Minutes

HEALTH AND SOCIAL CARE SELECT COMMITTEE

22 November 2022

Meeting held at Committee Room 5 - Civic Centre

	Committee Members Present: Councillors Nick Denys (Chairman), Philip Corthorne (Vice-Chairman), Tony Burles, Reeta Chamdal, Alan Chapman, Barry Nelson-West and Sital Punja (In place of June Nelson) **Also Present**: Clinton Beale, Stakeholder Engagement Manager (North West), London Ambulance Service Richard Ellis, Joint Lead Borough Director, North West London Clinical Commissioning Group (NWL CCG) Nicholas Hunt, Director of Service Development, Royal Brompton & Harefield NHS Foundation Trust Toby Lambert, Director of Strategy and Population Health, NWL ICS Dr Ritu Prasad, Chair, Hillingdon GP Confederation Chris Reed, Hillingdon Group Manager, London Ambulance Service NHS Trust Derval Russell, Royal Brompton and Harefield NHS Foundation Trust Lisa Taylor, Managing Director, Healthwatch Hillingdon Patricia Wright, Chief Executive Officer, The Hillingdon Hospitals NHS Foundation Trust **LBH Officers Present**: Nikki O'Halloran (Democratic Services Manager)
32.	**APOLOGIES FOR ABSENCE** *(Agenda Item 1)* Apologies for absence had been received from Councillor June Nelson (Councillor Sital Punja was present at her substitute).
33.	**DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING** *(Agenda Item 2)* There were no declarations of interest in matters coming before this meeting.
34.	**MINUTES OF THE MEETING HELD ON 12 OCTOBER 2022** *(Agenda Item 3)* **RESOLVED: That the minutes of the meeting held on 12 October 2022 be agreed as a correct record.**
35.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 4)* **RESOLVED: That all items of business be considered in public.**

36.	**HEALTH UPDATES** *(Agenda Item 5)* <u>Healthwatch Hillingdon</u> Ms Lisa Taylor, Managing Director at Healthwatch Hillingdon, advised that the organisation was a charity which engaged with the local population to capture the patient voice and act as an advocate for residents. It was central to ensuring good service delivery and held statutory powers to enter and view. Healthwatch Hillingdon offered patients advice and guidance and listened to / acted on behalf of residents. In addition, the organisation had developed an engagement programme for young people called Young Healthwatch. <u>North West London Integrated Care System (NWL ICS)</u> On 1 July 2022, NWL ICS was put on a statutory footing and NWL Integrated Care Board (ICB – known as "NHS NWL") was established, taking on many of the functions of the eight NWL Clinical Commissioning Groups. The NWL Integrated Care Partnership (ICP) was a Committee that had no staff or budget and brought the NHS and local authorities together to set the strategy for health and care. The ICB and ICP were part of the ICS which included all organisations involved in the commissioning and oversight of health and social care. Mr Toby Lambert, Executive Director of Strategy and Population Health and NWL ICS, advised that the introduction of the ICS provided an opportunity to set an exciting vision and strategy for NWL that built on achievements to date and took advantage of the strengthening collaboration across health and care. It was thought that this would: improve outcomes for residents and communities; address long standing inequalities in access, experiences and outcomes; improve value for money; and deliver wider benefits across NWL. NWL ICS brought together health and care partners around four key aims: • Improve outcomes in population health and healthcare • Tackle inequalities in outcomes, experience and access • Enhance productivity and value for money • Help the NHS support broader social and economic development At borough level, the focus was to build and strengthen partnerships between health, local authority, other stakeholders and service providers who could work together and improve outcomes for residents. It was anticipated that these would become more formalised during the year and take on delegated functions from the ICB from April 2023. In NWL, eight local Borough Based Partnerships (BBPs) had been developed to deliver the strategy and, in Hillingdon, was known as Hillingdon Health and Care Partners (HHCP). Members were advised that the work that had been undertaken building HHCP had put Hillingdon in a good position to quickly move forward towards delegation. Mr Richard Ellis, Joint Borough Lead Director at NWL ICS, advised that the team provided commissioning services for primary care and mental health and oversight for the delivery of integration between and across health and social care. NWL ICS actively worked with the local authorities and had specifically been working on patient access to general practice over the winter period and winter planning in general. They had also been working with The Hillingdon Hospitals NHS Foundation Trust (THH) and the Council on patient flows through the hospital and to ensure that discharges ran smoothly.

Mr Ellis noted that the Crisis House in Hillingdon had recently opened. Although it currently had a six bed capacity, it was hoped that this would be increased over time. The Crisis House had had an impact on partners, helping to reduce the pressure on A&E at Hillingdon Hospital. Work was also underway with the police regarding improved crisis services for those with mental health issues, especially in relation to Section 136 detentions.

Members queried how funding decisions were made, given that each of the bodies involved from the eight boroughs would have a different perspective. Mr Lambert advised that NWL ICS commissioned the NHS Trusts and that primary care and continuing healthcare was commissioned at a local level (in Hillingdon this would be via HHCP). Mr Ellis noted that the process for funding decisions was still a work in progress, with HHCP keen to take on more delegated budget responsibilities. Direct local control was held with regard to local primary care and the Better Care Fund but NWL ICB would have several pots of money from NHS England in relation to winter planning, some of which would likely be distributed on a population basis for projects in each of the boroughs rather than based on need.

Governance groups in Hillingdon had been looking at the overall funds that were available and partners would need to identify and agree projects that would support residents over the winter. Consideration was being given to how these projects would be monitored over Christmas.

<u>Hillingdon GP Confederation / Hillingdon Health and Care Partners (HHCP)</u>
Dr Ritu Prasad, Chair of Hillingdon GP Confederation, noted that the Confederation was an overarching body across all GP practices in Hillingdon and worked as part of Hillingdon Health and Care Partners (HHCP). It provided services that needed to be undertaken at scale, e.g., vaccinations. Although not involved in commissioning, Dr Prasad was able to suggest projects and proposals that would benefit residents and those with additional needs.

Mr Ellis advised that the GP Confederation had played a crucial part in the Covid vaccination programme. Hillingdon had achieved the highest number of Covid vaccinations across the whole of London in the previous year. This year the vaccination programme delivered by GPs and community pharmacies had included Covid, flu and polio boosters.

Dr Prasad advised that HHCP was an alliance between the GP Confederation, Central and North West London NHS Foundation Trust (CNWL), H4All and THH, and that it worked alongside the Council and NWL ICS. HHCP's strategic aims were in relation to:

- Improving the outcomes for our population - delivering Hillingdon's Joint Health and Wellbeing Strategy
- Delivery of sustainable, person-centred, joined up models of care aligned to the new hospital plans and activity assumptions
- Delivering the NWL ICS priorities through local models

In 2019, Primary Care Networks (PCNs) were set up. Each of these PCNs comprised a group of practices that served 30-50k residents and delivered integrated models of care. Neighbourhood teams were used as a delivery model covering services and patients and included partners such as the police and London Ambulance Service to provide joined up care.

The Council and HHCP had refreshed the Hillingdon Joint Health and Wellbeing Strategy and identified six priorities:

- Support for children, young people and their families to have the best start and to live healthier lives
- Tackling unfair and unavoidable inequalities in health and in access to and experiences of services
- Helping people to prevent the onset of long-term health conditions such as dementia and heart disease
- Supporting people to live well, independently and for longer in old age and through their end of life
- Improving mental health services through prevention and self-management
- Improving the ways we work within and across organisations to offer better health and social care

Partners, including Public Health, had been looking at data together to identify priorities at Borough and Neighbourhood levels including the national "Core 20 + 5" framework. This approach had been trialled with a focus on preventing falls and, in one of the Neighbourhoods, care for those with diabetes and obesity. The learning from these projects would be taken forward as a consistent way of working was developed.

HHCP had three themes to work on during 2022/2023: developing Hillingdon 'Place'; building "Team Hillingdon"; and delivering transformation programmes. Key next steps included:

- Focus on population health and engagement, establishing priority areas from the refreshed joint strategic needs analysis
- Working together to develop joined up plans for winter resilience
- Delivering objectives including the transformation programmes
- Working with NWL ICB in order to be ready for delegation from April 2023

Although these were thought to be good ambitions, Members queried how health colleagues would be evidencing progress to know when the objectives had been met. Dr Prasad advised that each transformation project had Key Performance Indicators (KPIs) and targets which would be assessed on a regular basis. For example, there was a target around the number of patients that avoided emergency admission and consideration could be given to the fulfilment of end of life plans. Dr Prasad agreed to bring evidence of the objectives being met to the Committee's meeting on 26 April 2023.

Members queried whether the interests of all boroughs in NWL aligned and how any differences were accommodated. It was also queried whether Hillingdon had a representative on the ICS or whether it was actually an ICS representative in Hillingdon. Mr Lambert advised that the current structure of ICS/ICB had been set nationally so could not change. He noted that the strategy regarding commissioning intentions had been developed from the Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessment. Scales had been used to ensure the most efficient and effective use of resources, whilst also ensuring that local priorities were continued. There was a large degree of commonality between the boroughs in NWL but there were also some areas where a borough would benefit from the support that NWL ICS would bring.

Mr Ellis advised that, from a Hillingdon perspective, the Health and Wellbeing Board was an important vehicle for testing views of the strategy. There had been some

significant gains that had arisen from Public Health input and resources. Consideration also needed to be given to the additional pressures felt in Hillingdon from the increase in asylum seekers which needed to be shared across NWL.

Members queried the progress being made with regard to the number of GP vacancies in Hillingdon and the recruitment activity that was being undertaken to address this. Dr Prasad noted that, although Hillingdon was slightly under-doctored, a lot of work had been undertaken by the Confederation to provide training and support for existing GPs and new GPs had been coming to Hillingdon to train. GP levels were currently manageable locally but recruitment was a national challenge. Mr Lambert advised that additional investment had been identified for alternative roles in general practice to free up GPs. Thanks largely to digital options, GPs in NWL were now providing 35% more consultations that they had been before the pandemic so there had been a huge increase in demand rather than resources being extracted from general practice. Consideration would need to be given to how demand could be managed and shifted.

With resources being held at a NWL level, concern was expressed about the possibility of resources being extracted to focus on areas that were a priority for NWL but not a significant issue within Hillingdon and the ability of each borough to be able to ringfence resources for its priorities.

<u>The London Ambulance Service NHS Trust (LAS)</u>
Mr Clinton Beale, Stakeholder Engagement Manager at LAS, advised that his work covered NWL as well as across the whole of London. The LAS was the only NHS Trust that covered the whole of London and was the busiest ambulance service in the UK with approximately 3k emergency jobs every day and 2m 999 calls every year. The LAS looked after 1.2m 999 and NHS 111 calls for London per annum (this figure was rising), had around 8k staff and covered the 620 square mile area within the M25. There were around 26k NHS 111 calls per month (14k were dealt with on the phone and closed through 'Hear & Treat' and around 11k were triaged into A&E via 111) and 31k patients per month were treated and discharged at the scene.

The LAS worked collaboratively with the ICB and acute trusts on a daily basis to deal with issues as they arose as a shared risk, solving them across the wider system. Although, along with partners such as the London Fire Brigade and police, the LAS was prepared for unexpected major challenges, this meant that resources needed to be set aside to ensure this readiness.

NHS 111 meant that more patients than ever were being treated over the phone than ever before. It had been difficult to treat patients before without access to their medical records, so the introduction of Urgent Care Plans (UCPs – which had been an evolution of the Coordinate My Care Plan) produced on the system had enabled paramedics to get access to these medical records en route to the patient. Dr Prasad advised that Hillingdon had the highest number of UCPs in place with clear information therein about patient needs.

Technology had moved on and all ambulance staff were now issued with a tablet to access records and share with hospitals before arrival through a web portal (it was anticipated that this would eventually be integrated into hospital systems). Mr Beale noted that it would be good to see and measure the improvements brought about by the UCPs which would include better outcomes for patients. He advised that mental health response cars were in place with a mental health nurse and paramedic on board and that there was a mental health nurse in the control room too. However, demand

for mental health services was high and the mental health nurses in the response cars were only in place for approximately three months before rotating back to their own Trust and being replaced by a new nurse.

The Chairman noted that LAS performance-related information had been shared at a recent NWL Joint Health Overview and Scrutiny Committee meeting. The Democratic Services Manager would forward this information on to Members of the Committee.

Mr Chris Reed, Hillingdon Group Manager at LAS, advised that the LAS categorised calls as 1-4 and that the biggest concern was in relation to response times for Cat 1 and Cat 2. Over the last few weeks, resourcing changes had led to changes in the model used in NWL to ensure that fast response units were available to deal with calls. This had meant that the LAS had managed to achieve the 7-minute response target for Cat 1 calls in the last two weeks. However, demand for Cat 2 calls had been increasing. Members were keen to see what action would be taken to improve the Cat 2 response time.

To ensure achievement of the 7-minute average response time for Cat 1 calls in Hillingdon, the LAS had double-crewed ambulances and 3-4 fast response cars strategically placed at any one time (these were used less than the ambulances so that they could concentrate on the Cat 1 calls). In addition, Mr Reed sat on meeting about HS2 so was able to ensure that the roads were clear for LAS staff. Traffic would always be a challenge but this was something that the LAS just dealt with.

Action had been taken to improve the education of those on the front line to give them the confidence to make the right decision on scene and refer to alternative pathways where appropriate (rather than conveying all patients to A&E). Generally, 50% of patients were still taken to hospital and Mr Reed was grateful to the staff at Hillingdon Hospital for the collaborative work that had been undertaken to reduce ambulance waiting time at A&E.

Ms Patricia Wright, Chief Executive at THH, advised that the current layout of A&E was not conducive to some of the solutions being proposed to handover delays but that staff made every effort to work around and do what they could in a crowded department.

With Covid still at the forefront of people's minds and the impact that it could have on the respiratory system, Members queried whether there were more calls generated by related concerns. Mr Reed advised that a panic attack would need to be assessed face-to-face and on an individual basis as everyone had different medical histories and things like pulmonary embolisms needed to be ruled out. Mr Beale noted that, during the height of the pandemic, referral to alternative services had been stopped but that this pathway was now coming back online.

Mr Lambert advised that there had been three effects from the pandemic:

1. There had been an undertreatment of patients as they had been hesitant to present during the pandemic but were now more comfortable getting their health issues dealt with;
2. Some services had been stood down and action was now being taken to raise awareness of them again; and
3. There had been a reduction in individuals' general resilience to be able to deal with their own health issues that had been driven by psychology.

The Hillingdon Hospitals NHS Foundation Trust (THH)

Ms Patricia Wright, Chief Executive at THH, advised that winter pressures seemed to be around throughout the year, especially with respiratory illnesses caused by pollution and allergies all year round. THH had just published its strategy for the next five years and Ms Wright would forward a copy to the Democratic Services Manager for circulation to the Committee. The strategy covered the journey that THH would take to transition to the new hospital as it would not just be a case of moving current ways of working to the new build. It set out the vision for the organisation to deliver the best possible care for people who needed THH's services.

As it was recognised that the Trust did not always get things right, the CARES values had been retained and six strategic priorities had been set which included: quality, staff, performance, finances and working in partnership. Hillingdon Hospital was classed as a small to medium sized hospital which meant that it was unable to do some things at scale. As such, working in partnership was essential, for example, sharing respiratory consultants with Harefield Hospital. THH had developed a good working relationship with HHCP and needed to be part of the journey with partners.

Work was underway in relation to ensuring that patient records were up to date. Currently, THH used a range of different systems to record various details about patients. From November 2023, a new shared system solution would be initiated which would facilitate the management of patient care and the seamless transfer of care with links to community services, helping care to be more proactive. One current innovation was a system which allowed GPs able to submit information about patients onto an IT referral system with consultants able to provide advice and guidance online. This had reduced referrals to hospital and provided more joined up care, moving the care out of hospital.

Since April 2022, THH had been part of the Acute Care Collaborative with a single Chairman covering Imperial, Chelsea and Westminster, London North West and THH. Each of these organisations existed in its own right but worked collaboratively, looking at economies of scale in things like back office functions.

Members were advised that the hospital rebuild strategic programme was progressing and that an announcement from the Treasury about the next tranche of money was awaited. The planning application for the new hospital was also being progressed.

THH was able to provide elective and emergency care and it was recognised that the quality of care at Hillingdon Hospital had been judged inadequate at the last CQC inspection. Although the Hospital had not yet been reinspected, the improvement notices issued in 2020 had been removed. An unannounced visit had also taken place on 1 November 2022 to look specifically at some medical and care of the elderly services in response to some concerns that had been raised by patients with the CQC about the quality of care. Informal feedback had been positive in that THH had taken action in relation to some of the issues that had been raised.

A&E performance against the 4 hour target had been in line with other London Trusts for some time, although below the national target of 95%. However, performance had deteriorated over the last 2-3 months. Although capacity at the Hillingdon A&E department was around 130-150 per day, the hospital regularly saw 200 patients per day (plus another 200 patients per day in the Urgent Treatment Centre). A&E was now also monitored on 12 hour waits in the department so THH needed to focus its effort on how this could be improved.

With regard to elective care, effort was needed to return to 2019/2020 levels and Ms Wright was confident that no patient would be waiting longer than 78 weeks by the end of the year. This would be a challenge as Covid had not gone away. Contingencies had been put in place for the winter with virtual wards being able to monitor patients at home.

Concern was expressed about staff morale and the challenges of recruitment and retention. Ms Wright advised that the staff were tired and it would be important to look after them as much as looking after patients. Morale levels had dropped from 2016 levels but had held last year (despite levels dropping across the rest of the NHS). It was unclear whether morale would hold to these levels again this year because of the impact of the cost of living and travel.

Funding had been made available from the ICB to recruit around 120 international nurses and these were now in post. There had been some issues with recruiting to medical specialities but very high calibre individuals had been appointed and a cohort of young and enthusiastic consultants were now in post. There had been a high turnover in Healthcare Assistants (HCAs) and estates / facilities staff (as well as in the Senior Leadership Team) but the Trust was working hard to tackle any issues that arose.

It was queried whether work by social care and the hospital around delayed discharge had been impacted by changes in funding streams. Ms Wright advised that discharge was regularly monitored and that there had not been a huge decrease in discharge performance. There had been a little blip when the Discharge 2 Assess model had been removed (there had been an increase in length of stay at the end of last year but this had now dropped by one day), but a modified version of the discharge lounge process was now being used.

Insofar as physiotherapy services were concerned, Members were advised that physiotherapy was provided by CNWL in the community as well as by the hospital for inpatients. There was sometimes confusion about the move to community physiotherapy once a patient had been discharged from hospital. Mr Ellis advised that consideration was being given to recruitment so that GPs could also refer to them.

<u>Royal Brompton and Harefield NHS Foundation Trust (RBH)</u>
Mr Nick Hunt, Executive Director of Service Development at Harefield Hospital, advised that the Trust was performing well in relation to elective performance as it had not been as affected by Covid as other hospitals. No patient was currently waiting longer than 18 months. However, in anticipation of the proposed strike by the Royal College of Nursing, it was thought that cardiac performance might derogate from that as the overwhelming vote from staff was to strike.

The Trust continued to face challenges with the recruitment of critical care staff, radiographers and cardiologists. However, Brunel University was providing some assistance with the expansion of cardiology and radiography related training.

Mr Hunt noted that David Simmonds MP had visited Harefield Hospital and had written to the Secretary of State about capital spending restrictions which were a challenge. It would be important for the Treasury to start releasing money.

Ms Derval Russell from RBH, advised that there had been an uptick on non-elective

	activity and that investigations were being undertaken to establish the reason. It could be that patients had waited until after the pandemic had calmed a little before they raised their symptoms as an issue but it was not yet clear if this was a contributory factor. There had been a huge dip in referrals during Covid and it was possible that the increase could be these patients now surfacing. Patients were now waiting longer than they had pre-Covid but a digital platform was being rolled out for patients to highlight any issues experienced during their wait. This digital project had been funded by NHS England. **RESOLVED: That:** **1. Dr Prasad bring evidence of the ICS objectives being met to the Committee's meeting on 26 April 2023;** **2. the Democratic Services Manager forward the LAS performance data from the NWL JHOSC meeting to Members of the Committee;** **3. Ms Wright forward a copy of THH's five year strategy to the Democratic Services Manager for circulation to the Committee; and** **4. the presentations be noted.**
37.	**CABINET FORWARD PLAN MONTHLY MONITORING** *(Agenda Item 6)* Consideration was given to the Cabinet Forward Plan. It was noted that an item in relation to the *2022/23 Better Care Fund Section 75 Agreement* would be included on the agenda of the Committee's next meeting on 7 December 2022. **RESOLVED: That the Cabinet Forward Plan be noted.**
38.	**WORK PROGRAMME** *(Agenda Item 7)* Consideration was given to the Committee's Work Programme. It was agreed that the Committee's next major review be in relation to children's mental health and that a scoping report be included on the agenda for the meeting on 26 January 2023. **RESOLVED: That:** **1. a scoping report on children's mental health be included on the agenda for the meeting on 26 January 2023; and** **2. the Work Programme be noted.**
	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.