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# External Services Select Committee

**Date:** **TUESDAY, 20 JULY 2021**

**Time:** **6.30 PM**

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

**Meeting Details:** Members of the Public and Media are welcome to attend. This meeting will also be broadcast live.

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**Councillors on the Committee**

Councillor Nick Denys (Chairman)
Councillor Devi Radia (Vice-Chairman)
Councillor Simon Arnold
Councillor Darran Davies
Councillor Heena Makwana
Councillor Peter Money (Opposition Lead)
Councillor June Nelson

**Published:** Monday, 12 July 2021

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**Putting our residents first**

**Lloyd White**
**Head of Democratic Services**
London Borough of Hillingdon,
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## External Services Select Committee

This Committee has an external mandate and reviews the performance and accountability of local service providers other than the Council. It also has statutory responsibilities to scrutinise the local health sector and community safety partnership.

### Membership

7 Councillors appointed on a proportional basis.

### Terms of Reference

1. To undertake the powers of health scrutiny conferred by the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

2. To work closely with the Health & Wellbeing Board & Local HealthWatch in respect of reviewing and scrutinising local health priorities and inequalities.

3. To respond to any relevant NHS consultations.

4. To scrutinise and review the work of local public bodies and utility companies whose actions affect residents of the Borough.

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

6. 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.

The External Services Select Committee may establish, appoint members and agree the Chairman of a Task and Finish Select Panel to carry out matters within its terms of reference, but only one Select Panel may be in operation at any one time. The Committee will also agree the timescale for undertaking the review. The Panel will report any findings to the External Services Select Committee, who will refer to Cabinet as appropriate.

# 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


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|---|---|---|
| **4** | Minutes of the previous meeting - 16 June 2021 | 1 - 8 |
| **5** | Children's Dental Services | 9 - 18 |
| **6** | Developments in Adult Phlebotomy Provision in Hillingdon | 19 - 46 |
| **7** | Work Programme | 47 - 52 |


## PART II - PRIVATE, MEMBERS ONLY

*That the reports in Part 2 of this agenda be declared not for publication because they involve the disclosure of information in accordance with Section 100(A) and Part 1 of Schedule 12 (A) to the Local Government Act 1972 (as amended), in that they contain exempt information and that the public interest in withholding the information outweighs the public interest in disclosing it.*

**8** Any Business transferred from Part I

# Minutes

**EXTERNAL SERVICES SELECT COMMITTEE**

**16 June 2021**

**Meeting held at Committee Room 6 - Civic Centre, High Street, Uxbridge**

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|---|---|
| | **Committee Members Present**:<br>Councillors Nick Denys (Chairman), Nicola Brightman (In place of Simon Arnold), Darran Davies, Heena Makwana, Peter Money (Opposition Lead) and June Nelson<br><br>**Also Present**:<br>Dr Lalit Patel, Chair of Hillingdon Local Dental Committee, Hillingdon Local Dental Committee (LDC)<br>Dr Andrew Read, Clinical Director Dental Services / Deputy Chair - Managed Clinical Network for Paediatric Dentistry in NWL, Whittington Health NHS Trust<br><br>**LBH Officers Present**:<br>Shikha Sharma (Consultant in Public Health) and Nikki O'Halloran (Democratic Services Manager) |
| 3. | **APOLOGIES FOR ABSENCE AND TO REPORT THE PRESENCE OF ANY SUBSTITUTE MEMBERS** *(Agenda Item 1)*<br><br>Apologies for absence had been received from Councillor Simon Arnold (Councillor Nicola Brightman was present as his substitute) and Councillor Devi Radia. |
| 4. | **DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING** *(Agenda Item 2)*<br><br>There were no declarations of interest in items coming before this meeting. |
| 5. | **EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 3)*<br><br>**RESOLVED: That all items of business be considered in public.** |
| 6. | **MINUTES OF THE MEETING ON 28 APRIL 2021** *(Agenda Item 4)*<br><br>**RESOLVED: That the minutes of the meeting held on 28 April 2021 be agreed as a correct record.** |
| 7. | **MINUTES OF THE MEETING ON 29 APRIL 2021** *(Agenda Item 5)*<br><br>**RESOLVED: That the minutes of the meeting held on 29 April 2021 be agreed as a correct record.** |
| 8. | **MINUTES OF THE MEETING ON 20 MAY 2021** *(Agenda Item 6)*<br><br>**RESOLVED: That the minutes of the meeting held on 20 May 2021 be agreed as a correct record.** |

9. **CHILDREN'S DENTAL SERVICES** *(Agenda Item 7)*

The Chairman welcomed those present to the meeting. He advised that, under normal circumstances, there would have been a large number of witnesses attending the meeting. However, with the ongoing pandemic and the legal requirement that Council meetings were now held in person, this had reduced the number of witnesses in attendance. It was suggested that the Chairman and the Labour Lead meet with those organisations that were unable to attend in person to ask questions and gather information outside of formal Committee meetings which could then be reported back to the other Committee Members and used to inform the final report.

The issue of children's dental services had first been considered by the Committee in 2019 and had prompted the creation of a Select Panel to undertake a more in-depth review. The pandemic had halted the review after only one evidence gathering session. Rather than reinstating the Select Panel to complete the review, Members had hoped to scrutinise the subject in one Committee meeting with additional information gathered in informal meetings outside of the formal meetings.

Some key lines of enquiry had been included in the report. Members were advised that there was no requirement for them to use the questions in the report but that they might give them some ideas on scrutinising the issue.

Dr Andrew Read, Clinical Director of Dental Services at Whittington Health NHS Trust and Deputy Chair of the Paediatric Dental Network (PDN) in North West London (NWL), joined the meeting via Microsoft Teams. Dr Read advised that the Trust provided specialist community dental services in Hillingdon as well as promotional programmes.

The PDN comprised clinicians from the NHS with a focus on paediatric dentistry. Work had been channelled towards addressing the huge backlog of children that had needed dental treatment under general anaesthetic (GA) by trying to increase capacity. A network of dental practices was also being developed to help improve skills.

It was suggested that there needed to be a greater focus on supporting upstream public health programmes as the driver for GA activity was tooth decay in children. Although the level of tooth decay in children aged 3 and 5 in Hillingdon was one of the worst in London, it was not the worst in NWL. There was no easy explanation for why levels of tooth decay were higher in NWL than elsewhere as it was a complex matter and drivers were not always easy to tease out.

In terms of addressing levels of tooth decay in the Borough were concerned, it was suggested that strategies were needed to improve access to services but also to reduce the need for services. A number of schemes had taken place to promote oral health in children and young people which had included: supervised brushing in schools; the distribution of toothbrush and toothpaste packs; and train the trainer sessions. Unfortunately, the level and type of oral health promotional activity in Hillingdon was likely to fall short of that required to address the high level of tooth decay in the Borough. What was required was more targeted programmes, such as fluoride varnish and toothbrushing programmes, which had evidence to show reduction in decay levels.

Concern was expressed that access to dental services had been negatively impacted by the pandemic with residents finding it difficult to schedule an appointment or to register with an NHS dentist. In addition, dental related hospital admissions had been

highest for those aged 5-9.

Ms Shikha Sharma, Consultant in Public Health at the Council, advised that NWL had an issue with poor dental health amongst children which was significantly worse that the England and London averages. It was suggested that the issue might be worse in NWL because of deprivation and population transience but that the reason would be multifaceted.

With approximately 4,000 births each year, action needed to be taken to develop a sustainable programme of prevention for the long term rather than ad hoc initiatives. It was agreed that access to dental services also needed to be improved which might be as a result of parental lack of awareness or parents being refused access. It was noted that, since 2006, residents had not needed to be registered with a dentist to receive treatment from them.

Ms Sharma noted that campaigns to raise awareness of the need for good oral health and to provide signposting had taken place in the Pavilions shopping centre in Uxbridge before the pandemic. Action had also been taken to ensure that new dental practices were commissioned by NHS England / Improvement (NHSE/I) in Harefield and Yiewsley following the closure of the previous practices. Promotional activity had also been taken with regard to weaning and healthy eating and staff and parents in early years settings had improved their understanding about the impact of things like sugary foods.

A project had been undertaken working with dentists and schools to apply fluoride varnish in areas where issues of poor dental health amongst children had been identified. It was noted that dental decay had been strongly linked to deprivation so these areas needed to be consistently targeted.

It was thought important that maternity services raise awareness amongst expectant and new mothers that they were able to receive free NHS dental care until the baby was one year old and that the child would also receive free dental care. These contacts could also be used as an opportunity to provide the mothers with information about how and when to brush their babies' teeth/gums.

Other action that had been taken included targeting particular communities about the need for a healthy diet to maintain oral health and improvements to the food offered at schools. A Children & Young People's Dental Health steering group had been set up in Hillingdon to target specific areas so that the different organisations involved could collectively look at improving children's oral health in that area. This group included representation from NWL Clinical Commissioning Group, Whittington, London Borough of Hillingdon, Local Dental Committee and GPs. The Democratic Services Manager would contact the Children & Young People's Dental Health steering group to see if Councillors Denys and Money would be permitted to attend the meeting at 11am on Thursday 17 June 2021 as observers.

Dr Lalit Patel, Chairman of the Hillingdon Local Dental Committee (LDC), advised that the London Confederation was made up of 19 LDCs. In 2006, dental practices had been issued with new contracts by NHSE/I which gave a figure for a practice in return for a specified number of UDAs (Units of Dental Activity). The number of UDAs each practice was awarded varied and the value of each UDA varied for each practice but the number of UDAs needed for a particular procedure was the same for every practice. Practices had not been given any guidance or direction on how many of their UDAs should be used on adults or how many on children. If, at the end of the year, a

practice had not used all of its UDAs, these (and the associated funding) would be clawed back by NHSE/I from the practice and put back into general funds. This clawed back funding would not be ringfenced for reinvestment into dental services.

In 2019, Hillingdon had a population of around 309,000. The NHSE/I spend on dental services had been around £391m in London and Hillingdon had been 22nd in terms of the amount of funding it had received. The Borough had 33 dental practices with an NHS contract and 103 dentists. However, given the current contract arrangements, there was no opportunity for practices to expand or develop insofar as NHS patients were concerned.

It was noted that the current NHS contracts were coming to an end and were due for negotiation and reform in April 2022. Dr Patel suggested that the new contracts should specify the proportions of UDAs that should be used by a practice on each age cohort.

Dr Patel stated that water fluoridisation would help reduce dental decay significantly. Dr Read noted that a reorganisation of the NHS had been set out in a White Paper which would also make it easier to fluoridate the water. Although this would reduce inequalities, there were significant challenges associated with fluoridating the water supply to 32 London boroughs. As this was not possible, the next best thing would be fluoride varnishing. Whittington had undertaken a programme of fluoride varnishing in schools elsewhere in London some time ago and, 10 years later, the level of dental caries had reduced significantly. During the programme, the parents of those children who were found to have decay were being advised to take them to the dentist. Although effective, this was the most expensive type of intervention. Dr Read would provide the Democratic Services Manager with information about this programme and the long-term impact.

Dr Patel acknowledged that access to dentists during the pandemic had been more difficult. In his own practice, Dr Patel advised that there were around 250 people on a list waiting to join the practice but that the priority was to see existing patients first. Dr Read advised that the pandemic had impacted on dental practice capacity but that recovery action was underway to address the backlog.

Concern was expressed that access to NHS dental services appeared to be limited and Members queried how this was freed up. Dr Patel advised that, once registered, a patient would stay with that dental practice and would not be removed until they left. Often, if a patient did not attend for a number of years, when they did eventually attend, they required a lot of treatment and used a lot of UDAs. As a practice would be limited on the number of UDAs that they were allocated in their contract, this meant that they would be unable to take on additional dentists unless it was for private practice.

With a large number of dental practices in the Borough not taking on new NHS patients, Members queried what effect this would have on children's oral health. Concern was expressed that no organisation appeared to have responsibility of picking up those children that had been left without a routine NHS dental service available to them.

It was recognised that dental practices were under pressure. They had had to close towards the end of March 2020 and did not reopen until June 2020. Once reopened, the practices had had to build in fallow time between patients if an aerated procedure had been undertaken which had reduced the number of patients that could be seen each day. As such, practices had been focussing on clearing the backlog of demand from their existing patients before they would be able to take on new patients. It was

noted that Healthwatch Hillingdon had produced a report on dental services which had highlighted this issue.

In Hillingdon, four urgent care centres had been created which could be accessed by calling NHS 111. However, these centres were for those residents that were in urgent need of dental treatment rather than routine dental care. Dr Read advised that the Secretary of State for Health was responsible for securing access to dental treatment for residents.

In addition to dental treatment, dentists provided patients with advice and guidance on things like when to start brushing your child's teeth/gums and when to bring them into the surgery for a check-up. Concern was expressed that there would be parents who were not registered with a dentist that would therefore not be getting this advice and guidance. Dr Read advised that the highest need would be those families who accessed dental services the least. Every now and then a campaign was run to improve access but this always seemed to fail. Ideally preventative action was needed so that children had better oral health.

It was noted that there were a number of factors which indicated that a child might be more susceptible to dental ill health. These included: the child not being registered with a dentist; the parents not being registered with a dentist or not attending if they were registered; child being bottle fed; and living in a deprived area. Dr Patel advised that bottle feeding had been the biggest cause of dental decay and that the promotion of breast feeding helped to reduce this. Members queried whether these high-risk factors were mapped across the Borough so that areas for intervention could be targeted.

Ms Sharma advised that a needs assessment had been undertaken some time ago and that work had been undertaken with maternity services and health visitors to identify families who needed additional support with regard to oral health. There was an opportunity to look at how the mapping of high risk factors could be built in. Although partners had an idea of where the target population was located, it would be important to listen to these families' fears and address their barriers to access. Further community involvement work would be needed to identify and overcome these barriers.

It was suggested that health visitors got to know parents and would be able to identify those that had not registered with a dentist and those whose children were bottle fed. Action could then be taken to get fluoride varnishing for these children. In addition, consideration needed to be given to including information about dental health in the Personal Child Health Record (red book). In the past, dental packs had been given to new mothers being discharged from the maternity ward. This initiative had enabled reinforcement of the message that new mothers were eligible for free dental work until baby's first birthday as well as pressing the need to maintain babies' oral health from an early age and get them registered at a dentist.

Ms Sharma advised that, between March 2020 and March 2021, 3,180 brushing packs had been distributed in schools around Hillingdon. 600 packs had also been supplied to three special educational needs (SEN) schools who had engaged during lockdown. Although annual dental screening was still undertaken in SEN schools, there was no further information available about whether or not a child subsequently sought further treatment from a dental practice. Action was needed to ensure that this work was intelligence led so that resources were being directed to the children that were most in need.

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| | Providing new and expectant mothers with information about maintaining babies' oral health was thought to be key. It was suggested that information could be disseminated through antenatal classes (as pregnant women wanted what was best for their child) or through platforms such as Facebook, Mumsnet, etc. A lot of activity had been undertaken on this by the Children & Young People's Dental Health steering group with things like drawing competitions, Guinness world record attempt, campaigns and activities.<br><br>Concern was expressed that dental health did not appear to be seen as a priority and had seemingly been forgotten. Although thought did not have to be given to accessing primary medical care, consideration did need to be given to accessing good quality paediatric dental care. The nature of the current contracts held by dental practices meant that children's dental care was not seen as a priority. With good networks already in place for physical and mental health, it was suggested that dental health be included as part of this existing system rather than working in isolation.<br><br>Members were advised that data was available on the percentage of pregnant women who accessed NHS dental services during pregnancy. However, NHSE figures were not routinely available to the Council so the maternity treatment update figures would need to be requested.<br><br>It was agreed that further information would need to be sought from maternity services and Healthwatch Hillingdon. Dr Read, Dr Patel and Ms Sharma all stated that they would be happy to provide further information if needed.<br><br>**RESOLVED: That:**<br>**1. Democratic Services Manager establish whether Councillors Denys and Money would be permitted to attend the Children and Young People's Dental Health steering group meeting at 11am on Thursday 17 June 2021 as observers;**<br>**2. Dr Read provide the Democratic Services Manager with information about the fluoride varnishing programme undertaken elsewhere in London the long-term impact of this intervention; and**<br>**3. the discussion be noted.** |
| 10. | **WORK PROGRAMME** *(Agenda Item 8)*<br><br>Consideration was given to the Committee's Work Programme. It was agreed that, given the depth of the subject, the Committee's next meeting on 20 July 2021 would again focus on children's dental services and the scrutiny of digital connectivity would be moved to a future meeting.<br><br>Members confirmed that they were happy for the Committee's draft response to the Central and North West London NHS Foundation Trust quality report for 2020/2021 be submitted. It was noted that The Hillingdon Hospitals NHS Foundation Trust quality report would not be received until Monday 21 June 2021 at the earliest. Once received, it would be circulated to Members of the Committee, and a response would be drafted which would have to be submitted by Tuesday 29 June 2021.<br><br>Although all Members on the Committee were encouraged to question all of the health partners that attended meetings, it was agreed that, as health was so vast, there was value in specific Members building up a knowledge and expertise of a particular organisation. As such it was agreed that the lead Member for each health partner would be as follows: |

1. London Ambulance Service NHS Trust (LAS) – Councillor Darran Davies
2. The Hillingdon Hospitals NHS Foundation Trust (THH) – Councillor Simon Arnold and Councillor Peter Money
3. Central and North West London NHS Foundation Trust (CNWL) - Councillor Nick Denys
4. Royal Brompton and Harefield NHS Foundation Trust (RBH) – Councillor June Nelson
5. Clinical Commissioning Group (CCG) – Councillor Devi Radia
6. Hillingdon Health and Care Partners (HHCP) – Councillor Heena Makwana

The Chairman suggested that new Members to the Committee might like to watch the YouTube broadcast of the Committee's meeting on 28 April 2021 where an update had been provided on the Hillingdon Hospital redevelopment. A public virtual consultation would be launched on Tuesday 22 June 2021 and it was suggested that all Members on the Committee might like to take a look.

**RESOLVED: That the Work Programme, as amended, be agreed.**

The meeting, which commenced at 6.30 pm, closed at 8.05 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.

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# EXTERNAL SERVICES SELECT COMMITTEE – CHILDREN'S DENTAL SERVICES

| | |
|---|---|
| **Committee name** | External Services Select Committee |
| **Officer reporting** | Nikki O'Halloran, Corporate Services and Transformation |
| **Papers with report** | None |
| **Ward** | n/a |

**HEADLINES**

Members are to scrutinise action taken in Hillingdon by external partners to address health inequalities in relation to dental health.

**RECOMMENDATION:**

**That the External Services Select Committee notes the content of the report and seeks clarification about matters of concern in the Borough.**

**SUPPLEMENTARY INFORMATION**

On 21 May 2015, the Council's Social Services, Housing and Public Health Policy Overview Committee presented a report to Cabinet on children's oral health. During this single meeting review, Members considered information from witnesses about the work that was being undertaken in child oral health in the Borough; noting the preventative measures being taken such as the Early Years Programme and Brushing for Life campaign. Action has yet to be taken in respect of some of the recommendations. However, further to the review, progress has been made with the addition of two new general dental practices in Harefield (which previously didn't have an NHS dentist) and Yiewsley and the launch of a fluoride varnishing programme.

**National trends and focus**

In the UK, oral health is steadily improving for both adults and children. The proportion of adults with no natural teeth is at an all-time low, while the proportion of those with 21 teeth or more has been consistently rising. However, there are concerning levels of variation between different parts of the country and socioeconomic groups. On the whole, dental health is better in the south and east of England, and poorer in the north of England.

Poor oral health has been linked to a number of general health issues including lung disease and poor diabetic control, there is also an association between chronic gum disease and cardio-vascular disease. The cost to the NHS of treating oral health conditions is around £3.4 billion per year. Dental decay (also known as caries) and gum disease are the most common oral conditions, and are largely preventable through the maintenance of good oral health practices.

Good oral health is fundamental in facilitating good general health and wellbeing. In recent years, there has been a focus on adopting preventative strategies to combat major public health concerns facing the UK. There are large scale public health campaigns addressing widespread

concerns such as obesity and type-II diabetes. However, more needs to be done to ensure that the focus on prevention in dental health is joined up with wider efforts to prevent ill health.

**Impact of COVID-19 on NHS dental services:**

In addition to the ongoing issues, COVID-19 pandemic has further complicated access to dental services which have been severely limited. A report by the General Dental Council (GDC) acknowledges that the time needed to recover from this situation will be significant, where uncertainty continues about what services are available to the public and patients, and where some sections of the population are either unwilling or unable to access oral health care services. In the meantime, the needs are increasing and a Healthwatch report highlights confusion owing to lack of information. It is therefore important to establish:

a) what routine NHS and emergency dental care services are currently available?
b) how are residents being informed about the level of provision?
c) what is being done to 'catch up' with pending treatments which have been 'on hold' over the lockdowns?
d) what is being done to prevent / reduce potential inequalities?

**Regional concerns and health inequalities**

There are concerning levels of variation between different parts of the country and socioeconomic groups. The quality of dental health is better in the south and east of England, and poorer in the north of England. However, in 2019, those in London were the least likely to see an NHS dentist, with just 44% having had a check-up in the previous 24 months. Nationwide, the number of adults accessing NHS dental services had fallen to a 10-year low with just 50.2% of adults reporting to have seen a dentist within the previous two years. Attendance of NHS dentistry services has become of growing concern and links have been drawn between the prevalence of gum disease and individuals who do not visit the dentist regularly.

The most prominent reason cited for the lack of people accessing dental services is the increasing cost, more than a third of survey respondents (36%) admitted to sacrificing dental visits in order to keep their bank balance in check. Cost is not the only reason behind not attending a dentist. Anxiety (22%), the fear of getting bad news (18%) and work commitments (8%), are all reasons why people stay away. Since 2010, net Government expenditure in England on dental services has dropped by £550 million in real terms; over the same period, the cost of NHS dentistry services has increased by more than 30%.

NHS dental treatment is free for:

- anyone under 18 years old;
- adults under 19 years old, in qualifying full-time education;
- pregnant women, or women who have had a baby in the previous 12 months;
- being treated in an NHS hospital and your treatment is carried out by the hospital dentist; and
- those receiving low-income benefits, or if they are under 20 years old and a dependant of someone receiving low-income benefits.

There is a need to emphasise the availability of free NHS dental treatment, specifically for those receiving low-income benefits, as access to these services remains low for this demographic. During the current situation, it is even more important to promote NHS dental services and increase availability, especially among population groups and communities which are traditionally

known to not access these services.

Lifestyle choices impact on a person's oral health - for example, tobacco use and drinking alcohol above the recommended levels are risk factors for oral cancer. The combined effect of drinking alcohol and using tobacco multiplies the risk of developing mouth cancer. Other factors, often associated with socio-economic circumstances, such as poor diet, contribute to health inequalities and a divide in the quality of oral health from the most deprived to the least deprived areas.

**Hillingdon**

There are a number of dental health concerns within the Borough. However, one had been prioritised as forming part of Hillingdon's Health and Wellbeing Strategy for 2018-21. Namely, that young children in Hillingdon have levels of dental decay that are higher than the average for England. The level of dental decay in Hillingdon for 0-5 year olds is 32.5% compared to the average for England (23.3%) and London (25.7%). This paints a picture of a localised issue in West/North-West London as Harrow also experienced a high proportion of child dental decay at 34.2%. The prevalence of decay was attributed to long term bottle use, this suggests that action to discourage long term bottle use and sugary drinks consumption will be needed if oral health levels are to be improved.

A 2010 Oral Health Needs Assessment, conducted by NHS Hillingdon, found that in Hayes and Harlington there was a particularly high unmet need in both referral for specialist services and community dental services.

**'The Sugar Tax' - Practical implications on dental health**

The Government's Soft Drinks Industry Levy (SDIL), more commonly known as the sugar tax, was introduced in April 2018 as part of the childhood obesity strategy; the measure introduced levies of 24p per litre for drinks containing >8g of sugar per 100ml and 18p per litre for drinks containing 5-8g of sugar per 100ml. Its aim was to reduce sugar consumption, a leading cause of dental caries[1], by persuading companies to reformulate their high sugar brands and avoid paying the levy.

In the two years preceding the introduction of the tax, many soft drinks manufacturers reduced the sugar content of their beverages in preparation for the levy; because of this, HMRC reduced their revenue forecast from the levy to £275m from an initial £520m during the first year of operation. Total SDIL receipts for the financial year 2019/2020 were £336 million and for the financial year 2018/2019 were £240 million[2].

The revenue generated from the SDIL was to be earmarked to help fund physical education activities in primary schools, the Healthy Pupils Capital Fund and provide a funding boost for breakfast clubs in over 1,700 schools. However, as the primary objective of the levy was to tackle childhood obesity rates, there were calls from the Global Child Dental Fund for 20% of the proceeds to be reinvested into innovative oral health prevention strategies.

Research on the practical implications of the UK's SDIL on dental health is in its early stages;

[1]Sugars and Dental Caries: Evidence for Setting a Recommended Threshold for Intake., Advances in Nutrition. 2016 Jan; 7(1): 149–156. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4717883/

[2] Soft Drinks Industry Levy Statistics Commentary 2020: https://www.gov.uk/government/statistics/soft-drinks-industry-levy-statistics/soft-drinks-industry-levy-statistics-commentary-2020#soft-drinks-industry-levy-receipts

however, a 2019 Dutch-German study found that a 20% taxation on sugary beverages would result in a €159m saving in terms of dental care expenditures[3]; concluding that an intervention of this kind could substantially improve oral health and reduce the caries-related economic burden.

There are frequent calls for the sugar tax to go further and cover other confectionary products. Although soft drinks account for 10% of a child's sugar intake, confectionaries such as sweets, ice cream and puddings make up more than a fifth of their sugar intake. The early successes of the SDIL in changing the behaviours of soft drinks manufacturers has fuelled calls for a more extensive sugar tax, particularly to help address wider health problems (29% of UK adults classified as obese and nearly five million people living with type-II diabetes).

**Responsibilities**

Dentistry can be separated into two distinct strands: general dental services and community dental services. Both of these strands are commissioned by NHS England (NHSE) with the advice of Public Health England (PHE); locally, this feeds down to North West London CCG. Most dentistry within the Borough is provided by private practitioners paid to deliver frontline NHS services, most of whom also provide, on a commercial basis, services which the NHS does not provide, largely cosmetic. This differs from the way in which GP surgeries function.

The Hillingdon Health and Wellbeing Strategy for 2018-21 noted the formation of the North West London Sustainability and Transformation Partnership (NWL STP). The Health and Wellbeing Strategy also highlighted the 10 transformation themes and 5 overarching delivery areas which were key to improving health outcomes in North West London. Delivery area 1 pertains to 'Prevention and Wellbeing' with good children's dental health forming an integral part of it. This is to be facilitated by transformation theme 7, 'Integrated Care for Children & Young People', a key outcome of which being to increase the dental health of 0-4 year olds to the national average by 2021. Children's dental health formed part of the strategy in direct response to the high proportion of children in the Borough with dental decay. However, the Health and Wellbeing Strategy does not detail any key actions or outcomes for the dental health of adults.

**Select Panel Creation and Terms of Reference**

At its meeting on 18 December 2019, the External Services Select Committee agreed the Terms of Reference for a Select Panel to undertake a review of dental service provision for children and young people in the Borough and the effectiveness of preventative measures taken by partners in relation to caries and other oral health issues. The Select Panel's Terms of Reference for the review set out the objectives of the review:

1. To gain a thorough understanding of the current dental service provision offered to children and young people within the Borough and to consider possible areas for improvement;
2. To explore the current situation in relation to the dental health of children and young people in the Borough and to consider how this can be improved on;
3. To identify barriers to attendance – reasons for current low attendance rates and what can be done to address this issue;
4. To review current and future plans by health partners to prevent incidences of caries and to improve oral health;
5. To examine best practice elsewhere through case studies, policy ideas and witness sessions;

[3] *The caries-related cost and effects of a tax on sugar-sweetened beverages.,* Public Health. 2019 Apr; 169: 125–132. https://www.sciencedirect.com/science/article/abs/pii/S0033350619300344

6. To review the current policies, legislation, research and campaigning by Government to improve children's oral health and to explore best practice and advice that could be adopted by the NHS; and
7. After due consideration of the above, to bring forward recommendations to Cabinet for Council endorsement, before being sent to health partners to consider.

**Select Panel Witness Session – Information gathered**

The first meeting of the Select Panel took place on 12 February 2020, just before the Covid-19 pandemic put the country into lockdown. The aim of this meeting was to gain a more thorough understanding of current dental provision for children and young people and the challenges faced, with a focus on preventative action, possible solutions and access to services.

At this meeting, Panel Members observed that many other London boroughs were doing significantly better than Hillingdon in terms of children's oral health and commented that it would be useful to draw on their experience and establish what they were doing differently. It was noted that Bexley is a similar borough to Hillingdon, yet that borough appears to be achieving better results.

Community dental services had previously been the responsibility of Central and North West London NHS Foundation Trust (CNWL) but the contract was awarded to Whittington Health NHS Trust (WH) in April 2019. The transition to a new provider had meant that a new premises was required but building work had been needed to improve accessibility to the new which had impacted access to community dental services for a significant period of time. Work at the Uxbridge Community Dental Clinic in Redford Way had been completed with a new lift giving access to the first floor facilities.

In February 2020, there were 33 dental practices in Hillingdon and a total of 308,000 units of dental activity (UDAs) had been commissioned for Hillingdon. These units are utilised exclusively for NHS work and are a measure of work done during dental treatment but have no uniform financial value. The value of a unit will vary across practices and the figures used to generate UDA are not standardised across the board and are higher in areas where there are fewer NHS dentists. More complex dental treatments count for more UDAs than simpler ones, for example a filling would equate to approximately 3 units while more complex work might equate to up to 12 units. Units of dental activity are allocated per practice and there is no optimum number but circa 6,000 units per year is thought advisable. UDA contracts were awarded in 2006 based on historic activity so were very out-of-date and it is unclear whether NHSE is commissioning sufficient UDAs to meet the needs of Hillingdon residents.

All dentists are allocated a number of UDAs annually to use between 1 April and 31 March. Those dentists who have large contracts are often unable to meet their targets but any funds that they are unable to spend during the year would be clawed back by NHSE. This money would not be made available to other dentists in the area as the funds are not ring-fenced. In 2019, in London alone, £10m was clawed back and none of this money was re-invested in dental practices. As a result of this funding method, patients sometimes struggle to register with an NHS dentist.

Unit allocations vary across practices and, if a practice has no UDAs remaining, they would be unable to accept any new patients until the new allocation of UDAs was released. Dental practitioners therefore have to do private work to enable them to survive. Some practices have

negotiated exempt-only contracts whereby they are only obliged to treat children, those on benefits, etc.

NHSE had launched Starting Well 13 - A Smile4Life Initiative which was a programme of dental practice-based initiatives aimed to reduce oral health inequalities and improve oral health in children under the age of five years. The programme would focus mainly on those children who were not currently visiting a dentist and under one-year-olds. It would ensure that evidence-based preventive advice about reducing sugar intake and increasing the exposure to fluoride on teeth was given to parents. Practices had been invited to tender for this service (worth approximately £30,000 - £40,000 per annum) in addition to their allocation of UDAs. The initiative had already proved to be successful in the north of England.

A survey of 3 year olds carried out in 2012 showed that 16% of 3 year olds in Hillingdon (the highest in the country - compared with 3.9% in England) had incisor caries (decay of front teeth) which showed how dental decay started at a very early age and could be related to poor infant feeding practices. The 2012 data is quite old so a new survey of 3 year olds was undertaken and was underway back in February 2020. As such, it is anticipated that more up to date information should now be available.

The survey in 2012 showed that NWL was generally the worst affected area in London with the highest rates of dental caries. NWL also had the highest number of hospital extractions. As the data was based on a survey of 250-300 children per borough, further analysis to examine smaller areas, e.g., electoral wards or ethnic population, was not particularly reliable. In addition, there had been a campaign to encourage parents to register children with local dentists and, in 2015, a fluoride varnish project involving local dentists had taken place in local schools situated in areas of high need.

It is thought that the variation in children's dental decay could, in part, be attributed to the fact that, in some regions, fluoride is added to the water (and children's dental health is significantly better in those areas); this is not the case in London. Water fluoridation is not implemented everywhere due to strong opposition to it as a number of people believe fluoride to be poisonous and are concerned that the fluoridation of water could cause bones to become weaker. At present, 10% of the water in the UK is fluoridated.

Obesity and poor diet are other contributing factors to children’s dental decay and the situation is generally worse in the south of the Borough. Modification of lifestyle choices of newly arrived populations is also particularly challenging.

At the Select Panel meeting on 12 February 2020, a local dentist advised the that he had been working with a number of primary schools across the Borough for approximately 12 years to raise awareness of the importance of oral health. He regularly spoke at school assemblies and invited groups of under 5-year-olds to attend 1½ hour sessions at his dental practice during which their teeth would be checked, fluoride varnishing applied and advice given. It had become apparent that many of these children had never visited a dentist before which was very concerning. This dentist provided information to school nurses to cascade to the children and this approach seemed to work well and make a real difference.

In the past, maternity dental packs were routinely given to new mothers but this is no longer the case. Many parents lack awareness and understanding of the need to look after their children’s teeth from a very early age. Staff at children’s centres are expected to promote oral health, as

are school nurses and health visitors (every family receives a mandatory visit from a health visitor contracted by Children's Services). In reality, this does not always happen and there are currently no KPIs in relation to the work of school nurses and health visitors.

There was a drive to re-procure the 0-19 service and, in December 2019, Cabinet agreed a one-year extension to the contract, with a review of its specification and scope to reflect the need for oral health promotion. It had been proposed that KPIs be put in place to ensure that the service was delivered at the level required, particularly in the south of the Borough. It was anticipated that this contract would be re-tendered and awarded by the end of the 2020/2021 financial year 2021.

Health beliefs and communication difficulties can, at times, act as barriers to maintaining the oral health of children; it is likely that different work will be required in the south of the Borough. Another challenge is in relation to religious beliefs in that some patients of Islamic faith are reluctant to allow fluoride varnishing as they believe it was contrary to their religion. A statement advising that this was not the case has been released by the Sharia Council but, back in February 2020, had not been widely communicated. However, it is acknowledged that fluoride varnishing per se is not the answer - behaviours need to change too.

The reinstatement of free dental packs on discharge from maternity units, together with verbal advice, would be invaluable. The Select Panel also suggested that The Personal Child Health Record (also known as the PCHR or 'red book') that is given to parents/carers at a child's birth should include information about dental health. Members also felt there was a need to strengthen the role of health visitors and school nurses in relation to the oral health of children.

It appears that the NHS model focusses on commissioning services to treat the problem rather than to prevent it from occurring in the first place. The NHS plan highlighted the importance of prevention work and taking a population approach. It is not clear how dental services are embracing the application of these aspects.

It is thought that education is key and that there would be benefits in schools linking up with dental practices to promote the oral health message. A programme of supervised toothbrushing was in operation within Hillingdon before the pandemic and ten schools had signed up to it. Some schools had refused to do so, perhaps due to time constraints.

**Select Committee Witness Session – Reconvening the review**

The Select Committee reconvened the review and held a second witness session on 16 June 2021 which was attended by representatives from the Local Dental Committee, Hillingdon Public Health and Whittington Health NHS Trust / Managed Clinical Network for Paediatric Dentistry in NWL. Given the ongoing pandemic, representatives from some organisations had been unable to attend this meeting. As such, where appropriate, it was agreed that informal virtual meetings would be arranged for the Chairman and the Labour Lead with external organisations.

**BACKGROUND PAPERS**

21 May 2015: Social Services, Housing and Public Health Policy Overview Committee Report: Children's Oral Health

**POSSIBLE KEY LINES OF ENQUIRY**

1. Across all partners, what budget is available for children's dental care?
2. What are the limitations of the current contracts with dental practices? How could this be improved?
3. What improvements (if any) could be gained from the ability to commission dental services locally?
4. Is there a single source of information for residents to access in relation to all dental services?
5. How is information about dental services (access and availability) currently publicised?
6. How is dental health linked to physical health with regard to health planning in the Borough?
7. Which practices had had unspent UDAs at the end of the year (before COVID, and since) which was clawed back by NHSE? How much did this equate to in total and UDAs per person?
8. What is the impact of COVID on the a) availability b) uptake of routine NHS appointments?
9. What efforts are being made to make populations aware about dental services available to them?
10. Does the allocation of UDAs for a particular practice take account of the local health inequalities and level of dental caries in children?
11. What impact had the NHSE programme Starting Well 13 - A Smile4Life Initiative had? How many Hillingdon practices have participated in this initiative?
12. Following the 2012 survey of 3 year olds which showed that 16% of 3 year olds in Hillingdon had incisor caries, a new survey was underway in February 2020. What was the outcome of this survey with regard to Hillingdon?
13. What are the up-to-date figures in relation to dental caries and uptake of services in Hillingdon, London and England as a whole?
14. What has been achieved to date with regard to dental caries and children's dental health in Hillingdon?
15. What NHS dental services are available to 0-19 year olds in Hillingdon?
16. What recent oral health improvements have there been for children and adults in England (and, more specifically, Hillingdon if that information is available)?
17. What dental care services are commissioned for care homes in Hillingdon?
18. What domiciliary services are commissioned in England/Hillingdon?
19. What community dental services are commissioned by NHS England?
20. What community dental services are provided in Hillingdon? Have the access issues highlighted in the past been resolved?
21. What is the eligibility criteria for accessing community dental services?
22. Is there sufficient capacity in community dental services provision in Hillingdon?
23. What are the waiting times for an appointment?
24. What are the challenges faced by patients trying to join a practice list as an NHS patient?
25. What charges are made for patients that do not turn up for their appointments?
26. What range of dental treatment can patients get on the NHS?
27. Are older/elderly people entitled to free dental treatment?
28. What arrangements are in place for those people on low income with regard to receiving dental treatment?
29. What action has been taken by PHE to:
    a. provide dental public health and health improvement support for the London Borough of Hillingdon and NHS England, including collaborative commissioning of oral health improvement programmes.
    b. contribute to Hillingdon's Joint Strategic Needs Assessments (JSNA), strategy development, oral health needs assessment.
    c. address oral health inequalities in Hillingdon.

d. ensuring patient safety and governance systems.
e. inform and develop national oral health policies and clinical guidelines.
f. support Hillingdon in its role in relation to water fluoridation.

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# EXTERNAL SERVICES SELECT COMMITTEE – DEVELOPMENTS IN ADULT PHLEBOTOMY PROVISION IN HILLINGDON

| | |
|---|---|
| **Committee name** | External Services Select Committee |
| **Officer reporting** | Richard Ellis - NWL CCG Hillingdon Borough Director |
| **Papers with report** | Appendix 1 - Examples of patient feedback on Primary Care Phlebotomy Service<br>Appendix 2 - Hillingdon Adult Phlebotomy Equality Impact Assessment |
| **Ward** | n/a |

## HEADLINES

This paper is to brief Members of the Committee on developments in phlebotomy services provided over the period of the pandemic and into recovery. Phlebotomy services are now provided at locations across the Borough with positive feedback being heard from patients and staff alike.

## RECOMMENDATION

**That the External Services Select Committee notes the content of the report and seeks clarification about any matters of concern in the Borough.**

## SUPPORTING INFORMATION

### 1.0 Introduction and Background

#### 1.1 Covid-19 response by Hillingdon Hospitals (THH)

The outbreak of COVID-19 in 2020 has triggered reviews of many local services due to the need to reduce the risk to patients from unnecessary exposure to potential sources of COVID-19 infection, and to minimise cross-contamination through use of strict decontamination protocols. Consequently, a review of Hillingdon Hospitals' out-patient services identified that these requirements in the interests of patient safety impacted on the capacity of hospital services. For example, by lengthening appointment slots to allow for infection prevention and control (IPC) processes (and on the use of the physical estate) for instance, by the requirement to implement social distancing guidance, to have separate entry/exit points, and waiting rooms with sufficient space to help maintain separation and reduce risk.

As a result of this reduced capacity, the number of available appointments was severely restricted. In addition, capacity was further reduced by redeployment of clinical staff to more urgent clinical duties, and by absent staff who were shielding or ill.

#### 1.2 Consequences for Phlebotomy Services at THH

Phlebotomy services (i.e., taking samples of patients' blood for laboratory testing and analysis) in Hillingdon have traditionally been a hospital-based service, with 86% of bloods taken in hospital-

based clinics prior to Covid. Over 187,000 patient attendances were recorded annually (15,590 per month) at walk-in phlebotomy clinics at Hillingdon Hospital or Mount Vernon Hospital (MVH). A limited number of appointments were also available at 8 outreach clinics across the Borough, as well as a home visiting service (operated by CNWL).

These were habitually very busy clinics, with 12 patients being seen every hour in 5-minute slots. This regularly led to long waiting-times for patients; even at the start of clinic, at 7.30 am, there were often more than 30 people waiting to be seen, with waiting-times during the day sometimes reaching 2-3 hours.

The numbers of patients involved, the limited clinical and waiting space available, and the pressures on the service meant that responding effectively to the IPC expectations caused by Covid reduced walk-in capacity at THH by 61%, since hospital appointment slots needed to lengthen to 10-12 minutes, with only 5 or 6 patients bled an hour. The impact of staff absence due to shielding or illness also meant that THH was forced to close half of the 8 outreach clinics.

Initially the impact for patients of the reduction in capacity was minimal because referrals from GPs also reduced, since they were required to focus on Covid-19 and urgent or essential services only.

By August 2020, however, the lack of capacity and the growing backlog of patients who needed blood tests led to waiting-times lengthening and considerable patient queues. This itself caused IPC concerns as the hospital outpatients waiting area can only safely accommodate 40 socially-distanced patients (as opposed to 80 pre-Covid), and MVH has very limited waiting space. The outreach walk-in clinics also proved difficult to manage social distancing in a safe manner, due to the unpredictability of the numbers of patients arriving at any one time.

In September 2020, following the Care Quality Commission's visit to Hillingdon Hospital, Trust management took the decision to close the phlebotomy clinics on the main hospital outpatient site, on the basis of patient safety and the proper protection of all staff, patients and carers attending the service.

Hillingdon CCG, with local Primary Care Networks and general practices, therefore decided to work with stakeholders, including THH and CNWL, to devise appropriate alternative arrangements that would maintain this fundamental clinical service for the benefit of patients.

## 2.0 A Practice-Based Phlebotomy Model

### 2.1 Local alignment with national good practice

As noted above, phlebotomy in Hillingdon has traditionally been hospital-based, but this is unusual both inside and outside North West London. Across London, most CCGs have had for several years a Local Enhanced Service (LES) for phlebotomy services provided by GPs in their practices, offering patients a more local and convenient service. The crisis of Covid therefore offered the opportunity to explore the feasibility of a safer service and one more local to patients' homes and communities.

Close collaboration with practices, Primary Care Networks (PCNs), Hillingdon Health and Care Partners (HHCP), CNWL and THH staff have developed the new service in 3 main stages over the last 12 months.

### 2.2.1 Initial Covid response (August/September 2020)

With the planned lifting of Covid restrictions last summer, there was a requirement to introduce services to manage the backlog of demand for phlebotomy, while maintaining a safe service for patients and staff. Hillingdon CCG therefore developed an interim solution to support the hospital to bridge some of its capacity gap and offer services in a safe environment. The Hillingdon GP Confederation set up and staffed 3 Primary Care sites in GP Practices, as a rapid interim solution, with the opportunity to test the running of phlebotomy in a primary care setting.

### 2.2.2 Interim Response to THH Phlebotomy Clinic Closure (January 2021)

The initial intention was to run this primary care-based service, alongside THH and the walk-in clinics, as a transitional service pending the development of a local phlebotomy LES from April 2021. However, the second wave of Covid-19, and the consequent decision by THH to close its phlebotomy clinics at Hillingdon Hospital in January 2021, meant that the CCG had rapidly to bring forward the introduction of a more locally-based service.

With the support of GPs, the Confederation, HHCP, CNWL and THH, replacement services were developed, comprising:

- new clinics in 3 GP Practices;
- additional clinics at MVH and existing Community Health Centres; and
- extra clinics available at weekends.

### 2.2.3 Longer Term Recovery and Management of Backlog (April 2021 to date)

Between April and July 2021, a primary care-based service has been steadily rolled out across the Borough, predominantly in individual practices but with some joint services between neighbouring practices or at a shared hub. All patients in all 45 practices across Hillingdon now have access to local phlebotomy services, and no longer need to travel to THH or MVH unless for other clinical reasons.

It is likely that the existing MVH service will be transferred to practices once there is demonstrable and sustainable capacity to manage this service locally. This will have the added advantage of enabling the Trust to free up their phlebotomists to work on inpatient wards. However, this will be the subject of discussion with local practices, patients, MVH and THH staff.

Phlebotomy services continue on both hospital sites, not only for hospital ward and A & E clinical needs, but also for urgent same-day-result bleeds to support GPs with their clinical consultations, and for some specialist blood tests which require to be processed within a short time-period.

Contracting with the practices to provide this service will be done via a Locally Enhanced Service, likely to be offered from July 2021 by NWL CCG. The volumes of clinical samples will be monitored carefully throughout 2021/2022 to ensure that sufficient capacity is provided at a local level, with appropriate waiting times and of course in a safe clinical environment. Although exact comparison of clinical activity has its own challenges, we are confident that the number of appointments offered in general practice will be higher than those historically offered in THH, with demonstrably improved local access.

A number of benefits for patients have already been demonstrated, as set out in section 3. These will continue to be monitored during 2021/2022.

## 3. Benefits

### 3.1 Accessibility

Lord Carter's classic report into NHS Pathology Services concluded that: "priority should be given to ensuring that pathology services are made more responsive to users' requirements; and, in particular, that phlebotomy and sample collection services should be made more accessible and convenient."

Since 14 June 2021, all Hillingdon practices are now offering a phlebotomy service either in their own practice or through a hub in their local Primary Care Network. This has particularly improved access for patients in the South of the Borough by offering more convenient local access and thereby helping to reduce inequalities. We hope that, as the service becomes established, some practices will be looking to offer evening and weekend appointments.

Practices have already received feedback from their patients that they are delighted that they no longer have to travel to hospital for a blood test, with requirements for parking and associated stress. The unpredictable waiting-times had sometimes meant that patients were travelling across the Borough and needing to wait for up to 2 hours to have a blood sample taken in a 5 minute appointment. Examples of feedback are attached in Appendix 1.

### 3.2 Patient safety

Offering booked appointments at the patient's practice enables safe management of patient flows and effective social distancing. Local services are safer for patients who previously were required to travel on public transport across the Borough to the hospitals.

### 3.3 **Equality and Diversity**

There are no implications for groups with protected characteristics. An Equality Quality and Impact Assessment has been undertaken and is attached at Appendix 2.

### 3.4 **Paperless system**

A practice-based service ensures that the phlebotomist has access to the EMIS GP system and is able to see the test request in the system, just as the GP is able to access the test result later at their convenience. The previous system, with transactions between the GP practice and THH, required a pathology test request from the GP. If this was mislaid, this would often cause delay and occasionally require the patient to return to the hospital with a replacement form.

### 3.5 **Patient Experience**

Blood tests taken in the practice offer continuity of care for patients in familiar surroundings, with a known clinician. The opportunity to choose an appointment date and time has been shown to improve patient satisfaction.

### 3.6 **Carers Experience**

Convenient local access means that carers will no longer have to travel to hospital with the patient they care for.

### 3.7 **Clinical Effectiveness**

Improved capacity and availability of urgent appointments in practices supports timely availability of test results to support evidence-based clinical intervention and reduces the need for the patient having to travel to the hospital for an urgent bleed.

### 3.8 **Productivity and Innovation**

Local GP-based services link with the proposals in the THH Redevelopment Plans for more community-based care, where safe and clinically sustainable. This model helps to relieve the pressure on the secondary care phlebotomy service to focus hospital phlebotomy services on those for whom these are most appropriate, while freeing up resources to support inpatient wards.

Where practices manage their own phlebotomy services, this enables them to offer “one stop shop” services, and holistic Year of Care support, to patients with long term conditions.

### 3.9 **Staff Satisfaction**

Clinical staff within the practices report improved job-satisfaction through providing holistic care to their patients. A reduced level of complaints from patients (indeed, an improved patient experience and higher satisfaction levels) supports the ability of both professional and non-clinical staff to provide the quality of care they aspire to.

## 4. Disbenefits

It is acknowledged that some patients prefer the convenience of walk-in services. There is some evidence that these services reduce DNAs (since there are fewer booked appointments made). However, it is evident that booked appointments are far more effective at protecting patients (and staff) from Covid infection risk.

The LES service specification enables practices/PCNs to offer a walk-in service if they are able to manage it in a Covid safe way, should they feel this is best for their patient population.

## 5. Engagement

Due to the nature of our COVID-19 response and our requirement to expedite changes at pace to keep patients and staff safe, we have not been able to engage and consult with our local communities on these service changes in as much detail as we would normally have wished.

However, we believe that these actioned changes take into account the wider strategy outlined in the NHS Diagnostics Recovery and Renewal Plan (2020) that ‘community phlebotomy services should be improved, so that all patients can have blood samples taken close to their homes, at least six days a week, without needing to come to acute hospitals.’

Stakeholders have reviewed and assessed the most effective way to provide a more accessible service to Hillingdon patients while taking into consideration the strict infection prevention control measures that have to be adhered to as we continue to respond to the COVID-19 pandemic and the need to align services with the other 7 boroughs in NWL.

Patient feedback about the benefits and impacts of these service changes will be sought over July and August by:

- Reviews from patients who have used the phlebotomy service recently
- Practice Patient Participation Groups
- holding patient focus groups
- the general practice survey
- A patient experience questionnaire (paper and online versions) in conjunction with HealthWatch

A detailed engagement plan is being finalised. This feedback will be collated, reviewed and used for any necessary changes in the light of experience, and will support future development and continuous improvement of the service.

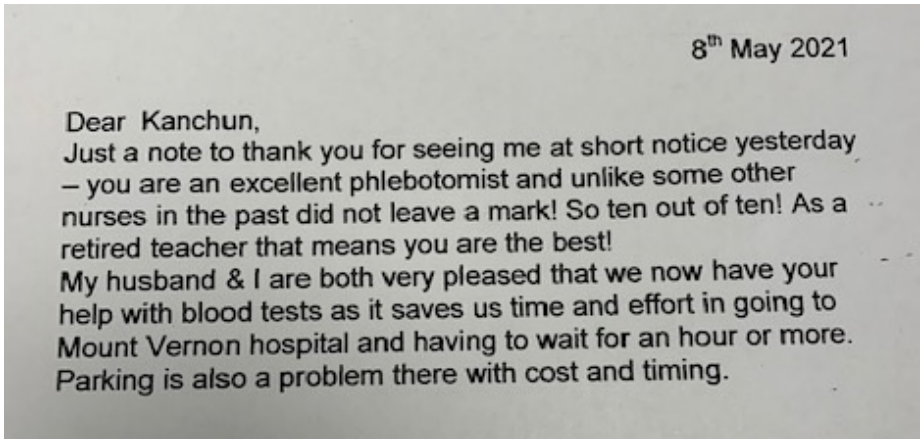
**BACKGROUND PAPERS**

The NHS Long Term Plan: https://www.longtermplan.nhs.uk/wpcontent/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

Report of the Review of NHS Pathology Services in England Chaired by Lord Carter of Coles Carter Report second Dec08.pdf (networks.nhs.uk)

NHS Diagnostics Recovery and Renewal Plan (2020)
BM2025Pu-item-5-diagnostics-recovery-and-renewal.pdf (england.nhs.uk)

**APPENDIX 1 – Examples of patient feedback on Primary Care Phlebotomy Service**



8th May 2021

Dear Kanchun,
Just a note to thank you for seeing me at short notice yesterday – you are an excellent phlebotomist and unlike some other nurses in the past did not leave a mark! So ten out of ten! As a retired teacher that means you are the best!
My husband & I are both very pleased that we now have your help with blood tests as it saves us time and effort in going to Mount Vernon hospital and having to wait for an hour or more. Parking is also a problem there with cost and timing.

Quote from Dr Selvi Dinakarababu Townfield Doctors Surgery Hayes.

*"my patients love the practice Phlebotomy service particularly the elderly patients. When I say to them they need a blood test they say oh no I don't want to have to go to the hospital to have my blood taken. Then when I tell them that we can take the bloods in the surgery they are extremely happy."*

From feedback questionnaires of The Confederation service run by St Martins (Ickenham), Kincora (Hayes) and Acorn (Uxbridge) Medical Centres:

| |
|---|
| • *Social distancing was properly maintained by the staff. The lady who took the samples was really good and she did her job really well while maintaining all the safety measures.* |
| • *Social distancing was properly maintained by the staff. The lady who took the samples was really good and she did her job really well while maintaining all the safety measures.*<br>• *The lady who took my blood was incredibly gentle and calm, she made me feel completely relaxed. It was amazingly quick and painless, extremely professional! Thank you, I'm usually so nervous and faint-y with blood tests but she was perfect. I only want my blood tests done by her!* |
| • *Great! Everything very clean, organized and very friendly people! I am very happy with all the services! Miss. who collected my blood is also a love!!* |
| • *Charming friendly phlebotomist* |
| • *Very pleasant from reception & the person who done the phlebotomy.* |
| • *The nurse the carried out my blood test was amazing kind and patient. So helpful to me as I was very teary and find this a traumatic experience. Please can she be thanked for such kindness. Thankyou. Nurse was based in room 1.* |
| • *It was a wonderful experience and the staff were good and helpful* |
| • *My Phlebotomist was so lovely, really pleasant and smooth. She did it so quickly and painlessly. It was all done so promptly. I was called in to my appointment very promptly and the receptionist answered all my questions. Can't speak more highly of my Phlebotomist and experience.* |
| • *Person collecting my blood sample made me feel extremely comfortable when I said that I am scared about the pricking part. I am very glad and thankful for her to make me feel this good. She made my day.* |
| • *Can recommend this place very highly. The very helpful and friendly receptionist was fantastic. The superb, young nurse was very caring, gentle, friendly, lovely with great manners and she knew her way with a needle. She is amazing.* |

| |
|---|
| • *The lady who did my bloods was amazing and very professional. She's a real asset to the practice and NHS* |
| • *The lady that did the blood test was very good. I'm needle phobic and she put my mind at ease, was quick and reassured me throughout. The most pleasant blood test I've had.* |

# Hillingdon Clinical Commissioning Group (HCCG)
# EQUALITY IMPACT ANALYSIS (EIA)

NHS
Hillingdon Clinical Commissioning Group

1. An **Equality Impact Analysis (EIA)** must be completed for any change of service (commission, re-commission/redesign, de-commission) policy, strategy or other substantial set of decisions by Hillingdon Clinicial Commissioning Group (HCCG), here called the '**scheme**'. This is a legal requirement and the responsibility of the Governing Body. In Hillingdon the Public Participation, Involvement and Equality (PPIE) committee assures the Governing Body that the EIA is adequate to meet the standard of '**Due Regard**' as required in the Public Sector Equality Duty. Also see HCCG Corporate Risk Register, and Strategic (Commissioning) Intentions.
2. The EIA identifies where some **populations** of people who share certain characteristics (eg. their sex or their ethnicity), currently have disproportionately poor health as a group when compared with other social groups in the current situation (Section 2). It can be other disadvantages affecting health outcomes such as poorer utilisation or access than others. **Positive actions** based on evidence of inequality can be planned into schemes to 'level up' and make access to health more equitable for more equal health outcomes in future.
3. The EIA also identifies future risks relevant to the new scheme, where groups of people might face disadvantages in future in relation to the new scheme, for example around access or self-help (Section 3).
4. The EIA indicates high risk areas where there is a high likelihood of negative impact. **Mitigating actions** are required to reduce risk of negative risk.
5. **Positive** and/or **mitigating** actions are then reflected when developing service specifications and operational planning (Section 4).

-Text in red: Hints and suggestions to help complete the EIA and can be deleted.

-(N#): See Supporting Notes at the end of the document for more information.



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| **SCHEME TITLE** | **Adult Phlebotomy** | | | |
| **SCHEME SRO** | Tarvinder Kalsi Assistant Director Primary Care Hillingdon CCG | | | |
| **SCHEME CRO** | Dr Mayur Nanavati Hillingdon CCG | | | |
| **EIA AUTHOR/S / Clinical input** | Caroline Davidson Commissioning Manager Long Term Conditions | | | |
| **APPROVED / REVIEWED AT COMMITTEES AND DATES** | *as applicable* | Date reviewed | Date approved | Date next update/review due |
| | PPIE | 19.02.2021 | 24.02.2021 | |
| | QCSR | | | |
| | GB (N14) | | | |
| | Contract meetings | | | |
| **PUBLISHED ONLINE** | Is there any reason not to publish this EIA? : ~~Yes~~ / No If yes, explain<br>Is there any reason not to publish appendices including data : ~~Yes~~ / No If yes, explain<br>Date published online : (Once approved all EIAs should be published) | | | |

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| **SECTION 1: GENERAL INFORMATION** | In response to Covid19 the walk in phlebotomy offer at THH reduced by 61% due to hospital appointment slots of 10 to 12 minutes with 5 or 6 patients bled an hour versus 12/ hour preCovid. Also the OP waiting area can only socially distance 40 patients (as opposed to 80 precovid) and patients are queuing up outside. In November when the CQC inspected Hillingdon Hospital it noted the high footfall in the OP department and the covid risk to patients. Due to the Phlebotomy clinics being in the main building and in the OP department the Trust has had to close these clinics.<br><br>In November/ December additional phlebotomy capacity was quickly stood up to compensate for capacity issues at Hillingdon hospital site and then the subsequent closure of the clinics on the recommendation from CQC that footfall must be reduced at Hillingdon hospital outpatients. This was a temporary stop gap and has managed demand in the short term while practices have been focusing on essential services only. This has created a backlog in blood test requests which needs to be urgently worked down and along with a return to business as usual with GPs resuming routine referrals for phlebotomy this will mean a deficit in capacity. The interim service model is not financially sustainable so it is not feasible to expand recent arrangements. |



## Snapshot of Hillingdon CCG Equality Objectives 2020 -2024

| **HILLINGDON CCG EQUALITY OBJECTIVES 2020 - 2024** Approved Feb 2020 | | Tick relevant HCCG's Equality Objectives (EO), (N2) |
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| **EO1: HCCG's Governing Body** will ensure HCCG's work is making progress towards eliminating discrimination, ensuring equal opportunity for all and fostering good relations by ensuring equality analysis and review processes are in place, drawing on sound evidence, and used effectively in HCCG decision-making e.g. Good quality Equality Impact Analysis (EIA) is used effectively throughout the organisation. | a) Establish and consolidate sound equality structures and processes in the Hillingdon Integrated Care Partnership.<br>b) Maintaining due regard and progress, during transition to one CCG.<br>c) Ensuring providers, as 'agents' of the CCG are complying with statutory Equality and Health Inequality duties.<br>d) Maintain good equality practice within HCCG processes. | |
| **EO2: HCCG Staff:** To reduce health inequalities in Hillingdon and address possible and actual risks of health inequality, support staff to identify, design, commission and procure equitable services for all, including mitigating actions where there is a risk that commissioning or decommissioning services may have a negative impact on any equality population in Hillingdon. | Support staff to make best use of EIAs and Equality Objectives. | |
| ***Characteristic / Equality Population–based Positive Action*** | | |

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| **EO3: Identify priority populations** in Hillingdon facing unequal Health Outcomes and/or at risk of disadvantages where positive action can be taken to reduce the risk of disadvantage.<br>- Improve appropriate use and effective access for the following disadvantaged groups - Others to be explored. | - Equitable access to Primary Care in Hillingdon (See Objective 4):<br>- Parents and Carers of Disabled children, particularly children with learning difficulties (See Objective 5),<br>- Cancer screening (See Objective 6) | |
| **EO4: Primary Care** Improve appropriate use and effective access for the following disadvantaged groups to **Primary Care** in Hillingdon:<br>HCCG Members, staff and Governing body will identify populations at risk of or facing health inequality in Hillingdon because of poor or inappropriate access to Primary Care. | a) Population Health data<br>b) Race: particularly people who have migrated to the UK who may be less familiar with the NHS, regarding access to right care, right place.<br>c) Race and Disability: Language and access to interpreting (including BSL) in primary care.<br>d) Race / Disability: access to support for self-care. | |
| **EO5: Learning Disability (LD)/Autism** Improving access to useful support for parents of children with Learning Disability (LD)/Autism | | |
| **EO6: Cancer Screening** To increase uptake of cancer screening for patients with protected characteristics that are identified as having disproportionately low take up in Hillingdon. | Initial priorities: a) Race/identified minority ethnic groups, ethnic minority women; b) Disability – mental health; c) Disability – mental health and Sexual Orientation; d) Disability - Carers | |

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| **SECTION 2:**<br><br>**EXISTING UNEQUAL HEALTH OUTCOMES – *THE <u>CURRENT</u> SITUATION***<br>*(past and present)* | Phlebotomy is a generic service that is available to all patients for the purpose of taking blood samples for testing to support diagnosis and management of a wide range of illnesses and conditions including cancer and Long Term Conditions (LTCs) such as diabetes, respiratory and cardiovascular diseases.<br><br>Across London most CCGs have a Local Incentive Scheme (LIS) for phlebotomy services provided in GP practices and in NWL Hillingdon is the only CCG that does not have a LIS for the provision of Phlebotomy by GPs. PreCovid approx. 187,000 patients per year attended walk in phlebotomy clinics at Hillingdon Hospital or MVH. 86% of bloods were taken in the THH and MVH walk-in 14% of activity is provided in 8 outreach clinics across the borough. This means that patients in the South of the borough have limited access to phlebotomy services without having to travel across the borough. The Hospital clinics are walk in which while favourable to many patients is also restricting for patients who work or have caring responsibilities or want to be able to plan their appointments to reduce uncertainty and risk around waiting times since often there are minimum 30 people waiting from 7.30am and often up to 120 people waiting 2 to 3 hours. This is creating risk of Covid19 infection for patients especially as Covid19 infection control processes has reduced phlebotomy capacity to 61% due to hospital appointment slots of 12 minutes verses 5 minutes with 4 or 5 patients bled an hour versus 12 per hour preCovid.<br><br>Currently there is a requirement for patients to bring the pathology test form to the Phlebotomy appointment because the hospital does not have an administrator in the clinic and does not have access to ICE therefore if patients forget to take the pathology request form with them to the clinic the phlebotomist is unable to take the bloods. This may prove challenging for some patients. A PCN Service has access to EMIS and ICE should the patient forget their form. Also with greater use of telephone/ virtual consultations by GPs this means that the GP texts a pdf of the form the patient has to print out the form at home but not all patients have a printer, otherwise the form is either posted or left in reception for the patient to pick up causing delay.<br><br>To illustrate how inequalities affect the demand for the service for blood tests to diagnose, monitor and manage disease and also the need to improve access to support earlier diagnosis, Long term conditions has been used as examples below.<br><br>• Black and Minority Ethnic (BAME) groups account for 45% of the Hillingdon population and White ethnic groups account for 55%[1]. The population for each locality is evenly distributed across the localities but in Hayes and Harlington the population is more dense and the proportion of ethnic minorities is twice that of the other localities. Ethnicity is closely linked to health status, inequalities and poor health outcomes<br>• Public Health data helps us to assess the future demand for the treatment of certain conditions which are more prevalent in specific population groups e.g. Type 2 Diabetes. Hospital admissions from Diabetes were highest from the South of the borough (Botwell, Townfield, West Drayton and Pinkwell wards) while Northwood and Northwood Hills had the lowest number of admissions[2].<br>• There will be a predicted 9% increase in the number of people aged over 65 between 2015 – 20203. The population in the South of the borough is younger with higher ethnicity while in the North it tends to be older and less ethnically diverse. |

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| | •There are Inequalities in life expectancy due to circulatory, cancer and respiratory diseases. Circulatory diseases account for 31% of all deaths with the highest mortality rates from coronary heart disease in the South of the borough. Deaths from all cancers accounted for 29%[4]. The gap in male life expectancy between Eastcote and East Ruislip in the north of the Borough and Botwell in the south of the Borough is 8.55 years whilst premature deaths in males <65 are highest in the Heathrow Villages.<br>• Hypertensive disease is the most prevalent condition recorded on GP registers at 13% (although expected prevalence is double), followed by obesity (9%) and diabetes (6%)[6]. Hillingdon has the highest levels of excess weight in London with 67% of the adult population are estimated to be overweight or obese[7]and this is linked to LTCs such as diabetes and heart disease. Also the prevalence of asthma is 92% higher in obese patients and 30% higher for patients who are overweight.<br>•Rising numbers of people with a LTC and an aging population means that increasing numbers of people will find themselves responsible for the day to day care of a relative. In the 2011 census[3] 25,702 people identified themselves as carers (9.5% of the resident population). There is an even distribution of carers across the localities, however in the North of the borough carers tend to be aged 50+ and in the south of the borough carers are younger. Therefore many carers themselves may have LTCs.<br>•30% of people with an LTC also have a related mental health problem specifically anxiety and depression[8].<br>• In addition around 40% of people with depression and anxiety also have a LTC.<br><br>**References:** 1.Greater London Authority 2012 Round Final Ethnic Group projection figures (GLA EGRP 2012); 2.Joint Strategic Needs Analysis 2011; 3.Office for National Statistics 4.Office for National Statistics; 5.Greater London Authority; 6.Quality Outcomes Framework; 7.Public Health England. 8 Cimpean and Drake 2011. |
| **HCCG Highlight relevance to equality groups defined in HCCG Equality Objectives** | |
| **EO4** Equitable Access to Primary Care | Access to the hospital Phlebotomy Service is inequitable because Mount Vernon Hospital is much less accessible for patients in the South of the borough. Attending a hospital increases patient risk of infection from Covid19. The PCN Phlebotomy Service reduces this risk and the service has bookable appointments which reduces the number of patients in the waiting rooms and ensures an orderly flow of patients whereas the hospital service is walk in with 50% less waiting room capacity and double the length of slots to provide time for infection control processes so it often means patients are queuing outside the building. However if practices / PCNs are confident to manage patient flows they may offer walk in if they wish where there is patient preference for it. The PCN service improves access for patients because they are based in GP practices and there is a site in each PCN across Hillingdon but especially improves access for patients in the south of the borough. |
| **EO5** LD/Autism | There are 980 people on the QoF LD register (0.3%) |
| **EO6** Cancer Screening | Blood tests are first line diagnostic for identifying possible cancer therefore access to Phlebotomy is key to cancer screening. The LTC cohort of patients using this service have an increased risk of developing cancer particularly COPD patients (of whom 90% are smokers) and patients with heart disease or diabetes who are obese. Hence managing patients conditions better through quicker access to phlebotomy clinics will reduce this risk. The Covid 19 pandemic has discouraged patients from seeking advice from their GP and caused the suspension of outpatient and |

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| | elective services which has increased waiting times and delayed diagnosis. By ensuring patients have the diagnostics they need the service may support detection of cancer by enabling quicker diagnosis through increased capacity and availability for phlebotomy. |

| **Equality Act 2010 Equality Populations by All Protected Characteristic** | |
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| Age | Hillingdon has a higher proportion of 5-19 and 50+ year olds, than 25-39 year olds<br><br>The service is available for patients aged 14+, however there is a separate Paediatric Service provided by the Confederation in the Community. Blood tests are a key tool in the diagnosis of condition affecting people of all ages.<br><br>Many long term conditions (LTCs) and drug therapies require regular monitoring and blood tests and since many LTCs are age related (eg. Heart Failure, COPD, hypertension, diabetes) and conditions such as arthritis treated with strong medications require regular monitoring of kidney/ liver function etc are mostly age related. This means that older patients are more likely to need access to Phlebotomy services. The primary care sites improve access for the elderly especially if they travel by public transport. It will reduce their risk of Covid 19 infection by having more local access and not attending hospital particularly as it is >60s who have highest risk of complications from Covid 19.<br><br>Bookable appointments also reduces lengthy waiting times up to 2 hours experienced at the hospital walk in service. They also enable people of working age to take minimum time off work.<br><br>People engaged in full time employment or education, or those with carer responsibilities may have difficulty accessing services during working hours. Extended hours is being considered. However it is possible to book phlebotomy appointments via the Extended access phlebotomy service provided by the Confederation in the hubs. |
| Disability | The 2011 Census identified that there were 37,850 people in Hillingdon who considered their day to day activities were limited by a disability or long term illness. 69% of these were aged 50+ and more at risk of developing LTCs and hence require phlebotomy services for regular monitoring via blood tests.<br><br>People with mobility impairments can experience difficulty accessing services, depending on their means of travel and the severity of any underlying impairment. Anxiety, panic and depression is associated with restrictions on mobility (Cleland, Lee & Hall, 2007; Moore & Zebb, 1998; TenVergert et al., 1998; Weaver, Richmond & Narsavagel, 1997; Coventry & Gellatly 2008) and can affect motivation to attend appointments<br>Bloods for housebound patients are managed by District Nurses or the Rapid response service.<br><br>Many of the patients using the service will have a LTC that will need to be monitored by blood tests. of 30% of people with an LTC also have a related mental health problem specifically anxiety and depression[2]. In addition around 40% of people with depression and anxiety also have a LTC. There are 2628 people on the QoF MH register (0.8%) In 2018/19 approx 6,600 patients were referred/ self referred to Talking therapies. 1275 people had a LTC.<br><br>*2011 Census showed that there are 25,702 carers in Hilliingdon.* |

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| | *0 - 24 2,450*<br>*25 - 64 18,609*<br>*65 + 4,643*<br><br>Of those who live with parents or other relatives who are their main Carers 35% of these Carers are 65+ and 5% are 75+ and hence likely to have a condition that needs monitoring via blood tests. It is unclear how many carers need to access interpretation service's for themselves and for those they care for. A high proportion of carers will be working and may have difficulty accompanying the patient to appointments or accessing services themselves during working hours. Extended hours is being considered. However it is possible to book phlebotomy appointments via the Extended access phlebotomy service provided by the Confederation in the hubs.<br><br>Eyesight deteriorates with age so visual impairment prevalence is increasing due to aging population. The RNIB suggest a figure of 1 in 500 as an estimated basis of people who would qualify to be registerable visually impaired. People with visual impairment are likely to have difficulty accessing services and not have appropriate information. Visually impaired people are at higher risk of depression which can affect motivation to attend appointments so easier access is important. localised PCN sites mean reduction in travel distance to less familiar locations, which may make access easier for people with visual impairments.<br><br>Hearing deteriorates with age and a large cohort of patients requiring phlebotomy services are elderly.<br><br>People with learning disabilities need a sufficient number of staff who are appropriately trained and confident in working with patients with learning disabilities in your service. Key issues for this cohort of patients include capacity for consent for the procedure, accessible information and heightened anxiety – even phobia – related to needles. Reasonable adjustments should include less invasive alternatives such as the possibility of a finger prick blood test as opposed to venepuncture or checking saliva levels rather than blood levels. the use of topical applications to numb the skin prior to needle insertion. Arranging pre appointment visits to the site to help the person be less sensitised to the procedure is another adjustments.<br><br>The PCN sites will improve access for people with disability especially if they travel by public transport. It will reduce their risk of Covid 19 infection by having more local access and not attending hospital. |
| Gender Reassignment | Inequality when accessing services is a significant issue for trans people. Blood tests are an important part of the treatment plan for people undergoing transition and on a very regular basis afterwards for measurement of hormones and a host of other markers. Trans people encounter issues when using the NHS due to the negative attitudes and lack of knowledge or understanding from some healthcare professionals. Research carried out on the experiences of trans people accessing health services by Healthwatch (March 2020), found that key issues include communication and admin for example the wrong title is 'often used' on blood forms e.g. Mr and then the female name, causing distress. In addition, NHS numbers do not always match as they should and consequently, the results of the blood test are lost. National LGBT survey (2018), 21% of trans people who responded said their specific needs were ignored or not considered when they accessed, or tried to access, healthcare services in the 12 months preceding the survey. These on-going challenges have led to trans gender people not attending |

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| | appointments as they should because they fear of discrimination and prejudice, which may be contributing to the inequalities in health in this population compared with the general population. |
| Marriage & Civil Partnership | The service is available to all patients regardless of their relationship status. |
| Pregnancy & Maternity | The PCN sites will improve access for pregnant patients who may require blood tests especially if they travel by public transport. It will reduce their risk of Cvid 19 infection by having more local access and not attending hospital particularly as pregnancy increases risk of complications from Covid 19. |
| Race | According to the Greater London Authority in 2017, 46.9% of Hillingdon population is from Black & Minority Ethnic groups (source: GLA 2015 Round Demographic Projections, 2016). 51.1% of people living Hayes and Harlington are from BME groups. 8,240 residents (16.8%) stated they cannot speak English well or at all.<br><br>People from BME populations are at higher risk of developing some cancers and LTCs such as diabetes and heart disease. The service will improve access in the South of the borough where the biggest BME populations and those for whom English is not a first language, live. Hillingdon practices routinely offer interpretation services and so can access this for phlebotomy patients.<br>People with LTCs require regular monitoring via blood tests and so these patients will benefit from improved access to phlebotomy. |
| Religion & Belief | The predominant religions in the borough at 2011 (Census data) are:<br>Christian 134,813 49.2%<br>Muslim 29,065 10.6%<br>Hindu 22,033 8.0%<br>Sikh 18,230 6.7%<br>Buddhist 2,386 0.9%<br>Jewish 1,753 0.6%<br>No Religion 6,492 17%<br>Other (Mormons, Jehova's Witness) 23,303 8.5%<br><br>Also 8.5% of residents stating other (23,303) which includes Mormons and Jehova's witness who may have concerns regarding a blood sampling service. |
| Sex | No adverse impacts identified for this protected characteristic. |
| Sexual Orientation | There is an absence of reliable statistical data on sexual orientation The service is available to all patients regardless of their sexual orientation. |

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| | Similar to transgender people, people who are LGBT are known to experience prejudice and discrimination in health services. |
| **Other priority disadvantaged groups noted by NHS.** | |
| Homeless, travellers and people with high mobility | Homeless people have disproportionately higher respiratory disease because 85% are smokers. 20% have asthma and 4.9% have COPD. These patients will benefit from improved access to Phlebotomy as their LTCs will require regular monitoring. |
| Ex-Service personnel | Ex-Service personnel may suffer PTSD and have poor mental health so may be prescribed strong medications that require regular monitoring of kidney/ liver function via blood tests. These patients will benefit from improved access to Phlebotomy. |
| Asylum-Seekers and Refugees (see also 'Race') | See above "race" |
| Obesity | In Hillingdon 62% of the adult population are overweight or obese8. Obesity increases risk of diabetes and heart disease. Also the prevalence of asthma is 92% higher in obese patients and 30% higher for patients who are overweight. These patients will benefit from improved access to Phlebotomy as their LTCs will require regular monitoring. |

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| **SECTION 3:**<br><br>**THE PROPOSED SCHEME - *RISK OF DIRECT OR INDIRECT DISCRIMINATION (in future)*** | 3. Give a brief description of the approach and design of different elements of the scheme, ie. what will be delivered and how. Briefly highlight any significant changes from previous relevant schemes.<br><br>**Care pathway**<br><br>1. GP/healthcare professional (HCP) will ensure the patient does not fall within the exclusion criteria for the service (excluded patients will be advised of alternative provider locations.)<br>2. HCP will Complete the appropriate requisition/blood form {see comments in Trans gender section}<br>3. HCP will book a practice/ PCN appointment on EMIS (unless walk in is available).<br>4. Phlebotomists at all providers to have access to ICE and if possible EMIS to ensure digital transfer of patient information and tests requested. see comments in Trans gender section<br>5. Patient attends appointment Phlebotomist checks patient details and runs through covid check list questions then draws blood from patient as indicated by the referring HCP. see comments in Trans gender section and in Disability (LD section)<br>6. Advise the patient regarding the test result follow-up process.<br>7. Sample bottles are clearly and appropriately labelled - see comments in Trans gender section<br>8. Samples are sealed in appropriate bags and are stored in a safe and appropriate clinical environment prior to transportation to the Pathology Department, in accordance with the specimen handling section of Infection Prevention and Control Guidance for Primary Care<br>9. The phlebotomist logs details of patient contact on appropriate system using codes specified in section 9.<br>10. Collection of specimens and transport to secondary care pathology department<br>11. Results returned to patient's GP practice<br>12. Appointment waiting times should not exceed 7 days for routine bloods and 2 days for urgent bloods. Appointments should be flexible for patients with additional needs such as learning difficulties where best practice should be followed.<br>13. The premises should be easily accessible with provision for people with disabilities including waiting areas. |

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| **a) RISK OF DIRECT DISCRIMINATION**<br><br>Deliberately causing disadvantages to people with protected characteristics. | 4. What level of **risk** is there that people will face <u>direct discrimination</u> at any point in connection with this scheme or change in policy?<br><br>a) Does the scheme bring members of the public into direct contact with each other? Never ~~1~~ ~~2~~ ~~3~~ ~~4~~ ~~5~~ ~~Constantly~~<br>(Have you considered waiting rooms, self-help groups etc.)<br><br>b) Is there individual discretion in decisions about access (eg. booking appointments) or care for individuals?<br>Never ~~1~~ ~~2~~ ~~3~~ ~~4~~ 5 Constantly |

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| | c) Are reasonable precautions taken in the scheme to reduce the risk / prepare a response if there are incidents of direct discrimination? (*Have you considered* warning notices, complaints processes, staff support and whistle blowing policies etc.)<br>Yes 1 ~~2 3 4 5~~ No<br><br>d) Summary of Risk of Direct Discrimination: Low 1 ~~2 3 4 5~~ High<br>e) Is additional action required? No 1 ~~2 3 4 5~~ Yes |

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| **b) BACKGROUND RISK OF INDIRECT DISCRIMINATION**<br><br>Unintentionally causing disadvantages to people with protected characteristics. | 5. In the table below, consider each equality population and each element designed into the scheme.<br><br>a) Describe any risk that people in that population could be unintentionally, or unavoidably, disadvantaged in ways that might impact on their health and wellbeing. Give special attention to those identified in Section 2. as already having poorer health outcomes. Positive action, reasonable adjustments, accessible communications that are *already confirmed* as part of the design of the new scheme should be noted here. Likely positive impacts can also be noted, (though not scored).<br>A risk of negative impact does not stop the scheme being approved. But where there is a high risk of negative impact for a certain equality population/s, mitigating actions should be considered (Section 4) to reduce either likelihood or the scale of the negative impact.<br><br>There is no set checklist of issues to consider. You can consider how the following might affect people in different social groups:<br>- awareness of referral routes, levels of GP registration, access issues, existing familiarity with NHS services and access,<br>- physical mobility and transport, locations and venues, timings,<br>- communication including use of online or digital tools, access to IT, skill in understanding and speaking in English, literacy,<br>- potential to make best use of self-help/self-care,<br>Also consider social factors, eg. how some social groups are constrained by caring roles, gendered relationships, social perceptions, stigma etc.<br><br>b) Put a score in the columns. The score should be for the risk after taking *confirmed* positive actions and adjustments into account.<br>What is the likelihood of people in that population being disadvantaged, from 1-5 where 5 is high.<br>What could be the impact of people in that population being disadvantaged, from 1-5 where 5 is high.<br>It may be useful to refer to guidance for the Corporate Risk Register on impact / scale of risk. |

| **Population** | **Description of risk** | Likelihood of -ve impact **1-5** | Scale of -ve impact **1-5** | Likelihood x Scale = Risk Score |
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| **HCCG Highlight relevance to equality groups defined in HCCG Equality Objectives** | | | | |
| **EO4** Equitable Access to Primary Care | The Primary Care Service improves access for patients because they are based in GP practices but especially improves access for patients in the south of the borough. | 1 | 1 | 1 |
| **EO5** LD/Autism | | | | |
| **EO6** Cancer Screening | Blood tests are first line diagnostic for identifying possible cancer therefore access to Phlebotomy is key to cancer screening. The service will enable quicker diagnosis by increasing capacity and availability for phlebotomy. | 1 | 1 | 1 |
| **Equality Act 2010 Equality Populations by All Protected Characteristic** | | | | |
| Age | The service improves access for all patients aged 14+ | 1 | 1 | 1 |

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| | The primary care sites improve access for the elderly especially if they travel by public transport.<br><br>Bookable appointments enable people of working age to take minimum time off work.<br><br>Extended hours is being considered. However it is possible to book phlebotomy appointments via the Extended access phlebotomy service provided by the Confederation in the hubs.<br><br>Contractual reporting requirement to monitor access to the service by people by age and undertake patient satisfaction audits. | | | |
| Disability | The primary care sites improve access to phlebotomy for people with disability as outlined in section 2 especially if they travel by public transport.<br><br>Provide access and facilities for patients with disabilities, in accordance with the Disability Discrimination Act 1995<br>Red Flag on electronic records<br><br>ensure appropriate signage and information materials<br><br>Emphasis on good verbal communication<br><br>Improve staff awareness of risk of depression and use of Patient Health Questionnaire PHQ4 which is embedded in EMIS. Inform all patients of the availability of IAPT and that they can self refer.<br><br>Identify carers and offer a Carers assessment and provide information on IAPT.<br>Appropriately targeted information<br>Provide appointment booking by email<br>Ensure sign language services are available at appointments and Monitor usage as part of KPI<br>Ensure there are loops for deaf people in the hubs<br>Contractual reporting requirement to monitor access to the service by people with disability and undertake patient satisfaction audits. | 1 | 1 | 1 |
| Gender Reassignment | Training for PCN site staff to raise their awareness around issues related to communication (use of correct pronouns and titles) and admin (checking that labels are correct) So as to avoid loss of samples | 1 | 1 | 1 |

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| | or delay in processing samples) Staff should be encouraged to ask how an individual likes to be addressed so that the preferred name, pronoun or term is used in communications. | | | |
| Marriage & Civil Partnership | The Primary care sites improve access to phlebotomy for all patients regardless of their relationship status. | 1 | 1 | 1 |
| Pregnancy & Maternity | The Primary care sites will improve access for all pregnant patients who wont need to travel across the Borough to hospital. | 1 | 1 | 1 |
| Race | The service is available to all patients regardless of their race. The service will improve access in the South of the borough where the biggest BME populations live.<br><br>Ensure that information and communications are delivered in other languages and that interpreting services are made available to all people who require them.<br><br>Identify champion groups to promote smoking cessation and pulmonary rehab.<br><br>Monitor usage of Language Line etc as part of KPI<br><br>Contractual reporting requirement to monitor access to the service by people of different races and undertake patient satisfaction audits | *1* | *1* | *1* |
| Religion & Belief | The Primary care sites improve access to phlebotomy for all patients regardless of their religion or beliefs<br><br>Services delivered in a private treatment room to be sensitive to the needs of specific groups eg. shaperones.<br><br>Practices and hub staff to consider religious/faith/belief festival periods i.e. Ramadan (fasting) | 1 | 1 | 1 |
| Sex | The Primary care sites improve access to phlebotomy for all patients regardless of their sex.<br><br>Target information and communications to women and male groups<br>Contractual reporting requirement to monitor access to the service by these groups and undertake patient satisfaction audits. | 1 | 1 | 1 |
| Sexual Orientation | Training for staff on the sensitivities for LGBT issues.<br>Target information and communications LBGT groups<br>Contractual reporting requirement to monitor access to the service by these groups and undertake patient satisfaction audits. | 1 | 1 | 1 |
| **Other priority disadvantaged groups noted by NHS.** | | | | |

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| Homeless, travellers and people with high mobility | The Primary care sites improve access to phlebotomy for all homeless, travellers or high mobility patients regardless of their sexual orientation.<br><br>In Hillingdon Homeless people are able to register with a gp practice.<br><br>Target information and communications to homeless groups and hostels | 1 | 1 | 1 |
| Ex-Service personnel | The Primary care sites improve access to phlebotomy for all Ex-service personnel. | 1 | 1 | 1 |
| Asylum-Seekers and Refugees (see also 'Race') | see 'Race' | 1 | 1 | 1 |
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| **SECTION 4 : ACTIONS - POSITIVE and MITIGATING ACTIONS** | **Positive action** is encouraged in law when there is evidence that extra effort is needed to help specific populations overcome disadvantages, ensure their participation and use and provide for any special needs to prevent further disadvantages in future. An EIA is a significant tool to justify positive action and ensure equitable services.<br>The law also requires **reasonable adjustments** and **accessible communications** to support equal opportunities for disabled people. |
| **Summary of Confirmed Positive Actions** | 6. Summarise the positive actions that have already been confirmed for this scheme (these may have also been noted in Section 3)<br><br>Refer to section 3 |
| **Summary of further potential Positive Actions** | 7. What other positive actions are being considered to address existing health inequalities, if any?<br><br>Refer to section 3 |
| **Summary of Mitigating Actions** | 8. Regarding the equality populations identified in Section 3 where the Risk Score is over 6, give a brief description of confirmed and proposed mitigating actions?<br>**Mitigating actions** should be considered where certain equality populations have been identified who will be disadvantaged by a new scheme, whether that is by the whole scheme or just one element or design feature of the scheme. |

| **Brief description of mitigating action** | **Populations served by this mitigating action** | **Confirmed or Proposed?** |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | To add rows, put cursor in last box and press tab |

| | | |
|---|---|---|
| **SECTION 5: EQUALITY DATA - MONITORING AND REVIEWING EQUALITY IMPACT / EVIDENCE** | What equality data will be collected?<br>- how, by whom, who, by when? (Eg. will this be a KPI?) | As NHS standard Contract KPIs and General Conditions. |
| | How will equality data and impact be reviewed with providers? (Eg. in contract meetings?) | In contract meetings |
| | How will HCCG internally review data on equality impact<br>- how, by whom, and when?<br>When will EIA be reviewed and updated?<br>*Review dates should be included on the front page and added to Forward Planners* | Commissioner in Contract meetings<br>In 12 months. |

**Appendix 2**

| | |
|---|---|
| **SECTION 6: EQUALITY EVIDENCE used in this EIA** | Please attach any data generated specifically for this scheme/EIA as appendices, including any internal reviews of equality data, PPI Engagement Logs (N15) etc.<br>For all data, please give reference and date so others can draw from the same sources. |

| **Source of Equality Data** | **Equality Data / Document details** (/online address) (Note if attached) |
|---|---|
| ***HCCG Internal Equality Evidence*** | |
| Equality Evidence Review / HCCG Equality Objectives (2019) | yes / no |
| PPI/Patient Experience/ Engagement*/Complaints (Attach engagement/consultation report as appendix) | ~~yes~~ / no - details |
| Local HCCG data: EMIS/BI/Other | ~~yes~~ / no - details |
| Data from Provider/ Performance/KPI data | ~~yes~~ / no - details |
| ***Other Hillingdon/North West London Equality Evidence*** | |
| LBH: JSNA / Census 2011 | yes / ~~no~~ – details see section 2 |
| Voluntary/Community | ~~yes~~ / no - details |
| Other BHH / NWL | ~~yes~~ / no - details |
| | |
| ***Other London/National Equality Evidence*** | |
| NHS England, DoH, | 1. yes ~~/ no~~ – details Department of Health (2011) Ten Things You Need to Know about Long-term Conditions. |
| NICE eg. Equality Assessmt | ~~yes~~ / no - details |
| EHRC | ~~yes~~ / no - details |
| Non-profit Sector/ Academic eg. BHF, Kings Fund | ~~yes~~ / no – details |
| **Refrences** | Greater London Authority 2012 Round Final Ethnic Group projection figures (GLA EGRP 2012); 2.Joint Strategic Needs Analysis 2011; 3.Office for National Statistics 4.Office for National Statistics; 5.Greater London Authority; 6.Quality Outcomes Framework; 7.Public Health England.Cimpean and Drake 2011.<br>DiMatteo et al 2000.<br>Reducing emergency admissions: unlocking the potential of people to better manage their long-term conditions. Sarah Deeny, Ruth Thorlby, Adam Steventon, 2018 |

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# EXTERNAL SERVICES SELECT COMMITTEE - WORK PROGRAMME

| | |
|---|---|
| **Committee name** | External Services Select Committee |
| **Officer reporting** | Nikki O'Halloran, Corporate Services and Transformation |
| **Papers with report** | Appendix A – Work Programme |
| **Ward** | n/a |

## HEADLINES

To enable the Committee to track the progress of its work and forward plan.

## RECOMMENDATIONS:

**That the External Services Select Committee considers the Work Programme at Appendix A and agrees any amendments.**

## SUPPORTING INFORMATION

1. Committee meeting will usually start at 6.30pm. Should the need arise, the Committee will be able to vary the start time on an ad hoc basis.

2. The meeting dates for the 2021/2022 municipal year were agreed by Council on 25 February 2021 and are as follows:

| Meetings | Room |
|---|---|
| ~~Wednesday 16 June 2021, 6.30pm~~ | ~~CR6~~ |
| Tuesday 20 July 2021, 6.30pm | CR6 |
| Wednesday 15 September 2021, 6.30pm | CR6 |
| Thursday 7 October 2021, 6.30pm | CR6 |
| Tuesday 23 November 2021, 6.30pm | CR6 |
| Thursday 27 January 2022, 6.30pm | CR6 |
| Tuesday 22 February 2022, 6.30pm | CR5 |
| Tuesday 22 March 2022, 6.30pm | CR5 |
| Wednesday 27 April 2022, 6.30pm | CR6 |

### Live Broadcasting of Meetings

3. It should be noted that Cabinet, at its meeting on 30 May 2019, agreed that all future select committee meetings would be broadcast live on YouTube. As such, all formal External Services Select Committee meetings will be broadcast live.

### Topics to be Scheduled into the Work Programme

4. To fulfil its statutory health scrutiny role, it should be noted that the Committee is required to meet with the local health trusts at least twice each year. To fulfil is statutory role to scrutinise the local crime and disorder reduction partnership (CDRP), the Committee is also required to scrutinise the work of the Safer Hillingdon Partnership (SHP).

5. Once the Work Programme for 2021/2022 has been populated with the Committee's statutory scrutiny responsibilities, there are opportunities to scrutinise other issues in the remaining meetings. At its meeting on 16 June 2021, Members agreed to include the following topics for consideration in these meetings:
    a. OWL/Neighbourhood Watch: OWL (Online Watch Link) keeps communities safe, helps reduce crime and keeps people informed of what's going on locally. It's a secure platform for the public and shared with the police and local authority to maximise the potential of Neighbourhood Watch, Rural Watch, Business Watch and dozens of other schemes. OWL sends subscribers the latest local crime alerts and provides management tools for maintaining and expanding watches. Possible witnesses could include: the police, Neighbourhood Watch organisers and local residents' associations; and
    b. Journalism and Local Democracy: To establish the role of journalism and online discussion forums in the Borough with regard to local democracy and look at how journalism has changed. How can journalism help residents to become more engaged in the local democratic process? How can democracy be promoted amongst young people? The Local Democracy Reporting Service (LDRS) is a public service news agency funded by the BBC, provided by the local news sector and used by qualifying partners (it's like a franchise where different companies with different approaches use common editorial standards and all publish into the same system). Possible witnesses could include: Brunel journalism students, the Council's Communications Team, LDRS journalist, and representatives from local radio and Nextdoor.

6. The issue of children's dental services was covered at the External Services Select Committee meeting on 16 June 2021 where useful and detailed discussion was undertaken with representatives from Hillingdon Public Health, Hillingdon Local Dental Committee and Whittington Health NHS Trust. Although this had initially been planned as a single meeting, there were a number of organisations who had been unable to attend the meeting. As such, it was agreed that the next meeting on 20 July 2021 would also concentrate on children's dental health in an attempt to encourage more witnesses to attend. For those organisations that are unable to send a representative to attend, effort will be made to arrange informal meetings with them and the Committee Chairman and Labour Lead.

7. Digital connectivity had provisionally been scheduled for consideration at the meeting on 20 July 2021. To enable the Committee to continue to scrutinise the issue of children's dental services at this meeting, Members agreed that digital connectivity be held in abeyance until it was possible to schedule it for a different meeting.

**BACKGROUND PAPERS**

None.

**APPENDIX A**

**EXTERNAL SERVICES SELECT COMMITTEE**

**WORK PROGRAMME**

*NB – all meetings start at 6.30pm in the Civic Centre unless otherwise indicated.*

*Shading indicates completed meetings*

| Meeting Date | Agenda Item |
|---|---|
| 8 September 2020<br><br>***Report Deadline**:*<br>*3pm Thursday 27 August 2020*<br><br>*Previously scheduled for 2 September 2020* | **Crime & Disorder**<br>To scrutinise the issue of crime and disorder in the Borough:<br>1. London Borough of Hillingdon<br>2. Metropolitan Police Service (MPS)<br>3. Safer Neighbourhoods Team (SNT)<br><br>**Hillingdon Hospital Development Update**<br>To receive an update on the progress of proposals for a new Hillingdon Hospital. |
| 8 October 2020<br><br>***Report Deadline**:*<br>*3pm Monday 28 September 2020* | **Mount Vernon Cancer Centre Update**<br>To receive an update on the progress of the review of the services provided at Mount Vernon Cancer Centre. |
| 10 November 2020<br><br>***Report Deadline**:*<br>*3pm Thursday 29 October 2020* | **Health**<br>Performance updates and updates on significant issues:<br>1. The Hillingdon Hospitals NHS Foundation Trust – CQC Inspection and Hospital Development<br>2. Royal Brompton & Harefield NHS Foundation Trust<br>3. Central & North West London NHS Foundation Trust<br>4. The London Ambulance Service NHS Trust<br>5. Public Health<br>6. Hillingdon Clinical Commissioning Group<br>7. Healthwatch Hillingdon |
| 12 January 2021<br><br>***Report Deadline**:*<br>*3pm Wednesday 30 December 2020* | **Great Western Rail Line**<br>Issues relating to British Transport Police, Network Rail and Crossrail. |

| Meeting Date | Agenda Item |
|---|---|
| 9 February 2021<br><br>***Report Deadline**:*<br>*3pm Thursday 28 January 2021* | **Post Offices**<br>An update on the provision post office services in the Borough.<br><br>**COVID-19 Vaccination Update**<br>Members to receive an update on the roll out of the COVID-19 vaccination programme as well as information on BAME COVID-related deaths and hospital admissions.<br><br>**Update on the implementation of recommendations from previous scrutiny reviews:**<br>• GP Pressures<br><br>**SEPARATE BRIEFING NOTE REQUESTED FOR *(to be circulated outside of meeting):***<br>• Hillingdon Clinical Commissioning Group (HCCG) – Update on the effectiveness of the flu vaccination programme<br>• Hillingdon Hospital redevelopment update |
| 23 March 2021<br><br>***Report Deadline**:*<br>*3pm Thursday 11 March 2021* | **Crime & Disorder**<br>To scrutinise the issue of crime and disorder in the Borough:<br>1. London Borough of Hillingdon<br>2. Metropolitan Police Service (MPS) |
| 28 April 2021<br><br>***Report Deadline**:*<br>*3pm Thursday 15 April 2021* | **Mount Vernon Cancer Centre Review**<br>Update on the review of services provided by the Mount Vernon Cancer Centre.<br><br>**The Hillingdon Hospitals NHS Foundation Trust (THH)**<br>Update on performance and the infection prevention and control measures put in place at Hillingdon Hospital.<br><br>Update on the development of the new hospital. |
| 29 April 2021<br><br>***Report Deadline**:*<br>*3pm Friday 16 April 2021* | **Health**<br>Performance updates and updates on significant issues:<br>1. Central & North West London NHS Foundation Trust<br>2. The London Ambulance Service NHS Trust<br>3. North West London Clinical Commissioning Group<br>4. Hillingdon Health and Care Partners<br>5. Healthwatch Hillingdon |
| 16 June 2021<br><br>***Report Deadline**:*<br>*3pm Friday 4 June 2021* | **Children's Dental Health**<br>Review of children's dental health services in the Borough (meeting 1 of 2). |

| Meeting Date | Agenda Item |
|---|---|
| 20 July 2021<br><br>***Report Deadline**:*<br>*3pm Thursday 8 July 2021* | **Children's Dental Health**<br>Review of children's dental health services in the Borough (meeting 2 of 2).<br><br>**Phlebotomy Services**<br>To receive an update on phlebotomy services in Hillingdon. |
| 15 September 2021<br><br>***Report Deadline**:*<br>*3pm Friday 3 September 2021* | **Crime & Disorder**<br>To scrutinise the issue of crime and disorder in the Borough, specifically: the coverage and effectiveness of OWL and Neighbourhood Watch in helping to achieve the targets as set out in the Safer Hillingdon Partnership (SHP) Plan. |
| 7 October 2021<br><br>***Report Deadline**:*<br>*3pm Monday 27 September 2021* | **Mount Vernon Cancer Centre Review**<br>Update on the review of services provided by the Mount Vernon Cancer Centre.<br><br>**Health Updates**<br>Performance updates and updates on significant issues:<br>1. The Hillingdon Hospitals NHS Foundation Trust<br>2. Central & North West London NHS Foundation Trust<br>3. North West London Clinical Commissioning Group<br>4. Hillingdon Health and Care Partners<br>5. Local Medical Committee<br>6. Healthwatch Hillingdon |
| 23 November 2021<br><br>***Report Deadline**:*<br>*3pm Thursday 11 November 2021* | **Journalism & Local Democracy**<br>To scrutinise the role of journalism and internet forums in local democracy in Hillingdon. |
| 27 January 2022<br><br>***Report Deadline**:*<br>*3pm Monday 17 January 2022* | **The Hillingdon Hospitals NHS Foundation Trust (THH)**<br>Update on the development of the new hospital.<br><br>**Update on the implementation of recommendations from previous scrutiny reviews:**<br>• GP Pressures |
| 22 February 2022<br><br>***Report Deadline**:*<br>*3pm Thursday 10 February 2022* | **Hillingdon Health & Care Partnership (HHCP) / Integrated Care System (ICS)**<br>To receive an update on the work and effectiveness of HHCP and the ICS. |

| Meeting Date | Agenda Item |
|---|---|
| 22 March 2022<br><br>***Report Deadline**:*<br>*3pm Thursday 10 March 2022* | **Crime & Disorder**<br>To scrutinise the work of the Safer Hillingdon Partnership. |
| 27 April 2022<br><br>***Report Deadline:***<br>*3pm Wednesday 13 April 2022* | **Health Updates**<br>Performance updates and updates on significant issues:<br>1. The Hillingdon Hospitals NHS Foundation Trust<br>2. Central & North West London NHS Foundation Trust<br>3. North West London Clinical Commissioning Group<br>4. Hillingdon Health and Care Partners<br>5. Local Medical Committee<br>6. Healthwatch Hillingdon |
| June 2022<br><br>***Report Deadline**:*<br>*TBA* | **TBA** |

| Possible future single meeting or major review topics and update reports |
|---|
| 1. Preventative health – this could be in relation to obesity, childhood immunisations, cancer screening, etc;<br>2. Apprenticeships and adult learning;<br>3. Environment Agency – work undertaken in Hillingdon with regard to river maintenance and upkeep (not canals or water treatment) to possibly include input from organisations such as Colne Valley Landscape Partnerships; and<br>4. Digital Connectivity – to scrutinise the issue of digital connectivity in the Borough with regard to the impact on the community and local economy, and assess community buy in to introducing a more advanced technology infrastructure. |