Health and Social Care Scrutiny Sub-Committee Agenda

Date: **Thursday 19 November 2020**

Time: **6.30 pm**

Venue: **Virtual Meeting - Online**

Membership (Quorum 3)

Chair:	**Councillor Rekha Shah**
Labour Councillors:	**Michael Borio** **Natasha Proctor**
Conservative Councillors:	**Dr Lesline Lewinson** **Vina Mithani (VC)**
Labour Reserve Members:	1. Niraj Dattani 2. Dan Anderson 3. Chloe Smith
Conservative Reserve Members:	1. Chetna Halai 2. Chris Mote

Advisers:

Julian Maw	– Healthwatch Harrow
Dr N Merali	– Harrow Local Medical Committee

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Useful Information

Meeting details

This meeting is open to the press and public and can be viewed on www.harrow.gov.uk/virtualmeeting

Filming / recording of meetings

Please note that proceedings at this meeting may be recorded or filmed. If you choose to attend, you will be deemed to have consented to being recorded and/or filmed.

The recording will be made available on the Council website following the meeting.

Agenda publication date: Friday 6 November 2020

Agenda - Part I

1. **Attendance by Reserve Members**
To note the attendance at this meeting of any duly appointed Reserve Members.

Reserve Members may attend meetings:-

(i) to take the place of an ordinary Member for whom they are a reserve;
(ii) where the ordinary Member will be absent for the whole of the meeting; and
(iii) the meeting notes at the start of the meeting at the item 'Reserves' that the Reserve Member is or will be attending as a reserve;
(iv) if a Reserve Member whose intention to attend has been noted arrives after the commencement of the meeting, then that Reserve Member can only act as a Member from the start of the next item of business on the agenda after his/her arrival.

2. **Declarations of Interest**
To receive declarations of disclosable pecuniary or non pecuniary interests, arising from business to be transacted at this meeting, from:

(a) all Members of the Sub-Committee;
(b) all other Members present.

3. **Minutes** (Pages 5 - 16)
That the minutes of the meeting held on 24 June 2020 be taken as read and signed as a correct record.

4. **Public Questions ***
To receive any public questions received in accordance with Committee Procedure Rule 17 (Part 4B of the Constitution).

Questions will be asked in the order in which they were received. There will be a time limit of 15 minutes for the asking and answering of public questions.

[The deadline for receipt of public questions is 3.00 pm, 16 November 2020. Questions should be sent to publicquestions@harrow.gov.uk

No person may submit more than one question].

5. **Petitions**
To receive petitions (if any) submitted by members of the public/Councillors under the provisions of Committee Procedure Rule 15 (Part 4B of the Constitution).

6. **References from Council and Other Committees/Panels**
To receive any references from Council and/or other Committees or Panels.

7. **Mount Vernon Cancer Centre Review Update - November 2020** (Pages 17 - 42)
Presentation from representatives of NHS England and NHS Improvement.

8. **Response to Covid Update**
Presentation from the Corporate Director of People.

9. **Progress on Out of Hospital Plan**
Presentation from the Corporate Director of People.

10. **Adult Social Care Strategy**
Presentation from the Corporate Director of People.

11. **Mental Health Strategy/Mental Health Review**
Presentation from the Corporate Director of People.

12. **Update from NW London Joint Health Overview and Scrutiny Committee** (Pages 43 - 46)
Report of the Director of Strategy and Partnerships.

13. **Any Other Business**
Which cannot otherwise be dealt with.

Agenda - Part II - Nil

*** Data Protection Act Notice**

The Council will audio record item 4 (Public Questions) and will place the audio recording on the Council's website, which will be accessible to all.

[**Note:** The questions and answers will not be reproduced in the minutes.]

HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE

MINUTES

24 JUNE 2020

Chair:	* Councillor Rekha Shah	
Councillors:	* Michael Borio	* Vina Mithani
	* Dr Lesline Lewinson	* Natasha Proctor
Advisers:	* Julian Maw	- Healthwatch Harrow
	* Dr N Merali	- Harrow Local Medical Committee
In attendance: (Councillors)	Simon Brown	Minute 78

* Denotes Member present

69. A Welcome and Notification of a Replacement of a Councillor on the Sub-Committee

The Chair welcomed all those present to the first virtual meeting of the Overview and Scrutiny Committee and made some general announcements. Present at the meeting were Members and Advisers of the Sub-Committee, Council Officers, representatives from Partner Organisations – CCG, NWLH NHS Trust, MIND in Harrow, CNWL – and the Portfolio Holder for Adults and Public Health.

The Chair informed the Committee that the meeting would be audio and video recorded and would be available on the Council's website.

In accordance with Council Procedure Rule 1.5, the Sub-Committee noted the replacement of Councillor Chris Mote by Councillor Dr Lesline Lewinson as

the main Member of the Health and Social Care Scrutiny Sub-Committee and that Councillor Chris Mote would occupy the position of 2nd Reserve. The Chair welcomed Councillor Dr Lewinson and thanked Councillor Chris Mote for the contributions made to the work of the Sub-Committee.

70. Attendance by Reserve Members

RESOLVED: To note that there were no Reserve Members in attendance.

71. Declarations of Interest

RESOLVED: To note that the following interests were declared:

Agenda Item 10 – Covid 19 - Recovery Plan for the Harrow, Health and Care Partnership

Councillor Dr Lesline Lewinson, a member of the Sub-Committee, declared a non-pecuniary interest in that her father was being cared for in a Care Home in Harrow. She would remain in the room whilst the matter was considered and voted upon.

Councillor Vina Mithani, a member of the Committee, declared a non-pecuniary interest in that, by virtue of her employment with Public Health England, she had been involved in the work relating to Covid-19. She would remain in the room whilst the matter was considered and voted upon.

72. Minutes

RESOLVED: That the minutes of the meeting held on 3 March 2020, be taken as read and signed as a correct record.

73. Appointment of Vice-Chair

RESOLVED: To appoint Councillor Vina Mithani as Vice-Chair of the Health and Social Care Scrutiny Sub-Committee for the 2020/2021 Municipal Year.

74. Appointment of (non-voting) Advisers to the Sub-Committee 2020/21

RESOLVED: That the following nominees be appointed as Advisers to the Sub-Committee for the 2020/21 Municipal Year:

Mr Julian Maw (Healthwatch Harrow)
Dr Nizar Merali (Harrow Local Medical Committee).

75. Public Questions

RESOLVED: To note that no public questions were received.

76. Petitions

RESOLVED: To note that no petitions had been received.

77. References from Council and Other Committees/Panels

None received.

RESOLVED ITEMS

78. Covid 19 - Recovery Plan for the Harrow, Health and Care Partnership

Prior to the introduction of the report, a Member stated that a glossary to this document and all future documents be provided to identify the collection of specialist terms used. The Corporate Director of People undertook to provide a glossary.

The Sub-Committee received a report, which set out the North West London Out of Hospital Recovery Plan for Harrow setting out how the Plan had evolved, including the journey towards integrated, person and community-centred care.

The Harrow Out of Hospital Recovery Plan set out:

- shared principles of the Harrow Integrated Care Partnership;

- how the health of the population of the borough would be managed and inequalities tackled;

- learning experiences from the Covid-19 response and the plans in place for recovery and an expected second wave of infection, whilst managing safety and risk;

- proactive planned care where PCNs (Primary Care Networks) would continue to work to provide a co-ordinated and proactive approach to long term condition management;

- how implementation would be supported through an integrated community based urgent care model.

The Corporate Director of People introduced the report and stated that the Plan showed positive partnership working in the midst of the Covid-19 pandemic tragedy and he commended the work of the Partners present at the meeting. He added that, looking ahead, the Partnership would need to evolve to ensure the continued care and good health of the people of Harrow.

The Managing Director of Harrow CCG (Clinical Commissioning Group) added that the Harrow Health and Care Executive had become the epi-centre of the ICP (Integrated Care Partnership) and its work with local partners on supporting each other in responding to Covid-19. The Health and Care Executive had brought together a number of sectors in a single discussion forum on a weekly basis to drive improvements in health and wellbeing. She highlighted the key aspects of the Plan with collaboration and integrated care

work being fundamental to the work of all Partners. She outlined the key elements which were:

- understanding shared partnerships;

- learning from each other;

- building on and strengthening key areas;

- continuing to plan for the future.

She added that shared ownership and collective responsibility were important and outlined the six areas in the Plan, such as providing support to children and care homes, all of which would be underpinned by education and training.

Members were also briefed on the next steps, the '100 day' priority, as follows:

- communicating and sharing the Plan with stakeholders and the voluntary sector;

- producing a video on actions taken and to explain the new normal;

- how patients could get engaged;

- embedding governance and leadership;

- organise and develop the Plan further and support its delivery.

The same representative invited views from the Sub-Committee to help enrich the Plan which had been brought about by exemplary partnership working.

The Chair of the CCG explained that, in her capacity as co-Chair of the Joint Management Board, she had been inspired by the coming together of all Partners during the Covid-19 pandemic and the best legacy that it could leave was to ensure that effective care was provided to all for the future.

The Vice-Chair of the Sub-Committee welcomed the Plan and recognised the amount of work that had taken place in its production. The Chair invited Members of the Sub-Committee to ask questions.

Integrated Care Partnership:

Question 1:

The decision around a single CCG for NW London was imminent and this would see the senior management capacity for the region shrink from 8 managing directors to 3, with changes planned from September 2020 for a 'go-live' in March 2021. How would the perspectives and priorities for Harrow be met through this new structure?

The Chair of CCG reported that the governing body had not taken a decision yet but had set out its aspirations. The CCG would follow the same footprint as that followed by the Integrated Care Partnership/System. This had been working well and was good for patients being cared for in the ICU (Intensive Care Unit).

She added that the plan was to focus on the Harrow Partnership with the CCG setting an example of how to facilitate change and how best to deliver care. A local voice for Harrow was required. An excellent system was in place led by the Managing Director of the CCG and supported by other Partners but providing best value was fundamental.

There were three potential future groupings but a decision had not yet been made and were subject to staff consultation. However, it was essential that systems and structures were fit for purpose and in place. It was too early to say how the changes proposed would work in practice.

Question 2:

How was the ICP (Integrated Care Partnership) different to what had existed before? What difference, if any, would it make to the patient's journey through Harrow's healthcare systems?

The Chief Operating Officer of CLCH was of the view that all out of hospital services needed to be brought together in order to ensure a 'proper' community for Harrow. In NWL it was only the Harrow system that had a level of co-ordination and engagement of all Partners and the creating of a single leadership that was working together in a way that would help improve health care for residents.

The Managing Director of Harrow CCG stated that it was pertinent to eradicate silo working and she was proud to report that the ICP (Integrated Care Partnership) was an aggregation of all Partnerships working together. It had been recognised that the work carried out needed to be done differently and at a faster pace and local partnerships had been galvanised as a collective during this period to do so thereby providing better needs led outcomes for local residents in a timely way.

Impact of Covid-19 on Harrow's Communities

Question 3:

More information on what was currently happening in Harrow was required to better understand the picture in Harrow.

With reference to the PHE (Public Health England) report on the disproportionate adverse impact of Covid-19 on BAME communities – what was the picture in Harrow? What can explain the disproportionate impact in Harrow – long-term conditions, 'lifestyle' factors, socio-economic factors e.g. lower paid jobs being those more likely to be exposed to the general public and/or the vulnerable.

The Director of Public Health reported as follows:

- a number of changes were taking place in Harrow and, in relation to Shielding, the Partners had had to react to the changes proposed by the government. It was important to ensure that Harrow did not experience a resurgence in infections and the Track and Trace system was a vital tool;

- the cases of infection in Harrow were very low and the highest number of infections in a day in the last two weeks was three people;

- the pandemic had shown a light on disparities which were due to a number of reasons. Harrow suffered from an ageing population with a large number being based in residential Care Homes;

- the BAME communities had been impacted upon but no data was presently available for Harrow. The inequalities highlighted by Covid-19 were not unfamiliar. The BAME communities suffered from long term health issues, lived in poor quality housing, suffered from overcrowding, education attainment levels and employment issues. These issues had been brought to the fore by Covid-19. The Council and its Partners would be addressing the issues around inequalities. A further report would be submitted to the Sub-Committee when relevant data was available.

Question 4:

What were the key public health messages that Councillors could reinforce with residents?

The Director of Public Health reported on the key messages: showing people how to wash their hands – handwashing/cleansing techniques with soap and water – and the proper wearing of appropriate PPE (Personal Protective Equipment). It was important for people to act responsibly and to wear face masks in order to protect others from the infection. Additionally, when wearing gloves it was important that people did not touch their faces in order to help reduce contamination.

She added that living a healthier life style was important to reduce long term medical conditions such as diabetes. A Health and Wellbeing Strategy would be launched at the July 2020 meeting of the Health and Wellbeing Board which would include plans to reduce obesity and provide support to those suffering from mental health issues.

Impact of Covid-19 on Health and Social Care Services

Question 5:

Track and Trace in Harrow, Testing in Harrow – Did this provide a positive picture and was additional tracking in place?

The Director of Public Health reported that there were very few cases of infection in Harrow and whilst the situation in Harrow's Care Homes had been escalated to a Tier 1 Category, the situation in the borough was not

approaching a community outbreak. She cited an example of the issues surrounding a homeless person who had been tracked and housed and the learning experiences that the situation had provided.

Question 6:

What Business Continuity Plans had been in place for a pandemic like Covid-19, for each individual trust and across partnership organisations?

The Deputy Chief Executive of North West London Hospitals NHS Trust reported that, due to the recent reduction in the presentation of Covid-19 in hospitals, the plan was for acute sites to bring back the elective services that had been stopped to deal with the pandemic. For example, the Trust had put in place arrangements for the Royal Marsden Hospital to provide access to patients needing urgent cancer care, other arrangements were in place for urgent non-cancer care at Clementine Churchill Hospital in Harrow. Within the Trusts own acute hospital sites, Covid clean protected pathways had to be created to separate potentially Covid positive and non-Covid patients and hand gels, face masks and other PPE were being provided. At Central Middlesex Hospital, the Trust had recommenced some elective surgery and endoscopy from 15 June 2020. Ealing Hospital and Northwick Park Hospital were having their Covid-protected pathways Peer Reviewed and were expected to recommence elective and diagnostic procedures during July 2020.

The Deputy Chief Executive added that the Trust had undertaken a review of its response to the Covid-19 outbreak and the lessons learnt were being incorporated into its Business Continuity Plan which would include the actions that would be required should a second wave present itself whilst protecting some of the existing elective and diagnostic pathways.

The Deputy Chief Executive responded to an additional question relating to staffing levels and capacity, including the availability of nurses should a second wave present itself. He explained that staffing challenges in key specialties within the hospital had been exacerbated by Covid-19. Northwick Park Hospital had trebled the number of critical care beds during the pandemic and the provision of care provided to those suffering from under Covid-19 was dependent on highly skilled staff working to intensive staffing rotas. The Trust was fortunate that its staff from across its Hospitals responded flexibly and with great courage to move from their existing areas of work to support critical care.. He added that 85% of those who had died from Covid-19 had been over the age of 60 years and that over 68% of all the Covid related deaths had 3 or more pre-existing conditions. Historically within the local population there was a bigger prevalence of conditions such as diabetes within the BAME communities.

Question 7:

As a result of Covd-19, patients were seeing changes in the way they contacted their GPs. A great deal of face-to-face communication had disappeared and had been replaced with virtual consultations. Was this

expected to be the new norm and were the e-consultation systems in place adequate?

The Chair of the CCG reported that due to e-consultations, the response rates from GPs were swifter than before. In Harrow, a 24-hour online service was provided by GPs and, whilst some practices were trialling this approach, this was not the general plan for Harrow as a whole. There was a need to be responsive to patients.

An adviser reported that the majority of patients seeking appointments were given one for the same or next day. Those without the necessary IT skills could telephone their GP and make appointments in the traditional manner. He clarified that patients who were able to book appointments on line continued to do so but the traditional telephone call to the receptionist continued with the same outcome in terms of swiftness of appointment. A national directive had been issued to GPs to offer electronic access and this had led to the introduction of two popular tools in Harrow - e Consult and Klinik.

The adviser who had asked the question stated that he was not overly concerned and had recognised that digital services were the way forward and would allow for a more efficient service. The change in interface with patients was happening and needed to be recognised.

Question 8:

What plans had been put in place to provide mental health support for staff?

The Partners reported that support was being provided in a number of ways such as:

- provision of adequate PPE in accordance with changing rules and guidance provided by the government since mid-April 2020. The PPE was now in better supply than before. Elective surgery would also require additional PPE. The surge in infections expected during the winter would also mean that the supply chain of PPE would need to continue. Hospitals in London were helping each other out to ensure that they all had adequate PPE;

- risks to staff were being assessed and the work was ongoing. Good thinking, London's digital mental well-being service had been an excellent support with the provision of trusted apps, NHS approved mental and wellbeing information and digital tools to support staff with stress, anxiety, low mood, sleep difficulties and bereavement. The resource was excellent and could be accessed by staff on line at a time that was convenient for them. Support was also available through Thrive London resources. Various organisations had put forward plans to support their staff who had also suffered personal losses with colleagues dying due to the pandemic;

- the Chief Executive of CNWL had set up a workforce taskforce to look at the different roles within the Health Service. It would look at the training required, provision of apprenticeships and support for BAME candidates.

Question 9:

A number of former NHS staff had come out of retirement to help. How had Covid-19 impacted on the recruitment of staff?

The Partners reported that hospitals had been blessed by the return of former colleagues to help with the pandemic and were pleased with the flexibility it had provided. It was now possible to support more women to work flexible hours, provide additional support in clinics and to allow staff to work around the needs of their families. This had helped to build trust.

The Chair of the CCG reported that there were questions to be answered about the future of front line health care professionals who had risked their own lives to provide care and the impact this would have on the next generation of health care professionals. They had stepped up and this needed to be recognised. The respect for them had increased and was at an all time high and this had to be welcomed.

Harrow was a high producing area for health care workers and it was hoped that this would help with the recruitment challenges facing local hospitals.

Question 9:

What had been the impact on Harrow's Care Homes and the care sector? What support had been provided to staff in Care Homes and had the provision of PPE been adequate?

The Director of Public Health acknowledged that the pandemic had had a huge impact on Care Homes, many of which had been adversely affected by the spread of Covid-19 from one person to many others living in the same Care Home.

The Director added that the issues in Care Homes in Harrow mainly related to the availability of PPE but the Council had been working with the West London Alliance and the supply chain had been good. London as a whole had received a regular supply of PPE but not in the quantities required although some stock had always been available. It was essential that appropriate masks were available for front line staff such as the MP3 version as these were close fitting.

Partnership working had helped towards a continual review of Care Homes in order to ascertain which required additional support and testing. The North West London CCG had set up an infection control team which had ensured the wearing of PPEs as a must and that those carrying Covid-19 were separated from others in the Care Homes.

The Council had passed on the funding received from the government to the Care Homes in Harrow which had helped them to engage additional staff and

meet various costs. Weekly meetings had been held with Care Home managers to ensure that the guidelines issued were being met as these were changing continuously. People living in Care Homes suffering from dementia were tested for Covid-19 and those living in supported accommodation were also kept under review.

The Corporate Director of People paid tribute to staff working in social care and applauded them for their work during the pandemic. It was essential that their skills were recognised and that they received parity with other health workers. It was also important to maintain a training system for them. He added that the Council's Adult Social Care staff had excelled themselves during the pandemic and had worked with the Hospital Discharge team to ensure a smooth transition of patients from hospital into the community.

The Portfolio Holder for Adults and Public Health thanked the health care professionals for their hard work. He added that those living in mental health institutions had also been provided with support. He also welcomed the CCG's move into the Civic Centre which would allow for improved integrated working. It was essential that the Partners were prepared to deal with the second wave and to lock down smaller areas within Harrow in the event of a spread in the virus within communities.

The Portfolio Holder was of the view that it was essential that hard to reach communities were supported. Additionally, the impact of health inequalities on Harrow residents needed to be addressed and this matter would be the subject of further discussion as part of the Council's Borough Plan.

Question 10:

Partnership working - how had the voluntary sector helped around the response to Covid-19 in terms of supporting health services and promoting health messaging?

A Member thanked the support provided by the voluntary sector who had helped to deliver prescriptions and food to many households.

The Corporate Director of People stated that there was a strong voluntary sector presence in Harrow and that they had been the foundation of the Council's overall response to Covid-19. Members were informed that weekly meetings had taken place with the voluntary sector who had helped to deliver food and other essential supplies to those shielded often on a daily basis.

The 'Help Harrow' portal had been launched to allow residents to seek Council help. Funding of £600k had been made available to support the voluntary sector with an additional amount of £100k to provide support to those bereaved. The Council was currently in the process of implementing a Recovery Plan and consideration would need to be given to residents who might loose their jobs as a result of the pandemic's impact on the economy.

The Chief Executive of MIND in Harrow, speaking in his capacity as Chair of Community Action Harrow, outlined the services that the organisation had delivered to vulnerable residents. The organisation had worked closely with

the Council and the positive relationship between the two organisations had helped to ensure a smoother operation. The good working relationship had been aided by the transition to digital services to provide support to the needy, particularly those residents who were shielding. Other organisations, such as SWISS, had supported with the distribution of food, and medicine. They had also helped to provide support to those suffering from social isolation and emotional wellbeing.

Question 11:

What would be long term impact of Covid-19 on the Council's finances, including those of its Partners? How would this impact on Harrow residents?

The Managing Director of the CCG stated that, at present, she was not able to provide an answer to this pertinent question as the CCG and indeed other parts of the NWL system were in the process of collating information in relation to the Covid-19 related spend. However, she expected conversations to begin soon. As the number of infections dropped, certain facilities/services which had specifically been put in place to respond to Covid-19 would need to be assessed for consideration of reduced opening hours and or being withdrawn as these may not be required anymore.

The Corporate Director of People stated that a surplus in the Council's budget was highly unlikely. There had been some recognition from the government of the financial challenges facing local authorities but additional support would be required and there was some trepidation amongst Councils when looking ahead.

Members of the Sub-Committee applauded staff and health care workers for their work, including staff working in laboratories, during the pandemic. The Chair thanked all those present at the meeting for their hard work and their contributions to the meeting.

(Note: The meeting, having commenced at 6.00 pm, closed at 7.43 pm).

(Signed) COUNCILLOR REKHA SHAH
Chair

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Mount Vernon Cancer Centre Review Update – Nov 2020

This pack provides information on:

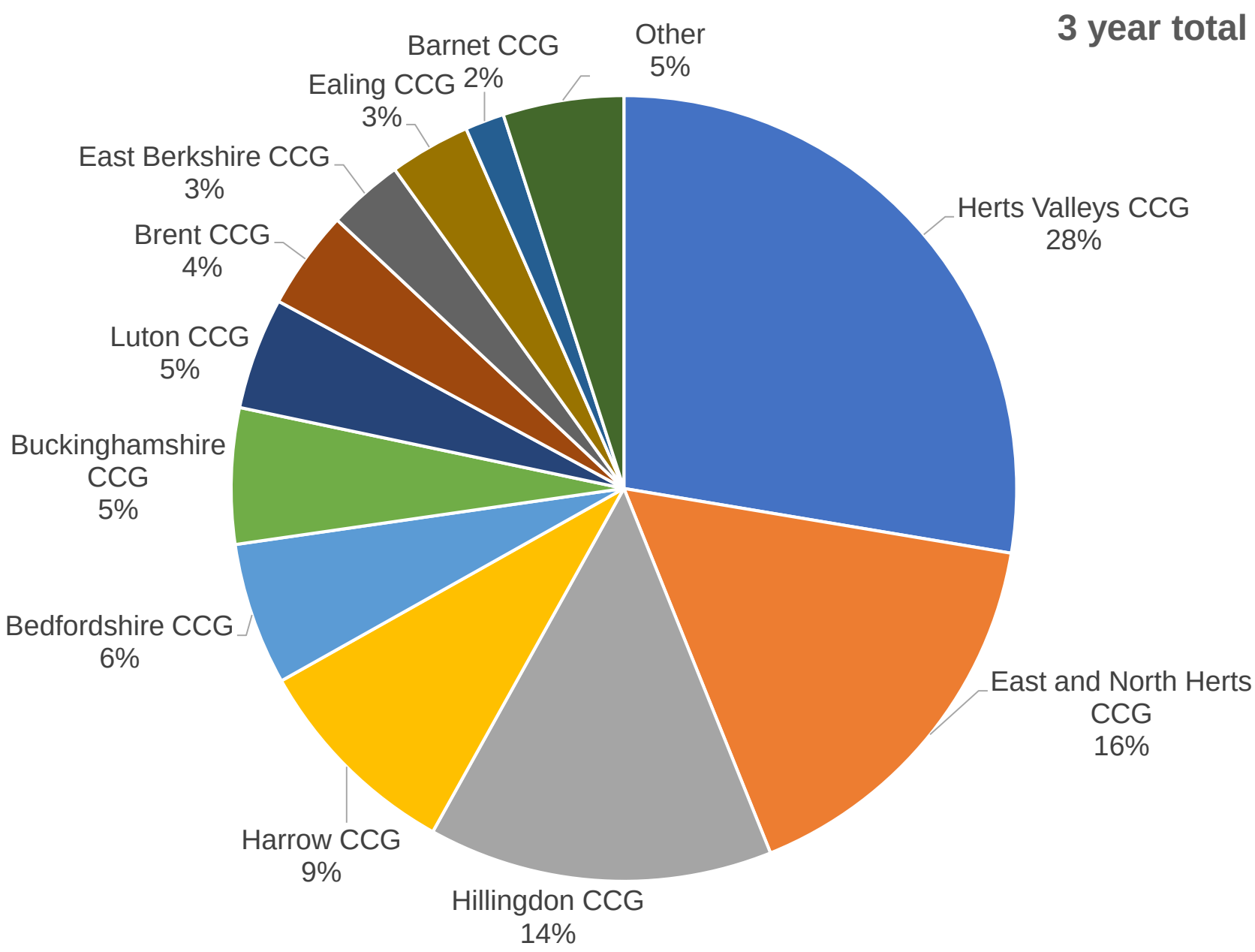
- What is the Mount Vernon Cancer Centre Review
- Why do we need to make changes?
- What has happened so far?
- Who is overseeing the review?
- What is happening now?
- What happens next?
- Timescale
- Our biggest challenges
- Questions and Answers

What is the Mount Vernon Cancer Centre Review?

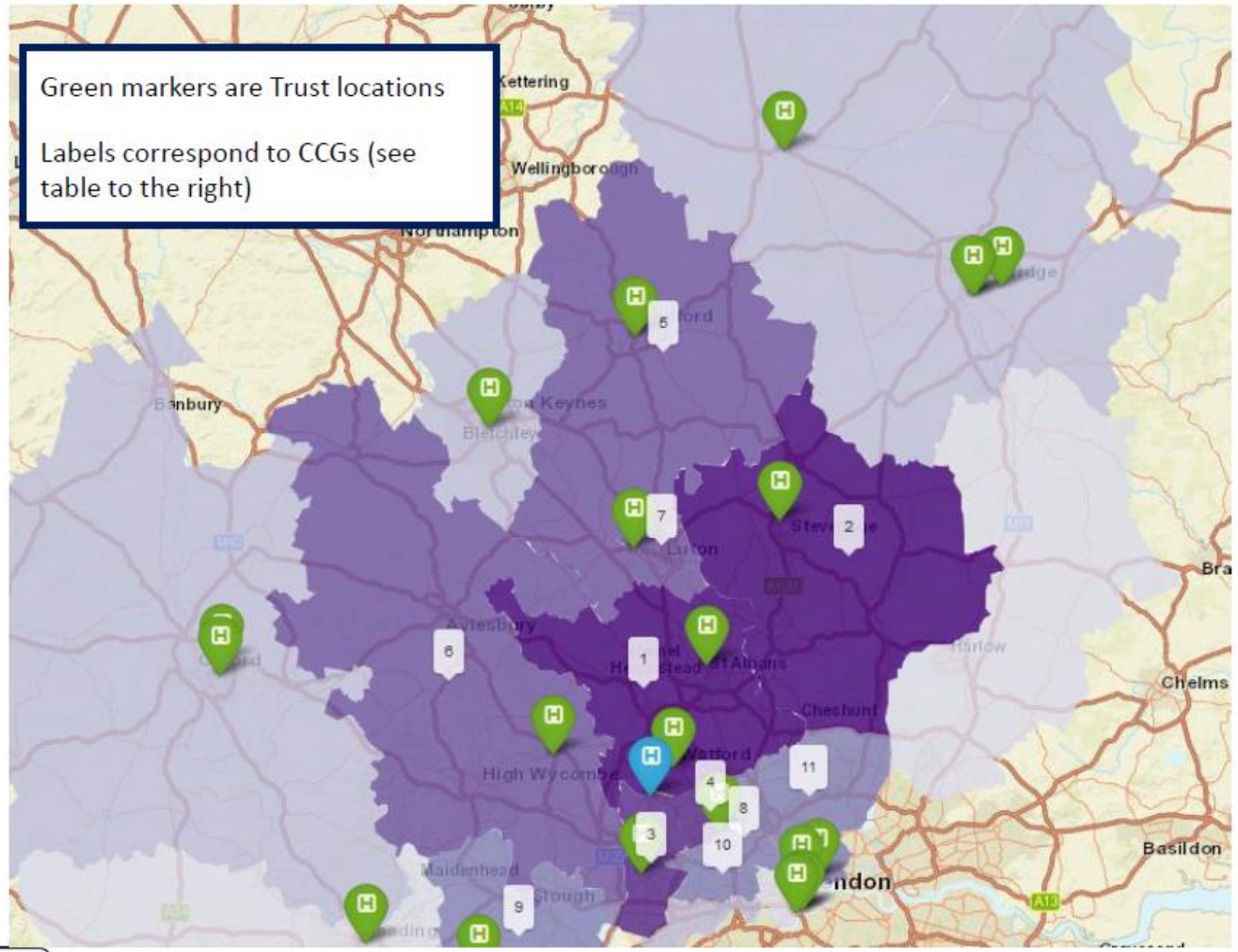
- The review is looking at all of the cancer services provided by Mount Vernon Cancer Centre and thinking about how they might need to change in the future.
- This includes outpatient chemotherapy, nuclear medicine, brachytherapy and haematology, provided by the Mount Vernon team, as well as radiotherapy and inpatient services.
- These services are provided at Mount Vernon but oncologists from Mount Vernon also run outpatient clinics at many local hospitals in the areas patients come from.
- Patients generally come from Hertfordshire, Bedfordshire, North West London, North Central London, Berkshire and Buckinghamshire, as well as a few from further away.
- An independent clinical team from a major cancer centre in a different part of the country, has made some recommendations about changes that are needed in the short, medium and long term.

Geographical Distribution of Patients

	CCG	2017-18	2018-19	2019-20	3 year total	%
	Herts Valleys CCG	3,515	3,375	3,364	10,254	29%
	East and North Herts CCG	1,612	2,215	2,212	6,039	17%
	Hillingdon CCG	1,804	1,753	1,702	5,259	15%
	Harrow CCG	1,099	1,075	1,080	3,254	9%
	Bedfordshire CCG	661	714	800	2,175	6%
	Buckinghamshire CCG	733	625	715	2,073	6%
	Luton CCG	550	543	612	1,705	5%
	Brent CCG	508	491	512	1,511	4%
	East Berkshire CCG	394	374	385	1,153	3%
	Ealing CCG	388	397	454	1,239	3%
	Barnet CCG	246	214	137	597	2%
	Other	527	714	603	1,844	5%


3 year total
Herts Valleys CCG 28%
East and North Herts CCG 16%
Hillingdon CCG 14%
Harrow CCG 9%
Bedfordshire CCG 6%
Buckinghamshire CCG 5%
Luton CCG 5%
Brent CCG 4%
East Berkshire CCG 3%
Ealing CCG 3%
Barnet CCG 2%
Other 5%

MVCC Catchment – patients attending MVCC 2019



Label	CCG	Unique Patients
1	NHS Herts Valleys CCG	3,056
2	NHS East and North Hertfordshire CCG	2,155
3	NHS Hillingdon CCG	1,550
4	NHS Harrow CCG	1,036
5	NHS Bedfordshire CCG	747
6	NHS Buckinghamshire CCG	645
7	NHS Luton CCG	616
8	NHS Brent CCG	394
9	NHS East Berkshire CCG	381
10	NHS Ealing CCG	346
11	NHS North Central London CCG	196

* Only CCGs with >100 patients are labelled

Why do we need to make changes?

- There have been a lot of reviews of Mount Vernon over the last 40 years, but it has always been difficult to find the right answer.

"The future of Mount Vernon Hospital has been a concern since I was first elected in 1979"

John Wilkinson MP

"I am sure that we shall achieve a reconfiguration for Mount Vernon Hospital that is clinically coherent and financially viable"

Paul Boateng, Under Secretary of State for Health

Hansard 1998

- As a result, the buildings are in a bad state, staff aren't always able to provide the care and treatment they would like, and patients care is sometimes split across different hospitals. This cannot continue.

Why do we need to make changes?

- Many of the buildings are not in a good state of repair, and concerns have been raised in relation to the long-term clinical sustainability of the Cancer Centre.
- Limited support facilities on site (for example intensive or high dependency care), and there are no other specialties on site so non-cancer specialty staff to call on if needed (cardiology for example). This limits the team's ability to deliver complex oncology care. This means:
    - Some newer treatments and research trials have high levels of toxicity. Without services such as high dependency or intensive care, patients will not have access to the latest treatments.

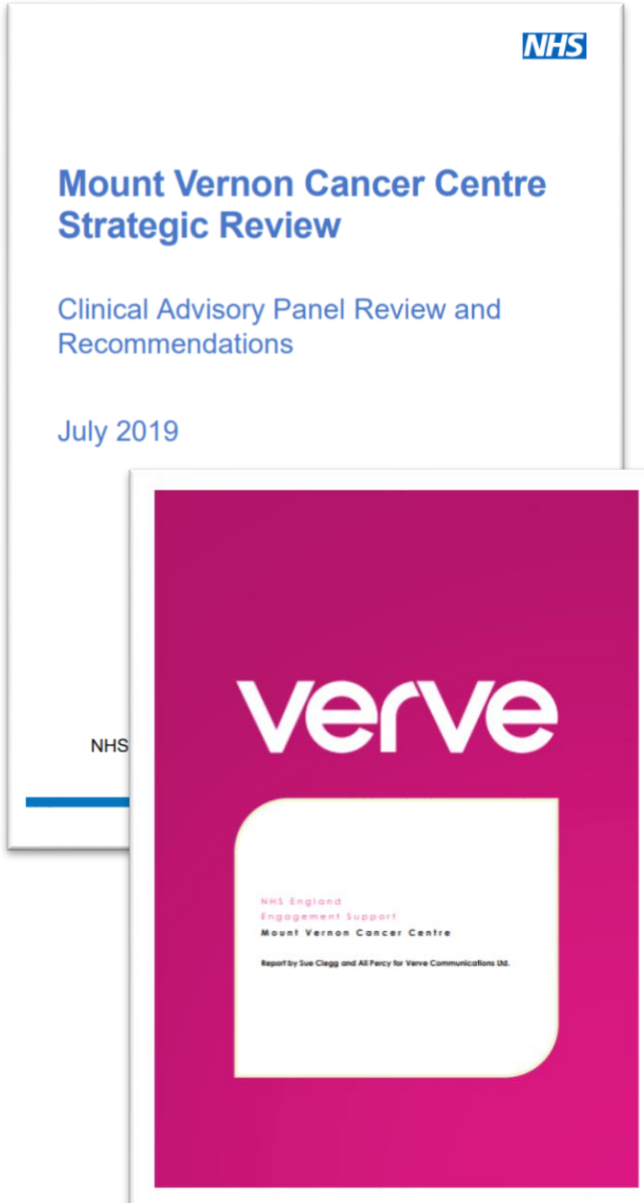
Why do we need to make changes?

- As people live longer, more people with cancer are also living with other illnesses or conditions which require treatment alongside their cancer treatment. This cannot be done at MVCC.
- The Mount Vernon have arrangements with 16 other hospitals to provide the support that is not available at MVCC – this can cause problems when those other hospitals have their own priorities, such as anaesthetics support during the first covid peak.
- This also means patients have to travel much further for some treatment, for example patients requiring treatment for haematological malignancy travel to UCLH.
- Staff want to be able to treat more complex patients to develop their skills and become experts in their field and there is a risk that Mount Vernon will not be able to recruit and retain staff if a long term solution is not agreed.

- Staff have done a good job, despite the conditions, in providing high quality treatment and ensuring patient safety. Patient feedback regularly shows that most patients are happy with the services they receive. However, a more permanent solution needs to be found to ensure the sustainability of the services in the long term.
- We want to organise services in ways that provide the best modern care for patients, including access to research trials and new technology and treatments, from good quality facilities.

What has happened so far?

- Reviewing of data (for example to improve understanding of where patients are referred from, for what services, how often they attend Mount Vernon)
- Interviews with clinical staff, stakeholders and patients
- Review of existing patient experience information
- Patient workshops (Tottenham Court Road, Uxbridge, Mount Vernon, Stevenage, Watford and Luton), survey and interviews with groups representing protected characteristics to inform early thinking and criteria
- Independent Clinical Review
- Response to short and medium term recommendations
  - New appointments and funding of additional staff (for example in the acute oncology service)
  - New policies (for example on admission criteria)
  - Increased ward rounds
  - Reviews of patients transferred to other hospitals
  - Planning to transfer management of service to specialist provider- UCLH (subject to due diligence)



Who is overseeing the review?

- The review is run by a Programme Board which is led by the Regional Director of Specialised Commissioning for NHS England in the East of England. Other members include:
  - Commissioners from NHS England in the East of England who commission the service, and from NHS England in London
  - Healthwatch Hertfordshire and Healthwatch Hillingdon
  - Cancer Alliances: East of England Cancer Alliance, North Central and East London Cancer Alliance, RM Partners West London Cancer Alliance
  - Local systems: Hertfordshire and West Essex ICS, North West London STP, Bedford, Luton and Milton Keynes ICS, Buckinghamshire Oxford and Berkshire West ICS / Thames Valley Cancer Alliance
  - CCGs: Bedfordshire CCG, Buckinghamshire CCG, East and North Herts CCG, Harrow CCG, Herts Valleys CCG, Hillingdon CCG, Luton CCG
  - London Radiotherapy Network
  - East and North Hertfordshire NHS Trust who runs the service now
  - UCLH who is providing leadership support and is the preferred specialist provider to run the centre in the future
  - Hillingdon Hospitals NHS Trust who own the land the centre is on
  - Paul Strickland Scanner Centre

The North West London health and care partnership

NHS

What do we want to achieve in cancer?

CANCER STRATEGIC DELIVERABLES:

- 75% of cancers should be diagnosed at stage 1 or 2
- Better 5 year survival
- Reduced cancer inequalities

KEY ENABLERS

- Sustainable workforce
- High quality care
- Innovation + Research
- Screening & population health
- Reducing variation
- Integrated systems

The North West London health and care partnership

NHS

How does NWL STP fit into the Programme Board for Mount Vernon?

- NWL members of Mount Vernon Programme Board

- In addition, the NWL ICS has convened a local group to understand how the proposals will impact on cancer care for NWL patients. This impacts 4 CCG's:
  - Hillingdon
  - Harrow
  - Ealing
  - Brent

- Patient engagement is through the main programme board

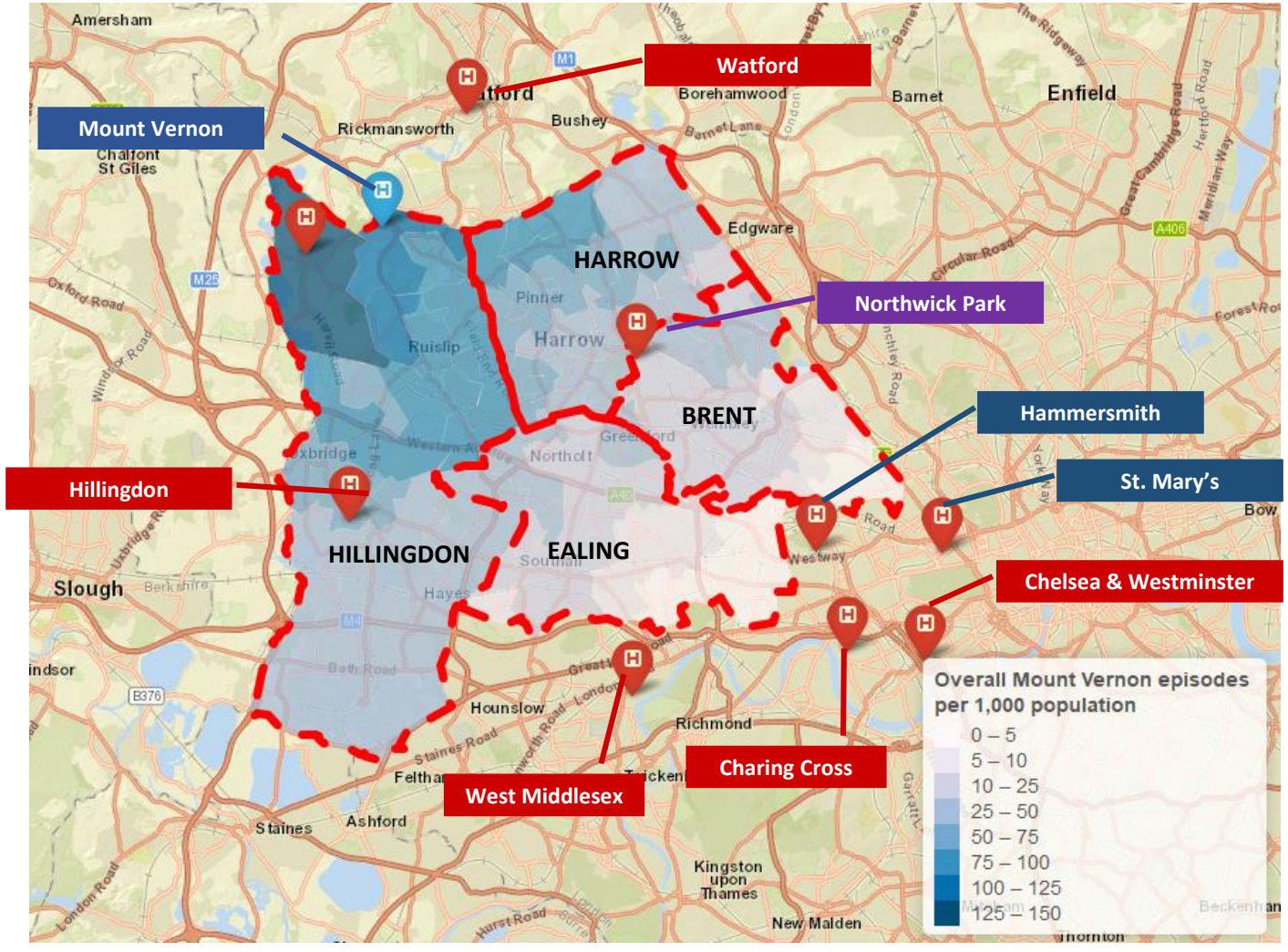
The North West London health and care partnership

NHS

Where do Harrow patients currently receive chemotherapy and radiotherapy?

- We are looking at a variety of data, including Cancer waits (first and subsequent) treatment data, and National RT data sets.

- We are also reviewing other data sets to get a better idea of overall flows and number of attendances to each service, as this gives us a much more granular understanding of activity.



What Harrow patients have told us - 2019

- Patients from Harrow were amongst those attending face to face workshops in 2019. Harrow residents generally attended one of the three workshops in North West London, although there was some London attendance at the Watford workshop. Accessibility, communication, environment, continuity and consistency of services, and quality of service was the key considerations for future planning that were raised by people at the workshops.
- Patients at the London events were more likely to speak negatively about the state of the facilities (small, dingy rooms) and positively about the environment (green spaces, place to get away from it all, a contrast to London), with the exception of the Northwood event where the conversation much more centred on the attachment the community has to the current site. Patients at the events outside London were much more likely to speak about travel and access and communication challenges.
- An integrated single site, was understood by many to be a good model, especially if some services could be delivered nearer to home for people in the north of the area. It was assumed that there would be advantages to having services on a single site, including continuity of care. The alternative, which proposed keeping some clinics at MVCC, tended to be preferred by those who had a great affinity for the buildings and the site. This model, however, caused some concerns about split sites and whether continuity of care would be affected.
- Although travel could be difficult for some patients there was agreement across all events that travelling a significant distance was worth it to access quality care in a centre of excellence, but that adequate transport infrastructure (including looking at improved options for hospital transport) must be built into any future plans. Receiving care across several sites tended to be seen as stressful. People desired continuity of care which they worried was less likely across different sites. People were also interested in hearing about, and considering, how population density, demand for cancer services and journey times/accessibility intersect across the catchment area; the broader context for delivery of cancer services can also be of interest, with some participants enquiring where else they are delivered, and what the options would be if they chose not to travel to MVCC (or any future site).
- A survey was also carried out last year. 11% of those responding said their nearest hospital was Northwick Park.
    - Building renovation, shorter waiting times, improved access and better facilities were the main changes people wanted to see.
    - 51% said they would keep staff quality the same, followed by 22% said they thought the quality of care should stay the same. 6% said the location should stay the same.
    - 57% said they would like to access more services closer to home (20% said no).
    - The most important thing to patients was to know their consultant and the team who are looking after them throughout their treatment (73%), followed by high quality care, even if it means travelling further (52%), information about treatment (35%), care provided locally (34%) and knowing who to call on if they become unwell at home (33%). 31% said having all their cancer treatment at one hospital was important to them.

What Harrow patients have told us - 2020

- This autumn, Healthwatch Harrow has participated in a Healthwatch workshop and has nominated two patient representatives to a patient reference group. Healthwatch Harrow representatives have also attended some of the recent focus groups.
- Following the Healthwatch workshop, Healthwatch Harrow has been asked to help with access to some local communities to undertake some bespoke work, for example with the Somalian community.
- The recent focus groups have covered a variety of subjects, including specific cancer pathways, satellite radiotherapy and clinical model and estates, as well as some general Q&A sessions. More than 30 small focus groups are taking place at the moment. These have been designed to be small to enable patients to feel comfortable sharing their experiences, some of which are quite personal. They have each lasted around 90 minutes and been held at a range of different times, days and on different platforms so people can choose the one that suits them best. Where numbers attending have been only one or two, the session has been run as a structured interview and has taken the full 90 minutes. The focus groups have been promoted via a range of methods, including distribution via Harrow CCG and Healthwatch Harrow.
- **Please note, we are part way through the focus group and the sample size for Harrow residents is currently small.**
- Generally patients across all areas agree there is a need to make changes to the Mount Vernon Cancer Centre
- Harrow has relatively good cancer outcomes compared with other areas – according to 2016 ONS data published by Harrow CCG, one year survival rates are better than the English average, and the third best across all London CCGs. This is reflected in feedback from patients and local people who tell us that their experiences have been good.
- The Harrow patients we have spoken to have told us that they have good access to Mount Vernon as well as to other hospitals where they either do, or could, have cancer treatment. They understand the need to make changes to Mount Vernon and generally prefer the idea of a large single site cancer centre which can do the things the Mount Vernon Cancer Centre currently cannot do due to limitations of the site. Access to research trials is a significant factor amongst Harrow residents.

What Harrow patients have told us

- Harrow residents' main concern has been the location of the new hospital given the size of the population it serves and the distance people have to travel. When looking at the map of the catchment Mount Vernon serves, and the travelling times for some patients from outside North West London, they feel that a case could be made to move the centre further North, but are worried about how they would then access the service. Luton in particular has been mentioned a few times as an area of concern. However, Watford seems to be more acceptable because it is the closest acute hospital to the existing site and importantly for the Harrow patients, is still part of the London transport system.
- Patients who have taken part in the focus groups from Harrow and other parts of North West London are less likely to drive than those from areas such as Hertfordshire and rely heavily on public transport. Public transport in areas such as Hertfordshire is poor, particularly from East to West, and so those residents need to be able to drive or else rely on long patient transport journeys.
- If the centre was moved North, Harrow residents would like to see improved access to services that could be delivered locally, such as chemotherapy, and depending on where the centre was, radiotherapy. They also expressed that there were other cancer hospitals they could reasonably easily get to for treatment they receive at Mount Vernon, and would be likely to do so if they felt they couldn't easily access the new Mount Vernon Cancer Centre.
- In contrast, residents of Hertfordshire have told us about journey times of an hour and a half to five hours because of poor transport infrastructure, and Luton has the poorest cancer outcomes of the area Mount Vernon serves. There are no other cancer hospitals in easy reach for these patients. These residents are used to their travelling times and are more likely to accept them as being 'normal' for expert care.
- Harrow residents have been positive about the staff at Mount Vernon, saying it is like a family and it is nice to recognise people. They have expressed concerns that moving between different hospitals often means patient notes or test results are not available at the place they are needed and in general would prefer a single cancer centre option to keep the team together and improve communication.
- Harrow residents have not expressed a preference for a site they would find most acceptable. However, in addition to comments about Luton and sites further away being too inaccessible, they have expressed doubts about Northwick Park or Hillingdon being the right site to due to issues such as the capacity of the sites, access, and with Hillingdon, other priorities of the hospital.

What is happening now?

- Discussions / workshops with each health system (x 6 – Hertfordshire and West Essex; North West London; Bedford, Luton and Milton Keynes; North Central London; Frimley Health and Care; Buckinghamshire, Oxfordshire and Berkshire West)
- More detailed analysis of travel times
- Patient Engagement programme
  - 5 x General Update Events, 30 x Patient Focus Groups, 4 x Feedback workshops
  - Survey – paper based and online (October and November)
  - Launch of interactive website using animations, polls, stories etc. (November)
  - Patient Reference Group to work with Clinical Working Group. Patient representatives nominated by all Healthwatch and Cancer Alliances (December) – Harrow has 2.
  - Work with Learning Disability and Autism Groups (November – December)
  - Work with specific community groups in areas, including Harrow.
  - Non- digital programme of engagement developed with Healthwatch, including marginalised and disadvantaged communities (November and December)
  - Staff engagement (October and November)

What happens next?

- The independent clinical team recommended two different models for future Mount Vernon cancer services.
- Feedback from the staff and patient events will be discussed by the clinicians who are looking at the future clinical model of the services – this includes whether there is a single new cancer centre, or whether there is also a day hospital (ambulatory centre) on a second site, or even if there is a variation of one of those.
- There are pros and cons of both options and the feedback from patients and staff will help the clinical team work out which is the best model to plan services from.
- The clinical team is going to make a recommendation in December. They are not looking at the location of the services.

What happens next?

- The clinical team will also start to think about whether any individual pathways would benefit from changes to improve outcomes and experiences for patients. Pathways are the way patients access treatment for different cancers from the moment they are referred to Mount Vernon to the end of their treatment and follow-up.
- The independent clinical team said that many of the services needed to be on a main hospital site that had intensive care and other facilities. In December the programme board will agree which hospitals within the existing area that patients come from will be considered. To be considered, hospitals will need to have the right facilities, space for a cancer centre to be built, and not make travel times worse for patients.
- From January, more detailed work will take place to develop detailed proposal for all the hospital sites that are shortlisted, and on the clinical model, to come up with a preferred option or options. We expect we will run a public consultation in June next year.

Timescale

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October – December 2020	• Patient, public and staff engagement • Patient Reference Group
December 2020	• Options for the clinical model developed • Shortlist of site options agreed (based on geographical access for patients, and clinical criteria)
March 2021	• Shortlisted options developed in full and tested against criteria agreed by the Programme Board after patient and public input into the criteria, to create a preferred option / options
April 2021	•UCLH Board decision on transfer
May 2021	• Assessment of plans
June 2021	• Likely date for public consultation to begin
October 2021	• Earliest decision on outcome of business case and public consultation
November 2021	• Planning for new cancer centre begins
April 2022	• UCLH takes on responsibility for the management of the service at MVCC (subject to April 2021 Board approval)

Our biggest challenges

- Making sure we can find the money that we will need to build the new hospital
- Making sure we understand the future cancer needs of all the areas the cancer centre covers and come up with the right plan for patients
- Making sure we hear from a wide range of patients and carers with different experiences of Mount Vernon Cancer Centre and from different areas, especially as we cannot meet face to face

Some questions we have been asked…

- Is this a foregone conclusion?
  - No – the Programme Board honestly do not know what the recommendations will be in December and in March. Logically it makes sense that moving the hospital a long way will not be an option.
- Given no other review has resulted in change, will this really happen?
  - Yes – as long as we can get together the capital money we will need.
- Will the transfer to UCLH mean the service is moving to Central London?
  - Definitely not. There are no plans to move any patients to Central London unless they would need to go there anyway. In fact, UCLH would like to explore the possibility of some patients currently being treated in central London, being treated at Mount Vernon instead, if the right clinical facilities were available.
  - It is more cost effective to build a new hospital than bring the current buildings up to the right standard. And improving the current buildings will not deal with the clinical issues on the site.
- Why can't intensive care services come on to the existing Mount Vernon site?
  - Mount Vernon needs access to intensive care beds, but not too many. To build such a small intensive care unit would not be safe. It would be extremely difficult to staff and it would be very expensive to run which would divert resources from elsewhere.

Find out more

- https://mvccreview.nhs.uk/

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Your Questions

- Thank you for your time. Over to you.

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Report for: Health and Social Care Scrutiny Sub-Committee

Date of Meeting:	19 November 2020
Subject:	Update from NW London Joint Health Overview and Scrutiny Committee
Responsible Officer:	Alex Dewsnap, Director of Strategy & Partnerships
Scrutiny Lead Member area:	Health: Policy Lead – Councillor Michael Borio Performance Lead – Councillor Vina Mithani
Exempt:	No
Wards affected:	All
Enclosures:	None

Section 1 – Summary and Recommendations

This report provides an update on discussions held at the meeting of the NW London Joint Health Overview and Scrutiny Committee (JHOSC) on 7 September 2020.

Recommendations:
The Sub Committee is asked to consider the update and provide any comments / issues that are to be raised through the JHOSC by Harrow's representatives.

Section 2 – Report

Background
The North West London Joint Health Overview and Scrutiny Committee (JHOSC) comprises elected members drawn from the boroughs geographically covered by the NHS NW London Shaping a Healthier Future (SaHF) programme and was set up to consider the proposals and consultation process formally between the period of 2 July and 8 October 2012. The proposals set out the reconfiguration of the accident and emergency provision in North West London. This included changes to emergency maternity and paediatric care with clear implications for out-of-hospital care.

The JHOSC published its final report in October 2012, making recommendations on how the SaHF proposals could be developed and implemented, including the risks that needed to be explored. The JHOSC also recommended that the committee continue to meet beyond the original consultation period to provide ongoing strategic scrutiny of the development and implementation of Shaping a Healthier Future.

Harrow's ongoing participation in the JHOSC examining the implementation of the SaHF ensures that scrutiny of the issues is maintained at a regional level and that Harrow residents' perspectives are put forward to the NHS as it implements the SaHF programme. The Health and Social Care Scrutiny Sub Committee receives regular update reports on the JHOSC so that it can pick up any local issues in its own work programme as well as feed into the JHOSC's agenda planning and deliberations. Harrow's member representatives on the JHOSC for 2019/20 are Councillors Rekha Shah and Vina Mithani.

On 26 March 2019, the Secretary of State for Health announced the closing down of the Shaping a Healthier Future programme. In a letter dated 26 March 2019, the NW London Collaboration of CCGs confirmed the decision and stated:

> *"All parts of the NHS are now in agreement to draw the SaHF programme to a conclusion and bring our on-going efforts to improve health and care together in a new programme as part of our NHS Long Term Plan response. We will not be taking forward the plans as set out in SaHF for changes to Ealing and Charing Cross hospitals, but this does not mean that services across NW London will not change…We want to work with local people, communities and organisations to develop this new plan for NW London, which ensures high quality care for all our residents. We think it should include continuing our expansion of primary and community services and the development of more integrated care. We are also clear that services will need to be configured in such a way as to build a health system that is both clinically and financially sustainable. If we are to improve care and outcomes for local residents, we know that the status quo is not an option. This new plan for health and care in NW London will therefore still need to include changes, involving some difficult decisions and trade-offs, if we are to offer high quality, person-centred care sustainably. By realigning under the NHS Long Term Plan, updating our planning assumptions and enabling all of our staff, patients, partners and*

stakeholders to be involved in its development and delivery over time, we will have the best possible chance of success."

The terms of reference for the JHOSC were revised to reflect the closure of the Shaping a Healthier Future programme.

JHOSC meeting 7 September 2020
The last JHOSC meeting held on 7 September 2020 was a virtual meeting hosted by the London Borough of Hammersmith & Fulham. The meeting was attended, for part, by Councillor Vina Mithani. The agenda for this meeting included a single item:

NW London Collaborative: The Case for Change for a Single CCG – the JHOSC discussed the proposed merger plans and the expected outcomes. Following stakeholder engagement throughout 2019, the NW London Collaborative of CCGs had proposed to merge the 8 CCGs in NW London to a single CCG. The rationale for this was that it would allow the local NHS to:

1. Reduce duplication in ways of working, allowing more time and money to be put into patient services.
2. Work more effectively with both NHS and local authority service providers to improve patient wellbeing and care, with improved quality and consistency of local health and care services.
3. React quickly and consistently to the continuing pandemic and recovery.
4. Support delivery of the ICS vision.

In terms of governance, each borough will retain a CCG borough committee, which will work with the local borough's Health and Wellbeing Board and Integrated Care Partnership.

The JHOSC meeting on 8 October was postponed given the stretch on NHS capacity in dealing with the ongoing Covid-19 pandemic. It has subsequently also been agreed not to hold any formal JHOSC meetings until 2021 and instead ask the NWL Collaboration of CCGs for answers to written questions from the JHOSC. These questions will be provided to the NHS in mid-November for response. Questions include hospital capacity to manage the impact of a second wave in the Covid-19 pandemic and the impact on local communities, including any lessons learnt from the first wave and any disproportionate impact on BAME communities in NW London.

Ward Councillors' comments
Not applicable as report relates to all wards.

Financial Implications
There are no financial issues associated with this report.

Performance Issues
There are no performance issues associated with this report.

Environmental Impact
There is no environmental impact associated with this report.

Risk Management Implications
There are no risk management implications associated with this report.

Equalities implications / Public Sector Equality Duty
An Equalities Impact Assessment has not been undertaken for this report as it summarises the activities of the JHOSC and does not propose any changes to service delivery.

Council Priorities
The work of the JHOSC relates most to the delivery of the council priority to:

- Addressing health and social care inequality

Section 3 - Statutory Officer Clearance
Not required for this report.

Mandatory Checks

Ward Councillors notified: No, as it impacts on all wards

Section 4 - Contact Details and Background Papers

Contact: Nahreen Matlib, Senior Policy Officer,
nahreen.matlib@harrow.gov.uk

Background Papers: None