Minutes

HEALTH AND SOCIAL CARE SELECT COMMITTEE

21 February 2023

Meeting held at Committee Room 5 - Civic Centre

	Committee Members Present: Councillors Nick Denys (Chairman), Philip Corthorne (Vice-Chairman), Shehryar Ahmad-Wallana (In place of Alan Chapman), Tony Burles, Reeta Chamdal, June Nelson (Opposition Lead) and Barry Nelson-West **Also Present**: Alex Coman, Director - Safeguarding, Quality Assurance and Partnerships, LBH Richard Ellis, Joint Lead Borough Director, North West London Integrated Care System (NWL ICS) Jane Hainstock, Head of Joint Commissioning, North West London Integrated Care Board (NWL ICB) - Hillingdon Dr Paul Hopper, Divisional Medical Director, Central and North West London NHS Foundation Trust (CNWL) Kelly O'Neill, Interim Director of Public Health, London Borough of Hillingdon Dr Ritu Prasad, Co-Chair, Hillingdon GP Confederation Keith Spencer, Managing Director, Hillingdon Health and Care Partners (HHCP) Tina Swain, Service Director for CAMHS & Eating Disorders - Goodall Division, Central and North West London NHS Foundation Trust (CNWL) **LBH Officers Present**: Nikki O'Halloran (Democratic Services Manager)
60.	**APOLOGIES FOR ABSENCE** *(Agenda Item 1)* Apologies for absence had been received from Councillor Alan Chapman (Councillor Shehryar Ahmad-Wallana was present as his substitute).
61.	**DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING** *(Agenda Item 2)* There were no declarations of interest in matters coming before this meeting.
62.	**MINUTES OF THE MEETING HELD ON 26 JANUARY 2023** *(Agenda Item 3)* **RESOLVED: That the minutes of the meeting held on 26 January 2023 be agreed as a correct record.**
63.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 4)* **RESOLVED: That all items of business be considered in public.**
64.	**CAMHS REFERRAL PATHWAY REVIEW - WITNESS SESSION 1** *(Agenda Item 5)* The Chairman welcomed those present to the meeting and noted that Members

continued to speak to families involved with children and young people's mental health services in the Borough.

Mr Alex Coman, the Council's Director of Safeguarding, Partnerships and Quality Assurance, advised that the Council had a role in early intervention and prevention as well as statutory intervention and prevention. Targeted adolescent services were available and included face-to-face sessions as well as online support. Group therapy sessions were also provided through Hillingdon MIND. It was noted that non-attendance at school impacted on a child's wellbeing.

In 2022, the service had received 380 referrals which were triaged within seven days. Of those, 350 were accepted and resulted in 1,500 counselling sessions with the children – around 100 children attended sessions each week. Consideration was being given to the development of further services such as providing counselling in the child's first language (this would be useful for asylum seeking children) and a yoga for wellness pilot.

Of the 20,000 contacts made each year, about 30% had a statutory assessment, and mental health featured in the top three biggest issues arising. During the year, many of these contacts would be signposted to mental health support. Emotional wellbeing had been included in the Child Protection Plans and the Your Choice programme used Cognitive Behavioural Therapy (CBT) to engage with families.

Members were advised that the School Inclusion Team had developed a guide for schools to help them to identify and deal with children with disruptive behaviour. It was important that services worked with the whole family to avoid escalation.

With regard to looked after children (LAC), Mr Coman advised that the Council acted as the corporate parent for around 350 children and young people. Research had shown that LAC were more likely to suffer with mental ill health. As such, assessments were undertaken annually with those aged over five and every six months for those under five years old. A strengths and difficulties questionnaire was completed by children and young people to measure their wellbeing and gave them a score out of 40 (with a lower score being better). In Hillingdon, LAC scored an average of 12.7 compared to a national score of 13.7. If a LAC in the Borough scored 13+, action would be taken to investigate the matter further and referrals could be made to the psychology service.

Members were advised that Give Space was a moving therapy that involved performing arts and had been piloted in Hillingdon with six young people. Ask Jan was also available and provided individual sessions to around 60 young people in the Borough (the contract for this service would end this year with the possibility of an extension).

When asked what success looked like, Mr Coman advised that all young people would have a plan in place based on their needs with targets, actions and outcomes identified. Key performance indicators (KPIs) were in place for things like assessment timescales and were monitored during the routine reviews of the child's plan. Every child with a plan had a social worker assigned to them who would be able to help ensure that the plan was followed and achieved. In addition, a strong accountability framework had been put in place where the Executive Leadership Group was ultimately responsible for safeguarding in the Borough.

Mr Coman noted that officers worked in partnership with the families and children as well as with other agencies where relationship-based worked allowed each organisation to hold the others to account. All agencies needed to talk to each other to ensure that they were putting the child at the centre of everything they did and to ensure that they were delivering on each child's plan. All professionals involved in a child's plan were responsible for the delivery of that plan.

The Children's Safeguarding Partnership Board had been active in promoting engagement and partnership working. Information sharing agreements had been put in place to ensure that information about a child was available at the point of need. The Stronger Families Hub provided a single point of entry to the system (once the family had a social worker, they could agree to their information being shared).

Although families could use the Council's formal complaints system, they could also submit an informal complaint. LAC had an independent service through which they could make a complaint but could also raise issues with the independent review officers who would make sure that what should be done, was being done. Child Protection Plans were agreed at Child Protection Conferences and actions were put in place by independent people, having sought the child's view.

Members were advised that schools had a significant amount of contact with children and young people so were well placed to contribute to a child's plan and form part of the way forward. Social workers were in contact with schools, Child Protection Advisors had been placed in schools and safeguarding training was being provided for Governors.

Members queried how accessible the non-statutory services were and how the success of the interventions could be measured. Mr Coman advised that the Stronger Families Hub provided a single gateway into services and provided access to a lot of information about services that were available in the Borough. Schools, GPs, primary care and community health services also played a big role in identifying issues as well as the family themselves (and extended family).

Ms Jane Hainstock, Head of Joint Commissioning at North West London Integrated Care Board (NWL ICB), advised that a fairly long list of services were commissioned that straddled the old tiers and delivered universal and targeted services and services to young offenders. Mental Health Support Teams had been set up in a number of schools in Hillingdon with direct access and it was anticipated that these would be rolled out to all schools in due course.

ARRS (Additional Roles Reimbursement Scheme) provided funding for 26,000 additional roles to create bespoke multi-disciplinary teams in Primary Care Networks. There were 12 new ARRS roles that could work across primary, secondary and community care, funded by the GP contract, which included: Clinical Pharmacist, Pharmacy Technician, Social Prescribing Link Worker and Health and Wellbeing Coach.

Ms Hainstock advised that specialist child and adolescent mental health beds were commissioned by NHS England. P3 was commissioned to provide emotional support workers to help older children with challenges in relation to things like money, work and relationships and to help younger children with things like bullying. It was important that all parts of the system were working together to deliver successful outcomes for young people.

	KOOTH provided a digital offer to children and young people for online counselling and support and HACS (Hillingdon Autistic Care and Support) and the Centre for ADHD and Autism provided support for those with autism and ADHD as they were more likely to have mental health issues. Work was also undertaken with the Youth Offending Service, particularly with young men that presented with speech and language difficulties. NWL ICB was able to respond to individual requests for support for issues such as Fragile X Syndrome and could also offer family support. A two-year population health management pilot project was being undertaken to determine what support and interventions young people wanted and how the offer could be improved. Benchmarking was also being undertaken in relation to individualised plans to see how the young person was feeling at the start of the plan and how they felt at the end. Members were advised that the Thrive methodology had been introduced to look at the needs based roots of children's mental health issues and to develop a systems approach to the support that was then provided. A mapping exercise had been undertaken to identify all of the help that was currently available and this information had been sifted through to develop a shared understanding of where each service sat. The micro, meso and macro levels had been worked through with partners to identify where improvements needed to be made. Concern was expressed that there were so many services offered to support children's mental health that it could make it difficult for parents and GPs to know where the child should go to get the best support for their situation. It was suggested that, if there was some uncertainty about where the child should be referred, it was likely that the child would be referred to CAMHS by default, even if it wasn't the most appropriate place for them. Ms Hainstock advised that the mapping exercise would continue with a view to eventually listing each of the services on the Internet with an explanation about the service that was provided and whether or not a referral was needed (and who could make the referral). Consideration was also being given to establishing a Children's Mental Health Hub and the associated costs so that this could work together with the Stronger Families Hub. Although the outcomes were measured across all services commissioned in Hillingdon, Ms Hainstock advised that conversations were ongoing with CAMHS to develop measures that were meaningful and HACS had been commissioned to provide pre-diagnosis for autism. Insofar as NWL commissioning was concerned, a series of programme boards had been set up to come together and make decisions and recommendations about service delivery (one of which was in relation to children and young people's mental health). It was at that level that influence needed to be exerted to ensure that Hillingdon maintained a voice. This structure also provided the opportunity to develop pilot projects. Ms Tina Swain, Services Director for CAMHS and Eating Disorders – Goodall Division at Centre and North West London NHS Foundation Trust (CNWL) advised that CAMHS provided 24 hour advice and support and provided an opportunity to signpost to other services. Information was shared with GPs when required. Members were advised that primary care made more referrals to CAMHS than any other sources such as urgent care, education, social services or paediatrics. It was anticipated that the Thrive model would provide a needs-led service to get children help at the earliest opportunity. For those children under five years old, parent training and

targeted support were provided.

After a young person had been referred to CAMHS, they could be accepted or declined. Currently, around 1,500 young people made up the Hillingdon caseload with 50 more referrals made each week. Ms Swain advised that a lot of work had been undertaken to manage waiting times but it was unclear whether the time to second treatment was going up or down so she would look into this and forward the information on to Members. Initiatives included alternative therapies for children coming into the service.

In order to ensure that the patient voice was heard, participation groups had been set up (Children and Young People Shadow Board and Parent Shadow Board) and a dedicated feedback week had been set up to provide an informal feedback opportunity. Routine site visits were undertaken and the Friends and Family test continued to be undertaken. The Urgent Care Team was also available to provide intensive community support to children, young people and their families to help them to maintain school attendance.

After a referral had been made to CAMHS (which could be made by the parent through CAMHS' Single Point of Access (SPA)), it could take a long time before the assessment was undertaken and, if accepted, for subsequent interventions to be put in place. It was queried whether there was adequate knowledge in place about alternative non-statutory services that the parents and children could be advised of during the intervening period. Ms Swain advised that CAMHS might suggest services provided by another organisation in the interim when waiting for an assessment and might signpost to services such as KOOTH whilst awaiting core CAMHS services. The Waiting Well initiative had also been put in place to provide CAMHS and the parents with regular touch points.

Members noted that 636 referrals had been declined between 1 April 2022 and 31 January 2023. Ms Swain would undertake a deep dive to ascertain why these referrals had not been accepted and bring this information back to the Committee at its meeting on 15 June 2023. Members suggested that the 5 Urgent referrals to CAMHS during this same period seemed quite low.

In terms of timescales, Members expressed concern that a six week wait for an appointment seemed like a very long time. Ms Hainstock advised that there were key performance indicators in place and that CAMHS had recently been meeting all of its targets. Dr Paul Hopper, Divisional Medical Director at CNWL, advised that the national CAMHS target from referral to treatment was 18 weeks and that, locally, CAMHS had been achieving 100% within 18 weeks from referral to first and second contact. P3 (which provided wellbeing support and drop-in advice for young people aged 13-25) could also hold a case whist the young person waited for CAMHS. However, sometimes families did not want anything other than CAMHS.

Ms Swain advised that provision had been made for a mental health specialist in some schools (children and young people's wellbeing practitioners (CWP)) and that other services could be put in place to support young people.

Concern was expressed that parents were not routinely advised of other services that were available to support their children and that timescales for contact were not always provided. It also seemed that the various agencies involved in supporting children and their families were not always communicating effectively. Members asked whether

	parents were advised at the outset of their initial contact with CAMHS about the procedure for making a complaint if the process was not working effectively. Ms Swain advised that this information was available online and on social media but that testing would be needed to establish if it was as accessible as it should be. It was recognised that there would be times when inappropriate referrals were made to CAMHS but Members queried how these cases were dealt with and whether staff were provided with training on dealing with the difficult task of rejecting a referral. Ms Swain advised that a vision and purpose had been set for the team which supported the need for their communication to be honest and transparent and to provide clear reasons for why the child had not met the threshold. It would be important to receive feedback when this was not the experience of parents so that action could be taken to rectify the situation for those parents as well as others. **RESOLVED: That:** **1. Ms Swain establish the waiting times to second treatment and forward the information on to Members;** **2. Ms Swain establish why 636 referrals had been declined between 1 April 2022 and 31 January 2023 and bring this information back to the Committee at its meeting on 15 June 2023;** **3. Ms Swain investigate whether or not information in relation to making a complaint was as accessible as it should be; and** **4. the discussion be noted.**
65.	**DEVELOPMENTS IN ADULT PHLEBOTOMY IN HILLINGDON** *(Agenda Item 6)* Mr Richard Ellis, Joint Lead Borough Director at North West London Integrated Care System (NWL ICS), advised that the move of phlebotomy to GP practices had taken place almost two years previously and it had been anticipated that it would have capacity for around 185,000 blood tests per year. This year, the service was on track to do approximately 165,000 tests so there was still some capacity in the system. It was noted that the actual number might have been lower than anticipated as the new system prevented some patients from having unnecessary repeat tests or the original data might have been incorrect. Members were advised that there had been a small logistical issue at one point in relation to a nation shortage of the bottles used to store the blood samples but that this had been resolved within 6-8 weeks. Although the majority of blood tests were routine for the ongoing monitoring of a patient's health and could wait for three days for the results, a new urgent blood test provision had been introduced that could get results by the end of the day. If the sample was taken in the morning, the results could be relayed by the GP to the patient in the afternoon. If the sample was taken in the afternoon, the results could be relayed to the patient by NHS 111 if the GP practice was closed. Mr Ellis noted that staff that had previously been employed at Hillingdon Hospital in the phlebotomy service had been given the opportunity to work in the GP practices when the service had transitioned (although there was still a phlebotomy service available at the hospital). Health Care Assistants (HCAs) had been given the opportunity to retrain as phlebotomists but there had been some delays. Some practices had felt that they were not able to provide the phlebotomy service and had made arrangements with another practice to do their phlebotomy for them. High demand had caused some bottlenecks in the service which had since been resolved.

	The concept of one GP practice providing services for another was being investigated further. Consideration was being given to the provision of tests such as ECGs across practices. The use of north, central and south hubs was also being looked at for the provision of diagnostic services so that local services could be arranged locally. Members were assured that these hubs would be based in an NHS GP practice. Dr Ritu Prasad, Co-Chair of the Hillingdon GP Confederation advised that the hubs would be GP-led, similar to the extended access hubs that were currently available in the Borough that were accessible to patients. There had been a significant increase in the number of request for GPs to carry out bloods on behalf of hospital departments and community services when the service had been modelled on GPs only managing this work up to the time when a patient attended hospital. As well as impacting capacity, this raised clinical governance issues as responsibility to manage the results fell to the clinician that requested the test when the GP might not know why the test had been requested. This was being addressed by the NWL ICB Primary Care Team. Members had received next to no recent complaints from residents about the new delivery of the service and were reassured that the challenges faced had been addressed. **RESOLVED: That the discussion be noted.**
66.	**HILLINGDON HEALTH AND CARE PARTNERS UPDATE** *(Agenda Item 7)* Mr Keith Spencer, Managing Director at Hillingdon Health and Care Partners (HHCP), advised that HHCP was not really an organisation but was a place-based partnership comprising The Hillingdon Hospitals NHS Foundation Trust (THH), Central and North West London NHS Foundation Trust (CNWL), H4All, and the Hillingdon GP Confederation. HHCP worked with the local authority and North West London Integrated Care System (NWL ICS) to get all parts of the system working together and holding each other to account to improve population health and join up care in the Borough. It was noted that HHCP and the Council had a Joint Health and Wellbeing Strategy with six priorities which included support for the mental health of children and young people. The delivery model included three big moving parts: 1. six integrated neighbourhoods – population health, proactive and anticipatory care and same day urgent primary care. These services aimed to move to local preventative interventions; 2. joined up Borough-based services – urgent same day unplanned community response. Currently, about 5,000 residents used 70% of Hillingdon's health and adult social care resource and this needed to be managed carefully; and 3. Hillingdon Hospital – hospital services. In terms of performance, Mr Spencer advised that NWL measured place based metrics, comparing each of the constituent local authorities and benchmarking against England / London. To ensure that any action taken really made a difference, the Borough had focussed on three key strategic priorities: 1. developing Hillingdon 'place'; 2. building 'Team Hillingdon'; and 3. delivering transformation programmes.

Dr Ritu Prasad, Co-Chair of the Hillingdon GP Confederation, advised that the national demand on GP appointments had increased by 35 million between 2019 and 2022 which had put massive pressure on the system, especially when trying to care for people with long term conditions. During the pandemic, systems had been rapidly digitised over a very short space of time and the choice for patients to have virtual consultations rather than face-to-face had been retained. Overall, there were more appointments available now than there had been before the pandemic. Although virtual appointments tended to be more convenient for individuals that worked, there were conditions that needed to be dealt with face-to-face and it often was better to see children in person.

The move to digital services had meant that data could be gathered to identify how many telephone / virtual (decreased from 39% to 30%) and face-to-face (increased from 61% to 70%) appointments had been booked and the number of patients that had not attended their appointment had reduced to around 9% in December 2022. It was thought likely that the percentage of virtual appointments would remain around 20-30%.

In between appointments, GPs undertook other tasks such as sorting out prescriptions, writing hospital letters, etc. It was anticipated that the move to digital services would help keep patients out of A&E but there were challenges with delays for elective surgery. In addition, GPs had continued to use the messaging services where appropriate.

With regard to GP appointments, Dr Prasad advised that PATCHS / eConsult (online consultation software) had been introduced for non-urgent appointments and GP Connect telephone system had been introduced across all practices. It was noted that the telephone calls to GP surgeries were incessant and each practice had a maximum capacity for dealing with these calls. Mr Spencer recognised that people with complex needs needed a continuity of care which was one of the drivers for simplifying access.

Members expressed concern that A&E had been facing huge demand which increased when patients were unable to get an appointment with their GP. Mr Spencer advised that around 30% of the patients in A&E had gone there as they felt they were unable to get a GP appointment and could get a complete treatment in hospital (with diagnostics, etc). It was anticipated that the new hubs, which would be able to provide diagnostics, would be up and running in the next few months to provide a proof of concept.

Concern was expressed that the GP surgeries in the Heathrow Villages had all closed and Members asked whether the new hubs would be located closer to this area. Dr Prasad advised that there had been a commissioning issue with regard to provision in the Heathrow Villages but that the hubs could potentially be located closer and help resolve the issue faced by residents. Mr Spencer advised that he had met with residents of Harmondsworth and Sipson and that investigations would be undertaken as part of neighbourhood working and he would be meeting with them again to see what action could be taken. It was noted that, as well as not having access to a GP practice or pharmacy, these residents were not even able to get prescriptions delivered. Mr Richard Ellis, Joint Lead Borough Director at North West London Integrated Care System (NWL ICS), advised that discussions were underway with Hounslow about cross-Borough working and the need for virtual GP consultations.

Dr Prasad advised that pharmacies were providing a lot more services than they had

	previously and advanced services were being investigated such as the provision of part time GPs. Since 2022, GPs were also able to refer patients to pharmacies for minor ailments. Lead pharmacies were attached to neighbourhoods on the Primary Care Networks (PCNs) which were able to do things such as blood pressure monitoring but the IT systems were not yet integrated. Dr Prasad advised that GP recruitment continued to be a challenge that would take some time to address and that Hillingdon was considered to be a high risk area. There were a number trainees in Hillingdon and interventions had been put in place to try to retain them after their training whilst avoiding them getting burnt out. Capacity was being built into the system by removing reliance on GPs and shifting some responsibilities to paramedics, pharmacists, etc. **RESOLVED: That the discussion be noted.**
67.	**IMPLEMENTATION OF RESOLUTIONS FROM PAST REVIEWS - REVIEW INTO CHILDREN'S DENTAL SERVICES 2021/2022** *(Agenda Item 8)* Ms Kelly O'Neil, the Council's Interim Director of Public Health, advised that some of the recommendations from the review into children's dental health needed to be revisited in light of the Health and Social Care Bill and the change in the Secretary of State for Health. Some of the issues had been superseded and the local strategy had not been sufficiently ambitious. As Hillingdon was unable to have its water supply fluoridated in isolation, there needed to be a consensus with other local authorities which was unlikely to happen. Some of the recommendations in the final report were included in the Healthy and Wise programme and needed parental support and some of them were more long term actions such as dental epidemiology which took a sample of around 250 children and then tracked them over time. Actions had been taken such as the fizzy drinks levy and Borough-based catering controls and these were seen as big ticket issues. However, there was some challenge about whether it should be the parents that took control rather than the Council. Whilst Hillingdon's children did not have the worst dental health in London, it was still very poor and a more ambitious approach was needed to address the issue. Ms O'Neill noted that it was not just about children being in pain from poor dental health and subsequent tooth removal, it was also about good dental health to promote self esteem, etc. She would return to a future meeting with clear success outcomes, the amount invested, return on investment and what this actually meant in terms of improving the situation. It was noted that the Hillingdon Health and Care Partners' Child Transformation Programme would be looked at in March and would fit closely with this work. **RESOLVED: That:** **1. Ms Kelly O'Neill provide Members with an update at a future meeting; and** **2. the discussion be noted.**
68.	**CABINET FORWARD PLAN MONTHLY MONITORING** *(Agenda Item 9)* Consideration was given to the Cabinet Forward Plan.

	RESOLVED: That the Cabinet Forward Plan be noted.
69.	**WORK PROGRAMME** *(Agenda Item 10)* Consideration was given to the Committee's Work Programme. **RESOLVED: That the Work Programme be noted.**
	The meeting, which commenced at 6.30 pm, closed at 9.21 pm.

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nikki O'Halloran on nohalloran@hillingdon.gov.uk. Circulation of these minutes is to Councillors, officers, the press and members of the public.