Minutes

EXTERNAL SERVICES SCRUTINY COMMITTEE

17 November 2015

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

	Committee Members Present: Councillors John Riley (Chairman), Ian Edwards (Vice-Chairman), Tony Burles, Brian Crowe, Phoday Jarjussey (Labour Lead), Allan Kauffman, John Oswell and Michael White **Also Present**: Phil Powell - London Ambulance Service Pauline Cranmer - London Ambulance Service Kim Cox - Central and North West London NHS Foundation Trust Maria O'Brien - Central and North West London NHS Foundation Trust Richard Connett - Royal Brompton and Harefield NHS Foundation Trust Joy Godden - Royal Brompton and Harefield NHS Foundation Trust Shane DeGaris - The Hillingdon Hospitals NHS Foundation Trust Dr Abbas Khakoo - The Hillingdon Hospitals NHS Foundation Trust Ceri Jacob - Hillingdon Clinical Commissioning Group Dr Cherry Armstrong - Hillingdon Clinical Commissioning Group Dr Chris Jowett - Hillingdon Local Medical Committee Dr Eleanor Scott - Hillingdon Local Medical Committee / Londonwide LMC Graham Hawkes - Healthwatch Hillingdon Ian Brandon - Care Quality Commission **LBH Officers Present**: Dr Steve Hajioff (Director of Public Health), Gary Collier (BCF Manager), Steve Powell (Category Manager) and Nikki O'Halloran **Press and public:** 3
31.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 3)* **RESOLVED: That all items of business be considered in public.**
32.	**MINUTES OF THE PREVIOUS MEETING - 30 SEPTEMBER 2015** *(Agenda Item 4)* **RESOLVED: That the minutes of the meeting held on 30 September 2015 be agreed as a correct record.**
33.	**MINUTES OF THE PREVIOUS MEETING - 8 OCTOBER 2015** *(Agenda Item 5)* **RESOLVED: That the minutes of the meeting held on 8 October 2015 be agreed as a correct record.**
34.	**SHAPING A HEALTHIER FUTURE UPDATE** *(Agenda Item 6)* Dr Cherry Armstrong advised that *Shaping a healthier future* (SaHF), which had been

launched in 2012, was an acute reconfiguration programme and formed part of a wider transformation programme. She noted that the maternity unit at Ealing Hospital had closed in July 2015 and the neonatal unit had closed in June 2015. No negative feedback had been received in relation to the transfer of care and 95% of respondents had advised that they would recommend or strongly recommend the service at Hillingdon Hospital.

Dr Abbas Khakoo, Medical Director at The Hillingdon Hospitals NHS Foundation Trust (THH), advised that, during the transition, there had been 15-18 local expectant mothers that had been unable to give birth in Hillingdon as out of area bookings were being made at that time (arrangements had been made for these women to have their babies in their second choice hospital). Since then, the introduction of the Central Booking System had improved the situation and all GPs in North West London (NWL) had been briefed on the bookings protocol. These bookings were monitored fortnightly by the SaHF Programme Board.

Significant work had been undertaken at Hillingdon Hospital to increase capacity to match the increase in demand and, so far, progress had been positive. Antenatal bookings were now done through the Central Booking System and antenatal and postnatal clinics were being held in the community to provide a higher quality and continuity of care for patients. In addition to the maternity staff that had transferred from Ealing Hospital, Hillingdon had recruited 13 new midwives.

A robust assurance process had been undertaken prior to the transfer which would have taken account of the changing demographics in the Borough. It was noted that this transfer was the first phase of the transition which would take the number of births at Hillingdon Hospital up to 5,000. Any further increase in the number of births at the site would require further investment.

Since the transfer, a booklet (*Giving Birth in North West London*) had been produced to provide expectant parents with information about their options. In addition, regular monthly reports were produced to identify the effect on quality and safety of the service. Although the midwife to birth ratio had improved (1:32), work was underway to improve this further with the recruitment of additional staff anticipated to bring this down to 1:3. Furthermore, there were now two middle grade doctors covering at night and the 12 week booking rate had also improved. It was noted that this was still short of the 130 hours cover in obstetrics units suggested in the independent review undertaken by the Secretary of State in 2013.

The number of unbooked deliveries at Hillingdon had increased in July and August 2015. Hillingdon Hospital had accommodated these births and it was though that this increase was an anomaly. There had also been an increase in the rate of postpartum haemorrhage which was being closely monitored. Dr Khakoo advised that, although the data included on page 48 of the agenda showed a stable trend with a slight decrease, Hillingdon had been identified as an outlier with regard to postpartum haemorrhage and investigations were being undertaken. As Members had expressed concern that, whilst this was true, a large number of neighbouring boroughs maintained much lower levels of postpartum haemorrhage and puerperal sepsis. Dr Khakoo and Ms Jacob advised that they would speak to colleagues and provide the Committee with further information.

As a result of the recent refurbishment, Hillingdon Hospital now had a midwife-led birth unit for the first time which allowed for the provision of additional care for mother and baby and a separate labour ward. An additional nine maternity beds had also been gained.

It was noted that Hillingdon residents would be given priority at Hillingdon Hospital. This was achieved through the use of the Central Booking System, which improved choice, flexibility, access and care. Non residents who had identified Hillingdon as their first choice but could not be accommodated, would be contacted by the Central Booking System and alternative options would be discussed with them. Contact could then be made with an alternative hospital.

Ms Ceri Jacob, Chief Operating Officer at Hillingdon Clinical Commissioning Group (HCCG), confirmed that she would provide the Committee with detailed information in relation to the services in Hillingdon that had been affected by SaHF over the last two years, how successful they had been and whether they had created capacity and/or delivered savings. It was acknowledged that it would take time for some of the changes to become embedded.

Members were advised that the SaHF programme had been implemented to deliver some financial benefits but that quality improvements were also hugely important. Mr Graham Hawkes, Healthwatch Hillingdon's Chief Executive Officer, advised that, although the initial revenue cost of SaHF had been £400m, this was now in excess of £1bn. Ms Jacob advised that she would provide the Committee with revenue and capital costs associated with SaHF and further information in relation to the impact on budgets and financial savings (whether they were on track and the associated deadlines).

RESOLVED: That:

1. **Dr Khakoo and Ms Jacob provide the Committee with further information in relation to levels of postpartum haemorrhage and puerperal sepsis in Hillingdon in comparison to neighbouring boroughs;**
2. **Ms Jacob provide the Committee with detailed information in relation to the services in Hillingdon that had been affected by SaHF over the last two years, how successful they had been and whether they had created capacity and/or delivered savings;**
3. **Ms Jacob provide the Committee with revenue and capital costs associated with SaHF and further information in relation to the impact on budgets and financial savings; and**
4. **the report and presentation be noted.**

35. **UPDATE ON THE PROVISION OF HEALTH SERVICES IN THE BOROUGH**
(Agenda Item 7)

Royal Brompton and Harefield NHS Foundation Trust (RB&H)
Mr Richard Connett, Director of Performance and Trust Secretary at RB&H, advised that the Trust's finances had been rated as 2* by Monitor (it had previously been rated as 3* or 4*) and it was planning for a £10m deficit this year. However, at month 6 there was a £6.5m deficit against the £8.6m plan. It was noted that the 2016/2017 tariff would be key to the Trust's future financial situation.

With regard to improvements projects, Mr Connett advised that £6m capital investment was expected at Harefield Hospital before the end of 2016 in relation to intensive care beds and imaging. The cost of the modular build had increased and, as such, the Trust was looking to refurbish G Floor instead.

Members were advised that RB&H was meeting its infection targets: there had been no cases of MRSA to date and, although there had been a number of Clostridium difficile infections identified, none of these had been as a result of a lapse in care. In addition,

the Trust had met its 'time to treatment' targets in the last quarter and its 14 and 31 day cancer access targets. However, action was being taken to identify the reasons behind the Trust not meeting its 62 day target regarding lung cancer (referrals were not always being made expediently). To this end, Mr Connett stated that the Trust was holding an event on 30 November 2015 at Harefield Hospital to bring together clinical staff from the Trust and clinical representatives from referring centres to identify possible improvements. In addition, radiologists from Harefield Hospital had offered to provide training to referral centres.

It was noted that RB&H had not yet been inspected by the CQC. As the inspection of all specialist trusts would need to be completed by 30 June 2016, an inspection of the Trust was likely to be announced in the near future.

Ms Joy Godden, Director of Nursing and Clinical Governance at RB&H, advised that the Trust looked at serious incidents in great detail and would forward further details to the Democratic Services Manager for circulation to the Committee. It was noted that there tended not to be particular recurring issues and that the Trust focussed on training and the safety culture. Members requested that each trust provide the Committee with 3/6 monthly updates in relation to serious incidents.

<u>The Hillingdon Hospitals NHS Foundation Trust (THH)</u>
Mr Shane DeGaris, THH Chief Executive, advised that, although there was a £1.1m deficit at the end of quarter 2 (Q2), the Trust was looking to achieve a financial breakeven this year in the face of increased demand. As type 1 A&E attendances had increased by 3% to date over 2014, the Trust had not met its Q2 four hour A&E target and was working with Hillingdon Clinical Commissioning Group (HCCG) to identify the reasons for this increase when other Trusts were experiencing decreases. A review of A&E activity had been commissioned by HCCG and the resultant report was expected next year. The review had already identified space constraints, with Hillingdon having 14 bays compared to the London average of 18½.

Members were advised that:

- there had been a 10% improvement in staffing levels between August 2014 and August 2015;
- mortality rates at THH were well below the national average, with below average mortality from weekend admissions;
- work had been undertaken to move the memorandum of understanding forward to agree the contractual position with East and North Herts; and
- out of the nine Clostridium difficile infections identified at the Trust, one had been as a result of a lapse of care. There had been no cases of MRSA this year to date.

Mr DeGaris stated that 95.7% of individuals responding to the Friends and Family test would recommend the Trust and there had been an increase in the number of people who would recommend A&E services. Furthermore, although there had been a 'blip' during a few months, responses to complaints were now back on track with 95.6% being answered within the agreed time frame.

It was noted that the transfer of maternity services from Ealing Hospital to Hillingdon Hospital had gone smoothly. In addition, although a number of operations had been moved to Mount Vernon Hospital, the theatres improvement programme at Hillingdon Hospital had been completed without any major cancellations.

The recruitment of Physicians Associates (PAs) was continuing and THH would be

able to provide the Committee with an update at a future meeting. Members were advised that there was a national programme to recruit 200 PAs and that 50 of these would be in North West London (NWL). It was likely that THH would be leading on this initiative in NWL and would be collaborating with Brunel to train 20 PAs in the next year who, it was anticipated, would then be able to diffuse and develop best practice.

Although there was currently no regulatory body in the UK for PAs, the UK Association of Physician Associates (UKAPA) and Royal College of Physicians of London had been working together to gain General Medical Council regulation. Although PAs were not thought to be an immediate resolution to the current shortage of doctors and nurses, it was anticipated that it would provide relief in the next 5-10 years.

Mr DeGaris advised that work had been progressing with regard to the integration agenda with the Trust Board considering the governance arrangements at its meeting in January 2016. It was noted that an integrated electronic multi-disciplinary care record was being piloted from November to December 2015 and that the findings would also be presented to the Trust Board in January 2016. Further information in relation this would be provided to Members at a future meeting.

Members were advised that master planning was underway to look at the future configuration of health services at both Hillingdon Hospital and Mount Vernon as well as looking at the best use of the sites and space available. To this end, a contractor had been appointed to collect data and analyse options over a 12 month period.

Dr Khakoo stated that the Paediatric Diabetes Outreach Service had proved to be a big success, dealing with approximately 150 children in the Borough. The full complement of Paediatric Diabetes Nurse Specialists visited the schools that these children attended to ensure the staff were aware of their condition and the best practice tariff. The multi-disciplinary clinics that were held in the schools were an effective use of resources as they resulted in a 0% non-attendance rate. In addition, a nurse or consultant was could be contacted on a mobile number 24/7 which had reduced the number of children admitted to hospital as a result of their diabetes. It was noted that the team included a psychologist and about half of the children seen had a social worker.

Although Members congratulated THH on the work that had been undertaken by the Paediatric Diabetes Outreach Service, it was suggested that more could be done to publicise these successes. Mr DeGaris advised that he would speak to the Trust's communications team to see if further publicity work could be undertaken.

Members were advised that action had been taken to reduce the number of nurse vacancies on acute wards. Furthermore, the Trust had moved to more ward based care as it was thought that the best standard of care was generally delivered by teams. In addition, THH had maintained the highest number of personal development templates for staff in London.

Additional beds had been available to mitigate the winter pressures in 2014 but these would not be available this winter until January / February 2016. There was a real risk that the Hospital would be under immense pressure over the winter period but the Trust had put contingency measures in place to mitigate the impact.

Although THH still had 50 vacancies, it had a full complement of staff on AMU and A&E. Nurses had already been recruited from Italy and Spain and, it was noted, overseas recruitment would need to continue as there were many trusts that were "fishing in the same pool" of staff. In addition, the Trust had organised weekend

recruitment events and had reduced the recruitment process time from four months to two months.

Members were advised that accommodation was an issue in relation to recruitment. As such, THH would continue to investigate possible ways forward including a review of its own assets. However, the Trust would need to be mindful not to raise expectations as there was no capital investment available.

With regard to the car park, it was noted that the case for the deck had been rejected on financial grounds. However, THH was now talking to the Council's Planning Department about an alternative option which would be considered by the Trust Board in December 2015/January 2016. Members were advised that the capital finance for the car park was currently still in place.

It was noted that there was no singular reason for individuals attending A&E rather than going to see a GP, for example, they did not know what else to do, they were aware that they could be seen and discharged in four hours, they were not registered with a GP, they had tried to access other routes unsuccessfully, they wanted a 2nd/3rd opinion, it was conveniently on their way home, etc.

Members were advised that any individuals attending the UCC that were not registered with a GP were encouraged to do so and provided with the relevant information. As a result, some of these patients did go on to register with a GP. Mr DeGaris advised that THH was reviewing the situation with HCCG and would be looking at the process that led these patients to attend A&E as well as looking at discharge times. He noted that the Trust did not maintain regular information in relation to the reasons for A&E attendance but that it did undertake snapshots. Ms Ceri Jacob, HCCG Chief Operating Officer, stated that managing demand was the responsibility of the CCG and that the older population tended to impact on A&E rather than on the UCC. She also suggested that geography was also an important factor with those living closer to the hospital being more likely to attend A&E, with higher levels of long term conditions, a growing population with increasing expectations also having an impact.

<u>Central and North West London NHS Foundation Trust (CNWL)</u>
Ms Maria O'Brien, Divisional Director of Operations, advised that CNWL had agreed a financial plan with Monitor this year which would see a surplus as a result of the sale of property and would give the Trust a risk rating on 3*.

The CQC inspection that had been undertaken earlier in the year had identified 24 'must do' actions for the Trust. Ms O'Brien noted that the planned actions had been agreed and were being delivered, with testing being undertaken on a monthly basis to ensure that the changes were sustainable. She was confident that the Trust was compliant with the 'must do' actions in relation to inpatient services (lockable space, observations panels, restraint and rapid tranquilisation, management and patient improvement and complaint information). It was not yet known when the CQC would re-inspect the Trust.

Ms O'Brien set out a number of environmental issues that were being addressed as part of the mental health ligature risk assessment which included the replacement of taps across the organisation. As this had been raised by the CQC in inspection reports for all mental health trusts, the tap supplier had run out of taps so there had been a delay in obtaining sufficient stock.

Mr Ian Brandon, Interim Inspection Manager (Hospitals) for the CQC in North West London, advised that CNWL was covered by the mental health team and, as such, he

was unable to provide any reasoning for the ligature risk evaluations.

Ms Kim Cox, Hillingdon Borough Director, advised that a one month staff consultation had been undertaken in relation to the CNWL mental health community service redesign. It was anticipated that the results would be published in the week commencing 23 November 2015. In addition, it was anticipated that the Home Rapid Response Team, which went live this week, would free up the community team to undertake other work.

Members were advised that the Single Point of Access (SPA) was likely to go live in January 2016 and would triage all new referrals and offer support to service users, carers, GPs and other services. Ms Cox noted that it was expected that approximately 50% of enquiries would be diverted to other services. Although data migration might be an issue, it was noted that a contingency had been put in place.

Ms O'Brien advised that a range of work had been undertaken with regard to CAMHS: recurrent funding had been agreed, the waiting lists had been reduced and staff had been recruited for the out of hours response service. Improvements had also been made to adult community health with a positive reduction in the length of stay on Hawthorne Intermediate Care unit, working with Hillingdon Hospital to support early discharge and implementing the Care Connections Team within GP practices to better manage frail/elderly patients.

Insofar as children's community health services were concerned, Members were advised that CNWL:

- was running an immunisations service for school aged children across Hillingdon ,Brent and Ealing;
- was looking to realign with the Children's Social Care Team following the transfer of commissioning for health visiting from NHS England to the Council in October 2015; and
- and other health partners had developed a partnership pathway to provide timely support to young children with speech and language communication needs.

It was noted that recruitment and retention of high quality staff continued to be a challenge, particularly in relation to mental health rather than physical. Other challenges included the increased demand for services by children with complex community health needs, pressures on in patient mental health beds and pressures on CAMHS. Although bed occupancy had reduced from the 120% that had been identified by the CQC, it was still 103% - CNWL was working with HCCG to provide additional community team investment to help address this.

Ms Jacob advised that HCCG did not have capital for investment or property and therefore had no control over such issues. However, when appropriate, HCCG did raise issues with NHS Property Services.

Members agreed that they would like further information in relation to adult and child mental health services at its next meeting on 12 January 2016.

<u>London Ambulance Service NHS Trust (LAS)</u>

Ms Pauline Cranmer, Assistant Director for Operations North West London, advised that the LAS had been inspected by the CQC in June 2015 and the report was expected imminently. However, no date had yet been set for a quality summit.

With regard to frequent callers to the LAS, it was thought that there were about 90 across the whole of the Trust. Only one of these callers lived in Hillingdon and support had been put in place by a range of services including the LAS, GPs and social services. It was noted that Mr Phil Powell, Stakeholder Engagement Manager at the LAS, would be investigating the way that the LAS worked with partners to identify the needs of these individuals before they became prolific callers.

Ms Cranmer noted that that were now 7 specialist mental health nurses working in the Control Centre that provided advice to staff and patients. In addition, a single point of access was available 24/7 for LAS crews across NWL.

Members were advised that a large piece of work was being undertaken (led by NHSE) across London to look at the transportation of Section 136 patients. It was anticipated that this would offer timely and appropriate transport, excluding the use of police vehicles. The LAS had been involved in this project since its inception and had participated in focus groups and steering groups as well as sharing data. It was noted that the LAS was awaiting the outcomes of the final report and its recommendations.

Ms Cranmer advised that there were 4,000 defibrillators across 3,000 sites in London; in addition to the 220 at Heathrow airport and those situated in obvious places like hospitals, she noted that Hillingdon had defibrillators located at the Civic Centre and in 5 GP surgeries, one police station and one school. Members advised that, in addition to these, the Council had provided all primary and secondary schools in the Borough with defibrillators and Dr Chris Jowett was unaware of any GP practice that did not have one.

Multi attendance ratios (MAR) aimed to reduce the number of calls where multiple resources were dispatched to a single patient and therefore increased vehicle availability. It was noted that the MAR were under constant 24 hour review with a target of 1.29%. In addition, a scheme had been introduced in early November 2015 where a solo member of staff (FRU, MRU) would now not be backed up automatically by an ambulance for an initial 9 determinants. This would allow the solo member of staff to choose the transport option most suitable to the patient's needs after they had completed a comprehensive examination of the number. It was anticipated that the number of determinants would be reviewed by the Medical Directorate in late November with a view to increasing them. Members were advised that the patient transport options available had reduced on 3 November 2015 from 8 to 4: Hot 1 (critical assistance); Hot 2 (immediate assistance required); Cold 1 (transport by emergency ambulance required); and Cold 2 (transport under non-emergency conditions required).

A number of changes had been made to clinical protocols following a full review of complaints that had been received. For example, following several cases involving the care provided to patients who had used cocaine, a reminder was issued that an ECG should be routinely taken as part of the assessment as cocaine could induce heart attack. Furthermore, it had been identified that not all maternity units had a dedicated facility to receive a pre-alert/blue call (this had been historically used to alert Emergency Departments that a patient was being brought to them as a high priority emergency so that a doctor and medical team could be prepared for the patient's arrival). As a result, a pan London audit was being undertaken in collaboration with maternity units to look at improving provision and practice.

Members were advised that the PARAMEDIC-2 double-blind trial, which was sponsored by Warwick University, was now fully live across Hillingdon. 287 local patients had been enrolled into the trial since recruitment began in December 2014 (800 nationally). In Hillingdon, 30 paramedics had been trained to enrol patients into

the trial. Although no results had yet been provided, Ms Cranmer advised that she would update the Committee with the results of the trial once they had been received.

With regard to serious incidents, the LAS had declared 53 in the last 12 months and these had been fully investigated and the lessons learnt used to initiate improvements. Ms Cranmer advised that there were no themes emerging from these incidents and that only one was linked to a delayed ambulance response where adequate resources were not available at the time they were needed. It was suggested that consideration be given to bringing forward the LAS' programme of activity to raise the standard nationally.

Hillingdon Clinical Commissioning Group (HCCG)

Ms Ceri Jacob, HCCG Chief Operating Officer, advised that, in 2015, NWL CCGs had commissioned an in-depth analysis of what commissioners were spending on mental health. This highlighted significant differences in spend per head of population across the CCGs in NWL, although Hillingdon was in line with other CCGs in its peer group. Other issues highlighted in this analysis were that:

- on a weighted population basis, CCG funding was reflective of need; and
- the recent discussions in relation to the Outcome work had confirmed that the complexity fact (based on 4 factors: trusts patients, psychosis, Mental Health section and CPA per 1,000 population) was strongly correlated with block spend per head of unweighted population. As the needs of mental health patients could not be generalised, HCCG was working with CNWL to gain a shared understanding.

Members were advised that two additional nurses had been recruited to the memory service. In addition, HCCG was working closely with the LAS, trusts and schools in relation to the local transformation plan.

Ms Jacob advised that, following ongoing engagement with patients and other stakeholders through the year, HCCG had published its Commissioning Intentions on 1 October 2015 (HCCG was required to provide 6 months notice to providers of potential changes). These set out any changes that HCCG may make to how services were commissioned and delivered in the following year and covered all services that HCCG was responsible for (including hospital, community, mental health and primary care (GP) services).

It was noted that HCCG entered into co-commissioning arrangements for general practice with NHSE in April 2015. A Joint Committee was in place and included representation from the Council and from Healthwatch Hillingdon. It was agreed that HCCG provide the Committee with a primary care co-commissioning update at its meeting on 12 January 2016.

A PMS (Primary Medical Services) review had been initiated by NHSE, and HCCG would be responsible for commissioning decisions moving forward. In addition, a new Primary Care Model of Care was in development that, it was anticipated, would deliver accessible, coordinated and proactive care.

Dr Cherry Armstrong noted that HCCG was working with the other 7 NWL CCGs and local mental health providers to implement the Like Minded transformation programme. This programme had included:

- the launch of a single point of access in November 2015;
- crisis support, including 24/7 timely assessment, more crisis management and recovery in a person's home and in the community; and

- enhanced psychiatric liaison services, including a newly commissioned mental health discharge lounge.

Healthwatch Hillingdon (HH)
Mr Graham Hawkes, Chief Executive Officer at HH, advised that HH would be working with Healthwatch Ealing to review the transfer of maternity services. HH would also be looking at the discharge from hospital of those aged 65+ and access to GPs. As HH had been contacted by some patients that had been refused registration at GP surgeries, Mr Hawkes asked that he be included as a witness in the forthcoming major review being undertaken by the GP Pressures Working Group.

Mr Hawkes recognised that a lot of positive work had been undertaken in relation to CAMHS. HH would be looking into the effect of the changes implemented as a result of this work at the end of 2016/2017 and would also look at schools and their influence regarding CAMHS. It was noted that the Council was looking to undertake a cross Policy Overview and Scrutiny Committee review of CAMHS in the next municipal year.

Hillingdon Local Medical Committee (LMC)
Dr Eleanor Scott, Secretary of the Hillingdon LMC, advised that the Health and Social Care Act 2012 prompted changes within a climate of increased financial restraint. This, and a residual history of under resourcing, had combined to place Hillingdon GPs under unprecedented pressure, against which they struggled to provide the quality of care they wished to provide. Although the Commonwealth Fund Commission (CFC) had ranked the UK first for its high performance health system, the UK had fallen in relation to leading healthy lives (this had been reflected in the Joint Health and Wellbeing Strategy refresh in 2014/2015). Members were advised that GPs had performed well with regard to the management of chronic disease and that access to GP services needed to be seen in context, as the UK had been ranked first in access to primary care (out of 11 countries). However, Dr Scott noted that GPs were reaching a point where the workload would not be sustainable and the service would deteriorate.

It was noted that a number of new funding streams had been announced by the Secretary of State for Health that aimed to support the transfer of care out of hospitals and into general practice. Dr Scott had hoped that any savings realised by the *Shaping a healthier future* programme would be transferred to primary care. She noted that the resources available in primary care had not kept pace with a rapidly ageing patient demographic that was prone to multiple conditions.

Dr Scott reiterated that approximately 90% of consultation took place with a GP but that primary care received only 8% of the budget. In addition, consultations had increased by 40% since 2008 with no comparable increase in staff or premises. The difficulty in obtaining reliable interpreting services was also placing patients at risk and was a significant stressor for GPs trying to meet the standard 10 minute consultation time. With consultations becoming increasingly complex, the limited time that GPs had with patients was under further pressure when an interpreter was needed.

Furthermore, practices were struggling to provide services, that had traditionally been delivered in an acute setting, without the necessary infrastructure. For example, consultants referring a patient back to their GP so that the GP could then refer them back to another consultant.

Dr Scott advised that general practice was no longer seen as an attractive career option for young doctors (only 15% of doctors would become GPs now compared to 80% previously) at a time when the transfer of hospital care into general practice meant that many more of them were required. This was compounded by the significant loss

	of GPs expected in London over the next few years as a result of retirement. Concern was expressed regarding the requirement to provide 12/7 access to routine GP services when it was difficult to provide this over five days. As wrap around services were not available to GPs like they were to hospitals, extended community care would be needed to support this. Many practices were constrained by their size and it was estimated that 40% of premises in London were deemed to be unsuitable. Dr Scott suggested that a more flexible, strategic and sustainable approach to premises investment was needed to ensure that there was recurrent funding to support continued development of services and to optimise the use of buildings and land owned by the NHS, the wider public sector and other community-based organisations. To try to meet some of the challenges facing GPs, practices had been working together in new GP Provider Network Companies of associated practices. The aim was to improve patient access to a wider range of services by supporting patients to see different GPs at different surgeries across the network to access the full range of out of hospital services if their own GP practice could not provide them. <u>Care Quality Commission (CQC)</u> Mr Ian Brandon, Interim Inspection Manager (Hospitals) for the CQC in North West London, advised that the CQC was looking at changes to the inspection process post June 2016, once the first round of inspections had been completed. Consultation had been undertaken with providers and it was likely that the CQC would go back to a risk based model and associated core services (e.g., inpatient medical services / sexual health services). The organisation would also be looking at the frequency of inspections with an increased frequency for those providers that had been rated as inadequate or poor. Members were advised that pilots on care pathways would be undertaken towards the end of 2015/start of 2016. For example, the end of life care pathway would be looked at in a locality to assess the patient journey. Outcomes from the pilots would then be assessed to identify any possible work that could be taken forward. **RESOLVED: That:** **1. all trusts provide the Committee with 3/6 monthly updates in relation to serious incidents on an ongoing basis;** **2. THH provide the Committee with an update in relation to the recruitment of Physicians Associates at a future meeting;** **3. THH provide the Committee with an update in relation to the integrated electronic multi-disciplinary care record pilot;** **4. CNWL provide the Committee with a report and further information in relation to adult and child mental health services at its next meeting on 12 January 2016;** **5. HCCG provide the Committee with a primary care co-commissioning update at its meeting on 12 January 2016;** **6. Mr Hawkes be included as a witness in the forthcoming major review being undertaken by the GP Pressures Working Group; and** **7. the report and presentations be noted.**
36.	**MAJOR REVIEW: ALCOHOL RELATED ADMISSIONS AMONGST UNDER 18S - DRAFT FINAL REPORT** *(Agenda Item 8)* Consideration was given to the draft final report of the Working Group's review into

	alcohol related A&E admissions amongst those aged under 18. The Committee noted that, although the subject matter of the review did not involve huge number of young people, it was still a serious issue. Dr Steve Hajioff, the Council's Director of Public Health, advised that Ms Sharon Daye, Consultant in Public Health, had already made some progress with regard to this issue which, it was anticipated, would add value to the process. The Working Group was congratulated for addressing the important issue of alcohol abuse which impacted on the NHS. **RESOLVED: That the Working Group report be presented to Cabinet for consideration at its meeting on 17 December 2015.**
37.	**WORK PROGRAMME 2015/2016** *(Agenda Item 9)* Consideration was given to the Committee's Work Programme. It was agreed that the following additional items be considered at the next meeting scheduled for 12 January 2016: • HCCG provide the Committee with further information in relation to levels of postpartum haemorrhage and puerperal sepsis in Hillingdon in comparison to neighbouring boroughs; • HCCG provide the Committee with detailed information in relation to the services in Hillingdon that had been affected by SaHF over the last two years, how successful they had been and whether they had created capacity and/or delivered savings; • HCCG provide the Committee with revenue and capital costs associated with SaHF and further information in relation to the impact on budgets and financial savings; • CNWL provide the Committee with further information in relation to adult and child mental health services; and • HCCG provide the Committee with a primary care co-commissioning update. Members agreed the GP Pressures scoping report and it was noted that the Working Group would comprise Councillors Chapman, East, Edwards, Lakhmana and Riley. **RESOLVED: That:** **1. the GP Pressures scoping report and the Working Group membership be agreed; and** **2. the Work Programme, as amended, be agreed.**
	The meeting, which commenced at 6.00 pm, closed at 9.00 pm.

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