London Borough of Hammersmith & Fulham

Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Agenda

Monday 9 March 2015
7.00 pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

Administration:	Opposition	Co-optees
Councillor Rory Vaughan (Chair) Councillor Elaine Chumnery (Vice-Chair) Councillor Hannah Barlow	Councillor Andrew Brown Councillor Joe Carlebach	Patrick McVeigh, Action on Disability Bryan Naylor, Age UK Debbie Domb, HAFCAC

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Date Issued: 26 February 2015

London Borough of Hammersmith & Fulham

Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Agenda

9 March 2015

Item		Pages
1.	**MINUTES OF THE PREVIOUS MEETING**	1 - 16
	(a) To approve as an accurate record and the Chair to sign the minutes of the meeting of the Health, Adult Social Care and Social Inclusion PAC held on 4 February 2015.	
	(b) To note the outstanding actions.	
2.	**APOLOGIES FOR ABSENCE**	
3.	**DECLARATION OF INTEREST**	

If a Councillor has a disclosable pecuniary interest in a particular item, whether or not it is entered in the Authority's register of interests, or any other significant interest which they consider should be declared in the public interest, they should declare the existence and, unless it is a sensitive interest as defined in the Member Code of Conduct, the nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent.

At meetings where members of the public are allowed to be in attendance and speak, any Councillor with a disclosable pecuniary interest or other significant interest may also make representations, give evidence or answer questions about the matter. The Councillor must then withdraw immediately from the meeting before the matter is discussed and any vote taken.

Where Members of the public are not allowed to be in attendance and speak, then the Councillor with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration. Councillors who have declared other significant interests should also withdraw from the meeting if they consider their continued participation in the matter would not be reasonable in the circumstances and may give rise to a perception of a conflict of interest.

Councillors are not obliged to withdraw from the meeting where a dispensation to that effect has been obtained from the Audit, Pensions and Standards Committee.

4.	**CENTRAL LONDON COMMUNITY HEALTHCARE NHS TRUST: THE NEXT FIVE YEARS**	17 - 25

Central London Community Healthcare will present an outline of its strategy for the next five years and an update on the progress it is

making towards becoming an NHS foundation trust.

5. THE ROLE AND WORK OF HEALTHWATCH DIGNITY CHAMPIONS IN HAMMERSMITH OF FULHAM 26 - 38

This report updates the Committee on the Healthwatch Dignity Champions project in the London Borough of Hammersmith and Fulham.

6. PROGRESS AND 'GO LIVE' IMPLICATIONS OF THE CARE ACT IMPLEMENTATION PROGRAMME 39 - 45

This report updates on the ‘go live’ implications to prepare for the requirements of the Care Act 2014.

7. SELF-DIRECTED SUPPORT PROGRESS UPDATE 46 - 52

This report provides a progress update on Self-Directed Support (SDS), including the Personalisation project, through which an improved operating system for Direct Payments (DPs) is being developed across the three councils.

8. OVERVIEW OF THE PUBLIC HEALTH SERVICE FOR THE THREE BOROUGHS 53 - 66

This report describes both the mandatory and non-mandatory public health responsibilities, functions and services delivered in the London Borough of Hammersmith & Fulham.

9. WORK PROGRAMME 67 - 68

The Committee is asked to consider its work programme for the remainder of the municipal year.

10. DATE OF NEXT MEETING

April 2015: Date to be confirmed.

London Borough of Hammersmith & Fulham

Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Minutes

Wednesday 4 February 2015

PRESENT

Committee members: Councillors Rory Vaughan (Chair), Elaine Chumnery (Vice-chair), Hannah Barlow, Andrew Brown and Joe Carlebach

Co-opted members: Patrick McVeigh (Action on Disability) and Bryan Naylor (Age UK)

Other Councillors: Vivienne Lukey (Cabinet Member for Health & Adult Social Care), Sue Fennimore (Cabinet Member for Social Inclusion) and Sharon Holder (Lead Member for Health)

Care Quality Commission: Professor Edward Baker (Deputy Chief Inspector of Hospitals), Dr Sanjay Krishnamoorthy (Clinical Fellow to Professor Baker) and Owen Davies (Senior Parliamentary and Stakeholder Engagement Officer)

Imperial College Healthcare NHS Trust: Dr Tracy Batten (Chief Executive), Professor Chris Harrison (Medical Director) and Professor Janice Sigsworth (Director of Nursing)

Hammersmith & Fulham Clinical Commissioning Group: Clare Parker (Chief Officer), Dr Tim Spicer (Chair) and Dr Susan McGoldrick (Vice-chair)

Officers: Liz Bruce (Executive Director of Adult Social Care & Health) and Sue Perrin (Committee Co-ordinator)

50. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 20 January 2015 were approved as an accurate record and signed by the Chair.

51. APOLOGIES FOR ABSENCE

Apologies were received from Debbie Domb.

52. DECLARATION OF INTEREST

Councillor Carlebach declared an interest in that he is a trustee of Arthritis Research UK, the second biggest landholder on the Charing Cross site and a non-executive director of the Royal National Orthopaedic Hospital, Stanmore.

53. NORTH WEST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

The terms of reference for the North West London Joint Health Overview & Scrutiny Committee (JHOSC) were received.

RESOLVED THAT:

1. The Committee endorsed its decision made at the meeting on 22 July 2014 to appoint Councillor Vaughan as the voting member and Councillor Holder as the alternate member of the North West London JHOSC

2. The terms of reference were endorsed, subject to the inclusion of Councillor Holder's name in a final version.

54. IMPERIAL COLLEGE HEALTHCARE NHS TRUST: CQC REPORT AND ACTION PLAN

Professor Baker and Dr Krishnamoorthy presented an overview of the Care Quality Commission (CQC) inspection of Imperial College Healthcare NHS Trust (ICHT), which had taken place in September 2014.

The CQC's new approach focused on five key questions: Is the service safe, effective, caring, responsive and well-led? Eight core services had been identified for NHS acute trusts: A&E, Medical care (including frail elderly), Surgical care (including theatres), Critical care, Maternity and family planning, Children and young people, End of Life care and Outpatients (selected).

Each service was rated on each of the five key questions and overall. There was a four point scale: Outstanding, Good, Requires Improvement and Inadequate.

The overall trust rating for ICHT was Requires Improvement. The key questions in respect of Effective and Caring had been rated as Good.

The presentation provided the individual ratings for the four hospitals (St Mary's (SMH), Charing Cross (CXH), Hammersmith (HH) and Queen Charlotte and Chelsea, by key question and overall.

SMH urgent and emergency services had been rated as Requires Improvement with the key question 'well-led' being rated as Inadequate. There were issues in respect of leadership and cleanliness and infection control in the A&E department.

Outpatients and diagnostic imaging had been rated as Inadequate across the three sites.

Professor Baker commented on the rating of the five key questions:

- 'Safe' had been rated as Requires Improvement, and immediate steps had been taken to improve cleanliness.
- Clinical outcomes were generally very good, and 'effective' had been rated as Good.
- There was high quality compassionate care, and 'caring' had been rated as Good.
- 'Responsiveness' had been rated as Requires Improvement, with outpatients being the most challenging area, and specifically appointment delays and cancellations.
- 'Well led' had been rated as Requires Improvement. The CQC considered that ICHT had a history of unstable leadership and was impressed with the change in leadership, although this had not yet been embedded.

The CQC was impressed with ICHT's response to the report and the immediate action to address the issues and develop long term plans.

Professor Baker responded to Councillor Carlebach that the Western Eye Hospital provided specialist services and had not been inspected on this occasion.

Professor Baker responded to Mr Naylor that some services had not been rated in the Effective category because of a lack of evidence on which to report.

Mr McVeigh noted that at the November inspection, ICHT, despite making significant improvements since the main inspection in November, had still been rated as Requires Improvement for the Safe category.

Professor Baker confirmed that the new inspections of hospitals were significantly more rigorous. 60% of hospitals had been rated as Requires Improvement. The inspections presented evidence which gave staff more insight into how to improve services.

Councillor Chumnery queried the potential impact of the inspection, if it had been undertaken before the closure of HH A&E. Professor Baker responded that the inspections did not relate to any proposals to reconfigure services and were not intended to inform any other decisions.

Dr Batten, Professor Sigsworth and Professor Harrison presented the top line findings overall of the CQC inspection and ICHT's response and key action points. Whilst the report clearly set out ICHT's challenges, it also recognised the positive impact of work over the past year and highlighted the good care that was being provided.

Councillor Brown queried whether ICHT had been disappointed with the results and whether they had been brought about by ICHT concentrating on ground breaking work at the expense of the basic aspects of healthcare. Professor Harrison responded that the Good rating achieved in the Caring category illustrated how doctors and nurses put effort into a caring service for local people, in addition to providing a specialist service for a much wider area.

Councillor Brown queried whether ICHT being spread over a number of sites was a contributory factor and how could the committee be re-assured that the leadership would continue to bring about improvements.

Dr Batten responded that ICHT was a complex organisation, spread over five sites, with some 10,000 staff. ICHT provided an extensive range of services and there were in the region of one million patients a year. The CQC inspection was the first time that there had been a comprehensive review of the quality of services delivered. The report was extremely constructive, and the feedback had been shared in an open forum with all staff. Although the overall rating was disappointing, there was optimism amongst staff. The changes to the executive team would ensure clear lines of accountability and robust clinical governance and would be embedded, going forward. Further to the merger of two trusts in 2007, there was still not consistency of policy and practices across the sites.

Mr Naylor queried the involvement of other organisations and patient groups in providing information and correcting the issues. Dr Baker responded that as part of the preparation for the visit, information had been sought from a wide range of groups. The visit would have been planned to target issues raised.

A list of groups consulted to be provided.

Action: Care Quality Commission

Professor Sigsworth stated that ICHT received quite a lot of help from independent groups, for example in the mini mock inspections of cancer services at CXH and frail elderly services at HH. There had been patient led inspections of cleanliness. ICHT involved both staff and non-employees. Going forward, ICHT would invite much more input from patient and public bodies and peer scrutiny, as part of mock inspections to ensure that the action plan was implemented. ICHT liaised with GP commissioners and Healthwatch, but there would only be small numbers from each borough.

Mr Naylor queried if this input had been shown in the action plan. Professor Sigsworth responded that the outcomes of the Quality Summit had been quite detailed to show that ICHT had taken seriously the feedback from stakeholders.

Councillor Vaughan queried how ICHT took into account the range of opinion from other organisations and patients in continuing to monitor and develop services; and how ICHT planned to embed this into the process going forward and capture in its culture. Professor Sigsworth responded that ICHT would adopt a similar approach to the CQC in a series of its own inspections, looking at areas in a more systematic way. Data from patients, Healthwatch, PALS and complaints would be cross referenced. ICHT would work with its internal audit to develop a framework to deliver the CQC's standards.

Councillor Vaughan queried the role of the Trust Board. Members were informed that the Board's Quality Committee monitored in depth how the Action Plan was being implemented across the organisation. A patient attended every Board meeting to talk about their experiences of care. This item was at the beginning of the agenda so that it fed into the remainder of the Board, and specifically performance and monitoring targets.

In addition, ICHT was really listening to staff about what it was like on the ground. Board members and senior managers were going out around the trust, and were able to demonstrate what they had seen and found.

Councillor Barlow queried whether ICHT had put in place measures to ensure that it met the CQC's requirements and whether it knew what it would have to achieve for the next CQC inspection. Professor Sigsworth responded that the Mid Staffordshire Inquiry and the Francis Report had impacted on the level of rigour adopted by the CQC. There had been a big change very quickly and ICHT had to redouble its efforts in a number of areas and services. Whilst there were not national quality requirements, the CQC had been clear in what it expected and it was clear what ICHT needed to do.

Professor Baker stated that the CQC had not identified new standards. It identified standards which a hospital needed to apply consistently and reliably. A hospital needed to be realistic about where it was and what it needed to do to improve. Requires Improvement did not mean that it was a failing hospital, but that it needed to deliver the identified changes.

Mrs Bruce queried the top line findings overall in respect of not meeting the target for sending out appointment letters to patients within ten working days of receiving the GP referral; and shortfalls in how the needs of people with dementia and learning disabilities were considered.

Professor Sigsworth responded that, in respect of people with dementia and learning disabilities, the issue related to inconsistencies in staff responses, rather than interaction with patients. More work was required on environmental issues, particularly A&E which could be unsettling for these patients.

Dr Batten responded that the Action Plan addressed the problems associated with the administration of appointments which were leading to unnecessary delays and indicated the work across each of the sites. There were a number of different ways in which patients could access Outpatients; phase 2 would establish a single point of access. There had been some quick wins, for example standardisation of the appointments letter and sending out letters in a more timely manner. A new patient administration system had been implemented in April 2014; technical support to Outpatients was being expanded to improve the check-in and booking function locally and achieve consistency every time on each site.

Councillor Lukey requested that she and Mrs Bruce be sent the work with the joint forum on improving the pathways for people with learning disabilities and dementia. Councillor Lukey stated that the Council would like to support this work. Professor Sigsworth responded that there was still an opportunity to refine and strengthen the action plan.

Action: Imperial College Healthcare NHS Trust

Councillor Fennimore requested more information in respect of available languages. Professor Sigsworth responded that ICHT provided interpreters. However, this could be difficult to co-ordinate and the service was often provided by telephone.

Action: Imperial College Healthcare NHS Trust

Councillor Chumnery queried the action point in respect of registrars not always available out of hours on the ICU at CXH and cover being provided by junior doctors, none of whom had the required skills on that particular evening. Professor Harrison responded that ICHT had addressed the issue as part of the review of critical care service to ensure that skills were available across the site, but this had not been in place at the time of the CQC inspection.

Councillor Chumnery queried the issues with the storage of medicines at the correct temperature in refrigerators. Professor Sigsworth responded that a twice monthly audit of some 200 refrigerators was now undertaken.

Councillor Holder suggested that negative feedback should have been included in the presentation, in addition to the positive feedback.

Councillor Fennimore queried how much of the report had been a surprise. Dr Batten responded that her presentation to the CQC before the inspection, had highlighted the areas which had a body of work in train, but this had not been embedded across the organisation. The report was therefore not entirely a surprise. ICHT would work towards all areas being rated Good and ultimately Outstanding across all domains of quality.

Mr Naylor queried the priorities and their outcome and timescale for older people, who often presented in Outpatients with a number of chronic conditions. Dr Batten responded that the Action Plan included: the reduction

of clinical cancellations at short notice to an absolute minimum; the reduction of patients who did not attend; support to doctors to arrive at clinics on time; review of bookings and timeslots; and improvements in correspondence with patients and GPs. ICHT would provide a joined up, less fragmented service.

Mr Naylor noted that transport was a common issue for older people.

A member of the public queried whether ICHT was building a relationship with the London Ambulance Service (LAS) and working to reduce spikes and the pressure on the LAS. Dr Batten responded that ICHT was particularly focused on 'off- loading', the time from which the ambulance arrived at the front door and ICHT received the patient and became the carer. In general, good times were achieved, enabling the LAS to get back on to the road quickly. ICHT aimed to smooth its demand and daily meetings were held across the sector. The data would be shared with the PAC.

Action: Imperial College Healthcare NHS Trust

A member of the public commented on the death rate figures across the country, published earlier that day, and queried the impact of the Stroke Unit moving out of CXH. Professor Harrison responded that ICHT morbidity rates were amongst the best in the country. In addition, Public Health had a role in supporting people to live healthier lives, and ICHT had a role to play in working with GPs, Public Health and Public Health England.

Dr Batten stated that it had always been intended to co-locate the Stroke Unit with the Major Trauma Unit at SMH, and there was a strategy for its relocation.

Councillor Vaughan queried whether IT in the Outpatients Department was actually working, and if there were plans to improve or replace. Dr Batten responded that a Cerner Patient Administration System (PAS) had been implemented in all Outpatients Department across ICHT in April 2014. Data quality was being monitored closely and was being tracked at Executive and Trust Board meetings. All data had been brought back to the levels recorded prior to go live of the Cerner PAS. The next step would be the roll out of clinical documentation, which was currently being piloted, together with electronic prescribing, at which point there would be greater benefits and efficiencies from the system. The implementation of the Cerner modules for theatre management and for the emergency department was on track to go live in early March.

Dr Batten responded to Councillor Brown that ICHT was working towards sending letters by e-mail. This opportunity would become available with one of the PAS modules. ICHT was also looking at good practice in other organisations. There were still some legacy systems in some Outpatient areas.

Councillor Vaughan asked for confirmation that the cleanliness issues identified by the CQC had been addressed. Professor Sigsworth responded that the CQC's finding that cleanliness in SMH A&E had not been acceptable,

related to the A&E cubicles not being cleaned in the way which they needed to be. The clinical schedule had been reviewed and processes improved to ensure equipment was always cleaned thoroughly and maintained to the required standards. Each cubicle now had an A4 checklist for completion with every patient coming in and going out. ICHT had worked through the cleaning pathway and clarified responsibilities and talked though in detail with staff.

Professor Baker responded to Councillor Carlebach that the CQC had inspected all services provided by ICHT, even if a joint venture but not services run by other providers. The Urgent Care Centres at CXH and HH were commissioned by H&F CCG, but run by ICHT and a local out of hours provider.

Councillor Vaughan queried whether the Action Plan to reduce nursing vacancy rates was adequate to provide cover by various grades. Professor Sigsworth responded that staffing levels were a nationally mandated process, with reports being submitted to the Quality Committee and Trust Board twice a year. ICHT was confident that the level was adequate. Currently levels were benchmarked across London. However, there could be an influx of trained nursing staff leaving the trust. Ideally, cover would be provided through ICHT's bank staff. Increasingly, less nurses were being employed through agencies. At the time of the CQC visit, there had been a high vacancy rate and a request for bank staff had not been filled.

The Action Plan included a focus on attracting student nurses into junior grade jobs and recruitment of experienced nurses. ICHT had a pool of nurse educators and specialist nurses who could be called upon to cover vacancies.

Professor Sigsworth stated that no beds had been closed as a consequence of the vacancies and confirmed that, should ICHT consider that staffing levels were not adequate, beds would be closed.

Professor Sigsworth stated that ICHT was confident that the Action Plan would achieve the CCG vacancy rate target of 5%.

Councillor Vaughan thanked the CQC and ICHT for attending and summarised the key points:

1. The committee shared ICHT's disappointment with the outcome of the CQC inspection.
2. There were some basic areas of cleanliness upon which ICHT needed to improve.
3. ICHT needed to build the feedback from patients, peers and other organisations. into its review of systems and decision making process.
4. The CQC was impressed with the current leadership, and the committee hoped that the CQC would continue to reach the same judgement in a year's time.
5. The committee requested that an update on the Outpatients PAS be brought back to a future meeting.
6. The committee requested that ICHT provided assurance to a future meeting that the progress in respect of cleanliness had been sustained.

55. IMPERIAL COLLEGE HEALTHCARE NHS TRUST: ACCIDENT & EMERGENCY DEPARTMENT WAITING TIMES

Dr Batten stated that whilst there had been some improvement in A&E performance, ICHT was still not achieving the national target of 95% of patients waiting four hours or less. An Action Plan was in place to systematically improve key areas in order to achieve and sustain the 95%, focusing on: the management of patients within the A&E department; the admission process; working closely with partners to streamline the discharge process so that patients could be discharged home or to supported care in the community as soon as they were ready; moving forward the discharge time for inpatients to before the peak in A&E attendances; and delayed transfers.

Councillor Holder queried if there was any reason why SMH rates improved and CXH worsened at the time of the CQC visit. Dr Batten responded that the two departments were run separately, and the reasons for changes in performance would be different underlying causes.

Further measures to increase capacity were being put in place. At SMH, extra space was being created for more serious emergency cases by moving the UCC treatment rooms out of the middle of A&E to a new unit nearby. In addition, there were more senior staff and clinicians working until later times. Additional capacity at CXH would be in place by late February.

Councillor Chumnery queried how ICHT intended to manage seasonal trends with the current low level of resources. Dr Batten responded that the recruitment process for further additional consultants had already commenced. An action plan was in place to sustain performance. Until recently, ICHT has consistently achieved good performance of 94%. In the last few months, there had been greater volatility of attendances and acuteness. The low spikes at CXH corresponded with the virus outbreak, at which time beds had been closed.

Councillor Barlow queried why some domains has been rated Good when targets had been missed. ICHT was unable to respond in respect of the CQC rating system.

Councillor Lukey queried whether ICHT had conveyed the problems to people in higher levels of the NHS. Dr Batten responded that ICHT felt extremely well supported by the NHS Trust Development Authority, the CCGs and NHSE.

ICHT was working with the CCGs to provide more appropriate care in more appropriate settings.

Councillor Vaughan concluded the discussion, stating that the committee welcomed the re-assurance that ICHT was working to achieve and sustain the 95% target. It would be helpful for the committee to be provided with the statistics on a monthly basis.

Action: Imperial College Healthcare NHS Trust

56. SHAPING A HEALTHIER FUTURE

Dr Tim Spicer updated on the current position in respect of Shaping a Healthier Future (SaHF). There was an integrated site strategy for the different ICHT sites. SMH had been designated a major hospital and major trauma centre. HH had been designated as a specialist hospital with an emergency heart attack centre and a 24/7 UCC. CXH was a local hospital, designed to meet the needs of the local population to remain independent. Services provided at CXH included; support for carers; a range of outpatient services; a one-stop shop to reflect the fact that many patients had multiple conditions; and specialist rapid access clinics for frail and elderly people. CXH was part of an integrated approach to healthcare.

There were GP hubs in the north and south of the borough, comprising 31 practices, all working from a single IT platform.

It was expected that the Keogh Review would transform Urgent and Emergency Care in the NHS.

Workforce was an issue throughout North West London and the whole of London. A key role was the development of training to enable staff to work within hospitals and the community.

An Implementation Business Case (ImBC) collated all the outline business cases (OBC) across North West London (including eight CCGs and nine acute trusts). The ImBC would be submitted to NHSE in mid-March. The process would involve the NHS, Department of Health and the Treasury. It was believed that completion would be from 2016/2017 until 2020/2021.

Councillor Vaughan queried the details in respect of CXH, and emergency facilities in particular. Ms Parker confirmed that these details would have been included in ICHT's business case, but this was still a draft and confidential. Dr Spicer added that the CCG would ask NHS London/NHE when the details could be revealed.

Action: H&F Clinical Commissioning Group

Councillor Lukey stated that it was deeply frustrating that there had been no information since the Independent Review and endorsement by Jeremy Hunt. There had subsequently been timetable slippage, the CQC report and ICHT not proceeding with foundation trust status application.

Councillor Lukey queried how public money would be sought for investment in the plans. Dr Spicer responded that CCGs could not raise capital and therefore the OBCs had to be handed over to an organisation which could raise capital. Ms Parker confirmed that implementation had slipped. The different OBCs had to be reconciled to ensure that no activity had been duplicated or missed.

Dr Batten responded that ICHT had to receive a CQC rating of Good or Outstanding to proceed with its foundation trust application, after which it would take approximately 12 months to achieve. Following approval of the ImBC, each trust would have to submit a final business case providing a detailed level of planning across the sites. This was likely to take 12 months to complete. There would then be a three/four year timescale for the capital programme.

Councillor Carlebach considered that as a draft had not been shared with the committee, the Medical Director and Chief Executive of NHS London should be formally contacted. Dr Spicer stated that substantial capital investment was required for North West London and therefore the support of NHS London was needed.
Councillor Brown queried the position in respect of the Central Middlesex Elective Surgery Centre. Ms Parker responded that ICHT would not be responsible for the PFI, responsibility would remain with the Trust. The Centre provided elective surgery for a number of trusts, providing better outcomes and safer facilities.

Councillor Brown requested clarification of the additional consultants and other staff in the A&E departments at CXH and HH.

Action: Imperial College Healthcare NHS Trust

The Chair proposed and it was agreed by the committee that the guillotine be extended to 10.15pm.

A member of the public queried the percentage of patients attending A&E compared with previous years. ICHT did not have this information.

The member of the public then commented on a recent press article in respect of telemedicine. Dr McGoldrick responded that three years previously the CCG had received funding to identify, in conjunction with ICHT, where telemedicine could be helpful. There had also been a number of national pilot sites. The evidence at that time indicated that telemedicine could be effective for patients living in more rural areas, but not so much for densely packed inner cities. There had been no consequent funding. The CCG had not seen a role for telemedicine at that point in time.

Dr Spicer responded to the member of the public's comments in respect of reductions in A&E demand by highlighting the whole systems work which was addressing the integration of acute and community care.

Mr Naylor emphasised that A&E needed back up beds and that the residents of the borough needed to be told what would be available at CXH. Dr Spicer agreed that there would always need to be beds, but the percentage and how arranged could change. There would be more consultants in A&E for more hours. There was evidence that consultant involvement earlier in the pathway resulted in improved decisions and reduced investigations, and patients being

more likely to be discharged rather than admitted. Some beds were currently blocked by people who were medically fit.

Mr McVeigh commented on the difference between the A&E figures reported on by the CQC and those provided by ICHT. Professor Sigsworth responded that the CQC inspection had been in September and they had looked at figures retrospectively, and had used a range of qualitative indicators. The graphs provided by ICHT had a quantitative basis, representing a range of service standards on which fundamental clinical decisions were made.

Councillor Chumnery referred to information which had previously been provided in response to her concerns in respect of communication of the Shaping a Healthier Future changes. Of the 257 groups listed, only 11 groups were based in Hammersmith & Fulham and had received communication in the form of leaflets. In addition, face to face meetings had been very limited.

Councillor Chumnery noted that there was a lot more work to do in respect of communication and that better communication was required going forward.

Action: H&F CCG to contact Councillor Chumnery to clarify communications.

Councillor Vaughan concluded the discussion by emphasising the committee's frustration at the lack of a clear business case for CXH and decision making process.

Councillor Vaughan thanked H&F Clinical Commissioning Group and Imperial College Healthcare NHS Trust for attending the meeting.

57. WORK PROGRAMME

The work programme was received.

58. DATES OF FUTURE MEETINGS

9 March 2015
13 April 2015

Meeting started: 7.00 pm
Meeting ended: 10.15 am

Chairman .....

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APPENDIX 1

Recommendation and Action Tracking

The schedule below sets out progress in respect of those substantive recommendations and actions arising from the Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Minute No.	Item	Action/recommendation	Lead Responsibility Progress/Outcome	Status
6.	Imperial College Healthcare NHS Trust: Cancer Services Update	Information to be provided in respect of: Vaccinations: (i) whether flu vaccines would also be offered to patients at Queen Charlotte's hospital: (ii) the number of vaccinations given to patients and staff, to include the provision of the shingles vaccine. (iii) Cancer Care: action to improve the time between a patient presenting at their GP and a clinical referral.	Imperial College Healthcare NHS Trust	Complete
7.	Shaping a Healthier Future: Update	Information to be provided in respect of: (i) current patient numbers and the capacity of the new Parkview Centre for Health & Wellbeing (ii) further detail in respect of where the patients who used the Central Middlesex and Hammersmith Hospitals lived Hammersmith Hospital (iii) the community groups identified	H&F CCG/Shaping a Healthier Future Information provided A full list of community groups which have received leaflets and posters about the changes as well as the list of organisations we are engaging in face-to-face meetings provided.	Complete

		(iv) communication plan: evaluation criteria (v) skills-gap analysis and methodology (vi) expected patient numbers following the closure of the A&E.		
17.	2015 Medium Term Financial Strategy	A written response in respect of servicing the Council's debt to be provided.	Response provided by Hitesh Jolapara.	Complete
18.	H&F Clinical Commissioning Group/Imperial College Healthcare Trust	Information to be provided in respect of: (i) flu vaccination rates for staff. (ii) the board level meetings at which the Shaping a Healthier proposals had been discussed. (iii) foundation trust application (if in public domain)	Imperial College Healthcare NHS Trust	Complete
27.	Independence, Personalisation and Prevention in ASC	(i) Members to be informed whether the tender included the requirement to pay the London living wage. (ii) The tender specification to be circulated to members.	Liz Bruce Paul Rackham	Complete
34	Under Fives Flu Vaccination Programme in H&F	Update	Response provided by Stuart Lines, 16 December. Agenda item, January 2015	Complete
40.	Imperial College	Update	Imperial College Healthcare NHS	Complete

	Healthcare NHS Trust: Accident & Emergency Waiting Times		Trust. Update provided to February 2015 meeting.	
41.	Under Fives Flu Vaccination Programme in H&F	Correct figures to be provided to Councillor Carlebach.	Explanation for discrepancy provided by CCG.	Complete
54.	Imperial College Healthcare NHS Trust : CQC Report and Action Plan	(i) A list of organisations consulted to be provided. (ii) Work in respect of improving pathways for people with learning disabilities and dementia to be provided. (iii) Information in respect of available languages to be provided. (iv) Data in respect of London Ambulance Service to be provided.	Care Quality Commission Imperial College Healthcare NHS Trust	Information circulated 26 February 2015 Chased
56.	Shaping a Healthier Future	(i) NHS London/NHSE to be asked when the details of ICHT's business case can be released. (ii) The number of additional consultants and other staff in the A&E departments at CXH and HH to be provided. (iii) Councillor Chumnery to be contacted to clarify communications.	H&F CCG Imperial College Healthcare NHS Trust H&F CCG	Chased Chased Chased

	London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY AND ACCOUNTABILITY COMMITTEE** **9 March 2015**
TITLE OF REPORT Central London Community Healthcare (CLCH): The next 5 years	
Report of the CLCH	
Open Report Yes	
Classification - For Information **Key Decision:** No	
Wards Affected: All	
Accountable Executive Director: n/a	
Report Author: Jonathan Gregory, Foundation Trust Project Manager, CLCH	**Contact Details:** Tel: 020 7798 1414 E-mail: jonathan.gregory@clch.nhs.uk

1. EXECUTIVE SUMMARY

1.1 CLCH presents an outline of its strategy for the next five years and an update on the progress it is making towards becoming a NHS foundation trust.

2. RECOMMENDATIONS

2.1. This report is for information.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	None		

Central London Community Healthcare NHS
NHS Trust

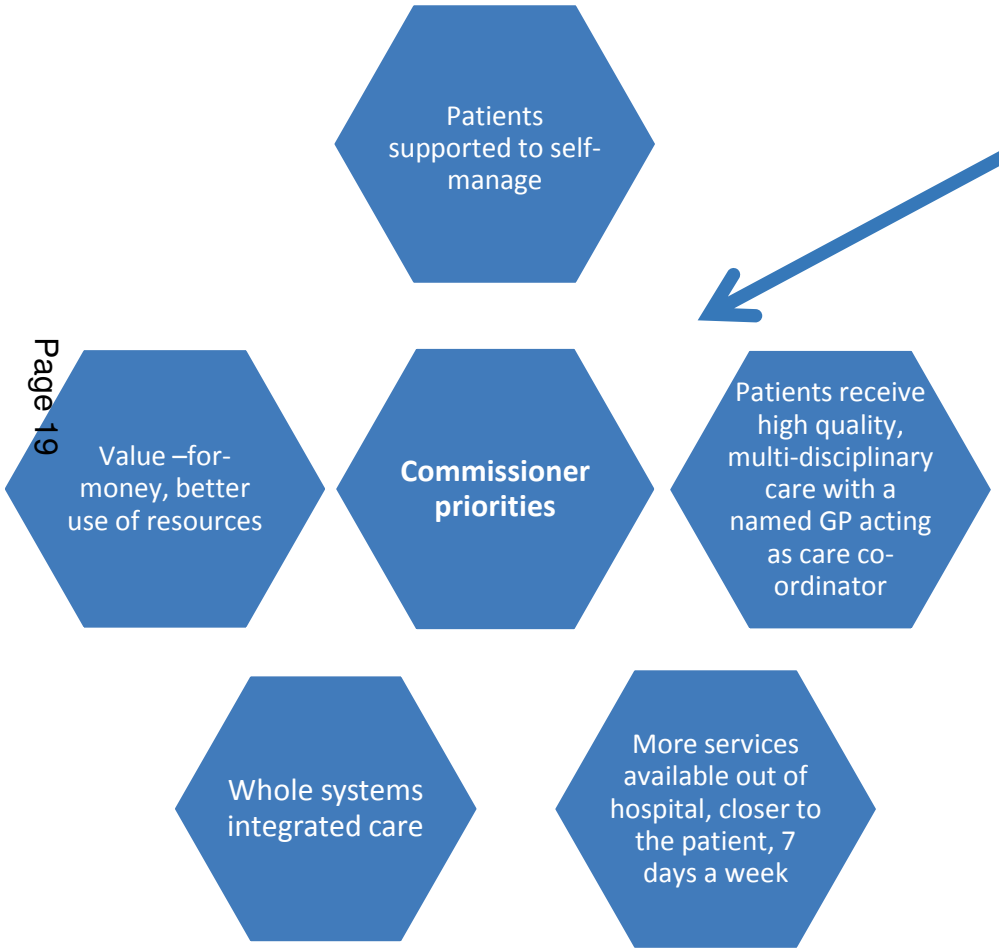
Barnet ▮ Hammersmith and Fulham ▮ Kensington and Chelsea ▮ Westminster

Your healthcare closer to home

CLCH: The next five years

Presentation to Hammersmith & Fulham Health, Adult Social Care & Social Inclusion PAC, 9 March 2015

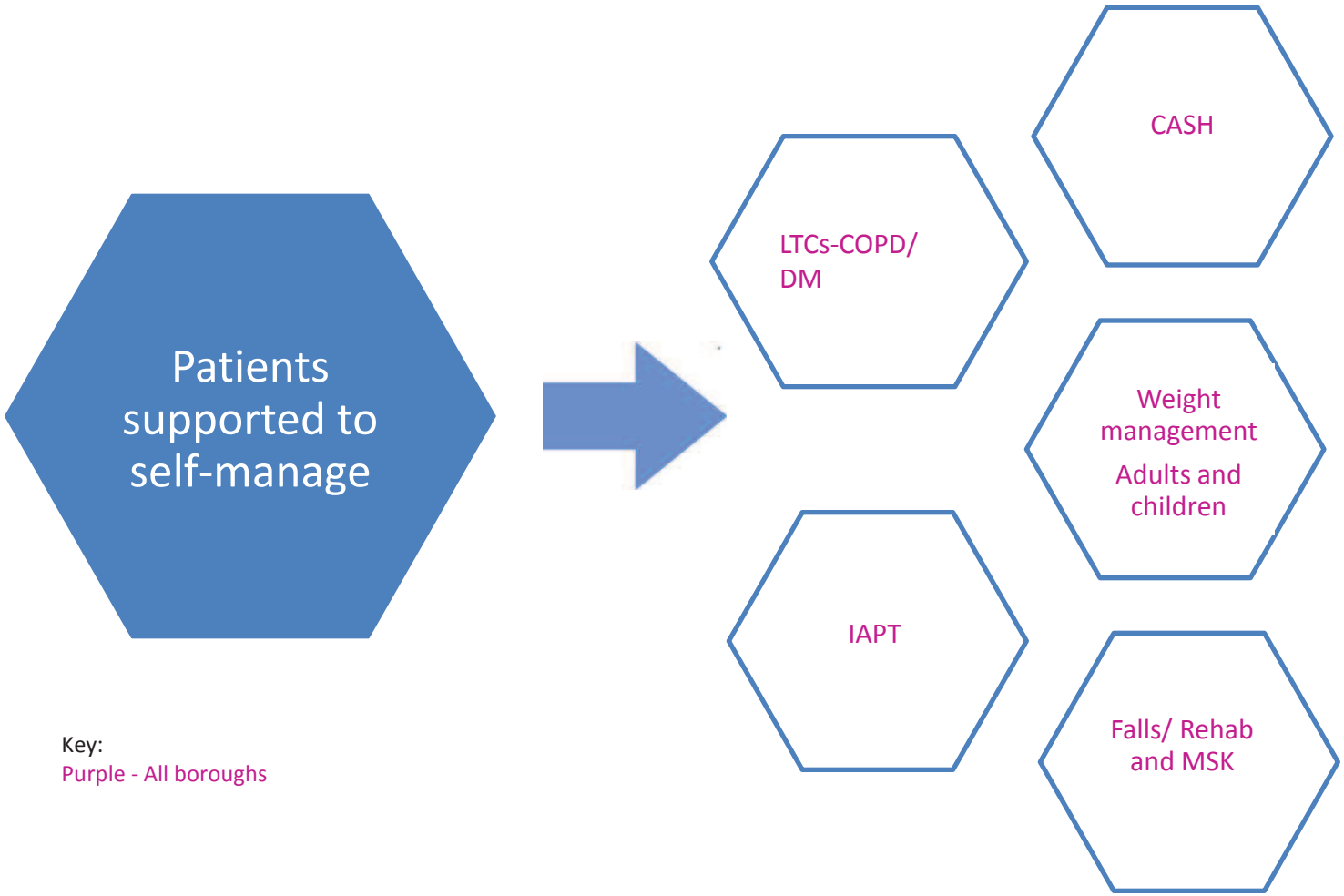
Commissioners' priorities



National context/ drivers

- Francis Report
- Five Year Forward View
- King's Fund: Community Services – how they can transform care; Making our health and social care system fit for an ageing population; Managing quality in community health services

Commissioners' priorities and our response



Key:
Purple - All boroughs

Quality | Transformation/ Integration | Value for Money | Effective Leadership/ Governance | Growth

Commissioners' priorities and our response

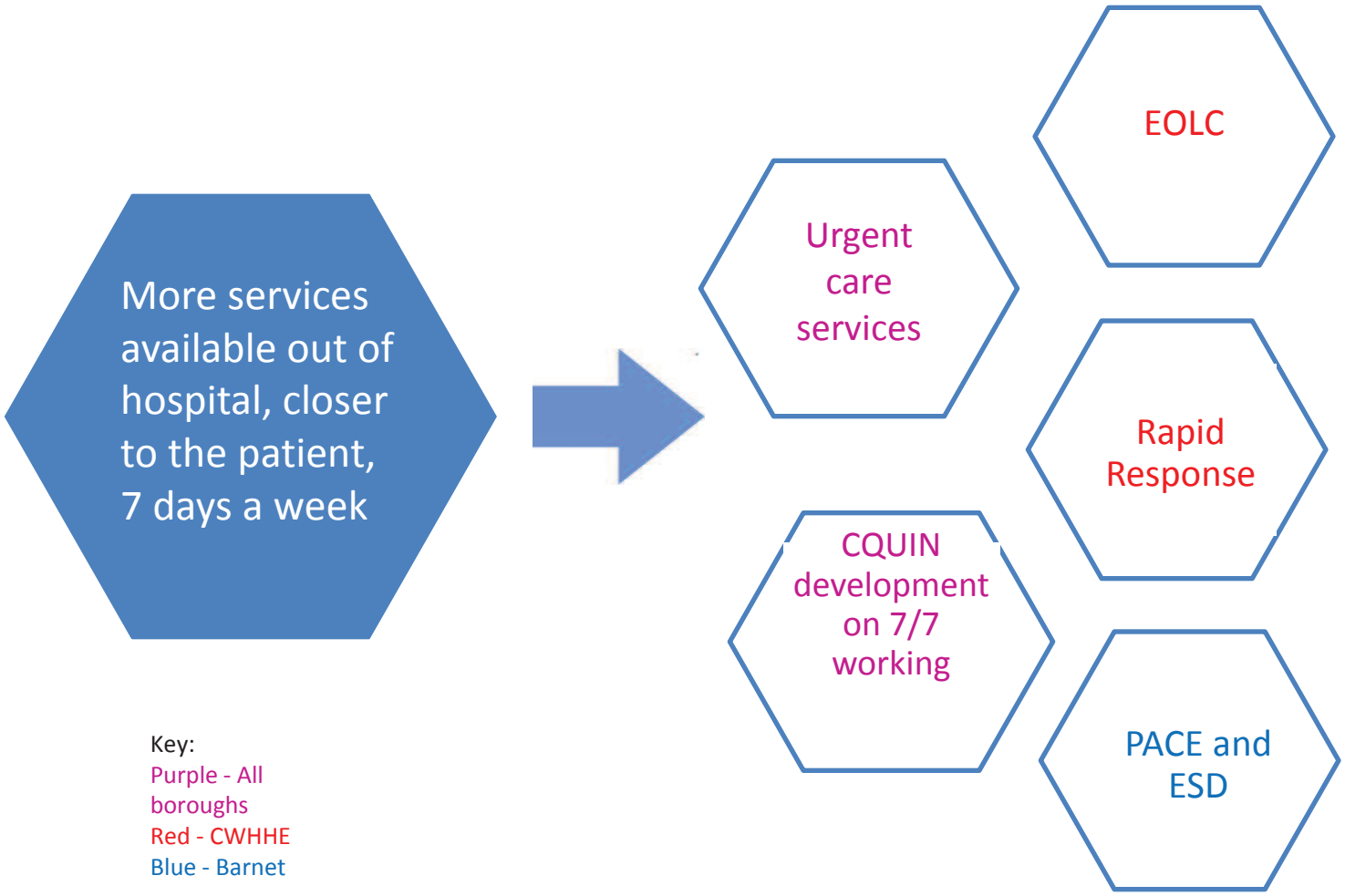
Patients receive high quality, multi-disciplinary care with a named GP acting as care co-ordinator

Key:
Purple - All boroughs
Red - CWHHE
Green - H/F
Rust - Central

- Wrapping DNs around practices. E.g. village meetings/ MDT meetings
- Care coordinators
- CIS 'Plus'
- Achieving excellence together
- Single care Record
- In reach

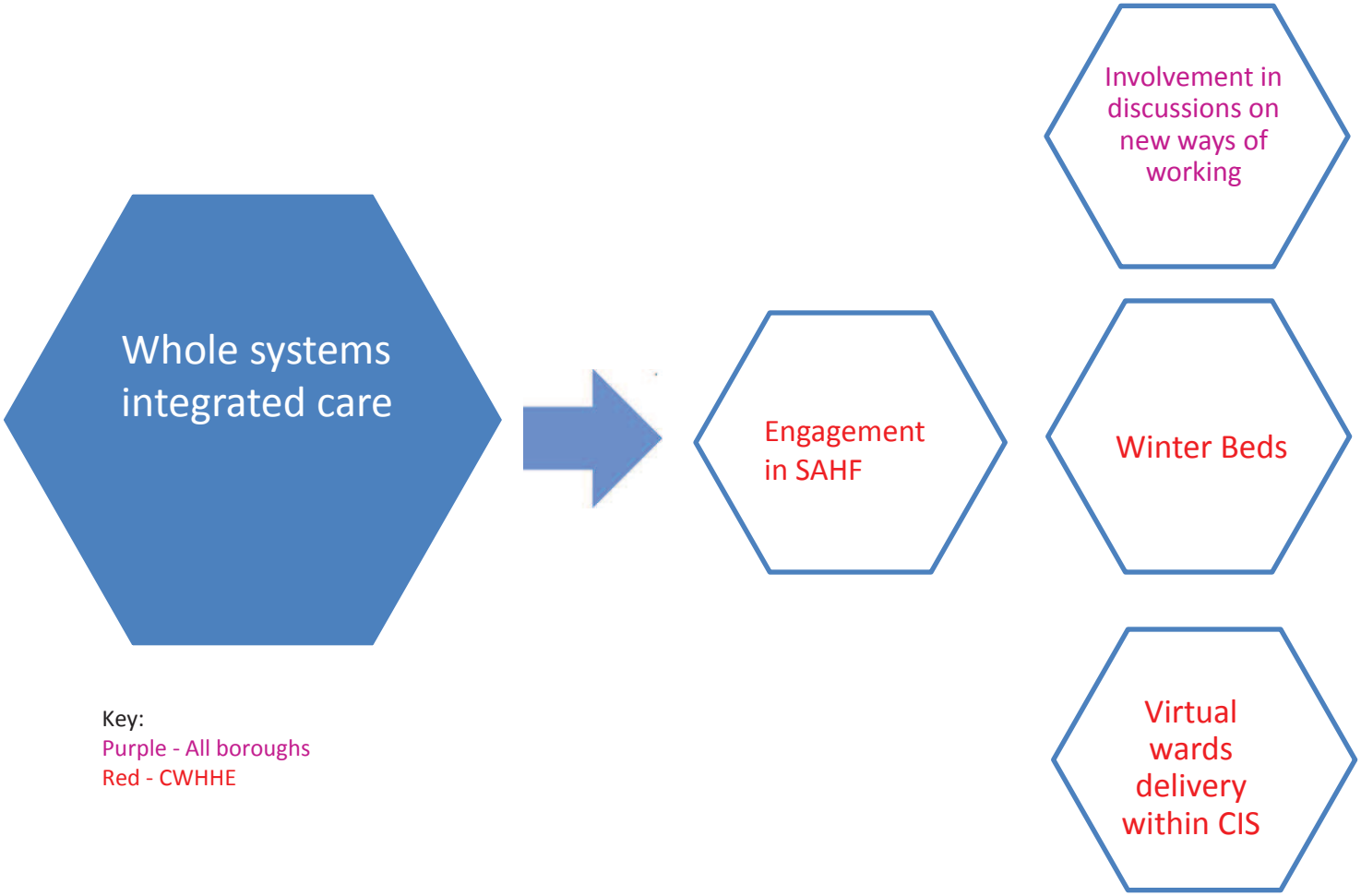
Quality | Transformation/ Integration | Value for Money | Effective Leadership/ Governance | Growth

Commissioners' priorities and our response



Quality | Transformation/ Integration | Value for Money | Effective Leadership/ Governance | Growth

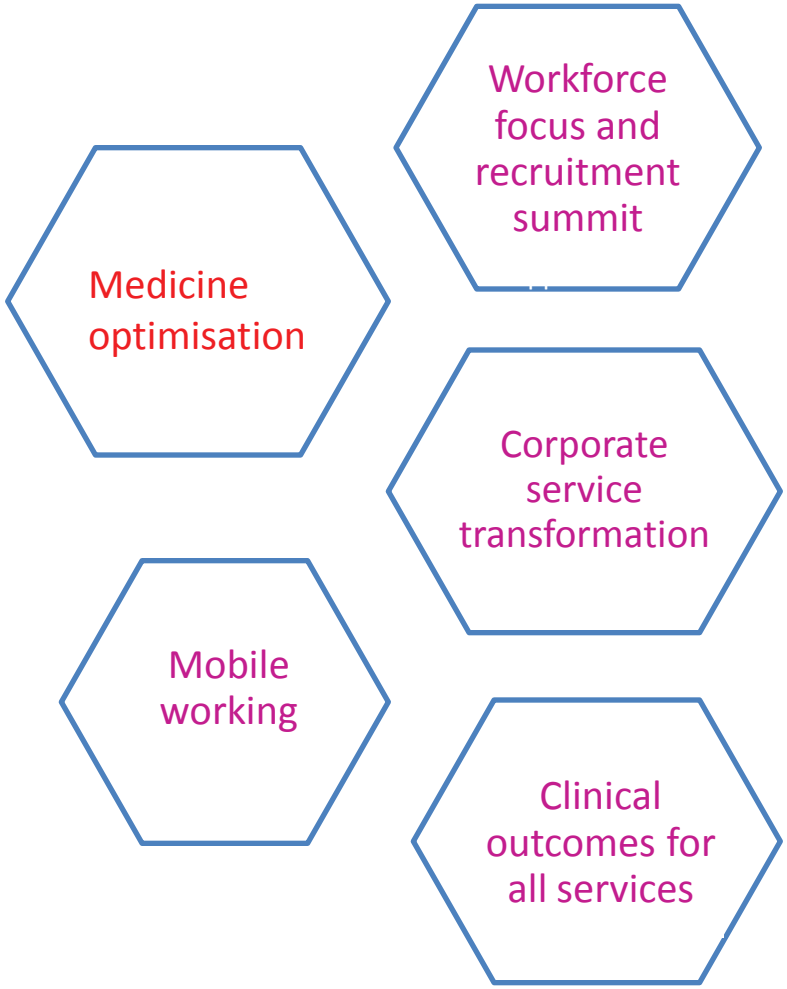
Commissioners' priorities and our response



Quality | Transformation/ Integration | Value for Money | Effective Leadership/ Governance | Growth

Commissioners' priorities and our response

Key:
Purple - All boroughs
Red - CWHHE



How FT will support us as an effective local partner

- FT is a not-for-profit community interest company accountable to the local community (Council of Governors)
  - Hammersmith & Fulham: 3 elected, 1 appointed local authority; 1 appointed CCG (NHS Hammersmith and Fulham CCG)
- On-going Board commitment to integrated whole system partnership
- Real powers to gain and retain resources (borrowing, estates and surpluses), and invest these in local service developments
- Real freedom to be more locally focussed and more agile in response to commissioner priorities (end of TDA accountability and demanding, on-going assessment processes)
- FT is an accreditation/system assurance
  - A more secure future
  - Recruitment and retention of more capable staff
  - Leadership for quality improvement
  - Assists in winning new business
  - Added assurance to partners of future sustainability
  - More legal powers to participate in joint ventures and partnerships

	London Borough of Hammersmith & Fulham **HEALTH, EQUALITIES AND SOCIAL INCLUSION POLICY AND ACCOUNTABILITY COMMITTEE** **9 March 2015**
TITLE OF REPORT The role and work of Healthwatch Dignity Champions in Hammersmith of Fulham	
Report of the (Cabinet Member) Vivienne Lukey, Cabinet Member for Health and Adult Social Care	
Open Report	
Classification - For Information **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Tri-borough Executive Director of Adult Social Care	
Report Author: Paula Murphy, Director, Healthwatch Central West London	**Contact Details:** Tel: 020 8967 6771 E-mail: paula.murphy@hestia.org

1. EXECUTIVE SUMMARY

1.1. This report updates the Committee on the Healthwatch Dignity Champions project in the London Borough of Hammersmith and Fulham.

1.2. Established under the auspices of the Health and Social Care Act 2012, Healthwatch Central West London is the independent consumer champion for health and social care services in Hammersmith & Fulham, Kensington and Chelsea and Westminster.

1.3. Healthwatch CWL has the statutory power to 'enter and view' publicly funded health and care services. The Healthwatch Dignity Champions are a group of local volunteers who carry out peer-led qualitative assessments of local services using this power. Healthwatch then produces a report on our findings and makes recommendations for improvements to the service. The report is submitted to the provider of the services for twenty working days. Within that timeframe the provider should respond with an action plan for improvement. After that time, Healthwatch CWL publishes the report and the response on our website (http://healthwatchcwl.co.uk/about/our-work/reports/)
A copy of both documents is also sent to the commissioner of the service

for follow up via their contract monitoring arrangements. Please see the flow chart at Appendix 2 for further detail.

2. RECOMMENDATIONS

2.1. The Committee is invited to review and comment on the attached report.

3. INTRODUCTION AND BACKGROUND

3.1 The Healthwatch Central West London is commissioned to conduct three 'enter and view' visits in each of Hammersmith & Fulham, Kensington & Chelsea and Westminster.

3.2 The Adult Social Care services in the Royal Borough of Kensington & Chelsea grant funds Healthwatch Central West London to conduct nine 'enter and view' visits for local residents.

3.3 Healthwatch staff support volunteers who are often 'experts by experience' to collect service users experiences as part of our duty to ensure that service users have a strong voice when it comes to monitoring the standards of services.

3.4 We currently have over 100 Dignity Champions who conduct our 'enter and view' visits, each of them has gone through a recruitment and training programme, including 'Disclosure and Barring' checks and safeguarding training, to ensure the quality of the project.

3.5 Many of them have also gone through specialist training around mental health and/or dementia to ensure adequate knowledge when assessing specialist services.

3.6 The project is coordinated by a part-time member of staff who plans a schedule of assessments, organises the recruitment and training of new volunteers and provides supervisory support for the Dignity Champions.

3.7 The Healthwatch CWL Dignity Champions follow the 10 standards set out in the Department of Health's 'Dignity Challenge[1]'

3.8 Assessments typically take place over one or two weeks and will involve multiple visits at varied times of the day and often on weekends. A typical visit will consist of between two – five Dignity Champions (supervised by a member of Healthwatch staff) speaking to service users about their experience of the services and making observations about the physical environment of the service and the behaviour of staff.

3.9 This report will be submitted to the service provider who will then have who will then have a statutory 20 day time limit to provide a response and action plan to Healthwatch. During these 20 days the report is private and confidential. After that time Healthwatch makes the report public and shares our findings with the commissioners of the service.

3.10 We also notify the Care Quality Commission of our schedule of visits and once our reports were published. The CQC use our intelligence to inform their schedule of inspections.

[1] http://www.dignityincare.org.uk/Dignity_in_Care_campaign/The_10_Point_Dignity_Challenge/

3.11 To maintain the quality of our assessments we hold quality circles with our champions to ensure they can debrief on their findings and to continuously review the suitability of our methodology.

3.12 Recent visits in Hammersmith and Fulham include a spot check to St Vincent's Care Home (December 2014) and a spot check to the Hammersmith and Fulham Mental Health Unit (WLMHT on Charing Cross site in February 2015).

4. PROPOSAL AND ISSUES

4.1. The Committee is invited to note:

- The work of the Healthwatch Dignity Champions in Hammersmith and Fulham
- The potential of this work to be expanded further in 2015/16 and
- The potential of this work to add value to contract monitoring.

5. CONSULTATION

n/a

6. EQUALITY IMPLICATIONS

6.1 There are no direct equalities implications arising from this report. Healthwatch Central West London is committed to representing the views of the whole community and promotes the involvement of a diverse range of people in the monitoring, commissioning and provision of local health and care services.

7. LEGAL IMPLICATIONS

n/a

8. FINANCIAL AND RESOURCES IMPLICATIONS

8.1. The total budget for Healthwatch Hammersmith and Fulham is £143,503.

9. RISK MANAGEMENT

n/a

10. PROCUREMENT AND IT STRATEGY IMPLICATIONS

Further to an open joint commissioning process, Hestia was awarded the contract for the three 'lots' in March 2013.
Each of the three Councils determined the resource allocation for Healthwatch in their locality so that their statutory obligations are met in line with guidelines from the Department of Health and requirements of secondary legislation.
Contract and performance management is led by the Royal Borough of Kensington and Chelsea with appropriate officer representation and support

from the London Borough of Hammersmith and Fulham and City of Westminster.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	None		

LIST OF APPENDICES:

Appendix 1: Healthwatch CWL Dignity Champions Project
Appendix 2: Information sharing protocol

healthwatch
Central West London

Healthwatch Central West London

Dignity Champions

1. Introduction

Healthwatch Central West London (Healthwatch CWL) is the independent consumer champion for health and social care services and has nearly 6,000 members who share a passion for improving these services in the London Borough of Hammersmith & Fulham, the Royal Borough of Kensington & Chelsea and the City of Westminster.

The Healthwatch CWL Dignity Champions are a group of local volunteers who work to improve people's experiences of health and social care in the borough. Under the auspices of the Health and Social Care Act 2012, the Dignity Champions carry out peer-led qualitative assessments of local health and social care services using our 'enter and view' power. Healthwatch CWL then produces a report on our findings and makes recommendations for improvements to the service.

The report is then submitted to the provider of the service for twenty working days. Within that timeframe the provider should respond with an action plan for improvement. After that time, Healthwatch CWL publishes the report and the response on our website (http://healthwatchcwl.co.uk/about/our-work/reports/). A copy of both documents is also sent to the commissioner of the service for follow up via their contract monitoring arrangements. Please see the flow chart at Appendix A for further detail.

The Dignity Champion project has been running for the past 5 years and in that time has been recognised with a 'Dignity in Care' award from the Royal Borough of Kensington and Chelsea, and at a national level by Mr Paul Burstow MP, former Minster for Care Services. Healthwatch Central West London (CWL) is keen to continue to build on the great work of this project in the future.

Healthwatch Central West London is commissioned to conduct three 'enter and view' visits in each of Hammersmith & Fulham, Kensington & Chelsea and Westminster. Adult Social Care services in the Royal Borough of Kensington & Chelsea grant funds Healthwatch Central West London to conduct nine 'enter and view' visits for local residents.

2. Who are the Champions?

The project supports volunteers who are often 'experts by experience' to collect service users experiences as part of our commitment to ensuring that service users have a strong voice when it comes to monitoring the standards of services that providers deliver.

We currently have over 100 Dignity Champions who conduct Enter and View visits, each of them has gone through a recruitment and training programme, including

'Disclosure and Barring' checks and safeguarding training, to ensure the quality of the project. Many of them have also gone through specialist training around mental health and/or dementia to ensure adequate knowledge when assessing specialist services. The project is coordinated by a part time member of staff who plans a schedule of assessments, organises the recruitment and training of new volunteers and provides supervision of the Dignity Champions.

3. How do the Champions measure dignity?

Our Dignity Champions' key priorities are to listen to and understand the views and experiences of local residents, and to speak up about dignity to improve the way services are organised and delivered. The Healthwatch CWL Dignity Champions follow the 10 standards set out in the Department of Health's 'Dignity Challenge[1]'.

The Dignity Challenge

High quality care services that respect people's dignity should:

1. Have zero tolerance of all forms of abuse
2. Support people with the same respect you would want for yourself or a member of your family
3. Treat each person as an individual by offering a personalised service
4. Enable people to maintain the maximum possible level of independence, choice and control
5. Listen and support people to express their needs and wants
6. Respect people's right to privacy
7. Ensure people feel able to complain without fear or retribution
8. Engage with family members and carers as care partners
9. Assist people to maintain confidence and a positive self-esteem
10. Act to alleviate people's loneliness and isolation

To maintain the quality of our assessments we hold quality circles with our champions to ensure they can debrief on their findings and to continuously review the suitability of our methodology.

Assessments typically take place over one or two weeks and will involve multiple visits at varied times of the day and often on weekends. A typical visit will consist of between two – five Dignity Champions (supervised by a member of Healthwatch staff) speaking to service users about their experience of the services and making observations about the physical environment of the service and the behaviour of staff. Dignity Champions use assessment tools tailored to an individual service to

[1] http://www.dignityincare.org.uk/Dignity_in_Care_campaign/The_10_Point_Dignity_Challenge/

collect appropriate information but will also have free form conversations with service users to collect more in depth qualitative information. Dignity Champions will also speak to the carers and family members of service users to seek their views on the service being assessed.

Healthwatch will then publish a report based on information collected during the visits complete with recommendations for service improvement. This report will be submitted to the service provider who will then have a statutory 20 day time limit to provide a response and action plan to Healthwatch. During these 20 days the report is private and confidential. After that time Healthwatch makes the report public and shares our findings with the commissioners of the service.

Over the past 12 months we have assessed the following local services:

Health

- Hammersmith Hospital[2]
- St Charles CNWL Mental Health Unit[3]
- Chelsea and Westminster Hospital (cancer)[4]
- Chelsea and Westminster Hospital (Nell Gwynne)
- Hammersmith and Fulham Mental Health Unit (WLMHT, Charing Cross Hospital site)[5]

Social Care

- Forrester Court [6]
- Farm Lane[7]
- Carlton Dene Elderly Resource Centre [8]
- St Vincent's House[9]
- Ellesmere Care Home (report awaiting publication)
- Urgent Care Centres (report awaiting publication)
- Tri-Borough Home care Services (ongoing).

4. Case studies:

[2] http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/Healthwatch-CWL-DC-assessment-of-Hammersmith-Hospital.pdf
[3] http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/Redwood-report-finalMC.pdf
[4] http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/Dignity-Champions-assessment-of-ChelWest-cancer-services.pdf
[5] http://healthwatchcwl.co.uk/wp-content/uploads/2013/09/HF-MH-Unit-WLMHT0314.pdf
[6] http://healthwatchcwl.co.uk/wp-content/uploads/2014/01/Forrester-Court-final-Post-visit-with-Beata.pdf
[7] http://healthwatchcwl.co.uk/wp-content/uploads/2014/01/Farm-Lane-report.pdf
[8] http://healthwatchcwl.co.uk/wp-content/uploads/2014/01/Carlton-Dene-Report-Final-Feb14.pdf
[9] http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/St-Vincents-Spot-Check-Final.pdf

4.1 Assessment of the service user experience of Tri-Borough home care services

Over the last four years (as LINk and as Healthwatch), we have spoken to hundreds of local home care users about their experiences and needs from the new contract. We established a project group of home care users and their representatives and co-produced the new contract with commissioners. We also empowered local users to speak to market testing events to ensure potential providers were clear on the customer need.

The findings of the assessment have been presented to Tri-Borough commissioners and to Councillors at Policy and Accountability committees in Hammersmith & Fulham, Kensington & Chelsea and Westminster.

From summer 2014 onwards, we have been conducting an updated assessment of the service user experiences across the three boroughs. Our Dignity Champions have been interviewing service users in person and over the phone. The purpose of this work has been to set a baseline for the re-design of the Tri-Borough Homecare service.

We plan to support users to engage with commissioners as part of the procurement process and through implementation. We are currently planning an event to support the new providers to meet the local community to help awareness and the delivery of person centred outcomes.

We will also produce a charter for service users/customers so people are clear on their rights and responsibilities including how to comment and complain. We hope that through triangulating data from Healthwatch (users and representatives), providers and contract management, Officers will have a better oversight of the new service.

This collaborative work between Healthwatch, service users, providers and commissioners provides a positive example of the kind of co-production in service monitoring and improvement and commitment to the principle of using service user views to deliver better services that the Dignity Champion Project represents, in this case service user feedback has directly influenced the Tri-Borough service specification and provided a template for ongoing service user involvement in the monitoring of this service.

4.2 Central North West London (CNWL) NHS Foundation Trust – Redwood Ward

Redwood ward is a mental health ward for older people based at St Charles in North Kensington. Our Dignity Champions assessed the ward in July 2014, speaking to patients on a variety of service issues including, the physical environment,

patient safety, relationships and communication with staff, care planning and discharge.

The assessment was carried out shortly after the Care Quality Commission lifted their restrictions on the provider. However, we found there was scope for further improvement.

The report generated by the assessment has acted as a galvanizing force in pushing forward service improvement, eliciting a positive response and action plan from the provider CNWL and being presented to the commissioners of the service, West London Clinical Commissioning Group at their Quality, Patient Safety and Risk Committee. This demonstrates how an assessment and report can bring together service user views, providers and commissioners to look at how a service can be improved.

4.3 Care UK care homes

Over the last year, Healthwatch has assessed three of the four local Care UK homes. Our champions alerted the local safeguarding team to concerns at all three homes at the time of our visits. Whilst we received action plans in response to our recommendations from all three homes, outstanding concerns remained. Through our role on the Safeguarding Information Panel we notified commissioners of issues we had observed at all three homes relating to the organisational culture. We also had concerns about the quality of the action planning received from the provider.

As with all our reporting, we notified the Care Quality Commission once our reports were published. The CQC use our intelligence to inform their schedule of inspections. Although some of the sites had been inspected in recent times, the CQC visited again and confirmed our findings.

A working group was established in Westminster to pick up on concerns. Adult Social Care met with the directorate for Care UK to agree next steps. This issue is now for the attention of Scrutiny/Policy and Accountability colleagues.

5. Next steps:

In a time of reduced resources and a changing health landscape, often patient experience is the first sign of an issue, quickly followed by patient safety. The dignity champions, as local volunteers, have a pivotal role in acting as the local eyes and ears in services and independently informing commissioners and the Care Quality Commission.

As the Labour Manifesto states ' *There are many skilled people in Hammersmith and Fulham looking to share their talents with the local communities.'* We support over 100 people to volunteer for the benefit of their wider community.

We want to protect, and where resources permit extend, this activity as part of our core offer as we have started to embed in health and care quality assurance processes.

'Develop partnerships with government agencies, the third sector, business and others to use resources better and take a more focused and joined-up approach towards tackling social exclusion.'

And

*'Currently, too much NHS, public health and adult social care activity is undertaken separately in silos.' (*Labour Manifesto*)*

We note that on page 17 of the Hammersmith and Fulham Labour Party manifesto[10] under ensuring high home care standards it states:

> *"We will ensure that users of the council's home care services receive high standards of care by giving service users, their carers and families a formal voice in ensuring that home care providers deliver those standards"*

Healthwatch Central West London supports these pledges and believes that the aims and outcomes of our Dignity Champion project works directly to these manifesto pledges.

Healthwatch is entering in to our third year; a year of transition with the agreed aim of achieving full independence from our parent charity Hestia. We have recently been conducting a scoping study to inform our business planning. The peer-led research element of dignity champions combined with our statutory powers and unique position as the only dedicated user involvement organisation in the three boroughs means we are well placed to build on this foundation. Pending funding, the potential future development of the dignity champions' project could go in many directions such as champion's visits to prisons or to developing a complementary befriending service to ensure we receive real time feedback between assessments.

We would welcome the opportunity to speak with you further about our future direction. In the interim, please see:

[10] http://gallery.mailchimp.com/f29e63ad0717fb2c8bb51fe61/files/5d4e2853-a38b-4ffa-ad4d-e87126e2425f.pdf

A full list of Healthwatch CWL reports: http://healthwatchcwl.co.uk/about/our-work/reports/

Older Dignity Champion reports: http://healthwatchcwl.co.uk/dignity-champions/

6. Contact details:

Paula Murphy

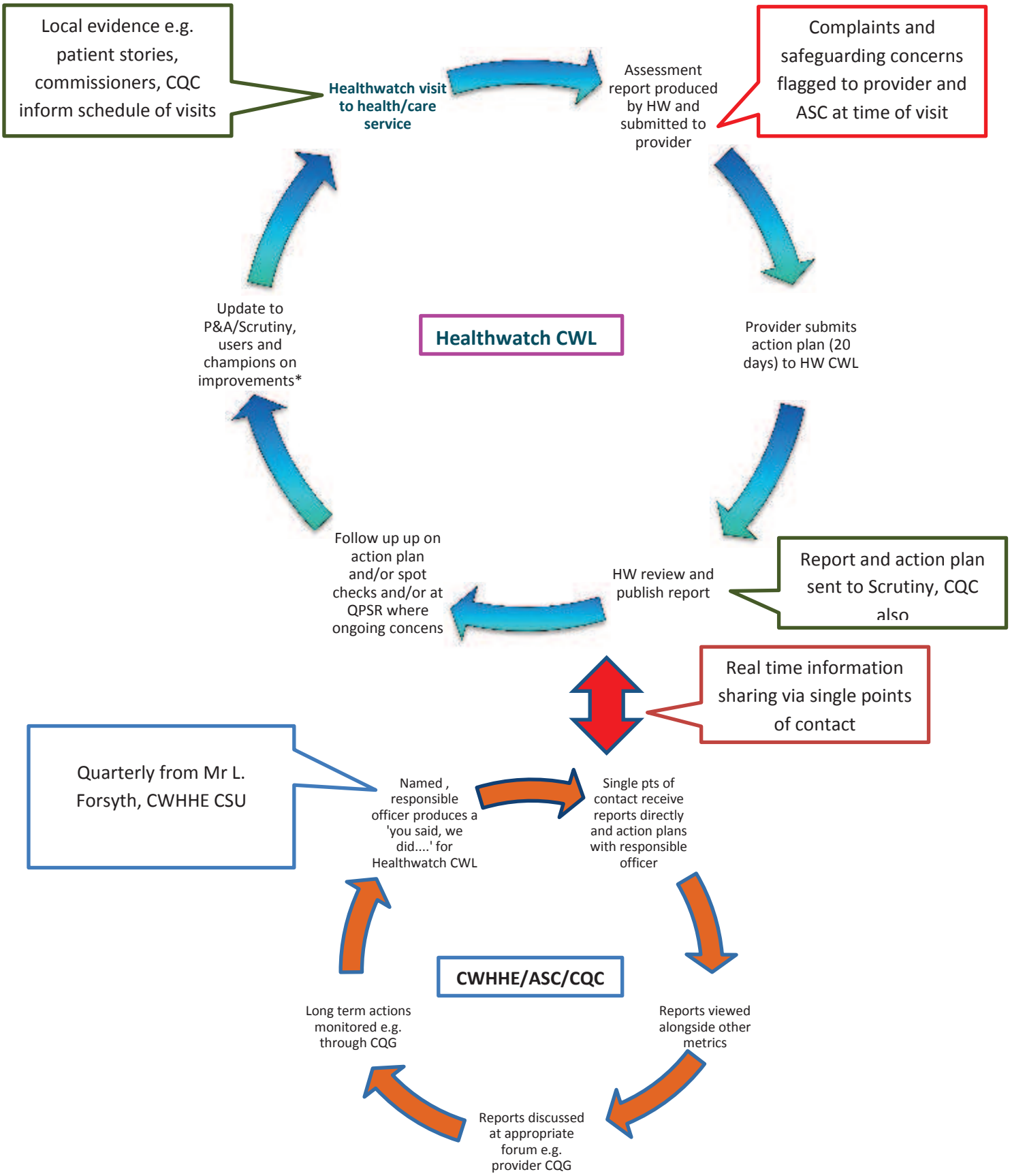
Director
Healthwatch Central West London

Ph: 020 8968 6771

Email: paula.murphy@hestia.org

Date: 16/02/2015

Appendix A: Process for sharing Healthwatch reports with CWHHE and ASC



*This can include the formal referral of outstanding concerns to Scrutiny and the CQC at this stage.

	London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE, AND SOCIAL INCLUSION POLICY AND ACCOUNTABILITY COMMITTEE** **9 MARCH 2015**
TITLE OF REPORT: PROGRESS AND 'GO LIVE' IMPLICATIONS OF THE CARE ACT IMPLEMENTATION PROGRAMME	
Report of the Corporate Director	
Open Report	
Classification - For Review & Comment **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director, Tri-borough Adult Social Care	
Report Author: Jerome Douglas	**Contact Details:** Tel: 020 8753 2306 E-mail: jerome.douglas@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. The purpose of this report is to update the Health, Adult Social Care, and Social Inclusion Policy and Accountability Committee on the 'go live' implications to prepare for the requirements of the Care Act 2014. The majority of provision comes into force in April 2015. Governance arrangements to implement the Care Act reforms have been in place since April 2014.

1.2. The changes required as a result of the Care Act will need to be fully embedded as part of an ongoing change management approach.

2. RECOMMENDATIONS

2.1. The Committee is asked to consider the information in this report.

3. INTRODUCTION AND BACKGROUND

3.1. A report was submitted to the Committee in July 2014 outlining the steps necessary to comply with the legislation. The Care Act applies to adult care and support in England, and all local authorities are expected to take necessary steps to prepare for the reforms.

3.2. Governance arrangements to implement the Care Act reforms have been in place since April 2014. This work is overseen by Liz Bruce, Executive Director for Adult Social Care and Health, as Senior Responsible Officer.

3.3. Workstreams are in place to implement the deliverables in Phase 1 and Phase 2, in alignment with the agreed schedule. Workstream leads regularly report progress to the Care Act Implementation Board, chaired by Liz Bruce. Board members hosted a challenge session in November 2014 to test the delivery approach and rationale for all workstream activities. Risks are regularly monitored by the programme and major risks logged on the corporate risk register. The key deliverables and 'go live' implications for the programme are highlighted in the paragraphs below.

3.4. Eligibility and the new National Minimum Threshold – work is underway to roll out the National Minimum Eligibility Threshold. Officers have completed a desktop review of existing FACS eligible service users. The aim is to provide local impact analysis in relation to understanding the new threshold.

3.5. All service users in receipt of personal budget (this includes a review of the appropriateness of the current Resource Allocation System, or RAS) – personal budgets are already part of the offer to service users with eligible needs in all three boroughs. Work is underway to review the existing resource allocation systems and optimise them in each of the boroughs.

Longer term, the aim is to adopt a new tool that improves the accuracy of indicative budget allocations. A number of RAS tools are being developed by software companies including FACE RAS, which appears to be in demand, to help local authorities address this in the near future.

The process for managing personal budgets has been outlined in a new set of Adult Social Care (ASC) standard operating procedures, which all ASC staff will adopt from April onwards. Our objective is to put in place a person-centred framework for setting personal budgets, linked to focussed outcomes for the service user, and greater transparency.

3.6. The complaints process – we have updated our standard operating procedures to align the complaints process to Care Act requirements; this will be adopted by all ASC staff from April onwards. All local authorities are being consulted by the Department of Health about Part 2 draft guidance on the appeals process, in relation to eligibility decisions taken by a local authority. This process is due to be implemented on 1st April 2016.

3.7. Assessment processes in line with Care Act requirements (this includes Carers Assessments, assessment of self-funders, and prevention duty) – we have built a revised assessment and support planning process into standard operating procedures, to be implemented in Framework-i. The process is included in our recently launched Care Act training programme, which ASC staff are now attending. This includes a new Carer's assessment process, piloted in December 2014.

A Carers Offer will be available from April, offering a range of support, from low-level, universally available support, through to carer's personal budgets for care and support based on eligibility. The purpose of the Carers Offer is to enable ASC staff to provide carers with detailed information about how they can manage their wellbeing effectively. The aim is to reduce overall costs to local authorities through a preventative model for carers, so they can continue their caring role whilst maintaining health and wellbeing.

3.8. Demand and Financial Modelling - the Care Act is expected to result in a significant increase in the requirement for assessments for carers, prison population and self-funders with needs for care and support. Work has been undertaken to predict the level of demand, and interim workforce capacity will be put in place to respond to increased demand from April 2015 onwards. The demand levels are shared below.

3.8.1. Self Funders - The estimated number of self funders could represent (up to) an additional 15-20% of customers, when compared to the number of customers supported by the local authority. Self funders will need to be assessed to access the financial protection offered by the Care Cap. This demand will be staged, however, as Care Cap is not due to come into effect until April 2016. To manage demand the three local authorities plan to assess 25% of self funders in quarters three and four of 2015/16, with the remaining self funders assessed in 2016/17. Once assessed self funders will need to be reviewed annually.

3.8.2. Carers - Modelling suggests there is likely to be 119% increase in carers to be assessed in London Borough of Hammersmith and Fulham (LBHF).

3.8.3. Prisoners - For LBHF only. Demand modelling indicates up to 81 prisoners a year may require an assessment; a relatively low figure compared with an annual prison population turnover of between 6500-8000 persons.

3.9. Duties towards Prison Population - the Care Act extends social care duties to the prison population. For the LBHF this relates to Wormwood Scrubs prison. Work is underway to ensure a more joined up health and social care assessment is available to people with care and support needs whilst in prison. This includes building a social care element into the offer from

the existing care provider contracts, working with NHS England commissioning.

3.10. Implementation of new safeguarding duties – the London Association of Directors of Adult Social Services (ADASS) is developing a Care Act compliant set of protocols for safeguarding that will be rolled out to all London local authorities by April 2015. In addition, the standard operating procedures have been amended to ensure Care Act compliance, and these will be adopted by ASC staff from April onwards.

3.11. Market shaping responsibilities embedded – a Market Position Statement has been drafted to support market shaping through engagement with local providers and the public. The market position statement is designed to help to inform commissioning of new, innovative services for local residents. A draft provider failure protocol is also under development. This will inform decisions about how to support the transfer and continuity of care for service users in the event the incumbent provider is unable to support them, due to business failure or a major dip in the quality of care provision.

3.12. Managing transition from children and young people services to adults services – work is underway to build the Education, Health and Care transition pathway and protocol, which has been embedded in our standard operating procedures. Staff in the Learning Disability and transitions teams will receive training prior to adopting the new way of working from April onwards. This will ensure a more holistic approach is adopted that supports young people requiring an “adults” assessment prior to their 18th birthday.

3.13. Information and advice provision (across operations and commissioned services) and provision of preventative services – the workstream activity to deliver compliance includes development of all information and advice formats, including the People First website and leaflets. An audit checklist of the full range of information and advice required has been completed. The next stage, to refresh the content for each topic area, is well underway. The work on information and advice also links closely with new duties to promote prevention, and a mapping exercise is underway to document the existing prevention offer. This work will continue beyond April, to ensure that all information and advice is continually refreshed and up to date as newer services come on-stream; for example, new advocacy contracts or preventative services.

3.14. Advocacy Support Services – a procurement process is underway to develop the service so that the three local authorities can routinely offer independent advocacy support to anyone who requests it, as part of the assessment and support planning process. The new advocacy support services will be established by July 2015. In the meantime, through ongoing dialogue with the existing providers, commissioners have confirmed that the current provision will be Care Act compliant by April 2015.

3.15. Fees, Charging, and Deferred Payment Agreements - The funding reform workstream has developed a new model that will provide a more consistent approach to deferred payment agreements across all three boroughs, including adoption of appropriate interest charge rates. Details will be presented in the annual fees and charging Cabinet Member reports for decision in February / March.

3.16. Workforce trained and developed to meet the new operational requirements – a workforce development programme has been prepared using a mix of internal and external resources. This follows engagement with staff and managers about the workforce implications of the Care Act reforms, and completion of a training needs analysis. Care Act awareness sessions have already been rolled out to ASC staff and to other departments across the local authority, externally to health partners including the Clinical Commissioning Groups (CCG's), and to the voluntary and private sector. The workforce training programme was launched at the end of January 2015 and is now well underway. Training will be extended to other key departments including Housing, the Mental Health Trusts, GP's and Health. Work is underway to review the training offer to external providers and information and advice providers will receive training in early March.

3.17. Communications - successful 'show and tell' events have been held in all three boroughs to promote the work of the programme and encourage stakeholders to engage in the implementation. A communications plan has been developed to co-ordinate key messages to all stakeholders, and a regular update is published in the monthly Triangles newsletter to ASC staff. The communications plan is aligned with the Public Health England Campaign to share information with the general public about the Care Act. Local communications are underway from February onwards to ensure residents are fully aware of the reforms. The People First and corporate websites have been amended to include relevant information.

4. CONSULTATION

4.1. On 4th February, the Department of Health (DoH) launched a consultation on the guidance and legislation in relation to the cap on costs for self-funders and the associated appeals process which come into force April 2016. The consultation will run until 30th March 2015. Subject matter experts within the Care Act implementation programme have been tasked with the systematic examination of the draft guidance and regulations to inform the Council's feedback response to the consultation, and to help identify any new risks. Staff will also be invited to feed comments and responses to the consultation questions directly to the programme manager; this will form part of our overall consultation response.

4.2. Following the consultation, the DoH intends to publish the final documents in September 2015; this will give local authorities seven months to finalise arrangements to comply with the cap on costs and appeals requirements of the Care Act.

5. LEGAL IMPLICATIONS

5.1. The Care Act 2014 comes into force in two stages, with most provisions coming into force on 1st April 2015. Funding reform provisions come into force on 1st April 2016.

5.2. Guidance and Regulations were finalised and published relatively recently, on 23rd October 2014. All local authorities are facing significant challenges in preparing to implement the most significant changes to community care provision in the last 60 years. However, although the Care Act 2014 includes new provisions, the majority of the requirements consolidate good practice, which is already part of the ASC operating framework.

5.3. The main areas of significant change are outlined in this paper.

5.4. Legal Services is carrying out a review of the extensive final version of Part 1 of the Guidance and Regulations as compared to the Tri-Borough response to the national consultation process carried out in summer 2014. Draft ASC standard operating procedures which include a set of policies will be reviewed in light of that exercise.

5.5. All local authorities face a degree of uncertainty regarding the potential for legal challenges when the bulk of the provisions of the Act come into force on 1st April 2015. We anticipate a period of national uncertainty until the courts begin to provide case law guidance. All three boroughs continue to prepare so that they are best placed to respond to any such challenges.

6. FINANCIAL AND RESOURCES IMPLICATIONS

6.1. Analysis and modelling continues to be undertaken locally in order to estimate the financial impact of implementing the Care Act. The latest estimates for Hammersmith and Fulham, covering the next five years, are attached as appendix 1. Modelling the impact of the Care Act is challenging due to the large number of variables and 'unknowns', particularly in relation to the number of self funders and carers that will present themselves to the authority. Hence these estimates will still need to be treated with a degree of caution but are a good indication of the likely scale of the impact. The main financial implications will stem from the cap on care costs, changes to the means tested support thresholds, increased number of assessment and reviews likely to be required, and the infrastructure needed to support the changes.

6.2. The total estimated costs are £1.7m in 15/16 and £9m over the next five years. The main cost impact in the early years is in relation to assessment and reviews (both self funders and carers) and carers' packages and other costs. It is estimated that it will cost £1.0m to £1.2m a year to carry out these functions. The care cap is also likely to have a significant financial

impact, again in the region of a £1.0m a year. This will be in the latter years, however, as costs to be set against the cap only begin in 2016/17 and only impact on the authority once the client reaches the cap. Any relevant cost impact from the national eligibility criteria will be built into the estimates following the results of the desk top review of existing eligible service users.

6.3. In December, Government funding for the Care Act in 2015-16 was announced. Hammersmith and Fulham will receive £840k. The grant has four components:

a) early assessments,
b) deferred Payments,
c) carers and care act Implementation and
d) social care in prisons)

In total the Council will have £1.7m (including £600k from the Better Care Fund) of funding in 2015/16 to meet the Care Act implementation costs. Future years funding is unknown at this time.

7.0 RISK MANAGEMENT

7.1 A lack of clarity about the true cost of Care Act implementation to support additional demands from self funders and carers may impact on Adult Social Care operations across the three boroughs. The Funding Reform workstream will continue to develop financial modelling to inform agreement of future funding arrangements with the Department of Health for 2016/17 to address the impact of the Care Act.

7.2 The Care Act places significant duties on local authorities to work in a more co-ordinated way to meet the wellbeing needs of people. Other council departments including Housing and external organisations including Health (i.e. CCG's and Mental Health Trusts) are therefore involved in developing collaborative and integrated working to respond to these duties, e.g. the Community Independence Service and the Customer Journey programme. This change management work will continue beyond April 2015 to fully embed improved ways of working with partner organisations.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	None Applicable		

LIST OF APPENDICES:
Appendix 1 – Latest Projected Costs and Funding for Care Act Implementation – Hammersmith and Fulham

h&f hammersmith & fulham	**London Borough of Hammersmith & Fulham** **HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY AND ACCOUNTABILITY COMMITTEE** **9 March 2015**
TITLE OF REPORT Self-Directed Support Progress Update	
Report of the Executive Director, Adult Social Care and Health	
Open Report	
Classification - For Review & Comment **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce	
Report Author: Toni Camp	**Contact Details:** Tel: 020 7361 2065 E-mail: toni.camp@rbkc.gov.uk

1. EXECUTIVE SUMMARY

1.1 This report provides a progress update on Self-Directed Support (SDS), including the Personalisation project, through which an improved operating system for Direct Payments (DPs) is being developed across the three councils.

2. RECOMMENDATIONS

2.1. The Committee is asked to review and comment on the contents of the report.

3. INTRODUCTION AND BACKGROUND

3.1 The Committee has been receiving regular updates on SDS since January 2013, at which time the DP Support Service provided by Action on Disability (AoD - formerly HAFAD) was preparing to close, following a council procurement exercise in 2012.

3.2 This topic was last considered by the Select Committee in April 2014. The report presented to that meeting summarised the outcome of a review of

existing DP cases in Hammersmith and Fulham, undertaken during 2013/14 and explained that a major project was underway to develop an improved DP offer across the three councils. This would be based on an 'in-house' operating model, meaning that all aspects of the DP system would be run internally, by ASC staff.

3.3 The Committee noted this development and raised a number of questions and comments, focusing on the need for effective two-way communication with customers regarding the changes, the need for effective DP support arrangements, both currently and in the future, and the planned introduction of pre-loaded payment cards. An update report was added to the Committee's work programme.

3.4 Currently in H&F a total of around 370 customers are making use of a DP. While there is a steady, though small demand for new DPs to be set up, the overall number of cases has remained relatively static over the past two years. This is due to a similar number of payments being discontinued, for one reason or another.

3.5 DP uptake is expected to increase as result of the improvements described in this report – please see below for further details.

4. PROGRESS UPDATE

Pre-loaded payment cards

4.1 The introduction of a new pre-loaded payment card for DP users is central to our plans for an improved DP offer. Pre-loaded cards are already in use in RBKC and Westminster but the current product does not work well for customers and better alternatives are now on the market. The Council is in the process of procuring a new card for use across the three authorities. The card will initially be introduced on a pilot basis for six months and if successful, the expectation is for it to become the usual way of receiving a DP, bringing significant improvements in ease of use and more efficient administration of public funds.

4.2 The introduction of the new card is expected to increase DP take-up by up to 20%. The purpose of the six month pilot and evaluation period is to enable issues to be identified and hopefully addressed. It will also allow for negotiation with the card provider, if necessary, thereby ensuring the best possible product. Success criteria include:

- Improvement of Personal Budget (PB) processing time
- Service User satisfaction with product, measured through personal outcomes evaluation
- Successful reporting functionality to identify variance from expected spend
- Improved financial control including ability to recover unspent funds.
- Departmental satisfaction with online systems and service provided by card provider.

4.3 This workstream has been subject to some delays. Originally, it was planned to procure a suitable card from a national framework agreement being developed by the Government Procurement Service (GPS), which was expected to go live in late 2013. However the GPS did not stick to its original timescale; the date was pushed back several times and the framework is still not in place. By summer 2014 it was clear that a different approach would be needed locally and the Council decided to run its own tender which will deliver a card for use in the three local authority areas. We are aiming for a start date in April/ May, with wider roll-out of the card taking place during the second half of 2015/16, subject to the outcome of the pilot.

4.4 Throughout the six month pilot period, all new customers interested in a DP will be offered the card as the default option. No new DP bank accounts are to be set up during the pilot unless in exceptional circumstance. Current preloaded card holders will be strongly encouraged to trial the new card, but will not required to do so as part of the pilot. If the outcome is successful, the card will become the default option and a DP bank account would only be agreed with a manager's agreement.

4.5 This workstream is being overseen by a project board which ultimately reports to the Director of Finance for Adult Social Care. There is a customer reference group, convened by Healthwatch, which has met at several key points to feed in to the work, including comments on the service specification and the success criteria for the pilot. The group will continue to meet over the coming 12 months to inform the implementation phase of the project, so helping to ensure a strong customer voice in the piloting and roll-out of the new card.

Towards a single operating system for DPs

4.6 A second major workstream is aimed at replacing the three separate (and significantly different) DP operating systems in place until now with a single one. This change is linked to the introduction of the new pre-loaded card and will have similar benefits in terms of an improved customer experience, better management of risk and more efficient administration of the money, with the potential for financial savings.

4.7 Given the different starting points in the three boroughs and wider changes that will affect the way ASC operates as a result of the Customer Journey project, the move to a single operating system is happening incrementally. The stage now reached is described in paragraphs 4.8- 4.11 below.

DP Support

4.8 An in-house DP support function for H&F has been in place since April 2013. From April 2015, a single team of five staff will provide DP support for all three boroughs, with their main focus on supporting the work of mainstream staff, rather than working directly with customers. This is based on the assumption that all social workers will understand DPs well

enough to provide high quality basic advice and information to customers, throughout the process of considering and taking up a DP and subsequently to check on their support arrangements at review. The five DP support staff provide expert back-up with an emphasis on continuing to up-skill mainstream staff, intervening directly where the issues are particularly complex. Other key functions of the team are as follows:

- Helping to up-skill staff in this area, not taking responsibility away.
- Working to improve support planning skills by demonstrating best practice and the benefits of this.
- Developing and embedding tools to assist staff in setting up and reviewing DPs
- Providing specific advice, guidance and training around employing Personal Assistants through DPs.
- Co-ordinating the ongoing programme of DP reviews in each borough, ensuring all cases are reviewed on schedule with appropriate input from Finance and care management.
- Providing assistance with reviews involving employment issues / other complexity or where appropriate undertake reviews directly.
- Development work to establish effective micro-commissioning for DPs. This will include: - mapping the current care market across Tri-Borough; mapping voluntary sector and universal resources; bringing customers together to pool budgets; negotiation with providers to meet customer needs or reduce prices.
- Supporting the implementation of the pre-loaded cards pilot (more work needed in H&F as cards not currently in use).

4.9 The DP support arrangements described above have so far been agreed on an interim basis, to 31 March 2016, to allow for wider changes arising from the Customer Journey project which will begin to take shape over the coming months. While the DP support functions outlined in paragraphs 4.8 will still be required, DP support arrangements going forward from April 2016 will be determined as an integral part of the Customer Journey redesign, rather than being considered in isolation.

Single DP finance team

4.10 In parallel to the single DP support team, a new DP finance team is being established, bringing together a number of existing posts based in the three finance teams under a single manager. The new team will be responsible for all aspects of DP administration, based on the new pre-loaded cards when introduced and a shared operational policy across the three councils. In the meantime existing manual systems will remain in place.

4.11 The reorganisation will be achieved without any loss of posts and is currently out for consultation with staff and trade unions. Subject to the outcome, implementation will commence from late April/early May.

Managed DP service

4.12 The other key development which has taken place over the past year and is now almost complete is the expansion of the current 'Managed DP service hosted by the RBKC ASC Finance Team, to cater to customers in LBHF. This service manages DP funding on customers' behalf, holding the money in an individual account, processing all relevant payments and providing the customer with regular statements. Where possible a Managed DP is seen as temporary option rather than long term, with customers being supported to move to self-management or management by a relative.

4.13 The in-house Managed DP has been running successfully for nearly four years and has proved both cheaper than externally provided options and more effective, in that finance officers work in close liaison with assessment and care management staff, ensuring that any warning signs such as build-up or misuse of DP funds are picked up without delay. The extension of this offer to H&F customers provides a much-needed new option for those who would struggle with money management or be placed at risk if left with this responsibility.

4.14 Following the planned introduction of preloaded cards, it is expected that the need for this option will reduce, as the card will make it viable for many more people to self-manage their DP, as well as reducing the risks associated with this option currently. Nevertheless the Managed DP option will still play an important role in facilitating DP use for a small proportion of customers.

Single DP Policy and legal agreement

4.15 There is a single DP policy in place across the three councils and linked to this a common DP agreement, setting out the roles and responsibilities of both parties (ie the customer and the council). Both have been in operation for just over 12 months and will be reviewed early in the new financial year with input from staff and customers. A 'user-friendly' version of the DP policy is overdue and will be produced in the next few months in collaboration with the customer reference group. Staff training on the new policy and agreement is being provided on a rolling basis.

Embedding personalisation

4.16 As earlier reports have emphasised, personalisation is a broad and inclusive concept, applicable to all ASC customers. It's about providing support tailored around the individual and the way they want to live their life - the opposite of a 'one size fits all' approach.

4.17 A personalised way of working needs to be the norm in adult social care, regardless of whether someone chooses to design and set up their own support arrangements, using a DP, or prefers the council to arrange support on their behalf. Embedding a personalised ethos throughout our

assessment and care management service is a long term task which has been underway for some years but requires ongoing attention. Recent discussions with frontline staff have highlighted the need to reinvigorate the values of choice and control and this will be a key focus for training over the coming year. In addition we will provide ongoing training around the use DPs, including updates on the improvements to our DP offer as these take shape. Parallel communication will also take place in relation to customers and the wider public to increase awareness of DPs and how to access them,.

4.18 While recognising that DPs are not the right solution for everyone, it is clear that local uptake is still relatively low. Given the potential benefits of DP use, it is planned to identify a number of practitioners, including a practitioner lead, to champion these changes in culture and practice, as well as continuing to embed personalisation in its wider sense.

5. CONSULTATION

5.1 Council officers have continued to be in regular liaison with AoD. A specific development has been that AoD have received funding to pilot a peer support project, building on the existing peer support group that had been running for a number of years. As well as offering continuity for customers during a period of significant change and uncertainty, there was evidence that such a service, run by a user-led organisation, could work in a way that adds value to the overall operating model for DPs. The project has been funded to April 2016 and is exploring various ways of supporting and empowering DP users through peer-to-peer contact, information exchange and opportunities to join up.

5.1 As noted above there is a customer reference group attached to the pre-loaded cards project. This group has had direct input into shaping how the cards will operate and will continue to do so over the coming year. The group has also discussed some wider issues of personalisation and received a briefing on the Customer Journey project, with the invitation to comment on service design proposals as these emerge over the coming months. In addition the group will be involved in the forthcoming review of the new DP policy and agreement.

5.2 To follow-up on a number of points raised at the last discussion on SDS, at the Committee meeting in April 2014, council officers attended a meeting of the AoD peer support group in June 2014. Group members had prepared a list of questions for officers at an earlier meeting so the agenda was focused around these. Questions focused on:

- A lack of clarity around DP support arrangements and the need for better communication about the service available.
- DP take-up, the new policy and specific areas of this.
- The availability and quality of support plans and the frequency of care management reviews for DP users.

Notes were written up by AoD and circulated to all those who had helped draft the questions as well to everyone else on their mailing list (a total of over 400 individuals).

6. EQUALITY IMPLICATIONS – N/A

7. LEGAL IMPLICATIONS – N/A

8. FINANCIAL AND RESOURCES IMPLICATIONS

8.1 The cost of the in-house DP support for H&F customers in 201/16, described in para 4.8, will be approximately £75,000. This will be met through the existing funding allocation.

8.2 The creation of a single DP finance team across the three boroughs will be achieved by reorganising existing staff with a nil cost implication.

9. RISK MANAGEMENT

9.1. There are some risks associated with DP use if customers do not have access to appropriate advice and support or if reviews are carried out without the necessary expertise to check on employment arrangements. These risks are effectively mitigated by the DP support arrangements described in this report. Similarly the financial risks posed to the councils as a result of DP use will be mitigated by tighter administration through the new shared DP finance team, with the new pre-loaded cards making a major impact from the second half of 2015/16 onwards (subject to successful piloting).

10. PROCUREMENT ISSUES – N/A

11. CONCLUSION

11.1 Good progress is being made in developing an improved DP offer across the three councils. The piloting of the new pre-loaded payment card has been delayed but this will now go ahead very shortly and is expected to bring substantial benefits, including increase uptake of DPs. Meanwhile the initiatives to promote culture change within our operational teams, embedding personalisation as an ethos which underpins our service offer as a whole, will bring benefits to all ASC customers.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
	None		

	London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY AND ACCOUNTABILITY COMMITTEE** **9 March 2015**
TITLE OF REPORT: OVERVIEW OF THE PUBLIC HEALTH SERVICE FOR THE THREE BOROUGHS	
Report of the Executive Director, Adult Social Care & Health	
Open Report	
Classification - For Scrutiny Review & Comment **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director, Adult Social Care & Health	
Report Author: Stuart Lines, Deputy Director of Public Health	**Contact Details:** Tel: 020 76414690 E-mail: slines@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1. This paper describes both the mandatory and non-mandatory public health responsibilities, functions and services delivered in the London Borough of Hammersmith & Fulham.

1.2. This report was deferred at the January 2015 PAC meeting.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	None		

LBHF PAC 20th JANUARY 2015

OVERVIEW OF THE PUBLIC HEALTH SERVICE FOR THE THREE BOROUGHS

1. INTRODUCTION

1.1 This paper describes both the mandatory and non-mandatory public health responsibilities, functions and services delivered in LBHF.

1.2 Under Section 12 of the Health & Social Care Act 2012 [i], from 1 April 2013, unitary local authorities have a duty to improve the health of the public, including for example: [ii]

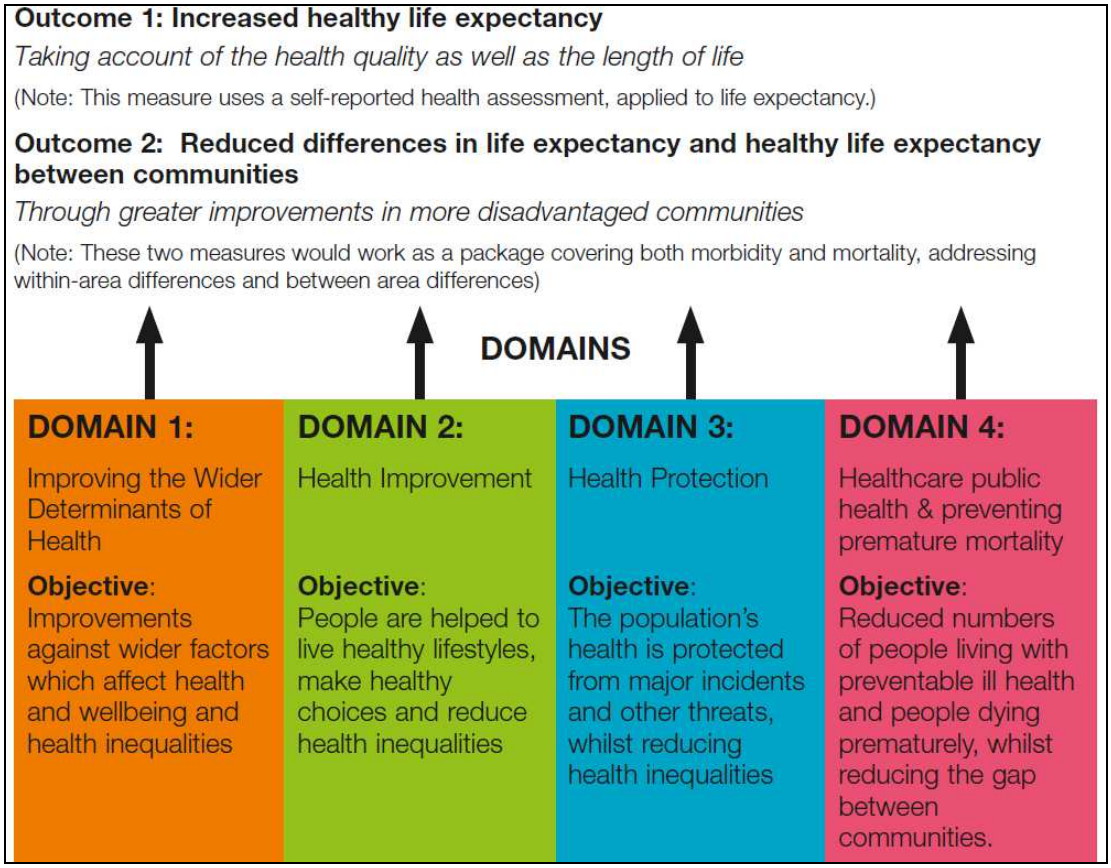
- providing information and advice (for example giving information to the public about healthy eating and exercise); and
- providing or making arrangements for the provision of services for the management of health risk factors such as such smoking, and overweight and obesity).

1.3 Regulations [iii] made under Section 6c of the NHS Act 2006 mandate local authorities to:

- provide for the weighing and measuring of children in reception classes and Year-6 (the National Child Measurement Programme);
- provide for the provision of health checks for people aged 40-74 years;
- provide for the provision of open access sexual health services;
- provide or make arrangements for the provision of a public health advice service to CCGs in their area; and
- provide information and advice on the preparation for and the management of threats to people's health such as infectious diseases, environmental hazards and extreme weather conditions.

1.4 The Health & Social Care Act 2012 also requires unitary authorities to have regard to the Department of Health's Public Health Outcome Framework (PHOF)[iv] which includes a range of measures across two key outcomes and four domains:

[i] http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted/data.htm
[ii] Local authorities' public health responsibilities
http://www.parliament.uk/business/publications/research/briefing-papers/SN06844/local-authorities-public-health-responsibilities-england
[iii] http://www.legislation.gov.uk/ukdsi/2012/9780111531679
[iv] http://www.phoutcomes.info/



The public health team provides leadership on these outcomes through working closely with colleagues across Council departments and with external partners, such as the NHS and voluntary sector.

Further detail on the indicators is provided in appendix 1.

2. FUNDING AND CAPACITY

2.1 Public health currently has a stand-alone ring-fenced public health grant, which is required to be used for health improvement, health protection, reducing health inequalities and for providing public health advice to CCGs [v].

Further detail on the public health budget may be found in Appendix 2.

2.2 The public health team is currently structured as follows:

- Intelligence, including – data analysis and evidence, public health advice service to CCGs, JSNA process
- Children and families, including – childhood obesity, school nursing, health visiting transfer

v https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/388172/final_PH_grant_determination_and_conditions_2015_16.pdf

- Behaviour change, including – commissioning of health checks, community champions, diabetes champions, smoking cessation
- Substance misuse and sexual health - service commissioning
- Health protection, including advice and assurance on infectious disease
- Social determinants, including supporting collaboration across council functions to deliver public health outcomes

The structure of the public health team is currently under review.

3. THE DRAFT PUBLIC HEALTH STRATEGY

2.1 A Public Health Strategy is currently being developed, which aims to help the three councils focus on their joint and individual priorities for improving health outcomes.

There are six proposed joint priorities:

- reducing smoking rates
- reducing levels of obesity in adults and children
- improving sexual health
- reducing substance misuse
- improving preventative health care
- improving mental well-being

2.2 Each of these priority areas, in addition to other work, will contribute to the council's mandatory public health duties and to its wider public health duty to improve the health of the local population.

2.2.1 *Smoking* is the primary cause of preventable illness and premature death[1] and smokers are twice as likely to die before the age of 70 years as are life-long non-smokers.[2] Some 65% of adult smokers start smoking before the age of 18 years; only 6% start aged over 25 years.[3] LBHF has higher rates of smokers (21.4%) than the other two boroughs and more than the average for England (19.5%).

An important public health priority therefore is to both help people to quit and reduce the likelihood of children starting to smoke.

2.2.2 *Overweight and obesity* are major problems because they substantially increase the risk of developing a number of long-term conditions. Principal among these is type 2 diabetes because it substantially increases the risk of heart disease, blindness, kidney failure and early death.[4] Overweight and obesity also substantially increase the risk of developing high blood pressure, raised blood cholesterol levels, osteoarthritis, sleep apnoea (an interruption of breathing during sleep that increases the risk of sudden cardiac death), stroke, a number of

cancers, and dementia.

Our priority therefore should be helping people of all ages to avoid becoming overweight and obese and reducing the risks of disease by helping people to reduce excess weight.

2.2.3 *Sexual health* is significant because of the propensity of sexually-transmitted infections to be spread easily and amongst many people (the number of people infected increases year-on-year), leading to a variety of different health problems requiring treatment, and the very substantial cost of HIV treatment. In addition, 'unsafe' sex can not only lead to infection but also to unplanned pregnancy. In 2012, Hammersmith and Fulham had the 5th highest rate of STIs in England.

The treatment of sexually-transmitted infections is now the responsibility of local councils. The LBHF budget for this alone in 2015/16 is £6.4m. Unless we do more to identify people with such infections at an earlier stage (enabling treatment and thus reduced risk of infection of others) and encourage greater condom use (for example through the development of condom negotiation skills) the need for such treatment services will continue to rise.

2.2.4 *Substance misuse* includes the use of illicit drugs and so-called legal highs as well as alcohol. The contribution of drug-use disorders to mortality has increased very substantially in the last 20 years[5] as has the number of people admitted to hospital because of alcohol misuse and deaths due to alcohol-related non-violent causes (such as liver failure).[6] Hammersmith and Fulham has the 3rd highest rate of deaths due to chronic liver disease in London and alcohol-related hospital admissions have more than doubled over the last decade.

It is also significant that whilst drug use is likely to have a proportionately much greater deleterious impact on the life and health of the user, the number of people drinking alcohol in excess of recommended guidelines presents a much larger problem overall. Substance misuse is one of the largest areas of expenditure from the public health budget at £5.5m for 2015/16 in LBHF.

2.2.5 *Improving preventive health care* includes promoting screening (for example, health checks) and assuring adequate immunisation coverage.

Currently, there is conflicting evidence on the effectiveness of health checks, but our experience so far is that we are identifying a moderately high proportion of people with previously unknown remediable risk factors for heart disease, stroke, diabetes and kidney failure. Health checks are mandatory services for local councils to provide. We are likely to improve people's health most by concentrating our health check activity more in deprived areas.

Immunisation is second only to a clean water supply in reducing the burden of ill-health.[7] The council role in immunisation is principally to

assure the process which is commissioned solely by NHS England.

2.2.6 *Improving mental well-being* is of particular importance in LBHF. There is a clear link between loneliness and poor mental and physical health (i.e. tackling loneliness and social isolation, supporting people to remain connected to their communities and to develop and maintain connections to their friends and family). In 2013/14, 38.4% of Hammersmith and Fulham residents who use services reported that they had as much social contact as they would like, which was significantly lower than England (44.5%).

3. KEY WORK AREAS TO MEET OUR MANDATORY DUTIES AND TO IMPROVE HEALTH

3.1 *Smoking cessation* is particularly cost-effective[8] and has short-term benefits (such as a statistically significant risk reduction of planned surgery within 4-8 weeks of quitting[9]), medium term benefits (such as reducing the risk of heart attack within 12 months[10]) and long-term benefits (such as reducing the risk of cancer over several years[11]).

We are working with Hammersmith & Fulham CCG to develop ways to encourage patients who smoke to quit whilst they are receiving treatments and to help patients quit smoking before elective surgery.

We commission a local provider, *Thrive Tri*be, to deliver stop smoking services and training to GP practices and pharmacies so they can deliver stop smoking advice. The contract prioritises residents in the top two quintiles of deprivation, where prevalence rates on a ward basis can reach 25%.

In addition we commission the local provider to deliver the three national campaigns and three local campaigns each year, as well as a service which aims to stop young people from starting to smoke.

3.2 *Health checks*, a mandated service for local councils, help identify people at risk of conditions such as heart disease, stroke, diabetes and kidney failure before symptoms develop. We are concentrating our efforts particularly in the borough's more deprived areas where disease rates are higher and the consequences more significant. Health Trainers have been commissioned to deliver health checks in community settings.

We also intend to tender for cardiovascular disease (CVD) prevention services, concentrating on family-level interventions as well as individual ones. The service will be for people identified as at medium or high risk of developing CVD in the next ten years. Major referral sources for this are GP and community pharmacy health checks. We are amending the key performance indicators away from process measures to health outcomes.

3.3 *Community Champions* are a valuable way of influencing people's health behaviour at a 'street level'. Community champions deliver work

across a broad range of public health outcomes, including mental health, employment and employability, weight loss, increased physical activity and community cohesion.

We currently have three community champion projects, in Edward Woods, Old Oak and in the Parkview Centre in White City. The SROI (Social Return on Investment) evaluation of the projects revealed that for every £1 invested in the project, there is a return of £5.05.

In addition we have a Maternity Champions project in Old Oak, to support expectant parents in accessing services at an early stage and to make sure every child gets the best start in life. The project is working closely with midwives, health visitors and children's centres.

Working in collaboration with housing associations, we plan to extend these projects to include new ones in Shepherds Bush Green, North end Road and Lillie Road.

3.4 *Diabetes Champions* are volunteers affected by diabetes who work in communities to raise awareness of diabetes risks and how to reduce them. With the continuing rise in the prevalence of overweight and obesity, this is an especially important subject. In the first two quarters of this year our provider ran 38 events involving 636 people. An evaluation of similar work locally in 2012 showed 95% of event attendees improved their knowledge of diabetes; 80% made changes to increase their physical activity, and 75% made changes to improve their diet.

3.5 *Child obesity prevention and healthy family weight services* are a key component of councils' responsibilities to deal with wider determinants of poor health. We are currently procuring services to help establish 'healthy habits for life' in the context of eating, cooking and physical activity. The wider child obesity prevention strategy is working with NHS services, Schools, Children & Family services, and parks, sport and leisure services.

We will continue our statutory duty to deliver the National Child Measurement Programme (NCMP), which includes providing feedback to parents and supporting access to obesity prevention and management programmes.

3.6 *Genito-urinary medicine (GUM) and other sexual health service commissioning* will also continue but we are looking to reduce the cost of both GUM and contraceptive services; decommission some services related to HIV that are not part of our obligation under the Health & Social Care Act 2012; increase the range and reach of prevention services and advice; and, as much as possible, move contract key performance indicators away from service provision measures to hard outcome and proxy outcome measures.

3.7 *Substance misuse service* funding will be shifted from the General Fund to Public Health Grant monies.

3.8 *Mental health* problems are common, with some 30% of people who see their GP having a mental health component to their illness,[12] and about one in four experiencing a mental health illness at least once.[13]

We are exploring ways in which we might improve people's mental health wellbeing, particularly in terms of identifying potential problems at an early stage.

3.9 *Health protection* work will continue. For example, one role of councils is now to provide assurance that immunisation rates are adequate. Immunisations are commissioned from primary care by NHS England and we are working with them to see how we can obtain more accurate data on immunisation uptake as well as contribute to increasing uptake.

We have also provided advice on Ebola virus infection for staff and local GP practices and keep this up to date.

4. SERVICE PROVIDERS

4.1 We have a large number of contracts with a wide range of providers to deliver various public health interventions. These include several individual GP surgeries, some community pharmacies, third sector organisations, NHS community services providers and NHS acute trusts.

4.2 This diversity of provision enables better service access both in terms of choice, and, importantly, in terms of sensitivity to and appeal for different population groups.

5. RISKS

5.1 The NHS public health function was moved to local councils in 2013 because the majority of the key 'upstream' determinants of health, such as education, employment, housing and environment, lie outside the NHS remit and fit more closely with local authority functions.[14]

A number of other functions, such as the treatment of sexually-transmitted diseases and school nursing services, were transferred at the same time.

5.2 Local councils face a reputational risk should they not be seen to improve people's health and reduce health inequalities. Mitigating this will require effective integration of the public health function into council working and adequate investment in key areas affecting people's health.

APPENDIX 1
Public Health Outcomes Framework (PHOF) key indicators

1 Improving the wider determinants of health
Objective Improvements against wider factors that affect health and wellbeing and health inequalities
Indicators • Children in poverty • School readiness • Pupil absence • First-time entrants to the youth justice system • 16-18 year olds not in education, employment or training • Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation • People in prison who have a mental illness or a significant mental illness • Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services • Sickness absence rate • Killed and seriously injured casualties on England's roads • Domestic abuse • Violent crime (including sexual violence) • Re-offending levels • The percentage of the population affected by noise • Statutory homelessness • Utilisation of green space for exercise/health reasons • Fuel poverty • Social isolation • Older people's perception of community safety

2 Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

- Low birth weight of term babies
- Breastfeeding
- Smoking status at time of delivery
- Under 18 conceptions*
- *Child development at 2-2½ years (under development)*
- Excess weight in 4-5 and 10-11 year olds*
- Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years
- Emotional well-being of looked after children
- *Smoking prevalence – 15 year olds (placeholder)*
- Self-harm
- Diet
- Excess weight in adults
- Proportion of physically active and inactive adults
- Smoking prevalence – adult (over 18s)
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Recorded diabetes
- Alcohol-related admissions to hospital
- Cancer diagnosed at stage 1 and 2
- Cancer screening coverage
- Access to non-cancer screening programmes
- Take up of the NHS Health Check Programme – by those eligible*
- Self-reported wellbeing
- Falls and injuries in people aged 65 and over

3 Health protection

Objective

The population's health is protected from major incidents and other threats, while reducing health inequalities

Indicators

- Fraction of mortality attributable to particulate air pollution
- Chlamydia diagnoses (15-24 year olds)*
- Population vaccination coverage
- People presenting with HIV at a late stage of infection
- Treatment completion for Tuberculosis (TB)
- Public sector organisations with board-approved sustainable development management plan
- Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies*

4 Healthcare public health and preventing premature mortality
Objective Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities.
Indicators • Infant mortality • Tooth decay in children aged 5 • Mortality from causes considered preventable • Mortality from all cardiovascular diseases (including heart disease and stroke) • Mortality from cancer • Mortality from liver disease • Mortality from respiratory diseases • Mortality from communicable diseases • Excess under 75 mortality in adults with serious mental illness • Suicide rate • Emergency readmissions within 30 days of discharge from hospital • Preventable sight loss • Health-related quality of life for older people • Hip fractures in people aged 65 and over • Excess winter deaths • Estimated diagnosis rate for people with dementia

APPENDIX 2
The LBHF public health budget

	Actual Budget 2014/15 £'000	Proposed Budget 2015/16 £'000	Estimated Budget 2016/17 £'000	Estimated Budget 2017/18 £'000
Income/ Funding				
Public Health Grant Income	(15,228)	(15,228)	(15,228)	(15,228)
Substance Misuse Grant	(5,627)	(5,627)	(5,627)	(5,627)
0-5 Programme incl Health Visiting (from Oct 2015)	-	(1,833)	(3,667)	(3,667)
Drawdown from PH Reserves	-	(783)	(327)	-
Total Income	**(20,855)**	**(23,471)**	**(24,849)**	**(24,522)**
Contract Expenditure				
Substance Misuse	5,464	5,464	5,191	4,931
Sexual Health	6,978	6,410	6,169	5,986
Behaviour Change	2,110	2,753	2,953	2,953
Families and Children's Services	2,607	5,135	6,968	6,968
Intel & Social Determinants	41	89	89	89
Total Contract Expenditure	**17,200**	**19,851**	**21,370**	**20,927**
Overheads and Other Expenditure				
Salaries and overheads	1,431	1,435	1,435	1,435
Unallocated budget	2,570	-	-	116
PHIF projects	-	1,817	1,676	1,676
Children's services funding	-	368	368	368
Total net expenditure (General Fund)	**346**	**0**	**0**	**0**

Contract Expenditure	2014/15 Budget £'000	Budget 2015/16 £'000	Budget 2016/17 £'000	Budget 2017/18 £'000
Detox & Residential Placements	590	590	561	532
Community Based Services	3,518	3,518	3,342	3,175
Reducing Reoffending	280	280	266	253
Dual Diagnosis	100	100	95	90
other	976	976	927	881
Substance misuse	**5,464**	**5,464**	**5,191**	**4,931**
			-	-
GUM	4,300	4,026	4,026	3,870
Chlamydia Screening	375	375	375	375
HIV Contracts	764	562	351	351
Contraception	1,165	1,072	1,050	1,030
Other	374	375	367	360
Sexual Health	**6,978**	**6,410**	**6,169**	**5,986**
			-	
Health Checks	414	414	414	414
Smoking Cessation	901	924	924	924
Heath Trainers	503	777	777	777
Community Champions	257	403	403	403
Cardiovascular risk management programme	-	200	400	400
Other	35	35	35	35
Behaviour Change	**2,110**	**2,753**	**2,953**	**2,953**
			-	
Obesity & Dietetics	395	944	944	944
School Nursing	1,920	1,920	1,920	1,920
Healthy Schools	60	60	60	60
Domestic violence	127	127	127	127
Dental health	41	41	41	41
Mental Health	33	33	33	33
Healthy Start Vitamins	31	31	31	31
Tackling Childhood Obesity program/ pilot	-	145	145	145
0-5 Programme incl Health Visiting	-	1,834	3,667	3,667
Families and Children	**2,607**	**5,135**	**6,968**	**6,968**
Libraries work around health	17	17	17	17
Health Promotion Recource Centre	24	23	23	23
PublicHealth Leadership Forum	-	6	6	6
Making Every contract count	-	15	15	15
Specialist project work	-	15	15	15
Software	-	5	5	5
JSNA Website	-	1	1	1
NHS Data access	-	7	7	7
Intel & Social Determinants	**41**	**89**	**89**	**89**
Total	**17,200**	**19,851**	**21,370**	**20,927**

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Agenda Item 9

Health, Social Care and Social Inclusion Policy and Accountability Committee

Work Programme 2014/2015
22 July 2014
Imperial College Healthcare NHS Trust: Cancer Services Update Shaping a Healthier Future: Update on programme and decisions to date. Healthwatch: Presentation on its Role and Work Care Act: Update
7 October 2014
Hammersmith & Fulham Foodbank Imperial College Healthcare NHS Trust: (i) update following closure of Hammersmith Hospital Accident & Emergency Department (ii) update on outline business case for clinical services across the three main hospital sites, following Trust Board meeting Medium Term Financial Strategy (Update)
17 November 2014
Adult Social Care Information and Signposting Website – People First Call for Evidence: Engaging Home Care Service Users, their Families and Carers Independence, Personalisation and Prevention in Adult Social Care and Health Safeguarding Adults: Annual Report
3 December 2014
Healthwatch Adult Social Care Customer Feedback: Annual Report 2013/2014 Customer Journey: Improving Front-line Health & Social Care Services Meals on Wheels Under Fives Flu Vaccination Programme in Hammersmith & Fulham
20 January 2015
Imperial College Healthcare NHS Trust: Accident & Emergency Waiting Times 2105 Medium Term Financial Strategy Abolition of Charging for Home Care Services Overview of Public Health Services for the Three Boroughs Under Fives Flu Vaccination Programme in Hammersmith & Fulham
4 February 2015
Imperial College Healthcare NHS Trust: CQC Report and Action Plan Imperial College Healthcare NHS Trust: Accident & Emergency Performance Shaping a Healthier Future: Update
9 March 2015
Care Act : Go Live Implications Central London Community Healthcare NHS Trust: Five Year Strategy and Foundation Trust Status Update Healthwatch Dignity Champions Self Directed Support: Update Overview of Public Health Services for the Three Boroughs

April 2015
Carers' Survey Equality and Diversity Programmes and Support for Vulnerable Groups GP Networks and Enhanced Opening Hours Imperial College Healthcare NHS Trust: Actions in response to the Francis Inquiry recommendations Review of Learning Disabilities Day Services Transition from Children's to Adult Social Care
2015/2016 Meetings
Chelsea and Westminster Hospital NHS Foundation Trust: CQC Report and A&E Waiting Times Customer Journey: Update Customer Satisfaction Digital Inclusion Strategy H&F CCG: Performance Report H&F Foodbank Imperial College Healthcare NS Trust: Outpatients PAS Update Integration of Healthcare, social care and public health Meals on Wheels: Future Arrangements Safeguarding Adults: H&F Report