Minutes

EXTERNAL SERVICES SCRUTINY COMMITTEE

28 October 2010

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

	Committee Members Present: Councillors Mary O'Connor (Chairman), Michael White (Vice-Chairman), Phoday Jarjussey, Judy Kelly and Peter Kemp **Witnesses Present**: Tom Pharaoh – Commissioning Support for London Sue Nunney – Hillingdon PCT Jacqueline Totterdell – The Hillingdon Hospital NHS Trust Richard Connett – Royal Brompton & Harefield NHS Foundation Trust Nicholas Hunt – Royal Brompton & Harefield NHS Foundation Trust Dr Mitch Garsin – Hillingdon LMC Andy Michaels – BMA / LMC Amanda Brady – Care Quality Commission (CQC) **Others Present**: Councillors John Hensley (in part) and Dominic Gilham Allan Edwards, Standards Committee Chairman Malcolm Ellis, Standards Committee Vice-Chairman **LBH Officers Present**: Linda Sanders, Ellis Friedman, Nav Johal and Nikki Stubbs **Public present:** 2	
13.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 4)* **RESOLVED: That all items be considered in public.**	**Action by**
14.	**HEALTH INEQUALITIES WORKING GROUP - DRAFT FINAL REPORT** *(Agenda Item 6)* Councillor John Hensley, Chairman of the Health Inequalities Working Group, introduced the Working Group's draft final report on the effect of overcrowding on educational attainment and children's development. Members were advised that the Working Group had been acutely aware that the effects of overcrowding had the greatest impact on the development of children under five. Councillor Hensley advised that his meeting with a young person whose attainment and development had been hindered by overcrowding had been very emotional. The report looked at the existing good practice already undertaken and proposed recommendations to build on this work. Dr Ellis Friedman was thanked for his considerable contribution to the Working Group meetings.	**Action by**

	It was noted that Councillor Phoday Jarjussey, who had been a Member of the Working Group, had not agreed with recommendation 6 in the draft final report. **RESOLVED: That the report of the Health Inequalities Working Group be agreed and submitted to Cabinet for consideration at its meeting on 18 November 2010.**	
15.	**PROVISION OF HEALTH SERVICES IN THE BOROUGH** *(Agenda Item 5)* The Chairman welcomed those present to the meeting. <u>Cardiovascular and Cancer Services</u> Mr Tom Pharaoh, Senior Project Officer at Commissioning Support for London, gave a presentation on the work that had been undertaken to develop models of care with regard to cancer and cardiovascular services across London. In developing the proposals for cancer services, consideration had been given to early diagnosis, common cancers/general care and rarer cancers/specialist care. These work areas had been investigated by a project board which had received evidence and information from an expert reference group for each work area, an overarching expert reference panel, a patient panel and experts from outside of London. Although there were areas of excellence in London in terms of mortality for all cancers, there were significant inequalities in access and outcomes. It was noted that later diagnosis had been a major factor in causing poorer relative survival rates. It had been suggested that specialist surgery be centralised and that common treatments and surgery be localised where possible. It was also suggested that organisational boundaries should not be a barrier to the strong commissioning that was required for high quality comprehensive care pathways. The following recommendations resulted from the work that was undertaken: • Early diagnosis: o Direct access to some diagnostic investigations from primary care o Increase the uptake rates of screening programmes o Understand and address inequalities to increase awareness and reduce late presentation • Common cancers/general care: o Centralisation of some surgical services and localisation of others o Standardised best practice (day case breast surgery, laparoscopic colorectal surgery, enhanced recovery programmes to minimise lengths of stay) o High quality, safe local delivery of chemotherapy o Acute oncology services in emergency departments o Complement traditional follow-up with bespoke follow-up	**Action by**

based on survivorship model

- Rarer cancers/specialist care:
  - Concentration of some rarer cancer services beyond minimum NICE requirements to help ensure high quality experience and outcomes
  - Minimum caseloads for specialist oncologists for each rarer tumour type to maintain their specialist expertise
  - Consider centralised commissioning of all radiotherapy (to include specialist radiotherapy) to ensure equal access to treatment for all Londoners

In developing proposals for cardiovascular services, the focus had been on emergency and complex hospital care in the following work areas: vascular surgery – surgery on veins and arteries; cardiac surgery – surgery on the heart; and cardiology – less invasive procedures on the heart. This project had been led by a clinical expert panel for each work area and a patient panel. It was noted that the proposals that came out of the investigation were in relation to how cardiac surgery was organised rather than where heart bypass surgery was provided.

Suggestions for improvements included:

- Vascular surgery
  - All emergency and elective complex vascular surgery should be centralised into high volume hospitals
  - Local hospitals should continue to deliver the bulk of the vascular service: outpatients and diagnostics; varicose vein surgery
- Cardiac surgery
  - Concentrate the expertise of surgeons and teams performing mitral valve surgery
  - Improve urgent cardiac surgery by using electronic referral system and standardising the method of assessing the urgency of each patient
- Cardiology
  - Should patients not be directly transferred to heart attack centres they should be risk assessed at local A&E departments and high risk patients transferred to a centre for an angiogram with 24 hours
  - Hospitals organised into electrophysiology networks
  - Local hospitals should implant simple devices and link to specialist sites for complex care

Furthermore, the patient panel believed that improvements were required in order to improve quality, reduce deaths and give people better lives. It was suggested that improvements in the following areas would be beneficial to patients:

- Former patients being available for support
- Explanations of medical terms without prompting
- Continuity of care on wards
- Patients being discharged to their GPs with a care plan
- Consultants to have an interest in all aspects of patient care

	The proposed models of care for cardiovascular and cancer care were published by Commissioning Support for London in August 2010. Although the formal consultation on the documents would end on 31 October 2010, Mr Pharaoh advised that consideration would be given to submissions after this date. It was noted that an online questionnaire soliciting feedback on the proposals was also available. A financial analysis on the cost of implementing the proposals had been produced and published alongside the proposed models of care. Although it was anticipated that the proposals would increase the speed of cancer detection as well as the number of detections (and therefore the associated cost), it was believed that savings could be made elsewhere in the pathway. Concern was expressed that the cancer services provided by the Mount Vernon cancer network had not been acknowledged in the proposals. These services were of a very high standard and there was a worry that their transfer to a hospital in central London would not be of benefit to Hillingdon residents or residents in the surrounding area. Whilst, on the face of it, the proposals with regards to acute oncology, etc, appeared to be very positive, concern was expressed that there was very little detail. Those present were advised that an acute oncology pilot had been undertaken at Whittington Hospital and had resulted in significant savings. With regard to the cardiovascular proposals, it was noted that additional work needed to be undertaken in relation to educating the public and raising awareness of heart attacks. Heart attack victims would often be driven to the nearest hospital by someone that was with them at the time of the attack. The public needed to be encouraged to dial 999 for heart attacks so that the victim could be taken by ambulance to the closest hospital that specialised in the type of care that the patient needed. The centralisation of vascular services was generally supported but concern was expressed by Ms Jacqueline Totterdell, Chief Operating Officer at The Hillingdon Hospital NHS Trust (THH), that this could put additional financial pressure on THH. Patients were often admitted to one hospital for care and then transferred to another. In this circumstance, it was deemed important to ensure that the costs associated with a patient were shared between the two healthcare providers. Concern was also expressed that the lack of funding in the NHS could lead to a rationing of expensive operations such as implanting internal cardiac defibrillators. On the whole, it was agreed that the evidence suggested that the proposals included within both reports were following the right direction of travel. <u>Health White Paper</u> Dr Mitch Garsin, Chairman of Hillingdon LMC, advised that, although the White Paper proposals had caused trepidation, the changes would offer real opportunity to improve care pathways. It was noted that there	

	was a lack of detail in the Paper which Dr Garsin suggested might have been done so that GP consortia developed the proposals themselves. Members were advised that, although no decision had yet been finalised, it was likely that there would be one GP consortium created that was coterminous with the local authority boundaries. However, if this proved too small, the Hillingdon consortium would need to work with other consortia in the area. It was noted that the Practice Based Commissioning (PBC) Board had expressed an interest in gaining pathfinder status which, if successful, would have funding attached. The Committee was supportive of the PBC Board applying for pathfinder status as it would take some uncertainty out of the system. As well as concern about the limited funding that would be available over the next five years, Dr Garsin was concerned about the level of support that would be made available to the consortia. GPs were expected to take on a new role and the associated responsibilities at the same time as maintaining their regular surgeries and patient contact. It was anticipated that there would be some support provision from NHS personnel but that a more substantial support vehicle was needed. Ms Sue Nunney, Director of Corporate Affairs at Hillingdon PCT, advised that, although a number of PCT staff would be moving to the national Board, the PCT hoped to provide support to the GP consortium. Concern was expressed that hard-working, knowledgeable and valued PCT staff would move away from the health sector as the PCTs wound down. It was noted that these staff had the option of creating a social enterprise which could then be used to support the GP consortium. It was agreed that effective partnership working with the Trusts (particularly THH) and Hillingdon Council was key to ensuring that the proposals were implemented efficiently. The White Paper proposals had prompted an improvement in the communication between clinicians and it was noted that there had been more communication (in terms of both quality and volume) between GPs and Hillingdon Hospital over the last 2-3 months that there had been in the previous four years. This partnership working would enable different ways of working to be developed so that the health economy was able to cope with the anticipated increase in demand – working quicker, smarter, better. Ms Nunney advised that Hillingdon, Ealing and Hounslow PCTs had formed a cluster which, it was anticipated, would deliver management cost savings. Although, there would only be one Chief Executive heading the cluster, there would continue to be three Boards representing each of the areas. Consultation was currently underway in the North West London sector for each cluster to create one management team and also streamline the cluster organisations. As far as non-executive appointments to the Board were concerned, it was possible that these posts would not be re-appointed to when their term of office ends and this was being discussed with the Appointments	

	Commission. It was hoped that the changes that would come about from the White Paper would not have a negative impact on patients. To ensure this smooth transition, the GP consortium would need to ensure that it worked far more closely with the public than GPs had before. It was anticipated that members of the public and representatives from the local authority would be able to sit on the Board and additional media communication would need to be employed to raise public awareness of the changes. There would also be the possibility of being able to share the risk with other consortia. Dr Garsin advised that he had been unaware of many of the 'Cinderella' services (such as the wheelchair service) and he was dependent on concerned residents or Councillors to ensure that these services did not slip through the net. The PCT would ensure that training was provided and events staged to ensure that the GPs were aware of all of the services that the consortium would need to provide. Although there had been a change in the focus of the CQC, the Trusts were keen to ensure that the work they had undertaken to reduce waiting times was not overridden. Members were advised that the THH management had been in discussions with MONITOR over the last month with regard to the Hospital's application for Foundation Trust status. THH had now written to MONITOR to formally agree that the historic due diligence work would commence in December 2010 with a view to completing the process by April 2011 at the earliest. Dr Garsin stated that there was a desire to redesign the urgent care service and that plans would be drawn up sometime in the next year. Consideration was given to the Royal Brompton & Harefield (RBH) NHS Foundation Trust Clinical Quality Report for the period ending 30 September 2010 which had been considered by the Trust Board on 27 October 2010. The report included the MONITOR declaration for quarter 2 and advised that the Trust was now fully compliant with all 16 of the Care Quality Commission essential standards of quality and safety. It was noted that the Trust's target for number of operations cancelled had again not been met. Members were advised that, according to the CQC target definition, an operation was classed as cancelled if it was cancelled on the day of the scheduled start time. Because the Trust made every effort possible to ensure that the maximum number of operations were performed, it was inevitable that some cancellations would happen on the day of operation. Mr Nicholas Hunt, Director of Service Development at the Trust, advised that the team would continue to operate in this manner as patient care carried the higher priority. Although the number of complaints received by the Trust was not a national target, RBH reported these statistics to its Trust Board and	

	Commissioners to ensure transparency, and to make sure that focus is maintained on this important measure of quality. <u>Care Quality Commission (CQC)</u> Ms Amanda Brady, from CQC, advised that, since 1 April 2010, the CQCs relationship with the NHS had changed so that it was now a legal relationship. The CQC no longer produced the commissioning report and had instead moved into monitoring and compliance. <u>Stroke</u> Ms Totterdell circulated information in relation to the North West London Stroke Unit length of stay and activity to Members. She advised that, although the length of stay at Hillingdon Hospital seemed to be long, it appeared that there might be some shorter stay patients that were being cared for at Northwick Park rather than being sent back to Hillingdon Hospital. This would have a significant effect on the THH average length of stay. Ms Totterdell stated that North West London NHS had been asked to look at the home address postcodes of these patients to make sure that they were being cared for in the correct Stroke Unit. <u>Hillingdon Hospital Site Visit</u> It was noted that Members of the Committee had visited Hillingdon Hospital on Monday 11 October 2010 and were joined by representatives from Age UK. The purpose of the visit was to witness the procedures that had been put in place to ensure that patients' nutritional intake was monitored. The Members had split up and visited three different wards: surgical, medical and stroke. Overall, the Members had been very impressed with the procedures that had been put in place. Councillor O'Connor advised that Ms Totterdell had gained a promotion and would be leaving THH and, as such, this would be the last time that she attended an External Services Scrutiny Committee meeting. The Members thanked her for the work that she had undertaken whilst at THH and wished her well in her new position. **RESOLVED: That:** **1. the report be noted; and** **2. the presentation from Commissioning Support for London on cardiovascular and cancer services be noted.**	
16.	**MINUTES OF THE PREVIOUS MEETING - 14 JULY 2010** *(Agenda Item 3)* **RESOLVED: That the minutes of the meeting held on 14 July 2010 be agreed as a correct record.**	**Action by**
17.	**WORK PROGRAMME** *(Agenda Item 7)* <u>24 November 2010</u> It was noted that Councillor White would not be present at the Committee's next meeting on 24 November 2010 and that, should he have any questions in advance of the meeting for the witnesses	**Action by**

	attending, these would be forwarded to Democratic Services. <u>Children's Self-Harm Working Group</u> It was agreed that the scrutiny review on children's self-harm would focus on children/young people up to the age of 18 and vulnerable young people up to the age of 25. It was anticipated that, although the review would primarily consider physical self-mutilation, it would also touch on other related issues such as anorexia and drug and alcohol abuse. A Health Visitor from Hillingdon Hospital would be invited to attend the first witness session. Other potential witnesses included representatives from Relate, YMCA, Mind, Metropolitan Police Service, Social Services. Officers would contact BBC Radio 4 to establish whether it would be possible to obtain a transcript from an item on children's self-harm that had been broadcast in the last three months. It was agreed that the Working Group would include Councillors O'Connor and Kemp. The appointment of the remaining membership would be delegated to Councillor O'Connor in consultation with the Chief Whips. The dates of the Working Group meetings would be agreed with Councillor O'Connor in advance of the Committee's next meeting. **RESOLVED: That:** **1. Councillor White's apologies be noted for the meeting on 24 November 2010;** **2. officers contact BBC Radio 4 to obtain a transcript of the item on children's self-harm;** **3. the appointment of the remaining membership of the Children's Self Harm Working Group be delegated to Councillor O'Connor in consultation with the Chief Whips;** **4. the dates of the Children's Self Harm Working Group meetings be agreed with Councillor O'Connor in advance of the Committee's next meeting; and** **5. the Work Programme be agreed subject to the above amendments.**	Nav Johal / Nikki Stubbs Nav Johal / Nikki Stubbs
	The meeting, which commenced at 4.30 pm, closed at 6.32 pm.	

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