Minutes

EXTERNAL SERVICES SELECT COMMITTEE

13 November 2018

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

	Committee Members Present: Councillors John Riley (Chairman), Nick Denys (Vice-Chairman), Simon Arnold, Ian Edwards (In place of Teji Barnes), Kuldeep Lakhmana, Ali Milani, June Nelson and Devi Radia **Also Present**: Kim Cox, Hillingdon Mental Health Borough Director, Central & North West London NHS Foundation Trust Imran Devji, Director of Operational Performance, The Hillingdon Hospitals NHS Foundation Trust Graham Hawkes, Chief Executive Officer, Healthwatch Hillingdon Nicholas Hunt, Director of Service Development, Royal Brompton & Harefield NHS Foundation Trust Turkay Mahmoud, Vice Chairman, Healthwatch Hillingdon Caroline Morison, Managing Director, Hillingdon Clinical Commissioning Group Maria O'Brien, Executive Director, Central & North West London NHS Foundation Trust Vanessa Saunders, Deputy Director of Nursing and Patient Experience, The Hillingdon Hospitals NHS Foundation Trust (THH) Dr Veno Suri, Vice Chair, Hillingdon Local Medical Committee (LMC) Natasha Wills, The London Ambulance Service NHS Trust, Assistant Director of Operations, North West **LBH Officers Present**: Kevin Byrne (Head of Health Integration and Voluntary Sector Partnerships) and Nikki O'Halloran (Democratic Services Manager) **Press and Public: 3**
29.	**APOLOGIES FOR ABSENCE AND TO REPORT THE PRESENCE OF ANY SUBSTITUTE MEMBERS** *(Agenda Item 1)* Apologies for absence had been received from Councillor Teji Barnes. Councillor Ian Edwards would attend the meeting as her substitute.
30.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 3)* **RESOLVED: That all items of business be considered in public.**
31.	**MINUTES OF THE PREVIOUS MEETING - 30 OCTOBER 2018** *(Agenda Item 4)* Consideration was given to the minutes of the meeting held on Tuesday 30 October 2018. A number of small typographical errors were identified and amended. In addition, it was agreed that the following amendments be made: 1. Minute Number 26, Paragraph 3: The sentence beginning “The first that Ms

Byrne had known…" be changed to "Ms Byrne stated that the first that she had known…".

2. Minute Number 26, Paragraph 5: The final sentence be amended from "…noted that Ms Byrne did attend ENH Board meetings…" to "…noted that Ms Byrne did attend Heads of Department meetings with a standing item on fundraising for services…".

RESOLVED: That, subject to the above amendments, the minutes of the meeting be agreed as a correct record.

32. **HEALTH UPDATES** *(Agenda Item 5)*

The Chairman welcomed those present to the meeting.

Royal Brompton and Harefield NHS Foundation Trust (RBH)
Mr Nick Hunt, Director of Service Development at RBH, noted that the Trust's Clinical Quality Report Month 5 2018/19, which was considered by the RBH Board on 26 September 2018, had been circulated to Members before the meeting. He noted that the CQC had undertaken a spot inspection where the focus at Harefield Hospital had been on surgery. There was a possibility that the Hospital could receive an 'Outstanding' rating.

With regard to the relocation of the Royal Brompton Hospital to a new site, work was ongoing with Kings Health Partners.

Mr Hunt advised that he had joined the Hillingdon Transformation Board as a result of Harefield Hospital's role on the possible development of a new acute hospital and medical training courses at Brunel University. He noted that Brunel University owned a large amount of land which was officially greenbelt but which had formerly been a nursery and market garden. As a result, there were asbestos lined pipes still in situ that had been used for the greenhouses. It was clear that Hillingdon Hospital needed a new building and concerns had been expressed regarding the longevity of the existing building. Lord O'Shaughnessy, Parliamentary Under Secretary of State at the Department of Health, Sir Robert Naylor, who had undertaken a review of NHS property and estates, and various politicians had expressed their support for a new hospital development on the Brunel land.

If the project was to go ahead, it was likely that Harefield Hospital would transfer in its entirety, thus releasing 45 acres of greenbelt land in Harefield. This move would mean that Harefield's iconic heart transplant service would be co-located with Hillingdon Hospital, offering significant pathway synergies. Consideration was also being given to the use of technology to support resources such as remote access clinics. If the project went ahead, the aim would be develop a completely digitally supported building. It was thought that the commissioners were very excited by the proposals.

Members were aware that there had been noises made about the need for a new hospital for some time. It was agreed that the project needed to be driven forward within a reasonable timescale. Although there had been a proposal for a land swap between Harefield Hospital and Brunel University, it was unclear how far this suggestion had progressed.

The London Ambulance Service NHS Trust (LAS)
Ms Natasha Wills, Assistant Director of Operations North West at LAS, apologised for Mr Ian Johns not attending the last health update meeting on 10 July 2018. She noted that the LAS had moved to Ambulance Response Programme (ARP) performance

measurements.

With regard to the recruitment and retention of staff in the call centre, the LAS had been bound by a national pay agreement which had not aligned with the other emergency services. This pay agreement had now been renegotiated and aligned with the other services and this had helped to improve recruitment. It was noted that the LAS had implemented a programme to recruit 171 Full Time Equivalents (FTEs) by 31 March 2019. Forecasts indicated that the Trust would recruit 169 FTEs by the end of this period. Retention had also improved as a result of training opportunities for staff and the proportion of BME staff had increased from 9% last year to 11%.

Ms Wills advised that staff were being issued with iPads which enabled them to access Coordinate My Care (CMC) records. The LAS was also committed to moving to Electronic Patient Report Forms (EPRFs) next year. These two developments were currently work in progress.

The LAS had undertaken a pilot in Newham where the Trust had gained access to GP patient records. There had been a number of lessons learnt from this scheme such as the need to gain permission from each surgery to access their patient records. Ms Wills advised that the LAS only needed to gain access to a patient's notes and not the rest of their record. Any further developments in relation to this would need to adopt a pan-London approach.

Ms Wills advised that the LAS was also looking at maternity services across London. A pilot was currently underway in Brent. Evidence would be gathered and analysed at the end of the pilot.

LAS response time targets had changed on 1 November 2017. During the last 12 months, the Trust had developed a baseline. Members were advised that the LAS had been rated first nationally with regard to response times this week. Although this changed each week and there had been challenges in relation to meeting the Category 3 (urgent) target and dealing with increased demand at weekends, the LAS was usually in the top three performing areas.

Ms Wills noted that the volume of demand in London was being used to help inform the national picture in terms of target setting. As a result, ARP metrics would now be reviewed on an ongoing basis and include LAS involvement.

A mental health car had been piloted in London. The effectiveness of the pilot was being monitored and an analysis of the evidence and historic demand would be undertaken once the pilot had ended to ensure that resources were targeted effectively. This type of mobile resource would have a mental health nurse and a higher trained paramedic on board.

Ms Wills noted that a mental health nurse was available in the control room at all times. This nurse was able to assess patients on the phone, provide advice to crews on the scene and was more familiar with accessing mental health pathways. She also advised that a falls vehicle would be trialled in North West London (NWL). Ms Maria O'Brien, Executive Director at CNWL, noted that work around falls was becoming an increasingly important area in Hillingdon. Resources needed to be targeted effectively to respond to patients quickly in their own homes. She advised that staff from CNWL and the LAS had spent time in each other's place of work to get a better understanding of the other's skills and challenges faced. It was agreed that an update on this work be provided to Members at a future meeting.

Ms Caroline Morison, Managing Director at Hillingdon Clinical Commissioning Group (HCCG), advised that the LAS contract was managed across the NWL area. Ms Wills noted that demand for the LAS service was more effectively addressed when the Trust was able to work across CCG boundaries.

Ms Kim Cox, Borough Director for Central and North West London NHS Foundation Trust (CNWL), advised that there had been an increase in the number of calls received by CNWL. The Rapid Response Team (RRT) was in place to help avoid admission to a mental health inpatient ward by providing intensive support to people in acute mental crisis in their homes. The RRT was meeting its targets and was able to provide support when a mental health nurse or an ambulance crew alone were not enough.

Ms O'Brien advised that the Trust had developed a Single Point of Access. Although this was being pushed, demand needed to be mapped out and areas where resources could be shared needed to be identified.

Ms Cox advised that CNWL had been working the Metropolitan Police Service to look at addressing the issue of frequent callers. This SIM project would be initiated early next year and Ms Cox would be happy to provide Members with an update at a future meeting. Ms Wills noted that the LAS had joint response units which had access to police radios. National conversations were being held with regard to joint working which was undertaken wherever possible (for example, the LAS worked with the London Fire Brigade).

Mr Graham Hawkes, Chief Executive Officer at Healthwatch Hillingdon (HH), advised that HH received very little feedback from members of the public in relation to the LAS. He noted that conversations had been undertaken between the LAS and HH some time ago regarding the need to gather feedback on LAS patient experience. Due to a lack of funding to support the project, this had not yet come to fruition. Mr Hawkes stated that direct access would be good and could provide some synergies.

A lot of work had been undertaken locally in relation to End of Life Care (EoLC) to work towards helping people to die at home rather than in hospital. Dr Veno Suri, Vice Chair at Hillingdon Local Medical Committee (LMC), advised that GPs had shared palliative care information on CNC with the LAS. However, not all organisations were able to access the information as there were issues regarding governance (where some patients didn't want their information shared) and with the incompatibility of some IT systems used by partners.

Where a patient had requested that they not be resuscitated, a copy of the CPRDNR (signed by the GP) would be in the patient's house and another at the GP practice. Hospital consultants might also complete a separate form. Ms Morison advised that the ability of the different partners to share information was a priority. Although the challenge was partly in relation to access, the Medical Interoperability Gateway (MIG) was able to connect different healthcare software. She expressed concern that the most significant risk was associated with not sharing information in a patient's records that could prove to be critical. Mr Hawkes noted that this situation had not been helped over the last couple of years by the negative publicity regarding information sharing.

<u>The Hillingdon Hospitals NHS Foundation Trust (THH)</u>
Mr Imran Devji, Director of Operations at THH, noted that during the last six weeks there had been an improvement in the Trust's performance against the four hour standard. He advised that this had resulted from a huge amount of work by staff in the Emergency Department (ED) and on the wards and that there was clear evidence that better systems and control had made the service safer and more responsive for

patients.

The four hour emergency care standard measured the time from which a patient presented at the hospital to the time that they were either admitted or discharged. Members queried how the four hour target could be stated as 84.8% in October 2018 when the NHS England (NHSE) website stated that Hillingdon had the worst Type 1 performance in London and the fifth worst in England. It was noted that Type 1 related to ED attendances, Type 2 related to specialist attendances such as eye and dental and Type 3 related to Urgent Care Centre (UCC) attendances. Ms Morison advised that different Trusts reported their attendance in different ways which meant that they were not always comparable but noted that, irrespective of whether they were Type 1 or 3, all patients needed to be seen within four hours. Some Trusts provided both UCC and ED services (such as Homerton) whilst others, like THH, provided the ED service with the UCC being provided by an external organisation. It was recognised that the UCC service (Type 3) had been performing well whilst improvements were still needed around the ED (Type 1) performance.

Mr Devji advised that the ED had been designed for 135-140 attendances and 40-45 ambulances, yet actual attendance and ambulances were around twice these figures. THH had been using different models to address the physical constraints as well as looking at bed pressures and models of care in the community.

Hunter Healthcare had been appointed to look at the flow from admission to discharge of patients that were fit to leave hospital. Four work streams had been identified: ED; site management; interface for the discharge of stranded patients (those that had been in hospital for more than six days); and a medical model. THH had been working with HCCG to develop procedures for tracking, escalating and resolving stranded patients (the number of stranded patients had reduced from approximately 225 in March/April 2018 to 175-180 now). Ambulatory care was also being streamlined and THH had been working with health partners on a revised model which would be effective from 14 November 2018. If this model worked as anticipated, it would free up 13-14 beds.

A Rapid Assessment Medical Unit had been developed to provide a dedicated area for medical patients to be seen. This would prevent these patients from having to go to the ED and reduce bottlenecks. Mr Devji noted that, on Monday 5 November 2018, there had been 238 attendance in the ED (not including UCC attendances) and 96 ambulance conveyances (85 was the maximum capacity and 50-60 was the usual number of conveyances). Staff had managed patient flows well during this very busy period which illustrated the need to consistently challenge processes and procedures. These systems would be reviewed after 30, 60 and 90 days and then on an ongoing basis to ensure that the practices were embedded within the organisation.

Members were advised that the ED expansion was due to be completed and opened on Monday 19 November 2018. The new area included examination cubicles for ambulance streaming and overflow, a separate dedicated room for patients with mental health issues, dirty and clean utility rooms and a triage room. It was noted that the majority of the £2m needed for this expansion had been given to THH by the Department of Health following a bid process during the previous year. Mr Devji advised that, whilst the expansion had provided 35-40% more capacity, new models would help to further improve the Trust's ability to deal with the increasing volume of patients presenting at A&E. Communication had been undertaken with front line staff to ensure that they were involved in finding solutions to the challenges faced by the Trust and that they adopted some level of ownership for the implementation of solutions.

Mr Devji stated that, at the end of September 2018, THH was nearly £6m overspent against its deficit budget. The Trust had advised NHS Improvement (NHSI) that it would not achieve its budget by the end of the year and it was noted that, if the current level of spending was not addressed, the Trust would be overspent by approximately £12.6m by the year end. Mr Devji believed that the non-clinical improvements being made would help to reduce this to an overspend of approximately £7.2m. He went on to advise that NHSI had required THH to engage Kingsgate (an organisation specialising in transformation, turnaround and transition) to identify solutions. Discussions with Kingsgate regarding support were underway and the organisation would be working with THH until February 2019.

Following the CQC inspection, THH continued to work with NHSI and the CQC, with monthly evidence meetings to demonstrate progress on the CQC implementation action plan. Mr Devji advised that he would provide Members with an update on progress at a future meeting.

Hillingdon Improvement Practice (HIP) had initially been a three year programme to introduce an improvement methodology across the Trust. It was intended to be a long term practice, engaging with both organisational culture and performance delivery and was based on Lean methodology principles. A series of large and smaller scale organisational development events had taken place to look at operational pathways and to enable staff to improve their own ways of working. Mr Devji noted that this level of large scale change and development took time to implement but provided the opportunity to reap significant rewards. For example, the ambulance hand over times had been improved. Mr Devji provided Members with illustrative return on investment (ROI) figures with regard to the HIP programme. The conservative ROI figures provided had been based on one major programme per year and a low estimate of cash releasing improvement to be achieved by individual improvement programmes.

Members were aware that ambulance crews remained with the patient that they had conveyed to hospital until they had been handed over properly. Sometimes this involved a significant wait. Mr Devji reassured Members that THH staff undertook initial observations on the patient's arrival via ambulance as soon as possible.

The Hillingdon Health and Care Partnership (HHCP) partners had been developing a new model of integrated care for the Borough. THH had been working alongside all providers, including social services and care homes, and it was anticipated that the work would help to address the funding gap on the whole health system. To help achieve its goals of improving patient experience (by speeding up service delivery, minimising duplication and reducing unnecessary hospital activity), HCCP would focus on the following five key projects over the next 12 months: improving musculoskeletal services; improving the management of frailty and falls; active case management; same day emergency care; and developing Locality Neighbourhood Teams.

Members were advised that THH had entered into a 10 year contract to provide support for community health services in Ealing, including care of the elderly and children's services. THH would receive an annual income of approximately £2m for this service provision which had resulted from a partnership to deliver Ealing community services led by West London NHS Trust and which included CNWL.

Ms Vanessa Saunders, Deputy Director of Nursing at THH, provided Members with more detailed analysis of the results of the Friends and Family Test (FFT) for maternity services. Splitting this information out had provided a much clearer picture of the service and had highlighted areas where female respondents needed to be targeted differently. For example, consideration was being given to possible improvements to

increase community responses as patients tended not to return completed surveys in order to maintain their anonymity. Ms Saunders noted that this level of detail would continue to be produced and might also be used by the THH Board.

Mr Devji advised that a programme had been devised to bring all male and female day case patients into one unit, co-located next to theatres to improve patient flows and protect beds against emergency admissions. These spaces would be ring fenced for surgical day case patients to ensure that patients were able to have their surgery as planned through the difficult winter months in a predictable manner. Further work would be undertaken next year to ensure day care comprised three areas with 20 trolleys fitted with piped gases and a call bell system and which could be used for male or female patients. It was agreed that an update be provided at a future meeting on the Trust's performance against the 18 week referral to treatment target.

<u>Central and North West London NHS Foundation Trust (CNWL)</u>
Ms Kim Cox, Hillingdon Mental Health Borough Director for CNWL, advised that Lifeline 24/7 aimed to support people to be cared for and die in their preferred place. It also aimed to contribute to the provision of End of Life Care (EoLC) in Hillingdon and support patients, carers and all other healthcare professionals involved. The service comprised:

- A 24 hour telephone line offering support and advice for patients, carers and other healthcare professionals. Since the service had been launched on 26 September 2018, it had received 128 calls (57 of which were out of hours), helped 7 people in September and 22 people in October to die in their preferred place, made 31 visits and received referrals from District Nurses, RRT and Harlington Hospice;
- Palliative overnight nursing service which visited patients in their own homes to support them to be cared for and die at home according to their wishes; and
- Collaboration with all services involved in aspects of EoLC in Hillingdon, operating a 'no wrong door' policy.

Concern was expressed that residents were unaware of the availability of the 24 hour support line and had experienced problems in getting someone to come out. Ms O'Brien advised that this was a new service and that CNWL was working to raise awareness of the service which also included the ability for nurses to go out into the community. She would be happy to speak to Councillors outside of the meeting to address any specific issues.

Joint working had been ongoing between the Child and Adolescent Mental Health Service (CAMHS) and community paediatricians to look at developing a shared pathway for Autistic Spectrum Disorder. This had not been quite as straightforward as one might think. Ms Cox agreed to provide Members with an update at a future meeting.

HHCP put CNWL in a prime position to offer integrated physical and mental health community based services. Work was underway to offer integrated teams whilst maintaining specialism and expertise to ensure that patients received the care that they needed. The teams would be constituted based on the needs of each neighbourhood, population data and robust risk stratification, and the changes made would be in relation to service delivery rather than the services themselves. From a systems perspective, it was noted that models were driven by need. By looking at the population data, CNWL would be able to compile a single data set and ensure that the teams placed in each area had a neighbourhood feel to them which reflected the needs of that community.

Ms O'Brien advised that CNWL had not previously had an inpatient mental health unit for children and young people in NWL. On 12 November 2018, Lavender Walk was opened to provide 12 beds, supplemented by a day programme. The existence of this unit meant that young patients would no longer have to go to inpatient facilities in places as far afield as Colchester and Edinburgh which had proved to be stressful for the young people and their families. Two children had been admitted to the unit so far (one was from Hillingdon) and the co-location of the unit alongside Chelsea and Westminster was thought to provide additional benefits.

The provision of urgent response to children's mental health issues had been remodelled to cover the NWL STP footprint. The model focussed on supporting the crisis pathway by providing brief admissions which would lead to supported discharge and ongoing treatment at home.

A new single point of referral service for older people had commenced on 1 September 2018. Staff were rotated daily into this service to provide cover, and dedicated space in the reception area at the Woodlands Centre was now operational for the service. Ms Cox advised that mental health services were also changing their patient record system to ensure that a single electronic system was used across all services provided to promote integrated working across the Trust. This would ensure that records could be shared when relevant.

It was noted that work to replace the patient record system had commenced five or six years ago as notice had been given that the system used by CNWL's physical health services would become obsolete. As community health services used a completely different system, this was used as an opportunity to align the technology. Although CNWL had made it clear that interoperability was very important, options had been limited. Ms O'Brien advised that, although there was no reason why the SystmOne and EMIS systems used by GPs could not interface (a Medical Interoperability Gateway (MIG) system would sit over the top of all of these systems and pull relevant data out when requested), there was still some resistance from the two major GP software suppliers to progress this fully.

Concern was expressed regarding the ability for Ealing community services and the eight NWL CCGs to work closely together to look at cross border issues (for example a Hillingdon resident who's GP was in Ealing). Although it was thought likely that close working would be able to counter any cross border issues with neighbouring boroughs, this would be determined by what it was that commissioners were asking CNWL to do.

Members were advised that CNWL had taken action to address the negative feedback that had been submitted. Examples of the action taken were provided to the Committee.

Ms Cox stated that when the Trust had previously been inspected by the CQC, it had been rated as Good. The CQC would be returning in March 2019 to re-inspect the 'Well led' elements of the Trust. The CQC would also be re-inspecting most areas and had already arrived in some of the inner London boroughs and had made large data requests. In addition, Ms Cox advised that Deloitte had recently reviewed CNWL's 'Well led' domain and the initial feedback received had been promising.

<u>Healthwatch Hillingdon (HH)</u>
Mr Graham Hawkes, Chief Executive Officer at HH, advised that HH had been an advocate for change and it was pleasing to know that the work undertaken by the organisation helped to inform and change services. The hospital discharge review undertaken by HH had received an award from Healthwatch England.

The 27 young people engaged with Young Healthwatch had been busy. Healthfest 2018 had been held in the Middlesex Suite at the Civic Centre in Uxbridge in September. Around 100 young people had attended and an account of the event would be included in the next Annual Report.

Mr Hawkes noted that challenges still remained within Hillingdon Hospital, community mental health services, staffing and prompt response. During the course of his eight years in the Borough, Mr Hawkes believed that HH and healthcare had come a long way with some organisations making significant improvements.

The Chairman thanked Mr Hawkes for the work that he had led over the last eight years and noted the progress that had been made with regard to patient engagement and the professional acclaim received by the organisation. Extraordinary advances had been made and Mr Hawkes had been instrumental in this as well as in the development of good relations in the healthcare sector.

Mr Hawkes advised that, despite leaving, he would like to continue to provide input into HH over the next year, particularly in relation to the Annual Report. He appreciated the Committee's recognition of the work that he and his colleagues at HH had undertaken.

Hillingdon Clinical Commissioning Group (HCCG)

Ms Caroline Morison, Managing Director at HCCG, advised that around 4% of GP appointments were deemed DNA (Did Not Attend). Although this figure seemed reasonable, HCCG would continue to monitor DNA rates as it might change over the winter months.

It was noted that the eight NWL CCGs continued to develop their approach to collaboration with a view to reducing variation in care, improving cross border issues, reducing duplication and improving efficiency. For example, consideration was being given to how diabetes was dealt with in the eight boroughs with a view to identifying good practice and replicating that across all of the boroughs. Collectively, the NWL CCGs would also have better leverage for change with Trusts. To date, a number of appointments had been made which would cover the NWL area.

A joint committee of the eight NWL CCGs had been set up in shadow form and met in public on a monthly basis at different venues around NWL (these meeting were broadcast live on the Internet). On 19 October 2018, the CCG membership voted to fully establish the joint committee of NWL CCGs, permit electronic voting and reduce the quorum from 75% to 66%. It was hoped that the joint committee would meet again in December 2018 and then in January 2019, following ratification of the amendment by NHS England, HCCG would move to a quarterly schedule of governing body meetings to align with the joint committee timetable.

Ms Morison advised that, in 2016, the Wood Review of local safeguarding children boards had recommended changes to the way that the Child Death Overview Panel (CDOP) function was delivered so that the panels covered larger areas where trends and patterns could be assessed and learning disseminated across a wider area. Currently, there were six CDOPs to oversee the review of child deaths in the eight NWL boroughs. A successful bid had been made by Harrow on behalf of the eight NWL boroughs for funding from the Department for Education (DfE) and NWL was now an Early Adopter Site for developing new arrangements which were still a work in progress and open for debate.

HCCG had been working closely with partners on a number of initiatives to manage

demand on the urgent care system. The programme of integrated discharge that was in place across HCCG, the Council and THH continued to develop and improve and now took more than 60 patients home each week more efficiently. The Council had also been allocated an additional £1m funding to support discharges from hospital over the winter period. Partners were currently collating data to support discussions as to how this might be used to best effect. Members were assured that system-wide plans were in place to support the management of the winter surge pressures across Hillingdon.

Members were advised that HCCG had been working with partners to agree a roadmap towards an integrated care system for Hillingdon. A new '10 Year Plan' for the NHS was expected in December 2018. This would provide further guidance regarding the national expectations for integrated care development as well as confirmation of CCG allocations.

It was noted that HCCG continued to work with partners to ensure that there were appropriate services available throughout the Borough for the provision of end of life care following the closure of the Michael Sobell Hospice Inpatient Unit. Following the Committee's meeting on 30 October 2018, East and North Hertfordshire NHS Trust had requested a meeting with HCCG and Hillingdon Hospital to discuss options regarding the service. It was anticipated that the Committee would receive an update at its meeting on 11 December 2018.

Ms Morison advised that NHSE had confirmed that HCCG had been awarded a rating of 'Good' for the 2017/2018 assurance process. This reflected achievement against a number of financial, leadership and clinical domains. 58 indicators for the 2018/2019 assurance process had recently been published.

The Committee was advised that, with regard to estate developments, there were two areas with which HCCG was involved:

- Out of Hospital Hub Strategy – three hubs had been planned: the HESA Centre in Hayes was already operational and preferred locations had been identified in the options appraisal for the centre and North of the Borough.
- GPs – the management of the NHS estate had been transferred to NHS Property Services (NHS PS). HCCG supported this process in terms of grants and funding. There had been delays in developments caused in part by GPs (as tenants) and in part by NHS PS. There had been a number of challenges with the Yiewsley development and development delays were sometimes caused through an inability for the GPs and NHS PS to agree the lease. These time delays meant that there was a real possibility that funding could be lost. Lately, there had been a change in NHS PS and things were looking more promising, although improvements were still needed.

<u>Hillingdon Local Medical Committee (LMC)</u>

The Chairman advised that dates were being set up for the GP Pressures Select Panel. Dr Veno Suri would be welcome to attend these meetings. Dr Suri, Vice Chair at Hillingdon LMC, noted that the number of GPs leaving the profession exceeded those starting in it which meant that approximately 5,000 more GPs were needed across the country. There were effectively fewer GPs now than there had been before despite schemes to entice them to stay in Hillingdon. The LMC had been working closely with HCCG to address this, as well as look at the pressure that was then felt by those GPs that remained in the profession. The Chairman confirmed that the Select Panel would be looking at GP recruitment and retention and working conditions during its review.

	Dr Suri advised that funding for GP estate expansion or rejuvenating a practice was not an easy process **RESOLVED: That** **1. The LAS provide the Committee with an update on the joint working with CNWL and familiarisation sessions at a future meeting;** **2. CNWL provide further detail on the joint SIM project with the Metropolitan Police Service regarding frequent callers at a future meeting;** **3. THH provide the Committee with an update on progress against the CQC implementation action plan at a future meeting;** **4. THH provide the Committee with an update at a future meeting on the Trust's performance against the 18 week referral to treatment target;** **5. CNWL provide the Committee with an update at a future meeting on the joint work between the Child and Adolescent Mental Health Service (CAMHS) and community paediatricians to look at developing a shared pathway for Autistic Spectrum Disorder; and** **6. the presentations be noted.**
33.	**WORK PROGRAMME** *(Agenda Item 6)* Consideration was given to the Committee's Work Programme. The Chairman noted that a lot of feedback had been received following the last meeting where Members looked at the provision on inpatient hospice services in the North of the Borough. It had been resolved that the Democratic Services Manager investigate the possibility of referring East and North Hertfordshire NHS Trust's (ENH's) lack of consultation and/or notification to the Secretary of State. After seeking legal advice, it would appear that this course of action was not as straight forward as it might first have seemed. As such, it was agreed that, rather than fitting the Committee's action into the legislation, a letter be sent to the Secretary of State (copying in the Permanent Secretary) setting out what had happened. The letter would also set out an alternative method for referrals. Action would also be taken to draft a scrutiny protocol. Insofar as the closure of the Michael Sobell Hospice was concerned, the Committee was keen to continue to gather information about what had actually happened as it still was not clear. It was also noted that there was no contract between ENH and The Hillingdon Hospitals NHS Foundation Trust with regard to leasing building on the Mount Vernon Hospital site. The Committee agreed that they were keen to ensure that an inpatient hospice provision was reinstated as soon as possible for a period of time. It was appreciated that there may be a new model of provision for the future. Mr Hawkes commended the Committee on its scrutiny of the closure of the inpatient unit at Michael Sobell Hospice at the last meeting where it appeared that Members had undertaken a lot of preparation. Although feelings were currently running high, it would be important to establish where the money raised by Michael Sobell Hospice Charity was going to be spent if it would no longer be contributing more than £800k to pay for NHS staff. Furthermore, the Committee would need to establish where any shortfall would come from to pay for the service and what would the service actually look like once reinstated. It was agreed that the crime and disorder meeting on 12 February 2019 would look at youth violence, shootings, knife crime and drug networks as well as any preventative action taken in relation to these crimes. The Committee also agreed that it would look at post office services at its meeting on 13 March 2019.

	RESOLVED: That: **1. a letter be sent to the Secretary of State for Health;** **2. a scrutiny protocol be drafted for the Committee;** **3. the meeting on 12 February 2019 look at youth violence, shootings, knife crime and drug networks as well as any preventative action;** **4. the meeting on 13 March 2019 look at post office services; and** **5. the Work Programme be noted.**
	The meeting, which commenced at 6.00 pm, closed at 8.42 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.