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A

External Services Scrutiny Committee

Councillors on the Committee

Michael White (Chairman)
Bruce Baker (Vice-Chairman)
Josephine Barrett
Dominic Gilham
Phoday Jarjussey (Labour Lead)
Peter Kemp
John Major
John Morgan

Date: **WEDNESDAY, 21 SEPTEMBER 2011**

Time: **6.00 PM**

Venue: **COMMITTEE ROOM 5 - CIVIC CENTRE, HIGH STREET, UXBRIDGE UB8 1UW**

Meeting Details: Members of the Public and Press are welcome to attend this meeting

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Terms of Reference

1. To scrutinise local NHS organisations in line with the health powers conferred by the Health and Social Care Act 2001, including:

   (a) scrutiny of local NHS organisations by calling the relevant Chief Executive(s) to account for the work of their organisation(s) and undertaking a review into issues of concern;

   (b) consider NHS service reconfigurations which the Committee agree to be substantial, establishing a joint committee if the proposals affect more than one Overview and Scrutiny Committee area; and to refer contested major service configurations to the Independent Reconfiguration Panel (in accordance with the Health and Social Care Act); and

   (c) respond to any relevant NHS consultations.

2. To act as a Crime and Disorder Committee as defined in the Crime and Disorder (Overview and Scrutiny) Regulations 2009 and carry out the bi-annual scrutiny of decisions made, or other action taken, in connection with the discharge by the responsible authorities of their crime and disorder functions.

3. To scrutinise the work of non-Hillingdon Council agencies whose actions affect residents of the London Borough of Hillingdon.

4. To identify areas of concern to the community within their remit and instigate an appropriate review process.

Agenda

PART I - MEMBERS, PUBLIC AND PRESS

Chairman's Announcements

1 Apologies for absence and to report the presence of any substitute Members

2 Declarations of Interest in matters coming before this meeting

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4 Exclusion of Press and Public

To confirm that all items marked Part 1 will be considered in public and that any items marked Part 2 will be considered in private

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PART II - PRIVATE, MEMBERS ONLY

10 Any Business transferred from Part 1

Minutes

EXTERNAL SERVICES SCRUTINY COMMITTEE

20 July 2011

Meeting held at Committee Room 5 - Civic Centre, High Street, Uxbridge UB8 1UW

HILLINGDON
LONDON

	Committee Members Present: Councillors Michael White (Chairman), Bruce Baker (Vice-Chairman), Josephine Barrett, Dominic Gilham, Phoday Jarjussey, Peter Kemp, John Major and Andrew Retter (substituting for Councillor John Morgan) (in part) **Witnesses Present**: Helen Delaitre – Lead for Unscheduled Care, NHS Hillingdon Dr Kuldhir Johal – Local Lead GP for Unscheduled Care/Eastbury Surgery, Northwood David Penfold – Director of Operations, Harmoni Trevor Begg – Chair, Hillingdon LINk Ian Diamant – Vice-Chair, Hillingdon LINk Graham Hawkes – Manager, Hillingdon LINk Gary Jacobs – Executive Director, Groundwork Thames Valley Simon Williams – Divisional Director, North Western London, London Specialised Commissioning Group Peter Kohn – Strategy, Planning and Development Director, London Specialised Commissioning Group Piers McCleery – Director of Strategy and Planning, Royal Brompton & Harefield NHS Foundation Trust Keith Bullen – Borough Director, NHS Hillingdon Sandra Brookes – Service Director, Central & North West London NHS Foundation Trust **LBH Officers Present**: Linda Sanders, Ellis Friedman, Kevin Byrne, John Wheatley (in part) and Nikki Stubbs **Also Present**: Councillors George Cooper and Judith Cooper Malcolm Ellis – Standards Committee Vice Chairman	
8.	**APOLOGIES FOR ABSENCE AND TO REPORT THE PRESENCE OF ANY SUBSTITUTE MEMBERS** *(Agenda Item 1)* Apologies for absence were received from Councillor John Morgan. Councillor Andrew Retter was present as a substitute.	**Action by**
9.	**DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING** *(Agenda Item 2)* Councillor Peter Kemp declared a personal interest in Agenda Item 7 – Hillingdon LINk: 3rd Progress Report, as he was a Governor at Central & North West London NHS Foundation Trust (CNWL), and remained in the room during the consideration thereof.	**Action by**

	Councillor Phoday Jarjussey declared a personal interest in Agenda Item 7 – Hillingdon LINk: 3 rd Progress Report, as he was a member of the Shadow Board of The Orchard Medical Practice Community Interest Company and a member of CNWL, and remained in the room during the consideration thereof. Councillor George Cooper declared a personal interest in Agenda Item 7 – Hillingdon LINk: 3rd Progress Report, as he was a Trustee of Groundwork Thames Valley, and remained in the room during the consideration thereof. Councillor Judith Cooper declared a personal interest in Agenda Item 7 – Hillingdon LINk: 3rd Progress Report, as her husband was a Trustee of Groundwork Thames Valley, and remained in the room during the consideration thereof.	
10.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 4)* **RESOLVED: That all items of business be considered in public.**	**Action by**
11.	**NHS 111** *(Agenda Item 5)* The Chairman welcomed those present to the meeting. Ms Helen Delaitre, Lead for Unscheduled Care at NHS Hillingdon, advised that Harmoni had been contracted to provide the NHS 111 service in Hillingdon. Mr David Penfold, Director of Operations for Harmoni, advised Members that research had shown that the public found it difficult to access NHS services when they developed unexpected health care needs. The introduction of new services such as Walk In Centres and Urgent Care Centres had added to the complexity of the unscheduled health care system which meant that many individuals were unclear about the services that were available to meet their needs and how these could be accessed (particularly outside normal working hours). It was proposed that NHS 111 would not be a replacement for the NHS Direct service or the 999 service and that it would provide access to unscheduled non-urgent care. The service would be available 24 hours a day, 7 days a week, 365 days a year and would provide information about the services that were available at the time that the telephone call was made. Members were advised that NHS 111 had already been piloted in County Durham and Darlington, Nottingham City, Lincolnshire and Luton and would now be rolled out in Hillingdon. A soft launch of the two year pilot in Hillingdon would take place on 25 October 2011 to ensure that any issues with the system were ironed out before the public launch in mid-November 2011. It was anticipated that the service would achieve pan-London coverage by 2013 but it was unclear whether it would ultimately be commissioned as a pan-London or local service.	**Action by**

A recent survey undertaken by Healthcare for London had identified that 88% of respondents would use the new service. In addition to this public support, NHS 111 was supported by professional bodies such as the British Medical Association (BMA) and the Royal College of General Practitioners (RCGP). Hillingdon LINk had also been involved with the Hillingdon 111 Project Team in the development of the Communications and Engagements Plan.

It was anticipated that the service, which was locally driven by GPs, PCTs, local authorities and other stakeholders, would make it easier for individuals to access unscheduled health care and would drive improvements in the way that the NHS delivered care. The service would also enable call handlers to direct patients to the right local service first time and would be used by patients when they:

- thought they needed Accident & Emergency (A&E) or urgent care;
- thought they couldn't wait for a GP appointment; or
- didn't know who to call for medical help.

The NHS 111 call handlers would receive two weeks intensive training and would be based in Southall so would have local knowledge – they would be based at the site of the existing out-of-hours call handling centre. However, Mr Penfold stressed that the handlers were not clinicians and that the service would assess the needs of a patient but not give a diagnosis.

It was anticipated that NHS 111 would reduce the number of non-emergency 999 calls, avoidable ambulance journeys and unnecessary hospital referrals. It would also improve access to unscheduled health care services by providing a simple, free to call, easy to remember three-digit number that was available all day, every day. Furthermore, the service would enable the commissioning of more effective healthcare services by:

- identifying those services that were under or over utilised;
- providing information about an individual's needs and the services that they were directed to; and
- increasing the understanding of the demand for each service.

Mr Penfold explained that NHS 111 would be operated in conjunction with NHS Pathways and the London Directory of Services database (DoS). NHS Pathways was a clinical decision support tool (software) for triaging telephone calls from the public (based on the symptoms that they reported when they called) and had been in use elsewhere in the NHS for more than 4 years. A clinical assessment would be undertaken by the call handler which, as each call progressed, would give leads to a pre-determined level of care for the patient based on the information provided. Once the clinical assessment had been completed, an automatic search would be carried out using the web-based London DoS to locate an appropriate service in the patient's local area that offered the specific clinical skills needed within the timeframe required.

Work was currently underway to populate the DoS database with information on the various health care services currently commissioned

locally in the Borough.

It was anticipated that, as well as providing a more comprehensive and timely service to the public, NHS 111 had the potential to save millions of pounds. Future developments included:

- the potential for call handlers to make GP appointments for callers, which would increase the number of patients attending the surgery and reduce the number of hospital attendances;
- the creation of speed dial transfers so that callers who needed one of the emergency services could be immediately transferred to the correct service; and
- the London Ambulance Service using NHS 111 for triage following the Olympics in 2012.

Members were reassured that at the end of an assessment, if the caller was not happy with the outcome, they would be able to speak to a doctor or nurse (whichever was most appropriate). There would also be systems in place to identify repeat callers and, if the caller chose not to be anonymous, their GP would receive an automatic feedback message about the outcome of the call.

As this pilot service was directed at Hillingdon residents, callers from outside of the Borough would be advised that the service did not operate in their area.

It was noted that the Hillingdon 111 Project Team was working with NHS London to ensure that publicity for the service was produced centrally in a joined up way with the three other pilot London boroughs. This awareness raising campaign would include posters and would be done in consultation with the LINk and other stakeholders. Members were asked to contact Dr Johal with suggestions for publicity to raise awareness of the service locally.

Ms Linda Sanders, the Council's Director of Social Care, Health and Housing, suggested that the pilot was arguably a missed opportunity to provide a whole system approach to health and social care. For example, it could have been useful for the call handlers to have been based at the Civic Centre which was open 24/7 and from where all out of hours LBH Housing were to be based, e.g., TelCareLine Repairs Management Services, out of hours Emergency Duty Team, Home Carers, etc. In the absence of co-location, Ms Sanders advised that work would need to be undertaken to ensure that there was a seamless out-of-hours service provided that included referral to these Council teams. Ms Delaitre advised that the incorporation of these local services into DoS could be included as the next step. Ms Sanders advised that it would be better for the DoS to only cover NHS provision as other directories existed and should not be duplicated.

Mr Penfold offered to attend a future External Services Scrutiny Committee meeting to update Members on NHS 111 following its launch in Hillingdon in November 2011. In the meantime, he advised that the Hillingdon 111 Project Team would continue to work closely with the Hillingdon LINk.

	RESOLVED: That: **1. the report be noted; and** **2. Ms Delaitre, Dr Johal and Mr Penfold be invited attend a future Committee meeting to give an update on NHS 111 following its launch in Hillingdon in November 2011.**	Nav Johal / Nikki Stubbs
12.	**SAFE & SUSTAINABLE - A NEW VISION FOR CHILDREN'S CONGENITAL HEART SERVICES IN ENGLAND** *(Agenda Item 6)* Mr Simon Williams, Divisional Director, North Western London at the London Specialised Commissioning Group, advised that the Safe and Sustainable review of children's congenital heart services in England had been undertaken following requests from clinicians and parents for an improved service. An independent panel of experts, chaired by Professor Sir Ian Kennedy, reviewed all 11 centres in England that provided these services against various criteria and scored each of them accordingly. The children's cardiac surgeons had agreed that the clinical evidence showed that each of the centres needed to be undertaking at least 400 procedures every year (preferably 500 with a push towards undertaking 700+ each year to match international levels) and that the team at each centre comprise at least four highly skilled surgeons. Of the 2,000+ possible combinations available, the Joint Committee of Primary Care Trusts (JCPCT) then narrowed the options to its preferred four which were then assessed by the following weighted criteria: access and travel times (14); quality (39); deliverability (22); and sustainability (25). It was proposed that the number of centres providing children's congenital heart services be reduced from 11 to 6 or 7 (this would include a reduction from 3 to 2 centres in London). Currently, approximately 1,250 such surgeries were undertaken each year in the three London centres, which would mean that, in order to reach the number required, patients would need to be diverted from other areas. Mr Williams advised that, during the consultation period, the Royal Brompton & Harefield NHS Foundation Trust (RB&H) had raised concerns about the impact that the withdrawal of the service would have on other services provided by the Trust. As a result, a further independent review of the proposals would be undertaken in September 2011 to look at the impact on RB&H. The findings would then be compiled for the JCPCT in November 2011 so that a decision could be made. Mr Piers McCleery, Director of Strategy and Planning at RB&H, advised that closure of the Trust's Paediatric Intensive Care Unit (PICU) would result in the closure of all its paediatric services. He expressed concern that this would reduce the Trust's income by approximately £10m and would take around 3-5 years to build additional services to regenerate this income. Mr Williams believed that the PICU would be unviable without the provision of surgery and that its withdrawal should not impact on the Trust's other services.	**Action by**

Mr McCleery stated that he was unhappy about the business case behind the proposals as only two of the centres in England currently met the criteria for undertaking 400 procedures each year with a team of 4+ surgeons. RB&H was one of these two centres (the other was Great Ormond Street Hospital (GOSH)) and yet it hadn't been included in the JCPCT's preferred options. It was noted that RB&H had been granted a judicial review in this regard which would take place on 29 September 2011.

Members were advised that RB&H had worked with GOSH in 2009 to produce proposals to bring together children's heart and lung services in a phased process over a number of years. These proposals would have resulted in a jointly owned and operated service. Further work had also been undertaken in 2010 by the three London centres to provide better outreach services. Mr McCleery advised that Mr Williams had been involved in this work.

It was noted that, although the Safe and Sustainable consultation had closed on 1 July 2011, the deadline for Overview and Scrutiny Committees to submit responses was 5 October 2011. Consideration would be given to the Committee submitting a response.

Members queried whether Safe and Sustainable was a cost cutting exercise. Mr Williams advised that the proposals would not result in a reduction of primary care cardiovascular services (PCCS) and that it was likely that additional funding would be provided to improve standards in the support infrastructure. Mr Peter Kohn, Strategy, Planning and Development Director at London Specialised Commissioning Group, added that Safe and Sustainable was a whole system process than had been clinically led. He advised that there was widespread support for the principle of the review.

Mr Williams stated that consideration had previously been given to a single network in London prior to the launch of the consultation. The consultation had involved parents of children that used the services and illustrated their anxiety regarding diagnosis and ongoing care – these were services that the parents wanted delivered locally. However, it had been clear that parents would travel considerable distances to get the right treatment for their children.

The consultation had received more than 30,000 responses and had included a number of stakeholder events across the country. A series of focus groups had also been held with parents at each of the centres. Further work had been undertaken to consult with hard-to-reach groups.

It was noted that the proposals would result in longer journey times for some parents but that these distances were still deemed 'acceptable'. It was thought that this was not such an issue in the South East of England as the proposed centres were not that far apart but would be more significant in the North. Mr Williams advised Members that the NHS provided a retrieval service which picked up children from their locality and transferred them to the relevant hospital for surgery. Mr

	Kohn added that only 50% of children with congenital heart problems required surgery and that 80% of these children only needed surgery once. Parents were then keen for their children's follow-up appointments and after care to be delivered locally. Members acknowledged that parents were prepared to travel considerable distances to get the right treatment for their children. As such, it was queried why consideration was being given to geographical location of the centres. It was suggested that, to get the best treatment for children, it would be better to keep those centres that performed well. The retention of centres that were not performing as well would mean that more resources would be needed to bring them up to an acceptable standard. Mr Williams advised that, of the centres that were currently delivering children's congenital heart surgery, there was no issue about the surgical quality. However, he confirmed that improvements would need to be made to the infrastructure that supported the surgery at some of these centres. Members were advised that there was not a shortage of highly skilled surgeons in England – there was approximately the right number – but that these were spread across too many centres and too many teams. It was suggested that a better option for parents would be the creation of two surgical teams in London that operated from the three existing centres. Mr Williams advised that parents had made similar suggestions. He confirmed that the primary aim of the review was to improve the service delivery. Mr McCleery supported the idea of a collaborative approach as it would be better for sub-specialisation. **RESOLVED: That:** **1. the presentation and report be noted; and** **2. consideration be given to the Committee submitting a response to the consultation.**	Nav Johal / Nikki Stubbs
13.	**HILLINGDON LINK: 3RD PROGRESS REPORT** *(Agenda Item 7)* Mr Kevin Byrne, the Council's Head of Policy and Performance, advised that Groundwork Thames Valley (GTV) had taken over as the Host for the Hillingdon LINk contract 18 months ago. During the last year, significant progress had been made by the LINk. Mr Trevor Begg, Chair of Hillingdon LINk, thanked GTV and Mr Graham Hawkes, Hillingdon LINk Manager, for their support over the last 12 months. Work that the LINk had been involved in during this period included: • the provision of support and assistance to the patients on Daniels Ward and their families; • setting up in one of the units at the Pavilions Mall – this unit had been provided rent free to the LINk; • the hospital discharge project; • HESA Centre and Orchard GP Surgery projects; • Somali Community Survey and EMAP report; and • Responding to national consultations. It was noted that the Lord Howe, Parliamentary Under Secretary of	**Action by**

	State for Quality, and representatives from the Department of Health had attended a meeting at the HESA Centre in Hayes Town Centre. Consideration was given at this meeting to cross boundary working between the North West London LINks and the potential transition into Health Watch. Mr Ian Diamant, Vice-Chair of Hillingdon LINk, advised that future work included: • A review of the Well-Being Centre at Boots in September 2011; • Provision of community equipment; and • Work towards the transition of the LINk into Health Watch. Mr Diamant thanked Mr Keith Bullen, Borough Director at NHS Hillingdon, for his prompt responses to queries and Councillors East, Kemp and Major for their regular attendance at LINk Board meetings. He stated that he would be recommending that these Councillors be made regular members of the Board which would enable them to remain in the room during the consideration of confidential information. Mr Gary Jacobs, Executive Director at GTV, advised that GTV had been pleased to take over as the Host for the LINk. This role had complemented the other work that GTV had undertaken in the community. Mr Jacobs thanked Mr Hawkes for the excellent work that he had completed at the front end of the operation. Members congratulated the LINk and GTV for the improvements that had been made and the outcomes achieved over the last 12 months. Work was ongoing with regard to carers' respite funding that had been put in place by the Government in 2010. The LINk would continue to pursue this funding and establish how many hours of respite were available to Hillingdon carers. With regard to publicity and advertising, it was noted that the LINk did not have a large budget and its success had been largely down to the dedication of staff and volunteers. The LINk communicated regularly with the Gazette and had received publicity in the Hillingdon People. **RESOLVED: That the report and presentation be noted.**	
14.	**UPDATE ON RECOMMENDATIONS OF PREVIOUS MAJOR SCRUTINY REVIEWS** *(Agenda Item 8)* Consideration was given to the update on recommendations of previous External Services Scrutiny Committee major reviews. It was noted that, with regard to action taken in relation to recommendation 10 of the Transition from Child to Adult Mental Health Services report, Ms Linda Sanders, the Council's Director of Social Care, Health and Housing, advised that: *In Hillingdon, all complaints managers are independent of front-line services and offer support (including making arrangements for advocacy) should individuals need representation to make a complaint or raise a concern. Arrangements for making a complaint are made at times and places which meet the needs*	**Action by**

	of service users and their carers. Actions to resolve complaints are agreed with the complainant and, where necessary, complaints managers work together across health and social care to ensure a resolution is reached. **RESOLVED: That the report be noted.**	
15.	**WORK PROGRAMME 2011/2012** *(Agenda Item 9)* Consideration was given to the Committee's Work Programme and the four scoping reports. Ms Sandra Brookes, Service Director at Central & North West London NHS Foundation Trust (CNWL), advised that dementia and children's mental health were key issues for CNWL. She went on to state that, with regard to dementia, the Committee could look at early intervention and how resources could be shifted from longer care to improve this intervention. Furthermore, drugs and alcohol had strong links to reoffending and end of life care was linked to the NHS 111 work. It was suggested that sentencing policy could be included in a review of re-offending. Whilst this was something that could be investigated as part of the review, it was noted that the scope of reviews needed to remain focussed. Members agreed that the Committee's first major review during this municipal year would be on re-offending and that the second review would be on dementia. Councillor Kemp requested that he be part of the Working Groups that would be set up to undertake each of these reviews. Councillor Judith Cooper, Chairman of the Council's Social Services, Health and Housing Policy Overview Committee, advised that she would discuss the children's mental health scoping report with her Committee Members as a potential review topic. **RESOLVED: That:** **1. the report be noted; and** **2. the a Working Group be set up to look at re-offending as the Committee's first major review of this municipal year.**	**Action by** Nav Johal / Nikki Stubbs
16.	**MINUTES OF THE PREVIOUS MEETING - 8 JUNE 2011** *(Agenda Item 3)* **RESOLVED: That the minutes of the meeting held on 8 June 2011 be agreed as a correct record.**	**Action by**
	The meeting, which commenced at 6.00 pm, closed at 8.55 pm.	

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nikki Stubbs, Democratic Services Manager / Nav Johal, Democratic Services Officer on 01895 250472 / 01895 250692. Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.

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COMMISSIONING OF A CONSULTANT LED COMMUNITY OPHTHALMOLOGY SERVICE

Officer Contact	Katrina Mindel, GP Commissioner
Papers with report	None

REASON FOR ITEM

Information item to inform the Committee of the proposed Consultant Led Community Ophthalmology Service to be commissioned by NHS Hillingdon and the Hillingdon Clinical Commissioning Group (HCCG).

OPTIONS AVAILABLE TO THE COMMITTEE

1. To note and ask questions about the proposals and the presentation.

INFORMATION

Hillingdon Demographics - background

NHS Hillingdon is responsible for the health of approximately 275,000 people living in Ruislip and Northwood, Uxbridge and West Drayton and Hayes and Harlington localities. Within Hillingdon there are:

- 50 GP Practices
- 65 Community Pharmacies
- 37 Optical Providers (practices)
- The total GP registered population in Hillingdon is approximately 275,000.

The population of children (0-15) and the elderly population (Age 65+) are expected to increase in the next 5 years. Compared to national statistics, Hillingdon is 3% younger than the England population and has 17% higher levels of ethnicity – overall. Both age and ethnicity have an impact on expected prevalence of glaucoma, but ethnicity is limited as a risk factor for glaucoma to an increase risk for black African populations only, not all ethnic groups. Black African population within Hillingdon is 2.82% as compared to national population of 1.52% - overall. However, when split further the differential is more significant in the working age population as the black African population for this group (16 – 64) is higher (3% population rate compared to a national rate of 1.8%). In conclusion, this means that whilst there is not additional expected prevalence for the current 65+ age group cohort (0.5% Hillingdon compared to 0.3% national), this will impact in the next few years as the current working age group cohort get older.

At year end 2010/11, Practice Based Commissioning (PbC) accounts indicated a marked trend of over-performance of Ophthalmology first outpatients (per 1000 population), for most practices in the North Locality, approx half the practices in Uxbridge and West Drayton, and approximately a quarter of practices in Hayes. This mirrors the older population mix in each of the localities. In addition to the increase in activity, Ophthalmology is listed within the QIPP (Quality, Innovation, Productivity and Prevention) plan as an area which requires service redesign due to the financial implications. Geographically, activity for Ophthalmology outpatients per 1000 population is similar for North Hillingdon and Hayes and Harlington, slightly less for Uxbridge and West Drayton.

Hillingdon Diabetic Retinopathy Screening Service (DRSS)

All newly diagnosed diabetic Hillingdon patients are offered diabetic retinopathy eye screening within 3 months of notification from the GP. Depending on the outcome of their results, they could be invited for a 12 month recall (according to NSC guidelines) or referred to an Ophthalmologist for further assessment. There are 3 screening locations for Hillingdon patients; these are the HESA centre in Hayes, Northwood Health Centre and Uxbridge Health Centre. Eligible patients are automatically re-invited every year for routine screening. The service is currently provided by NHS Hillingdon in collaboration with The Hillingdon Hospital NHS Foundation Trust and Medical Imaging UK Ltd.

The Hillingdon DRSS is not within the scope of this paper.

Ophthalmology provision in Hillingdon

Currently services are provided in a range of locations across primary, community and secondary care. 37 ophthalmology practices provide general optical services, and there are currently no enhanced practitioners contributing to the community service. Secondary care services are provided mainly by Hillingdon Hospital (70% Adult activity and 95% Paediatric activity) but also at other Acute Trusts such as Imperial (Western Eye), Moorfields (operating from their own sites plus Northwick Park and Ealing Hospital sites), West Hertfordshire Hospitals NHS Trust, etc.

Ophthalmology Services

Ophthalmology services may involve professional multidisciplinary teams including ophthalmologists, GPs, ophthalmic medical practitioners, ophthalmic nurses, hospital optometrists, community optometrists, dispensing opticians, orthoptists, school nurses, health visitors, social services and voluntary sector professionals.

Options for community provision in Hillingdon

At the July Clinical Commissioning Group Board meeting, detailed options including historic activity and financial data, together with an options appraisal considering financial implications of the options were presented. The following is a summary of the issues:

1. Glaucoma Referral Refinement Scheme (GRRS)

To take into account changes in NICE Clinical Guideline 85 (Diagnosis and management of chronic open angle glaucoma and ocular hypertension) which created a referral threshold for this condition. There has been an increase in referrals as a result, and such referrals could be further refined by optoms (or similar) prior to secondary care referral.

Issues:

- The current set of optometrists would need to be assessed and accredited to ensure that they have the knowledge and skills needed to provide this service.
- Effective implementation of GRRS may involve the development of a new specification to be applied to existing providers. This will require the co-operation of current local secondary care service providers – where relationships are not particularly good.
- There will be a requirement for performance monitoring of such Local Enhanced Services (LES) provision, and it is questionable as to PCT resource availability to undertake this.
- Investment in further training, development and equipment may be needed to ensure that a high quality of care is provided.
- Refresher training must be provided for those eye care professionals requesting it.
- The optimum pathway as recommended in Local Optometric Committee (LOC) guidance is for ALL optoms within a health economy to undertake such LES services. However ,the Hillingdon scheme anticipates using only 3 already identified optom practices, one

each in Ruislip, Hillingdon (near Hillingdon Health Centre) and Hayes (near HESA Centre).

- The expected savings of such a scheme in the first instance is minimal, and possibly would not cover the cost of the commissioning resource required to monitor such contracts, nor the cost of initial equipment and training.
- Such a scheme would require the cooperation of all optometrists in Hillingdon, whether or not they are taking part in the scheme.
- LOC guidance document suggests that the success of such a scheme is dependent upon all optometrist providers in the locality take part in the scheme, the Hillingdon scheme is recommending only one optometry provider in each locality.

2) A community based contract for Ophthalmology Services

This will provide a consultant led community service catering for the management of adult and paediatric ophthalmology in a primary care setting, within a block tariff. As such the provider would be required to manage demand and ensure patients are treated within the overall costs with no activity or coding creep. Such services will be held in each of the three localities, in locations to be agreed by the commissioner, suitable in terms of patient access and geography. Cataracts, glaucoma, blepharitis, watery eye, flashers and floaters can all be triaged/treated by the consultant ophthalmologist and their team in the community clinic. Patients requiring surgery or further treatment will then to be referred at the appropriate secondary care provider. Any re-tests ordered under GRRS would be included within this scheme in addition to more specialised glaucoma services.

It is anticipated that approximately 25% activity would be diverted from secondary care into the Community Service.

The three PCTs within the Outer North West London sub cluster are currently undertaking a formal open tendering exercise for such a service. The procurement timescales for such a service are for the service to open in March 2012.

Advantages:

- Increase the quality of referrals ensuring that patients are referred into secondary care only when necessary, whilst benefiting from specialist input for minor eye conditions.
- Bringing such clinics into the community enabling secondary care providers to concentrate on patients with complex needs or co-morbidities.
- Reducing patient requirement to attend Hospital for more minor issues, offering better quality in terms of time taken to attend appointment, options of appointment times, speed of access and travel requirements.
- Ability to manage one contract rather than needing to manage several smaller contracts – leading to more efficient use of commissioning resource.
- Significant levels of cost savings, in addition to the quality issues already stated.

Issues:

- There will be a requirement to provide robust and clinically sound service specification which encompasses internal audit to ensure that the service complies with the relevant clinical governance requirements.
- This will require significant commissioning input both for start up of the contract and ongoing during the life of the contract.

Conclusion

The HCCG Board was asked to consider the options under discussion within the briefing paper with a view to moving rapidly towards service redesign. Given the financial and operational inefficiencies of an optometrist provided (fragmented) service, it was decided to undergo tendering for a Consultant Led Community Ophthalmology Service.

The tender process is now underway, a patient and GP consultation has been undertaken. It is anticipated that the service will start in March 2012. A detailed draft service specification will be submitted to the Hillingdon Clinical Executive Committee for overarching clinical governance considerations, and will be considered by the HCCG Board in October ready for service mobilisation.

SUGGESTED COMMITTEE ACTIVITY

1. Members note the report and presentation.

2. Members to ask questions of the witnesses and seek clarification, as appropriate.

BACKGROUND DOCUMENTS

None.

SAFER TRANSPORT

Officer Contact	Nav Johal, Central Services
Papers with report	None

REASON FOR ITEM

To enable the Committee to review the work being undertaken with regard to safer transport in the Borough.

OPTIONS AVAILABLE TO THE COMMITTEE

1. Question the witnesses using the suggested questions/key lines of enquiry
2. Ask additional questions as required
3. Make recommendations to address issues arising from discussions at the meeting

INFORMATION

Background

1. The Committee have asked to examine this issue on an annual basis following concerns raised by local residents about anti-social behaviour on buses and trains and on the way to and from public transport stops and interchanges.
2. The main points noted in previous years are:
    - The Council had been working with schools in the Borough to develop School Travel Plans (STP) and there were only two schools in the Borough that did not have one.
    - Work was underway to look at the North/South bus provision in the Borough. Proposals were still at the conception stage and being explored with Transport for London (TfL).
    - New software was being developed to measure the Council's carbon footprint and it was anticipated that this would be incorporated into current systems by 2011.
    - The Safer Transport Team (STT) covered overland areas: buses, bus shelters and bus routes as well as the routes in between.
    - In Hillingdon, there had been a 5.6% reduction in bus crimes in last year's report (down from 644 offences to 608 offences).

- The STT had visited Year 6 pupils in 22 schools in the Borough to assist with the applications for free travel cards (Zip cards); the young people had signed the behaviour code as an integral part of this process.

- TfL had permanently removed more than 5,000 cards from young people since the Zip Card scheme was introduced in June 2008 with many more being removed temporarily and then reinstated when the young person shown a willingness to work with TfL to get it back.

- STT worked closely with Operation Bus Tag, which was funded by TfL and tackled criminal damage and anti-social behaviour on London buses using CCTV.

- There had been a reorganisation at TfL which meant that Hillingdon would no longer be considered a priority area as the work that had been undertaken had been very successful in reducing the fear of crime.

- The number of reported robberies had reduced and one of British Transport Police's (BTP) ten priorities was to increase the number of ASB detections by 20%.

TfL has informally accepted the Council's Local Implementation Plan (LIP) for transport for the period 2011-2014 with projects, proposals and programmes through to 2014. LIP Objective 4 is concerned with improving safety and security of the transport system, including the number of collisions. The Borough is performing well on road safety with some encouraging trends showing reductions at least in line with the rest of London.

The Council has continued working with schools in developing and implementing School Travel Plans (STP). It is the first time ever that the LIP allocation has a very substantial component to fund measures to help schools encouraging school communities to travel more actively.

Various bus services have been subject to dedicated surveys and action programmes to improve behaviour on different school routes. In partnership with the police, Safer Neighbourhood Teams (SNTs) and the Council's parking enforcement team, safety and compliance in school environments are pro-actively being addressed in a systematic manner.

Work is ongoing with a view to introducing at North/South bus provision in the Borough. Cost and difficulties in assessing demand are the main problems in progressing implementation.

Consultants have provisionally established Hillingdon's carbon footprint based on the base material available to date. Software has been developed to measure the effect of significant developments and measures proposed in the LIP.

The aim of this meeting:

- Receive an annual up-date about the role and impact of the Hillingdon Safer Transport Team, the Community Safety Team and British Transport Police.
- Examine any issues that may undermine or affect their effectiveness.

Witnesses

3. The representatives from the following organisations have been invited to attend the meeting:

    - British Transport Police
    - Community Safety, LBH
    - Safer Transport Team, Metropolitan Police Service

SUGGESTED SCRUTINY ACTIVITY

Members to question representatives from the Metropolitan Police Service, British Transport Police and Transport for London on the developments regarding safety and decide whether to take any further action.

BACKGROUND REPORTS

Council's Local Implementation Plan (LIP):
http://www.hillingdon.gov.uk/index.jsp?articleid=9096

SUGGESTED KEY QUESTIONS/LINES OF ENQUIRY

1. What are the major Anti Social Behaviour (ASB) problems on public transport in Hillingdon?

2. What activities has the Hillingdon Safer Transport Team (STT) undertaken to address these problems?

3. What difference has the STT made to ASB on public transport in the last year?

4. How does the STT work with the British Transport Police?

5. How are the priorities for the STT decided (i.e. how and where the STT will be deployed)?

6. For how long is the STT funded? Can the officers be abstracted to other duties?

7. Where does the remit of STTs end – e.g., are officers able to deal with the issues around graffiti and vandalism of bus shelters?

8. What is the pattern in terms of ASB on buses: has the situation improved or deteriorated in the last year?

9. What has been the impact of the free travel initiative?

10. Could the process for identifying perpetrators of ASB and then removing free travel entitlement be improved?

11. What role does the Council have in tackling ASB on public transport? Could this role be enhanced or developed?

12. What issues undermine or affect the effectiveness of the STT/BTP? How could the STT/BTP become more effective?

13. How will the changes being made to the number of SNT sergeants affect safer transport in the Borough?

14. Will there be any changes to the structure of SNT/STT and how will this affect the levels of policing in the Borough?

15. Will there be any changes to the structure of BTP and how will this affect the levels of policing in the Borough?

16. How are the different organisations continuing to work with schools to reduce ASB?

INTEGRATED CANCER SYSTEMS IN LONDON BRIEFING

Officer Contact	Nav Johal, Central Services
Papers with report	None

REASON FOR ITEM

Information item to inform the Committee of the proposed implementation of the cancer model of care.

OPTIONS AVAILABLE TO THE COMMITTEE

1. To note and ask questions about the proposals and the presentation.

INFORMATION

London Health Programmes identifies the health needs of Londoners and redesigns services to improve the way healthcare is delivered in the capital.

Supported by clinical and health intelligence, the models of care are clinically led with input from patients and commissioners to ensure that the services we are designing improve clinical outcomes, patient experience and the efficiency of the health service.

Employing an efficient, once for London approach, services are developed on behalf of London's commissioners and in partnership with the health sector to ensure that the capital's health needs are met and that care is delivered to a consistently high standard. They seek to reduce the fragmentation of care and improve communication between all providers, leading to better outcomes and experiences for patients.

Over 13,000 people die from cancer in London each year, with more than half of these under 75 years of age. The number of cancer cases in London is expected to increase as the population ages and continues to grow.

London Health Programmes want to make sure cancer is diagnosed as quickly as possible and are working to improve care and ensure equitable access to specialists, GPs, hospitals and healthcare professionals.

August Briefing Update

1. In December 2010, a case for change for cancer services in London was published. It showed that the lack of progress in implementing co-ordinated cancer services across the capital means that services may be excellent in some instances but is hugely variable. This has an impact on clinical outcomes and means patients often experience fragmented care.

2. A proposed model of care was published in August 2010. The model of care details clinically-developed solutions that will ensure that radical improvements are made to London's cancer services.

3. The proposed model of care was the subject of a three-month engagement process with GPs, the public and Local Authorities. The feedback received was supportive and the proposals are now being taken forward.

4. Central to the implementation programme is the expectation that providers will work together in *integrated cancer systems* to ensure that patients experience seamless care. These systems, rather than individual organisations, will be commissioned to deliver pathways of care from next April.

5. An integrated cancer system is defined as a group of providers that comes together in a formal, governed way to provide services across the whole of the cancer pathway. The integrated cancer system will be commissioned to provide cancer care based on defined care pathways to meet patients' needs.

6. A workstream has been established to explore and develop the commissioning process for integrated cancer systems. The working group will develop commissioning specifications for pathways including pathway contracting arrangements and tariffs, and establish key measures for pathways and integrated cancer systems.

7. To facilitate the development of integrated cancer systems the implementation team worked closely with providers to develop a specification against which providers submitted their proposals to become integrated cancer systems. The specification states that systems should have clear organisational and integrated governance (including clinical governance) systems and structures with clear lines of accountability and responsibilities for all functions.

8. Two groups of providers have submitted their proposals to become integrated cancer systems. One encompassing the providers in north east and north central London (London Cancer), and the other the providers in south east, south west and north west London (working title 'The Crescent'). They were required to demonstrate that they can meet the final specification and deliver the recommendations of the model of care.

9. Submissions are currently being assessed against the criteria set out in the final specification. Both the strength of the proposed integrated cancer system arrangements and the strength of service proposals will be assessed.

10. Ongoing work with the emerging systems will take place throughout the assurance process and the implementation team will continue to work with clusters, GPs and commissioners to ensure that local plans are aligned to the implementation programme.

11. The case for change also highlights that the earlier that cancer is diagnosed and treated, the greater a patient's chance of survival and improved quality of life. It is estimated that 1,000 lives per year could be saved in London through earlier diagnosis.

12. A Public Health and Primary Care working group has therefore been established to work with GPs, public health professionals, commissioners and existing cancer networks to

support the ongoing implementation of the cancer model of care. The work is predominantly led by the cancer networks

13. The work will focus on developing a strategy for improving early diagnosis and driving the ongoing implementation of the National Awareness and Early Diagnosis Initiative (NAEDI). Key recommendations include improving public awareness of cancer symptoms, increasing GP access to diagnostics, maximising effectiveness of referrals to secondary care, improving the patient pathway and reducing health inequalities. This work also includes the ongoing implementation of new models of post treatment community based care.

14. The group has worked with the emerging Innovative Cancer Solutions (ICSs) to ensure that there is a focus on early diagnosis that will see increased benefits to patients, not only in saving lives but also in improving patients' experience of their cancer journey.

SUGGESTED COMMITTEE ACTIVITY

1. Members note the report and presentation.

2. Members to ask questions of the witnesses and seek clarification, as appropriate.

BACKGROUND DOCUMENTS

None

SUGGESTED KEY QUESTIONS/LINES OF ENQUIRY

1. What interaction have you had with health professionals in Hillingdon with regard to the proposals?

2. What impact will the changes of the proposals have on the delivery of services to Borough residents?

3. What additional pressure will there be, if any, on other organisations under the new proposals?

4. How confident are officers on the smoothness of the transition of the new proposals? What action has been / will be taken to ensure the transition is seamless?

5. Are there any new impacts to services that need to be considered as a result of the proposal?

6. Are there any concerns about the level of support that would be made available?

WORK PROGRAMME 2011/2012

Officer Contact	Nav Johal and Nikki Stubbs, Central Services
Papers with report	Appendix A: Work Programme 2011/2012

REASON FOR ITEM

To enable the Committee to track the progress of its work in accordance with good project management practice.

OPTIONS AVAILABLE TO THE COMMITTEE

1. Note the proposed Work Programme.

2. To make suggestions for/amendments to future working practices and/or reviews.

INFORMATION

1. At its last meeting, the Committee agreed the attached Work Programme. All meetings would start at 6pm with the exception of the Community Cohesion meeting which would start at 5pm. Pale shading indicates completed meetings.

2. With regard to the major reviews that the Committee will undertake during the current municipal year, Members agreed at the last meeting that the following Working Groups would be set up:
    - Re-offending
    - Dementia Care in Hillingdon

3. Conservative Members of the Re-offending Working Group have been agreed, Labour Members need to be agreed. Dates and times of its meeting need to be agreed.

4. Members agreed that the second review topic would be Dementia Care. As it will not start until the first review has been completed, consideration could be given to this matter later in the year. This will enable Members to discuss any alternative topics that they have identified for possible scrutiny.

5. Members are also asked to agree the issues that they would like to consider at the External Services Scrutiny Committee meetings on:
    - 23 November 2011
    - 11 January 2012

SUGGESTED COMMITTEE ACTIVITY

1. Members note the Work Programme and make any amendments as appropriate.

2. Ensure Members are clear on the work coming before the Committee.

BACKGROUND DOCUMENTS

None.

APPENDIX A

EXTERNAL SERVICES SCRUTINY COMMITTEE

2011/12 WORK PROGRAMME

NB – all meetings start at 6pm in the Civic Centre unless otherwise indicated.

Shading indicates completed meetings

Meeting Date	Agenda Item
8 June 2011	• Briefing Paper on Organisations Regularly Called to Attend External Services Scrutiny Committee • Update on Recommendations of Previous Major Scrutiny Reviews
20 July 2011	**LINk** To receive a report on the progress of LINk in the Borough since the last update received by the Committee in June 2010.
21 September 2011	**Safer Transport** To scrutinise the issue of safety with regards to transport in the Borough (Safer Transport Team, Metropolitan Police Service and British Transport).
26 October 2011	**NHS & GPs** Performance updates, updates on significant issues and review of effectiveness of provider services: • Hillingdon Primary Care Trust (PCT) • The Hillingdon Hospital NHS Foundation Trust • Royal Brompton & Harefield NHS Foundation Trust • Central & North West London NHS Foundation Trust • London Ambulance Service • GPs • Hillingdon LINk
23 November 2011	
11 January 2012	
22 February 2012	**Crime & Disorder** • Metropolitan Police Service • Metropolitan Police Authority • Safer Neighbourhoods Team • Hillingdon Primary Care Trust (PCT) • London Fire Brigade

Meeting Date	Agenda Item
	• Probation Service • British Transport Police • Safer Transport Team
28 March 2012 – 5pm	**Community Cohesion Review** The review the achievements of the following organisations since March 2011 with regards to Community Cohesion: • Metropolitan Police Service • London Fire Brigade • University of Brunel • Union of Brunel Students • Hillingdon Primary Care Trust (PCT) • Strong & Active Communities • Hillingdon Inter Faith Network • Hillingdon Association of Voluntary Services
25 April 2012	**Quality Accounts & CQC Evidence Gathering** • Hillingdon Primary Care Trust (PCT) • The Hillingdon Hospital NHS Foundation Trust • Royal Brompton & Harefield NHS Foundation Trust • Central & North West London NHS Foundation Trust • London Ambulance Service • Care Quality Commission (CQC) • Hillingdon LINk

Themes	Future Work to be Undertaken
Re-offending Working Group Comprising Councillors: • Michael White • Dominic Gilham • Peter Kemp • Bruce Baker • John Hensley • John Morgan Labour Members • To be agreed.	Detailed review of local arrangements to address re-offending in the Borough. Working Group Meeting dates: • To be agreed Witnesses • To be agreed

Themes	Future Work to be Undertaken
Dementia Working Group Comprising Councillors: • To be agreed	Detailed review of improvements and formalisation of the Council's arrangements for addressing the issue of dementia in the Borough. Working Group Meeting dates: • To be agreed Witnesses • To be agreed

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