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A

External Services Scrutiny Committee

Councillors on the Committee

Councillor John Riley (Chairman)
Councillor Ian Edwards (Vice-Chairman)
Councillor Teji Barnes
Councillor Mohinder Birah
Councillor Tony Burles
Councillor Brian Crowe
Councillor Phoday Jarjussey
Councillor Michael White

Date: **THURSDAY, 11 JANUARY 2018**

Time: **6.00 PM**

Venue: **COMMITTEE ROOM 6 - 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

Chairman's Announcements

PART I - MEMBERS, PUBLIC AND PRESS

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

2 Declarations of Interest in matters coming before this meeting

3 Exclusion of Press and Public

To confirm that all items marked Part I will be considered in public and that any items marked Part II will be considered in private

PART II - PRIVATE, MEMBERS ONLY

7 Any Business transferred from Part I

Minutes

EXTERNAL SERVICES SCRUTINY COMMITTEE

14 November 2017

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

	Committee Members Present: Councillors John Riley (Chairman), Ian Edwards (Vice-Chairman), Teji Barnes, Mohinder Birah, Tony Burles, Brian Crowe and Michael White **Also Present**: Richard Connett, Director of Performance & Trust Secretary, Royal Brompton & Harefield NHS Foundation Trust Kim Cox, Hillingdon Borough Director, Central & North West London NHS Foundation Trust Imran Devji, Director of Operational Performance, The Hillingdon Hospitals NHS Foundation Trust Graham Hawkes, Chief Executive Officer, Healthwatch Hillingdon Nicholas Hunt, Director of Service Development, Royal Brompton & Harefield NHS Foundation Trust Ian Johns, Assistant Director of Operations - North West Sector, London Ambulance Service NHS Trust Caroline Morison, Chief Operating Officer, Hillingdon Clinical Commissioning Group Maria O'Brien, Divisional Director of Operations, Central & North West London NHS Foundation Trust Vanessa Saunders, Deputy Director of Nursing and Patient Experience, The Hillingdon Hospitals NHS Foundation Trust (THH) **LBH Officers Present**: Kevin Byrne (Head of Health Integration and Voluntary Sector Partnerships) and Nikki O'Halloran (Democratic Services Manager) **Press and Public: 2**
32.	**APOLOGIES FOR ABSENCE AND TO REPORT THE PRESENCE OF ANY SUBSTITUTE MEMBERS** *(Agenda Item 1)* Apologies for absence had been received from Councillor Phoday Jarjussey. On behalf of the Committee, the Chairman wished him a speedy recovery.
33.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 3)* **RESOLVED: That all items of business be considered in public.**
34.	**MINUTES OF THE PREVIOUS MEETING - 11 OCTOBER 2017** *(Agenda Item 4)* The Chairman thanked Councillor Edwards for chairing the meeting in his absence. It was suggested that BT be invited back to a future meeting to specifically talk about the plans the organisation had in place regarding the advancements in mobile technology.

	RESOLVED: That the minutes of the meeting held on 11 October 2017 be agreed as a correct record.
35.	**HEALTH UPDATES** *(Agenda Item 5)* Hillingdon Clinical Commissioning Group (HCCG) Ms Caroline Morison, Chief Operating Officer at HCCG, advised that a lot of work had been undertaken since she had last updated the Committee. The Joint Health and Wellbeing Strategy (JHWS) had been signed off by the Health and Wellbeing Board for pubic consultation. To ensure cohesion, the JHWS was being used to align all other related plans with five overarching delivery areas: 1. prevention of disease and ill-health through tackling risk factors, early detection, early intervention and proactive case management in primary care; 2. improving the management of long term conditions; 3. providing a better experience and choice for older people; 4. improving outcomes and opportunities for residents with mental ill health; and 5. ensuring the provision of safe, high quality, sustainable services, seven days a week. A system wide outcomes framework was being developed to measure progress against these delivery areas. The findings from the consultation would be reported to the Hillingdon Health and Wellbeing Board at its meeting on 12 December 2017 along with the refined outcomes framework. Members were advised that the Hillingdon Better Care Fund Plan 2017-2019 had been approved by NHS England (NHSE) with no conditions. The Plan set out how the local authority and HCCG would pool resources and the priorities. It was noted that the pooled fund for 2017/2018 totalled £36m and that this would rise to £54m in the following year. The plan focussed on a number of joint initiatives which supported the JHWS: • developing the Accountable Care Partnership (ACP); • developing a single point of access for older people; • an integrated approach to supporting carers; • getting hospital discharge right; • exploring the use of Disabled Facilities Grant (DFG) flexibilities; • joint market management and development approach - the joint brokerage arrangements had been piloted and it was anticipated that it would be rolled out across the Borough over the next few months; • closer alignment between adult social care and Care Connection Teams (CCTs); and • development of specialist Dementia Resource Centre (DRC). Ms Morison advised that HCCG was redesigning the Urgent and Emergency Care services into an integrated system. The current Urgent Care Centre (UCC) contract would end on 31 March 2018 which provided HCCG with the opportunity to commission a service to ensure that Hillingdon met the new NHSE 'Urgent Treatment Centre' (UTC) specification (to replace the UCC). This procurement process was underway and a strategy had been developed to address the challenges faced. Although there would not be a significant number of changes, key changes would include the ability to: • book 'urgent' appointments with the UTC via NHS 111, London Ambulance Service (LAS) and GPs (where clinically appropriate); • book direct appointments from the UTC into general practice;

- access and use the Directory of Services to support effective onward signposting to alternative services;
- provide a patient education function for long term behaviour change; and
- provide IT interoperability with wider integrated urgent care services.

HCCG had been through an engagement process, the resultant feedback had been incorporated into the specification for the service and the bid evaluation process was now underway. It was anticipated that further information on the outcome would be available in December 2017.

Ms Morison noted that the Primary Care Commissioning Board now oversaw primary care commissioning and had pulled together a strategy to address the challenges and support primary care at scale. Although the strategy sought to reduce the differences across the Borough, it was important to ensure that the needs of local communities were addressed. It was anticipated that the locality health profiles would help to determine the basis of service provision needed in each area. Furthermore, additional funding had been provided for extended hours at hubs over the winter period. Usage of this additional capacity would be monitored as, in some areas, it was thought that additional capacity was actually required during core hours. The primary care investment programme was also looking to increase clinical capacity to address gaps and make practices more efficient.

Mr Graham Hawkes, Chief Executive Officer at Healthwatch Hillingdon (HH), advised that HH had just launched a Borough wide survey of extended hours and was asking about preferred access times. Thoughts were also being solicited on the introduction of video conferencing. The online survey would close on 12 January 2018.

It was noted that all but two of the general practices in Hillingdon had joined the Hillingdon Confederation. Analysis of the challenges identified a need to focus on managing and developing the provider landscape by supporting the development of the GP Confederation and general practice resilience.

HCCG was looking at outcome based approaches to commission contracts at appropriate levels and would be prioritising the commissioning of proactive and coordinated care. Action was also being taken to ensure better and appropriate access to general practice with three locations in the Borough where residents registered with any Hillingdon practice could now access appointments up to 8pm from Monday to Friday and 8am to 8pm on Saturdays and Sundays. It was hoped that this extended availability would help to embed the idea that GPs should be one of the first points of contact.

Work had been undertaken with regard to atrial fibrillation and identifying people at risk of stroke. This work had won an award and was now being rolled out across all GP practices in the Borough.

With regard to the HCCG financial position, Ms Morison noted that the organisation was still forecasting to be on plan. Work was now underway to plan the 2018/2019 budget.

The Prescribing Wisely (formerly known as Choosing Wisely) initiative had gone live on 30 October 2017 with a view to reducing prescribing waste. Communication about the initiative would continue and ongoing impact analyses would be undertaken.

The eight CCGs in North West London (NWL) were reviewing their collaborative

working arrangements to maximise their ability to take a strategic and transformational approach to commissioning. Consideration was being given to identifying whether there were any other work streams that could be streamlined such as one Administrative Officer and one Chief Finance Officer for NWL. Ms Morison advised that changes to governance would be investigated but that, for the time being, each area in NWL would retain its own CCG.

Members expressed concern about reports that had been received in relation to the Uxbridge Medical Centre being overcrowded and under pressure to cope with the increased level of demand resultant from the St Andrews Park development. Ms Morison noted that there not being a practice on St Andrews Park was less than satisfactory. However, an outline options appraisal had been developed to increase capacity and was currently being worked up. It was noted that the feasibility study in relation to the Uxbridge Medical Centre was in the public domain.

The NHSE Online Consultation Fund had recently been highlighted in the media. Ms Morison advised that an application was being made collectively by the NWL CCGs. A pilot study had been undertaken elsewhere in NWL which had been halted as a result of the system directing the majority of users to A&E which was not helpful. Whilst this funding would introduce a stream of access, it didn't specify what the model of care should be and, as such, NWL CCGs would need to identify which medical conditions would be best able to benefit from such a system.

Royal Brompton and Harefield NHS Foundation Trust (RBH)

Mr Nick Hunt, Director of Service Development at RBH, noted that the Operational Performance Metric and Quality Indicators report for month six that had been circulated to Members had been considered by the Trust Board on 25 October 2017.

Mr Richard Connett, Director of Performance & Trust Secretary at RBH, advised that there had been 13 cases of Clostridium Difficile in the year to date and that one of these had been as a result of a lapse in care where the patient had not been put in isolation soon enough. There had been no cases of MRSA in the year to date. In month 6, there had been no instances of: urgent operations cancelled for the second time; cancelled operations (not carried out within 28 days); or cancelled procedures (not carried out within 28 days).

Performance against the 18 week Referral-to-Treatment (RTT) standard for month 6 had been 93.29%. There had been some data quality issues which were being addressed and Standard Operating Procedures were being reviewed and would be used to inform further training. Mr Hunt noted that this measure only applied to the elective cardiac pathway. As such, elective surgeries would be delayed if there were urgent surgeries that needed to be undertaken (there had been an increase in transplants) and this would affect achievement of the target. RBH continued to actively monitor those elective patients whose surgeries had been delayed and none had come to clinical harm. It was noted that six additional critical care beds had been created and would be opened in December 2017.

There had been one breach of the 52 week RTT target and the investigation into this case was still live. Against the National Operational Standards of 85% for the 62 day cancer target to first treatment, RBH had achieved 69.23%. The improvement trajectory agreed with NHS Improvement for Month 6 was 67.3%, so this had been met. It was noted that there had been 4 breaches of the 62 day target in September where all of these patients had been referred to RBH after day 38 and three of them had been as a result of patient choice. The Trust had achieved 100% against its 31

day cancer pathway targets.

With regard to the CQC ratings, it was noted that the CQC Insight report, as at 3 October 2017, showed the Trust was improving against 'well led' and 'medical care performance', and was stable against 'caring, 'effective, 'safe' and 'responsive. The core services of surgery, outpatients and diagnostic imaging were also noted by the CQC to be stable.

Members recognised that, when looking at small numbers, an increase or decrease may look significant when it may not necessarily be.

Mr Hunt advised that the consultation responses to the proposal to reconfigure the paediatric cardiac services would be considered by NHSE at its Board meeting on 30 November 2017 where it would take a view. It was noted that Sir Bruce Keogh, who had been leading the review, would retire on 30 November 2017.

During the service review, there had been a significant leadership changes in the NHSE team responsible for the programme and communication had been poor. RBH had submitted a response to the consultation in June 2017 and had still not received a response or feedback. It was hoped that changes would be focussed around services in Manchester and Leicester.

One of the requirements of the proposals was that changes to the service specification must be in place by March 2018. It was thought unlikely that every Trust affected would make that target date. As such, it was queried whether NHSE would be considering accepting a direction of travel at the March 2018 deadline.

The Committee had expressed its concerns about the proposals and had met with representatives from NHSE. At that meeting, NHSE had allayed some of the Members' fears. It was suggested that, if there was going to be a change in leadership, there might also be a change in view.

<u>The London Ambulance Service NHS Trust (LAS)</u>
Mr Ian Johns, Assistant Director of Operations - North West Sector at the LAS, advised that the A8 (serious and life threatening calls) performance target had not been met. However, there had been a 9.2% increase in demand for the service in North West London since April 2017 so the Trust had been performing better than it had the previous year, despite not achieving the target. Demand had increased across London by 6% (+7,888 calls) in 2017 Q1 when compared with 2016 Q1 and performance had improved from 65.9% in 2016 Q1 to 71.8% in 2017 Q1.

Hillingdon's performance was, on average, roughly the same as the overall London performance. The main reasons for calls to the LAS in Hillingdon were: NHS 111 transfers (13.6% = 3,258 calls); falls (12% = 2,884 calls); unconscious/fainting (9.5% = 2,280 calls); breathing problems (9.2% = 2,213 calls); and non-traumatic chest pain (8.8% = 2,118 calls).

Mr Johns noted that LAS had been working collaboratively with HCCG and Hillingdon Hospital to address issues that had arisen such as reducing the time taken to hand over patients. Approximately 435 patients were transported by LAS to Hillingdon Hospital each week. The average total time lost by LAS each week at Hillingdon Hospital (over the target 15 minute handover time per patient) was 57.6 hours. It was noted that 68.1% of patients were handed over within 15 minutes. Further work was being undertaken with the Accountable Care Partnership to identify patients that did not

need to be transported to hospital.

Insofar as appropriate care pathways were concerned, a single point of access for NWL mental health went live in October 2017. This was deemed to be a significant leap forward. The NWL prevention of admission programme had also gone live in October 2017. NWL was thought to be more advanced than other areas of London in terms of alternative care pathways. However, it was recognised that this put staff in the dispatch centre under increasing pressure. Members were advised that clinicians were available in the dispatch centre to call patients back where required, taxis could be deployed to pick up patients and paramedics could advise patients that they needed to speak to a pharmacist rather than being taken to hospital.

It was noted that patient facing vehicles hours was affected by staff holidays and sickness absence. As such, work was being undertaken to even out these peaks and troughs throughout the year. Members were assured that there were no issues with the vehicle fleet and that, as well as the imminent delivery of 120 new ambulances, a lot of work had been undertaken by the fleet logistics team over the last 12 months to maintain and develop the fleet.

Members were advised that a new ambulance response programme had been introduced by LAS on 1 November 2017. The old system had been overly risk averse. The new system split calls into:

- Category 1: life threatening event. This was likely to form 8% of the LAS workload;
- Category 2: emergency - potentially serious event. This was likely to form 48% of the LAS workload;
- Category 3: urgent problem. This was likely to form 34% of the LAS workload; and
- Category 4: less urgent problem. This was likely to form 10% of the LAS workload.

The new response programme had reduced the number of sickest patients seen from about 1,400-1,600 per day to around 250 per day. This meant that LAS resources were being freed up to deal with other issues (LAS was still dealing with 5k calls per day and responding to 3k patients each day) and the whole system was being joined up in a national framework. As the programme was new, Members were advised that it was not likely that performance data would be available until the next financial year.

Members congratulated the LAS on the quality of the information that had been forthcoming to the Committee. It was recognised that the new response programme was more focussed on conditions and appropriate response, resulting in a more efficient and effective service provision. The Committee questioned why it had taken so long to implement the change. The changes had been made as a result of evidence based practice where the sickest patients needed to receive the fastest response (for example, heart, stroke, major trauma, fitting and serious haemorrhaging).

In June 2015, LAS had been inspected by the CQC and, as a result, was put in special measures. Following a significant amount of work, in February 2017, the Trust was reinspected and the CQC rated LAS as 'Requires improvement'. Improvements had been made to the Trust leadership, vehicles and equipment and frontline capacity had been increased. The LAS' systems of medicines management had been improved so that administered drugs could now be tracked to individual patients (there was now an app based system which would help to achieve further improvements). Mr Johns felt that, although staff care and commitment remained as high as it always had been, the

changes made had had a significant impact.

In terms of recruitment, there were approximately 50 vacancies in NWL. In addition to the 100 Australian paramedics that would be starting work for LAS just after Christmas, internal training was being undertaken and rolled out across NWL. It was thought that this overseas recruitment legacy would be continued for some considerable time. Although the new intake would increase the Australian staff contingent within the LAS to around 600, recruitment was also being undertaken locally. Staff were on a two year contract and it was inevitable that there would be a certain level of churn.

<u>The Hillingdon Hospitals NHS Foundation Trust (THH)</u>
Mr Imran Devji, Director of Operational Performance at THH, advised that the Trust had a policy of no cancellation for cancer patients and had achieved all of its cancer related targets in the year to date. He also noted that pressures on emergency care remained. THH had been working with HCCG and had achieved 87.5% against the 95% A&E 4 hour standard in Q2. Given the increased demand on A&E, this target had been revised by the regulator to 90%. It was reassuring to note that clinical practice remained safe even during these times of significant demand. However, it was recognised that further work was needed to reduce the amount of time that LAS staff were waiting at the hospital.

Mr Devji advised that the new LAS system would see the sickest patients conveyed to hospital quickly and that other patients seen by LAS might be advised to visit the pharmacy or their GP rather than attend A&E. Although the new system had only been in place for two weeks, THH had not yet seen a reduction in the number of ambulance conveyances to A&E.

Members were advised that there were a number of THH work streams which included:

- Demand management - needing to ensure that processes were applied consistently and looking at how patient flow was managed since it had changed from two separate flows to a single flow;
- Acute Medical Unit and medical centre - all assessments centres were based in one place and 45 assessment spaces had been created to prevent delays and reduce the pressure on A&E;
- Delays - the Red2Green initiative had been rolled out across the Trust. A nurse would go through all Red2Green reports every morning to pick up any discharge issues and raise these with CNWL. This initiative was being led by the Medical Director;
- PJ Paralysis - this was a national initiative which formed part of rehabilitation and had been incorporated into the Red2Green initiative; and
- Discharge to Assess (D2A) - this was an integrated discharge work stream that was moving forward with a memorandum of understanding.

Members were advised that THH's infection prevention and control position was still strong. There had been one case of MRSA which had not been as a result of a lapse of care. There had also been five cases of Clostridium Difficile, none of which had been as a result of a lapse in care.

Hillingdon Health and Care Partnership (HHCP), Hillingdon's Accountable Care Partnership (ACP), had been providing vital support to keep residents in their homes for longer. Care Connection Teams (CCTs) had been introduced in all GP practices in the Borough and comprised a Guided Care Matron and a Care Coordinator who worked alongside GPs and other local health and care practitioners. The aim was to keep the most vulnerable elderly patients safely cared for in their own homes wherever

possible.

THH had adopted a 'Home first' policy approach to managing patients which was aligned with the HCCP work and supported the D2A initiative. This approach looked to ensure that patients that were discharged under D2A were assessed in their own home within two hours of getting home. An overall assessment of the patient's needs was undertaken in liaison with Social Services, CNWL Community Services and the voluntary sector to ensure that all needs were being addressed.

Members were advised that Delayed Transfers of Care (DToCs) had a national classification which was anything over 72 hours. However, this was not a reliable measure of delay. CNWL, HCCG and THH were collectively reviewing all R2G patients this week. If this model worked well, it would be introduced as the Hillingdon model.

Ms Vanessa Saunders, Deputy Director of Nursing and Patient Experience at THH, advised that the Trust had received high Patient-Led Assessment of the Care Environment (PLACE) scores for cleanliness, appearance and food. The PLACE review had been led by external assessors from the local community and NHS Trust staff and the areas reviewed had been identified by Healthwatch Hillingdon. THH had achieved its highest score in the 'external tidiness and appearance' category which would have been influenced by the introduction of dedicated grounds maintenance teams earlier in the year. There had also been a 7.83% increase in the PLACE assessment 'disability' category in relation to how well the Trust catered for the needs of patients and visitors with a disability and how well it provided access.

THH had been a member of NHS Improvement (NHSI) End of Life Collaborative which was progressing key work streams to improve the end of life experience. This had involved: staff training; the use of Comfort Care Plans for patients in the last days of life; ACP discharge summaries; the use of Coordinate My Care (CMC); refurbishment of the aged accommodation; and raising awareness.

Ms Saunders advised that the Trust Charity had funded a furnished 'quiet room' on Hayes Ward and a day room and doctors' office for Hayes Ward and Grange Ward. Furthermore, the THH team had won an award at a recent NHSI event for implementing innovative ideas at pace.

The Trust's Carers Strategy had been published in 2017. Year one of the action plan had been progressing: Carers Charter; carer beds (funded by the Trust Charity); carers survey (which would be available online); and service specific actions. The use of the carer beds would be monitored to establish whether additional beds were needed.

Members were advised that a significant programme of work was underway to increase recruitment and retention across staff groups. A comprehensive branding project was being undertaken as part of the recruitment and retention programme with the recruitment campaign being extended nationally and internationally (particularly in Europe and India). Ms Saunders noted that conditional offers of permanent employment had been made to third year student nurses but that there were some who had already been offered places elsewhere.

Concern was expressed regarding the growing dependence on staff from overseas and whether this could potentially leave the Trust workforce in a vulnerable position. Ms Saunders agreed to provide a breakdown of staff at the Trust if this information was available. She noted that the population of the Borough was diverse and, as such, a

workforce that reflected this diversity was a positive attribute. Consideration was also being given to apprentices and associate nurses but it was recognised that this would take a number of years to come to fruition.

In August 2017, staff and volunteers at Hillingdon Hospital joined forces with fire fighters for an emergency evacuation exercise. 'Patients' (role played by volunteers) were moved from the eighth floor of the tower block in a scenario where there had been reports of a fire in a linen cupboard which was burning through the floor below. 'Patients' that were able to walk were escorted downstairs by staff and bed-bound 'patients' were lifted onto 'ski pad' evacuation devices and slid down the stairs. Recommendations had been made following this exercise.

Members were advised that the Friends and Family test needed to be completed within 48 hours of the patient's discharge. Currently, the response rate was around 30-40% for inpatients. Consideration was being given to the introduction of a text response option but it was acknowledged that this would come at a cost.

Mr Devji assured Members that THH's cyber resilience was high. THH had been one of the few Trusts that had not been impacted by the recent cyber attacks. However, it was recognised that there was no room for complacency and upgrades were routinely installed. Particular care was given to the security of those areas of the Trust that were high priority.

<u>Central and North West London NHS Foundation Trust (CNWL)</u>
Ms Kim Cox, Hillingdon Borough Director at CNWL, advised that the Trust had been working on a number of key priorities for Hillingdon in 2017/2018:

- Developing a sustainable model for CAMHS and building on crisis work (demand v capacity);
- Expanding the range of services and integration across the HHCP including mental health;
- Reducing mental health bed occupancy through providing more core community based support;
- Delivering further integration across physical and mental health services to improve outcomes and user experience; and
- Maintaining high quality services and delivering financial sustainability in the Borough.

Ms Cox advised that 78% of children were now seen by CAMHS within 18 weeks of being referred (against a target of 85%). This had been a significant increase on the 47% reported in October 2016. There had been an increase in capacity for face to face sessions and an increase in the flow in the system. This had helped to produce 70% positive outcomes for patients after treatment where they were discharged from mental health services.

The CAMHS eating disorders service had been commissioned and was now provided by CNWL with a hub and spoke model across the five boroughs. Urgent referrals were being seen within one week and routine referrals within four weeks. It was noted that this service was not an adaptation of an adult service but was a specialist team of CAMHS and eating disorders clinicians.

A new CAMHS out of hours and crisis service had been introduced which had nurses and doctors working across the five boroughs. This development had improved the urgent response to children and young people at Hillingdon A&E and reduced the number of breaches there. Positive feedback had been received for this service which

sought to get the right people in the right place at the right time.

Developments in 2015/2016 meant that children and young people with a learning disability (LD) or challenging behaviour would have a service in Hillingdon. A multi disciplinary CAMHS LD team was available and included psychology, behaviour analysts, paediatrician sessions and psychiatry sessions. These developments had enabled the children's families, schools and social care services to work together.

Members queried whether the criminalisation of looked after children (LAC) was linked to LD. Ms Cox advised that CNWL met regularly with the police and that CAMHS worked closely with the Council's Youth Offending Team and the court. As such, referrals were made where deemed appropriate. In addition, school nurses and health visitors were also able to follow up on these issues. Ms Maria O'Brien, Divisional Director of Operations at CNWL, advised that, although there was a LAC churn through the Borough, these children should be picked up through their health assessments. However, it was recognised that this was not always the case and there were many referrals to the Early Intervention and Psychosis Team that came from the court.

Ms Cox noted that HHCP was now established and CNWL continued to put practical things in place to ensure that the partners worked together as a single entity. The 15 Care Connection Teams (CCTs) were settling in and working to keep older patients in their own homes for as long as possible. Hillingdon H2A was currently leading across NWL with regard to taking the highest number of patients home on this new pathway.

With regard to children's community services, Members were advised that a three month pilot for out of hours health visiting support would start in December 2017. In addition, the children's teams had now amalgamated into 0-19 hubs, Hillingdon had the fourth highest continued breast feeding rate nationally at 6-8 weeks and the children's contact centre had been in operation since October 2017.

The CQC had reinspected older adult mental health services at CNWL in January 2017 which had resulted in the service being deemed 'Good'. The community mental health team had been reinspected in May 2017 and had not identified any improvements needed that were specific to Hillingdon. As a result of these reinspections, the overall Trust rating for CNWL had now moved to 'Good'.

Ms Cox noted that inpatient bed pressures continued to be a huge issue and financial pressures persisted. Although nurse recruitment remained a challenge, staff retention had improved.

Members were advised that there had been an increasing number of section 136 presentations via the Hillingdon Mental Health Suite. There had been around 40 per month in August, September and October 2017 compared to less than 20 per month in the corresponding period in 2015.

<u>Healthwatch Hillingdon (HH)</u>
Mr Graham Hawkes, Chief Executive Officer at HH, noted that the new services had helped to reduce the pressure on the CAMHS service and that this had resulted in the provision of excellent feedback. However, early intervention was still deemed to be an issue as, although direction of travel had been agreed, progress was slow. Mr Hawkes advised that the work undertaken by the Anna Freud National Centre for Children and Families had been frustrating as the findings had replicated those in the HH report that had been published 2½ years previously.

	HH had secured external funding to offer a 16 week course on mental health at Barnhill High School. This course had been aligned to the Healthy Schools Programme and, if successful, HH had applied for additional funding to roll the course out to other schools. In the longer term, HH would need to establish whether HCCG would be prepared to fund the course. Mr Hawkes advised that HH had received nine months of funding to develop a Young Healthwatch Hillingdon (YHH) for those aged 14 to 24 which was now being promoted. YHH would replicate the HH Board (which the Chair of YHH would also sit on). Consideration would need to be given to how this could be sustained. Members were advised that HH was undertaking a Borough wide survey on extended GP hours. Access to GPs and staff attitude were two of the biggest complaints received by HH. It was noted that there had been a lot of work undertaken to improve patient flow through hospital and discharge times. However, it was suggested that further work was still needed in relation to mental health discharge as this encompassed a much wider range of partners. Mr Hawkes was saddened to report that Raj Grewal would be moving with his family to the Sudan for three years. Although Raj would remotely cover the governance work for HH in the interim, consideration would need to be given to how to replace such an irreplaceable member of the HH team. Members agreed that all Trusts be asked to produce an 'Operational Performance Metric and Quality Indicators' report (similar to that provided by RBH at this meeting) for inclusion on subsequent Trust health update agendas. **RESOLVED: That:** **1. Ms Saunders provide the Committee with a breakdown of where THH staff were from;** **2. all Trusts be asked to provide Operational Performance Metric and Quality Indicators reports for inclusion on future agendas; and** **3. the presentations be noted.**
36.	**WORK PROGRAMME 2017/2018** *(Agenda Item 6)* Consideration was given to the Committee's Work Programme. It was suggested that, in the 2018/2019 municipal year, consideration be given to a major review of mental health discharge. At its meeting on 13 February 2018, the Committee would be undertaking its regular review of the Safer Hillingdon Partnership. It was suggested that the Fire Brigade be invited to attend and consideration would need to be given to the specific lines of questioning that Members would like to follow. Councillor Edwards updated the Committee on the progress that had been made in relation to the Community Sentencing review and the London CRC's failure to engage with the Working Group. Recommendations had been drafted for this review and a report would still be submitted to Cabinet. **RESOLVED: That the Work Programme be agreed.**

	The meeting, which commenced at 6.00 pm, closed at 8.50 pm.

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nikki O'Halloran on 01895 250472. Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.

EXTERNAL SERVICES SCRUTINY COMMITTEE - HEATHROW VILLAGES GP SERVICE PROVISION

Contact Officer: Nikki O'Halloran
Telephone: 01895 250472

Appendix A: Map of GP Practices in Hillingdon (2018)
Appendix B: Background and Challenges

REASON FOR ITEM

To enable the Committee to receive information on the provision of GP services in the Heathrow Villages area of the Borough.

OPTIONS AVAILABLE TO THE COMMITTEE

Members are able to question the witnesses and make recommendations to address issues arising from discussions at the meeting. Members may also request further information from witnesses.

INFORMATION

In addition to GP practices, primary care covers dental practices, community pharmacies and high street optometrists. For the purposes of this meeting, the Committee will be looking solely at the provision of GP practices in the Heathrow Villages area of the London Borough of Hillingdon. A map of the GP practices in Hillingdon in 2018 has been included at Appendix A.

For a number of years, access to primary care has been a source of frustration for residents in Heathrow Villages. Currently there is no GP (or pharmacy) provision in the area. Further information on the background to the current situation and the challenges now faced by residents can be found in Appendix B.

Members of the Committee are asked to review the current situation and question witnesses to establish what action is being taken to ensure that adequate primary care access is provided to residents in Heathrow Villages. To assist, background information has been provided below regarding the Heathrow Villages composition and the role of Hillingdon Clinical Commissioning Group (HCCG). Information has also been provided below which sets out the principles and values on which the NHS is based.

Heathrow Villages

Heathrow Villages lies in the South of Hillingdon and is bordered by West Drayton and Pinkwell as well as the London Borough of Hounslow and Surrey. The 2011 Census shows Heathrow Villages population as 12,199 residents, an increase of 19.40% since 2001 (10,217). Heathrow Villages ward is one of the least densely populated wards of the Borough with 5.2 people living per hectare which is well below the Borough average of 23.7 people living per hectare. The average number of people per household is 2.7. The proportion of men to women in the ward shows that there is a higher percentage of men to women, 52.5% to 47.5%. This is a change from 2001 when there was a 49.5% to 50.5% male to female ratio.

Primary Care Commissioning
From 1 April 2017, NWL CCGs took on delegated Primary Care Commissioning from NHS England. It is anticipated that there will be a direct positive impact on patient services with benefits that include:

- a greater autonomy from NHS England with a much clearer remit and mandate to support and develop primary care that CCGs did not previously have;
- CCGs being able to invest in primary care through formal mechanisms that are available through fully delegated co-commissioning;
- a team that knows the local practices and issues, and can provide support with local sensitivity; and
- a local team that supports practices, is responsive to needs and has local knowledge, resourced to provide help and advice to practices, to be available for crisis support and day-to-day assistance.

NHS Principles and Values
Principles
The NHS was created out of the ideal that good healthcare should be available to all, regardless of wealth. When it was launched by the then minister of health, Aneurin Bevan, on 5 July 1948, it was based on three core principles:

- that it met the needs of everyone
- that it be free at the point of delivery
- that it be based on clinical need, not ability to pay

These three principles have guided the development of the NHS over more than 60 years and remain at its core. In March 2011, the Department of Health published the NHS Constitution which sets out the guiding principles of the NHS and individuals' rights as an NHS patient.

There are now seven key principles which guide the NHS in all it does and which are underpinned by core NHS values that have been derived from extensive discussions with staff, patients and the public. The NHS principles are:

Principle 1: The NHS provides a comprehensive service available to all
This principle applies irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. The service is designed to diagnose, treat and improve both physical and mental health.

Principle 2: Access to NHS services is based on clinical need, not an individual's ability to pay
NHS services are free of charge, except in limited circumstances sanctioned by Parliament.

Principle 3: The NHS aspires to the highest standards of excellence and professionalism
In relation to:

- the provision of high-quality care that is safe, effective and focused on patient experience
- the people it employs and in the support, education, training and development

they receive
- the leadership and management of its organisations
- its commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population

Respect, dignity, compassion and care should be at the core of how patients and staff are treated - not only because that is the right thing to do, but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported.

Principle 4: The NHS aspires to put patients at the heart of everything it does
It should support individuals to promote and manage their own health. NHS services must reflect, and should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers.

Principle 5: The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
The NHS is an integrated system of organisations and services bound together by the principles and values reflected in the NHS Constitution. The NHS is committed to working jointly with other local authority services, other public sector organisations and a wide range of private and voluntary sector organisations to provide and deliver improvements in health and wellbeing.

Principle 6: The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
Public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves.

Principle 7: The NHS is accountable to the public, communities and patients that it serves
The NHS is a national service funded through national taxation. The Government sets the framework for the NHS, and it is accountable to Parliament for its operation. However, most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are rightly taken by the local NHS and by patients with their clinicians. The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff. The Government will ensure that there is always a clear and up-to-date statement of NHS accountability for this purpose.

NHS Values
Patients, public and staff have helped develop this expression of values that inspire passion in the NHS, and that should underpin everything it does. Individual organisations will develop and build upon these values, tailoring them to their local needs. The NHS values provide common ground for cooperation to achieve shared aspirations, at all levels of the NHS.

- Working together for patients - The value of "working together for patients" is a central tenet guiding service provision in the NHS and other organisations providing health services. Patients must come first in everything the NHS does. All parts of the NHS system should act and collaborate in the interests of patients, always putting patient interest before institutional interest, even when that involves admitting mistakes. As well as working with each other,

health service organisations and providers should also involve staff, patients, carers and local communities to ensure they are providing services tailored to local needs.

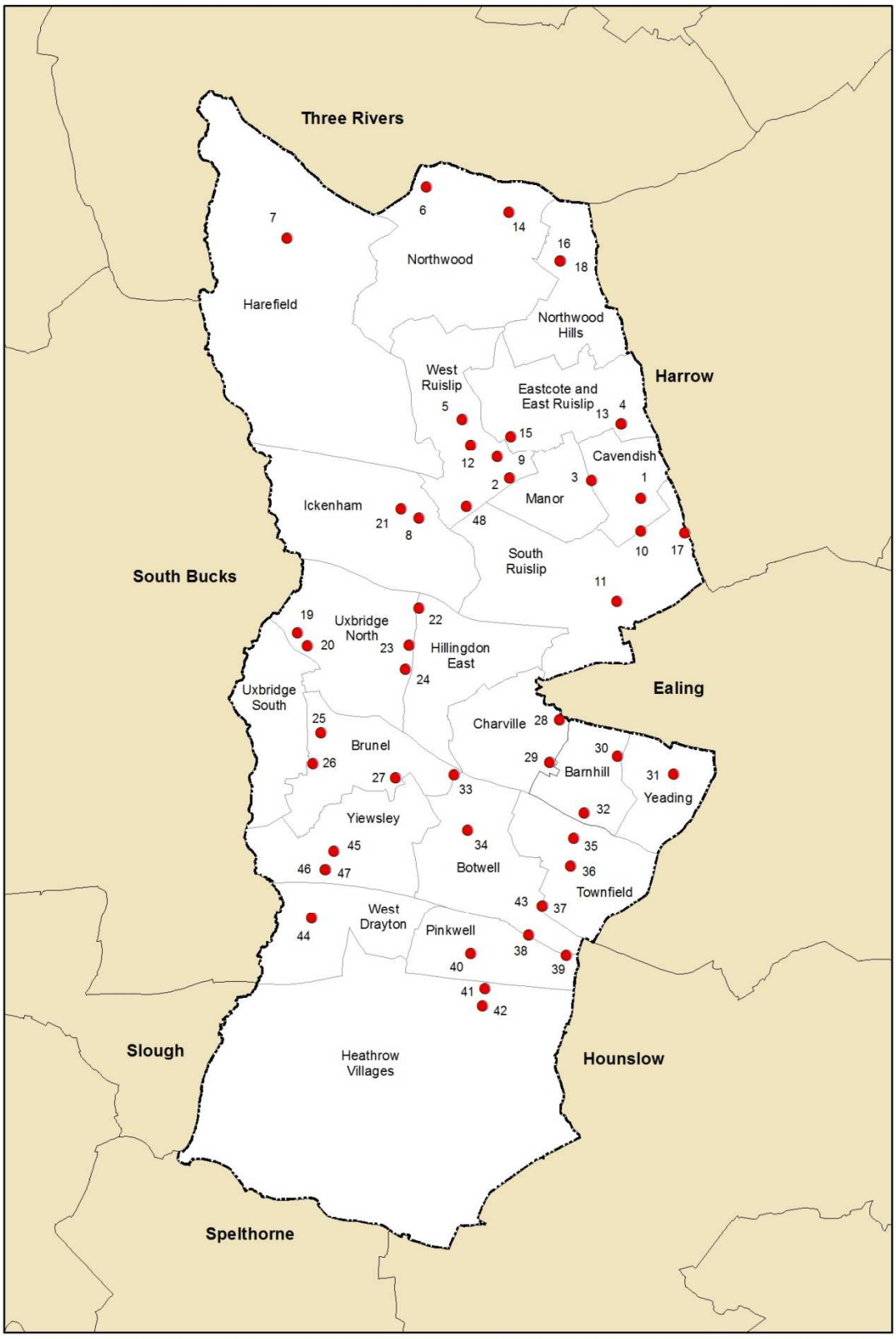
- Respect and dignity - Every individual who comes into contact with the NHS and organisations providing health services should always be treated with respect and dignity, regardless of whether they are a patient, carer or member of staff. This value seeks to ensure that organisations value and respect different needs, aspirations and priorities, and take them into account when designing and delivering services. The NHS aims to foster a spirit of candour and a culture of humility, openness and honesty, where staff communicate clearly and openly with patients, relatives and carers.
- Commitment to quality of care - The NHS aspires to the highest standards of excellence and professionalism in the provision of high-quality care that is safe, effective and focused on patient experience. Quality should not be compromised – the relentless pursuit of safe, compassionate care for every person who uses and relies on services is a collective endeavour, requiring collective effort and collaboration at every level of the system. The delivery of high-quality care is dependent on feedback: organisations that welcome feedback from patients and staff are able to identify and drive areas for improvement.
- Compassion - Compassionate care ties closely with respect and dignity in that individual patients, carers and relatives must be treated with sensitivity and kindness. The business of the NHS extends beyond providing clinical care and includes alleviating pain, distress, and making people feel valued and that their concerns are important.
- Improving lives - The core function of the NHS is emphasised in this value – the NHS seeks to improve the health and wellbeing of patients, communities and its staff through professionalism, innovation and excellence in care. This value also recognises that, to really improve lives, the NHS needs to be helping people and their communities take responsibility for living healthier lives.
- Everyone counts - We have a responsibility to maximise the benefits we obtain from NHS resources, ensuring they are distributed fairly to those most in need. Nobody should be discriminated or disadvantaged, and everyone should be treated with equal respect and importance.

Witnesses

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

- Hillingdon Clinical Commissioning Group (HCCG)
- Hillingdon Clinical Commissioning Group (HCCG) Primary Care Board
- Healthwatch Hillingdon
- Heathrow Villages resident representative
- Hillingdon Local Medical Committee (LMC)

Map: GP practices in Hillingdon



GP practices in Hillingdon:

Key	Practice name
1	Oxford Drive Medical Centre
2	Wood Lane Medical Centre
3	Cedars Medical Centre
4	The Abbotsbury Practice
5	Dr Karim's Practice, Ladygate Lane
6	The Mountwood Surgery
7	The Harefield Practice
8	Swakeleys Medical Centre
9	King Edwards Medical Centre
10	The Medical Centre, Queenswalk
11	Dr Siddiqui's, Walnut Way
12	Southcote Clinic
13	Devonshire Lodge
14	Eastbury Surgery
15	St Martin's Medical Centre
16	Acre Surgery
17	Acrefield Surgery
18	Carepoint Practice
19	The Belmont Medical Centre
20	Uxbridge Health Centre
21	Wallasey Medical Centre
22	Hillingdon Health Centre
23	Oakland Medical Centre
24	Acorn Medical Centre

Key	Practice name
25	Brunel Medical Centre
26	Church Road Surgery
27	West London Medical Centre
28	Cedar Brook Practice
29	The Pine Medical Centre
30	Yeading Court Surgery
31	Willow Tree Surgery
32	The Warren Practice
33	Parkview Surgery
34	Kingsway Surgery
35	Townfield Doctors Surgery
36	Kincora Doctor's Surgery
37	Hayes Town Medical Centre
38	Hayes Medical Centre
39	North Hyde Practice
40	Shakespeare Surgery
41	Heathrow Medical Centre
42	Glendale House Surgery
43	Orchard Practice
44	The Medical Centre, The Green
45	Otterfield Medical Centre
46	Yiewsley Family Practice
47	The High Street Practice
48	St Martin's Medical Centre

PRIMARY CARE PROVISION IN THE HEATHROW VILLAGES OF HARMONDSWORTH, LONGFORD AND SIPSON

The Heathrow Villages of Harmondsworth, Longford and Sipson have not been directly served by a GP for nearly 40 years. The last GP service provided in the three villages closed circa 1979. This was a satellite practice led by a GP from an Ickenham Surgery which opened for one afternoon each week. Due to it being open only one afternoon a week, it was not popular with the villagers and those who could went to Cranford (Hounslow) and West Drayton to register with GPs who were more regularly available.

The closest GP to the villages was Dr Singh's Practice on Harmondsworth Road, West Drayton. When Dr Singh died in 2008, the NHS Hillingdon Primary Care Trust (PCT) sent the 1,500 registered patient list to The Green in West Drayton for six months and then permanently.

The surgeries in Cranford, Heathrow Medical Centre and Glendale Medical Centre are almost two miles away from the villages and, with no direct bus route, residents found it difficult to access them without a car. As a result, most residents went to The Green in West Drayton. The Green struggled to accommodate these additional patients, it was difficult to recruit additional GPs and the waiting times to routinely see a GP rose to nearly 4 weeks, which was unheard of at that time.

In January 2010, as a solution to the issues at The Green, the PCT proposed controversial plans to move the surgery to a new medical centre to be built on the former National Air Traffic Service site at Porters Way. Villagers, fearing further loss of services, joined residents at two public meetings with NHS managers to oppose the proposals. They asked for a new GP surgery at Porters Way in addition to The Green to ease pressures and waiting times for a GP. Plans to move The Green where abandoned, as was the building of the new medical centre in Porters Way.

The PCT then outlined a plan in 2011 to provide additional GP services in West Drayton, at a new medical centre to be built on the site of the Yiewsley Pool. Although demolition took place in early 2012, no medical centre was built.

Healthwatch Hillingdon, and their predecessor Hillingdon LINk, first became involved with the residents of the villages during the proposed plans to move The Green. This coincided with LINk receiving calls from new residents who had moved into Longford being refused registration at a GP practice as they lived under a postcode that fell outside of any GP catchment area. LINk arranged registration for those residents with the PCT and met with the residents of the villages to get an understanding of their experiences. At this meeting, the residents explained that not only were there no GP services within the villages but, similarly, the closest dentist and chemist were also in Harlington and the residents used West Drayton, Uxbridge or the Terminals at Heathrow Airport as they were all served by buses.

LINk, and subsequently Healthwatch Hillingdon, continued to support the villagers to raise their concerns with commissioners and, in 2013 joined them to meet the new NHS Hillingdon Clinical Commissioning Group at a meeting arranged by Harmondsworth resident Mrs Armelle Thomas.

GP registration for new Longford residents continued to be an issue, with NHS England assigning patients to GP practices. These patients were mainly from a hotel being used in the village by the Home Office to house refugees.

In 2015, Healthwatch Hillingdon began to receive a number of calls from new and existing residents of the three villages complaining that GP Practices were refusing to register them. Investigation showed that, with rising patient lists and pressure growing upon GPs, practices were becoming stricter in applying their boundaries.

Whilst a solution was being sought to the registration issue, as a temporary measure, patients were also assigned to GP Practices over 2 miles away in Hayes Town who had agreed to take them.

Led by Mrs Thomas, the villagers were also looking to not only overcome this current issue, but for a more permanent solution for GP provision in the villages. In May 2016, Mrs Thomas was invited to a private meeting with the Hillingdon CCG and NHS England and a further public meeting was held in Harmondsworth in July 2016 with the CCG.

Negotiations between NHS England and practices did not resolve the issue and, in September 2016, Hillingdon CCG, NHS England and Healthwatch Hillingdon met with local practices. As a result of this meeting and further work by NHS England to look at the original boundaries outlined in the contracts signed by the practices, it was agreed that The Green and Glendale Medical Centre had a legal responsibility to register residents from the villages and that both The Orchard Practice and Hayes Town Medical Centre would continue to register patients.

This solution did not provide the permanent solution to GP provision within the three villages that the villagers desired. Their issues were then further compounded in September 2016 by the announcement that the Podiatry Services and Musculoskeletal Services provided in West Drayton would be moved to Uxbridge and the Phlebotomy Services provided on the same premises would be adversely affected. This prompted the villagers to write to the CCG to express their extreme concern, “Following your visit to the villages in July, we were hopeful that our ability to access medical services, as and when we needed them, would improve. However, these cuts suggest the reverse is happening.”

The Phlebotomy Service was subsequently fully reinstated in February 2017, but the residents' campaign for provision of primary care services in the villages continues.

Led by Mrs Thomas, the villagers are urging Hillingdon CCG to meet with Heathrow Airport Ltd as a solution to the issue. At the recent Heathrow Local Forum on 6 December 2017, CEO, John Holland-Kaye, said, “We have very little health provision on the airport and I know you are concerned about how Heathrow is a burden on local services. We have upgraded our occupational health area and are organising a drop in GP centre. If this is successful we can look at a centre for colleagues and a place for visitors who need healthcare. We have a plan that is coming together on health provision and are trying to fill that gap”

Mrs Armelle Thomas – For Heathrow Villages
Graham Hawkes – Healthwatch Hillingdon

EXTERNAL SERVICES SCRUTINY COMMITTEE - WORK PROGRAMME 2017/2018

Contact Officer: Nikki O'Halloran
Telephone: 01895 250472

Appendix A: Work Programme 2017/2018

REASON FOR ITEM

To enable the Committee to track the progress of its work in 2017/2018 and forward plan its work for the current municipal year.

OPTIONS OPEN TO THE COMMITTEE

Members may add, delete or amend future items included on the Work Programme. The Committee may also make suggestions about future issues for consideration at its meetings.

INFORMATION

1. The Committee's meetings tend to start at either 5pm or 6pm and the witnesses attending each of the meetings are generally representatives from external organisations, some of whom travel from outside of the Borough. The meeting dates for this municipal year are as follows:

Meetings	Room
Wednesday 14 June 2017, 6pm	CR6
Tuesday 11 July 2017, 6pm	CR6
Wednesday 6 September 2017, 6pm	CR5
Thursday 14 September 2017, 6pm	CR6
Wednesday 11 October 2017, 6pm	CR6
Tuesday 14 November 2017, 6pm	CR5
Thursday 11 January 2018, 6pm	CR6
Tuesday 13 February 2018, 6pm	CR6
Wednesday 14 March 2018, 6pm	CR6

2. It has previously been agreed by Members that consideration will be given to revising the start time of each meeting on an ad hoc basis should the need arise. Further details of the issues to be discussed at each meeting can be found at Appendix A

3. At the meeting on 13 February 2018, the Committee will be receiving its bi-annual update on crime and disorder in the Borough. Members are asked to suggest possible crime and disorder related topics for consideration at this meeting.

BACKGROUND DOCUMENTS

None.

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APPENDIX A

EXTERNAL SERVICES SCRUTINY COMMITTEE

2017/2018 WORK PROGRAMME

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

Shading indicates completed meetings

Meeting Date	Agenda Item
14 June 2017 ***Report Deadline**:* *3pm Friday 2 June 2017*	**Update on the implementation of recommendations from previous scrutiny reviews:** • Alcohol Related Admissions Amongst Under 18s **Major Review (2017/2018):** Consideration of scoping report.
11 July 2017 ***Report Deadline**:* *3pm Friday 30 June 2017*	**Health** Performance updates and updates on significant issues: 1. The Hillingdon Hospitals NHS Foundation Trust 2. Royal Brompton & Harefield NHS Foundation Trust 3. Central & North West London NHS Foundation Trust 4. The London Ambulance Service NHS Trust 5. Public Health 6. Hillingdon Clinical Commissioning Group 7. Healthwatch Hillingdon **NHS England Consultation on the Future of Congenital Heart Disease Services** **CQC Consultation Response**
6 September 2017 ***Report Deadline**:* *3pm Friday 25 August 2017*	**NHS England - Proposals to Implement Standards for Congenital Heart Disease (CHD) Services for Children and Adults in England** To provide Members with an opportunity to speak to representatives from NHS England about the proposals for children's congenital heart disease services in England.
14 September 2017 ***Report Deadline**:* *3pm Monday 4 September 2017*	**Crime & Disorder** MOPAC - Public Access and Engagement Strategy: To review the consultation document and provide comment. LAC offenders: To scrutinise the issue of crime and disorder in the Borough: 1. Community Safety 2. Youth Offending Service 3. Corporate Parenting 4. Public Health

Meeting Date	Agenda Item
	How many LAC offend as a result of substance misuse? What proportion of young offenders are LAC? What proportion of LAC offenders go on to reoffend?
11 October 2017 ***Report Deadline**:* *3pm Friday 29 September 2017*	**Update from Utility Companies on Plans to Accommodate Increasing Demand on Services** To receive an update on plans to accommodate the increasing demand on services that has resulted from increased housing development in the Borough. **2017/2019 Better Care Fund Plan** To receive an update on the Better Care Fund (BCF).
14 November 2017 ***Report Deadline**:* *3pm Thursday 2 November 2017*	**Health** Performance updates and updates on significant issues: 1. The Hillingdon Hospitals NHS Foundation Trust 2. Royal Brompton & Harefield NHS Foundation Trust 3. Central & North West London NHS Foundation Trust 4. The London Ambulance Service NHS Trust 5. Public Health 6. Hillingdon Clinical Commissioning Group 7. Healthwatch Hillingdon
11 January 2018 ***Report Deadline**:* *3pm Tuesday 2 January 2018*	**GP Service Provision in Heathrow Villages** To scrutinise the issue of GP service provision in Heathrow Villages: 1. Hillingdon Clinical Commissioning Group (CCG) 2. Public Health 3. Hillingdon Local Medical Committee 4. Healthwatch Hillingdon 5. Service Users
13 February 2018 ***Report Deadline**:* *3pm Thursday 1 February 2017*	**Crime & Disorder** To scrutinise the issue of crime and disorder in the Borough: 1. London Borough of Hillingdon 2. Metropolitan Police Service (MPS) 3. Safer Neighbourhoods Team (SNT) **4. London Fire Brigade** 5. London Probation Area 6. British Transport Police 7. Hillingdon Clinical Commissioning Group (CCG) 8. Public Health **Major Review (2017/2018) - Community Sentencing:** Consideration of final report from the Community Sentencing Working Group

Meeting Date	Agenda Item
14 March 2018 ***Report Deadline**:* *3pm Thursday 1 March 2018*	**Health** Performance updates and updates on significant issues: 1. The Hillingdon Hospitals NHS Foundation Trust 2. Royal Brompton & Harefield NHS Foundation Trust 3. Central & North West London NHS Foundation Trust 4. The London Ambulance Service NHS Trust 5. Public Health 6. Hillingdon Clinical Commissioning Group 7. Healthwatch Hillingdon
Possible future single meeting or major review topics and update reports	
• Telecommunications - plans in place by BT regarding advancements made in mobile technology • Mental health discharge • Update on the implementation of recommendations from previous scrutiny reviews: Hospital Discharges (SSH&PH POC)	

PROPOSED MAJOR SCRUTINY REVIEW (WORKING GROUP)

Members of the Working Group:

- Councillors Edwards (Chairman), Allen, Dann, Higgins, Khatra and Palmer

Topic: Community Sentencing

Meeting	Action	Purpose / Outcome
ESSC: 14 June 2017	Agree Scoping Report	Information and analysis
Working Group: **1st Meeting -** 5pm 28 June 2017	Introductory Report / Witness Session 1	Evidence and enquiry: • National Probation Service ○ How does the management split work in practice?

Working Group:
2nd Meeting -
CANCELLED
5pm 20 July 2017
	Witness Session 2 (Management)	Evidence and enquiry:
		• Magistrates
		  ○ How many community sentences given? For what duration?
		  ○ How many repeat offenders?
		  ○ Magistrates' expectations of community sentences?
		  ○ Standards expected from offenders (e.g., behaviour, attendance)?
		  ○ Do Magistrates think community sentencing works well? How could it be improved?

Working Group: **3rd Meeting -** **CANCELLED** 5pm 1 August 2017	Witness Session 3 (Operational)	Evidence and enquiry: • Community Rehabilitation Company ○ What community sentence work is done in LBH and how often? • Community Safety Team
Working Group: **4th Meeting -** 5pm 21 September 2017	Witness Session 2	Evidence and enquiry: • National Probation Service • West London Local Justice Area • Community Safety Team
Working Group: **5th Meeting -** 5pm 29 January 2018	Consider Draft Final Report	Proposals – agree recommendations and final draft report
ESSC: 13 February 2018	Consider Draft Final Report	Agree recommendations and final draft report
Cabinet: 15 March 2018 *(Agenda published 8 March 2018)*	Consider Final Report	Agree recommendations and final report

Additional stakeholder events, one-to-one meetings and site visits can also be set up to gather further evidence.