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A

External Services Select Committee

Date: **TUESDAY, 9 JULY 2019**

Time: **6.00 PM**

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

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

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Councillors on the Committee

Councillor John Riley (Chairman)
Councillor Nick Denys (Vice-Chairman)
Councillor Simon Arnold
Councillor Vanessa Hurhangee
Councillor Kuldeep Lakhmana
Councillor Ali Milani
Councillor June Nelson
Councillor Devi Radia

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Putting our residents first

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

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

3. To respond to any relevant NHS consultations.

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

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

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

'Select' Panel Terms of Reference

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

Agenda

Chairman's Announcements

PART I - MEMBERS, PUBLIC AND PRESS

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

2 Declarations of Interest in matters coming before this meeting

3 Exclusion of Press and Public

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

PART II - PRIVATE, MEMBERS ONLY

8 Any Business transferred from Part I

Minutes

EXTERNAL SERVICES SELECT COMMITTEE

12 June 2019

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

	Committee Members Present: Councillors John Riley (Chairman), Nick Denys (Vice-Chairman), Nicola Brightman (In place of Simon Arnold), Vanessa Hurhangee, Peter Money (In place of Kuldeep Lakhmana), June Nelson and Devi Radia **Also Present**: Kathie Binysh, Head of Screening, NHS England Caroline Blair, Programme Director Renal and Cancer, NHS England Hazel Fisher, Head of Delivery for NWL, Specialised Commissioning London, NHS England (London) Nicholas Hunt, Director of Service Development, Royal Brompton & Harefield NHS Foundation Trust Jessamy Kinghorn, Communications and Engagement Lead / Head of Communications and Engagement / Senior Responsible Officer, NHS England Specialised Services Turkay Mahmoud, Interim Chief Executive Officer, Healthwatch Hillingdon Piers McCleery, Director of Strategy and Planning, Royal Brompton & Harefield NHS Foundation Trust Claire McDonald, Communications and Engagement Adviser, NHS England Johanna Moss, Director of Strategy and Development, Moorfield's Eye Hospital NHS Foundation Trust Joe Nguyen, Deputy Managing Director, Hillingdon Clinical Commissioning Group Nick Strouthidis, Medical Director, Moorfield's Eye Hospital NHS Foundation Trust Dr Stephen Vaughan-Smith, Mental Health Lead, Hillingdon Clinical Commissioning Group Dan West, Director of Operations, Health Watch Hillingdon **LBH Officers Present**: Dr Steve Hajioff (Director of Public Health) and Nikki O'Halloran (Democratic Services Manager)
3.	**APOLOGIES FOR ABSENCE AND TO REPORT THE PRESENCE OF ANY SUBSTITUTE MEMBERS** *(Agenda Item 1)* Apologies for absence had been received from Councillor Simon Arnold (Councillor Nicola Brightman was present as his substitute), Councillor Kuldeep Lakhmana (Councillor Peter Money was present as her substitute) and Councillor Ali Milani.
4.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 3)* **RESOLVED: That all items of business be considered in public.**

5.	**MINUTES OF THE MEETING ON 30 APRIL 2019** *(Agenda Item 4)* It was suggested that other Trusts could learn a lot from the good practice demonstrated by Central and North West London NHS Foundation Trust. It was noted that there were a number of resolutions in these minutes that had not yet been actioned. It was anticipated that further information on these would be forthcoming at the Committee's next meeting on 9 July 2019. **RESOLVED: That the minutes of the meeting held on 30 April 2019 be agreed as a correct record.**
6.	**MINUTES OF THE MEETING ON 1 MAY 2019** *(Agenda Item 5)* **RESOLVED: That the minutes of the meeting held on 1 May 2019 be agreed as a correct record.**
7.	**MINUTES OF THE MEETING ON 9 MAY 2019** *(Agenda Item 6)* **RECOLVED: That the minutes of the meeting held on 9 May 2019 be agreed as a correct record.**
8.	**UPDATE ON THE IMPLEMENTATION OF CONGENITAL HEART DISEASE STANDARDS** *(Agenda Item 7)* The Chairman welcomed those present to the meeting. Ms Claire McDonald, Engagement and Communications Lead, Specialised Commissioning – NHS England (NHSE) London Region, noted that she had last attending a Committee meeting to talk about this issue in 2017. Congenital Heart Disease (CHD) standards had been consulted upon and agreed by the NHSE Board in 2015. It had been noted that the Royal Brompton Hospital had not met the standard for paediatric colocation on the Chelsea site as the other specialist children's services required for hospitals providing children's CHD were not located on site. In order to meet the standards, the Royal Brompton Hospital had proposed a partnership with Guys and St Thomas' Hospital which was compliant with the CHD standards. The proposal had been to move all paediatric services from the Chelsea site (children's heart surgery (including CHD and intensive care), children's respiratory services for children with cystic fibrosis, primary ciliary dyskinesia and other conditions and children who required long term ventilation in hospital and at home) as a 'joint venture'. Three proposals had been identified by the following organisations: 1. Royal Brompton Hospital and Kings Health Partners - move all services from the Royal Brompton Hospital Chelsea site to new buildings on the Guys and St Thomas' Westminster site as part of a joint venture. Mr Piers McCleery, Director of Strategy and Planning at Royal Brompton and Harefield NHS Foundation Trust (RBH), advised that this collaborative proposal would not just meet the CHD standards but would also improve things like the estate, rotas and opportunities to fulfil academic potential. Collaboration would provide RBH, Guys and St Thomas' and Kings College with the opportunity to improve. It was anticipated that all proceeds from the sale of the Royal Brompton Hospital would be reinvested in this proposal which would develop a network of care for 15m people. Mr Nick Hunt, Director of Service Development at RBH, advised that this proposal was fit for mid-21st century, was network driven and would provide modern care, making it easier to recruit new staff.

2. Chelsea & Westminster and Imperial College Healthcare – move cystic fibrosis services from the Royal Brompton Chelsea site to the Chelsea & Westminster Hospital, cardiac (not adults or children's CHD) and other respiratory services to Hammersmith Hospital and CHD and ECMO to Guys and St Thomas' Hospital.
3. NHSE – move paediatric CHD from the Royal Brompton site to another compliant CHD provider either in total or split along with adult CHD and associated services. This had been the original proposition in 2017.

Mr McCleery suggested that any proposal that sought to pick off services or sub sections of services would not work as well as RBH's proposal which embraced wider collaboration. He noted that taking the paediatric CHD services away from RBH would render other services at the Royal Brompton Hospital unsustainable.

Ms Hazel Fisher, Programme Director Cardiac and Paediatrics Specialised Commissioning – NHSE London Region, advised that none of the proposals would change the services provided at Harefield Hospital and that the organisation was keen to ensure that non-congenital cardiac and respiratory services stayed in London. However, it had been suggested that the proposals would have a knock on effect on the services provided at Harefield Hospital and its sustainability would depend on the option that was eventually chosen. Ms Fisher reassured Members that clarity and support for the future of Harefield Hospital would be a key factor in moving forward. She stated that she would be happy to attend a future meeting to talk to Members about the proposals and how they would address the sustainability of Harefield Hospital.

Ms Fisher noted that the different propositions were being worked through and capital costs and interdependent services were being investigated. Members were advised that no service had been deemed so material that it would be prevented from being moved.

Ms Fisher stated that 2.4% of activity at the Royal Brompton Hospital was in relation to Hillingdon patients. Although consideration would need to be given to the wider referral geography, it had already been established that the proposed changes would have little effect on patient travel times. It was noted that an assessment of travel issues would need to be undertaken before formal communication started with Transport for London (TfL) and the Mayor of London. Consideration also needed to be given to building signage, communications out of hours, and appointment bookings irrespective of which change might be commissioned.

Members were advised that the Royal Borough of Kensington and Chelsea was looking to establish a formal Joint Health Overview and Scrutiny Committee (JHOSC) to look at this issue in more depth. A formal Committee in Common was being formed from the commissioning CCGs which would include the North West London CCG. It was anticipated that the consultation would start towards the end of 2019.

When this issue had first arisen in 2017, Members had expressed concern regarding the impact that proposals would have on attracting and retaining experts. To ensure that this was not impacted further, there was a need for a definitive timeline and certainty about the future. Concern was also expressed that the removal of paediatric CHD would take away the foundation of services provided at the Royal Brompton Hospital.

Ms Fisher advised that the benefits of each of the proposals were currently being investigated. Consideration would need to be given to how each of the proposals: met the CHD standards; improved the quality of service; improved net care; offered value

for money; and improved recruitment and retention. Ms Fisher was aware that recruitment and retention would be a key component of the proposal that went forward. She noted that a resolution was unlikely to be undertaken in one step and that the proposals needed to be deliverable.

The NHSE Board had set timescales for the changes to paediatric CHD service in November 2017. An outline business case to reconfigure paediatric services would need to be ready by November 2019 and consultation would need to be ready to start in January 2020. Mr McCleery advised that RBH was keen to progress its proposal as soon as possible and to start the process of integrating services. Whilst the Trust would like to work within the NHSE timescales, there were constraints.

RESOLVED: That the discussion be noted.

9. **PROPOSED MOVE OF MOORFIELD EYE HOSPITAL'S CITY ROAD SERVICES**
(Agenda Item 8)

Mr Nick Strouthidis, Medical Director at Moorfields Eye Hospital NHS Foundation Trust (MEH), advised that Moorfields was the oldest and largest centre of its kind in Europe. It trained approximately half of all eye surgeons in the UK. The Trust provided excellence in eye care, ground breaking research and comprehensive training.

The Trust operated from 31 sites with City Road being the main site from which 30% of activity was undertaken. Moorfields had been located at the City Road site since the 1890s and, since then, the services available and the needs of patients had changed. As such, the building had some constraints and patient experience was not always acceptable with regard to, for example, way finding.

Members were advised that 10 of the other 30 sites performed surgery (for example, Ealing Hospital) and the others offered a clinic facility. They were reassured that the proposed move to St Pancras would not replace any of the services provided from the other 30 locations. These services were provided in areas where the Trust had been invited by the local CCG and the Trust was actively looking to identify different ways of delivering care.

It was suggested that a move to a new site would enable the Trust to integrate various strands of expertise (for example, research and education) with the intention of stimulating interaction between clinicians, educators and researchers. Ms Johanna Moss, Director of Strategy and Development at MEH, advised that the options appraisals had been assessed and had resulted in the proposal to buy two acres of land for a purpose built facility on the St Pancras site. This move would also help in the regeneration of a deprived area.

Since 2013/14, the Trust had been considering next steps and had been receiving consistent messages regarding the need for accessibility and transport hubs. Investigations had shown that a move from City Road to St Pancras would make an average difference of 3½ minutes to a patient's journey time. The challenge would be how to get patients from the termination of their chosen form of transport to the new site (known as the last half mile). Currently, it took patients 10 minutes to travel the last half mile; it was likely to take 10-20 minutes for the new site. Discussions had been undertaken with RNIB and it was likely that extra support would need to be put in place during the transition period which could include the use of volunteers to signpost. Consideration would also be given to the use of digital technology. It was suggested that Network Rail, Transport for London (TfL) and the Mayor of London be contacted to consider permanent step free access. Mr Turkay Mahmoud, Interim Chief Executive

	Officer at Healthwatch Hillingdon, advised that he would liaise with the other North West London Healthwatch bodies to gain their thoughts on this proposal. Concern was expressed that the move to St Pancras might impact on the stability of the Western Ophthalmic Hospital (WOH) as it was located just along the Circle line. Mr Strouthidis advised that WOH served a different target audience in the North West corridor. There had been active conversations between the two Trusts and he did not anticipate there being any significant competition between them. Mr Strouthidis also advised that there was no intention to scale back the services provided by MEH from the new site. It was noted that the current City Road site would need to be sold and the proceeds would be used to develop the new site. Other sources of funding would include Government funding, capital reserves and fundraising. Concern was expressed regarding the risk associated with not meeting the fundraising target. The financial modelling undertaken had identified a lot of initial risk but the Trust was in the early stages of fundraising. At the end of the consultation period, the Trust would produce an outline business case and would still have time to raise the remainder of the funds needed. Ms Moss advised that MEH would be holding public sessions to solicit feedback from residents and stakeholders. Members were asked to let her know if they were aware of any other pre-scheduled meetings that MEH ought to attend. It was noted that, in 2017/18, there had been 3,636 patients from Hillingdon attending the City Road site and 730 specialised patients. Mr Strouthidis advised that it would not be practical to replicate the current services in a new location as this would not be sustainable in the longer term as demand for ophthalmology services continued to grow at a steady pace. There was also a need to ensure that patients were seen face-to-face when needed and that tests were completed in quick succession so that they could be reviewed remotely by a consultant in a timely manner. **RESOLVED: That the discussion be noted.**
10.	**CANCER SERVICES IN THE BOROUGH** *(Agenda Item 9)* <u>Cancer Screening and Diagnosis</u> Dr Kathie Binysh, Head of Screening at NHS England (NHSE) and NHS Improvement (NHSI), advised that there were currently three cancer screening programmes running: bowel, breast and cervical. Concern was expressed that, nationally, there had been a reduction in the number of women participating in cervical screening which was reflected in the local uptake. In a move to provide improvements to the service and more reliable results, a single laboratory on Euston Road was being established which would process all cervical screening results in London by March 2020. 100% of GPs in the Borough had signed up for the text service to remind patients to have a cervical smear. With regard to breast screening, Hillingdon had performed second worst in the country 25 years ago. Significant improvements had been made in the interim. Bowel cancer screening had been introduced in 2015. A new test had been introduced on 10 June 2019 which meant that there was no longer any need for three samples to be taken and a 7% increase in coverage was expected as a result. Hillingdon's performance with regard to bowel cancer screening was lower than the England

average and lower than other outer London boroughs. There had been historical concerns that the test kits had not been arriving in Hillingdon but this had been addressed when the service transferred to a new provider last year. It was suggested that consideration be given to enabling patients to order their own tests online for bowel cancer screening. NHSE was now looking to set ambitious bowel cancer screening targets.

GPs in Hillingdon would be meeting soon to look at improvements to colorectal (bowel) cancer screening. Mr Joe Nguyen, Deputy Managing Director at Hillingdon Clinical Commissioning Group (HCCG), advised that a lot of work had already been undertaken with GPs and a patient engagement event in relation to cervical screening had been undertaken with Somali women.

Hillingdon had been performing well in comparison to the rest of North West London but was below the national average. Whilst Members acknowledged that the Borough's performance was adequate, it was clear that there was still more work to do. Dr Binysh advised that consideration was being given to adopting the test reminder system across the whole of London and national campaigns were being developed to raise awareness. Thought was also being given to how practices with a low uptake could be targeted and well as how to target those with learning difficulties (LD) or severe mental illness. A lot of work had already been undertaken to get the message through to those with LD and these would need to be replicated for mental health services. He noted that HCCG would also be able to help NHSE with ways to increase reach to those with LD. Consideration could also be given to using Hillingdon Care Partners to help increase uptake.

Dr Stephen Vaughan-Smith, Cancer Lead at Hillingdon Clinical Commissioning Group (HCCG), suggested that the recent increase in the uptake of health checks should help to increase the uptake of the screening programmes. Ethnic difference would also have an impact on uptake.

It was noted that sexual health screening had moved to an online model. This had shown that a proportionate number of older people were using the service.

Dr Vaughan-Smith advised that Hillingdon Hospital had today issued a press release stating that Hillingdon had been deemed the best in London (and nationally) for the treatment and diagnosis of cancer. There was, however, still a significant need for improvements.

Members were advised that there was currently no screening programme for prostate cancer. Whilst previous tests had produced unreliable results, a new MRI test was thought to be potentially very good but more work was still needed. Kits were used initially to screen for cancer. If the kits gave a positive result, or if the individual was symptomatic, they were invited for an endoscopy.

<u>Mount Vernon Cancer Centre (MVCC) Review</u>
Ms Caroline Blair, Programme Director Renal and Cancer at NHSE, advised that a letter had been sent out from NHSE and NHSI - East of England to stakeholders in April 2019. A meeting was being held on 13 June 2019 to look at the options available for the site and it was noted that reviews had been undertaken at the Mount Vernon site at various times. East and North Hertfordshire NHS Trust (ENH), which provided the cancer services at Mount Vernon Hospital, had effectively requested the review of cancer services provided at the site.

The concerns raised by ENH had been in relation to the estate and facilities on the site.

In addition, there was no ITU / HDU facility on site. Dr Vaughan-Smith advised that immunotherapy was an expanding area of treatment which meant that there was a growing need to have access to an ITU. However, repairs had been made when issues had been reported. It was noted that there had been a growth in referrals and attendance at MVCC.

Ms Jessamy Kinghorn, Head of Communications and Engagement at NHSE Specialised Services, advised that NHSE had been approached by ENH at the end of March/early April and the review was currently at the data gathering stage. An external review had been commissioned, a site visit would be undertaken the following week and telephone interviews would be undertaken. NHSE would be able to report back on these findings in July 2019. Four patient engagement events/workshops had also been scheduled in North Hertfordshire, West Hertfordshire, Hillingdon and North West London. Focus groups would then be set up to fill any gaps in the feedback. Data was being gathered from other sources such as the national patient survey, a Healthwatch Hillingdon report from last year and the Macmillan Advisory Group. The patient/public voice was being considered alongside the clinical voice.

Members were advised that fifteen hospitals fed into MVCC with 13.09% of the patients coming from Hillingdon. Consideration would be given to the deliverability of various options. It was anticipated that the review would result in a more sustainable service. If options looked like changes would be needed to the patient pathway, an options appraisal/plan would need to be undertaken.

Concerns had previously been raised by Members regarding ENH's ability to be a fit and proper provider. There had been a particularly difficult issue whereby ENH had refused to provide a service unless enormous capital investment was undertaken. It was thought suspicious that ENH had tried to relinquish hospice services and was now looking at its involvement in cancer services. It was unclear how the services at Mount Vernon could remain stable when these issues had already prompted a number of staff to resign.

It was important to provide the best possible service to the best of the providers' ability in the circumstances available. Ms Kinghorn advised that clinicians were currently working up options and she would need to come back to a future meeting to talk through these options once determined.

Member queried who would be responsible for any expenditure that would be needed on the building as a result of the MVCC review. Ms Kinghorn advised that she would need to investigate this matter further and would provide the Democratic Services Manager with a definitive response for circulation to the Committee as soon as possible. It was suggested that, if The Hillingdon Hospitals NHS Foundation Trust (THH) was responsible, it would be worth liaising with the Trust so that they could identify where the money might come from as they already had a £26m deficit. Ms Kinghorn advised that THH was part of the Programme Board so she would be able to ask the question at their next meeting.

Mr Nguyen advised that the majority of patients in North West London were from Hillingdon. He noted that there was an immediacy needed with regard to engagement with staff. It was also suggested that a relocation to Lister Hospital would not be good for Hillingdon residents. However, it was thought that, if a decision was made to move the service to Stevenage, it was likely that Hillingdon patients would go to a London hospital such as the Royal Marsden. Mr Nguyen advised that a request had been made to include Hillingdon's Clinical Lead on the Programme Board.

	RESOLVED: That: **1. Ms Kinghorn attend a future meeting to talk through options for the MVCC;** **2. Ms Kinghorn provide the Democratic Services Manager with a definitive answer to which organisation would be responsible for paying for repairs to the MVCC estate; and** **3. the discussion be noted.**
11.	**UPDATE ON THE IMPLEMENTATION OF RECOMMENDATIONS FROM PREVIOUS SCRUTINY REVIEWS** *(Agenda Item 10)* It was noted that, as agreed by Cabinet, letters had been sent to the Ministry of Justice, Secretary of State for Housing, Communities and Local Government and Chairman of the Parliamentary Select Committee on 8 June 2018 with regard to the findings of the Community Sentencing Working Group. Although a response had been received from the Ministry of Justice, no formal response had been received in relation to the other two letters. Members were advised that the evidence gathered by the Council's Working Group had fed into a larger Government Select Committee review of Community Rehabilitation Companies (CRCs). This review had resulted in the recent public announcement that the supervision of all offenders on probation in England and Wales would be put back in the public sector after a series of failings following the part-privatisation of the system. **RESOLVED: That the update be noted.**
12.	**WORK PROGRAMME** *(Agenda Item 11)* Consideration was given to the Committee's Work Programme. The Committee agreed to continue to undertake lead Member responsibilities for specific Trusts. Whilst all Members were encouraged to ask questions of all witnesses that attended the Committee meetings, these lead roles had led to more in-depth questioning resulting from more thorough research of the Trusts. It was agreed that the lead Members for each Trust would be as follows: • Councillor June Nelson: Royal Brompton and Harefield NHS Foundation Trust (RBH) • Councillors Simon Arnold and Ali Milani: The Hillingdon Hospitals NHS Foundation Trust (THH) • Councillors Kuldeep Lakhmana and Devi Radia: Hillingdon Clinical Commissioning Group (HCCG) • Councillor Nick Denys: Central and North West London NHS Foundation Trust (CNWL) • Councillor Vanessa Hurhangee: London Ambulance Service NHS Trust (LAS) Following the discussion earlier in the meeting in relation to bowel, cervical and breast screening in the Borough, it was agreed that an additional meeting needed to be arranged that focussed entirely on this issue. It was also agreed that an additional meeting was likely to be needed in relation to the Mount Vernon Cancer Centre review in due course. **RESOLVED: That the Work Programme be agreed.**
	The meeting, which commenced at 6.05 pm, closed at 8.32 pm.

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

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EXTERNAL SERVICES SELECT COMMITTEE – HOSPICE PROVISION IN THE NORTH OF THE BOROUGH

Committee name	External Services Select Committee
Officer reporting	Nikki O'Halloran, Chief Executive's Office
Papers with report	None
Ward	n/a

HEADLINES

To enable the Committee to question representatives of those organisations responsible for delivering hospice provision in the North of the Borough about the closure of Michael Sobell House and the action taken to ensure future hospice provision.

RECOMMENDATION: That the External Services Select Committee makes comment on the information provided and notes the presentations.

SUPPORTING INFORMATION

On 30 October 2018, a special meeting of the External Services Select Committee was convened to look at the provision of hospice services in the North of the Borough. Given the importance of the issue, subsequent meetings were scheduled for 11 December 2018 and 28 February 2019 to enable Members to continue their questioning of the witnesses whilst providing them with sufficient time to be able to take action that would help to resolve the matter.

At the meeting on 28 February 2019, Members were advised that Hillingdon Clinical Commissioning Group (HCCG) had written to East and North Hertfordshire NHS Trust (ENH) setting out its commissioning intentions for the provision of the service. These intentions included three elements: inpatient beds (around eight); 24 hour consultant-led support line; and day centre. It was hoped that the procurement exercise would be completed and a new provider identified by the end of April 2019 for an initial 12 month contract. Due diligence action would then need to be undertaken to mobilise the plan to get the service up and running in its original location as soon as possible (it was anticipated that there would be a 3-4 month mobilisation period). This would include the TUPE transfer of staff, estate condition assessment and undertaking repair works. Once the new service had been commissioned, ENH would facilitate the transfer of the building to the new provider.

Ideally, the service would be up and running again by the summer of 2019 but it was recognised that recruiting specialist end of life staff was a challenge. Although some of the staff from the MSH inpatient unit had been retained in the Borough, recruitment would still need to be undertaken and consideration would need to be given to the skills mix needed for the short and medium term.

At that time, action was being taken to estimate the remedial works that would be needed to get the building into a sufficient state for the service to recommence. There had been significant differences of opinion with regard to the scale of the works needed and the CQC would need to

be consulted on what was deemed acceptable in terms of the condition of the building. Ultimately, the building only needed to be made good for a relatively short period of time. Members were advised that, as Michael Sobell Hospice Charity had reserves/funds that could be diverted, it would be able to make a reasonable contribution towards the building repair costs.

At the meeting on 28 February 2019, it was agreed that an update be provided to the Committee and that partners come prepared to explain what steps they have taken to ensure that this situation is never again repeated. In terms of the timing of this update meeting, Members believed that early July 2019 would provide all partners with ample time to ensure that the inpatient service at Michael Sobell House was up and running again.

The aim of hospice care is to improve the lives of people who have an incurable illness. Hospices provide care for people from the point at which their illness is diagnosed as terminal to the end of their life, however long that may be. That doesn't mean hospice care needs to be continuous. People sometimes like to take a break from hospice care if their condition has become stable and they are feeling well.

Hospice care places a high value on dignity, respect and the wishes of the person who is ill. It aims to look after all their medical, emotional, social, practical, psychological and spiritual needs, and the needs of the person's family and carers. Looking after all these aspects is often referred to as "holistic care". Care also extends to those who are close to the patient, as well as into the bereavement period after the patient has died.

Most hospice care is provided in the patient's own home, but it can also be provided in a care home, as an in-patient at the hospice itself, or as a day patient visiting the hospice. Hospice care is a style of care, rather than something that takes place in a specific building. Hospice teams include doctors, nurses, social workers, therapists, counsellors and trained volunteers. Hospices aim to feel more like a home than hospitals do and can provide individual care more suited to the person who is approaching the end of life, in a gentler and calmer atmosphere than a hospital.

The hospice care sector supports more than 200,000 people with terminal and life-limiting conditions in the UK each year. This amounts to more than four in ten people of those estimated to need expert end of life care. Hospices also have an important role in supporting people's families, especially in providing bereavement support. A total of 46,000 people in the UK receive bereavement support from hospices each year. Hospices support people with a wide range of conditions including cancer, motor neurone disease, cardio-vascular diseases, dementia, multiple sclerosis and Parkinson's disease. They are increasingly supporting people with multiple life-limiting conditions.

The majority of hospice care (84%) is provided in community-based settings, including home care / hospice at home, outpatient services and hospice day care. More than 125,000 people give their time to volunteer for hospices each year.

Charitable hospices in the UK raise the bulk of their funding through support from their local communities including: fundraising, hospice charity shops, legacies, hospice lotteries and investments. They receive some statutory funding, although levels vary across the UK between the different nations and also within different regions. In Scotland, hospices receive (on average) 39% of their income from the Government; in England, it is 32%; in Northern Ireland it is 37%; and in Wales it is 27%. CCG funding for adult hospices varies widely. Across England,

CCGs make contributions to hospice care costs which range from less than 1% to more than 50%.

Collectively, charitable hospices in the UK need to raise around £1 billion each year from their local communities – which amounts to approximately £2.7 million per day. Hospices in the UK spent a total of £1.4 billion on their services in 2016, of which £914 million was spent directly on care, with the remainder on costs including fundraising, compliance and governance.

End of Life Care (EOLC) commissioning is a complex area involving a large number of providers, services and cross-cutting agendas. A simplified model with six aims has been produced. One of these aims is that all people approaching the end of life and their carers and family receive well-coordinated, high-quality care in alignment with their wishes and preferences. Another aim is that sectors work together in collaboration to deliver cross-boundary care: health (adult child, mental, physical, spiritual); social care (Local Authorities, Health and Wellbeing Board); and voluntary/third sector/independent sector (hospice, charitable, independent and patient/users' groups). To enable this, agreement would be needed on outcomes and alignment of goals, shared funding, service specifications and means of practical collaboration.

Michael Sobell Hospice Charity (MSHC)

As well as at providing 10 bed inpatient unit at Michael Sobell Hospice on the Mount Vernon Hospital site, the Hospice provides an outreach service to provide patients and families with access to specialist nursing care in their own homes.

The Michael Sobell Hospice Charity (MSHC - formerly the Friends of Michael Sobell House) is dedicated to supporting the work of Michael Sobell Hospice, providing specialised end of life care and support to local people, their families, friends and carers. Michael Sobell Hospice is run by East and North Hertfordshire NHS and jointly funded by the NHS and MSHC.

This year, MSHC has to raise over £1.6 million to ensure vital services are maintained, around 40% of the overall running costs of the Hospice. Its mission is to develop and motivate the community to donate time and money to support and maintain the work and vision of Michael Sobell Hospice. Thanks to the support provided by the local community, the charity contributes £2 of every £5 that is spent on patient care at the Hospice.

In June 2018, a decision was made to close the Hospice's inpatient unit and move the patients to Wards 10 and 11 in the cancer centre at Mount Vernon Hospital. These patients were then moved again to other wards within the same hospital whilst Wards 10 and 11 were refurbished. The External Services Select Committee received no formal or timely notification of the proposed closure of the Hospice inpatient unit.

East and North Hertfordshire NHS Trust (ENH)

As well as providing services at Hertford County hospital (Hertford), The Lister hospital (Stevenage) and The New QEII hospital (Welwyn Garden City), ENH runs the Mount Vernon Cancer Centre (Northwood), which is one of the country's top five cancer treatment centres, providing specialist radiotherapy services along with chemotherapy for local people.

When it comes to the provision of services, the Trust often works closely with a number of third party organisations, including charities. At the Mount Vernon Cancer Centre, services to

patients are provided by the Paul Strickland Scanner Centre, Lynda Jackson Macmillan Centre and the Michael Sobell Hospice.

The Michael Sobell Hospice Charity (MSHC) is a separate organisation to ENH with its own management team and trustees. ENH does not own the hospice or the land on which it is situated. However, ENH does have a contractual relationship MSHC to provide nursing care to the inpatient service.

ENH has advised that there was no Service Level Agreement (SLA) for its provision of palliative care at MSH. In addition, ENH had not completed an EIA for the move on 18 June because it was thought to be "a simple 'lift & shift' move to a more appropriate care environment". The Trust had concerns about the inappropriate care environment in MSH and these concerns were reinforced by CQC inspectors when they visited in March and reported in July.

Now that palliative care patients are being cared for in MVCC, ENH is confident that all care and quality issues are reported and actioned appropriately at its monthly cancer divisional board meetings. As such, ENH believes that governance has improved under the new arrangements.

Hillingdon Clinical Commissioning Group (HCCG)

The Hillingdon End of Life Joint Strategy 2016-2020 sets out Hillingdon's vision for end of life care, identifies key issues and gaps in service delivery and articulates how the Borough's health and social care services will commit to achieve this vision by 2020. One action identified within the document is the need to ensure that access to hospice and continuing care beds reflects local need.

The report notes that, in April 2016, that there was a chronic shortage of nursing home beds and hospice places in the Borough which limited the choice for patients and families at the end of life.

The Hillingdon Hospitals NHS Foundation Trust (THH)

THH provides cancer services which are dedicated to providing high quality, rapid and comparable cancer services across the UK. The Palliative Care Department is based at Hillingdon Hospital and in the community. A team of specialist nurses, doctors and other healthcare professionals provide palliative care and symptom and pain control for patients with cancer and life-limiting illnesses. The service is linked to the Michael Sobell House Palliative Care Unit at Mount Vernon Hospital and Harlington Hospice.

In June 2018, MSH published a statement advising it had moved hospice patients into two wards operated by ENH at Mount Vernon Hospital. THH maintains that the move was incorrectly reported as being necessary because of 'structural problems' at Michael Sobell House. A historic structural issue in the building had been fully addressed in 2017 when the whole building had been underpinned. THH owns the building, acting as a landlord, and claimed that it had not been advised of further structural issues by any organisation.

WITNESSES

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

- Michael Sobell Hospice Charity

- The Hillingdon Hospitals NHS Foundation Trust
- East and North Hertfordshire NHS Trust
- Hillingdon Clinical Commissioning Group
- Healthwatch Hillingdon
- Harlington Hospice

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EXTERNAL SERVICES SELECT COMMITTEE - HEALTH UPDATES

Committee name	External Services Select Committee
Officer reporting	Nikki O'Halloran, Chief Executive's Office
Papers with report	Appendix A – Hillingdon Clinical Commissioning Group Report Appendix B – Central and North West London NHS Foundation Trust Report
Ward	n/a

HEADLINES

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

RECOMMENDATIONS:

That the External Services Select Committee notes the presentations.

SUPPORTING INFORMATION

The Hillingdon Hospitals NHS Foundation Trust (THH)

THH services are provided from both Hillingdon Hospital and Mount Vernon Hospital. The Trust has a turnover of around £222 million and employs over 3,300 staff. It delivers high quality healthcare to the residents of the London Borough of Hillingdon, and increasingly to those living in the surrounding areas of Ealing, Harrow, Buckinghamshire and Hertfordshire, giving a total catchment population of over 350,000 people.

Providing the majority of services from the Trust, Hillingdon Hospital is the only acute hospital in Hillingdon with a busy Accident and Emergency, inpatients, day surgery, and outpatient clinics. Some services are also provided at the Mount Vernon Hospital in co-operation with the East & North Hertfordshire NHS Trust. Mount Vernon Hospital has a modern Diagnostic and Treatment Centre which comprises a two-storey building and the existing Princess Christian Unit. These buildings house four state-of-the-art operating theatres to carry out elective surgery, plus outpatient services, a spacious waiting area and coffee shop.

Care Connection Teams (CCT)

The Hillingdon Health Care Partnership (HHCP) comprises The Hillingdon Hospitals NHS Foundation Trust; Central North West London NHS Foundation Trust (CNWL); H4All, a partnership of voluntary sector health care providers; and Hillingdon's GP Federation, which brings together all of Hillingdon's GPs.

HHCP brings hospital services, GPs and community care together in Care Connection Teams (CCTs), designed to help prevent emergency admissions to hospital among older residents, many of whom have complex medical conditions. It also prioritises the identification of older people who might be at risk of an emergency hospital admission, and makes treatment in their own home the norm.

After a home visit from a Guided Care Nurse, which includes a top-to-toe medical examination and review of the patient's medication, a care plan is drawn up in consultation with family and carers, and given to the patient with guidance on how to use it. For example, it might include information about symptoms, so the patient can call the team for advice such as when to start medication if their situation has changed. This helps to take pressure off GPs, reassures the patient that support is always available and, because they are known to the team and their treatment is regularly discussed, stops them having to endlessly describe their varying medical problems. The whole system is designed to head off an admission to hospital through the use of early intervention.

The Brunel Partners Academic Centre for Health Sciences

The Brunel Partners Academic Centre for Health Sciences was officially launched at Brunel's Uxbridge campus in November 2017. The establishment of the Centre is a pioneering new partnership between The Trust, Central and North West London (CNWL) NHS Foundation Trust and Brunel University London. The new Centre, jointly funded by the three partners, aims to revolutionise the way health and social care is delivered to meet the changing needs of society - moving away from delivering in a supply model, to where customers see it designed around them, and can exercise their own choice. The Centre will bring about this transformation in Hillingdon by providing the perfect setting for research and developing new methods of healthcare delivery across allied health, nursing, social care and medicine.

The Centre's work will focus on five distinct areas:

- research and innovation
- educating the workforce
- outcomes-based care
- quality improvement
- digital health.

Central and North West London NHS Foundation Trust (CNWL)

CNWL is a large and diverse organisation, providing health care services for people with a wide range of physical and mental health needs. The Trust employs approximately 7,000 staff who provide healthcare to a third of London's population and across wider geographical areas, including Milton Keynes, Kent, Surrey and Hampshire.

Community Mental Health Teams (CMHTs) work with patients to develop recovery goals and offer continuity of care. They will assess the needs of the patient to make sure the treatment provided is personalised. They also offer more intensive care when people need it most and help patients to work towards greater independence in managing health and wellbeing.
The Community Rehabilitation Team offers care coordination and support to people with a mental illness in supported living or care homes, with a view to helping develop independent living skills and improving quality of life. Staff from a range of clinical backgrounds work within the CMHTs/Community Rehabilitation Teams, in addition to peer and employment support advisors.

- Single Point of Access - The Single Point of Access (SPA) offers mental health triage for routine, urgent and emergency referrals, mental health signposting, information and advice, 24 hours a day, 7 days a week, 365 days a year. SPA also incorporates CNWL's Urgent Advice Line (UAL), providing out of hours crisis support and advice. The team consists of qualified clinicians who are able to direct callers to the most appropriate service to meet their needs.

- Primary Care Mental Health Team - The team works within GP surgeries, helping people to adjust once discharged from secondary mental health services, or providing advice to GP's on what services to offer their patient.
- Talking Therapies - Hillingdon Talking Therapies is a free, confidential NHS service, which provides psychological treatment for depression and anxiety disorders, phobias and post-traumatic stress disorder. Conditions are treated using a variety of therapeutic techniques, including cognitive behaviours therapy (CBT), interpersonal therapy (IPT) and couples therapy. The service accepts referrals from GPs, health care professionals and self-referrals.
- Crisis and Home Treatment Team (HTT) - The team has doctors, nurses, social workers, occupational therapist and support workers who are available to support patients, carers and their families 24/7. The team supports people in mental health crisis in their own homes and seeks to avoid unnecessary admissions to mental health inpatient settings.
- Liaison Psychiatry Team - The liaison psychiatry team work 24/7 alongside colleagues in A&E and general hospital wards, providing assessment, treatment and signposting to people who have a mental illness.
- Early Intervention Services - The service offers intensive support and treatment to people who have been diagnosed with a psychotic illness for the first time. They work with people from 14 years old and offer support for up to 5 years.
- Child and Adolescent Mental Health Services (CAMHS) - CAMHS services are mostly provided in the community, but CNWL also has a specialist inpatient service for 8-13 year olds. Family therapy plays an important role in CAMHS care

Acute mental health services provide assessment and treatment for adults with severe mental illness. This may mean a person needs care as an inpatient in hospital or intensive support through a home treatment team in the community.

Royal Brompton and Harefield NHS Foundation Trust (RBH)

Royal Brompton and Harefield NHS Foundation Trust (RBH) is the largest specialist heart and lung centre in the UK and among the largest in Europe. The Trust works from two sites:

- Royal Brompton Hospital in Chelsea, West London
- Harefield Hospital near Uxbridge

The Trust is a partnership of these two specialist heart and lung hospitals which are known throughout the world for their expertise, standard of care and research success. They only provide treatment for people with heart and lung disease and carry out some of the most complicated surgery, and offer some of the most sophisticated treatment that is available anywhere in the world

Specialist trusts treat patients with rare and complex conditions in a specific area of health. Their clinical teams are skilled in the development and early adoption of new therapies and techniques, and many of the patients they care for cannot be treated in general hospitals.

Specialist trusts are at the forefront of innovation in healthcare and are often responsible for breakthroughs in treatments, which are then adopted by the whole healthcare system. Clinical staff at specialist hospitals are experts in their chosen field and often relocate to specialist centres to further develop their skills. UK specialist trusts welcome clinical specialists from around the globe.

Among their many achievements, experts at RBH:

- pioneered intricate heart surgery for newborn infants born with a congenital heart disease
- performed the first successful heart and lung transplant in Britain
- implanted the first coronary stent
- achieved a world first by implanting a Tendyne transcatheter mitral valve system to treat a leaking mitral heart valve.

Research programmes play a vital role at both our hospitals. This is because the most talented medical experts are rarely content with using tried and tested methods to treat their patients. The opportunity to influence the course of modern medicine by developing new treatments is a prospect that attracts them to specialist centres, where research opportunities are a fundamental part of delivering patient care. Many medical advances made at the Trust have been taken up across the NHS and beyond.

Each year, between 500 and 600 papers by researchers associated with the Trust are published in peer-reviewed scientific journals, such as The Lancet and New England Journal of Medicine. The Trust's main partner is the National Heart and Lung Institute at Imperial College, London. Additional research projects are run with other hospitals and universities in the UK and abroad.

RBH is the leading UK provider of respiratory care and is the national leader in the specialist areas of paediatric cardiorespiratory care, congenital heart disease and cystic fibrosis. In 2016, the Trust cared for around 200,000 patients in its outpatient clinics and supervised around 40,000 inpatient stays. It is one of the country's largest centres for the treatment of congenital heart disease, treating both children and adults and its clinical teams treat more than 10,000 patients with these diseases each year (many receive care from their first few days of life through to adulthood).

The RBH heart attack centre at Harefield has pioneered the use of primary angioplasty for the treatment of heart attacks and has one of the fastest treatment times in the country at only 27 minutes, compared to the national average of 42, a crucial factor in patients' survival. The on-site foetal cardiology service enables clinicians to begin caring for babies while still in the womb; some are scanned and diagnosed at just 12 weeks, when the heart measures just over a millimetre.

Harefield Hospital has more than 1,300 staff, five operating theatres and four catheter laboratories. It has 168 beds, including beds for:

- cardiac and thoracic surgery
- cardiology
- day case unit
- adult intensive care
- the transplant unit.

The hospital is a major centre for the treatment of:

- lung cancer
- chest cancer and oesophageal cancers
- other chest surgery.

The hospital is one of the largest and most experienced centres in the world for heart and lung transplants and has jointly pioneered work in the development of 'artificial hearts' (also known as left ventricular assist devices or LVADs).

RNH's dedicated heart attack centre deals with heart attack emergencies from outer north-west London, providing primary angioplasty in its specialist catheter laboratories. It is thought that the Trust's arrival-to-treatment time of 27 minutes is one of the fastest in Europe, where speed of treatment has been shown to be crucial to survival in these cases.

In the Care Quality Commission inspection report published on 10 January 2017, Harefield Hospital received an overall rating of Good.

NHS Hillingdon Clinical Commissioning Group (HCCG)

The proposal for new clinical commissioning groups was first made in the 2010 White Paper, 'Equity and Excellence: Liberating the NHS' as part of the Government's long-term vision for the future of the NHS. In order to shift decision-making as close as possible to patients, power and responsibility for commissioning services was devolved to local groups of clinicians. The role of CCGs is set out in the Health and Social Care Act 2012 and specifies that CCGs will:

- Put patients at the heart of everything the NHS does
- Focus on continually improving those things that really matter to patients – the outcome of their healthcare
- Empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services

HCCG has a governing body which meets in public each month and the agendas and papers for these meetings can be found on the CCG website. The governing body is made up of GPs from the Hillingdon area and at least one registered nurse and one secondary care specialist doctor. It is responsible for planning, designing and buying/commissioning local health services for Hillingdon residents including:

- Planned hospital care
- Urgent and emergency care
- Rehabilitation care
- Community health services
- Mental health and learning disability services

HCCG covers the same geographical area as the London Borough of Hillingdon and comprises all 46 GP practices across the Borough of Hillingdon. As members of the HCCG, they guide the organisation and make sure the CCG is getting the most from the money it is allocated from the Government.

As a GP-led organisation, HCCG is in the unique position of being able to draw upon the first-hand experience of our patients who use the health services that it commissions. Taking into account their experiences, and talking to them about how best to meet their healthcare needs, HCCG can then commission the services that best meet their needs.

Hillingdon is the second largest of London's 32 boroughs covering an area of 42 square miles. Hillingdon's population for 2011 was estimated at 273,900 (13th largest in London), an increase of 2.93% over midyear estimates for 2010. Hillingdon has a significantly higher population of young people (aged 5-19) compared with England and London. The population of older age groups (50+) is also larger than London but smaller than England. Both groups are expected to increase ahead of average population growth rates.

HCCG's vision is for a high performing, good quality and cost effective acute and community based health system for local residents, in an environment that delivers quality care, supports

clinicians and is satisfying for all staff and members. To help the Trust achieve this vision, it has three key strategic programmes in place:

- the reconfiguration of hospital services through 'Shaping a healthier future';
- out of hospital strategy; and
- financial recovery and savings programme.

The success of these programmes will be measured through a range of services outside of acute hospitals including expanded primary and community care which will lead to a reduction in acute activity and spend, and better integrated hospital and community care, including social care. Working closely with providers, the local authority and community and voluntary sector groups is essential in for HCCG to achieve this.

In North West London (NWL), the CCGs are working together across the NHS to improve healthcare services for the two million residents who live in the area. By working together, the CCGs can ensure that residents have better access to care, around the clock. Whether that means being able to get appointments with a GP quickly and conveniently; making sure more specialist doctors are available, no matter what day of the week it is; that their mental health is considered at the same time as their physical health, with a single, coordinated approach by health and voluntary sector organisations; and that when a resident needs longer term care from different people, it is joined up and they don't need to keep repeating their story.

NWL CCGs are also making sure the public helps shape care, involving them from an early stage in the design of services, and listening to their feedback along the way. Through this joint approach, NWL CCGs will improve people's health and wellbeing, giving them a better quality of life.

Sustainability and Transformation Plan

The NHS Five Year Forward view set out a national requirement for all local health and care systems to be integrated by 2020 in 2015. In December 2015, it was announced that local areas would need to deliver this vision through sub-regional Sustainability and Transformation Plans (STPs). The NHS North West London Collaboration of Clinical Commissioning Groups (CCGs) decided to form a sub-regional plan for eight CCGs and corresponding local authorities: Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea, and Westminster.

In NWL, there is currently significant pressure on the whole system. Both the NHS and local government need to find ways of providing care for an ageing population and managing increasing demand with fewer resources. Over the next five years, the growth in volume and complexity of activity will outstrip funding increases. But this challenge also gives partners an opportunity. It is recognised that services are not joined up and don't treat people holistically, that there is duplication and gaps and that there are inefficiencies that mean patients often have poor experiences, making them feel that their time is not necessarily valued. NWL is focused on helping to get people well, but does not spend enough time preventing them from becoming ill in the first place.

The NWL STP is the CCG plan for North West Londoners to be well and live well. It gives the partners the opportunity to deliver better and more integrated health and social care and seek to address the three identified gaps over a five year period:

- The health and wellbeing gap – by preventing people from getting ill where possible and supporting people to stay healthy.

- The care and quality gap – by ensuring the delivery of consistently high-quality and person centred care.
- The £1.3 billion funding and efficiency gap – making sure services are structured and delivered as effectively and efficiently as possible.

The NHS and all eight local authorities across NWL are working together to deliver a better health and care system. Although there will be points of disagreement between different stakeholders, there is a general consensus that these points of disagreement will not stop the different parties from working together to improve the health and wellbeing of our residents.

In NWL, a working partnership between the NHS and the relevant local authorities has been the approach for a while. The NWL CCGs are proud of their record of working together with all of the councils in NWL and the wider NHS and community and voluntary sector to deliver new and improved integrated services.

As part of the STP's development, a governance structure has been established to oversee the delivery of the plan over the next four years, maintaining the links with local health and wellbeing boards. This includes a Joint Health and Care Transformation Group that acts as the system leadership group and oversees the delivery of the STP. Group representation comes from system leaders across NWL, including council, NHS and lay partners. Meetings take place on a monthly basis.

HCCG works closely with the London Borough of Hillingdon on health and social care issues. This close relationship with the Council is more important than ever as we deliver the Better Care Fund (BCF), which is a single pooled budget to support health and social care services to work more closely together in local areas.

The London Ambulance Service NHS Trust (LAS)

The LAS is the busiest emergency ambulance service in the UK and provides healthcare that is free to patients at the time they receive it. It is also the only London-wide NHS trust. The LAS has around 5,000 staff who work across a wide range of roles based in 70 ambulance stations and serve more than eight million people who live and work in the London area. The service operates over an area of approximately 620 square miles, from Heathrow in the west to Upminster in the east, and from Enfield in the north to Purley in the south.

The LAS' main role is to respond to emergency 999 calls, providing medical care to patients across the capital, 24 hours a day, 365 days a year. Other services offered include providing pre-arranged patient transport and finding hospital beds. Working with the police and the fire service, the LAS is prepared for dealing with large-scale or major incidents in the capital.

As the mobile arm of the health service in London, the LAS' main role is to respond to emergency 999 calls, getting medical help to patients who have serious or life-threatening injuries or illnesses as quickly as possible. The majority of patients, however, do not have serious or life-threatening conditions and they don't need to be sent an ambulance on blue lights and sirens. Often they can receive more appropriate care somewhere other than at hospital.

As an emergency service in the capital, the LAS needs to be prepared to deal with large-scale incidents. The biggest challenges the Trust has faced have been the London bombings in July

2005, the Westminster and London Bridge terror attacks in 2017 and the tragic fire at Grenfell Tower in 2017.

The LAS was assessed by the Care Quality Commission (CQC) in June 2015 when the Trust was given an overall rating of 'inadequate'. After being given a rating of 'Requires improvement' in a report published in June 2017, in May 2018 the LAS was rated as 'Good' overall and the care it provides was again rated as 'Outstanding'.

Healthwatch Hillingdon

Healthwatch Hillingdon is a health watchdog run by and for local people. It is independent of the NHS and the local Council. Healthwatch Hillingdon aims to help residents get the best out of their health and social care services such as doctors, dentists, hospitals and mental health services and gives them a voice so that they can influence and challenge how health and care services are provided throughout Hillingdon. Healthwatch Hillingdon can also provide residents with information about local health and care services, and support individuals if they need help to resolve a complaint about their NHS treatment or social care.

Healthwatch Hillingdon is one of 152 community focused local Healthwatch. Together, they form the Healthwatch network, working closely to ensure consumers' views are represented locally and nationally-led by Healthwatch England.

Healthwatch Hillingdon is all about local voices being able to influence the delivery and design of local services. Not just people who use them, but anyone who might need to in the future. By making sure the views and experiences of all people who use services are gathered, analysed and acted upon, Healthwatch can help make services better now and in the future.

To make sure that the voices of children and young people are heard, Healthwatch Hillingdon created Young Healthwatch Hillingdon (YHwH). YHwH is made up of volunteers who represent the views of children and young people living, working or studying in Hillingdon. They do this by:

- Sharing and promoting information about health issues and services that affect children and young people through events, social media updates and reports.
- Speaking to children and young people and gathering their views about what health issues and services are important to them.
- Working with health and social care services representatives to try to shape and improve services for children and young people.

Local Medical Committee (LMC)

Londonwide LMCs supports and acts on behalf of 27 Local Medical Committees (LMCs) across London. LMCs represent GPs and practice teams in their negotiations with decision makers and stakeholders from health and local government to get the best services for patients. They are elected committees of GPs enshrined in statute. Londonwide LMCs and LMCs also provide a broad range of support and advice to individuals and practices on a variety of professional issues.

A local medical committee is a statutory body in the UK. LMCs are recognised by successive NHS Acts as the professional organisation representing individual GPs and GP practices as a whole to the Primary Care Organisation. The NHS Act 1999 extended the LMC role to include representation of all GPs whatever their contractual status. This includes sessional GP and GP

speciality registrars. The LMC represents the views of GPs to any other appropriate organisation or agency.

In the United Kingdom, LMCs have been the local GP committees since 1911. They represent all General Practitioners in their geographical area which is historically coterminous with the successive Primary Care Organisations or other healthcare administrative areas. As the organisation and complexity of primary care has increased, and along with the call for increased professionalism and specialisation of, for instance, negotiators, LMCs' administrative structures have developed from a pile of papers on the kitchen table of the LMC medical secretary to permanent staff and offices with substantial assets. This has allowed the LMCs to develop relationships ranging over time, topic and space between mutual suspicion and antagonism to useful cooperation for common benefit with NHS administrative organisations.

Care Quality Commission (CQC)

The Care Quality Commission (CQC) makes sure that hospitals, care homes, dental and GP surgeries, and all other care services in England provide people with safe, effective, compassionate, high-quality care and encourages care services to improve. The CQC does this by inspecting services and publishing the results on its website to help individuals make better decisions about the care they receive.

The CQC:

- registers care providers.
- monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety and publishes what it finds, including performance ratings to help people choose care.
- sets out what good and outstanding care looks like and makes sure services meet fundamental standards below which care must never fall. Where the CQC finds poor care, it will use its powers to take action.
- takes action to protect people who use services.
- speaks with its independent voice, publishing its views on major quality issues in health and social care.

Throughout its work, the CQC protects the rights of vulnerable people, including those restricted under the Mental Health Act. It also listens to and acts on residents' experiences, involves the public and people who receive care and work with other organisations and public groups.

Activities regulated by the CQC include:

- Treatment, care and support provided by hospitals, GPs dentists, ambulances and mental health services.
- Treatment, care and support services for adults in care homes and in people's own homes (both personal and nursing care).
- Services for people whose rights are restricted under the Mental Health Act.

Witnesses

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

- The Hillingdon Hospitals NHS Foundation Trust (THH)
- Central & North West London NHS Foundation Trust (CNWL)
- Royal Brompton & Harefield NHS Foundation Trust (RBH)
- Hillingdon Clinical Commissioning Group (HCCG)

- The London Ambulance Service NHS Trust (LAS)
- Healthwatch Hillingdon (HH)
- Hillingdon Local Medical Committee (LMC)

ESSC 9 July 2019

Hillingdon CCG Update

Commissioning Reform – Case for Change

Following the publication of the NHS Long Term Plan the eight clinical commissioning groups which cover NW London are considering a proposal to formally merge into one single organisation. The North West London Collaboration of CCGs has published a case for change, setting out why we believe working as one organisation will mean greater efficiency and more resources being freed up for patient care.

Following publication of the case for change, the next step is for us to carefully consider the views of staff, GP members, patients, local authorities and other stakeholders before progressing further. The CCGs will be discussing the proposed move to a single organisation at governing body meetings in public over the coming months. There is a process through which people can submit and ask questions. There will also be a series of rigorous discussions with GP members, local authorities, provider trusts, Healthwatch and other patient groups.

Retaining local accountability will be a key criterion for any future operating model. We will always be strongly committed to meaningful engagement with Healthwatch and local patient groups, and to working locally with Health and Wellbeing Boards and Overview and Scrutiny Committees. GPs will continue to play a key role in shaping and commissioning services for their local populations. And we will continue to work more closely with provider trusts as we move towards an integrated care system across North West London and local integrated care partnerships.

The timescale for change set out by NHS England is that there should be single CCGs aligned to regional Integrated Care Systems no later than April 2021. Following the feedback provided to the case for change the eight CCGs will consider whether this timescale might be brought forward to April 2020.

In parallel, work on the development of Integrated Care Partnerships (ICPs) is continuing across the patch. This is with a view to ensuring that local relationships and accountabilities can be embedded within the governance and structures set up to take forward delivery of ICPs.

Primary Care Networks in Hillingdon

General practices in Hillingdon have been working together with the support of the CCG and the Primary Care Confederation to develop primary care networks covering populations of 30,000 – 50,000.

The networks enhance the work already started in Hillingdon to establish ‘neighbourhoods’ of community and primary care services wrapped around local populations as well as implementing the requirements of the new national primary care contract (Direct Enhanced Service or DES).

The DES will fund primary care networks to build a multi-disciplinary workforce including link workers that will undertake social prescribing and first contact practitioners to provide interventions and advice for patients with musculo-skeletal conditions. Both these roles align with the models of care in development as part of our integrated care partnership working.

National guidance states that each primary care network must have a boundary that makes sense to:

(a) its constituent practices;
(b) other community-based providers, who configure their teams accordingly;
(c) its local community. The agreement of any PCN arrangement should therefore be in partnership with relevant community and mental health NHS providers in that area, considering the MDT approaches

Networks were requested to submit a completed registration form to their CCG by 15th May with the new network contract going live from July 1st. In Hillingdon 9 applications were received with 6 confirmed as fulfilling the national requirements. The CCG is working closely with the three networks that are as yet not compliant with requirements due to the population size covered.

Two practices in Hillingdon have chosen not to align with a network. National guidance states that should a practice choose not to participate in the DES, provisions must be made for their patients to access the relevant services via local practices. We are therefore working with the practices concerned to ensure their patients are able to benefit from the range of services that will be on offer.

Update on Mount Vernon Cancer Services Review

The Cancer Centre treatment service at the Mount Vernon Hospital is a standalone cancer centre that primarily serves the populations of Hertfordshire, South Bedfordshire, North West London and Berkshire. The Centre provides outpatient chemotherapy, nuclear medicine, brachytherapy and haematology as well as radiotherapy for these populations. There are also inpatient and ambulatory wards. The services are commissioned by NHS England's specialised commissioning team and by Clinical Commissioning Groups.

NHS England are undertaking a strategic review of the cancer services provided at Mount Vernon Cancer Centre (MVCC) that is run by East and North Hertfordshire NHS Trust (ENHT) that commenced in May 2019. The review will also involve East of England and the London Cancer Alliances. It will involve peer reviews of the services, and engagement with, and the involvement of patients, clinicians, non-clinical staff and key stakeholders. It will also include a piece of work to examine the long-term health needs for the population that it serves and a separate exercise to examine radiotherapy demand and capacity.

The review is a result of concerns that have been raised regarding the difficulties in recruiting and retaining some of the cancer workforce and also the poor standard of the estates that will require significant capital investment to support long-term sustainability.

NHSE have advised that the review will lead to the development of options which will be designed to ensure the sustainability of cancer services for the populations served by the Mount Vernon Cancer Centre. Also, that there are no set ideas of the outcome of the review. HCCG has responded and advised that as a number of Hillingdon patients receive cancer and cancer-related palliative care treatment at MVCC and that there is a need for engagement to encompass not only cancer but also End of Life (EoL). Cancer clinical and non-clinical leads across NWL, THH and the CCG will be involved in the review and consultation.

NHSE have established a Programme Board, a Clinical Advisory Group (CAG) and a Communications and Engagement Oversight Group (CEOG). The CEOG meets fortnightly and are developing a Communications and Engagement Strategy to be approved by the Board in May 2019. The CAG will review the list of viable clinical model options based on feedback from the engagement process that will be presented at the Programme Board in early July 2019. The financial implications for each of the options will be developed thereafter.

Lower Back Pain Report Recommendations

Following the publication of the report written and published by HealthWatch Hillingdon regarding the changes to policy on treatment for Lower Back Pain the CCG and Hillingdon Hospital have worked together to address the issues and recommendations raised in the document. It is clear that a number of patients did not have the experience they should expect.

In joint working with The Hillingdon Hospitals NHS Foundation Trust, the CCG has reviewed the events leading up to, during and after the implementation of the North West London policy change. As a result we have developed a joint governance and implementation process with The Hillingdon Hospitals Trust. This will ensure more clear and consistent communications to patients and clinicians as well as confirming roles and responsibilities for delivering service transformation.

We will further strengthen the Public, Patient, Involvement and Equality Committee in overseeing the engagement and equalities impact in the Borough. This will support transparency and accountability for our patients.

In addition we very much welcome the offer from HealthWatch to include their details in future correspondence to patients regarding service changes.

We would like to thank HealthWatch Hillingdon for undertaking this valuable work both in regards to the report and the clear recommendations as well as for the support provided to patients during the process.

End of Life Services

Following written confirmation of commissioning intentions to East and North Hertfordshire Trust (ENHT) in February 2019, and completion of an OJEU compliant process, Hillingdon CCG has awarded a contract to Harlington Hospice for provision of:

- Inpatient hospice care
- Day centre-based palliative care
- A 24/7 consultant–led telephone support service

Despite Hillingdon CCG providing ENHT with the requested confirmations of the scope of the hospice services commissioned and the process undertaken we have been unable to progress mobilisation of the services as planned due to constraints on estate and workforce.

A number of meetings have been cancelled by ENHT and despite written requests for confirmation of their intentions regarding the Michael Sobell House inpatient unit (which has been vacant since the withdrawal of services from the site in June 2018) no response has been forthcoming.

The Trust has stated it requires confirmation of commissioning intentions from all commissioners prior to progression with any transition arrangements. A deadline of 5th July 2019 has been set by East and North Hertfordshire CCG (ENHCCG) for all commissioners to provide written confirmation of their intentions for the service with a meeting arranged for 11th July to agree next steps with the Trust.

Hillingdon CCG has escalated and continues to escalate concerns regarding the lack of engagement and pace of implementation of the commissioning changes to both ENHT and ENHCCG.

Appendix 1

NHS
North West London
Collaboration of
Clinical Commissioning Groups

Commissioning reform in North West London

The case for change

28 May 2019

Foreword

This case for change document is written in response to the NHS long term plan which suggests that the number of CCGs will be significantly reduced to align with the number of emerging integrated care system (ICSs). The long term plan raises other issues: how a NW London integrated care system would operate; how integrated care partnerships (ICPs) would develop at a more local level and the development of primary care networks.

This document focusses on the first of those issues- a proposed change that would see NW London moving from eight CCGs to a single CCG.

NW London CCGs have a long and successful history of working together, particularly over the last five years. Building upon our existing relationships, we want to strengthen our collaborative working to commission and deliver high quality, best value, and safe care for the residents of NW London. We need to continue to work to reduce inequalities for our residents, improve our staff experience and deliver the optimum value for the NHS.

We see this as an opportunity to accelerate and streamline our systems and processes, reduce duplication and improve the offer of care to NW London residents. In doing this, we will learn from the experience of previous large-scale operating models, ensuring that we maintain a strong focus on public and stakeholder engagement in each of our eight boroughs.

This document does not hold all the answers - it sets out the implications of this change for comments and feedback from staff and stakeholders to help us to develop a full proposal that we intend to take to our CCG governing bodies later in the year.

The number of CCGs will significantly reduce over the next two years. We recognise that there will be differing views on how this should happen that we will need to resolve. The key areas we need to address now in NW London are:

- Whether this change to the number of CCGs happens by April 2020 or later, in April 2021
- What functions should be delivered at a NW London level and what should be organised more locally;
- How would the finances work; and
- How the changes to our CCGs relate to: changes at NW London with the development of an NW London integrated care system, the development of integrated care partnerships (ICP), based on boroughs, current CCG footprints, or groupings of boroughs, and the development of sub-borough structures such as primary care networks (PCNs).

We believe we have set out a good starting point for discussion. We now need your help to improve the proposals further and help us implement new arrangements that better serve our patients and staff.

Mark Easton
Chief Officer
NHS North West London Collaboration of CCGs

Dr Neville Purssell
Chair
NHS Central London CCG

Dr Andrew Steeden
Chair
NHS West London CCG

Dr Ian Goodman
Chair
NHS Hillingdon CCG

Dr Tim Spicer
Chair
NHS Hammersmith & Fulham CCG

Dr Genevieve Small
Chair
NHS Harrow CCG

Dr Mohini Parmar
Chair
NHS Ealing CCG

Dr Nicola Burbidge
Chair
NHS Hounslow CCG

Dr M C Patel
Chair
NHS Brent CCG

Contents

1 – Introduction

About NW London – background and our history of collaboration

NW London has a diverse population of 2.2million across eight London boroughs, served by eight Clinical Commissioning Groups (CCGs). Although the CCGs have worked together collaboratively since they began, partnership working between the eight CCGs has increased significantly over the last eighteen months.

- In June 2018 a single Accountable Officer (AO) was appointed for all eight CCGs
- We have a single Chief Financial Officer and a single Director of Nursing and Quality for all eight CCGs
- In December 2018, a Joint Committee of the CCGs was formed with delegated powers for acute and mental health commissioning, and to support delivery of the NW London clinical and care strategy and sustainability and transformation plan (STP).

During this time, the eight local CCGs have remained the statutory and accountable organisations and decision making is through their eight individual Governing Bodies.

Moving to a single CCG is the next step in our evolution to accelerate and deliver our aims and objectives.

Further partnership working is also in place beyond CCGs - with provider Trusts, other NHS bodies and our local authorities. This was formalised after the publication of the NHS Five Year Forward View which set out the requirement for areas to develop a Sustainability and Transformation Plan/Partnership (STP). The NW London STP was published in October 2016 and the NW London Health and Care Partnership, a coming together of 30 organisations across NW London, was formed.

The NW London health and care system in NW London is a partnership of 30 organisations across health and social care, with a clear objective to improve and deliver high quality, safe and best value care for the residents of NW London. Our NW London health and care partnership is comprised of eight CCGs, six local authorities, and seven NHS Trusts.

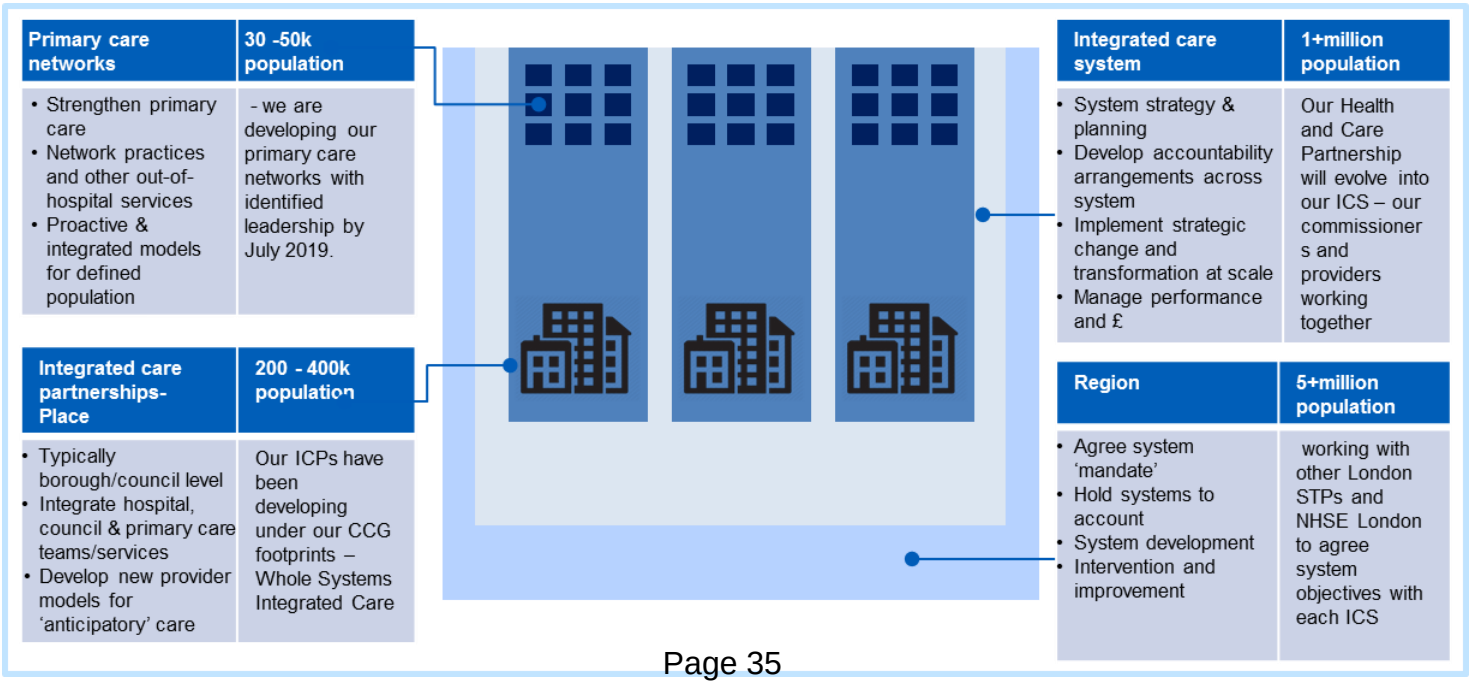


Figure 1: Integrated care as a system of systems

In early 2019 the NHS England 10 Year Long Term Plan was published. This outlines a number of goals for the NHS as a whole including the development of Integrated Care Systems (ICS) and more local Integrated Care Partnerships (ICP) which would be underpinned by Primary Care Networks (PCN). It also included a vision that each ICS would consist of just a single CCG – rather than the eight that NW London has now.

NW London is currently developing the local response to the long term plan, of which this case for change is one related element.

NW London has been working in partnership for some years and with some key successes but challenges still remain – including significant variation in care for patients - and our financial position is in deficit and deteriorating. We believe that we can address our challenges better by bringing together our eight organisations into one strategic commissioning entity to make our decision making and administration as effective and efficient as it can be, with strong borough based local integration. A move to a single CCG will also support the move away from the payment by results system towards capitated outcome- based budgeting, support consistency and equity in our methods for engagement, and simplify system wide financial planning.

We explore those challenges further within this document and set out:

- why we believe a change in commissioning arrangements in NW London is necessary
- what the change might mean and the benefits it will bring to the system
- what this means for our staff, stakeholders and residents
- areas where further discussions are required.

North West London – our challenges and ambitions

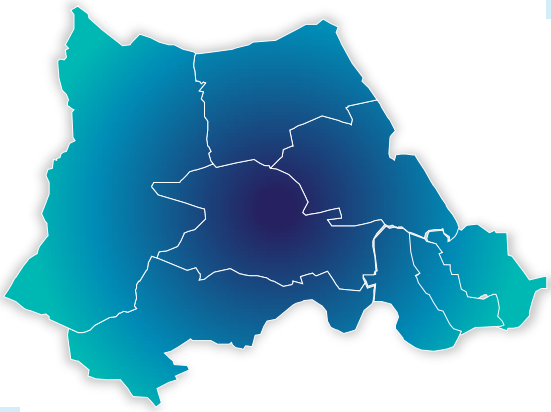
In NW London we want to deliver high quality, best value, and safe care in an environment which supports our staff and improves the experience of care for all NW London residents.

- **379 GP practices**
- **8 boroughs**
- **7 hospital trusts**

Over 30% of patients in acute hospitals do not need to be in an acute setting and should be cared for in more appropriate places

People with serious and long term mental health needs have a life expectancy 20 years less than the average

20% of people have a long term condition



Your chance of being admitted to hospital following a visit to A&E varies from 26%-50% depending on which hospital you visit. This is partly explained by alternative community pathways being present in some areas but not others

Life expectancy varies by 10 years from east to west

Service provision varies – the average length of stay can be 4.3 days or 7.5 days for the same procedure depending on which hospital you go to

Some community staff can administer treatments and services that in other areas require a visit to hospital, such as IV antibiotics

Spend on, and access to, continuing healthcare varies enormously with a range of £14.2 – £23.2m

The NW London CCGs ended 2018/19 with a deficit of £56.7m. Once non-recurring items are stripped out we enter the year with an underlying deficit of £99.6m. CCGs nationally have to cut their administrative costs by 20% compared to their 2017/18 spend.

Figure 2: NW London statistics

Quality and safety

- We will continue to drive high quality safe services, with consistent outcomes for our residents. We will reduce the variation in service provision, standardise pathways and ensure better care is delivered to our population
- We will progress our work to create a stronger, clearer and more consistent commissioning 'voice' for our area, built on the strong foundations of network-based, clinically-led commissioning, and drive forward the changes needed to deliver the resilient and sustainable NHS services that local people need
- Patient flow is often across borough/CCG boundaries, but over 80% of our residents receive care within the NW London area. North West London is a logical basis on which to commission services in order to best support our patient flow.

- By consolidating decision making, we will be able to better drive quality and focus on the important issues, working together to solve them.

Financial stability and sustainability

- We aim to make our financial situation sustainable. At the end of financial year 2018/19 the eight CCGs in NW London had collectively overspent their budgets by £56.7m – we aim to manage our spending within our budgets
- Once non-recurring items are stripped out we enter the year with an underlying deficit of £99.6m. In addition to this, CCGs nationally have to cut their administrative costs by 20% compared to their 2017/18 spend
- Maintaining eight separate statutory bodies is difficult to justify when there is so much pressure on health spending, and each statutory body costs an average of about £680k to run. In NW London we have already saved about 10% of our costs through the changes implemented last year and will endeavour to make further savings through this organisational restructure rather than only looking at changes to front line services
- We want to eliminate the administrative burden that comes from running eight statutory organisations and the transactions costs of the payment by results system. Operating a single administrative and governance function with capitated outcome-based budgets would enable us to focus more of our people and resources on delivering improved services and better patient experience.

Partnership working

- We will strengthen our individual borough relationships with local government, primary care, mental health, community services and the voluntary sector
- We will do this by building on our long history of collaboration locally and solid foundations of working as part of a wider system. Partners in NW London are committed to acting as an integrated care system. The concentration of NHS commissioning focus, through the merger of the eight CCGs in NW London, is an one essential element of these future arrangements, providing a single coherent strategic commissioning voice within an increasingly integrated care system
- We can maintain strong local relationships with our residents, staff and local government partners, without the need and cost of eight statutory bodies. We will have strong and visible local representation in each borough. Some parts of NW London are already making significant progress towards the development of integrated care partnerships which will be the focus of local health and care delivery in the future
- We will need to be clear about the strategic role of the integrated care system, operating at NW London level, and how we will work with our local authority partners in integrated care partnerships at borough level.

Workforce

- Our biggest asset is our workforce and we aim to make NW London a great place to work where staff experience is positive, and we make the best use of our skills and expertise
- We will do this by developing a talent pool and supporting our staff development more easily as one organisation.

2 – Changing at a NW London level

We want to create one integrated care system covering NW London and working together to maximise benefits to residents and staff. We want to achieve improvements in consistency of outcomes, and the highest achievable quality of care, for every one of our two million-plus residents – and the most rewarding working conditions for our thousands of staff who serve them every day.

We believe a single CCG would be an enabler for implementing an effective integrated care system and delivering on our clinical strategy – this document and the subsequent engagement will allow us to explore that and fully understand what a single CCG would enable us to do that we cannot do now with our existing partnership working.

Currently, there are unwarranted variations in case across NW London. Frailty is an example of where there is considerable variation. We have a clinical vision for improving care for the frail and older people - our geriatricians have developed a set of clinical standards for acute frailty services to promote equity of access and outcome for older people in crisis. However, expecting eight CCGs to come up with a way of solving things through eight decision making processes is unlikely to yield a consistent approach that reduces variation as effectively as working together and streamlining decision making.

A single CCG in NW London would become our statutory body for commissioning health care in NW London. The CCG's overarching focus would be commissioning the strategy and priorities of the integrated care system, focusing on patient experience and outcomes, population health management, and governance of tax payers' money

A NW London CCG would have a similar governing body to the current joint committee of CCGs, namely a combination of clinical leaders from the local teams, together with lay members, and managers. A single streamlined decision-making process would reduce decision making costs, reduce unnecessary duplication and improve consistency in service provision.

The CCG would continue to be clinically led, and would have a strong focus on partnerships, driving out variation and have a strong public voice. This public voice will need to be much more than having lay members on the governing body. We plan for to significant public engagement and involvement, so that local residents can help us shape services and provide feedback on how they are working, in a process of continuous engagement.

What we still need to explore

- What safeguards would a single CCG need to ensure it was responsive to local needs?
- What considerations should there be about a single CCG governance arrangements?
- How do we get a strong public voice into a CCG at NW London level?

3 – Changing at a local level

Strong local and visible NHS presence at the borough level remains essential. A health system as large and complex as NW London's could not be run from a single headquarters. We believe that local staff must be working to deliver needs of local populations by working in partnership with local government, primary care, community services and the voluntary sector to integrate health and social care. To achieve that, will maintain our relationships at borough level and improve our integration with local authorities. We will continue to strengthen our joint working in our Health and Wellbeing Boards to demonstrate and deliver local accountability.

There will continue to be teams of local CCG staff working with senior clinicians on local commissioning arrangements with delegated budgets. A key part of their role will be the development of integrated care partnerships.

Integrated care partnerships are vehicles for delivering seamless, integrated care to their local populations (servicing population of about 200,000- 400,000). They are usually in-line with local government boundaries and are part of an overall system of integrated care, governed at a strategic level by and integrated care system. In London, integrated care partnerships are likely to be in-line with the boundaries of boroughs or groups of boroughs, although two of our CCGs are not currently co-terminus with borough boundaries.

Where borough-based effective integrated commissioning arrangements already exist they will continue to be maintained and strengthened.

The NW London CCGs are at various stages in developing integrated care partnerships (ICPs). There is unlikely to be a single model suitable for all parts of NW London, (indeed the national guidance reproduced in appendix 1 suggests six different options) but given ICPs need to fit into a wider system it is important that arrangements do not develop in an inconsistent or contradictory fashion and north west London is developing a framework for ICP development. Our primary focus is to deliver consistent outcomes for the residents of NW London, reducing health inequalities and improve safe quality care.

Critical to each borough or place -based system will be its local general practice delivery and the development of primary care networks (PCNs). PCNs are explained in section 6.

What we still need to explore

- The operating model to determine functions which continue at local level will be developed over the summer as part of the engagement process
- We need to develop further the framework for ICP development and encourage those who are furthest ahead to make progress.

4 – Finance

To ensure effective and on-going delivery of health and care for the residents of NW London, we need to ensure the financial foundations are both stable and sustainable. We believe that this can be best achieved through a move to a single CCG as it will enable greater economies of scale, a stronger negotiating position when commissioning services and the ability to share financial skills.

Currently, our biggest challenge is finding a way to deliver the high-quality safe services for all the residents of NW London within the constraints of our budget. We can continue to improve our decision-making process to make it less fragmented, to allow for economies of scale and improve the quality of care offer for all NW London residents. The NHS long term plan asks us to make 20% savings on our management costs, coming together as a single CCG allows us to make that more easily than as eight organisations.

Becoming a single NW London commissioning entity presents a number of opportunities to maximise our current resources. Operating at-scale, we can strategically commission services, and make it easier for providers to deliver better value. This will mean that providers have more clarity in what we expect and be better able to deliver this. We will establish common standards for providers across NW London to deliver against. Furthermore; those providers who would benefit from more support will have a partner who can more easily mobilise resources to support them. The large NHS providers in NW London have fed back to us that working with a single commissioner in NW London would drive consistency in care and improve efficiency.

Although NW London CCGs as a whole are in significant deficit, individual CCGs are in very different positions, ranging from one in surplus, to others at or close to breakeven and others in significant deficit. Spending on services per CCG is highly variable, often driven by the historic variation in capitation (funding per head of population). Creating a single CCG will raise fears that better funded areas are going to be levelled down, and there will be a loss of local accountability for budgetary decisions. We will need to be sensitive to these issues and ensure that good financial management across NW London is not seen as a punishment on some. Given the sensitivity of this issue we need to be cautious that we do not de-stabilise current arrangements. There is likely to be some London guidance on this issue to ensure some consistency across the capital.

In NW London, there has been historic variation in investment priorities, now we have the opportunity to focus NW London ideas, energies and resource on achieving consistently high standard of outcomes across the ICPs and ICS.

What we still need to explore

- To what extent are there greater opportunities to work with local government from a financial perspective?
- What local level relationships and understanding need to be retained within the financial function?
- We need further understanding of the national and regional timeline on equalising financial allocations to target levels.

5 – What this means for local government

We view our local authorities as key partners within our vision of integrated care for NW London. They are pivotal both to the delivery of population health and through their democratic responsibilities for ensuring that the local voice is determining priorities. Through the development of our integrated care partnerships we want to strengthen this local accountability.

We want to build on the existing partnership arrangements and relationships and move towards greater integration with the eight local authorities in NW London. We believe doing so will enable us all to achieve more for our residents in improving health and care services within the budgets we have.

Integrated care partnerships will encourage innovation and give local freedom to determine how best to collectively work to deliver the agreed outcomes for local residents. In doing so they will build on the existing good practice, for example, in areas where we already have joint appointments and shared work programmes these arrangements should be enhanced further, in others they should provide the environment for these to be explored.

We envisage that Health and Wellbeing Boards' role of providing a strategic steer for effective local delivery of health and care outcomes would continue and the importance of the local authorities in scrutinising health services would of course continue under any reform of commissioning structures. Similarly there would be no impact on the Better Care Fund (BCF) as NW London will continue to meet BCF commitments regardless of CCG structure.

Local government would continue to work with local teams and in some areas may wish to take on more of a leadership function. Given the move to a NW London-wide organisation, these local relationships will become more important than ever in maintaining engagement and involvement at borough level. The local authorities will be key partners in local integrated care partnerships. Health and wellbeing boards in each borough will also continue to play a key role in shaping and developing local services.

What we still need to explore

- How do we ensure that the local voice is strengthened?
- The local partnership between health and local authorities will be key to delivering the outcomes the NHS Long Term Plan – how do we ensure this is most effective?
- What works really well currently that we need to develop further for the benefit of our residents?
- What level of integration is appropriate and achievable?
  Where are the opportunities to capitate and delegate budgets?

6 – What this means for GPs

CCGs are membership organisations, and a NW London CCG would be no different. Members would adopt a new constitution and elect representatives to the governing body as they do now. Commissioning of primary care would be undertaken by the CCG and managed locally with clinical input. This local input is important to ensure we continue to be fully responsive to local population health needs. It is our priority that GPs experience the same level of service, or better, from our commissioning function, we want to keep primary care management, relationships and operational support, including IT, local and will do this by maintaining local delivery teams.

Clinical leadership

Clinical leadership, the ability of clinical leaders across both commissioner and provider organisations to own and drive the local agenda, will continue to be important, irrespective of at which level commissioning operates. We want to continue the good relationships we have with our local GPs and we will not lose the understanding of local issues and needs, that has been a real benefit to our eight CCGs.

Our model is emergent and we have a triple aim for clinical leadership and engagement in development:

1. Maintain clear clinical decision making at a local level and develop system-wide speciality leadership
2. Improve quality of care and reduce health inequalities
3. Partnership working with local government, primary care, community services and the voluntary sector

We have strong clinical leadership in our system on which we will build. Clearly the role of clinical leadership will develop in the new operating model, but it is our priority that we continue to embody the ethos of clinically-led local decision making to suit local population needs, reducing health inequalities and improving patient experience. This means that we need to strengthen:

- Our system clinical commissioning leadership – moving away from traditional models of leadership to a shared leadership model; coaching and enabling collaborative decision making and building specialism. We will continue to strengthen the on-going quality assurance and clinical input to outcomes attainment and standard setting across NW London.
- Our local clinical leadership – acting as the clinical voice in borough-based systems and leading the ICP and the PCNs in the area.
- The interaction between clinical delivery at a local level in both primary and secondary care, and
- The interaction between local leadership, management and delivery with the integrated care system as a whole.

The below diagram is an illustrative example of how we may strengthen clinical leadership at all levels of our ICS. It is intended for description only as ICPs may form various models (see appendix one and two for further information).

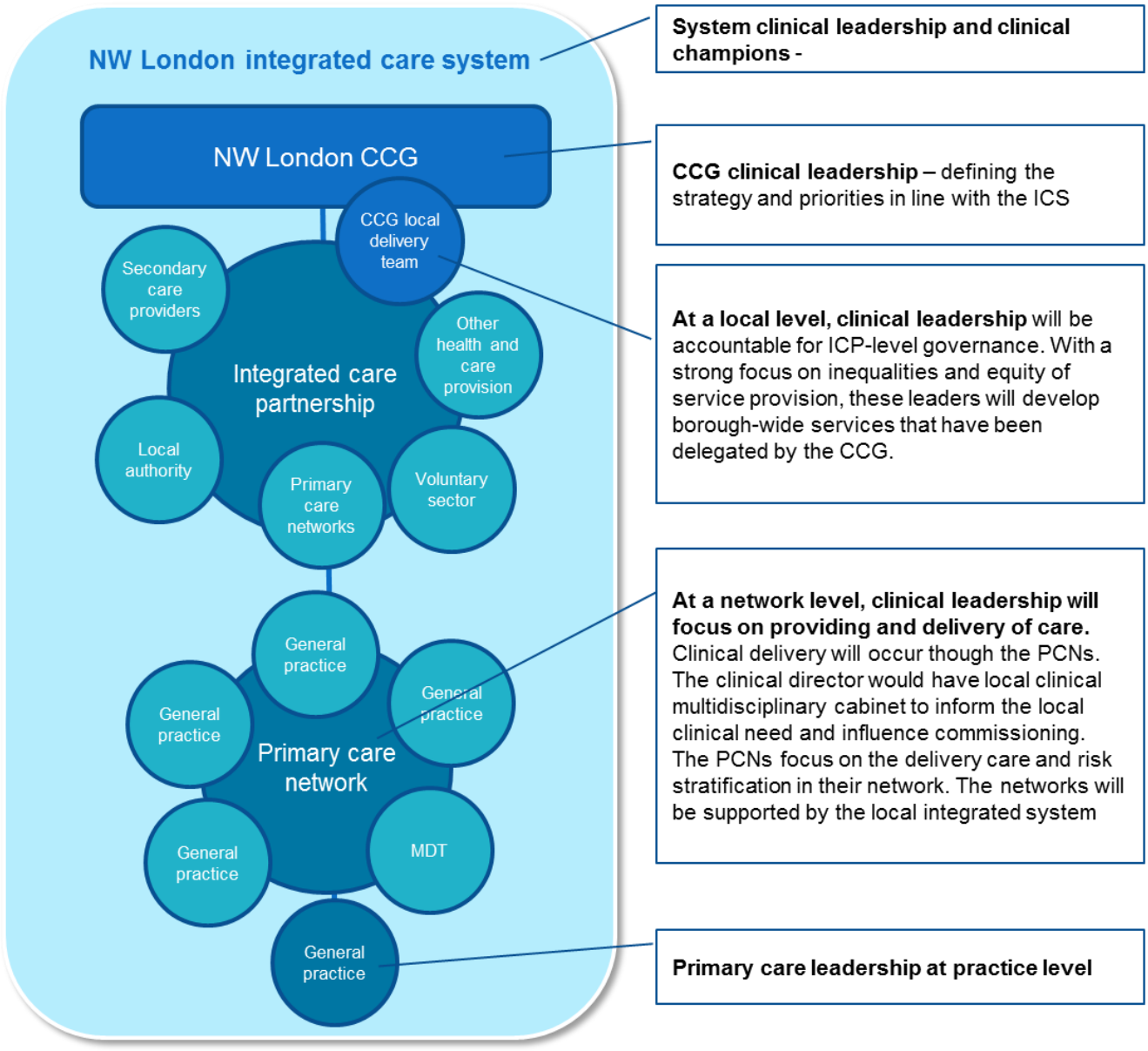


Figure 3: clinical leadership occurs at every level

What we still need to explore

- How best to hear member practices at NW London level if there is a move to a single CCG
- How we can best support transition?
- What impacts do GP practices feel this could have which hasn't been addressed?

7 - What this means for patients and the public

This case for change is about an internal structural change rather than patient facing service changes. However it is intended that the greater efficiencies gained from moving to a single CCG will enable us to be more financial sustainable, more streamlined in our decision making and ultimately lead to more opportunities to address health inequalities across the region.

The proposal for a single CCG for NW London coincides with a drive to improve our engagement with residents and patients across our eight boroughs.

We have positive relationships with our local Healthwatch partners, patient representatives and other community and voluntary sector groups. Healthwatch has always been represented in our entire governance structure and will continue to be so. Their active participation has enabled effective engagement across NW London, regular patient involvement in project development and implementation and also helped us address accessibility and access concerns when we moved to some of our decision making occurring through the Joint Committee.

As part of any changes in decision making in the region, we want to ensure we are representing the differences across NW London and that there continues to be public accessibility and involvement in our decision making. The single CCG would meet in public and rotate meetings across the region, much as the joint committee does now.

We recognise that the people of NW London are not a homogenous group and that there will be different opinions, interests and priorities among different stakeholders and communities. We also acknowledge that people identify with their local area or borough rather than 'NW London'. Most of our public engagement is currently based at borough level, where existing relationships and partnerships are vitally important these local arrangements would continue.

We have ambitious plans to transform the stakeholder engagement landscape in NW London. This will be based on a process of continuous engagement with our residents and stakeholders, offering many more opportunities for the public to feedback on how services are working to help the local voice be heard loudly at regional level. Public engagement should not be limited to proposals to change services or explaining national initiatives – our overall approach will be based on listening to and learning from what the people who use our services and work with us are saying. As part of this plan, we are putting in place a 3,000-strong Citizens' Panel across NW London – a demographically representative group from which we will regularly seek feedback.

We will need to carefully consider any impacts on groups protected under the Equality Act of changes to the way in which we structure our CCGs.

What we still need to explore

- How will we engage with patients/public at local level?
- How would patients and residents be involved in decision-making?
- How should we maintain local accountability?

8 – What this means for CCG staff

As part of a move to a single CCG, we would want to build on staff feedback and improve ways of working for staff. Previous staff engagement surveys have shown that there is limited career progression within the organisations and challenges around retaining staff. People leave one organisation to seek another role in a different organisation a few miles away or sometimes on a different floor within the same building.

The removal of organisational boundaries would allow us to create a shared talent pool. This would give staff the flexibility to progress, develop and use their skills in more challenging and interesting ways, with 'organisational friction' reduced for vertical and horizontal progression across NW London.

The significant amount of duplication which often occurs, especially when working on projects across more than one CCG, causes frustration for staff with the differing governance structures and processes in different areas proving confusing and time consuming. Working as a single CCG would enable us to establish greater consistency in standards and expectations so we can address this variation. For example, simplified governance structures would eliminate the need to pass papers through numerous committees. Common standards also ensure we have common expectations of each other, and would support shared ways of working so we can work in a truly agile manner throughout the organisation.

Any change by its nature introduces ambiguity which can have an impact on people's productivity as well as their health and wellbeing. We are also aware that there are many questions staff will have about this – especially in regard to likely structures – that will not be developed until later in the process. We are mindful of this and will be taking steps to ensure all staff are supported and involved as we develop these proposals.

Although we have to make cost savings as part of these proposals, given the number of vacancies and interim staff there are likely to be few compulsory redundancies amongst substantive NHS staff. Becoming a single CCG will not happen overnight, instead there will be a phased transitional period. During this period plans will be developed that ensure we make a smooth transition, and can realise the benefits outlined above whilst maintaining and building upon what works.

These phases will be:

- **Planning** – Human resources (HR) and operational development (OD) will provide support to map current functions and team structures in order to build a comprehensive picture that can used to develop detailed options
- **Pre-consultation** – HR&OD will carry out some early engagement around the options
- **Consultation** – All staff have an opportunity to feed into the process, raise concerns and make suggestions
- **Implementation** – Once consultation responses have been considered an outcome document will be produced detailing next steps
- **Delivery** – After the new structure becomes fully operational we would need to work together to manage any team dysfunctions, and it will take time to make new ways of working and practices part of business as usual.

Throughout the transitional period the HR&OD team will be working closely with colleagues across NW London to develop and implement plans. There will be a programme of regular communications which will ensure all colleagues are informed of progress, and everyone will have an opportunity to feed into the decision making process.

What we still need to explore

- How to engage staff in the development of plans?
- How can we maintain staff morale and retention through this period of change?

9 – Timeline

The Case for Change will be discussed with our governing bodies 5 -26 June 2019.

Our engagement period officially begins on 24 May and we will be talking to all of our stakeholders to gather their views on the questions posed throughout this document. We request comments, input and feedback by 24 July when we will begin to develop formal proposals, should we believe it is the right thing to do following engagement. Proposals would go to governing bodies in September for agreement with submission of our intention to NHS England by 30 September.

Ratification of changes are likely to require a vote of the council of members, which would take place after the decisions of the governing bodies.

During this time, we will carry out an equality and health inequalities impact assessment.

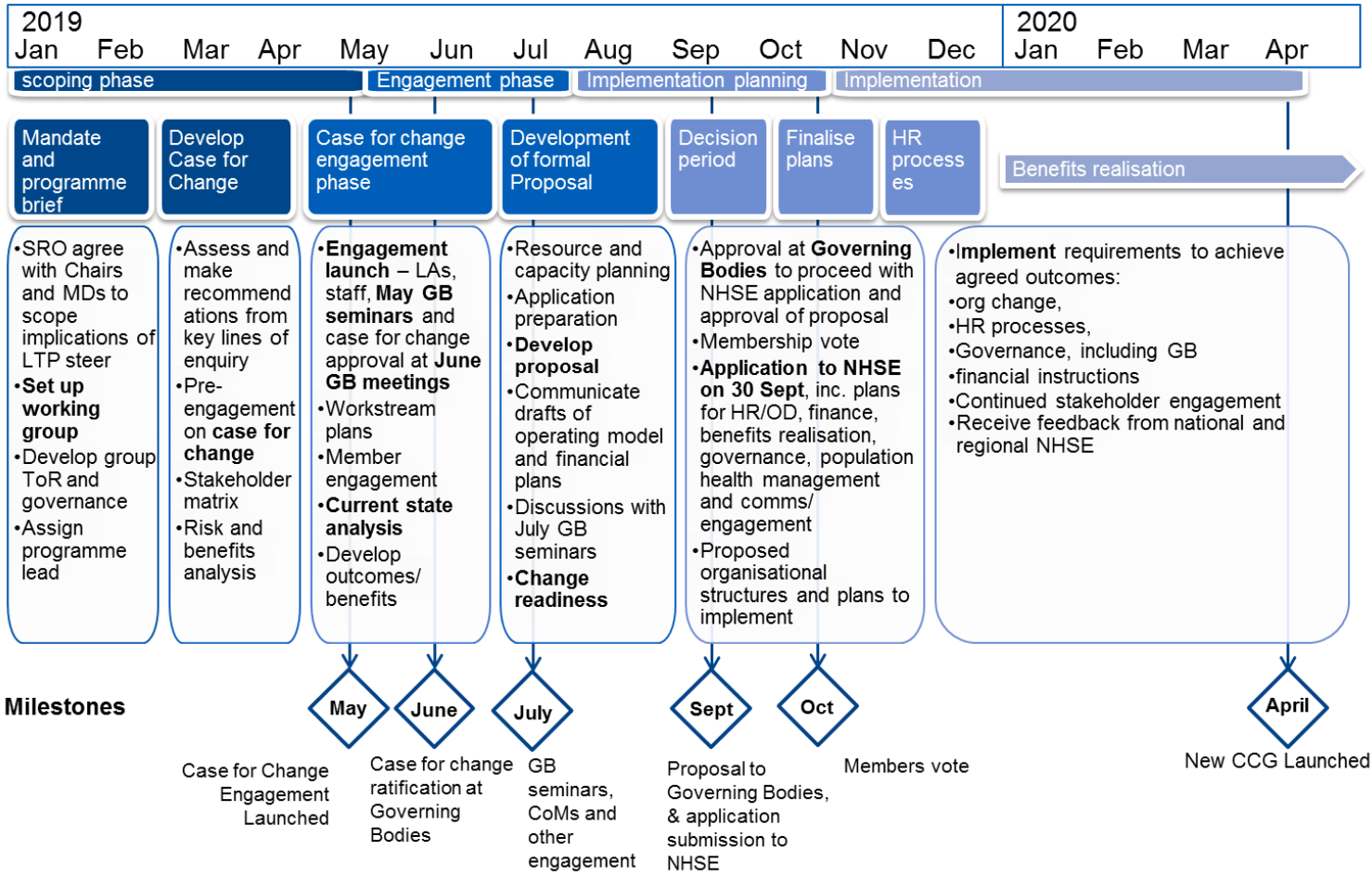


Figure 4: Illustrative high-level time line for 2020 launch

How to respond

Please send your comments by 24 July to: nwlccgs.commissioningreform@nhs.net or in writing to:

Accountable Officer's Office
NW London Collaboration of CCGs
87-91 Newman Street
London W1T 3EY

Appendix one: Our emerging integrated care system in NW London

What does an ICS mean for NW London?

The long term plan describes integrated care systems as follows:

"Integrated care systems (ICSs) are central to the delivery of the Long Term Plan. An ICS brings together local organisations to redesign care and improve population health, creating shared leadership and action. They are a pragmatic and practical way of delivering the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care.

The long term plan states that ICSs will have a key role in working with Local Authorities at 'place' level and through ICSs, commissioners will make shared decisions with providers on how to use resources, design services and improve population health."

Our agreed vision in NW London is to create one integrated health and care system working together to maximise benefits to residents and staff. We want to support the transition of our Health and Care Partnership into an ICS, integrating health and social care seamlessly for our residents.

We have begun this journey through our sustainability and transformation partnership – our NW London Health and Care Partnership, This partnership of over thirty organisations is working together to improve quality, patient and carer experience, staff experience, value and the reduce unwarranted variation.

We want to continue to develop integrated working at three levels, aligned with national strategy; system, place and network:

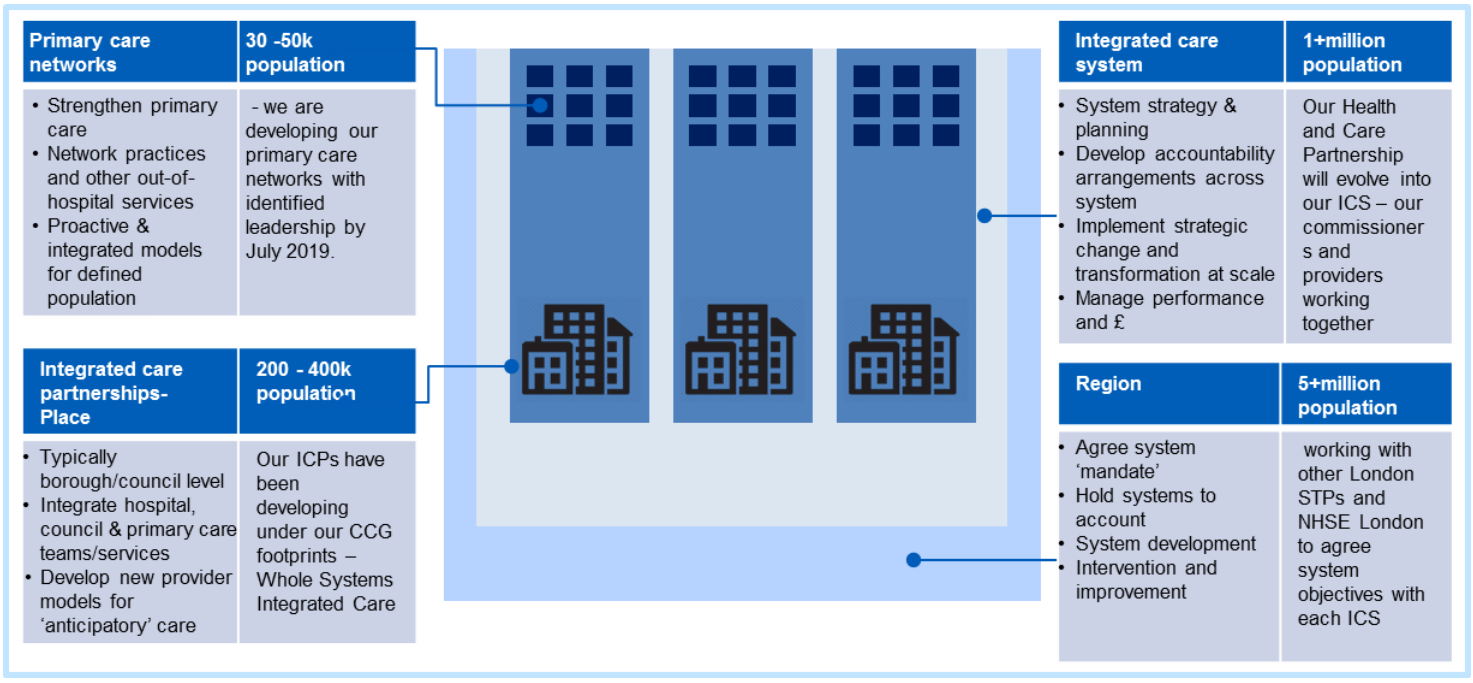


Figure 5: Integrated care as a system of systems

How does moving to a single CCG support our integration agenda?

The NHS long term plan states that "every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level. This will typically involve a single CCG for each ICS area. CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and long term plan implementation."

In order to support true integration of our system of health and care in NW London, we need to strengthen several aspects of our strategic and operational functions:

Figure 6: features of integration

At the moment, we operate with eight statutory accountability arrangements for our governance in commissioning, supported by our Joint Committee. Although we have made progress is simplifying our governance, we can go further to streamline decision making – by reducing our statutory boards to one.

This will also support the quick provision of data and information sharing, support consistency and equity in our methods of engagement, and simplify system wide financial planning.

How is an ICP different from a CCG?

An ICP is focused on care provision and delivery for a given population, most commonly, 200,000-400,000 people. A CCG is a statutory organisation that purchases services from providers to deliver care for a given population, and manages the contract for care delivery.

As we continue to fully integrate our health and care system in NW London, we will be moving away from the distinction between provider and commissioner as we manage care on a population health basis, working increasingly in partnership with local government and the voluntary sector.

Our CCG would be responsible for the commissioning of the ICP contract. In the future, it is possible that mature ICPs may form statutory bodies themselves, as their alliance working with partners is strengthened. Our ICPs will be underpinned by local delivery teams from our CCG.

Why are we developing primary care networks?

Primary care is the bedrock of care provision to our residents. We need to ensure GPs are supported to manage the health and care of their registered lists. As part of national policy GPs are coming together in primary care networks with a range of local providers to offer more personalised, coordinated health and social care to their local populations. This multidisciplinary working, led by clinicians, will be the heart of our integration to offer the best care to our residents in NW London.

How are we developing primary care?

We have been working to improve primary care in NW London for some time, implementing the GP forward view in order to meet the needs of our residents. To meet these needs, local practices have begun working together and with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in primary care networks (PCNs). The change in the way general practice is working helps teams build relationships with all other staff in their networks, and together, in partnership with patients and the public, use whole population health profiles to plan for and deliver integrated whole person care to the key groups of people

The local and NWL primary care strategies have consistently focused on improving the experience of working in primary care; streamlining workloads and improving our track record in retaining and recruiting staff; developing digital solutions; investing accordingly to achieve the standards in accessible, co-ordinated and pro-active care set out in London's Strategic Commissioning Framework.

Our next step is general practice 'working at scale'; with GPs supported by Primary care networks in partnership with local community services, mental health and social care. Ability to make that work for local patients will be enhanced by better working relationships between organisations across the system; consistent and inter-operable IT systems; and better data-sharing.

We have also been developing our system and local population health management plans so that childhood obesity, rising numbers of long-term conditions, dementia, mental health and related health concerns can be managed by the local GP, practice nurse, community nursing staff, community pharmacists and PCN effectively

Primary care networks (PCNs), although provider functions are important part of our health system and are described in this document for completeness. PCNs build on the core of current primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care. By working in this way, practice gain more local control over the health needs of their populations. Clinicians describe this as a change from reactively providing appointments to proactively care for the people and communities they serve.

The development of these networks are a key part of the NHS long term plan, with all general practices being required to be in a network by June 2019, and CCGs being required to commit recurrent funding to develop and maintain them. Primary care networks will be based on GP registered lists, typically serving natural communities of around 30,000 to 50,000.

Our practices will work together in our PCNs. Our PCNs will operate through multi-disciplinary working, delivering population health management, and support our ICPs to deliver the required health and care to our local populations. These networks will be the bedrock of local/borough-level arrangements.

Appendix two: Options for integrated care partnerships (ICPs)

How different commissioning structures can commission different configurations of services – draft

The draft ICP contract pack[1] sets out the following six scenarios:

Services to be commissioned	Mechanism under current legislation	Comments
1. A new care model providing primary medical services, community health services and acute car	The CCG would need to establish aligned budgets for the ICP (which can have a single contract), to ensure that primary medical care funding remains ring-fenced within the ICP's total budget	Primary medical care funding is currently ring-fenced under the delegation agreement
2. A new care model providing primary medical services, community health services, acute care, social care and LA commissioned public health	Under a s75 Partnership Arrangement; an aligned budget within the ICP contract for those service that cannot be included in a s75 arrangement but can be under a single contract	Exceptions as above plus: • surgery, radiotherapy, termination of pregnancies, endoscopy, the use of Class 4 laser treatments and other invasive treatments • s7a public health services • primary dental services • pharmaceutical services • primary ophthalmic services • emergency ambulance service
3. A new care model providing community health services, social care and LA commissioned public health with more than one LA	As above	Exceptions as above
4. A new care model providing community health services, acute care, social care and LA commissioned public health	As above	Exceptions as above
5. A new care model providing primary medical services, community health services, acute care, , social care, LA commissioned public health and s7A (**NHSE**) public health services	As above	Exceptions as above plus need regional agreement for NHSE to be a party to the contract and S7a functions cannot be given to more than one CCG jointly
6. A new care model providing primary medical services, community health services, acute care, social care, LA commissioned public health and specialised services	As above	Exceptions as above plus need regional agreement for NHSE to be a party to the contract and S7a functions cannot be given to more than one CCG jointly

[1] CCG roles where ICPs are established Draft Integrated Care Provider (ICP) Contract - consultation package August 2018

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Report for External Services Select Committee

Tuesday 9th July 2019
Kim Cox- MH Borough Director

Appendix B

Wellbeing for life

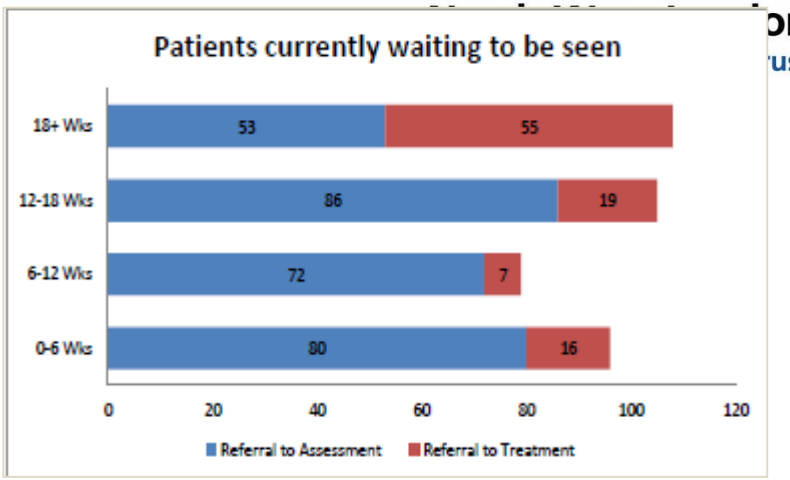
Introduction

This report will include updates from the following CNWL Hillingdon Services –

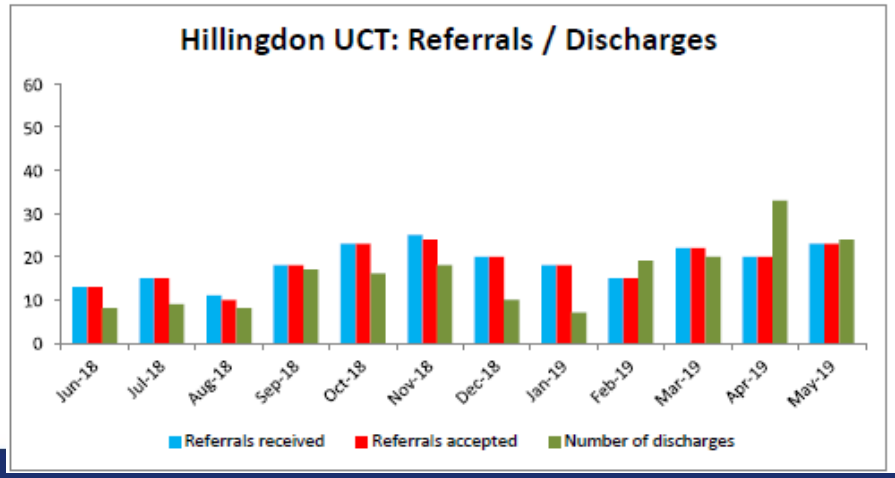
- Eating Disorder
- Child and Adolescent Mental Health Services (CAMHs)
- Children's Community Services
- Adult Community Services
- Immigration Removal Centre Health Services
- Hillingdon Drug and Alcohol Services

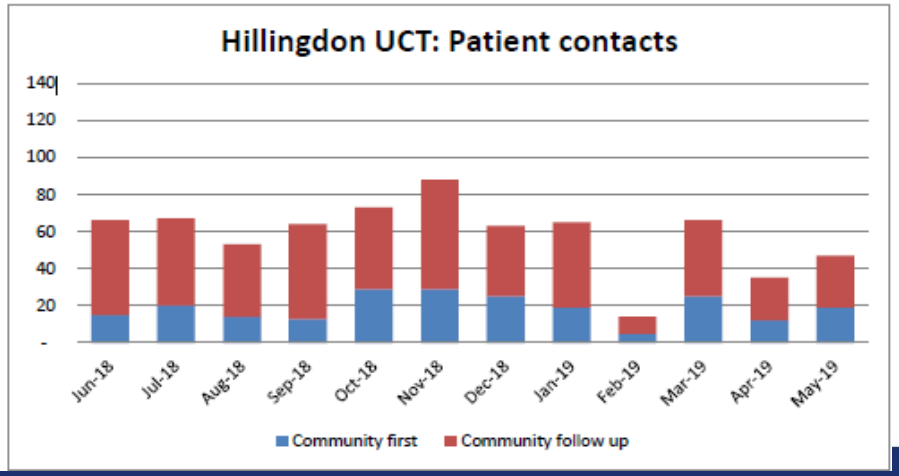
Hillingdon CAMHS

- **Workforce:** The funding provided by the CCG via NHSE to increase capacity by 3 CBT therapists working is coming to an end. The additional capacity reduced the internal CBT treatment waits. There is risk that the wait for this treatment may increase without these extra posts
- The team is looking to recruit a Borough Lead Therapist to join the senior leadership team
- **RTT list:** The team are using a QI project as a way of sustaining the 18 weeks referral to assessment target



Urgent Care Team (UCT)- CNWL now offer 24/7 first response to A&E departments by CAMHS





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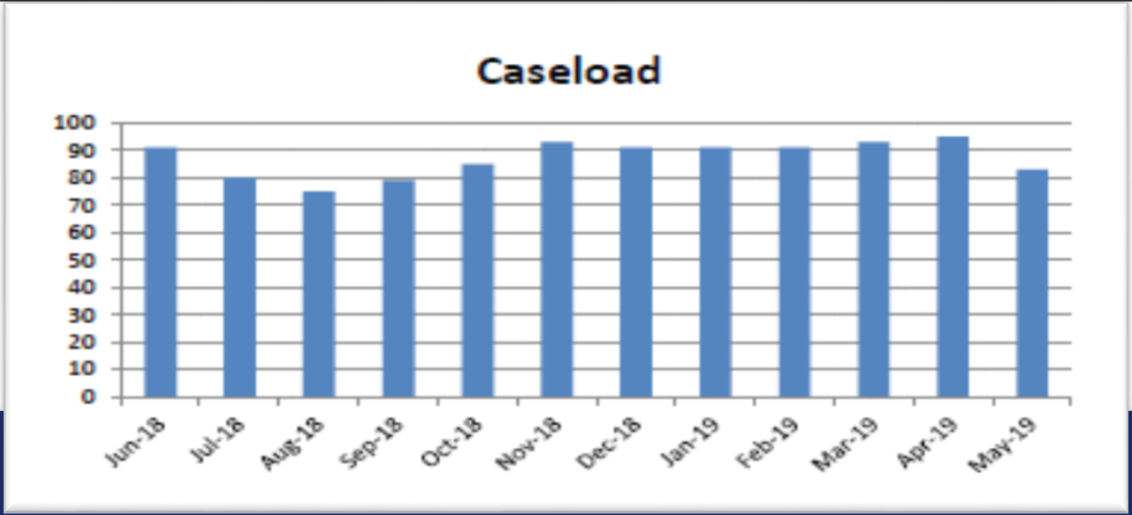
Eating Disorders Services

The CNWL Eating Disorders Service provides specialist help and support across all five boroughs (Brent, Harrow, Hillingdon, Kensington and Chelsea, Westminster)

There is a consistently high demand for the service as demonstrated by the high number of young people on the case load

However, the service continues to meet the referral to assessment targets

Target Description	Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Waiting times - routine	95%	100%	100%	96%	100%	100%	93%	100%	100%	100%	100%	100%	100%
Waiting times - urgent	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%



Children's Services

Developing an Integrated Hillingdon Paediatric Therapy Service to support a single point of easy access with a focus on early intervention by offering drop-in therapy sessions, an enhanced website (Hillingdon Talks, Moves and Plays) and advice line for referral and support.

CYP (0-25) multi agency workshops taking place to increase the integration of all services for children in Hillingdon

Working closely with social care to ensure we continue to meet 100% of Initial Health Assessments for Looked After Children

Hillingdon 0-19 Service has just delivered it's best ever quarterly performance for children and families

Working collaboratively with THH, LA and CCG to develop and support the delivery of effective pathways for young people transitioning to adult services

Continuing to achieve above NWL average delivery rates in immunisations for children and young people in Hillingdon

QI Projects taking place:

- Improving sleep management for children with additional needs
- Reduce waiting times for referral to assessment to the paediatric OT service
- Increase the number of OT contacts with children and young people

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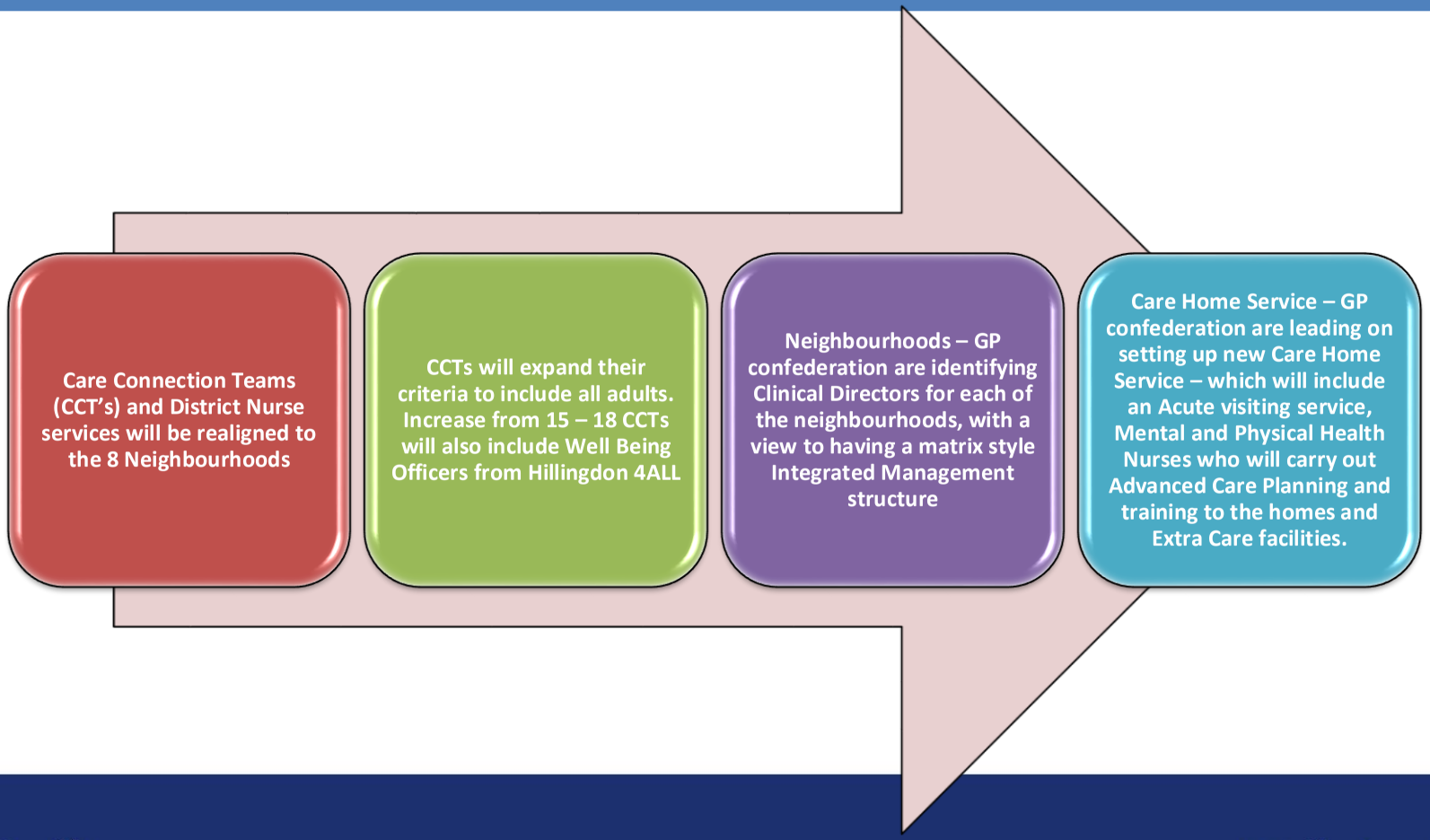
Hillingdon Health Care Partners



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CNWL Adult Services

Your Life Line 24/7 – successfully keeping people at home.

CARS 'Reducing Falls in Care Homes' – finalists at the May 2019 HSJ Value Awards

Bladder & Bowel and Tissue Viability have also engaged Care homes in providing training and preventing pressure ulcers.

CNWL have successfully recruited a Epilepsy and Parkinson's Disease Nurse

Heart Failure Services have had extra investment due to a significant increase in activity being diverted from the acute Trust.

Diabetes – we are currently working with the lead Commissioner at reviewing the service spec and what the service needs are to meet the increasing demand.

Hillingdon Mental Health Services

Central and North West London NHS Foundation Trust

Number of Section 136 (MHA) assessments hit all time high in April at 59

We have commenced a 'SIM' project jointly working with the Police to give intensive interventions from both a health and criminal justice perspective for a caseload of service users

NHS England

In partnership with health commissioners we have bid for additional available parity of esteem funding to increase the support in primary care for people with a mental health problem.

We have also bid for funding for a service specifically for our service users who suffer from a personality disorder

Bed pressures remain an ongoing issue which hopefully additional support in the community will reduce

Arch – Innovation

ARCH was awarded a public health grant to implement fibrous scanning on-site.

- Effective implementation of a comprehensive 'welfare, physical and wellbeing' offer for alcohol misuse clients in the borough, providing a 'health passport '.
- Training programme for all Arch Nurses to provide Fibroscanning.
- Provision of a wide range of non-stigmatising satellite settings and in -reach arrangements with housing and partner agencies- for this client group.
- Onsite provision of priority clinics in partnership with Hillingdon LA and the development of the Rough Sleepers Initiative project in 2019/20.
- Refurbishment of Arch Welfare Room- provision of clothes, food, toiletries and onsite support for housing and health & wellbeing with new pathway **.**
- Client access to Information and Communications Technology (ICT) Social Work support & housing clinics.
- **KPIs /outcomes – Increase in clients accessing Fibroscanning with health passports at Arch**
- **Increase in street homeless accessing Arch.**
- Increase in access to housing

Early intervention and prevention of liver disease
Reduction in inpatient bed days and length of Stay
Reduction in hospital admission episodes for alcohol-specific conditions and the mortality rate from alcohol liver disease.

New Contracts

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From 1st April 2019, ARCH have been awarded the contract by London Borough of Hillingdon to manage the provision of the new services including Smoking Cessation , Supervised Consumption, Needle exchange , GPSC and in-patient detoxification budget managed by Arch.

Priority Groups/KPIs – agreed outcomes ;

Children under 18, pregnancy/childbirth , MH, disability, routine manual occupations.

Smoking Cessation

- Innovative new pathway at Arch – covering the borough –providing a range of smoking cessation pharmacotherapy and psychological interventions.
- **Targeted groups & pathways**
- Hillingdon HHT- A&E, CDC, AMU Maternity, COPD, Respiratory pre-post operative.
- GPs/ links with GP consortium, GPSC, health Centres , Primary Care .
- Mental Health – Links with DD clients/disability teams .
- CNWL wide smoking cessation staffing campaign /staff living in Hillingdon.
- Staffing – extend to AP's Nurse's and team at Arch

IRC Heathrow Focus

Actions completed from CQC Inspection

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SUPERVISION

- CNWL Offender Care Directorate has strengthened the existing arrangements for supervision in line with Trust Policy.
- An immediate review of systems and processes resulted in a strengthened plan that is delivering both individual and group supervision.
- A target of 95% of staff to have received supervision in line with the policy (every 4 -6 weeks) has been set. April supervision rate – 79.1%.
- The governance and monitoring process for supervision completion has been made more robust.
- Supervision completions are monitored weekly through the local Senior Management Team (SMT) meetings and any outstanding supervision addressed with the supervisor and supervisee.
- Completion figures are now monitored through a monthly KPI (supervision completed within last 4-6 weeks) and are reported to the monthly Offender Care Business and Performance SMT meeting for oversight and scrutiny.

TRANSLATION SERVICES

- Monthly reporting of use of translating services
- All staff were reminded of the need to use professional interpreting services
- Posters are displayed for detainees in 14 languages advising them of the provision
- Posters are displayed and leaflets available advising detainees of healthcare services available at the IRC and translated into a variety of languages and in an easy read format
- User friendly written information has been made available in alternative languages and is on display in patient areas
- Health promotion information is available in a number of languages including diabetes, cancer awareness and heart disease
- A process has been established to ensure posters and health information is in place and updated monthly.
- The patient engagement lead continues to hold regular detainee forums to gather feedback from detainees and address any gaps in healthcare information needed.

Offender Care Liaison and Diversion Service – Hillingdon

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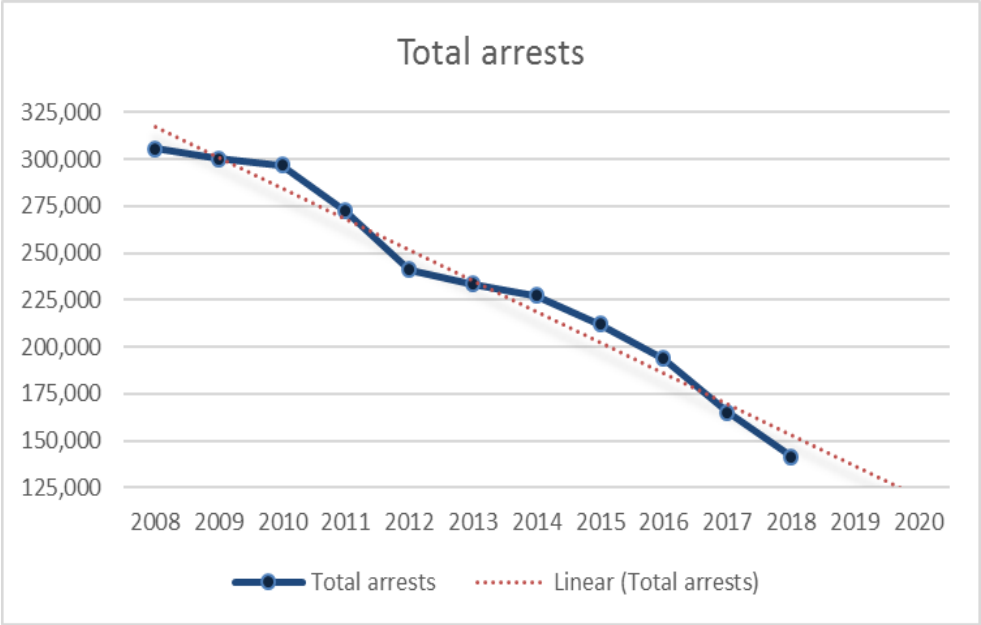
Operating an all age & all vulnerability model across 3 sites: Uxbridge Magistrate's Court, Heathrow Police Custody and Hillingdon Youth Offending Service

Aims:

- **Improved access to healthcare and support services for vulnerable individuals and a reduction in health inequalities**
- **Liaison with healthcare and support services to deliver a coordinated response, ensuring that the needs of individuals are met**
- **Diversion of individuals, where appropriate, out of the criminal justice system into health, social care, education and training, or other supportive services**
- **To reduce re-offending and/or escalation of offending behaviours**



Multi-disciplinary team consisting of:

- Team Manager
- Liaison and Diversion Practitioners
- Youth Justice Liaison and Diversion Practitioners
- Consultant Forensic Psychiatrist

Working in partnership with 'Together for Mental Wellbeing' and West London Mental Health Trust

EXTERNAL SERVICES SELECT COMMITTEE - WORK PROGRAMME

Committee name	External Services Select Committee
Officer reporting	Nikki O'Halloran, Chief Executive's Office
Papers with report	Appendix A – Work Programme
Ward	n/a

HEADLINES

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

RECOMMENDATIONS:

That the External Services Select Committee:

1. **determines which topic/s it would like to discuss at its crime and disorder meeting on 5 September 2019;**
2. **determines when it will consider the following issues:**
    a. **bowel, cervical and breast screening in the Borough; and**
    b. **Mount Vernon Cancer Centre review; and**
3. **considers the Work Programme at Appendix A and agrees any amendments.**

SUPPORTING INFORMATION

1. The Committee's meetings tend to start at either 5pm or 6pm and the witnesses attending each of the meetings are generally representatives from external organisations, some of whom travel from outside of the Borough. The meeting dates for this municipal year were agreed by Council on 17 January 2019 and are as follows:

Meetings	Room
Wednesday 12 June 2019, 6pm	CR6
Tuesday 9 July 2019, 6pm	CR5
Thursday 5 September 2019, 6pm	CR5
Wednesday 9 October 2019, 6pm	CR5
Thursday 7 November 2019, 6pm	CR5
Tuesday 14 January 2020, 6pm	CR5
Tuesday 11 February 2020, 6pm	CR5
Thursday 26 March 2020, 6pm	CR5
Wednesday 29 April 2020, 6pm	CR6
Thursday 30 April 2020, 6pm	CR6

2. It has previously been agreed by Members that, whilst meetings will generally start at 6pm, consideration will be given to revising the start time of each meeting on an ad hoc basis should the need arise. Further details of the issues to be discussed at each meeting can be found at Appendix A.

3. It should be noted that the Committee is required to meet with the local health trusts at least twice each year. It is also required to scrutinise the crime and disorder work of the Safer Hillingdon Partnership (SHP). To keep the crime and disorder meetings focussed, consideration will need to be given to the topic/s that Members would like to discuss at their next crime related meeting on 5 September 2019.

4. At its meeting on 12 June 2019, Members agreed that consideration would need to be given to scheduling additional meetings to consider the following issues:
    i) bowel, cervical and breast screening in the Borough; and
    ii) Mount Vernon Cancer Centre review.

Live Broadcasting of Meetings

5. It should be noted that Cabinet, at its meeting on 30 May 2019, agreed that all future policy overview and select committee meetings would be broadcast live on YouTube. As such, this and all subsequent External Services Select Committee meetings will be broadcast live. Where possible, these meetings have been moved into Committee Room 5 to facilitate better views of the meetings.

Reviews

6. As the meetings of the External Services Select Committee usually deal with a lot of business, the Committee is able to set up Select Panels to undertake in depth reviews on its behalf. These Panels are 'task and finish' and their membership can comprise any London Borough of Hillingdon Councillor, with the exception of Cabinet Members. A Select Panel has been established to look at developments since the GP Pressures review was undertaken by the previous Working Group.

BACKGROUND PAPERS

None.

APPENDIX A

EXTERNAL SERVICES SELECT COMMITTEE

WORK PROGRAMME

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

Shading indicates completed meetings

Meeting Date	Agenda Item
12 June 2019 ***Report Deadline**:* *3pm Friday 31 May 2019*	**Update on the implementation of recommendations from previous scrutiny reviews:** • Community Sentencing **Update on Cancer Screening and Diagnostics** **Update on Potential Changes at Moorfields City Road Site** **Update on the Implementation of Congenital Heart Disease Standards** (NHS England)
9 July 2019 ***Report Deadline**:* *3pm Thursday 30 June 2019*	**Health** Performance updates and updates on significant issues: 1. The Hillingdon Hospitals NHS Foundation Trust 2. Royal Brompton & Harefield NHS Foundation Trust 3. Central & North West London NHS Foundation Trust 4. The London Ambulance Service NHS Trust 5. Public Health 6. Hillingdon Clinical Commissioning Group 7. Healthwatch Hillingdon **Hospice Provision in the North of the Borough – Update** **Update on the implementation of recommendations from previous scrutiny reviews:** • Hospital Discharges (SSH&PH POC)

Meeting Date	Agenda Item
5 September 2019 ***Report Deadline**:* *3pm Friday 23 August 2019*	**Crime & Disorder** To scrutinise the issue of crime and disorder in the Borough: 1. London Borough of Hillingdon 2. Metropolitan Police Service (MPS) 3. Safer Neighbourhoods Team (SNT) 4. London Fire Brigade 5. London Probation Area 6. British Transport Police 7. Hillingdon Clinical Commissioning Group (HCCG) 8. Public Health **GP Pressures Select Panel** Possible consideration of draft final report.
9 October 2019 ***Report Deadline**:* *3pm Friday 27 September 2019*	**Dental Health Services – Single Meeting Review**
7 November 2019 ***Report Deadline**:* *3pm Monday 28 October 2019*	**Health** Performance updates and updates on significant issues: 1. The Hillingdon Hospitals NHS Foundation Trust 2. Royal Brompton & Harefield NHS Foundation Trust 3. Central & North West London NHS Foundation Trust 4. The London Ambulance Service NHS Trust 5. Public Health 6. Hillingdon Clinical Commissioning Group 7. Healthwatch Hillingdon
14 January 2020 ***Report Deadline**:* *3pm Thursday 2 January 2020*	**Post Office Services – Single Meeting Review**
11 February 2020 ***Report Deadline**:* *3pm Thursday 30 January 2020*	**Crime & Disorder** To scrutinise the issue of crime and disorder in the Borough: 1. London Borough of Hillingdon 2. Metropolitan Police Service (MPS) 3. Safer Neighbourhoods Team (SNT) 4. London Fire Brigade 5. London Probation Area 6. British Transport Police 7. Hillingdon Clinical Commissioning Group (HCCG) 8. Public Health

Meeting Date	Agenda Item
26 March 2020 ***Report Deadline**:* *3pm Monday 16 March 2020*	
29 April 2020 ***Report Deadline**:* *3pm Friday 17 April 2020*	**Health (1)** Quality Account reports, performance updates and updates on significant issues: 1. The Hillingdon Hospitals NHS Foundation Trust 2. Central & North West London NHS Foundation Trust 3. Public Health 4. Hillingdon Clinical Commissioning Group 5. Healthwatch Hillingdon
30 April 2020 ***Report Deadline**:* *3pm Monday 20 April 2020*	**Health (2)** Quality Account reports, performance updates and updates on significant issues: 1. Royal Brompton & Harefield NHS Foundation Trust 2. The London Ambulance Service NHS Trust 3. Public Health 4. Hillingdon Clinical Commissioning Group 5. Healthwatch Hillingdon
June 2020 ***Report Deadline**: TBA*	
July 2020 ***Report Deadline**: TBA*	**Health** Performance updates and updates on significant issues: 1. The Hillingdon Hospitals NHS Foundation Trust 2. Royal Brompton & Harefield NHS Foundation Trust 3. Central & North West London NHS Foundation Trust 4. The London Ambulance Service NHS Trust 5. Public Health 6. Hillingdon Clinical Commissioning Group 7. Healthwatch Hillingdon 8. Local Medical Committee
September 2020 ***Report Deadline**: TBA*	**Crime & Disorder** To scrutinise the issue of crime and disorder in the Borough: 1. London Borough of Hillingdon 2. Metropolitan Police Service (MPS) 3. Safer Neighbourhoods Team (SNT) 4. Public Health
October 2020 ***Report Deadline**: TBA*	

Meeting Date	Agenda Item
November 2020 ***Report Deadline**: TBA*	**Health** Performance updates and updates on significant issues: 1. The Hillingdon Hospitals NHS Foundation Trust 2. Royal Brompton & Harefield NHS Foundation Trust 3. Central & North West London NHS Foundation Trust 4. The London Ambulance Service NHS Trust 5. Public Health 6. Hillingdon Clinical Commissioning Group 7. Healthwatch Hillingdon
January 2021 ***Report Deadline**: TBA*	
February 2021 ***Report Deadline**: TBA*	**Crime & Disorder** To scrutinise the issue of crime and disorder in the Borough: 5. London Borough of Hillingdon 6. Metropolitan Police Service (MPS) 7. Safer Neighbourhoods Team (SNT) 8. Public Health
February 2021 ***Report Deadline**: TBA*	**Hospice Provision in the North of the Borough** 1. Michael Sobell Hospice Charity 2. The Hillingdon Hospitals NHS Foundation Trust 3. East and North Hertfordshire NHS Trust 4. Hillingdon Clinical Commissioning Group 5. Healthwatch Hillingdon
March 2021 ***Report Deadline**: TBA*	
April 2021 ***Report Deadline**: TBA*	**Health (1)** Quality Account reports, performance updates and updates on significant issues: 6. The Hillingdon Hospitals NHS Foundation Trust 7. Central & North West London NHS Foundation Trust 8. Public Health 9. Hillingdon Clinical Commissioning Group 10. Healthwatch Hillingdon
April 2021 ***Report Deadline**: TBA*	**Health (2)** Quality Account reports, performance updates and updates on significant issues: 6. Royal Brompton & Harefield NHS Foundation Trust 7. The London Ambulance Service NHS Trust 8. Public Health 9. Hillingdon Clinical Commissioning Group 10. Healthwatch Hillingdon

Meeting Date	Agenda Item
Possible future single meeting or major review topics and update reports	
• Telecommunications - plans in place by BT regarding advancements made in mobile technology • Mental health discharge • Collaborative working between THH and GPs in the community • Opportunities for local oversight of services provided in Hillingdon that had been commissioned from outside of the Borough • Transport provision within the Borough - Transport for London (TfL), Crossrail, bus route changes and Dial-a-Ride	

MAJOR REVIEW (PANEL)

Members of the Panel:

- Councillors Riley (Chairman), Edwards, Hurhangee, Lakhmana and Prince

Topic: GP Pressures

Meeting	Action	Purpose / Outcome
ESSC: 10 October 2018	Agree Scoping Report	Information and analysis
Panel: **1st Meeting -** 6 December 2018	Introductory Report / Witness Session 1	Evidence and enquiry
Panel: **2nd Meeting -** 23 January 2019	Witness Session 2	Evidence and enquiry
Panel: **3rd Meeting -** 27 February 2019	Witness Session 3	Evidence and enquiry
Panel: **4th Meeting -** 24 April 2019	Witness Session 4	Evidence and enquiry
Panel: **5th Meeting -** 29 May 2019	Witness Session 5	Evidence and enquiry
~~**Panel:**~~ ~~**6th Meeting -**~~ ~~25 June 2019~~ ~~CANCELLED~~	~~Witness Session 6~~	~~Evidence and enquiry~~
Panel: **6th Meeting -** 24 July 2019	Consider Draft Recommendations	Agree recommendations
Panel: **7th Meeting -** 11 September 2019	Consider Draft Final Report	Agree final draft report
ESSC: 9 October 2019	Consider Draft Final Report	Agree recommendations and final draft report
Cabinet: 24 October 2019	Consider Final Report	Agree recommendations and final report

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