Minutes

EXTERNAL SERVICES SELECT COMMITTEE

7 October 2021

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

	Committee Members Present: Councillors Nick Denys (Chairman), Devi Radia (Vice-Chairman), Simon Arnold, Darran Davies, Heena Makwana, Peter Money (Opposition Lead) and June Nelson **Also Present**: Tina Benson, Chief Operating Officer, The Hillingdon Hospitals NHS Foundation Trust (THH) Richard Ellis, Joint Lead Borough Director, NWL Clinical Commissioning Group Claire Eves, Associate Director of Outer London Services, Central and North West London NHS Foundation Trust Nicholas Hunt, Director of Service Development, Royal Brompton & Harefield NHS Foundation Trust Jessamy Kinghorn, Head of Partnerships and Engagement, NHS England & Improvement - East of England **LBH Officers Present**: Gavin Fernandez (Head of Service - Hospital, Localities, Sensory & Review) and Nikki O'Halloran (Democratic Services Manager)
25.	**APOLOGIES FOR ABSENCE AND TO REPORT THE PRESENCE OF ANY SUBSTITUTE MEMBERS** *(Agenda Item 1)* There were no apologies for absence.
26.	**DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING** *(Agenda Item 2)* There were no declarations of interest on matters coming before this meeting.
27.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 3)* **RESOLVED: That all items of business be considered in public.**
28.	**MINUTES OF THE PREVIOUS MEETING - 15 SEPTEMBER 2021** *(Agenda Item 4)* **RESOLVED: That the minutes of the meeting held on 15 September 2021 be agreed as a correct record.**
29.	**MOUNT VERNON CANCER CENTRE STRATEGIC REVIEW UPDATE** *(Agenda Item 5)* Ms Jessamy Kinghorn, Head of Partnership and Engagement at NHS England / Improvement (NHSEI) - East of England, advised that the report provided Members with a brief update on the Mount Vernon Cancer Centre (MVCC) strategic review.

Following the independent clinical review, it had been proposed that a new cancer centre be located in Watford with a chemotherapy centre at Hillingdon Hospital and a satellite radiotherapy centre in the north of the catchment area.

Although having the expertise under one roof at Watford was welcomed, concern was expressed that a catchment area with a 2.4m population seemed high. Ms Kinghorn advised that MVCC covered three NHS regions and that a 2.4m population was not excessively large.

An expression of interest had been submitted for the new cancer centre to be considered as one of the eight new hospital schemes which would added to the Government's health infrastructure plan. It was thought that this would be the best opportunity to secure capital to fund the project. The long listing of the expressions of interest would be undertaken in the autumn with a decision expected in the spring of 2022. In the meantime, NHSEI would continue to work on the busines case.

A significant amount of patient engagement activity had been undertaken and support for the MVCC proposals had been received from clinicians and the East of England Senate. Insofar as Hillingdon was concerned, there had been good engagement from local residents in the focus group activity with a mixed response. During the engagement activity, concern had been expressed that some patients had a 100 mile round trip for blood tests or chemotherapy. As a direct result, it had been proposed that blood tests be made available in primary care settings closer to home (where possible) and that a chemotherapy centre be established at Hillingdon Hospital. Enhancing capacity at Hammersmith Hospital would also be included as part of the plan.

Mr Richard Ellis, Joint Borough Director at NWL CCG, advised that, since the pandemic had started, all GP practices were now providing blood tests either individually or providing a shared service with other practices. This had been well received by patients and would reduce the number of routine blood test appointments needed at MVCC. However, urgent blood tests would continue to be undertaken at MVCC.

With regard the creation of a chemotherapy centre at Hillingdon Hospital, it was thought that around 356 patients would be able to use this service each year (this equated to 3-5 chairs per annum). It was thought that some tumours (such as some lung tumours) were so rare that they would need specialist treatment elsewhere to ensure that these patients received the best possible care. In addition, some Hillingdon patients were likely to choose to go to Northwick Park or one of the Imperial sites rather than travel to Watford.

It had been recognised that the MVCC catchment area included significant areas of deprivation. Luton was an area of deprivation and had been identified as having some of the worst outcomes. Thorough impact assessments had been undertaken and previous learning had been used to work through transport and access issues that these areas of deprivation might face. Consideration was now being given to identifying how travel routes could be made more accessible and to look at what else could be done to reduce the barriers to treatment (it was recognised that some individuals were not having treatment because of travel issues).

Ms Kinghorn noted that Watford had better transport links than the current MVCC site. As Watford would be a longer journey for some patients, the ability to have blood tests and chemotherapy more locally would reduce the impact of this increased distance.

	Insofar as ensuring that patients did not fall through the cracks during a transition of services from MVCC to Watford, a transition plan would need to be put in place. A transition plan would ensure that an individual plan was in place for each patient and that appropriate signage was also in place. However, this stage was still a long way off and funding would need to be secured before this level of detail was developed. Although the development of a new cancer centre at Watford was the preferred option, this would be reliant on securing the associated funding. If unsuccessful in the expression of interest process, investigations would need to be undertaken into alternative sources of funding or alternative action. But, whatever happened, a capital solution would be needed to ensure that cancer services continued to be provided to patients. **RESOLVED: That the discussion be noted.**
30.	**HEALTH UPDATES** *(Agenda Item 6)* <u>The Hillingdon Hospitals NHS Foundation Trust (THH)</u> Ms Tina Benson, Chief Operating Officer at THH, advised that, despite the pandemic, the Trust had received a number of awards and accolades. To build on achievements from the previous year, the Quality Priorities for 2021/2022 had included improvements to patient discharge. In the week commencing 18 October 2021, an event had been planned whereby consideration would be given to hospital discharge. Safer Care Bundles would be available for discharges from an acute site within 24 hours. It was noted that if no action was taken to improve the efficiency of discharge, the hospital would be 88 beds short of the number needed in January 2022. Even with the proposed action, it was thought that there would still be a shortage but that it was workable. Ms Claire Eves, Associate Director of Outer London Services at Central and North West London NHS Foundation Trust (CNWL), advised that progress over the last year had resulted in a more positive position to fully integrate the discharge team. Daily discharge monitoring had been undertaken to unblock any problems as they arose and improved communications and regular touchpoints had helped to reduce delays. The good relationship between THH, CNWL and Hillingdon Health and Care Partners (HHCP) had helped to improve hospital discharges. Therapy had been integrated into the discharge process. Brunel University trained a range of therapists so action had been taken to attract them into Hillingdon Hospital. Action had also been taken to join community and hospital therapy services which had been helped by Discharge to Assess. Use of the service was monitored as well as the availability of step down beds and rehabilitation beds in the community and the length of stay. Mr Richard Ellis, Joint Borough Director at NWL CCG, advised that twice daily discharge monitoring meetings were undertaken at Hillingdon Hospital, six days each week. There had been a particular focus on Fridays and Saturdays to ensure that discharges could still be undertaken over the weekends. This work had resulted in improvements to the safety of discharges and documents could be produced at any time of day. It would be important to continue to learn from past experience and implement improvements to the discharge process. Ms Benson would provide the Democratic Services Manager with statistics on the number of failed discharges at THH

going back as many years as was available.

With regard to winter planning, Ms Benson advised that the Trust anticipated a challenging period ahead. During the summer months, the demand for all services had increased to levels similar to those seen in the winter. Primary care surge hubs had been set up through the Primary Care Networks (PCNs) and the Rapid Response Team was available from 8am to 8pm. Members were advised that these services would be required of all Integrated Care Partnerships (ICPs) by April 2022 so Hillingdon was ahead of the curve.

Activity at Hillingdon Hospital's Accident and Emergency (A&E) department had already increased to winter levels. There had been 191 A&E attendances and around 250 Urgent Treatment Centre attendance (which had increased from 146 per day). Some individuals had been attending A&E when they did not necessarily need A&E but did need to attend hospital. As such, same day emergency pathways had been expanded to accommodate this.

A rapid improvement event had been undertaken in August 2021 where 150 improvement actions had been identified. These actions had included end of life care training, better internal communications with the CT scanner team and maintaining good handovers from the London Ambulance Service (LAS). Work had also been commissioned to motivate staff who were still tired post-Covid. The progress of the implementation of the actions would be reviewed next week.

Ms Benson advised that THH had had a couple of recent CQC inspections and that the Trust currently had conditions on its licence. However, following the most recent inspection where safety had improved, the Trust had applied to have these conditions removed.

With regard to other performance, THH had not achieved the 4 hour standard target for seeing the sickest patients presenting at A&E. Currently, around 50% of A&E patients were being seen within 4 hours and this needed to be 70%-80%. However, improvements were being seen with Hillingdon having improved from having the second worst performance in London, to having the fifth best performance in London this week (out of 16 Trusts).

Ms Benson noted that there had been a backlog in elective care at THH. Action needed to be taken to address the needs of 47 patients who had been waiting for 104 weeks and then the focus could switch to those that had been waiting for 78 weeks and then 52 weeks. Harm reviews were undertaken on patients waiting 52+ weeks and their treatment could be brought forward if requested by a clinician. The majority of those patients who had waited a long time were waiting for trauma, orthopaedic and pain services.

Members were advised that action needed to be taken to reduce the cancer services waiting times - the target was for 75% of patients to have a diagnosis within 28 days of referral. In addition, the Trust had a 50% vacancy level for radiographers which impacted on many pathways. An additional scanner would be arriving on Monday for a limited period which would help to address the backlog as 40% of patients waiting for an MRI scan at Hillingdon Hospital did not want to be seen at another hospital. Ms Benson would send a copy of the Integrated Quality and Performance Report (IQPR) which would provide detail of the delays in treatment and the action that was being taken to reduce this.

Mr Ellis advised that the Royal Marsden Hospital (RMH) provided the main cancer support to NWL and that there was a dedicated primary care clinical lead for cancer in Hillingdon. The 'See the Signs' campaign had improved the number of referrals to THH but an audit was being undertaken with RMH to determine whether or not cancer patients were presenting later than they would have previously.

Ms Eves noted that a lot of work had been undertaken by the PCNs to ensure that patients were not in hospital when they should have been in a mental health bed. CNWL had also been working with the GP Confederation to recruit roles which could sit within the PCNs and develop the associated induction and deployment.

With regard to weekend outpatient clinics, Ms Benson advised that additional lists had been running since September 2021. There had been a lot of annual leave taken by staff during July and August and it was anticipated that the October half term would be a pinch point in being able to resource these clinics. To try to meet demand, THH had been working with private hospitals to see if they could help. It was recognised that pain management had been badly affected by the delays and that it would take a long time to reduce the backlog whilst ensuring that the waiting list did not grow.

THH had met with the Council's planning officers on a number of occasions regarding the Hillingdon Hospital redevelopment and had worked with clinicians to establish the anticipated flow of the new hospital. Although engagement had been undertaken, this had been predominantly virtual due to the impact of the pandemic. A range of videos had been recorded and were being publicised to try to encourage residents to provide more feedback on the development proposals.

Members were advised that two modular buildings had been erected on the Hillingdon Hospital site to house the respiratory ward and ICU. Paediatrics had been included on the ground floor so that the patients had access to outside space. Further work included boreholes being drilled this week and work was still ongoing regarding securing the funding for the project.

Royal Brompton and Harefield NHS Foundation Trust (RBH)
Mr Nick Hunt, Director of Service Development at RBH, advised that Harefield Hospital currently had eleven Covid cases in Intensive Care. These patients tended to be young and unvaccinated and the prognosis was not generally positive. This use of ITU beds had impacted on cardiac surgery but the Trust was just exceeding its 95% target. However, performance was judged as part of the Integrated Care System (ICS) rather than as an individual organisation and this would contribute to whether or not the Trust was awarded its funding.

The winter pressures faced by Harefield Hospital would be in relation to Hillingdon Hospital and Watford Hospital transferring patients to them which would then put pressure on the Trust's elective workloads.

RBH currently had a shortage of nurses and allied health professionals which had been impacted by Brexit and the withdrawal of the bursary (which had recently been reinstated). In addition, individuals were still isolating when children caught Covid at school and staff had been using up the annual leave that they had accrued during the pandemic. It was hoped that the staffing situation would start to resolve itself next month and that changes to the guidance on the space required between beds would be revised so that more capacity could be built in.

Although RBH did have a backlog, there were not many patients that had been waiting

for more than 52 weeks. It was noted that the feed of patients into Harefield Hospital from district general hospitals had slowed. This could be for a number of reasons including patients being unable to get access to their GP and there being a 30% increase in cardiac admissions at THH. When this was resolved, it was anticipated that RBH waiting lists would increase.

Central and North West London NHS Foundation Trust (CNWL)
Ms Claire Eves, Associate Director of Outer London Services at CNWL, advised that the commissioning of community services was now undertaken by North West London Clinical Commissioning Group (NWL CCG) rather than at a local level (whereby CNWL had previously been able to submit bids for winter pressure funds). It was thought that the new way of working as part of a system would provide better coordination and a greater impact.

CNWL had used Ageing Well Funding to look at discharge and increase weekend slots to improve cover to keep discharges going. A new management team had been put in place to work with PCNs to identify patients with diabetes earlier by focussing on preventative screening.

An end of life pilot had been introduced in Hillingdon using winter pressures funding. An overnight response service had been put in place and a two hour response time had been introduced during the day.

In addition, further work had been undertaken to identify those patients who would be suited to having their IV antibiotics in the community rather than in hospital. An ambulatory IV nurse was being recruited for the winter period to determine the impact that this service would have on hospital length of stay.

With regard to children's services, CNWL had been working with the Council in relation to children's hubs and family hubs. Each Council ward had been reviewed to establish its population's needs and a hub and spoke model was being introduced with a pilot in October. The hub would be the main area for families and the spokes would be the specialist services for each ward. This work would include preventative measures in relation to childhood obesity and children's oral health and was being undertaken within existing resources. It was thought that agencies working together more effectively would result in a better service being provided but using less resources. Members were assured that children's centres would be retained.

Ms Eves noted that action was being taken to support discharge out of rehabilitation and to ensure that wrap around care was in place. A single point of access needed to be developed and there needed to be an expansion of addition workers in rehab beds.

The Senior Leadership Team (SALT) had been looking at how to tap into PCNs, etc, for model designs. It was also planned that mental health roles would be situated within primary care so that physical health nurses could learn from mental health nurses.

The 16-25 service model had been developed and signed off and looked at smoothing the transition from CAMHS to adult mental health services. The new model would be implemented from October 2021 and it was agreed that further information on this initiative would be brought back to the Committee's next meeting.

Insofar as CAMHS was concerned, it was noted that the service was not as joined up with children's services as it should be. CNWL had secured funds from NWL CCG to

enhance this service and access had subsequently increased in the first five months. However, in the twelve months to 31 August 2021, there had been more than 1,000 children and young people on the waiting list. The Autism Spectrum Disorder (ASD) assessment waiting list was very long. Ms Eves would provide the CAMHS numbers and the waiting times on various lists to the Democratic Services Manager.

Although additional funding had been secured for an enhanced staffing model to help these children, it was queried what support and wrap around services were available to them while they were waiting for their assessment. Ms Eves would ensure that further information was brought to the Committee's next health related meeting. It would be important to improve access to assessment and treatment as there was no point getting an assessment within a reasonable timeframe and then being unable to access treatment for an unacceptable period.

Mr Richard Ellis, Joint Borough Director at NWL CCG, advised that patients would not be turned away from CAMHS if they were judged to be vulnerable. However, they might be signposted to other services that were able to offer appropriate services and support more quickly than CAMHS. Access to the third sector did also provide these families with support as part of the service delivery.

It was thought that the systems approach seemed to be having a positive effect with things fitting together better. Ms Eves recognised that CNWL was good at numbers and percentages but less good at identifying outcomes and that actions taken to address issues such as obesity would need to be monitored for a longer period of time to be able to determine what the outcomes/deliverables had been. Members requested that further statistics and information on the effectiveness of actions being undertaken by CNWL be brought to the Committee's meeting on 22 February 2022.

North West London Clinical Commissioning Group (NWL CCG)
Mr Richard Ellis, Joint Borough Director at NWL CCG, advised that NWL CCG had come into effect on 1 April 2021 and would be replaced by the NWL Integrated Care System (ICS) in 2022. Benefits of the new arrangements included the ability to work at scale and to talk to NHS England at scale. Conversely, the speed of communication was likely to slow down.

Mr Ellis advised that the weekly Covid Hub monitoring meetings would become weekly winter pressure meetings from next week so that risks could be monitored. It was likely that these winter pressure meetings would remain in place until next year.

Ms Benson advised that the new arrangements had meant that THH had been able to be more agile and that there was system wide agility rather than just at a local level. Some barriers had been broken down and the regular NWL ICS meetings would be transitioning into winter pressure calls.

It was noted that 'Team Hillingdon' had been delivering a partnership approach for some time. This approach had been particularly effective with regard to initiatives such as the Covid vaccination programme and these skills were transferrable to deal with other things such as winter pressures. Mr Ellis praised the strong working relationship that had been developed with the Council's estates and Public Health teams in relation to Covid and projects such as a primary care service that had been commissioned to support 23 quarantine hotels in NWL, 15 of which were in Hillingdon.

The system had been working under winter pressure conditions for the last 18 months so 160 initiatives had been identified to help alleviate winter pressures. However, the

challenge in delivering these initiatives was in relation to having the appropriate estate in place and identifying the workforce to be able to take the initiatives forward. To this end, work had already started to identify partners' estate and look at how these physical buildings could be shared to best effect. Other work included the development of ingenious solutions to enable patients' digital access.

As well as partners sharing physical space, different teams were working together to improve the patient's journey and traditional budget frontiers were being addressed. Although the philosophy behind the ICS/provider alliances was that there should be a single budget, partners were not there yet. The Better Care Fund was one example of success where several budgets had been combined to deliver better outcomes for older people. Whilst a single budget did seem to be a good idea, consideration would need to be given to ensuring that partners were still accountable.

During the winter period, NWL CCG would be looking to support primary care with the discharge work and keeping elective referrals flowing. Covid had not gone away so the focus for primary care would be on preventative measures and self care. The Covid vaccination booster programme (which included care home and pharmacy staff) and the flu vaccination programme (10% of the priority groups had already been vaccinated) were already underway. It was hoped that as many Hillingdon residents as possible had received the flu vaccination by the end of November 2021 (approximately 175k) - Hillingdon had had the best performance in London in the previous year.

Handovers from the London Ambulance Service (LAS) to THH were being monitored as well as LAS handovers to other hospitals in NWL to ensure that any blockages elsewhere in the area did not then impact on Hillingdon Hospital (or vice versa).

Mr Ellis advised that consideration was being given to ensuring that primary care / GP appointments were available to residents from 8am to 8pm, seven days a week. There was a need to continue to promote that primary care was still available and open and that more people had been successful in getting an appointment that they had been in November (in January 2019, 89% of GP appointments were face-to-face; in January 2020 there had been 104k appointments; currently, 53% of the 117k GP appointments were face-to-face and 47% were virtual). The reality was that GP appointments were available but it was recognised that virtual appointments did not work for everyone or for every condition.

Members queried the quality of primary care following the forced move to the virtual model as a result of the pandemic. Mr Ellis advised that this was something that NWL CCG had been looking at for some time and that improvements had been made to ensuring that patients were asked the right questions to elicit feedback in relation to quality. A population health management pilot was being undertaken in NWL with eight PCNs and would be initiated in the Hayes and Harlington PCN. Patients were able to choose to see a GP face to face rather than a nurse / virtually but this might mean a longer wait for an appointment.

Mr Gavin Fernandez, the Council's Head of Service - Hospital, Localities, Sensory and Review, advised that, as a system, partners were currently working well. There had been good communications and Discharge to Assess had been working well.

RESOLVED: That:

1. **Ms Benson provide the Democratic Services Manager with statistics on the number of failed discharges at THH going back as many years as was available;**

	2. Ms Benson send a copy of the Integrated Quality and Performance Report (IQPR) to the Democratic Services Manager; **3. CNWL provide further information on the new 16-25 mental health service model at the Committee's next health related meeting;** **4. Ms Eves provide the Democratic Services Manager with CAMHS numbers and CAMHS waiting times for the various lists;** **5. CNWL provide further information at the Committee's next health related meeting on the support and wrap around services that were available to CAMHS patients while they were waiting for their assessment;** **6. CNWL provide further statistics and information on the effectiveness of actions being undertaken by the Trust to the Committee's meeting on 22 February 2022; and** **7. the discussion be noted.**
31.	**WORK PROGRAMME** *(Agenda Item 7)* Consideration was given to the Committee's Work Programme. It was noted that the Chairman would be presenting the Committee's final report on children's dental health to Cabinet at its meeting on 14 October 2021. Concern was expressed that the waiting times for a CAMHS assessment still appeared to be too long. During this time that they were waiting for professional intervention, the child's/young person's mental health was likely to be deteriorating and the parents were having to deal with this as well as things like having their child sectioned. It was agreed that the Committee hold a focussed discussion in relation to CAMHS as its first meeting in the 2022/2023 municipal year. The Chairmen of any of the Council's other relevant Select Committees would be invited to attend this meeting. As with the children's dental services review, if the there was more scrutiny needed following the meeting, this could be scheduled into the Committee's Work Programme. **RESOLVED: That:** **1. CAMHS be added to the Work Programme for the meeting in June 2022; and** **2. the Work Programme be agreed.**
	The meeting, which commenced at 6.30 pm, closed at 8.40 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.