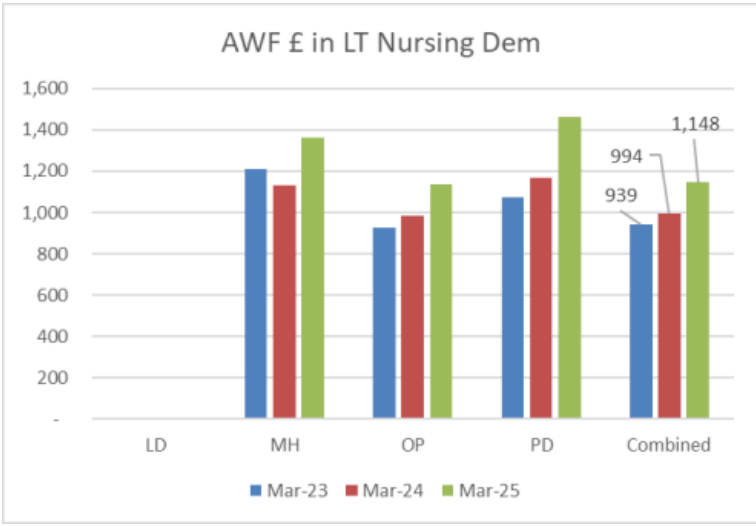
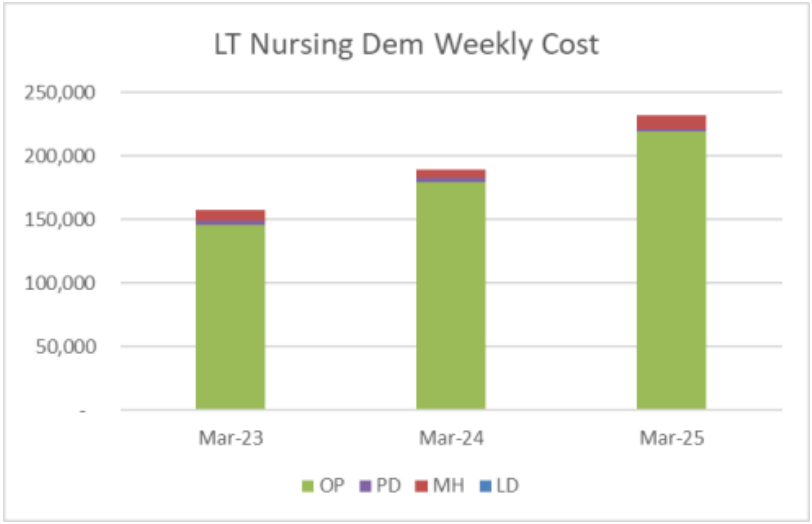

No. of Residents in LT Nursing
200
180
160
140
120
100
80
60
40
20
-
4 5 5
12 13 16
71 96 92
23 24 23
110 138 137
LD
MH
OP
PD
Combined
Mar-23 Mar-24 Mar-25

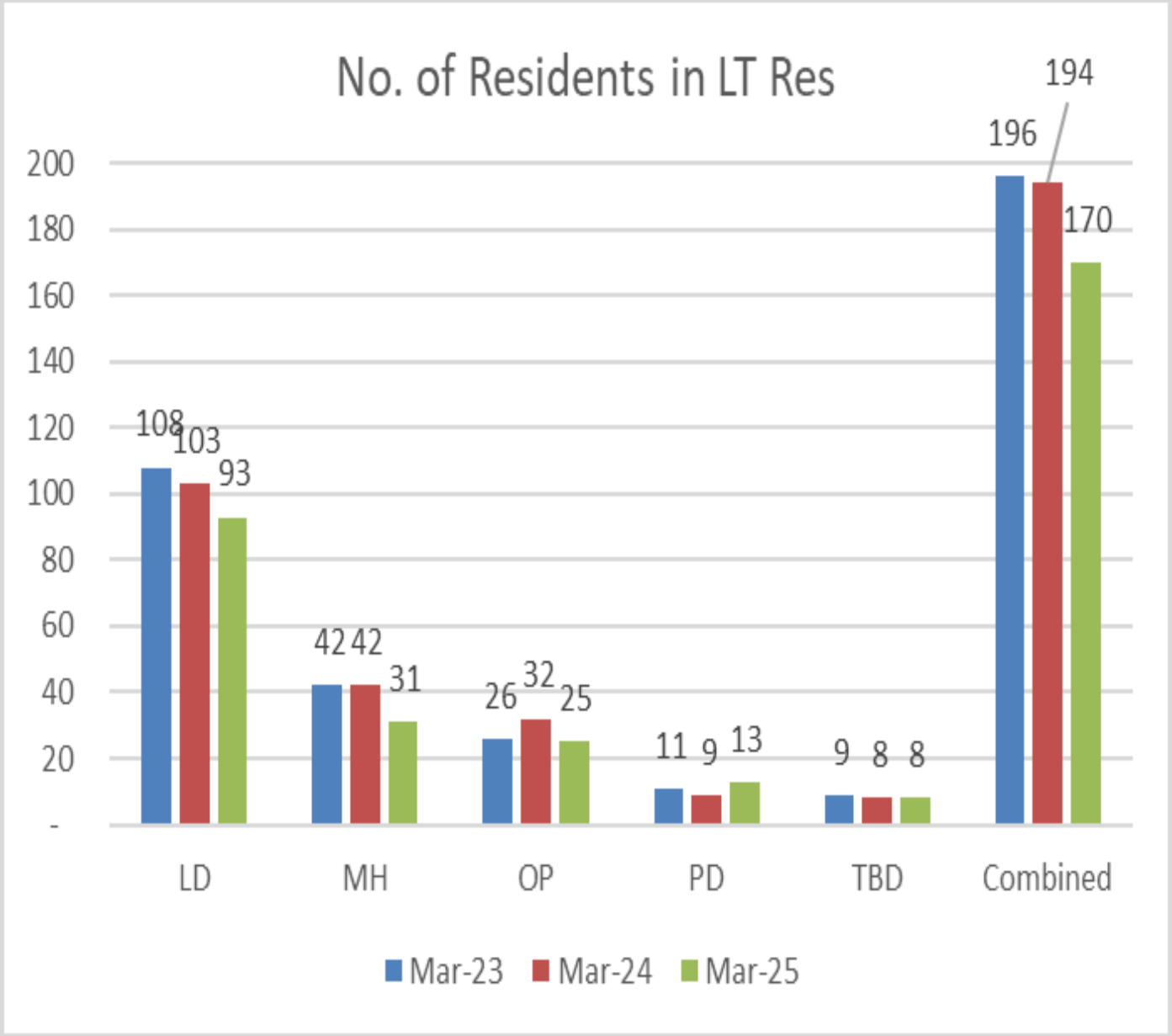

AWF £ in LT Nursing
1,800
1,600
1,400
1,200
1,000
800
600
400
200
-
969
1,010
1,179
LD
MH
OP
PD
Combined
Mar-23 Mar-24 Mar-25

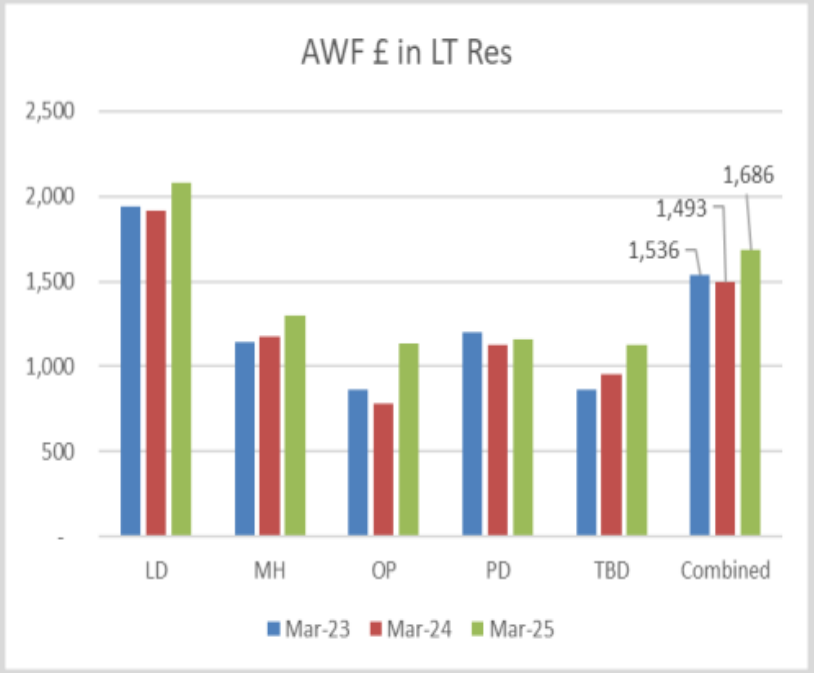

LT Nursing Weekly Cost £
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
-
Mar-23
Mar-24
Mar-25
OP PD MH LD TBD

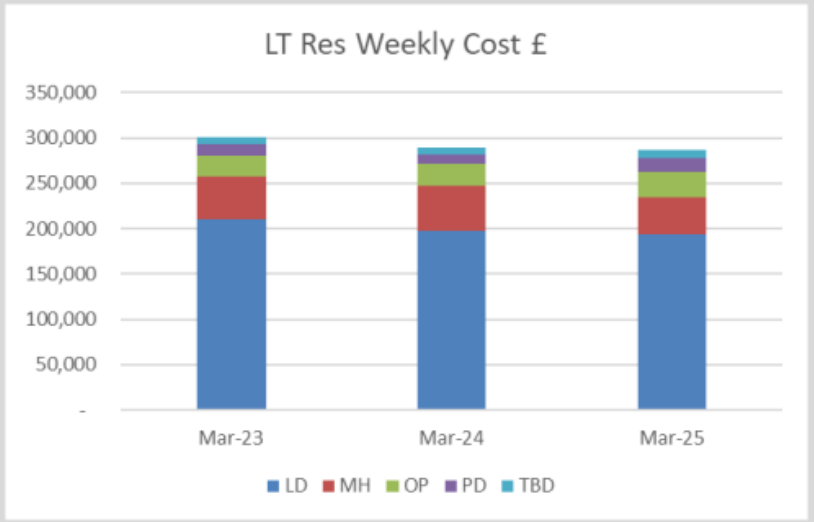

No. of Residents in LT Nursing Dem
220
170
120
70
20
-30
- - -
7 6 8
158 182 193
3 3 1
168 191 202
LD
MH
OP
PD
Combined
Mar-23
Mar-24
Mar-25

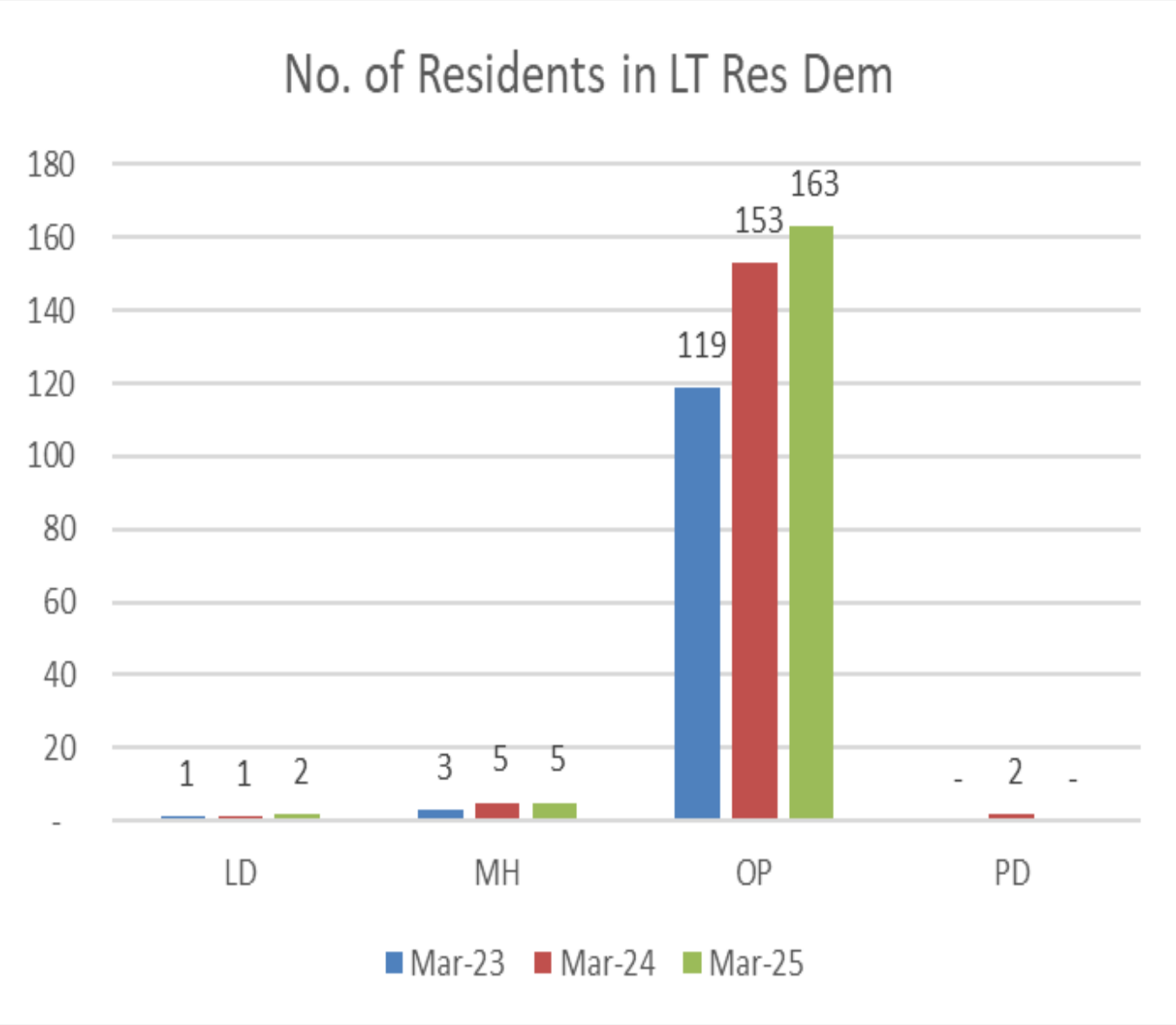

AWF £ in LT Nursing Dem
1,600
1,400
1,200
1,000
800
600
400
200
-
994
939
1,148
LD
MH
OP
PD
Combined
Mar-23
Mar-24
Mar-25

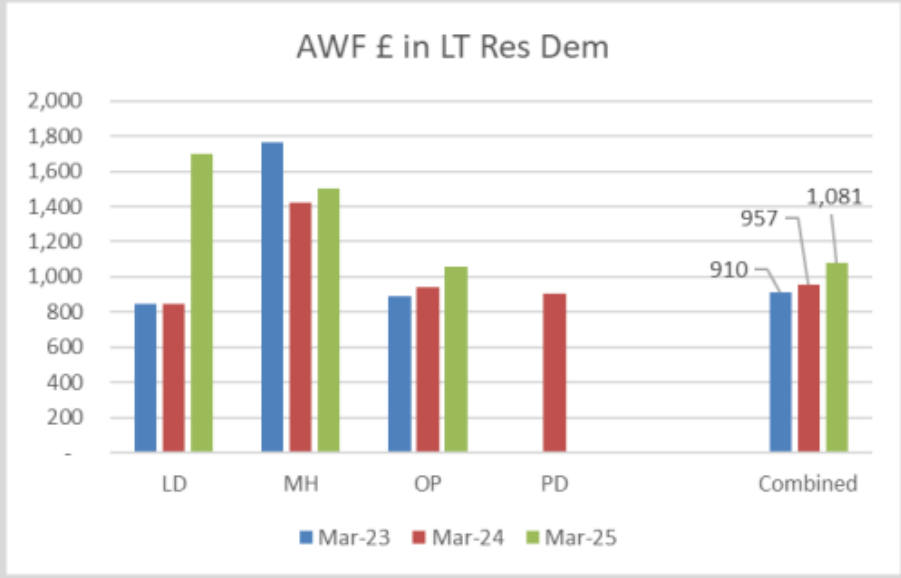

LT Nursing Dem Weekly Cost
250,000
200,000
150,000
100,000
50,000
-
Mar-23
Mar-24
Mar-25
OP
PD
MH
LD

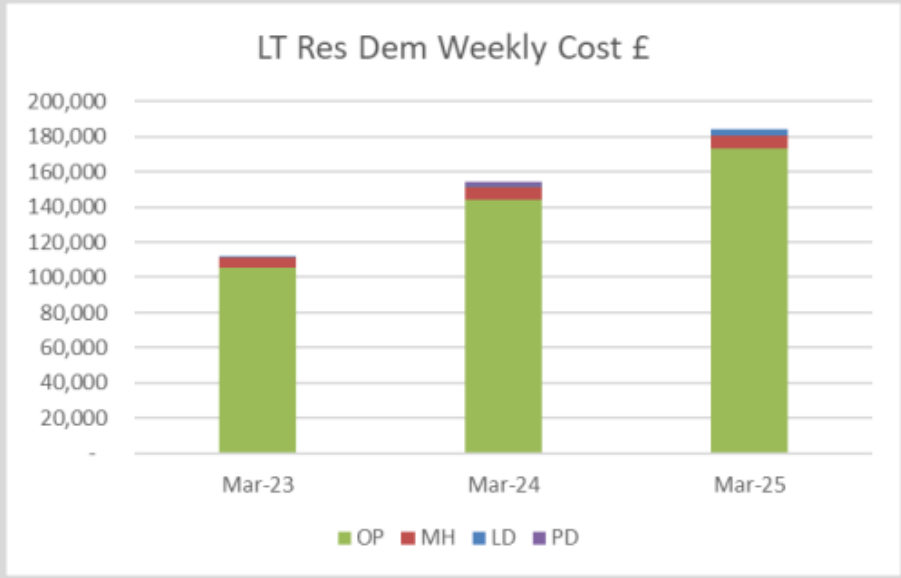

No. of Residents in LT Res
200
180
160
140
120
100
80
60
40
20
-
108
103
93
42 42
31
26
32
25
11
9
13
9
8
8
196
194
170
LD
MH
OP
PD
TBD
Combined
Mar-23
Mar-24
Mar-25

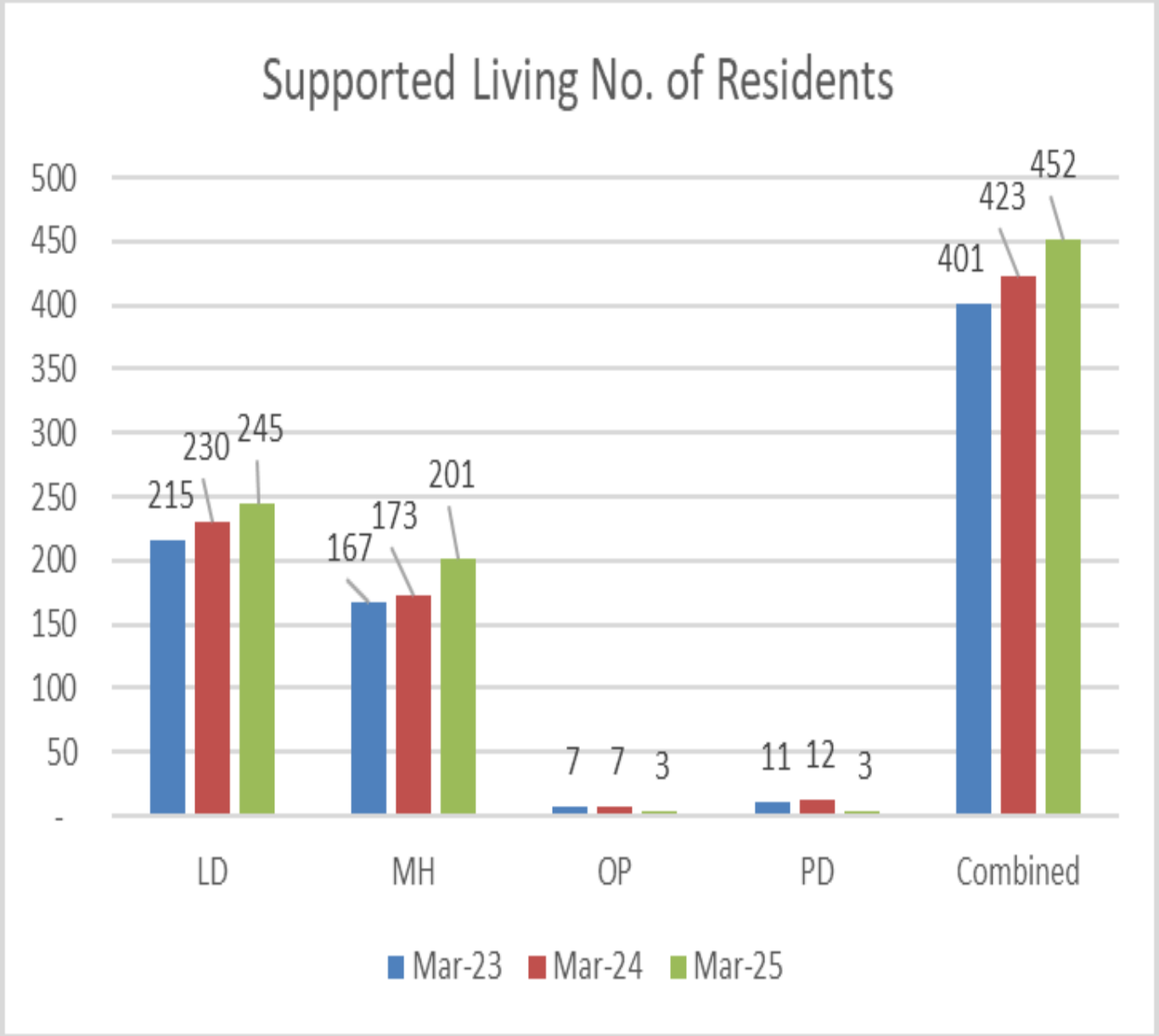

AWF £ in LT Res
2,500
2,000
1,500
1,000
500
-
1,536
1,493
1,686
LD
MH
OP
PD
TBD
Combined
Mar-23
Mar-24
Mar-25

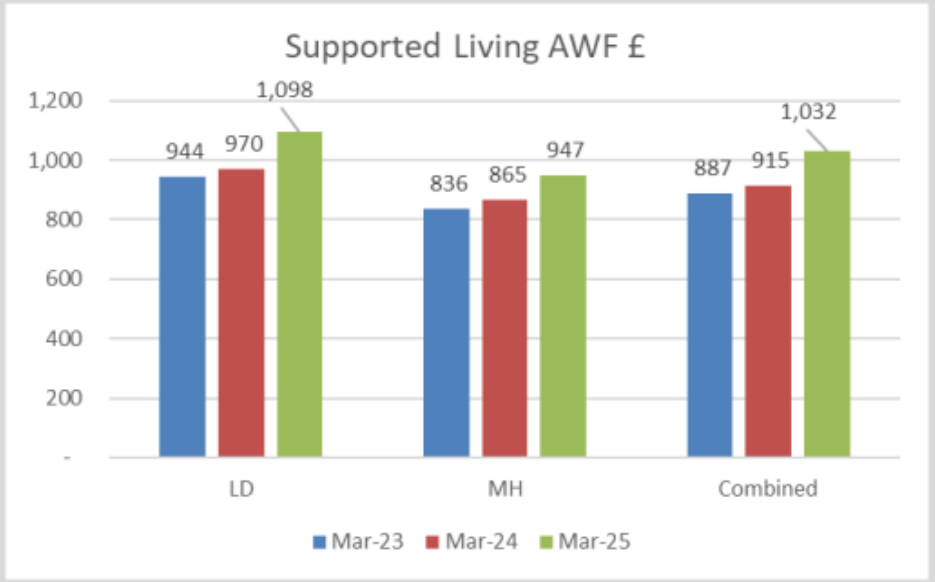

LT Res Weekly Cost £
350,000
300,000
250,000
200,000
150,000
100,000
50,000
-
Mar-23
Mar-24
Mar-25
LD
MH
OP
PD
TBD

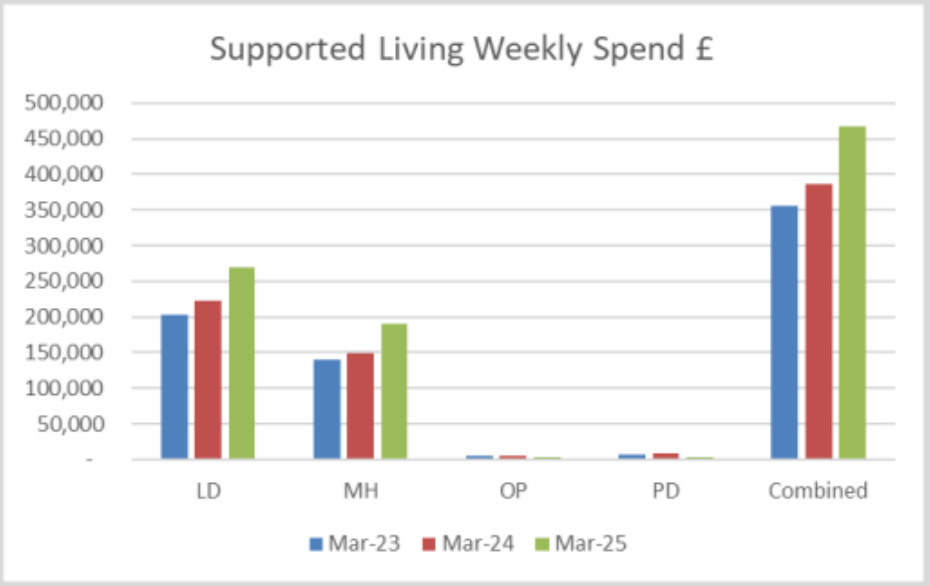

No. of Residents in LT Res Dem
180
160
140
120
100
80
60
40
20
-
1
1
2
3
5
5
119
153
163
-
2
-
LD
MH
OP
PD
Mar-23
Mar-24
Mar-25

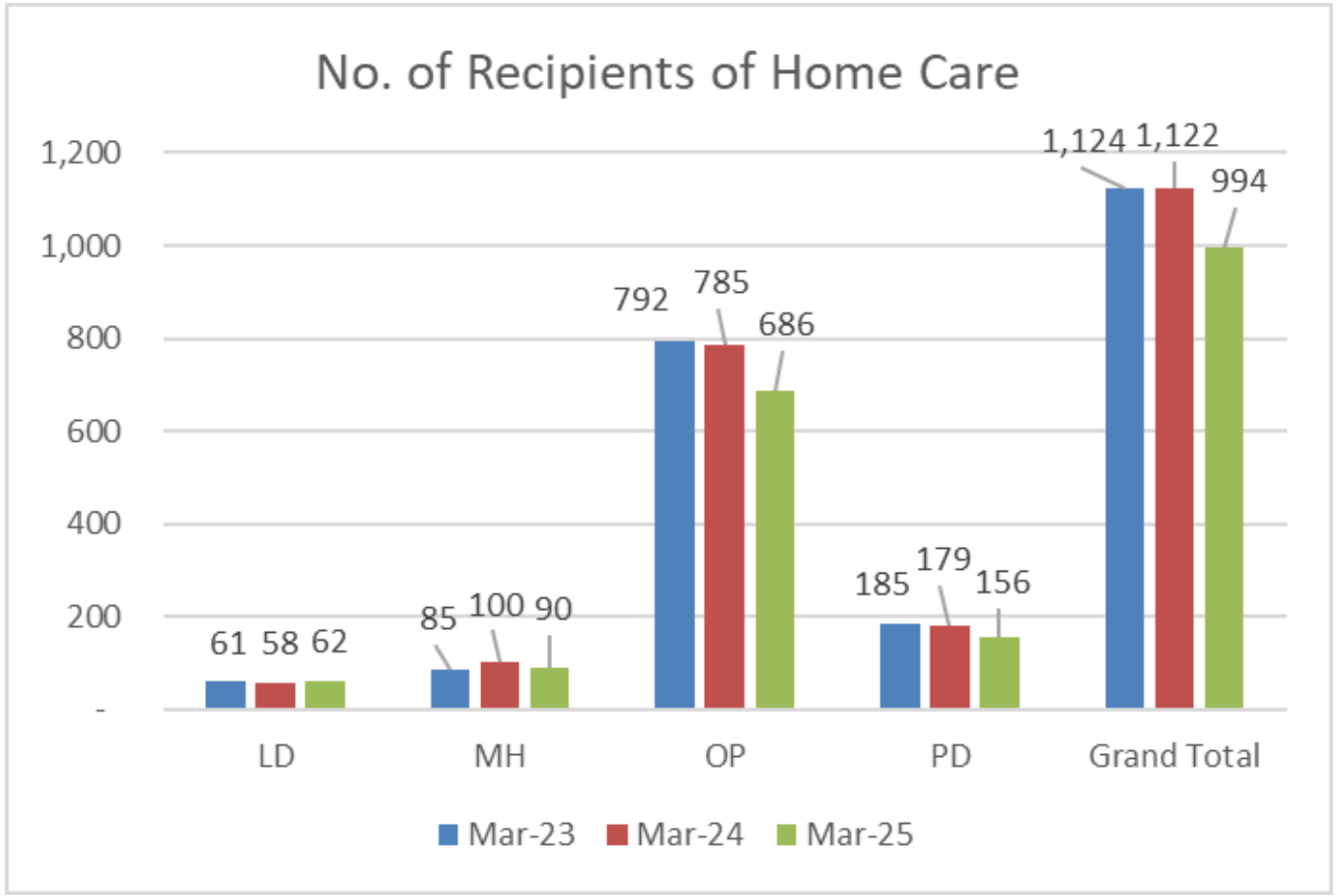

AWF £ in LT Res Dem
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
-
910
957
1,081
LD
MH
OP
PD
Combined
Mar-23
Mar-24
Mar-25

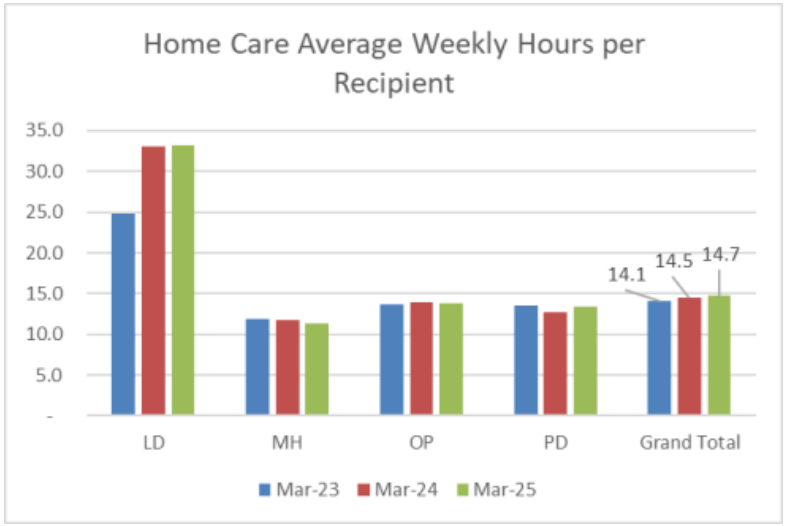

LT Res Dem Weekly Cost £
200,000
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
-
Mar-23
Mar-24
Mar-25
OP
MH
LD
PD

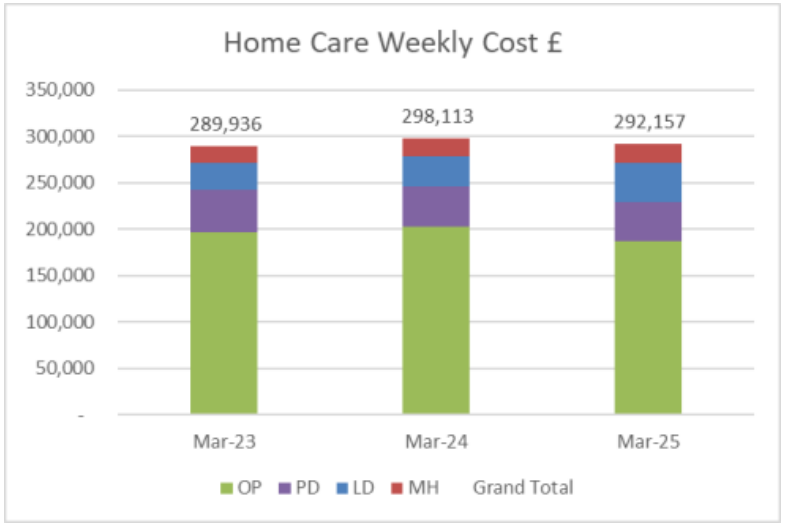

Supported Living No. of Residents
500
450
400
350
300
250
200
150
100
50
-
215
230
245
167
173
201
7
7
3
11
12
3
401
423
452
LD
MH
OP
PD
Combined
Mar-23
Mar-24
Mar-25

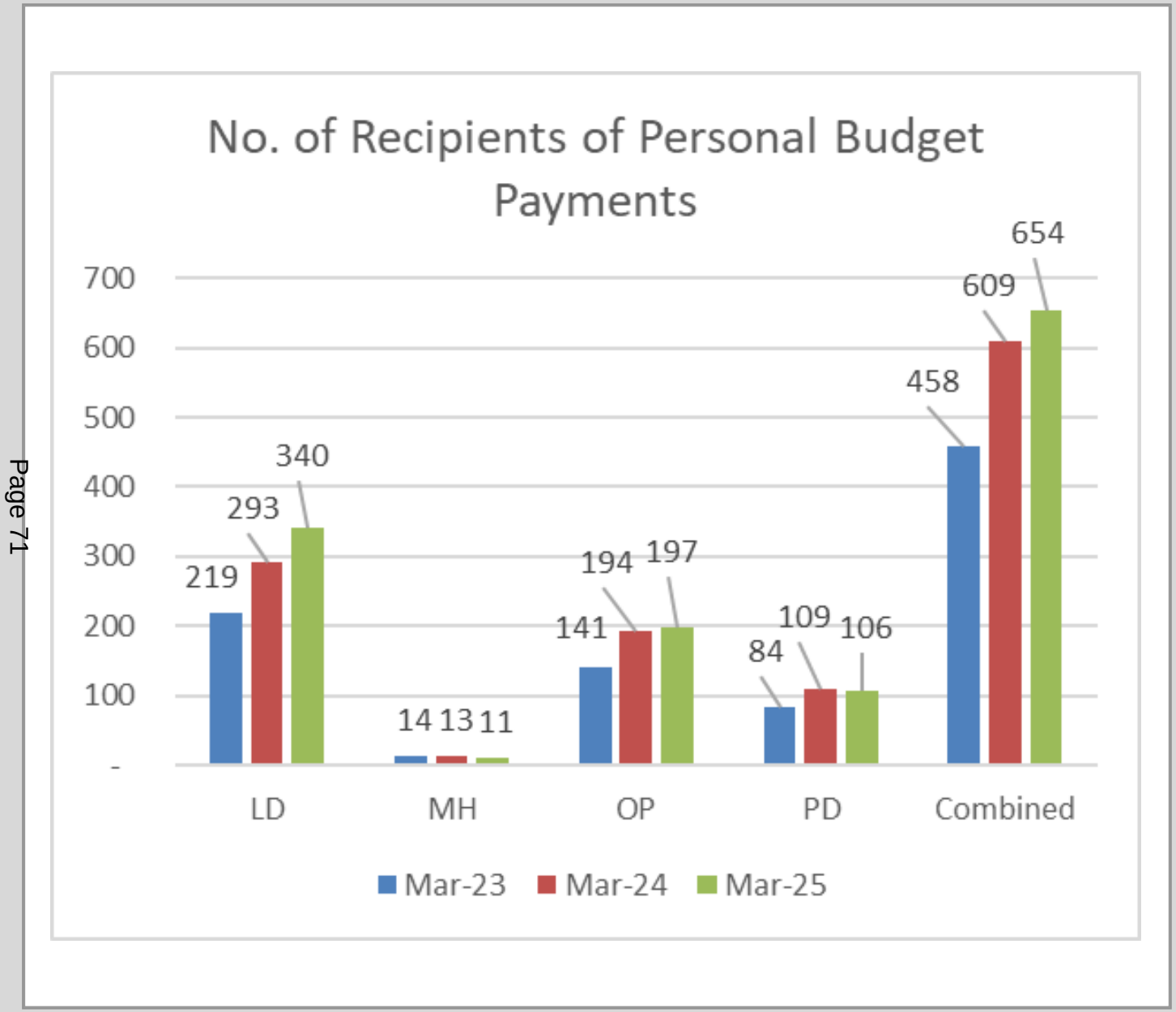

Supported Living AWF £
1,200
1,000
800
600
400
200
-
944
970
1,098
836
865
947
887
915
1,032
LD
MH
Combined
Mar-23
Mar-24
Mar-25

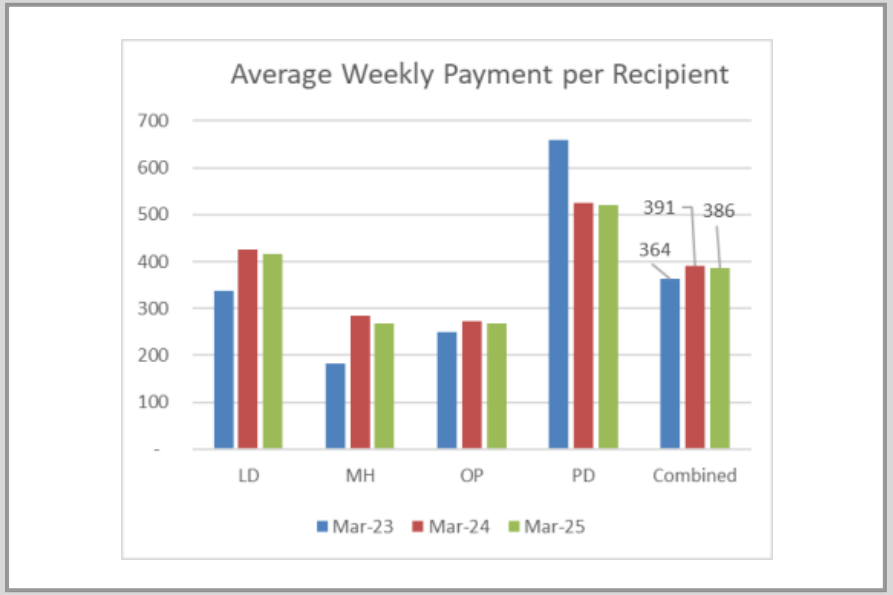

Supported Living Weekly Spend £
500,000
450,000
400,000
350,000
300,000
250,000
200,000
150,000
100,000
50,000
-
LD
MH
OP
PD
Combined
Mar-23
Mar-24
Mar-25

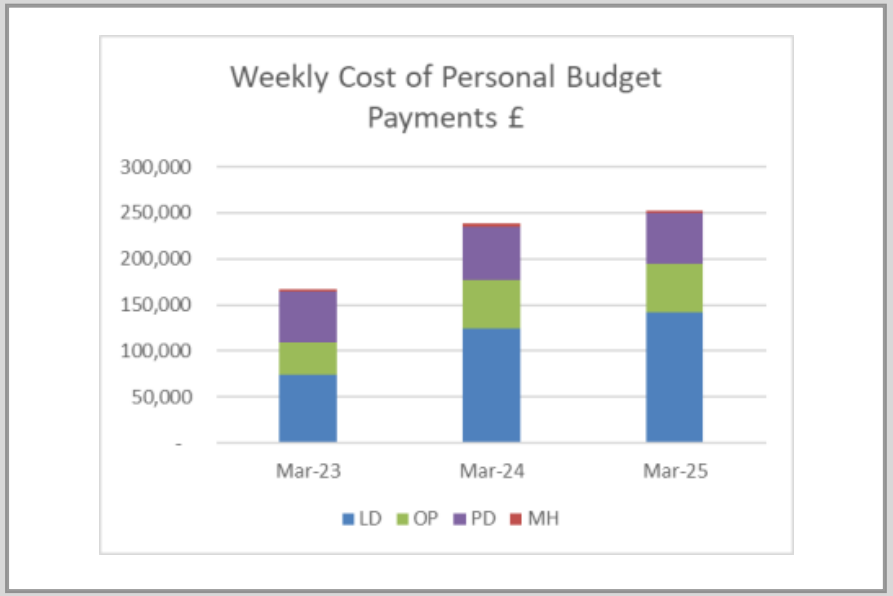

No. of Recipients of Home Care
1,200
1,000
800
600
400
200
-
61 58 62
85 100 90
792 785 686
185 179 156
1,124 1,122 994
LD
MH
OP
PD
Grand Total
Mar-23 Mar-24 Mar-25


Home Care Average Weekly Hours per Recipient
35.0
30.0
25.0
20.0
15.0
10.0
5.0
-
14.1 14.5 14.7
LD
MH
OP
PD
Grand Total
Mar-23 Mar-24 Mar-25


Home Care Weekly Cost £
350,000
300,000
250,000
200,000
150,000
100,000
50,000
-
289,936
298,113
292,157
Mar-23
Mar-24
Mar-25
OP PD LD MH Grand Total


No. of Recipients of Personal Budget Payments
700
600
500
400
300
200
100
-
219
293
340
14 13 11
141
194
197
84
109
106
458
609
654
LD
MH
OP
PD
Combined
Mar-23
Mar-24
Mar-25


Average Weekly Payment per Recipient
700
600
500
400
300
200
100
-
391
386
364
LD
MH
OP
PD
Combined
Mar-23
Mar-24
Mar-25


Weekly Cost of Personal Budget Payments £
300,000
250,000
200,000
150,000
100,000
50,000
-
Mar-23
Mar-24
Mar-25
LD
OP
PD
MH

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CABINET FORWARD PLAN

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

HEADLINES

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

RECOMMENDATION

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

SUPPORTING INFORMATION

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

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

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

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

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

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

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

BACKGROUND PAPERS

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

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					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)**
NOVEMBER 2025													
SI	**Reports from Select Committees**	Reports, findings and recommendations for consideration by the Cabinet, when referred from the appropriate Committee.	All		20 November				TBC	TBC	Democratic Services		Public
SI	**Public Preview of matters to be considered in private**	A report to Cabinet to provide maximum transparency to residents on the private matters to be considered later in Part 2 of the Cabinet meeting and agenda.	TBC		20 November				TBC	TBC	Democratic Services		Public
73	**Rural Activities Garden Centre**	Following Cabinet's decision to close retail operations on 26 June, following further consultation and engagement with those in receipt of assessed social care services and those who attend the RAGC as volunteers on proposals to relocate services, under delegated authority the Cabinet Member will make a decision on the future of the RAGC site and relocation of service provision accordingly.	Colham & Cowley			November			Cllr Eddie Lavery - Community & Environment	Residents' Services / Health & Social Care	Steve Brown	Dan Kennedy	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	NEW ITEM			20 November		Shareholder Committee Members	Health & Social Care	Sandra Taylor	Sandra Taylor	Private (3)
23	**Annual Performance Report**	Following Cabinet's recommendation in September, Council will receive for information, the Council's annual report performance report.	All					27 November 2025	Cllr Martin Goddard / All Cabinet Members	All	Ian Kavanagh	Matthew Wallbridge	Public
DECEMBER 2025													
26	**Biannual Performance Report**	Cabinet will receive its biannual report performance report for the current year, looking back on how the Council is delivering on key service metrics and the Council Strategy - and looking ahead at planned actions.	All	NEW ITEM	18 December				Cllr Martin Goddard / All Cabinet Members	All	Ian Kavanagh	Matthew Wallbridge	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)**
91	**Award of contracts for Lot 1: Deprivation of Liberties Service Contracts Lot 2: Advocacy Services**	Cabinet will consider procurement arrangements for statutory adult social care services, in particular in respect of advocacy which provides support to individuals in understanding and exercising their rights and making informed decisions and Best Interest Assessments which evaluate whether it is in the best interests of a person lacking capacity to be deprived of their liberty for their safety and well-being.	N/A		18 December				**Cllr Jane Palmer - Health & Social Care**	**Health & Social Care**	**Graham Puckering / Sally Offin**	**Sandra Taylor**	Private (3)
35	**Older People's Plan update**	Cabinet will receive its yearly progress update on the Older People's Plan and the work by the Council and partners to support older residents and their quality of life.	All		18 December				**Cllr Ian Edwards - Leader of the Council / Cllr Jane Palmer - Health & Social Care**	**Health & Social Care**	**Sandra Taylor**	**Sandra Taylor**	Public
SI	**Public Preview of matters to be considered in private**	A report to Cabinet to provide maximum transparency to residents on the private and confidential matters to be considered later in Part 2 of the Cabinet meeting and agenda.	TBC		18 December				**TBC**	**TBC**	**Democratic Services**		Public
SI	**Reports from Select Committees**	Reports, findings and recommendations for consideration by the Cabinet, when referred from the appropriate Committee.	All		18 December				**TBC**	**TBC**	**Democratic Services**		Public
SI	**2026/27 Budget and Future Medium-Term Financial Strategy (BUDGET FRAMEWORK)**	This report will set out the Medium Term Financial Strategy (MTFS), which includes the draft General Fund reserve budget and capital programme for 2026/27 for consultation, along with indicative projections for the following four years. This will also include the HRA rents for consideration and may include Council Tax Reduction Scheme proposals. Cabinet will also consider the outcome of consultation on proposed mid-year changes to fees and charges.	All		18 December			26 February 2026 - adoption	**Cllr Martin Goddard - Finance & Transformation**	**All**	**Andy Goodwin**	**Steve Muldoon**	Public
JANUARY 2026													

					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	**Public Preview of matters to be considered in private**	A report to Cabinet to provide maximum transparency to residents on the private and confidential matters to be considered later in Part 2 of the Cabinet meeting and agenda.	TBC		15 January				**TBC**	**TBC**	**Democratic Services**		Public
SI	**Reports from Select Committees**	Reports, findings and recommendations for consideration by the Cabinet, when referred from the appropriate Committee.	All		15 January				**TBC**	**TBC**	**Democratic Services**		Public
FEBRUARY 2026													
SI	**Public Preview of matters to be considered in private**	A report to Cabinet to provide maximum transparency to residents on the private and confidential matters to be considered later in Part 2 of the Cabinet meeting and agenda.	TBC		19 February				**TBC**	**TBC**	**Democratic Services**		Public
SI	**Reports from Select Committees**	Reports, findings and recommendations for consideration by the Cabinet, when referred from the appropriate Committee.	All		19 February				**TBC**	**TBC**	**Democratic Services**		Public
SI	**2026/27 Budget and Future Medium-Term Financial Strategy (BUDGET FRAMEWORK)**	Following consultation, this report will set out the Medium Term Financial Strategy (MTFS), which includes the draft General Fund reserve budget and capital programme for 2026/27 for consultation, along with indicative projections for the following four years. This will also include the HRA rents for consideration and any proposals for the Council Tax Reduction Scheme.	All		19 February			26 February 2026 - adoption	**Cllr Ian Edwards - Leader of the Council / Cllr Martin Goddard - Finance & Transformation**	**All**	**Andy Goodwin**	**Steve Muldoon**	Public
MARCH 2026													
SI	**Public Preview of matters to be considered in private**	A report to Cabinet to provide maximum transparency to residents on the private and confidential matters to be considered later in Part 2 of the Cabinet meeting and agenda.	TBC		19 March				**TBC**	**TBC**	**Democratic Services**		Public
SI	**Reports from Select Committees**	Reports, findings and recommendations for consideration by the Cabinet, when referred from the appropriate Committee.	All		19 March				**TBC**	**TBC**	**Democratic Services**		Public
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	**NEW ITEM**			19 March		**Shareholder Committee Members**	**Health & Social Care**	**Sandra Taylor**	**Sandra Taylor**	Private (3)
APRIL 2026													

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

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

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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	December 3	January 20	February 17	March 26	CANCELLED April 21	May No meeting	June	July	August No meeting	September
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										
Review C: GP Coverage										
Regular service & performance monitoring										
Bi-Annual Performance Monitoring							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		
Mid-year budget / budget planning report (July/September)										
Cabinet's Budget Proposals For Next Financial Year (Jan)		X								X
Cabinet Member for Health and Social Care		X								
Cabinet Forward Plan Monthly Monitoring	X	X	X	X			X	X		X
One-off information items										
Autism Update										
Supporting Carers Update		X								
Commissioning Model for delivery of health and social care services			X							
BCF Update			X							
Minor Injuries Unit Update	X									
Hospice and End of Life Services in the Borough										
Hillingdon Advice Partnership Update							X			
CAMHS Update			X							
HHCP Place Based Service Delivery		X								
Health External Scrutiny										
Mount Vernon Cancer Centre Strategic Review Update										
Hillingdon Hospital Redevelopment Update	X									
Health Updates	X			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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