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HILLINGDON
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A

External Services Scrutiny Committee

Councillors on the Committee

Mary O'Connor (Chairman)
Michael White (Vice-Chairman)
Phoday Jarjussey, Labour Lead
Judy Kelly
Peter Kemp

Date: **THURSDAY, 28 OCTOBER 2010**

Time: **4.30 PM**

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

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

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Contact: Nikki Stubbs
Tel: 01895 250472
Fax: 01895 277373
Email: nstubbs@hillingdon.gov.uk

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http://modgov.hillingdon.gov.uk/ieListMeetings.aspx?CId=118&Year=2010

Lloyd White
Head of Democratic Services
London Borough of Hillingdon,
3E/05, Civic Centre, High Street, Uxbridge, UB8 1UW
www.hillingdon.gov.uk

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Terms of Reference

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

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

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

   (c) respond to any relevant NHS consultations.

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

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

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

Agenda

PART I - MEMBERS, PUBLIC AND PRESS

PART II - PRIVATE, MEMBERS ONLY

Minutes

EXTERNAL SERVICES SCRUTINY COMMITTEE

14 July 2010

Meeting held at Committee Room 6 - Civic Centre, High Street, Uxbridge UB8 1UW

	Committee Members Present: Councillors Mary O'Connor (Chairman), Councillor Michael White (Vice-Chairman), Phoday Jarjussey, Judy Kelly and Peter Kemp **Witnesses Present**: Acting Chief Inspector Shakil Qasim – Safer Neighbourhoods Team, Metropolitan Police Service Inspector Steve Beattie – Safer Transport Team, Metropolitan Police Service Inspector Peter Miller – Officer in Charge, British Transport Police Kevin Dulling – Transport for London (TfL) Sharon Shepherd – Transport for London (TfL) **Others present:** Councillor Wayne Bridges Malcolm Ellis, Standards Committee Vice-Chairman **LBH Officers Present:** Ed Shaylor, Bob Castelijn and Nikki Stubbs	
8.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 5)* **RESOLVED: That all items be considered in public.**	**Action by**
9.	**SAFER TRANSPORT** *(Agenda Item 6)* The Chairman welcomed those present to the meeting. Consideration was given to the issue of safer transport in the Borough. Members were advised by Mr Bob Castelijn, the Council's Transport and Aviation Team Manager, that Hillingdon's Local Implementation Plan (LIP) for transport was being prepared in accordance with guidelines. The Hillingdon LIP set out the Council's transport projects, proposals and programmes through to 2011. It also set out how the Council proposed to implement the Mayor's Transport Strategy (MTS) and provided details on projects, proposals and programmes. The LIP's transport proposals focussed on eight priority areas and included timelines, funding information and monitoring to ensure the successful implementation of the initiatives. Mr Castelijn stated that the Council had been working with schools in the Borough to develop School Travel Plans (STP) and there were now only two schools in the Borough that did not have one. The improvements that schools had suggested in their STPs had been collated, costed and included in the Hillingdon LIP. The STPs also	**Action by**

gave Transport for London (TfL) an indication of whether or not there were enough buses on the different school routes.

The STPs were a voluntary arrangement with the schools so, if parents or pupils didn't follow the recommended route home, there was nothing that could be done. However, if parents were parking illegally, this was something that could be dealt with by the Council's parking enforcement team.

Work was underway to look at the North/South bus provision in the Borough. As the provision of additional routes would be costly, it was important to ensure that the potential demand was assessed. Proposals were still at the conception stage and being explored with TfL.

It was generally accepted that Hillingdon had a very large carbon footprint being an outer-London borough but work was underway to establish the exact level. New software was being developed to measure the Council's carbon footprint and it was anticipated that this would be incorporated into current systems by 2011.

Safer Neighbourhood Team (SNT)

There were 22 Safer Neighbourhood Teams in Hillingdon – one in each Ward. Acting Chief Inspector Shakil Qasim, from the Metropolitan Police Service (MPS), advised that the SNT had been working increasingly closely with the community to encourage engagement. Work was underway to double the number of Special Constables (currently 66) and volunteers by 2013, and increase the number of police cadets. Furthermore, it was anticipated that Special Constables would be deployed on buses in the next year or so.

Given the current economic climate, and the MPSs reduced budget, work was underway to look at how the SNTs could work more effectively. To this end, consideration was being given to aligning all MPS departments, for example, coordinating the hours worked by the CID and SNT teams.

Safer Transport Team (STT)

The STT covered overland areas: buses, bus shelters and bus routes as well as the routes in between. Inspector Steve Beattie, from the Metropolitan Police Service (MPS), advised that the STT (which was 90% funded by TfL) met regularly with TfL to look at issues that needed to be addressed. Current priorities for the Hillingdon STT included:

- anti-social behaviour (ASB) and criminal damage on the U4 bus route around Bourne Avenue;
- ASB, criminal damage and serious violent offences on the route and bus stops on Uxbridge Road, primarily between Point West and The Ossie Garvin roundabout;
- ASB, criminal damage and theft/forgery on the 140 bus route – a working group had been set up to specifically look at this issue; and
- ASB at the end of the school day on the buses and transport interchange within the area covered by the Hayes Hub Team.

It was noted that bus crime across London was at its lowest level for six years and was 8% lower than it had been in 2008/2009, despite an increase in the passenger numbers. There had been a 37% decrease in bus vandalism in London, a 10% decrease in violent offences against a person and an 8% reduction in robberies. In Hillingdon, there had been a 5.6% reduction in bus crimes in the last year (down from 644 offences to 608 offences).

Members were advised that the STT had worked with the local bus garage manager to arrange for a U4 bus to be scheduled for part of the route. Plain clothed police officers were then put on the bus to detect crime. This arrangement had taken place on two occasions over the last couple of months and had proved very successful, resulting in an arrest for criminal damage to a bus shelter. This arrangement was also proving to be a deterrent to criminals and would be continued. It was noted that the arrangement had been publicised in newsletters and had been adopted by other bus companies.

There had been some concerns about safety on the U7 bus route. The STT had arranged a Transport User Group meeting to discuss the problems and had invited those residents that had expressed concern. All of these invitees had declined to attend the meeting as the problems had actually been resolved.

TfL's behaviour code outlined what level of behaviour was expected on the buses and the circumstances under which the free travel concession could be removed. The STT had visited Year 6 pupils in 22 schools in the Borough to assist with the applications for free travel cards (Zip cards); the young people had signed the behaviour code as an integral part of this process.

The STT was liaising with local schools on troubled bus routes in Hillingdon. Early intervention letters were sent to the parents of young people that were misbehaving on the buses and reminded them of the behaviour code. Repeat offences could result in the young person's Zip card being withdrawn. TfL had permanently removed more than 5,000 cards from young people since the scheme was introduced in June 2008 with many more being removed temporarily and then reinstated when the young person shown a willingness to work with TfL to get it back. It was important to remember that the vast majority of children were well behaved and that it was only a small minority that were behaving badly on the buses.

PCSOs had been assigned to each of the schools in the Borough to work with them on reducing ASB. As well as sending out early intervention letters to the parents of those young people that had behaved badly, meetings could be set up with the parents to show them the CCTV footage of their child's behaviour on the bus. This procedure had proven to be effective since its introduction three months ago and there had not yet been any repeat offences. Penalties for a re-offence could include withdrawing the young person's Zip card, or implementing an anti-social behaviour contract or anti-social behaviour order (ASBO).

	The improved partnership working between the British Transport Police (BTP) and the STT had contributed to the decrease in crime around Hayes and Harlington. The STT also worked very closely with the Council's ASB officer and the Early Intervention Panel. The STT had conducted a survey at the beginning of July 2010 and the results were being analysed. A further survey would be undertaken approximately six weeks after the first to gauge how public perception had changed with regard to fear of crime. The STT also regularly met with bus drivers listen to their concerns and address any issues that had arisen. STT worked closely with Operation Bus Tag, which was funded by TfL and tackled criminal damage and anti-social behaviour on London buses using CCTV. The Operation was set up in November 2004 to combat the increasing trend of criminal damage on buses which increased the fear of crime on public transport. Since its inception, Operation Bus Tag had made over 3,000 arrests for on-bus criminal damage and further arrests for offences such as graffiti, seat and window damage, window etching and arson. Many of these arrests had resulted in a conviction and low re-offending rates. It was noted that ASB was predominant between 3pm and 5pm on school days. The deputy head teacher at Douay Martyr had been particularly helpful in taking steps to hold those students that had behaved badly to account. Additional buses were scheduled for those routes where ASB had arisen to alleviate the problem of overcrowding. All STTs were deployed during these times to patrol buses, bus stations, key bus stops and transport interchanges. The STT was also in the process of training three PCSOs to work alongside TfL's Safety and Citizenship Team. <u>Transport for London (TfL)</u> Mr Kevin Dulling, from Transport for London, advised that there was currently no approved data sharing protocol between TfL and London Borough of Hillingdon. The Safer Hillingdon Partnership's protocol had been forwarded and was being reviewed by TfL's solicitors. Mr Dulling would investigate the reasons for the hold up. Mr Dulling confirmed that, although TfL's budget had been cut by 50%, there were no indications that TfL funding for the STT would stop. There had been a reorganisation at TfL which meant that Hillingdon would no longer be considered a priority area as the work that had been undertaken had been very successful in reducing the fear of crime. As the changes had also meant that Mr Dulling's role would now be inward facing, a Borough Liaison Team representative would attend future Committee meetings and refer issues back to TfL. However, Mr Dulling advised that it was unlikely that there would be any dramatic changes in the service provision in Hillingdon. The minutes of the External Services Scrutiny Committee meeting held on 23 September 2009 stated that Mr Kevin Dulling would report back to the Committee on progress regarding the application for a grant from the Community Safety and Enforcement Directorate at TfL for financial	Kevin Dulling

	assistance with PCSOs. Mr Dulling had planned to work with the STT Sergeant but she had since moved on and no further action had been taken. A number of safety improvements had been agreed by TfL at the subway site in Carlyon Road. Mr Dulling advised that, although a number of improvements had already been implemented, and more minor improvements were planned, TfL would not be installing the CCTV system that it had originally agreed as the budget was not available. Mr Shaylor advised that the Council would continue to try to influence TfL on this decision. It was believed that TfL's long term plan would be to move away from subways entirely and move towards providing street level crossings.	Ed Shaylor
	It was noted that a small number of children living in Harvey Road on the South side of the A40 attended Bourne Primary School on the North side of the A40. As there was no pedestrian crossing, parents were having to drive their children to school every day. Ward Councillors had been requesting the installation of a pedestrian crossing for at least four years but to no avail. The Committee was advised that the installation of a crossing (such as a zebra crossing or footbridge) would depend, in part, on the traffic flows. It was noted that the Council would need to make a formal request – this could be progressed by Mr Castelijn speaking to PC Neil Corfield at the Metropolitan Police's Traffic Management Team.	Bob Castelijn
	Councillor O'Connor, on behalf of the Committee, thanked Mr Dulling for the support that he had given the Council, and particularly this Committee, over the last seven years. <u>British Transport Police (BTP)</u> The BTP, whose customers included station staff, train drivers and passengers, had undertaken a survey. The results had shown that passengers were more reassured now. It was noted that Hillingdon had 11 underground stations. Between 1 January 2010 and 30 June 2010, there had been 75 offences committed at Uxbridge station; the second most offences during that period had been committed at Hillingdon station with the third most at Northwood. Although the fleet of BTP vehicles had been reduced as a result of budget restrictions, this had meant that BTP officers were regularly travelling on the trains (and sometimes in with the driver). The number of reported robberies had reduced and one of BTP's ten priorities was to increase the number of ASB detections by 20%. This was linked to the reduction in the fear of crime. Knife arches had been used on numerous occasions in the stations. Knife crime was being targeted through Operation Portcullis, in conjunction with the Metropolitan Police Service (MPS), between 18 July 2010 and 30 July 2010. Further joint work had been undertaken with the MPS in schools.	

	There had been a number of dangerous incidents where stones had been thrown at the trains, particularly in Northwood and Northwood Hills. The BTP and MPS were visiting schools with the MPS helicopter as a preventative measure to raise awareness of just how dangerous this was. It was noted that the BTP was being more proactive and held regular monthly meetings with the public, station staff and station managers to exchange views on the situation with regard to crime. These meetings were well publicised on the website. With regard to passengers on public transport putting their feet on the seats, Members were advised that a byelaw covered this on the trains and underground as unacceptable behaviour. Although no byelaw currently existed to cover the matter on buses, one was in the process of being drafted. Inspector Miller suggested that the new byelaw for buses include provision for the perpetrator to be issued with a fixed penalty notice - this was not an option under the byelaw that covered trains and the underground. Members agreed that the Ward Panel meetings were a useful tool to engage with the public. It was important to proactively engage and increase the number of residents joining the Panels. Acting Chief Inspector Qasim advised that the MPS had tried a number of different ways to engage with the public with varying degrees of success. **RESOLVED: That the report and presentations be noted.**	
10.	**MINUTES OF THE MEETING - 9 JUNE 2010** *(Agenda Item 3)* **RESOLVED: That the minutes of the meeting held on 9 June 2010 be agreed as a correct record.**	**Action by**
11.	**MINUTES OF THE MEETING - 16 JUNE 2010** *(Agenda Item 4)* **RESOLVED: That the minutes of the meeting held on 16 June 2010 be agreed as a correct record.**	**Action by**
12.	**WORK PROGRAMME** *(Agenda Item 7)* <u>11 January 2011</u> It was agreed that the meeting scheduled for 11 January 2011 would be used to talk to GPs about the proposals contained within the Health White Paper published on 12 July 2010. Invitees would potentially include Dr Mitch Garsin (Chairman of Hillingdon LMC), Dr Tony Grewal (Medical Director of the Londonwide LMCs), the Chairman of Practice-Based Commissioning and some GPs. <u>Health Inequalities Working Group</u> It was agreed that the Working Group would hold four meetings: three witness sessions and a fourth meeting to review the draft final report before it went to the External Services Scrutiny Committee meeting for approval on 28 October 2010. These meeting dates would be arranged with the Working Group Members. The final report would	**Action by**

	then be sent to Cabinet on 18 November 2010. Dr Ellis Friedman (Joint Director of Public Health) and Dr Tony Grewal would be invited to attend all of the Working Group meetings. The Democratic Services Manager would contact the Directors of Adult Social Care, Health & Housing and Education & Children's Services to identify which officers would be best placed to attend the meetings. **RESOLVED: That:** **1. the Health White Paper be emailed to all Members of the Committee;** **2. the Democratic Services Manager contact the Members of the Health Inequalities Working Group to arrange four meeting dates;** **3. the Democratic Services Manager contact the Directors of Adult Social Care, Health & Housing and Education & Children's Services to identify which officers would be best placed to attend the Working Group meetings; and** **4. the Work Programme be agreed subject to the above amendments.**	Nikki Stubbs Nikki Stubbs Nikki Stubbs
	The meeting, which commenced at 6.00 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 Stubbs on 01895 250472. Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.

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PROVISION OF HEALTH SERVICES IN THE BOROUGH

Officer Contact	Nav Johal and Nikki Stubbs, Deputy Chief Executive's Office
Papers with report	Appendices A and B

REASON FOR ITEM

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

OPTIONS AVAILABLE TO THE COMMITTEE

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

INFORMATION

Background

Commissioning Support for London

Members will receive a presentation from Commissioning Support for London on cardiovascular and cancer services. "In the UK, nearly six million adults are living with the devastating and disabling effects of cardiovascular disease (which includes heart disease and stroke) and over 40,000 people die from premature cardiovascular disease each year. Cardiovascular disease is a largely preventable condition and it can be effectively tackled by making simple changes to diet, smoking status and physical activity."

Commissioning Support for London (CSL) was launched in April 2009. Its role is to support London's commissioners – those responsible for planning, developing, monitoring and reviewing health and social care services – to deliver a more efficient healthcare service, sharing best practice and reducing duplication.

The proposed models of care for future cancer and cardiovascular service provision in London have been published. At the request of London's health commissioners and the London Strategic Health Authority (SHA), Commissioning Support for London has worked with clinicians and patients to develop a case for change and proposed model of care for cardiovascular and cancer services in London.

Cardiovascular and cancer illnesses in London tend to have markedly poorer outcomes than they should when compared to results elsewhere in the UK and Europe.

NICE (National Institute for Clinical Excellence) and CfPS (Centre for Public Scrutiny) have published a '10 questions' guide to help OSCs, local authorities and other responsible leads to review and monitor practice within their region (attached as Appendix A). The guide is based on the evidence based recommendations from NICE about preventing cardiovascular disease at population level published in June 2010. The NICE guidance is aimed at commissioners, procurement leads, managers and practitioners working in local authorities and the NHS and the wider public, private, voluntary and community sectors. The guidance recommends making small changes across the whole population, because these will translate into very big improvements in health overall.

"Liberating the NHS" White Paper on NHS reform

The Health White Paper has serious implications for the future delivery of health services to our residents. Representatives from Royal Brompton & Harefield NHS Foundation Trust, Central & North West London NHS Foundation Trust, The Hillingdon Hospital NHS Trust, Hillingdon PCT, Local Medical Council (LMC - GPs), Ambulance Service and Care Quality Commission (CQC) have been invited to attend the meeting.

A Cabinet Member Decision (attached as Appendix B) was published on 6 October 2010 which set out the Council's response to the Government's "Liberating the NHS" White Paper on NHS reform. The closing date for consultation was 11 October 2010. The Chairman of External Services Scrutiny Committee had the opportunity to comment on the report which went to the Cabinet Member for Social Services, Health & Housing for a decision.

The Cabinet Member Decision set out the proposals, considered the implications and included this Council's proposed response to Government on NHS reforms. The proposals will impact on the Council's relationship with the NHS and offers the opportunities for effective partnership and to improve services for residents.

The Government is planning to create an independent National Commissioning Board for the NHS. The Board will allocate £80bn in funds to local GP consortia for them to use to commission local health services. Local authorities will take on responsibility for health improvement, currently held by Primary Care Trusts (PCTs). As a result of these changes, the Government expect PCTs to cease to exist from 2013 in light of the successful establishment of GP consortia. It is also planned that Strategic Health Authorities (SHAs) will no longer exist from 2012/13. In the meantime, PCTs and SHAs will have important roles to play in supporting the NHS through a period of change.

Guidance recommends that a GP consortium should have no fewer than 100,000 patients. Consortia will need to have been created in shadow form by 1 April 2011. The Care Quality Commission will be the quality regulator and HealthWatch will be linked to CQC.

Hillingdon PCT

Hillingdon PCT has made good progress in achieving national priorities and meeting its current commitments, receiving a rating of 'fair' for quality of service from the Care Quality Commission. It improved its rating for core standards from 'almost met' to 'fully met' and its rating for national priorities rose from 'weak' to 'fair'. Hillingdon PCT is expecting its rating will improve to 'good' through achieving the majority of national priorities when the results of the CQC are published this month.

During 2009/10 the following key targets were achieved:

- Four hour maximum wait for accident and emergency
- Maximum wait of 18 weeks (referral to treatment)
- Health Care Acquired Infection (HCAI) targets for C-diff and MRSA
- All mental health targets including crisis resolution and early intervention
- Immunisations and vaccinations
- Chlamydia screening
- Dental access

Hillingdon Hospital NHS Trust

The Patient Environment Action Teams (PEAT) results for 2010 were released in July 2010 and The Hillingdon Hospital NHS Trust scored two 'excellent' ratings and one 'good' rating for both Hillingdon and Mount Vernon Hospitals.

PEAT is an annual assessment of inpatient healthcare sites in England that have more than 10 beds. It is a benchmarking tool to ensure improvements are made in the non-clinical aspects of patient care including environment, food, privacy and dignity.

Both hospitals scored two 'excellent' ratings for food and privacy and dignity, and one 'good' score for environment. This year's result was an improvement on the results from 2009, where most of the Trust's six results (three for each hospital) were 'good' for both hospitals, except one 'excellent' rating for food at The Hillingdon Hospital.

The assessment team comprised of representatives from Estates/Facilities, Nursing/Matron, Infection Control, Catering and Domestic Services Provider, and patient and public representatives. The areas assessed included outpatient clinics, wards, A&E Minor Injuries, public and external areas. The assessors audited the above facilities from the patient perspective against the following specific elements:

- Cleanliness
- Toilet/bathroom
- Infection control
- Environment
- Access
- Food service
- Privacy and dignity
- Trust policy information
- Food policy information

The Trust has published its Annual Report for 2009/10. It expected to meet eight of the nine Care Quality Commission existing commitments such as: ensuring that 98% of patients attending A&E spend a maximum of four hours from arrival to admission, transfer or discharge; reducing delayed transfers of care (i.e. ensuring that mechanisms are in place to enable patients to be discharged when they are ready to do so); and ensuring a maximum two week wait for Rapid Access Chest Pain clinics.

The Trust has also performed strongly against the Care Quality Commission national priorities, including reducing the number of Clostridium difficile (C-difficile) infections and MRSA bacteraemia, ensuring that patients are seen and treated within 18 weeks, and meeting all waiting time targets for cancer services. Whilst the Trust has dramatically improved the

percentage of Stroke patients who spend at least 90% of their time in hospital on a specialised stroke unit from 60% last year to 91% at the end of 2009/10, the average for 2009/10 was 72%.

A key priority for the Trust has been to continue to drive improvements in the quality of our services. This year the Trust has, for the first time, produced Quality Accounts which give more information on its improvements in clinical quality and safety at the Trust.

Central & North West London NHS Foundation Trust – Mental Health

The country's first NHS Wellbeing Centre opened in the Boots store, at the Chimes Shopping Centre, Uxbridge on Monday 28 June 2010. This Centre provides people in Hillingdon with free advice on staying happy, healthy and well.

This is the first time an NHS centre has offered a range of services specifically aimed at promoting mental wellbeing from one site. As well as NHS staff, representatives from local support groups such as Hillingdon Mind, Alcohol Concern, Employment Link and Relate, are available to provide advice and information to improve quality of life.

The Centre was set up by Central and North West London NHS Foundation Trust (CNWL) in partnership with NHS Hillingdon and Hillingdon Council. A review of community mental health services in the Borough had identified the need for an easy access, informal advice centre in a central Hillingdon location.

CNWL, in its annual report, identified three priorities to improve its service:

- Access to services when in a crisis
- Respect and involvement
- Physical healthcare

These priorities emerged from what service users and carers told them, as well analysing complaints and incidents. These priorities were then tested with PCTs, LINks, service users, carers and members to seek the importance of them for improvement.

Royal Brompton & Harefield NHS Foundation Trust

Royal Brompton & Harefield NHS Foundation Trust is registered by the Care Quality Commission for the following regulated activities:

- Treatment of disease, disorder or injury
- Surgical procedures
- Diagnostic and screening procedures
- Assessment or medical treatment for persons detained under the Mental Health Act 1983

The Trust is compliant with 15 of the 16 Essential Standards of Quality and Safety and has been registered with the Care Quality Commission without conditions. The Trust's focus on a continuous cycle of improvement resulted in a rating of excellent for the quality of the services from the Care Quality Commission.

The Trust has identified three priority areas for improvement during 2010/11 for the purposes for their Quality Account:

- Patient Experience – making the discharge process easier for patients
- Clinical effectiveness – providing more training for staff in safeguarding children

- Patient Safety – ensuring the incidence of surgical site infection is reduced

Witnesses

The following stakeholders have been invited to attend the meeting:

- Professor Yi-Mien Koh: Chief Executive, Hillingdon Primary Care Trust (PCT)
- Sue Nunney: Director of Corporate Affairs (PCT)
- John Vaughan: Director of Strategic Planning and Partnership, Central & North West London NHS Foundation Trust
- Jacqueline Totterdell: Director of Operations, Hillingdon Hospital
- Dr Tony Grewal: Medical Director of Londonwide (LMC)
- Mark Lambert: Director of Finance and Performance, Royal Brompton & Harefield NHS Foundation Trust
- Richard Connett: Head of Performance, Royal Brompton & Harefield NHS Foundation Trust
- Adam Crosby: Hillingdon Ambulance Operations Manager, London Ambulance Service
- Peter McKenna: Assistant Director of Operations, London Ambulance Service
- Amanda Brady: Care Quality Commission (CQC)
- Tom Pharaoh: Senior Project Officer, Cancer Project, Commissioning Support for London
- Paul Harris: Project Administrator, Acute and Specialist Care, Commissioning Support for London

SUGGESTED SCRUTINY ACTIVITY

Members to question representatives from Commissioning Support for London, the PCT, The Hillingdon Hospital NHS Trust, Local Medical Committee (LMC), London Ambulance Service, Care Quality Commission (CQC), Central & North West London NHS Foundation Trust and Royal Brompton and Harefield NHS Foundation Trust on the health services provided within the Borough and decide whether to take any further action.

BACKGROUND REPORTS

Department of Health, “Liberating the NHS” White Paper: www.dh.gov.uk
www.cqc.org.uk

SUGGESTED KEY QUESTIONS/LINES OF ENQUIRY

- How will Commissioning Support for London use the NICE and CfPS guide to assist to review and monitor practice? Following the consultation period, what steps will be taken by Commissioning Support for London?

- What impact has the walk-in medical centre in Hayes had on the urgent care centre? When will the service provided by the walk-in centre be reviewed? Are there plans to introduce similar centres elsewhere in the Borough?

- How will the training and support needs of GPs be met in relation to the proposals in the White Paper for them to commission health services?

- What additional pressure will be put on GP's under the new proposals? What progress has been made with regard to the creation of GP Consortia for the Borough?

- What additional pressure will be put on other organisations under the new proposals?

- What impact will the changes of the Government White Paper have on the delivery of services to Borough residents?

- What procedures have been put in place to ensure that Centre & North West London NHS Foundation Trust retains its CQC financial management rating of 'excellent' in the next assessment?

- How successful has the NHS Wellbeing Centre in Uxbridge been to date? Are proposals afoot to roll this out elsewhere across the Borough?

- The new stroke pathway has now been in place for some months. How has this impacted on the care of stroke patients and on the work of the Ambulance Service and hospitals?

- What is The Hillingdon Hospital NHS Trust doing to ensure that it achieves Foundation Trust status?

cfps the centre for public scrutiny

better scrutiny for better government

Ten questions to ask if you are scrutinising… cardiovascular disease prevention through planning and procurement activities, and regional programmes

NHS
National Institute for Health and Clinical Excellence

Contents

The Centre for Public Scrutiny (CfPS)

The Centre for Public Scrutiny is an independent charity that promotes the value of scrutiny in modern and effective government, not only to hold executives to account but also to create a constructive dialogue between the public and its elected representatives to improve the quality of public services.

The Centre has received funding from the Department of Health to run a support programme for overview and scrutiny committees as they develop their power to promote the wellbeing of local communities through effective scrutiny of healthcare planning and delivery and wider public health and social care issues.

National Institute for Health and Clinical Excellence (NICE)

The National Institute for Health and Clinical Excellence (NICE) provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health.

NICE makes recommendations to the NHS on:

- new and existing medicines, treatments and procedures
- treating and caring for people with specific diseases and conditions.

NICE makes recommendations to the NHS, local authorities and other organisations in the public, private, voluntary and community sectors on how to improve people's health and prevent illness and disease.

Acknowledgements

CfPS and NICE are grateful to those who helped develop this guide. A list of acknowledgements is available on page 16.

Introduction

This guide is one of a series designed to help health overview and scrutiny committees (OSCs) carry out their work on various health, healthcare and social care issues. Other guides in the series include:

- 'Child and adolescent mental health' (CfPS 2006)
- 'NHS service design or reconfiguration' (CfPS 2007a)
- 'The effectiveness of your local hospital' (CfPS 2007c)
- 'Mainstream health services for people with learning disabilities' (CfPS 2008)
- 'Promoting physical activity through planning, transport, and the physical environment' (CfPS 2009)
- 'End of life care for adults' (CfPS 2009b)
- 'Eye care' (CfPS 2009c)
- 'Local involvement networks' (CfPS 2009d)

This guide can help OSCs influence development of the 10-year local delivery framework (LDF) for their area to ensure it supports programmes, planning and procurement efforts which aim to reduce the prevalence of cardiovascular disease (CVD) among the local population.

It is based on recommendations made by the National Institute for Health and Clinical Excellence (NICE) in public health guidance 25 on 'Prevention of cardiovascular disease' (2010).

These are national, evidence-based recommendations on how to effectively plan, develop, resource and lead population-level programmes to prevent cardiovascular disease. They demonstrate the importance of regional programmes and initiatives in this area and the need to evaluate how such work impacts on the public's health.

NICE has also produced other guidance which complements and supports this work (see related NICE guidance section).

Reviewing the local delivery framework and its impact on the prevention of cardiovascular disease

NICE guidance should be taken into account during the development of local and regional strategies, for example, regeneration and transport plans. OSCs have a key role in establishing to what extent this is happening.

These ten questions may help committee members when they are preparing for a review, or in developing their lines of questioning for invited witnesses at a formal, public meeting.

Consulting others

To get the full picture, OSCs need to speak to people representing a variety of perspectives. Possible witnesses are:

- directors of public health
- local commissioning leads
- local cardiac network leads
- local authority planning officers
- food procurement leads (for local authorities, health services, care homes, prisons and schools)
- trading standards and licensing enforcement leads
- environmental health officers
- directors of adult and children's social services
- head teachers, school governors and principals of academies
- local strategic partnership leads
- representatives from patient groups, the community and voluntary sector
- transport planners
- executive members with a remit for health

- directors of leisure services
- representatives of children and young people's partnerships
- non-government organisations and charities involved in improving the public's health.

Ten questions to ask if you are scrutinising cardiovascular disease prevention through planning and procurement activities, and regional programmes

Questions for OSC Members

1. Why should overview and scrutiny committees review the impact of local authority and primary care strategies on cardiovascular disease?

In England in 2007, cardiovascular disease (CVD) led to nearly 160,000 deaths – that is, nearly 34% of all deaths. Premature death from the condition (before the age of 75) is up to six times higher among lower socioeconomic groups. It is approximately 50% higher than average among South Asian groups[1]. Most premature deaths from CVD are preventable.

CVD is generally caused by reduced blood flow to the heart, brain or body caused by atheroma – a blockage or swelling in the artery walls, or thrombosis, which is a blood clot inside a blood vessel.

Diet, lack of physical activity, smoking and tobacco use and excessive alcohol consumption are all risk factors for CVD. An individual's lifetime risk of CVD is strongly influenced by these factors from childhood so it is important to ensure

[1] Used here, the term 'South Asian' refers to people originating from India, Pakistan and Bangladesh.

everyone, including children, has a healthy balanced diet, are physically active and do not smoke.

Tackling the risk factors for CVD at the population level within your region will bring savings for the local health economy and ensure a range of health outcomes are achieved, including those on adult and child obesity, all-age mortality rate, life expectancy and on reducing health inequalities. In addition, it will help reduce the number of cases of a range of other chronic conditions such as diabetes.

A scrutiny review of CVD can involve talking to a range of people working for councils and other parts of the public sector. In two tier areas, county councils and district councils need to co-ordinate their approach to reviewing CVD. OSCs may already have some experience of working together to scrutinise health issues in their regions. A review of the regional approach to reducing and preventing CVD would fit well with existing arrangements. Alternatively, such a review might be a way of bringing together OSCs to carry out some joint scrutiny work.

2. What information do OSCs need to prepare for the review?

OSC members should be aware of the risk factors for CVD, including the social and wider determinants of health[2]. They should also be aware of the key evidence-based population approaches that have been proven effective. As an example, local policies should make it possible for people to have a healthy diet by making various foods physically accessible and affordable. This should include fruit, vegetables, whole grains, fish and polyunsaturates,

[2] Dahlgren G and Whitehead M (1991): Policies and Strategies to Promote Social Equity in Health. Stockholm: Institute for Futures Studies.

while minimising the intake of salt, sugar, saturated fats and fast food.
A list of further information and background reading is provided on page 15.

In addition, a comprehensive local tobacco control strategy is essential to protect children from the dangers of second-hand smoke, to prevent young people from starting to smoke and to help those who already smoke to quit.[3]

Questions to ask…..

3. What services are available as part of the CVD prevention programme – and do they have a population-based approach?

Helping people to change their behaviour is an important part of work to prevent CVD. However, interventions focused on individuals will not reduce the overall prevalence within a given population, nor will they prevent new cases from occurring. Population-based interventions on the other hand, aim to tackle the social, economic and environmental factors that underpin CVD risks. As such, they are more likely to reduce health inequalities, as they do not rely on an individual's knowledge or ability to choose healthier options. Rather, they aim to improve social environments and ensure the healthy choice is the easy choice. This may involve planning, regulation, legislation or rearranging the physical layout of communities.

To illustrate this impact, data pooled from European CVD prevention strategies estimate that a population-wide reduction of 10% in blood cholesterol, blood pressure and smoking prevalence would save 9120 lives (per million population) over 10 years.

In contrast, treating 40% of high-risk individuals with a 'polypill' (to treat individuals with high cholesterol and high blood pressure) would save 3720

[3] For more details see NICE Public Health guidance PH14 "Preventing the uptake of smoking by children and young people"
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lives (per million). This figure also assumes long-term adherence to the medication, which is not always achieved.

Examples of successful population-based programmes can be found in 'Communities for health: learning from the pilots' (Department of Health and Inequalities Unit 2007).
OSCs could ask:

- Are there publicly-funded, population-wide programmes to prevent CVD within our region?
- If so, do they follow the good practice criteria detailed in NICE's guidance?
- Are they linked to existing interventions for people at particularly high risk of CVD, such as the NHS Health Checks programme?
- Do local regeneration policies include health as a priority area?

4. Are CVD prevention programmes sustainable for at least 5 years?

For a population-level CVD prevention programme to be effective, NICE recommends that it should last for a minimum of 5 years. OSCs could ask:

- Is there a long-term plan in place for this within the region?
- What local political commitment exists to fund such programmes over a 5-year period?
- How is multi-agency working enabled as part of this work?
- Are current programmes adequately staffed with dedicated leads? (NICE recommends staff should not have CVD prevention programme tasks added to their workload without being relieved of other tasks).

- Have senior figures been identified within NHS primary care organisations and local authorities as champions for CVD prevention?

5. Do planners and regeneration leads consider the impact of their policies on CVD locally?

There is clear evidence that the built environment can have a positive impact on levels of CVD within a population.[4] For example, that the design of outdoor space can encourage physically active modes of travel such as cycling.

OSCs could ask:

- Has part of the local transport plan been allocated to promote walking, cycling and other forms of travel that involve physical activity?
- Has there been an improvement in the way local strategies are used to increase physical activity levels?
- How does your region compare to others in significant areas such as spatial and transport planning, or the siting and regulation of food retailing?
- Has a benchmarking system been considered to help measure current and future progress on encouraging and supporting initiatives in these areas?
- Are physical activity initiatives referenced within local planning and procurement policies?

- [4] See 'Promoting physical activity through planning, transport, and the physical environment' (CfPS 2009)

6. How are local policies, strategies and plans developed?

NICE's guidance outlines a number of principles that need to be applied when developing policies, strategies and plans in relation to transport, public open spaces, public sector food provision and regulation of the local food economy.

OSCs could ask:

- Is there evidence of CVD prevention being a priority for local health and local authority leads when planning for changes to regional travel, the physical environment, workforce food provision or the local food economy?
- If this is the case what outcomes have been delivered as a result?
- Do all new policies and planning applications undergo a Health Impact Assessment[5]?
- If so, what evidence is there of changes being made because of these assessments? What health improvements can be tracked in the local population as a result?
- Are developers encouraged to ensure local facilities and services are easily accessible on foot, by bicycle or by other modes of transport involving physical activity?

[5] Health Impact Assessment is a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population.
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7. Is the impact of planning on the local population's health considered and how do planners and local councillors assess the potential affect of their decisions?

Policies in a wide variety of areas can have a positive or negative impact on CVD risk factors – and frequently the consequences are unintended. For example, planning regulations and policies can affect a community's access to outdoor space in the built environment. OSCs could ask:

- Does local authority Health Impact Assessments include a reference to the prevention of CVD? If yes, what outcomes were targeted and have been achieved?
- Do those responsible for carrying out Health Impact Assessments have access to high quality data?
- Do they also have adequate knowledge of the key factors to consider when assessing how policies impact on CVD rates?
- Is there evidence of planning officers being trained to conduct Health Impact Assessments as part of their routine work?
- Have existing powers been used to set limits for the number of take-aways and other food outlets in specific areas, including directives to specify the distance from schools?

8. Do local authority and NHS procurement managers include health in their specifications for providers?

NICE's guidance highlights how local authorities and primary care providers and commissioners can adopt practices to help prevent CVD. Local authority and NHS procurement managers could play a key role here.

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OSCs could ask:

- Has the local authority and those responsible for local health commissioning ensured healthy balanced meals and healthier food options are provided for the public, patients and staff?
  (For example, via service specifications for in-house catering or vending machines.)

- Do procurement leads include standards for the nutritional content of foods within tender documents and service level agreements?
  (For example, detail on maximum levels of fat, salt and sugar within the foods provided.)

- Where such standards are used, are they reviewed as part of the contract management process?

- Are these healthy food principles also included in specifications for suppliers of food to care homes and adult social services (for example, within contracts for meals-on-wheels provision)?

- Are attempts made to ensure healthier food and drink options are available at community events such as festivals?

- Are Health Impact Assessments included in supplier specifications across all procurement streams?

9. Do local authority services for children and young people treat health as a high priority?

Local authorities can help children and young people to develop positive, life-long habits in relation to food and physical activity. This can be achieved by ensuring the messages conveyed about food, the food and drink available –

and where it is consumed – is conducive to a healthy diet and that adequate and safe spaces to encourage physical activity are available.

OSCs could ask:

- Has the need for children and young people to be physically active been addressed within local plans, for example, including walking within school travel schemes?
- Have adequate play spaces and opportunities for formal and informal physical activity been provided for children and young people?
- Is there evidence of steps being taken to ensure the availability of healthier options such as fruit and water in schools, local authority settings and in venues used for school trips?
- Are venues frequented by children and young people (and supported by public money) encouraged to resist sponsorship or product placement from companies associated with foods high in fat, sugar or salt (this includes fun parks and museums)?

10. Do local authorities ensure that providing access to an affordable, healthy diet is given a high priority?

Public sector organisations provide around one in three meals eaten outside the home. Improving the nutritional quality of the food and drink provided would help ensure many people have access to an affordable, healthy diet and lower the risk of CVD (a healthy diet is defined as being low in salt, saturated fats and sugar). OSCs could ask:

- Have all publicly-funded catering departments met national dietary guidelines? This includes catering departments in schools, hospitals and public sector work canteens.

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- Have local authorities and primary care organisations taken steps to ensure all food procured by, and provided for, people working in the public sector – and all food provided for people who use public services:
  - is low in salt and saturated fats
  - is nutritionally balanced and varied, in line with recommendations made in the 'eatwell plate'[6]
  - does not contain industrially produced trans fatty acids (IPTFAs)?

- Is information on the links between nutrition and health included as an integral part of training for catering managers?

Further information

- Refer to local documents, such as the 'Annual public health report' and sections of the local development framework.

- 'Active travel strategy' (Department for Transport 2010)

- 'A smokefree future: a comprehensive tobacco control strategy for England' (DH 2010)
- 'Be active be healthy. A plan for getting the nation moving' (DH 2009)
- 'Fair society, healthy lives: strategic review of health inequalities in England post 2010' (Marmot 2010) [online]. Available from www.ucl.ac.uk/gheg/marmotreview/Documents/finalreport
- 'Food 2030' (Department for Environment, Food and Rural Affairs 2010)
- 'Healthy weight, healthy lives: a cross-government strategy for England' (DH 2008a)
- 'Tackling health inequalities: 2007 status report on the programme for action' (DH 2008b)

[6] The 'eatwell plate' illustrates food types and the proportions needed for a well-balanced diet. Further information via www.eatwell.gov.uk/healthydiet/eatwellplate/

- ‘Tackling inequalities in life expectancy in areas with the worst health and deprivation’ (National Audit Office 2010)

Related NICE guidance

- Promoting physical activity for children and young people. NICE public health guidance 17 (2009). Available from www.nice.org.uk/guidance/PH17

- Identifying and supporting people most at risk of dying prematurely. NICE public health guidance 15 (2008). Available from www.nice.org.uk/guidance/PH15

- Preventing the uptake of smoking by children and young people. NICE public health guidance 14 (2008). Available from www.nice.org.uk/guidance/PH14

- Promoting physical activity in the workplace. NICE public health guidance 13 (2008). Available from www.nice.org.uk/guidance/PH13

- Maternal and child nutrition. NICE public health guidance 11 (2008). Available from www.nice.org.uk/guidance/PH11

- Smoking cessation services. NICE public health guidance 10 (2008). Available from www.nice.org.uk/guidance/PH10

- Physical activity and the environment. NICE public health guidance 8 (2008). Available from www.nice.org.uk/guidance/PH8

- Behaviour change. NICE public health guidance 6 (2007). Available from www.nice.org.uk/guidance/PH6

- Workplace interventions to promote smoking cessation. NICE public health guidance 5 (2007). Available from www.nice.org.uk/guidance/PH5

- Four commonly used methods to increase physical activity. NICE public health guidance 2 (2006). Available from www.nice.org.uk/guidance/PH2
- Brief interventions and referrals for smoking cessation. NICE public health guidance 1 (2006). Available from www.nice.org.uk/guidance/PH1
- Obesity. NICE clinical guideline 43 (2006). Available from www.nice.org.uk/guidance/CG43

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Tim Gilling – Deputy Executive Director, Centre for Public Scrutiny

Robin Ireland – Chief Executive, Heart of Mersey

Lucy Johns – Health Partnership Officer, Dorset County Council

Adam Richardson – Member, Sandwell Council Scrutiny Committee

John Soady – Public Health Department, NHS Sheffield

Dr Jeffrie R Strang – NICE, External Reference Group member

Susan Weiner – NICE, External Reference Group member

Katie Wookey – Policy Researcher, The British Heart Foundation

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NHS REFORMS: IMPLICATIONS AND CONSULTATION RESPONSE

Cabinet Member	Councillor Philip Corthorne
Cabinet Portfolio	Social Care, Health and Housing
Officer Contact	Kevin Byrne, Deputy Chief Executive's Office
Papers with report	Annex A – Suggested Consultation Response

HEADLINE INFORMATION

Purpose of report	To inform Cabinet of proposals, consider implications and agree response to Government on NHS reforms.
Contribution to our plans and strategies	Proposals will impact on the Council's relationship with the NHS and offers opportunities for effective partnership and to improve services for residents.
Financial Cost	The proposals do not contain clear details of a financial cost to the Council at this stage.
Relevant Policy Overview Committee	External Services Scrutiny Committee
Ward(s) affected	All

RECOMMENDATION

That the Cabinet Member agrees a response, on behalf of the Council, to the "Liberating the NHS: Increasing democratic legitimacy in health" consultation be sent to the Department of Health as per Annex A.

INFORMATION

Reasons for recommendation

To enable officers to respond by the closing date for consultation of 11 October 2010.

Alternative options considered / risk management

1. Not to respond which would have forgone the opportunity to represent the interests of the Council and residents in the development of proposals.
2. There are opportunities and risks associated with the reforms which are explored further below.

Comments of Policy Overview Committee(s)

The contents of this report have been discussed with the Chairman.

Supporting Information

1. On 12 July 2010, the Secretary of State for Health, Andrew Lansley, set out his vision for the NHS under the Coalition Government through the publication of the Health White Paper "*Equity and Excellence – Liberating the NHS*".

2. In the subsequent 10 days, the White Paper was followed by a raft of four consultations:

- Liberating the NHS: Increasing democratic legitimacy in health
- Transparency in outcomes - a framework for the NHS
- Liberating the NHS: Commissioning for patients
- Liberating the NHS: Regulating healthcare providers

3. The most important of these consultations for local government is "*Increasing Democratic Legitimacy in Health"*. The reforms proposed in the White Paper cover the entire ambit of the NHS' operations, and place new responsibilities on local government. A proposed response to the consultation is at Annex A and more detailed information on the range of NHS reform is set out below.

The Council role

The White Paper sets out the future role expected of councils:

1. **Leading joint strategic needs assessments (JSNA) to ensure coherent and co-ordinated commissioning strategies** - collecting information on our population together with GP consortia in order to design, deliver and purchase the best possible services
2. **Supporting local voice, and the exercise of patient choice** – taking responsibility for the transformation of the local LINk into HealthWatch, and ensuring there are a range of council and health services available
3. **Promoting joined up commissioning of local NHS services, social care and health improvement** – hosting a statutory Health and Wellbeing Board where joined up commissioning plans for the local area are developed
4. **Leading on local health improvement and prevention activity** – with the responsibility for public health passing over from PCTs to councils

Emphasis is also placed on the potential role of place-based budgeting, or "community budgets" which are expected to be a major part of overall Government policy to be announced in the autumn.

These changes are positive and increase the role of councils in the provision of health, which is appropriate given dependencies with Adult Social Care, Children's Services and the ability of Council services to influence the wider determinants of public health.

However, we need to monitor the emerging detail of proposals for GP Commissioning, Joint Commissioning, Integration with Adult Social Care, Children's Services, the Council's Health and Wellbeing Boards, Public Health and HealthWatch to ensure they benefit residents.

Working together with GP Commissioners

The centrepiece of the NHS Reforms is the abolition of 10 Strategic Health Authorities by 2012 and 150 Primary Care Trusts by 2013, in theory releasing an overall management budget reduction of 45% from NHS commissioning.

The reforms will create an independent National Commissioning Board for the NHS. The Board will allocate £80bn in funds to local GP consortia for them to use to commission local health services.

With GPs taking over most of the NHS commissioning budget (apart from some areas delivered directly by the NHS board, e.g, maternity, specialist commissioning and hospital paediatrics), this means the consortia they are part of will purchase the following services for their local area:

- **Acute care** - medical and surgical treatment usually provided by a hospital
- **Secondary care** – specialist care, typically provided in a hospital setting or following referral from a primary or community health professional
- **Primary care** – community health services provided by doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners, practice nurses and allied health professionals
- **Social care** – integrated care for specialist groups, joint commissioning and reablement, potentially provided or funded with the Council

It will be important for local authorities to have a strong working relationship with GP consortia to ensure that commissioning plans for the local area are truly joined up, achieve efficiencies of scale, avoid duplication and meet the needs of local residents.

There are major benefits to closer working between councils and GPs including:

- A clear programme of potential service benefits and financial savings from joint commissioning with the Council and partnership working on public health
- Agreement on evidence and expert needs analysis through the Joint Strategic Needs Assessment (JSNA)
- Giving GPs access to the ways in which the Council and LSP partners exert influence on the wider determinants of health issues
- An improved Council joint commissioning service covering Prevention, Health Promotion, Adult Social Care & Children's Care
- Agreement and plans in place for further joint commissioning with the local health service, including a single vision, set of objectives and outcomes framework
- Places for GPs within the Local Strategic Partnership and Council governance structure. GPs should join the Wellbeing Board, in advance of formation of a statutory "Health and Wellbeing Board"
- There may be potential areas for co-location of social care and health staff working as an integrated team
- Involvement in developing the Council's new public health function

In Hillingdon, the Council is keen to ensure a local flavour is not lost to commissioning and community healthcare provision. It would therefore support a co-terminous GP consortium to achieve better and more efficient partnership working, while also warding off the possible fragmentation in services resulting from the NHS reforms.

Given the strength of existing partnership working, and the major dependencies between Council and health spending, it is also important for the Council to be a part of the drive by existing PCT managers to develop plans for a shadow GP Commissioning Support Vehicle.

Joint Commissioning

The Health White Paper and the "Local Democratic Accountability in Health" consultation paper both fully encourage the extension of joint commissioning: "*The full potential of joint commissioning, for example to secure services that are joined up around the needs of older people or children and families, remains untapped."*

Health and social care are two sides of the same coin, despite broadly being delivered by different sectors with different funding and governance arrangements. It makes sense from a value for money and quality of outcomes perspective for key areas of health and social care to be jointly commissioned and delivered. This helps ensure a seamless service for residents.

Currently, Hillingdon has a Joint Commissioning Team for Adult Services, covering Older People, Carers, Learning Disabilities, People with Physical and Sensory Disabilities, Drugs and Alcohol and Mental Health.

It is in the interest of local residents that this level of joint commissioning continues and is extended, possibly involving pooled budgets to ensure the delivery of value for money and integrated outcomes. This is in line with the proposed role of the statutory Health and Wellbeing Board in the "*Increasing Democratic Legitimacy in Health"* consultation (see Annex A).

Any proposal from existing PCT managers to the Hillingdon GP consortium will have to take account of joint commissioning. It is considered that there is scope for efficiency and more effective working by developing this further into a Council-led service, which would mean not making joint commissioning part of the PCTs commissioning support vehicle "offer" to the GP consortium. The Council would bid to provide the support for joint commissioning directly for GPs, with the commissioning support vehicle picking up the remainder of primary care commissioning. This would assure the continuation of a strong joint commissioning operation and would be consistent with the Council's role in convening the Health and Wellbeing Board, joining up commissioning and leading on the development of the JSNA.

Integrated working with Adult Social Care

In *'Commissioning for Patients'*, it is proposed that GP consortia be under a duty of partnership and that they will be required to demonstrate this by the NHS Commissioning Board. This is potentially helpful development but success will depend on what the primary and secondary legislation stipulates the consortia will have to do in respect of its relationship with the Local Authority and the commissioning of health and health improvement services.

Despite the likely additional statutory powers of the Health and Wellbeing Board, it is evident from the White Paper and the consultation papers alongside it that Health is regarded as the dominant partner in the relationship with Local Authorities when it comes to community health care and social care. These changes show an imbalance of power in the settlement announced by the White Paper. Within this, power has moved to GPs who will become decision-makers for most of the NHS' £80bn commissioning budget.

The ideal solution for residents is joined up or integrated health and social care, to decrease fragmentation and ensure they receive a seamless service. Similarly, more joined up health and social care ensures that in primary and acute settings, clinicians fully involve the local authority in decisions about placements in residential and nursing care.

Current joint commissioning arrangements and integrated services between PCTs and councils are unlikely to be unpicked by GP consortia. The House of Commons Health Select Committee is currently running an inquiry into commissioning to explore this concern. Universally, the White Paper and the Secretary of State for Health's comments have held up integrated working as the solution to better outcomes for service users and greater efficiencies.

Under the proposals, key decisions about the future of older residents – including whether they are able to return to their home, or whether they will need to move into a care home – would be made in a health context, rather than in partnership with social care. Therefore, close alignment with health, including integrated services, is crucial.

Health and Wellbeing Boards

The Government proposes that statutory Health and Wellbeing Boards run by the Council and LSP would have four main functions:

- To assess the needs of the local population and lead the statutory joint strategic needs assessment;
- To promote integration and partnership across areas, including through promoting joined up commissioning plans across the NHS, social care and public health;
- To support joint commissioning and pooled budget arrangements, where all parties agree this makes sense; and
- To undertake a scrutiny role in relation to major service redesign.

There will be a statutory obligation for the local authority and GPs to participate as members of the Board and act in partnership on these functions.

The White Paper states that membership would be down to individual authorities but *"the boards would bring together local elected representatives including the Leader or the Directly Elected Mayor, social care, NHS commissioners, local government and patient champions around one table. The Directors of Public Health, within the local authority, would also play a critical role. The elected members of the local authority would decide who chaired the board."*

The new Boards would replace current LSP Health Boards and also the Council's Health Overview and Scrutiny function. As such, the Board would be able to:

- call NHS managers to give information, answer questions and provide explanation about services and decisions and making recommendations locally;
- require consultation by the NHS where major changes to health services are proposed; and
- refer contested service changes to the Secretary of State for Health.

In Hillingdon, this effectively represents the conflation of our current LSP Wellbeing Board, chaired by the joint Director of Public Health with the External Services Scrutiny Committee. Putting Health and Wellbeing Boards on a statutory footing is a welcome development. In implementing this it will be important to ensure that:

- the Local Authority's unique democratic mandate through Members to represent local people via the scrutiny role is protected.
- the terms of the duty of partnership must be strong to ensure the Council can fully and properly discharge its role in joining up commissioning for the local area. Although there will be a duty of partnership on GPs, it is unclear what this will entail in practice. Engagement and partnership can be challenging and unappealing areas for clinicians, who perhaps see little benefit from working directly with managers in PCTs or councils.

- In addition, it is important that the timing of the introduction of the Board enables it to work in shadow form so as to be ready to support commissioning of services for Hillingdon residents well before the go live date in 2013. Until that time, the important role of scrutiny through OSC should continue.

Public Health

Subject to Parliamentary Approval, PCT responsibilities for local health improvement will transfer to local authorities, who will employ the Director of Public Health (DPH), jointly appointed with the new, national Public Health Service (PHS).

The DoH will create a ring-fenced public health budget and, within this, local Directors of Public Health will be responsible for health improvement funds. The allocation formula for those funds will include a new "health premium" designed to promote action to improve population-wide health and reduce health inequalities.

The Secretary of State, through the PHS, will agree with local authorities the local application of national health improvement outcomes. It will be for local authorities to determine how best to secure the outcomes.

Funding for health improvement will pass over to the Council from the PCT. It will cover the prevention of ill-health by addressing lifestyle factors such as smoking, alcohol, diet and physical exercise. Broadly, the public health budget will cover prevention, while the NHS budget will cover treatment

Inspection and regulation arrangements for health improvement will be aligned with future arrangements for outcomes in local government, and in particular with the approach to social care outcomes.

The target date is to have the new PHS operational by April 2012. Shadow public health functions will form in councils before then, although shadow public health allocations will not be made until late 2011 for 2012-13, and actual allocations will be made late 2012 for 2013-14. A White Paper on public health is expected in December 2010.

The reforms to integrate public health with councils are to be welcomed, as they will help to drive closer working with health and reflect the fact that Council services have a big effect on wider health determinants for the population. This builds on the work the Council has already begun in Hillingdon with the appointment of a Joint Director of Public Health earlier this year.

In London, it is likely the Mayor will retain certain strategic duties in relation to public health and it is possible certain additional duties and resources will be given to the Mayor. Further detail on this is expected and should be provided within the White Paper.

With public health becoming a Council responsibility, the accountability for the health promotion budget, and hence the overall population health outcomes of the local area will sit with us in future, led by the DPH. As a result, it will be very important to ensure that local GPs and clinicians have played a sufficient part in developing the strategy for health promotion, and that this is strongly linked to the strategy for health treatment (which sits with the NHS), so that there is a single, coherent overall approach to this work for the Borough. If this is not the case, accountability will lie with the Council while some of the tools for delivering improved population health will still lie with the NHS.

As it stands, the arrangements proposed for ensuring a coherent strategy may not be sufficient. While we are able to use the JSNA as the shared process for strategy development with health, this would be bolstered by a proposed additional set of responsibilities:

- A duty for the GP consortium to contribute to the development of the whole population health promotion strategy led by the Council, including a health promotion plan
- A duty for the Council to take into account the view of the GP consortium on the population health outcomes, health promotion and prevention plan

A separate, public health-focused governance arrangement where this work could take place may be necessary, which could report to the Health and Wellbeing Board.

The key requirement for the Council that underpins the transfer of health responsibilities is that the funding for public health is protected during the transition period, over which PCTs are required to make significant financial savings. A formula is being developed by central Government that will be used to calculate the funding allocation that should pass to the Council. This money will be ringfenced following the calculation.

We would recommend to the government that the funding should be allocated to councils in the first instance and not top sliced. Any levy from the Mayor of London on this allocation should take place retrospectively and following a dialogue on the outcomes achieved locally.

Local public involvement - HealthWatch

The consultation states LINks will turn into the local HealthWatch, which will act as local consumer champion across health and social care.

Significantly, LINks will need to scale up and "professionalise" certain functions to discharge their role as HealthWatch. New roles for the organisation include:

- A "Citizen's Advice Bureau" role for health and social care
- NHS complaints advocacy services
- Supporting individuals to exercise choice, for example helping them choose a GP practice.

This is in addition to the current roles of engaging local people on health and social care issues and giving them a voice, and reporting concerns about the quality of local provision.

Councils will continue to fund HealthWatch and contract for their services. Councils have an important responsibility in holding HealthWatch to account for delivering services that are effective and value for money. All the indications are that a good deal of expectation will be placed on the local HealthWatch to act as the independent consumer champion that helps facilitate choice and competition across local providers.
The consultation paper states that additional funding will be provided to match the additional functions. We would suggest that minimum outcome requirements are set for HealthWatch at a local level, but that councils can make their own judgements about the way of achieving these.

With an increasing role for HealthWatch, a more developed approach to risk management will be required. Clarity is needed regarding who owns the risk attached to the delivery of HealthWatch's operations, and for example whether a host organisation will be required in future in the way it is now. Councils must be trusted to carry out their own scrutiny, as they do in other areas.

Finally, the consultation paper is silent on whether children's social care is included within the remit of HealthWatch's role – where currently it is not covered by the LINk. This potential, further duty highlights the fact that a measured and scalable approach must be taken for the development of the new HealthWatch. A great number of new functions are being added and voluntary sector capability must be robust to carry these out. A "big bang" approach to introducing this change carries too much risk. It will be important to first establish the right governance and get the finance right, before gradually moving to a broad and effective HealthWatch.

Financial Implications

There are no clear financial consequences emanating from the proposals yet. Further down the line, as proposals are developed, we will need to monitor the implications for Council services.

EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

Agreeing the consultation response clarifies Hillingdon Council's position and enables officers to engage with the NHS on reforms and seek to influence development locally with NHS Hillingdon and General Practitioners.

It also provides practical input to Government on the implications of the proposals and suggests more effective ways of taking them forward, particularly in regard scrutiny and accountability of health provision.

The Government proposals for the NHS will, potentially, impact on all local residents. Responding to the consultation is the first step in developing Hillingdon Council's response to the opportunities and risks presented.

Consultation Carried Out or Required

None.

CORPORATE IMPLICATIONS

Legal

There are no specific legal implications at this stage. Once the Government introduces legislation to give effect to its proposals, further reports containing detailed Legal Advice will be made to Cabinet.

Relevant Service Groups

The response has been compiled across service groups.

BACKGROUND PAPERS

None.

Annex A

The White Paper team (consultation responses)
Department of Health
6th Floor
Richmond House
79 Whitehall
LONDON SW1A 2NS

By email: nhswhitepaper@dh.gsi.gov.uk

"Liberating the NHS" Consultation Response from London Borough of Hillingdon

In response to your consultation documents on the Health White Paper "*Equity and Excellence – Liberating the NHS*" , I offer the following views on behalf of the London Borough of Hillingdon on the reforms proposed. In addition, I attach at appendix 1 a direct response to the questions posed for local authorities in the paper *"Liberating the NHS: Increasing democratic legitimacy in health" July 2010.*

Building on Health and Social Care Joint Commissioning

The move to GP led commissioning should take account of the success of joint commissioning between councils and PCTs and seek to build on this. There is scope for efficiency and more effective working by developing this further into a council-led service. This could mean for example, not making joint commissioning part of the PCTs commissioning support vehicle "offer" to the GP consortium. Councils would bid to provide the support for joint commissioning directly for GPs, with any commissioning support vehicle picking up the remainder of primary care commissioning.

The continued success of a strong joint commissioning operation and would be dependent upon a shared vision and integrated working. The "duty of partnership" on GPs is helpful but it must ensure that this happens. It will reinforce the council's role in convening the Health and Wellbeing Board and leading on the development of the JSNA.

Budgets

There is a real concern that the eventual actions to implement commissioning decisions will be diluted due to budgetary pressures and funding being squeezed. It is essential that the residual PCTs are prohibited from asset stripping or designing solutions that do not take into account full costing of patient pathways.

Public Health

With public health becoming a council responsibility it will be very important to ensure that local GPs and clinicians have played a sufficient part in developing the strategy for health promotion, and that this is strongly linked to the strategy for health treatment (which sits with the NHS), so that there is a single, coherent overall approach to this work for the borough. If this is not the case, accountability will lie with the council while some of the tools for delivering improved population health will still lie with the NHS.

The key requirement for the council that underpins the transfer of health responsibilities is that the funding for public health is protected during the transition period, over which PCTs are required to make significant financial savings.

In addition, we understand, that in London, it is likely that the Mayor will retain certain strategic duties in relation to public health. We recommend that the funding should be allocated to councils in the first instance and not top sliced. Any levy from the Mayor on this allocation should take place retrospectively and following a dialogue on the outcomes achieved locally.

Timing of Health and Wellbeing Board

It is important that the introduction of the board enables it to work in shadow form so as to be ready to support commissioning of services for Hillingdon residents well before the go live date in 2013.

Cllr Philip Corthorne
Cabinet Member for Adult Social Care, Health and Housing

Appendix 1

Consultation questions from "Liberating the NHS: Increasing democratic legitimacy in health"

The official consultation response from the London Borough of Hillingdon:

Healthwatch
Q1 Should local HealthWatch have a formal role in seeking patients' views on whether local providers and commissioners of NHS services are taking account of the NHS Constitution?
Q2 Should local HealthWatch take on the wider role outlined in paragraph 17, with responsibility for complaints advocacy and supporting individuals to exercise choice and control?
Q3 What needs to be done to enable local authorities to be the most effective commissioners of local HealthWatch?

Hillingdon Response
Q1. HealthWatch must be driven by patient needs and not become preoccupied with bureaucracies surrounding the NHS such as its constitution. Ensuring or overseeing compliance with the constitution feels like a contractual or auditing issue for the NHS rather than a patient voice issue.

Q2. and Q3. A solution needs to be flexible to take account of local needs. Minimum outcome requirements should be set for HealthWatch at a local level and councils left to make their own judgements about the way of achieving these. A measured and scalable approach must be taken for the development of the new HealthWatch. For example, the consultation appears silent on whether children's social care is included within the remit of HealthWatch's role, where currently it is not covered by the LINk. A great number of new functions are being added and voluntary sector capability must be robust to carry these out. A "big bang" approach to introducing this change carries too much risk. We must first establish the right governance and get the finance right, before gradually moving to a broad and effective HealthWatch.

Joint Working and Commissioning
Q4 What more, if anything, could and should the Department do to free up the use of flexibilities to support integrated working?
Q5 What further freedoms and flexibilities would support and incentivise integrated working?
Q6 Should the responsibility for local authorities to support joint working on health and wellbeing be underpinned by statutory powers?

Hillingdon Response
Q4,Q5 & Q6. It is evident from the White Paper and the consultation papers alongside it that health is regarded as the dominant partner in the relationship with Local Authorities when it comes to community health care and social care. While councils are strongly reminded that they are not permitted to directly commission health care, the NHS Operating Framework 2010/11 has been altered to permit and encourage health to commission social care services. Similarly the paper proposes the removal of constraints on Foundation Trusts to enable them to augment their role, for example, by expanding into social care.

These changes with others show an imbalance of power in the settlement announced by the White Paper. The ideal solution for patients is joined up or integrated health and social care, to

decrease fragmentation and ensure they receive a seamless service. Similarly, more joined up health and social care ensures that in primary and acute settings, clinicians fully involve the local authority in decisions about placements in residential and nursing care.

The terms of the duty of partnership on GPs must be strong to ensure the council can fully and properly discharge its role in joining up commissioning for the local area. The removal of constraints on health providers needs to be balanced by a compulsion to work with LAs so that efficiencies can be achieved and planning be focused on improving outcomes for patients. Currently, health recommendations can be made without reference to the council, pushing residents into institutional care at great cost to their independence, and at great cost to the council – when a period of council-provided or council-commissioned "reablement" could have averted this. The statutory powers proposed, therefore, are essential and need to go far enough to ensure a shared vision and integrated working.

On Public Health, as it stands the arrangements proposed for ensuring a coherent strategy may not be sufficient. While we are able to use the JSNA as the shared process for strategy development with health, this should be bolstered by a proposed additional set of responsibilities:

- A duty for the GP consortium to contribute to the development of the whole population health promotion strategy led by the council, including a health promotion plan
- A duty for the council to take into account the view of the GP consortium on the population health outcomes, health promotion and prevention plan
- A duty that GP commissioners must involve the local authority in their treatment commissioning plans. This would allow the local authority/public health responsibility for population health outcomes to be discharged. In addition public health advice on needs and discussions on the LA/NHS interface eg hospital discharge planning would be facilitated.

Heath and Wellbeing board

Q7 Do you agree with the proposal to create a statutory health and wellbeing board or should it be left to local authorities to decide how to take forward joint working arrangements?

Q8 Do you agree that the proposed health and wellbeing board should have the main functions described in paragraph 30?

Hillingdon Response

Q7 and Q8. In Hillingdon, the proposals effectively represents the conflation of our current LSP Wellbeing Board, chaired by the joint Director of Public Health with the External Services Scrutiny Committee. Putting Health and Wellbeing Boards on a statutory footing is a welcome development and we would support this. In implementation it will be important to ensure that :

- Local Authority's unique democratic mandate through members to represent local people via the scrutiny role is protected.

- The terms of the duty of partnership must be strong to ensure the council can fully and properly discharge its role in joining up commissioning for the local area.

- In addition it is important that the timing of the introduction of the board enables it to work in shadow form so as to be ready to support commissioning of services for Hillingdon residents well before the go live date in 2013. Until that time the important role of scrutiny through OSC should continue.

Q9 Is there a need for further support to the proposed health and wellbeing boards in carrying out aspects of these functions, for example information on best practice in undertaking joint strategic needs assessments?

Hillingdon Response

Q9. Not especially. Much of this is in place and working reasonably well. The paper rightly positions the JSNA as the evidence base against which to judge commissioning decisions and review outcomes, an element of compulsion on GPs to commission against clear evidence of need would be helpful.

Q10 If a health and wellbeing board was created, how do you see the proposals fitting with the current duty to cooperate through children's trusts?

Hillingdon Response

Q10. In Hillingdon the current intention of partners is to continue with the Children and Families Trust arrangements. There is no need to stipulate in legislation clear demarcation between the Children's and the Wellbeing board as these issues are best resolved locally and flexibly. Many of the players and stakeholders would be common to both and it would only require clarity and agreement as to where to sit particular issues to ensure effective outcomes and avoid duplication. We do this at present in a number of subject areas such as crime prevention or community cohesion, for example.

Q11 How should local health and wellbeing boards operate where there are arrangements in place to work across local authority areas, for example building on the work done in Greater Manchester or in London with the link to the Mayor?

Hillingdon Response

Q11. Governance arrangements and accountabilities should be made as clear as possible. With public health becoming a council responsibility, the accountability for the health promotion budget, and hence the overall population health outcomes of the local area will sit with us the local authority, led by the DPH. We recommend that the funding for public health should be allocated to councils in the first instance and not top sliced. Any levy from the Mayor of London on this allocation should take place retrospectively and following a dialogue on the outcomes achieved locally.

Q12 Do you agree with our proposals for membership requirements set out in paragraph 38 - 41?

Q13 What support might commissioners and local authorities need to empower them to resolve disputes locally, when they arise?

Q14 Do you agree that the scrutiny and referral function of the current health OSC should be subsumed within the health and wellbeing board (if boards are created)?

Q15 How best can we ensure that arrangements for scrutiny and referral maximise local resolution of disputes and minimise escalation to the national level?

Q16 What arrangements should the local authority put in place to ensure that there is effective scrutiny of the health and wellbeing board's functions? To what extent should this be prescribed?

Hillingdon Response

Q12, Q13, Q14, Q15 &Q16. We agree broadly with proposals for membership.

Resolution of disputes would need backing up by clear mandates to challenge and to work collaboratively (see Q7). It is essential that the OSC role is subsumed into the Health and Wellbeing board so as to avoid duplication or worse potentially arrive at conflicting views on the way forward and causing dispute.

LAs should have the flexibility to develop the structure and scope of Health and Wellbeing Boards locally so as to ensure it is able to meet the much broader and challenging remit.

Q17 What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients, the public and, where appropriate, staff?

Hillingdon Response

Q17 Existing public duties and policies on equality provide sufficient protection

Timescales

Q18 Do you have any other comments on this document?

Hillingdon Response

Q18 Clear guidance on timescales is essential. The consultation paper is silent on when the new statutory duty on Health and Wellbeing board would come into force. As with other reforms proposed it is essential to have in operation a shadow arrangement in good time to enable shared approach to GP commissioning priorities before budgets actually transfer. This suggests that on current timing the board needs to be in place at least a year in advance (so April 2012 for GPs taking over in April 2013). In the interim the OSC should continue and the transition be managed so that it is seamless.

WORK PROGRAMME

Officer Contact	Nav Johal and Nikki Stubbs, Deputy Chief Executive's Office
Papers with report	Appendix A: Work Programme 2010/2011

REASON FOR REPORT

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

OPTIONS OPEN TO THE COMMITTEE

1. Note the proposed Work Programme.

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

INFORMATION

1. At its last meeting, the Committee agreed the attached Work Programme. Pale shading indicates completed meetings.

2. It had been agreed at the Committee's last meeting on 14 July 2010 that the meeting scheduled for 11 January 2011 would be used as an opportunity to speak to GPs about the implications of the Health White Paper.

3. As the Health Inequalities Working Group has now concluded its review of the effect of overcrowding on educational attainment and children's development, consideration needs to be given to the next review: children's suicide and self harm. A scoping report on this topic will be provided for the Committee's next meeting on 24 November 2010.

SUGGESTED SCRUTINY ACTIVITY

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

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

BACKGROUND DOCUMENTS

None.

APPENDIX A

EXTERNAL SERVICES SCRUTINY COMMITTEE

2010/11 WORK PROGRAMME

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

Shading indicates completed meetings

Meeting Date	Agenda Item
9 June 2010	**Community Cohesion Review** The review the achievements of the following organisations since April 2009 with regards to Community Cohesion: • Metropolitan Police • London Fire Brigade • University of Brunel • Union of Brunel Students • Hillingdon Primary Care Trust • Strong & Active Communities • Hillingdon Inter Faith Network • Hillingdon Association of Voluntary Services
16 June 2010	**LINk** To receive a report on the progress of LINk in the Borough since the last update received by the Committee in June 2009.
	Provider Services Detailed scrutiny of provider services, with particular reference to vertical integration and the proposed appointment of Central & North West London NHS Foundation Trust.
14 July 2010	**Safer Transport** To scrutinise the issue of safety with regards to transport in the Borough (Safer Neighbourhoods Team, Metropolitan Police Service and British Transport).
22 September 2010	**CANCELLED**
28 October 2010 - 4.30pm	**NHS & GPs** Performance updates and update on significant issues: • NHS • GPs

Meeting Date	Agenda Item
24 November 2010	**Provider Services** Review of effectiveness of provider services (with particular reference to end of life care, TB, children's speech and language therapy, physiotherapy and specialist community dentistry) and of the progress of the vertical integration: • CNWL • PCT
11 January 2011	**Health White Paper** Review the implications and proposals contained within the Health White Paper published on 12 July 2010. Invitees would potentially include: • Dr Mitch Garsin (Chairman of Hillingdon LMC) • Dr Tony Grewal (Medical Director of the Londonwide LMCs) • the Chairman of Practice-Based Commissioning • GPs
23 February 2011	**Crime & Disorder** • Metropolitan Police Service • Safer Neighbourhoods Team • Metropolitan Police Authority • PCT • London Fire Brigade • Probation Service • British Transport Police • Safer Transport Team
30 March 2011 – 5pm	**Community Cohesion Review** The review the achievements of the following organisations since June 2010 with regards to Community Cohesion: • Metropolitan Police Service • London Fire Brigade • University of Brunel • Union of Brunel Students • Hillingdon Primary Care Trust • Strong & Active Communities • Hillingdon Inter Faith Network • Hillingdon Association of Voluntary Services

Meeting Date	Agenda Item
26 April 2011	**Quality Accounts & CQC Evidence Gathering** • Hillingdon Primary Care Trust (PCT) • The Hillingdon Hospital NHS Trust • Royal Brompton & Harefield NHS Foundation Trust • Central & North West London NHS Foundation Trust • London Ambulance Service • Care Quality Commission (CQC)

Themes	Future Work to be Undertaken
Health Inequalities Working Group Comprising Councillors: • John Hensley (Chairman) • Beulah East • Phoday Jarjussey • Judy Kelly • John Major • Carol Melvin • Mary O'Connor • Michael White	Detailed review of the impact of housing overcrowding on educational attainment and children's development. Working Group Meeting dates: • 3 August 2010 • 31 August 2010 • 22 September 2010 • 19 October 2010 Witnesses • To be agreed
Children's Suicide and Self Harm Working Group	Detailed review of children's suicide and self harm. Working Group Meeting dates: • To be agreed Witnesses • To be agreed

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