Minutes

EXTERNAL SERVICES SCRUTINY COMMITTEE

12 January 2017

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

	Committee Members Present: Councillors John Riley (Chairman), Ian Edwards (Vice-Chairman), Teji Barnes, Mohinder Birah, Tony Burles, Raymond Graham (In place of Brian Crowe), Phoday Jarjussey and Michael White **Also Present**: Graham Hawkes, Chief Executive Officer, Healthwatch Hillingdon Caroline Morison, Chief Operating Officer, Hillingdon Clinical Commissioning Group Maria O'Brien, Divisional Director of Operations, Central & North West London NHS Foundation Trust Joe Smyth, Chief Operating Officer, The Hillingdon Hospitals NHS Foundation Trust **LBH Officers Present**: Gary Collier (Health and Social Care Integration Manager) and Nikki O'Halloran (Interim Senior Democratic Services Manager)
25.	**APOLOGIES FOR ABSENCE AND TO REPORT THE PRESENCE OF ANY SUBSTITUTE MEMBERS** *(Agenda Item 1)* Apologies for absence were received from Councillor Brian Crowe. Councillor Ray Graham attended as his substitute.
26.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 3)* **RESOLVED: That all items of business be considered in public.**
27.	**MINUTES OF THE PREVIOUS MEETING - 15 NOVEMBER 2016** *(Agenda Item 4)* It was noted that, following the Committee's meeting on 15 November 2016, representatives from the London Ambulance Service NHS Trust (LAS) would be invited to attend a future meeting to provide Members with updates on a range of issues that had been highlighted at the meeting. Councillor Jarjussey circulated a photo of a patient transport vehicle used in Hillingdon which had "NHS working in partnership with DHL" on the side. He noted that there had been issues with regard to the withdrawal of the service from a number of patients. Although Members were not concerned about NHS partners, the Committee wanted to ensure that partners were operating at a sufficient standard. The Chairman would ensure that Ms Vicki Hirst was asked to provide a written response, setting out the issue in Hillingdon and assurances of the standard of driver training/knowledge, the type/nature of any contracts and the monitoring measures in place. **RESOLVED: That:** **1. Ms Hirst be contacted to provide information in relation to the patient**

	transport services; and **2. the minutes of the meeting held on 15 November 2016 be agreed as a correct record.**
28.	**HEALTH UPDATES** *(Agenda Item 5)* The Hillingdon Hospitals NHS Foundation Trust (THH) Mr Joe Smyth, Chief Operating Officer at THH, advised that there had been significant activity at the Hillingdon A&E department and the number of acute patient admissions had been increasing. Compared to the same period the previous year, A&E attendances had increased as follows: • October 2016: +7.6%; • November 2016: +20%; • December 2016: +19%; and • January 2017: +20%. The majority of A&E attendances were self-presenters and Mr Smyth advised that Tuesday 10 January 2017 had been the busiest day ever recorded at Hillingdon A&E with 225 attendances. In 2012, A&E (which had capacity for 165 patients per day) saw an average of 145 patients each day. In November/December 2016, the average daily patient attendances increased to 195, and in January 2017 it had risen to more than 200 per day. As such, THH was not meeting the 95% standard of patients being seen within 4 hours. With regard to blue light/Category 1 attendances at A&E, ambulance staff rang ahead to advise the hospital that they would need one of the four beds in the resuscitation department. In November 2016, there was a 50% increase in these attendances compared with the previous year and in December 2016 there had been a 32% increase. Over the last two years, there had been a 53% increase in the number of Category 1 attendance which had overwhelmed the resuscitation department and meant that some patients had been moved to the majors area. It was noted that A&E capacity was being hindered by challenges in getting patients back out of the hospital once they had been treated. The department was thought to be too small and radical reform was needed to ensure that patients were quickly moved out of the hospital. Hillingdon Clinical Commissioning Group (HCCG) and THH had commissioned a review of the blue light attendances to establish whether the threshold had reduced. However, this work had identified that 90% of attendances really were Category 1 (with respiratory factors being a major component) and 10% were 'maybes' where it had been a judgement call. The Urgent Care Centre (UCC) at Hillingdon Hospital dealt with different types of patients and illnesses to those dealt with by A&E and saw approximately 220 patients each day. Mr Smyth noted that the UCC worked well with a quick patient turnaround and helped out with A&E when possible (although the UCC could not do blood or diagnostic testing). Patients arriving at the Hillingdon UCC/A&E were triaged by the UCC. If the patient needed to have a blood or other test that the UCC was not able to do, the individual would need to be seen by A&E staff. There were a significant number of patients that used A&E as a one stop shop so that they didn't have to wait for a GP appointment and then have to wait for an appointment for blood tests, etc. Some of these patients were

turned away from A&E and advised to contact their GP but it was sometimes difficult to assess how unwell a patient was. Although the vast majority were registered, hospital staff helped those patients that had not already done so to register with a GP. Concern was expressed that A&E staff were being prevented from helping very ill patients by these individuals who were using the resource inappropriately. It was suggested that, as many people were going to A&E to access primary care, consideration should be given to putting GP practices there.

The UCC was able to refer patients direct to a specialty. However, Mr Smyth acknowledged that this referral process needed to be smoothed out so that it provided maximum support to A&E.

Today's society was all about convenience and the patients attending A&E were predominantly aged 30-40 or under 5. It was thought that the increase in demand was likely to have been driven by people making a conscious decision to attend A&E rather than use their GP.

To cope with the increasing demand, THH had been reconfiguring its pathways, drafting in external staff to help and streamlining referrals and the ambulatory pathway. Although these measures would go some way to alleviating some of the pressure, it was likely that demand for services would continue to increase. As such, plans were being put in place to expand the A&E department by next winter.

Central and North West London NHS Foundation Trust (CNWL)

Ms Maria O'Brien, Divisional Director of Operations at CNWL, advised that the Trust's inpatient services had been re-inspected by CQC before Christmas and been rated as 'Good' overall. However, the Trust wanted to do more work in relation to adult and mental health services.

With regard to bed management pressures, approximately 25% of all inpatients could have been managed in a different environment if the resources had been available. Delayed Transfer of Care (DToC) in Hillingdon was higher than in other Boroughs (17-18%) and was sometimes slowed by a patient's complex challenging behaviour. The Challenging Behaviour Team was working on this as it had a knock on impact on A&E.

Although there were still quite a few, CNWL had halved its vacancies and improved retention through engagement. However, it continued to be a challenge to recruit new staff without having the inner London waiting incentive. Action that had been taken by the Trust included attendance at recruitment fairs across the country, local advertising campaigns and open days, offers of a golden handshake and more defined training and promotion opportunities.

The CAMHS Eating Disorders Team had been in place and had been accepting referrals since March 2016. The service had been meeting all of its targets with regard to urgent cases being seen within one week and routine cases being seen within four weeks. CAMHS had also been working with North West London (NWL) commissioners to develop the future Out Of Hours Service following the review of the pilot year. In was anticipated that the current service would continue, pending the review, but would be pressurised due to demand (Hillingdon children and young people were high users of this A&E based service).

One of two national pilots had been undertaken by West London Mental Health Trust in conjunction with NHS England (NHSE) and the Priory Group to manage the CAMHS Tier 4 budget and deliver new models of care to reduce the number of young people requiring admission. Phase 1 of the project looked at how to reduce the length of stay

for young people that would need a placement and Phase 2 looked at reinvesting the savings for crisis support at home. The project's focus would be on Brent, Ealing and Hillingdon as these boroughs had the highest number of crises.

Ms O'Brien suggested that more robust early interventions needed to be put in place to prevent young people from becoming really mentally unwell. Mr Graham Hawkes noted that many of these young people would approach their GP or school and the Government had said that it would look at placing counsellors in schools (this would be particularly important for young people in exam years at secondary schools).

To address the waiting times for core CAMHS services, three additional staff had been recruited in Hillingdon and additional funding had been provided by NHSE (£64k in 2016/17 and more expected in 2017/18). A new 6-8 session approach and group work had also been introduced and there had been a 20% reduction in waiting times since April 2016 (down from 190 in October 2016 to 120 in January 2017).

Although assessment appointments were usually within six weeks of referral, young people could wait as long as 11 months for treatment. During the interim, these young people needed to self help. Although the treatment waiting times had reduced, this would build up again if a whole system approach was not adopted that straddled all of the organisations involved. Healthwatch Hillingdon was working with CNWL to make improvements. It was noted that there had been a move towards a tier-less service and other boroughs such as Harrow, Westminster and Kensington & Chelsea had commissioned a different layer of support to signpost young people to services such as counselling and schools. Ms O'Brien suggested that this kind of intervention would help to relieve the CAMHS bottleneck. However, some schools appeared reticent to admit that their students were suffering from mental ill health. Furthermore, the Pupil Premium was sometimes used by schools to employ teaching staff rather than providing services such as counselling.

Social media, a fragmented family life and bullying had all contributed to an increase in young people's mental ill health. Parents tended to be more aware of depression and anxiety so, when identified in a young person, this needed a quick low intervention to prevent it from escalating. It was noted that the last in-depth research on young people's mental health had been undertaken in 1994.

Ms O'Brien advised that, following consultation on the proposed redesign, the Musculoskeletal (MSK) Physiotherapy and Podiatry services had now been consolidated.

The Accountable Care Partnership (ACP) work was now rolling out to 15 Care Connection Teams across the Borough. There had been positive results in relation to the proactive management of patients, with a reduction in the number of patients going through A&E. It was noted that the Federations were now in the process of recruiting Care Coordinators.

<u>Hillingdon Clinical Commissioning Group (HCCG)</u>
Ms Caroline Morison, Chief Operating Officer at HCCG, advised that the Sustainability and Transformation Plan (STP) was a five year plan to 2020/2021 developed as a 'place based system of care'. It covered the NWL footprint but was underpinned by a local Hillingdon plan and was based on the premise that if the health and care system was not transformed, there would be a £120m funding gap by 2020/2021 (against a NWL figure of approximately £1,409m).

The NWL plan centred on five delivery areas which had been mapped to ten local

transformation themes and six enabling work streams and drew on key NWL transformational programmes such as Like Minded and Local Services. The Hillingdon plan had been developed collaboratively with partners and shared at key forums such as the Hillingdon Health and Wellbeing Board. The CCG was now in the process of developing a full programme plan for implementation with proposed governance that included some shared decision making and a joint Programme Management Office. It was noted that CAMHS was a key pillar of the work being undertaken and that a significant amount of work was also being undertaken in relation to older people (taking account of the whole person in a joined up pathway that was linked to social care).

HCCG was achieving its year to date planned surplus of £2.1m and was forecasting achievement of its £3.6m planned surplus by the year end. HCCG's financial plan was based on achieving savings of £8.3m, predominantly within its acute contracts. Although the current forecast was that HCCG would achieve savings of £8m in 2016/2017 (a shortfall of £600k or 7%), this position had been improving month on month. However, due to new cost pressures, HCCG's acute contracts were forecast to be £5m over plan by the year end which equated to 2.5% of HCCG's budget for acute contracts.

The main pressures on HCCG's budget related to over-performance on acute contracts (THH - £2m, Royal Brompton and Harefield NHS Foundation Trust (RBH) - £1.7m) and continuing health care (£3m forecast of which around £800k related to a national price rise in funded nursing care costs). To mitigate its financial position, work was underway to clear the backlog of continuing health care case reviews and review costs of highest cost care packages. It was anticipated that the new model of care for end of life would also have a significant impact. Work was also underway with RBH to understand the drivers for the increase in activity, particularly in relation to pacing and ablations.

HCCG had successfully agreed all key contracts for 2017/2018 and 2018/2019. Acute contracts across NWL had been agreed using a common approach and the contract agreements were based on activity growth assumptions aligned with the STP and QIPP assumptions that matched the 'Shaping a Healthier Future: Strategic Outline Case'. Ms Morrison noted that the financial environment for 2017/2018 would be challenging and the agreed contract values represented a significant financial challenge to both commissioner and provider to deliver their respective control totals. It was anticipated that further collaborative work would identify opportunities to reduce activity and cost.

To manage the NWL system, a marginal rate of over-performance above the baselines had been set at 70% and performance below the baseline would be payable to 30%. There was also a 50% risk-share on high cost drugs above or below an agreed threshold.

As the three year community contract with CNWL would run until the end of 2018/2019, there would be minimal change from the previous planning assumptions. For the CNWL mental health contract, HCCG had increased its investment in mental health services in line with 'parity of esteem' assumptions, whilst also building in the delivery of significant transformation in mental health services. It was anticipated that there would be bold changes to the way that HCCG contracted services in 2017. Although this would not be a simple process, it would open up great opportunities to drive improvements to patient care.

National, regional and local initiatives were driving improvements to the resilience, effectiveness and efficiency of primary care in Hillingdon. There were a number of key

local priorities:

- The General Practice Forward View set out a programme to support general practice development and sustainability linked to investment which represented an opportunity for primary care in Hillingdon for:
    - GP extended hours (8am to 8pm, seven days per week);
    - online access and consultations;
    - provider development / resilience of general practice, which would include federation development, supporting vulnerable practices and managing workload;
    - workforce and redesigning roles (receptionists / care navigators / medical assistants / clinical pharmacist, etc); and
    - estates and technology transformation fund.
- Hillingdon GPs were looking to benefit from increased scale with the four GP networks in Hillingdon intending to come together as a Hillingdon-wide federation from April 2017. It was anticipated that this would enable HCCG to commission directly from individual practices (a pilot weekend visiting service had been set up through a network with the aim of reducing the number of people going into A&E from care homes); and
- A local primary care framework had been developed that set out a new model of care, including:
    - extended access hubs from 6.30pm to 8pm weekdays and weekend openings (currently piloting 8am to 8pm at Hesa Centre);
    - long term conditions and multi-morbidities (services would be contracted at practice and network / federation level with an emphasis on diabetes, cancer, prevention and out of hospital care); and
    - vulnerable patients (care homes, GP support services and mental health (parity of esteem)).

With regard to primary care co-commissioning, HCCG currently commissioned primary care (general practice) jointly with NHS England (known as 'level 2' delegated commissioning). NWL CCGs were considering whether to apply for and take on 'level 3' delegated commissioning from April 2017. This would mean that commissioning decisions related to primary care would be solely determined at a CCG level. Although an initial application had been submitted on 5 December 2016, the HCCG membership (GP practices) would need to agree to full delegation through a ballot which would be held in February 2017. If approved, the go-live date for new delegated arrangements would be 1 April 2017 (although property decisions would not be passed to HCCG).

A critical component of Hillingdon's strategy for integrated care had been the development of an ACP. Since 2013, the ACP had come a long way and was now established as Hillingdon Health and Care Partners and comprised: THH; CNWL; Hillingdon GP Federation (live from April 2017); and Hillingdon4All (a third sector provider collaboration). The ACP had already been working on piloting the Care Connection Team, a primary care-based co-ordinated approach for people with a high level of need, and had been developing its capabilities as a partnership, e.g., by recruiting an ACP director. The ACP planned to deliver an alliance contract for the care of people aged 65 and over from April 2017 which would involve an element of payment on performance and an element of capitated payment against an agreed set of system and patient outcome measures.

From April 2017, HCCG was looking to put in place an alliance agreement that bound the ACP together over the course of two years to deliver agreed outcomes. As HCCG needed to be assured that the ACP was able to work in this new way, a 'due diligence' type assurance process would be conducted comprising of seven domains: strategy and vision; leadership and governance; processes; technology; financial and risk

management; people; and culture and integration. Each domain had a number of criteria against which the ACP would need to evidence its performance and capabilities. Minimum thresholds had been set for year one and higher thresholds for year two. Performance would be assessed against four tiers: emerging, developing, established and leading. The process would include self-assessment, challenge panels and board-to-board sessions and would take place over two years. Challenge panels would include a wide range of stakeholders including lay representation, clinicians external to Hillingdon, local authority representation (including public health and social care) and some CCG involvement.

Six paediatric workstreams, governed through the Children's Strategic Transformation Group, were under review. It was noted that community respiratory clinics would be rolled out across the Borough in 2017 and HCCG had redeveloped the Strategic Transformation Group which included representation from the local authority, Hillingdon Hospital, Healthwatch Hillingdon and HCCG.

The four hour wait performance for children in THH A&E had improved from 86.4% (pre 30 June 2016) to 93.4% (in December 2016) and the Paediatric Assessment Unit opened at THH in September 2016 with an average of 60 children aged 0-18 using the unit each week (approx two children per bed). The pilot for a community integrated clinic had started in January 2016 and aimed to see children in a local GP practice, improve the paediatric skills sets of GPs and prevent the need for hospital care.

A review of CAMHS had been undertaken by HCCG and the local authority. The review had recommended a move away from the current tiered model of care to the THRIVE (tier-less) model of care for Hillingdon CAMHS and work was underway to implement this. Although the CAMHS waiting lists remained a challenge, additional resources had been released from NHSE to support the achievement of the NHS 18 week referral-to-treatment target. The CAMHS learning disability team was now fully staffed and operating from Woodend, Hayes, supporting children with complex behaviours and autism in the community.

Hillingdon had been selected to become an early adopter for delivering Improving Access to Psychological Therapies (IAPT) for people with long term conditions like diabetes, COPD and asthma. The team would support people with long term conditions to manage anxiety and depression. HCCG had been working with stakeholders to increase the number of people accessing IAPT in Hillingdon from 15% to 25% by 2020.

It was anticipated that there would be additional investment to Hillingdon and North West London perinatal services from NHSE. The investment would support families with mental health interventions during and after pregnancy. The enhanced Community Learning Disability Team, launched in July 2016, had benefited from additional CCG investment which meant they were now able to support more people with learning disabilities and able to undertake autistic spectrum disorders (ASD) assessments locally.

With regard to Yiewsley Health Centre, Ms Morrison advised that £500k would be spent on refurbishing the clinical rooms. Although there would be more capacity at the Centre, staffing levels would need to be considered.

Members were advised that a report detailing progress up to Q2 had been considered by the Hillingdon Health and Wellbeing Board at its meeting on 8 December 2016 regarding the Better Care Fund (BCF). A two year plan was under development, focussing on the integration of different Council departments and looking at how they fit

	with the STP. The draft BCF plan would be considered by the Health and Wellbeing Board at its next meeting on 14 March 2017. The BCF pilot phase had ended and now covered the whole of the Borough. Ms Morison noted that there were still plans to have a health presence on the St Andrews Park development. Conversations had taken place between developers and the Council's planning team about exploring an alternative site within the development. This would need to be finalised soon as it was anticipated that this would be a hub. <u>Healthwatch Hillingdon (HH)</u> Mr Graham Hawkes, Chief Executive Officer at HH, advised that there were concerns about pressures on the health system in Hillingdon. HH had reviewed hospital discharges from Hillingdon Hospital and the resultant report was expected by the end of the month, highlighting the impact on the care of residents. Of the 170 inpatients spoken to, 56 had follow ups after discharge. Mr Hawkes noted that care was as good as it could be in hospital with staff trying their best but that the care received was not necessarily as good as patients expected and satisfaction levels had dropped significantly. There also appeared to be room for improvement with regard to the coordination between the hospital and care at home and with regard to communication with patients in hospital. Recommendations had been included in the report in relation to the provision of written communication with patients, for example, a diary (so that the family could also write comments) and the development of a booklet to improve communication with older patients. A further recommendation had been included regarding standardising the discharge process across all wards. Members of the Committee would receive a copy of the report once it had been published. It was noted that the Council's Social Services, Housing and Public Health Policy Overview Committee had been undertaking a separate review of hospital discharges and had been liaising with HH. A lot of work was being undertaken with regard to the ACP. However, it was suggested that this work needed to include care homes and domiciliary care. **RESOLVED: That the presentations be noted.**
29.	**WORK PROGRAMME 2016/2017** *(Agenda Item 6)* Consideration was given to the Committee's Work Programme 2016/2017. The scoping report for the review of community sentencing was agreed. Once the membership of the Working Group had been agreed, Democratic Services would contact the Members to arrange the date of the first meeting. It was suggested that, because individuals were regularly attending A&E as it was a quicker option that visiting their GP, consideration be given to this as a review topic. This situation had resulted in A&E being overwhelmed and it was suggested that maybe GP surgeries should be replaced with an expanded A&E. Unless the capacity of Hillingdon A&E was increased, it would not be able to cope with the increased demand on its service. It was suggested that consideration be given to the Chief Executive and Chief Operating Officer at The Hillingdon Hospitals NHS Foundation Trust being invited to attend a future meeting to discuss this issue. Members were advised that the next meeting on 15 February 2017 would use a slightly different format. The meeting would be looking at progress made with regard to CSE since the Committee had last reviewed the issue in January 2015. **RESOLVED: That:**

	1. **a date be arranged for the first meeting of the Community Sentencing Working Group; and** 2. **the Work Programme be noted.**
	The meeting, which commenced at 6.00 pm, closed at 8.21 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.