London Borough of Hammersmith & Fulham

Housing, Health And Adult Social Care Select Committee

Minutes

Tuesday 17 July 2012

PRESENT

Committee members: Councillors Lucy Ivimy (Chairman), Joe Carlebach, Stephen Cowan, Peter Graham, Steve Hamilton, Peter Tobias and Rory Vaughan (Vice-Chairman)

Co-opted members: Maria Brenton (HAFAD)

Other Councillors: Marcus Ginn and Andrew Johnson

Officers: Mike England (Director Housing Options, Skills & Economic Development), Aaron Cahill (Head of Housing Assessments) and Sue Perrin (Committee Co-ordinator)

Central London Community Healthcare: Anne Barnard (Vice-chair) and James Reilly (Chief Executive)

NHS North West London: Daniel Elkeles (Director of Strategy), Dr Susan LaBrooy (Medical Director, Hillingdon Hospital), Dr Mark Spencer (Medical Director) and Dr Tim Spicer (Chairman, Hammersmith & Fulham Clinical Care Commissioning Group)

1. MINUTES AND ACTIONS

RESOLVED THAT:

The minutes of the meeting held on 17 April 2012 be approved and signed as an accurate record of the proceedings.

2. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Iain Coleman and Oliver Craig.

3. DECLARATIONS OF INTEREST

Councillor Carlebach declared a personal interest in respect of item 11, 'Housing Strategy Consultation', in that he had been a member of the Cabinet at the time the draft strategy had been approved, and remained at the meeting but did not vote.

4. MEMBERSHIP AND TERMS OF REFERENCE

RESOLVED THAT:

The committee's membership and terms of reference as agreed at the Annual Meeting of the Council on 30 May 2012 be noted.

5. APPOINTMENT OF CO-OPTED MEMBERS

RESOLVED THAT:

Maria Brenton, Chair of HAFAD, be appointed as a co-opted member for the 2012/2013 municipal year.

6. APPOINTMENT OF VICE-CHAIRMAN

RESOLVED THAT:

Councillor Rory Vaughan be appointed as Vice-chairman of the committee.

7. CENTRAL LONDON COMMUNITY HEALTHCARE NHS TRUST: APPLICATION FOR FOUNDATION TRUST STATUS

Mr James Reilly and Ms Anne Barnard presented the application by Central London Community Healthcare NHS Trust (CLCH) to achieve NHS Foundation Trust status in September 2013.

NHS trusts either had to achieve Foundation Trust status by April 2014 or merge with another trust which had already achieved Foundation Trust status. CLCH considered that it was of benefit to the local community to remain focused as a community organisation working in partnership with other organisations to provide integrated social and health care, rather than becoming part of a larger organisation.

Foundations trusts have a membership, comprising local people, patients and employees which elects a Council of Governors. This means that foundation trusts are more accountable to the people who use its services, its staff and local communities. They are able to be more innovative in developing their services and responding to the changing healthcare needs of their local communities. They have greater autonomy and freedoms, and specifically greater financial flexibility to invest any surpluses in existing services or to develop new services, rather than returning surpluses to the NHS.

Foundation trusts are regulated by Monitor, the independent regulator, and are responsible to the Secretary of State. There is a rigorous authorisation process, which takes over a year, in which trusts have to demonstrate governance and financial capabilities as well as the capability to deliver clinical effectiveness.

In response to members' questions Mr Reilly confirmed that CLCH was on schedule with its application, with only a five/six week delay in respect of the consultation because of the mayoral elections. The trust had considered the alternative of merging with another trust, but this would mean merging with an organisation providing hospital or mental health services, and losing the ability to focus purely on community healthcare. There had also been the option of forming a social enterprise structure. However, staff had indicated a clear preference for remaining within the NHS.

CLCH's application had been discussed with the North West London cluster and a formal agreement reached with the Strategic Health Authority and the Department of Health, which had to be satisfied that the programme was realistic and to sign off key milestones.

In addition to the statutory consultation with overview and scrutiny committees, there had been a series of public events, but these had not been well attended. Six people had attended the Hammersmith & Fulham event and attendances were similar for other events. There had been a number of outreach events, where patients had been interviewed at centres, where they were using the services. There had been a substantial mail out of the consultation document and 130 responses had been received to date. The benchmark figure for consultations of a similar size was 150.

In response to questions in respect of finance, Mr Reilly stated that CLCH had a £190million turnover, compared with an NHS average of £300 million. Some £36 million was in respect of provision of services to Hammersmith & Fulham residents. CLCH was required to achieve savings of 5%. A cost improvement programme was on target to deliver 5.6% (£10 million). In the previous year, CLCH had achieved a small surplus and had achieved its budget every year since becoming a trust, with a surplus of £8 million over this period.

Savings had been achieved primarily from overheads. There had been a management restructure, with the elimination of 70 management posts across the organisation. CLCH was looking to make further savings without impacting on direct patient care through information technology to increase productivity and reviews of administration and clerical support and the estate Mr Reilly stated that CLCH was working towards an integrated seamless approach to patient care and offered to attend a future meeting to discuss.

RESOLVED THAT:

The committee noted the application.

The committee then voted on supporting the application.

In favour: 5

Abstain: 2

RESOLVED THAT:

The committee supported the application.

8. SHAPING A HEALTHIER FUTURE: NHS PUBLIC CONSULTATION

NHS North West London briefly updated the committee on the hospital reconfiguration and the consultation which would end on 8 October 2012. The summary consultation document had been circulated in local newspapers and a flyer delivered to local households. A series of consultation roadshow events would be held, with events being held in Hammersmith & Fulham on 28 July and 19 September.

The Joint Health Overview & Scrutiny Committee, comprising seven of the North West London boroughs (Hillingdon was not participating) and the London Boroughs of Camden, Richmond and Wandsworth, which considered that the reconfiguration proposals would substantially impact on their residents, had met formally on 12 July and had agreed dates for four further meetings.

Members queried the underlying assumptions in the pre-consultation business case in respect of population predictions. Mr Elkeles responded that population figures were taken from the 2001 Census and the ONS predictions and the GLA growth rate for each borough. The predictions would be reviewed in line with the 2011 Census figures, which had just been released.

Members queried travel times and whether a risk analysis had been undertaken in respect of traffic jams. Dr Spencer responded that the travel times were based on a LAS review of travel times to stroke units. Data had been provided for both peak and off-peak times and for each of the service reconfiguration options. The data had been reviewed once and the results of a second review by a specialist travel firm would be available by the end of the consultation.

Councillor Cowan queried whether risk analysis had been undertaken in respect of a patient dying in an ambulance. Mr Elkeles responded that the maximum journey time was not materially different under the re-configuration options.

Councillor Ivimy suggested that a patient might be saved by a 20 minute ambulance journey, but die on route with a 40 minute journey. Dr Spencer responded that patients were stabilised within the ambulance, and there were only a small number of deaths. Dr LaBrooy added that a number of people who died in hospital could have been saved if moved quicker to another

hospital. There was evidence that time spent in an ambulance was less important than being taken to the right place.

Action:

Information to be provided in respect of:

(a) deaths during ambulance journeys; and
(b) the types of Accident & Emergency cases where travel times are critical.

Action: NHS NWL

Members suggested that the proposals were based on the requirement to make savings to fund increased demand. NHS NWL responded by referring to the workforce challenges particularly in paediatrics and obstetrics, and the shortage of consultants to maintain rosters and quality in existing services. A Clinical Review working group had been established in November 2011 to make recommendations on how to maintain quality in line with the financial and workforce problems.

Councillor Graham referred to the Secretary of State's four tests and queried whether the proposals, which would leave Hammersmith without an Accident & Emergency Department, had the full backing of GPs. Dr Spicer responded that the proposals had the full support of the Clinical Commissioning Group (CCG), which had developed the Out of Hospital aspects (OOH)

Dr Spicer responded to a query in respect of whether the CCG was representative of GPs in the borough that there was a spectrum of opinion amongst GPs. Dr Spencer added that the CCG in Ealing had unanimously voted to support the proposals. The role of the CCG was to reflect opinion, hold discussions with members and take decisions. There had been genuine patient engagement

Mr Elkeles clarified his comment in respect of petitions which had been reported in the press, He considered that petitions had limited impact when compared with a reasoned opinion, but would be taken into account.

Members queried whether Chelsea and Westminster Hospital had the capacity to cope with additional patients. Mr Elkeles responded that the proposals required an additional 80/100 beds. Chelsea and Westminster was a well designed site and it was practical to provide this additional capacity. The capital cost of moving Chelsea and Westminster facilities to Charing Cross was considerably more.

Members queried why surgeons did not move to different sites, rather than patients moving. NHS NWL responded that: premises costs were extremely high; if surgeons moved between sites, care would be compromised and guidance from the Royal College breached; and it was easier to move a patient that a surgical team.

Councillor Ivimy suggested that Charing Cross and Chelsea and Westminster should be a split site major hospital, with Chelsea and Westminster retaining paediatrics and an adult focus at Charing Cross. Dr LaBrooy responded that both sites would require a full range of diagnostic services to back up the emergency departments. Hammersmith Hospital, for example, would remain a major specialist hospital and retain full support for Obstetrics.

Mr Elkeles confirmed that savings of £1.6billion were required. Professional site values had been obtained for all North West London sites. Should the sites be sold, there could be significant variation in the market value, depending on the developments plans. NHS NWL had taken prudent values.

In response to questions in respect of how developments at Charing Cross would be progressed, Mr Elkeles stated that, should a new local hospital be built on the Charing Cross site, the square footage required would be retained and the remainder of the site released. The current gym area was given as an example of where this could be sited.

Councillor Cowan queried the importance of the £1.6billion savings. Dr Spencer responded that the clinical case for change had been developed first and the financial model afterwards. Mr Elkeles added that whilst NHS funding had increased, demand had grown faster and therefore delivery of services in places other than expensive hospital sites had to be considered. Savings and better outcomes could be achieved by looking after patients in the community.

Councillor Tobias queried developments outside North West London and the pairing of Charing Cross and Chelsea and Westminster. Dr Spencer responded that there were similar changes across London. Dr LaBrooy stated that the NHS intended to implement good cover with five major hospitals and equal distribution across North West London. Travel times had determined that Hillingdon Hospital and Northwick Park should be designated major hospitals. Modelling of patient flows between two hospitals in pairs for the remaining six hospitals had demonstrated where patients would go should one of the hospitals no longer have an Accident & Emergency Department. All local hospitals would have an Urgent Care Centre and a range of services, which would differ.

Councillor Carlebach queried the continuance of medical research at Charing Cross in view of the likely site reduction. Dr Spencer responded that this decision would be taken by Imperial College Healthcare NHS Trust (ICHT) in conjunction with Imperial College. He was aware however that an Academic Health Science Partnership was being formed through Imperial College which would be a conglomerate of all hospitals within North West London and also providers of primary care. This would present opportunities for research on a large scale, rather than being dependent on local patient flows.

Dr Spencer responded to a question that ICHT clinicians were members of the Clinical Working Group and that the Chief Executive and senior staff were supportive of the proposals. Under Option A, £100million net land sales would be required to fund the capital development. Whilst receipts from land sales were normally returned to the NHS, should a sale be made specifically to

invest in local services, the capital would be made available to Charing Cross. Councillor Cowan commented that should the 'capital be made available', interest could be charged.

NHS NWL confirmed that should ICHT become a Foundation Trust it would retain the proceeds of the land sale.

NHS NWL estimated that three quarters of the £100 million would be met from land sales at Charing Cross. This was a prudent figure, based on land values concluded in March/April 2012. The commercial figure could be higher, depending on plans for the whole site.

Action:

NHS NW London to provide a breakdown by site of the 'backlog' maintenance figure of around £53 million.

Action: NHS NWL

Councillor Vaughan commented that the NHS was moving from a simple to a complicated three tier system and queried how the NHS would educate the public. Dr Spencer responded that the changes would be implemented over the following three/four years and public education would be supported by the new '111' number. Access currently was not a simple model; Accident & Emergency Departments were not standardised, but disparate services of which the public was not aware.

Mr Elkeles stated that all evidence presented to NHS NW London had been brought to the committee and presented by experts. In addition, all analysis had been put into the public domain.

Councillor Ginn considered that whilst there was a strong clinical case, the proposals were finance based. The Council would want to extrapolate the link and to stress test the figures to ensure that they were positive for Hammersmith & Fulham, not just part of London.

Action:

NHS NWL to provide a definitive list of all individuals involved in the decision making process and declarations of interest.

Action: NHS NWL

RECOMMENDED:

1. That NHS NW London be invited to the September meeting.
2. The committee endorsed the appointment of external consultants to analyse the underlying assumptions in the pre-consultation business case.

In accordance with paragraph 27 of the Overview and Scrutiny Procedure Rules, the Committee extended the meeting by 30 minutes.

9. IMPERIAL COLLEGE HEALTHCARE NHS TRUST

This item was taken before item eight.

The Chairman updated the committee on the joint scrutiny meeting with Kensington & Chelsea and Westminster health scrutiny committees, which she had attended with three members and the Cabinet Member. The Chief Executive and senior officers from Imperial College Healthcare NHS Trust (ICHT) updated members and answered questions in respect of performance failures and mis-management of waiting lists, including a reporting break.

Members were concerned about: the standard of communication and the delay in reporting the problem and informing GPs; the independence of the External Governance Review; and the lessons learned. Members remained concerned that clinical implications had not been resolved and patients might have suffered.

NHS NWL was asked to comment on the above discussion in respect of ICHT and specifically whether ICHT had the competence to take on such large complex changes. NHS NWL responded that there had been a clinical review of the medical records of all affected patients. 25 sets of records for cancer waiting list patients had not currently been verified. Those patients who had been identified, had not suffered harm, but their medical records or GP had not been identified. ICHT was still working to track the notes and GP and was scheduled to complete within the next two weeks.

The external governance review, which had first identified the cancer waiting list problems, had stated that ICHT had put in place systems and process to manage waiting lists. Whilst there was concern that it had been possible for these waiting list problems to arise, it was believed that a safer system was now in place. There was no evidence of overall management problems.

NHS NWL stated that the hospital reconfiguration would not impact on patient outcomes and that there would be greater clinical risk without the changes. The changes, which would be implemented by the Clinical Commissioning Groups, were supported by ICHT. They would result in a single organisation, as opposed to the complexity of managing three sites.

Councillor Ivimy queried whether it was ICHT's opinion that managing three sites was too difficult and whether this was one of the critical pieces of information, which had led to the proposals. NHS NWL responded that one major acute centre would provide better patient outcomes. ICHT's problems were related to different information systems across the three sites; there were now new informatics across the sites. The management of a multi-site was not an issue, but just part of the reason why ICHT supported the proposals.

RESOLVED THAT:

ICHT would be asked to attend the September meeting of the Hammersmith & Fulham health scrutiny committee.

Action: Committee Co-ordinator

10. HOUSING STRATEGY 2007-2014

This item was replaced by the supplementary agenda 'Housing Strategy Consultation', shown as item 11.

11. HOUSING STRATEGY CONSULTATION

Mike England presented the report which incorporated four documents providing a statement of the Council's intent in driving forward the housing agenda and 'Building a Housing Ladder of Opportunity'. The documents were consultation drafts of the Housing Strategy, Tenancy Strategy, Scheme of Allocation and Homelessness Strategy, which had been approved by Cabinet.

The draft Tenancy Strategy proposed fixed-term tenancies for new social housing letting, typically five years, but two years in cases such as special schemes for working households. This did not automatically mean that tenants at the end of their fixed tern tenancies would not be able to have their tenancies renewed. In addition, there were a number of exceptions where secure/assured tenancies would still be granted. The implementation of the Tenancy Strategy would not affect existing tenants housed by all registered providers, i.e. the Council in its landlord role and housing associations.

The new Scheme of Allocation would give greater priority to those who were working, those in training leading to employment and those making a significant contribution to the community. It proposed changes to the Housing Register to clarify who qualified for Housing and restricted access to the Register to those who had a reasonable chance of being re-housed. It was proposed to replace the Choice-Based Lettings system with a system of 'Assisted Choice'. More detailed information in respect of people's requirements would be collected, and applicants would be offered a number of options.

The draft Homelessness Strategy set out how the Council would meet its statutory obligations in providing services to vulnerable people, but also proposed the fundamental change of breaking the automatic link between a homelessness application and a social housing tenancy through using its prospective powers to discharge its duty in the private housing sector.

Mr England stated that the consultation period had been extended by one week to 25 July 2012. There had been consultation with key agencies responsible for approving and/or delivering the Housing strategy and also with homeless groups. The consultation document was available on both the Council and the locata websites.

In response to a question, Mr England stated that it was intended to make available a summary of the consultation submissions, and agreed to make available the submissions to the committee.

Action:

Consultation responses to be made available to the committee.

Action: Mike England

In response to a question, Mr England confirmed that the Accessible Register would be maintained.

Councillor Cowan commented on the 'Ladder of Opportunity' that even with the Government's discounts for eligible households, home ownership remained of high value.

Mr England referred to the Government's consultation 'High Income Social Tenants: Pay to Stay', which set out the proposals to give councils and housing associations new powers to charge social tenants a higher rent where the income of a sole occupier or the two highest earning individuals whose joint income was above a threshold to be determined. Full market rents would be applied to Higher Income Social Tenants, with an increase in rent to 80% of market value in the interim.

Members queried the approach which would be taken with a person whose circumstances changed from a low to a higher income. Mr England responded that an applicant(s) with an income of over £40,200 (the mid-point of the Council's current Homebuy Register income range) would generally not be eligible to access the Housing Register and would be offered advice on other housing options, including joining the Council's Homebuy Register. There would be a financial assessment at the time of the offer, and people who could not afford to buy would be directed towards the GLA scheme which allowed the purchase of slithers of equity in council property.

Mr England responded to a query that the Council was alert to housing purchase scams and there was no evidence of any current scams. Members proposed that tenants should be advised that if they were interested in buying a Council property they should seek advice from Council officers.

Mr England responded to queries in respect of the capacity to undertake the financial assessments, that Housing and Regeneration continued to redirect resources to the front line. These officers undertook the assessments of people's circumstances. Prior to this, officers would have discussed the person's aspirations.

Members expressed concern that applicants who improved their circumstances would be penalised under the new system. Mr England stated that whilst shared ownership would be discussed, people on modest incomes would not be forced out of their tenancy. There would not be an automatic link between a tenancy and an increase in income. However, the Council wished to create incentives for tenants to maintain their homes in good

condition, for example pay rent on time and avoid anti-social behaviour, and there might be occasions when a person was asked to move.

Councillor Cowan queried the position of military services personnel. Mr England responded that there was not a link between the entitlement to lower rent and the allocation scheme. Subsequent opportunities would depend on a re-assessment of the person's resources.

In response to questions, Mr England provided the following information:

- There were approximately 400/500 new council house lettings each year and 300/400 registered social landlord lettings, with a dramatic drop in the previous year because people were not moving on.
- 211 Right to Buy applications were in progress and two homes had been sold.
- 80/100 applicants were currently likely to obtain shared ownership. There were constraints in respect of: supply of schemes; and applicants with the necessary means. Hammersmith & Fulham residents would be given first priority.

Action:

1. A profile in respect of income bracket of people buying homes under The Right to Buy and those moving into Home Buy to be provided.

2. Plans to encourage and monitor targets for Home Buy to be made available.

Action: Mike England

RESOLVED THAT:

The committee noted the application.

The committee then voted on approving and welcoming the strategy.

In favour: 4

Abstain: 2

RESOLVED THAT:

The committee welcomed and approved the strategy.

12. TASK GROUP: REPAIRS & MAINTENANCE

The Committee received the proposed terms of reference and membership for a Task Group: Repairs & Maintenance.

RESOLVED THAT:

The Committee recommended to the Overview & Scrutiny Board the establishment of a Task Group: Repairs & Maintenance, with the attached terms of reference and membership.

13. WORK PROGRAMME AND FORWARD PLAN 2012-2013

RESOLVED THAT:

1. The work programme for 2012/2013 be noted.

2. A date would be set for a report on Transition from Children's to Adult Social Care.

14. DATES OF NEXT MEETINGS

24 September 2012
14 November 2012
22 January 2013
19 February 2013
09 April 2013

Meeting started: 7.00 pm
Meeting ended: 10.30 pm

Chairman .....

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