

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

## Agenda

Monday 14 March 2016

7.00 pm

Courtyard Room - Hammersmith Town Hall

### MEMBERSHIP

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

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[http://www.lbhf.gov.uk/Directory/Council\\_and\\_Democracy](http://www.lbhf.gov.uk/Directory/Council_and_Democracy)

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

## Agenda

14 March 2016

<u>Item</u>	<u>Pages</u>
<b>1. MINUTES OF THE PREVIOUS MEETINGS</b>	1 - 17
<p>(a) To approve as an accurate record and the Chair to sign the minutes of the meetings of the Health, Adult Social Care and Social Inclusion PAC held on 19 January 2016 and 2 February 2016.</p> <p>(b) To note the outstanding actions.</p>	
<b>2. APOLOGIES FOR ABSENCE</b>	
<b>3. DECLARATION OF INTEREST</b>	
<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	

**4. UPDATE ON FUTURE PLANS FOR CHARING CROSS HOSPITAL AND THE IMPERIAL COLLEGE HEALTHCARE NHS TRUST AND THE CCG'S RESPONSE TO THE MANSFIELD INQUIRY**

A paper to follow.

**5. UPDATE ON CO-PRODUCTION IN COMMISSIONING**

18 - 24

The report produced by SOBUS on behalf of stakeholders provides information on the development of co-production in commissioning and outlines the next steps in the development of a Co-production Charter.

**6. WORK PROGRAMME**

25 - 26

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

**7. DATES OF FUTURE MEETINGS**

Monday 18 April 2016

Tuesday 14 June 2016

Tuesday 12 July 2016

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

Tuesday 19 January 2016

### **PRESENT**

**Committee members:** Councillors Hannah Barlow, Andrew Brown, Joe Carlebach, Rory Vaughan (Chair) and Natalia Perez

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

**Other Councillors:** Stephen Cowan, Sue Fennimore, Sharon Holder and Vivienne Lukey

**Officers:** Peter Smith (Head of Policy and Strategy), Chris Neill (Director, Whole Systems), Helen Banham (Strategic Lead Professional Standards and Safeguarding) and Kayode Adewumi (Head of Governance and Scrutiny)

### **38. MINUTES OF THE PREVIOUS MEETING**

- (i) The minutes of the meeting held on 4 November 2015 were approved as an accurate record and signed by the Chair.
- (ii) The outstanding actions were noted.
- (iii) The Committee asked that their best wishes be passed to Sue Perrin who had taken ill.

### **39. APOLOGIES FOR ABSENCE**

Apologies were received from Debbie Domb.

### **40. DECLARATION OF INTEREST**

Councillor Joe Carlebach declared an interest in item 4 (Independent Healthcare Commission for North West London) as Vice Chair of the Royal National Orthopaedic Hospital Trust, Stanmore.

### **41. INDEPENDENT HEALTHCARE COMMISSION FOR NORTH WEST LONDON**

Peter Smith summarised the background, process, key findings and recommendations of the Commission. The Shaping a Healthier Future (SaHF) programme was consulted on in 2012. Part of the business case was to reduce the number of major hospitals in North West London to 5 from 9. The Commission was launched in 2014 by 5 West London authorities in reaction to the closure of 2 accident and emergency departments. The Commission was chaired by Michael Mansfield QC with 2 other independent members. It operated like a Parliamentary Select Committee inquiry with an open call for written evidence followed by 4 public hearing sessions. The report was produced in December 2015, setting out the Commission's key findings and recommendations.

The key findings and recommendations were as follows:-

- Current and future healthcare needs

The data used by NHS for the public consultation in 2012 is now out of date. It did not take into account the significant increase in actual population and future projections across the region resulting from regeneration plans and economic development proposals for the area.

Recommendation – That the current business case should be made available immediately for proper public scrutiny.

- Finance and Economics

The projected cost of the programme has escalated from £112 million to over £1 billion. The return on this investment would be insufficient, based on the strength of the existing evidence. Evidence points to financial factors rather than patients' needs as playing a significant role in the SaHF programme's selection of major and local hospital designations.

Recommendation – That the National Audit Office should undertake a review of the value for money of the SaHF programme.

- Public Consultation

No additional engagement with the local public had been carried out since the public consultation exercise was conducted in 2012.

Recommendation – A fresh consultation on the latest version of the business case should be undertaken.

- A&E closures and other reconfiguration plans

The closure of Ealing Maternity department and the A&E services at Central Middlesex and Hammersmith Hospitals have had a huge impact on the provision of health services at Northwick Park Hospital leading to a deterioration of performance, particularly in relation to A&E waiting times.

Recommendation – The closures at Ealing and Central Middlesex should be reversed and no urgent care centre should be put in place without co-location of A&E provision.

- Out of hospital provision

Out of hospital provision is being developed in a piecemeal fashion and at a slow pace largely due to the lack of detailed plans.

Recommendation – That a substantial investment in GPs and out of hospital services is required within a sub-regional out of hospital strategy.

- Governance and Scrutiny

There is a lack of transparency in the governance arrangements for the SaHF programme resulting in unclear accountability for decision making across the programme.

Recommendation – That elected local authority representatives should be invited to attend SaHF programme Board meetings for greater accountability and transparency.

The Committee noted that ongoing follow up work was being undertaken. A letter had been sent to the Secretary of State for Health requesting a meeting to discuss the findings and recommendations.

Councillor Carlebach sought clarification on who owned the SaHF programme. It was reported that the Commission was unable to identify where the programme sat within the complex NHS governance structure as there was little clarity around the structure. He raised serious concerns regarding the level of care that could be provided to children referred to an urgent care centre which was not co-located with paediatric consultant provision. Officers noted that some GPs were refusing to refer children to Urgent Care Centres where there was no co-location with A&E provision. The evidence gathered by the Commission has shown that this has been the case at Hammersmith and Central Middlesex Hospitals. Councillor Carlebach suggested that officers should raise this point with the Royal College of Paediatricians.

Councillor Perez asked how the Neighbourhood Health Forum would engage with local residents. Councillor Holder said that although the Forums were not related to the Commission's work they will look in detail and focus on health care provision in Hammersmith. Stakeholders will be invited to listen to what the residents have to say. The 4 forums have been set up for North and South Fulham, Shepherds Bush and Hammersmith. The meetings will run from January to March. Councillor Carlebach asked that MENCAP be invited to the Forum meetings.

Bryan Naylor noted that the Older People Rapid Access clinic set up at Charing Cross hospital had improved services to older people. He inquired whether there would be a roll out of this successful programme across other hospitals. He also asked that the Commission's report should reference older peoples services. Officers reported that the council was working with the NHS to ensure that good practices from Community Independence Service at Charing Cross hospital were captured and rolled out across more hospitals. The work will continue in the current year but the local authority cannot guarantee continued provision as the SaHF programme business case had not been published.

Councillor Barlow inquired about the response from the stakeholders to the Commission's work. Officers noted that there was extensive media coverage. The public's reaction was very encouraging. The local authorities are awaiting a response from the Secretary of State. Although the response from the NHS had been muted, a letter was written by the Chairs of the Ealing and Hounslow CCGs to local GPs informing them that the programme would go ahead irrespective of the commission's findings.

The Leader noted that neither an updated business case nor detailed answers had been received from the NHS on the SaHF programme. The NHS structure showed that there was no one voice speaking on behalf of the region. The Council requires a meeting with the Secretary of State to speak with one voice and obtain detailed answers to figure out the way forward. Until the NHS is able to provide such answers the programme should be halted.

Councillor Brown noted that there are a couple of things in the report which he agreed with but felt a more politically neutral person would have been better suited as Chair. He asked how certain was the Commission that Charing Cross hospital would lose its A&E department as there was no clear evidence that it would be classified as a Class 3 A&E or Urgent Care Centre. If the evidence of a downgrade came to light, he would stand with residents and campaign against a closure of the A&E provision.

The Leader noted that Michael Mansfield QC was not chosen because of his political affiliation. He was selected because he was a good chair, an exceptionally talented legal lawyer who had led many national inquiries. The crux of the matter regarding the provision of A&E services was the new service definition of classes 1, 2 and 3. Charing Cross Hospital had been classified as a class 3 A&E service which was equivalent to an Urgent Care

Centre. Officers also highlighted that GPs and residents had raised the confusion about the classification of A&E services particularly what an Urgent Care Centre can deliver in ways of services and who should be referred there. For the benefit of residents and all the users of Charing Cross hospital, we need an absolute clarification on the state of the A&E service at the hospital.

Councillor Brown was of the view that it made sense for the NHS to review its programmes and provisions while taking into account changes in the demographics. He supported future clarity from the NHS and scrutiny of their business case. He accepted that there should be no further closure of services without scrutiny of the business case.

It was reported that Dr Anne Rainsberry said at a meeting with the Commission in September that the final business case was due to be sent to the Treasury and Department of Health for approval in January. Councillor Carlebach suggested that officers should write to Dr Anne Rainsberry seeking the current state of the business case, the timeline for implementation and an update on the approval process.

Councillor Brown noted that the report did not talk about outcomes nor provide an alternative course of action. The Leader stated that the implementation cost of the SaHF programme had escalated to over £1 billion. It was not possible to put forward alternative proposals without the prerequisite information received from the NHS about the SaHF programme and its business case.

The Chair invited questions and comments from residents in the audience.

A resident expressed concern about the lack of information regarding the SaHF programme. She was of the view that there were some benefits of centralising some services in the right areas but there was no justification for downgrading Charing Cross hospital's A&E. She understood from the Imperial College Healthcare NHS Trust clinical strategy that they want Charing Cross to be a GP-led A&E service.

Furthermore, she referred to Dr Ajaib Sandhu's blog which highlighted the problems of reduced A&E capacity in the area causing increased waiting times. In 2015, 217 people had waited more than half an hour in an ambulance. The NHS cannot afford to take more capacity out of the services. She urged the committee to support the Mansfield report and speak as one voice against the closures.

Another resident welcomed the report. She noted that the number of overnight beds proposed by Imperial made it impossible for Charing Cross to support a class 1 or 2 A&E service. The CCG had made it quite clear that they planned to proceed with the SaHF programme. She was of the opinion that the business case would be published after it had been approved without further public consultation or scrutiny.



She asked would the 5 local authorities seek a judicial review of the decision if the SaHF was not halted. The Leader expressed his gratitude for the work of the Save Our Hospitals campaign. He noted that the council had written to the Secretary of State requesting a meeting with the 5 Leaders to review where we are at and seek a halt to the closure programme. We do not want to preclude such discussions. But no one should doubt that the Leaders will not do everything to defend our hospitals and health services against closure.

Another resident expressed concern regarding the confusion around urgent care centres. She asked how a resident would be able to determine whether to attend an A&E or Urgent Care Centre. In noting her concerns, the Leader referred her to a video on the council's website where her question is addressed in interviews.

In conclusion, the Chair noted that Michael Mansfield QC and the commissioners had undertaken a very thorough review gathering evidence from a very wide range of stakeholders. The report drew out the concerns of residents, elected representatives, clinicians and others about the state of the SaHF programme particularly that the original consultation was out of date, demographic changes had not been taken into account and no further information on the business case had been provided. He thanked the Commission for producing such an important piece of work.

The Committee

- welcomed the report and endorsed its recommendations
- would invite the NHS England to a meeting to respond to the findings of the Commission
- called on the NHS to publish a full business case with an Equalities Impact Assessment and other appropriate assessments and to subject it to full public consultation and transparency before approval by the Treasury.

#### **42. SAFEGUARDING ADULTS EXECUTIVE BOARD: ANNUAL REPORT 2014/2015**

Mike Howard, Independent Chair, presented that Safeguarding Adults Executive Board Annual Report 2014/15 to the Committee. He noted that the Board works to ensure the safety of those people within the borough who are deemed to be most at risk of harm through the actions of other people. The Care Act 2014 was passed in April 2015 requiring:-

- Local authorities to establish an Safeguarding Adults Board
- The Safeguarding Adults Board to present an annual report
- Requiring Safeguarding Adults Board to commission Safeguarding Adults Review
- Developing a strategy in consultation with the local community and residents, and with Healthwatch.

He drew the Committee's attention to a display board which showed some of its work in involving local people in safeguarding adults. The display board highlighted comments from a consultation event in November 2015.

Some of the Board's achievements included:-

- Undertaking Safeguarding Adult case reviews
- Producing a Safer Recruitment guide for organisations
- Safeguarding Adult guidelines for staff

Thresholds for responding to safeguarding concerns

Members inquired about the Board's work around:-

- Terrorism and grooming of vulnerable adults.
- Homelessness and vulnerability
- The impact of benefit changes and new service provision
- People with learning disabilities
- Issues of isolation and neglect abuse

Mr Howard stated that the Board had raised issues with the Department of Health on behalf of providers about the rigidity of the Prevent training. They have been able to relax the delivery of the training. The Board had built good links with NHS England with a representative of the organisation its board.

The Board is not a lobbying organisation. Its Safeguarding Adults Case Review Sub Committee shares the lessons learnt from case reviews and tracks changes and improvement to member agency systems and practice'. The Board will soon be looking at the impact of financial abuse and vulnerability.

It was noted that the Board works with the Adult Social Care business intelligence to look at what patterns of referral tell us. The care of people with Learning disabilities was being scrutinised through safeguarding. It was agreed that there was an increasing number of older people living alone who were not in contact with the statutory services facing the issues of isolation and neglect. The Board had not yet considered this topic but is planning to theme a future meeting on self-neglect and hoarding

Councillor Lukey noted that the Safeguarding Board was putting many safeguards in place to reduce harm. Financial abuse which is an issue many people have faced but are reluctant to report- due to the stigma attached, is on its work programme.

Councillor Perez asked how does the third sector get involved in this work particularly victims or people who have survived abuse and are more likely to approach community based services. Also does the referral system work. Mr Howard stated that there are 30 members on the Board with representatives from MIND and Peabody. The Board has a community engagement sub group which was better placed to discuss issues with residents. Councillor Fennimore noted that the Board is working closely with Violence against Women and Girls Board through the Standing Together project to ensure issues of domestic abuse and modern-day slavery are responded to or prevented.

The Committee asked for a breakdown of the statistics 2013/14 vs 2014/15 showing the pathway of safeguarding in the next report. It was noted that the London Ambulance Service figures showed that other agencies are getting more involved in safe guarding.

Mr Howard reported that since the publication of the report some funding had been secured from the London Fire Bridge and Metropolitan Police. The Local authorities had supplied the staffing resources. A serious case review was joint funded from the CCG and adult social care budgets.

Moving forward, the Board was working out a plan that would help the man on the street would understand what safeguarding is.

The Chair thanked Mr Howard and officers for a clear and concise report.

The Committee

- Welcomed the report and noted the work the Board had undertaken over the past year
- Acknowledged the difficult task they faced in safeguarding some of the most vulnerable members of the community
- Invited the Board back to a future the meeting to report on its work.

#### **43. WORK PROGRAMME**

Councillor Vaughan stated that the response to the Mansfield report should be taken at the March meeting. Officers should invite Imperial Hospital NHS Trust and the CCG to the meeting to respond to the report.

Councillor Fennimore suggested that the Digital Inclusion Strategy should be considered soon. While Councillor Barlow requested that the impact of devolution on local health services should be placed on the work programme.

#### **44. DATES OF FUTURE MEETINGS**

Meeting started: 7.00 pm  
Meeting ended: 9.50 pm

Chair .....

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Minutes are subject to confirmation at the next meeting as a correct record of the proceedings and any amendments arising will be recorded in the minutes of that subsequent meeting.

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

Tuesday 2 February 2016

## **PRESENT**

**Committee members:** Councillors Hannah Barlow, Andrew Brown, Joe Carlebach, Rory Vaughan (Chair), and Natalia Perez

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

**Other Councillors:** Councillors Vivienne Lukey (Cabinet Member for Health and Adult Social Care) and Max Schmid (Cabinet Member for Finance)

**Imperial College Healthcare Trust:** Tim Orchard (Clinical Divisional Director for Medicine), Nicola Grinstead (Director of Operational Performance), and Kevin Jarrold (Chief Information Officer)

**Officers:** Hitesh Jolapara (Strategic Director of Financial Corporate Services), Rachel Wigley (Director of Finance for Adult Social Care), Andrew Lord (Head of Finance), Stella Baillie (Director of Integrated Care), and Mike Robinson (Director of Public Health)

## **45. APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor Sue Fennimore and Debbie Domb.

Apologies for lateness were received from Councillor Andrew Brown.

## **46. DECLARATION OF INTEREST**

Councillor Joe Carlebach declared a non-pecuniary interest as Vice Chair and Non-Executive Director of The Royal National Orthopaedic Hospital Trust.

#### **47. IMPERIAL COLLEGE HEALTHCARE NHS TRUST: A&E PERFORMANCE, MEETING WINTER DEMANDS, AND PATIENT DISCHARGE DELAYS**

The Chair welcomed representatives from Imperial College Healthcare Trust; Tim Orchard (Clinical Divisional Director for Medicine), Nicola Grinstead (Director of Operational Performance), and Kevin Jarrold (Chief Information Officer).

##### **The Cerner Programme**

Kevin Jarrold informed members that the Cerner system represented a move to a fully digital system, meaning that patient information would be available in real-time wherever it was needed. Implementation of the Cerner programme was currently in progress across the Trust; the digitisation of patient records and work to enable electronic prescription and administration of medications was due to be completed by March 2016. The Trust were also looking at replacing paper out-patient processes with digital systems.

Members asked if the system would be accessible for members of the public who did not have access to the internet or internet-connected devices. Kevin Jarrold responded that members of the public would still be able to choose their preferred methods of communication. The new systems would allow communications to be tailored to the individual.

Members asked if the new system allowed the Trust to track people through their hospital journey. Kevin Jarrold responded that the patient administration system did track patients through their hospital journey and, with the improved data gathered, allowed better management of recourses (i.e. fewer 'bed blockers').

Members asked what forms of communication the new system facilitated. Kevin Jarrold responded that the Trust's main form of communication was currently physical letters with a follow-up text message reminder. In future they anticipated that more people would chose email as their main form of communication.

Members asked if consideration was taken of people with vision disabilities and alternate forms of communications like voicemail would be used. Kevin Jarrold responded that the new system had been implemented at Western Eye and they were developing appropriate communication systems to address specialist services. Nicola Grinstead noted that the Trust had begun engagement events for both staff and patients (the first was held at Western Eye) to better understand their needs and ideas for the system.

Members asked that all impairments were considered, as well as language and literacy problems, when considering how the Trust communicated with patients.

Members asked for more detail on how patient information would be shared with referral services and how the Trust was managing patient's privacy considerations. Kevin Jarrold responded that the system would capture

consent for how the information to be shared. The patient would have granular control over which parts of their record can be shared, so mental health information could be made private while sexual health information could be made shareable with other organisations. They anticipated a future where the record could be shared across country, but the focus for now was on local patients.

Members asked if GPs would have access to system. Kevin Jarrold responded that at the moment only the clinical document library was shared with GPs. Currently Hospitals used very different IT systems to GPs and dealt with far more complex data so it was not all relevant to their work. The ambition was that a consultant working at a GP's office could update a patient's record and it would be viewable in a hospital the next day.

Members asked for more information about the integration of this system into the wider healthcare landscape at a future meeting.

Members asked if there were any data quality issues with the new system and what strategies had been put in place to mitigate them. Kevin Jarrold responded that there were always data quality issues with new systems but the Trust had taken a proactive approach to supporting users and providing training. Rather than doing 'classroom' style training, 250 floorwalkers (mainly recent IT graduates) had been hired to carry out intensive live-environment training with doctors, nurses, and support staff. The trust believed this approach helped drive adoption across the organisation.

Members asked what adoption levels were across the Trust. Kevin Jarrold responded that adoption by patient administration was at one hundred percent (as it was a mandatory part of the process), adoption from nurses and therapists was also at around one hundred percent, but adoption by doctors was lower.

Members asked what the system meant for staff on the frontline. Kevin Jarrold responded that it meant when a nurse is interacting with a patient they would record data electronically rather than on paper. Medical equipment was linked to the system and results would be fed in to the system directly reducing human error. Prescribing medication would also be handled completely electronically. Ultimately all of the information gathered would be made available to patients.

Members asked if the system would be available in different languages. Kevin Jarrold responded that there were a number of technological solutions available to assist users. It was possible for the system to translate to a number of languages but this needed further testing. Members said they would welcome engagement on this issue.

Members asked if there had been any internal or independent audits of the new system. Kevin Jarrold responded that there had been a series of both internal and external audits to evaluate progress of the new system. The data quality indicators also allowed the Trust to 'take the pulse' of the system. A

formal evaluation of the system would be undertaken and could be shared with members when completed.

Members asked if there had been feedback from patients on the new style of communications. Kevin Jarrold responded that the Trust had worked closely with patient representative groups and had two patient representatives on the governing body of the records programme. They were also setting up a patient user group.

### **Winter Pressures**

Nicola Grinstead informed members that the Trust was measured by its ability to ensure at least 95 percent of patients are seen within four hours. The report showed performance was down when compared with last year and remained under the national standard. There had been an increase in the acuity of patients attending A&E departments at both St. Mary's and Charing Cross hospitals and higher overall numbers at Charing Cross reduced capacity across the Trust. The Trust had anticipated that the position would worsen during winter so they took a number of mitigating precautions, including opening more beds, increasing hours of ambulatory care service, and introducing a seven day discharge service that was matched by social care colleagues. Over the longer term there was an action plan in place to better target resources and bring the figures back to 95 percent.

Members, referring to the delayed transfers of care chart on page 36 of the report, asked what percentage came from H&F. Nicola Grinstead responded that H&F patient numbers were relatively small when compared with the national picture due to strong links between services in the borough.

Members, noting the increase of thirteen percent at Charing Cross, asked if the Trust expected a rise in the future and if so what they were doing to ensure safety standards going forward. Tim Orchard responded that the Trust did have concerns and noted they were working with commissioners to allow patients to get the care they needed in a community setting.

Members asked if failing to meet the four hour waiting time target had impacted patient outcomes. Nicola Grinstead responded that outcomes had not been affected but the Trust were focused on meeting the target.

Members, noting Chelsea and Westminster's impressive performance, asked the Trust if they were learning lessons from other Trusts. Tim Orchard responded that Chelsea had a large medical assessment unit whereas St Mary's was very constrained. The Trust's bed occupancy is regularly at capacity. Recently Charing Cross opened twenty additional beds but they were quickly filled.

Members asked if inappropriate attendances to A&E were a significant issue. Tim Orchard responded that there was no such thing as an inappropriate attendance, just an inappropriate assessment. If urgent primary care was properly co-located with emergency care these issues would be mitigated.

Members asked how delayed transfers of care could be reduced. Nicola Grinstead responded that rapid assessment was key to improving transition. The Trust was looking at having a single point of decision making across multiple boroughs. Tim Orchard noted the need for greater coordination between health and adult social care. Cllr Vivienne Lukey reinforced the strength of the current partnership between health and adult social care and noted the significant improvements that had been made over the past year, particularly the community independence service (CIS).

Members asked what factors had driven the increase in admission numbers across London last winter. Nicola Grinstead responded that they did speak with other hospitals across London but the level of variation was significant; there were no consistent factors that could be planned for.

Members asked if there had been increases in homeless admissions. Nicola Grinstead responded that homeless admissions were on par with the previous year and there was a specialist team to manage homeless patients. Tim Orchard noted that they had seen an increase in patients with concurrent mental health problems.

Members noted that hospital staff were now carrying out care assessments and asked how they were validated. Nicola Grinstead responded that there were a number of checks including a dedicated assessor and partnership meetings to ensure the process was continually monitored and improved. Members asked for assurances about performance at Western Eye following concerns raised by Bryan Naylor.

Members, noting their support for the recommendations in Michael Mansfield QC's Independent Healthcare Commission for North West London report, asked if recent performance and capacity issues had made the Trust re-evaluate their plans. Nicola Grinstead responded that the Trust was formulating an official response to the report which would be the subject of the March meeting of the Committee. They would be considering emerging views on the future of emergency care across London.

The Chair expressed regret that Imperial was still not meeting its targets and noted that it reinforced the Committee's opposition to the 'Shaping a Healthier Future' proposals and the downgrading of A&E at Charring Cross hospital. Despite this opposition, the Committee understood the challenges faced by the Trust, particularly transfers out of hospitals where CIS was recognised as a model for others to follow. The Committee noted its appreciation for the good work being done to fix these issues.

## **RESOLVED**

1. The Committee requested the implementation timetable for the shared patient record programme, feedback from the system audits and patient representatives, and feedback on progress from the Sowerby Commission.



2. The Committee requested an analysis of why admissions increased over the winter months and what was responsible for the general uplift across London.
3. The Committee requested more information on performance at Western Eye.

#### **48. ADULT SOCIAL CARE PROPOSALS**

##### **Corporate Budget Presentation**

Hitesh Jolapara, Strategic Director of Financial Corporate Services, presented the corporate budget position for 2016/17.

Members asked for more information on the devolution of business rates and what it would mean for H&F. Cllr Max Schmid, Cabinet Member for Finance responded that they were waiting for the detail of the proposals from Central Government.

Members asked if the use of developer contributions was sustainable. Hitesh Jolapara responded that he was confident about the current level allocations and they would be reviewed on an annual basis.

Members asked for a schedule of developer contributions and what they would be spent on.

**ACTION: Hitesh Jolapara**

Members asked how many staff would lose their jobs as a consequence of the budget proposals presented. Hitesh Jolapara responded that the Cabinet and Council reports would contain that information.

##### **Adult Social Care Budget Presentation**

Rachel Wigley, Director of Finance for Adult Social Care, presented the Adult Social Care budget proposals.

Members asked if the past year's reduction to the meals on wheels charge had affected take-up. Rachel Wigley responded that numbers had been fairly steady; 123 in the 2014 as compared with 129 in 2015.

Members noted that the structure of Careline charges meant those in private housing paid more even if they were 'cash poor'. Officers responded that the service was being reviewed and they would feedback member comments on the fee structure.

Members, noting that contracts were a large proportion of the overall budget, asked how procurement was working with providers to ensure the best deal. Rachel Wigley responded that commissioners were working across the whole portfolio and looking at packaging contracts for the market. The service was using a new strategy that placed a greater emphasis on quality and ensured

care pathways made sense. Whole new strategy. Members asked for a report on the new commissioning strategy.

**ACTION: Rachel Wigley**

Members asked about the risks of provider failure. Rachel Wigley responded that the Council did have a duty of market management under the Care Act but noted it was a very challenging environment.

Members asked for future projections for demographics and growth over the medium term. Officers responded that the service produced projections over ten years and could share this information with members.

The Chair thanked officers for their presentations and noted that the Committee welcomed their work on the budget proposals given the financial pressures faced by the local authorities. The Committee also welcomed the measures to maintain the independent living fund payments, the further reduction in meals on wheels charges, and the payment of the London living wage to carers.

### **RESOLVED**

1. The Committee requested a report on provider procurement strategy.
2. The Committee requested that officers reconsider the structure of Careline charges.

## **49. PUBLIC HEALTH BUDGET PROPOSALS**

Rachel Wigley presented the budget proposals for public health.

Members noted that there was no mention of paediatric oral health in the budget. Mike Robinson, Director of Public Health, responded that this work was situated in the 0-5 service and was also being worked on by the school nurses team.

Members noted the excellent work carried out by the community health champions and asked why the associated budget was being reduced. Mike Robinson responded that the budget reduction was a saving on procurement and process, not a reduction in the champions themselves.

Members, noting a complaint about the sharp reduction in the sexual health service budget, asked how decisions were made. Mike Robinson responded that this was the first year of public health grant reductions but noted that there had been no cuts in frontline delivery.

Members asked if budget setting for adult social care and public health were considered together. Mike Robinson informed members that the current spend was based on historical analysis but the next phase was to do a zero-based review of expenditure. The vision for the services was for there to be a seamless link between public health preventative activities and adult social care services.

Some members felt that there should be more spending on cardiovascular preventative measures rather than stop smoking campaigns.

The Chair informed members that they had reached the guillotine and proposed an extension of 30 minutes. The Committee agreed the extension.

The Chair thanked officers for their presentations and noted paediatric oral health and childhood obesity as topics for the Committee to return to at a later date. The Committee welcomed that there would be no frontline cuts and hoped that the lessons from the flu vaccination programme could be replicated across the Council, with Public Health taking a coordinating role.

### **RESOLVED**

That the Committee considered the budget proposals.

## **50. WORK PROGRAMME**

Members asked for an item on vaccinations to be added to the work programme.

### **RESOLVED**

The Committee agreed the work programme for 2016/17.

## **51. DATES OF FUTURE MEETINGS**

Future meetings of the Committee were scheduled for:

- Monday 14 March 2016
- Monday 18 April 2016

## **52. UPDATE ON THE CARE ACT PART 1**

Stella Baillie, Director of Integrated Care, presented the report which provided an update on the impact of the Care Act 2014.

Members asked for more information on the new rights to an assessment and an advocate. Stella Baillie responded that now anyone who wanted an assessment was required to have one. Advocate use was still relatively rare but the Council had extended its advocacy contract.

The Chair asked for more information on the new provision that gave carers the same rights as carers. Stella Baillie responded that officers were working closely with GPs and other partners to identify carers, particularly focusing on those who provided twenty four hour care.

Members noted that many third sector organisations in this area were not aware of the support available to carers and suggested that the Council produced a carers guide to signpost to services. Stella Baillie noted that the

Council provided this information on its website but would look into producing a 'top tips for carers' leaflet.

Cllr Sharon Holder noted that the patient reference group were putting together a list of all local third sector organisations and could share with officers.

**ACTION: Cllr Holder**

**RESOLVED**

That the Committee noted the report.

Meeting started: 7.00 pm  
Meeting ended: 10.27 pm


Chair .....

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Minutes are subject to confirmation at the next meeting as a correct record of the proceedings and any amendments arising will be recorded in the minutes of that subsequent meeting.

# Agenda Item 5

 <p><b>London Borough of Hammersmith &amp; Fulham</b></p> <p><b>HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY AND ACCOUNTABILITY COMMITTEE</b></p> <p>14<sup>th</sup> March 2016</p>	
<b>Update on co-production in commissioning</b>	
<b>Report of the Executive Director for Adult Social Care and Health</b>	
<b>Open Report</b>	
<b>Classification - For Scrutiny Review &amp; Comment</b>	
<b>Key Decision: No</b>	
<b>Wards Affected: All</b>	
<b>Accountable Executive Director:</b> Liz Bruce, Executive Director for Adult Social Care and Health	
<b>Report Author:</b> Paul Rackham, Head of Community Commissioning for Adult Social Care	<b>Contact Details:</b> Tel: 020 7361 2408 E-mail: <a href="mailto:paul.rackham@rbkc.gov.uk">paul.rackham@rbkc.gov.uk</a>

## 1. EXECUTIVE SUMMARY

- 1.1. There is a manifesto commitment to greater involvement of local voluntary and community sector organisations to identify and solve problems.
- 1.2. The attached report, produced by SOBUS on behalf of stakeholders, provides information on the development of co-production in commissioning and outlines the next steps in the development of a Co-production Charter.

## 2. RECOMMENDATIONS

- 2.1 The Committee is asked to note the work led by SOBUS on developing the local approach to co-production in commissioning and the background information provided. The Committee is also asked to comment on the plans to further develop the Charter.

## 3. INTRODUCTION AND BACKGROUND

- 3.1 Involvement of residents and voluntary and community sector organisations is a key manifesto commitment. This report provides an update on the approach led by SOBUS, representatives of voluntary and community sector organisations and officers representing the Council and the Clinical Commissioning Group.
- 3.2 The report highlights the importance of understanding the language and process of co-production in order that those involved have a shared sense of purpose and clarity around any constraints.
- 3.3 Workshops have been held to identify priority areas for co-production and to help develop the Charter. Further work is planned to develop the Charter and to provide a report on lessons learned from the co-production pilots in services for carers and in supported employment.
- 3.4 Based on the lessons learned and further feedback from stakeholders, a final version of the Charter will be produced.

**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.			

*[Note: Please list only those that are not already in the public domain, i.e. you do not need to include Government publications, previous public reports etc.] Do not list exempt documents. Background Papers must be retained for public inspection for four years after the date of the meeting.*

# Co-production in Hammersmith and Fulham

## Executive Summary

Our collective vision is to radically transform the process via which services are designed and delivered locally; co-production is at the centre of this vision.

Co-production is a framework for design and delivery of services for stakeholders, which is person centred and therefore starts with residents not services or departments.

Co-production is a way of fully involving residents in decision making and a way of devolving power which enables the council to fulfil its manifesto commitments.

The co-production work and this report came out of the Leaders of the Voluntary and Community Sector meetings. Specifically, the need to find a new and more intelligent way to design, procure and delivery services in the light of reducing financial resources from central government.

The work has been supported by Cllrs Lukey, Fennimore, MacMillan and Coleman during its development and in ensuring that is discussed and debated within the council.

This paper is a summary paper with a background to co-production, the evidence of where it has been successful, how it has been applied locally and what the next steps area.

This report and the co-production work has been co-produced and had input from local residents, local organisations, council officers and CCG officers.

A full report will be brought to the council in later this year which will:

- Identify lessons learned
- Further demonstrate the benefits to the council and other stakeholders
- Provide recommendations for implementation



**Background**

The New Economics Foundation (NEF) working definition of Co-production is “A relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have vital contributions to make in order to improve quality of life for people and communities”.

		Responsibility for design of services		
		Professionals as sole service planner	Professionals and service users/ community as co-planners	No professional input into service planning
Responsibility for delivery of services	Professionals as sole service deliverers	Traditional professional service provision	Professional service provision but users/communities involved in planning and design	Professionals as sole service deliverers
	Professionals and users/communities as co-deliverers	User co-delivery of professionally designed services	Full co-production	User/community delivery of services with little formal/ professional
	Users/communities as sole deliverers	User/community delivery of professionally planned services	User/community delivery of co-planned or co-designed services	Self-organised community provision

There are six principles which are the foundation stones of co-production. Co-production in practice will involve alignment with all of these principles, and they are all underpinned by similar values.

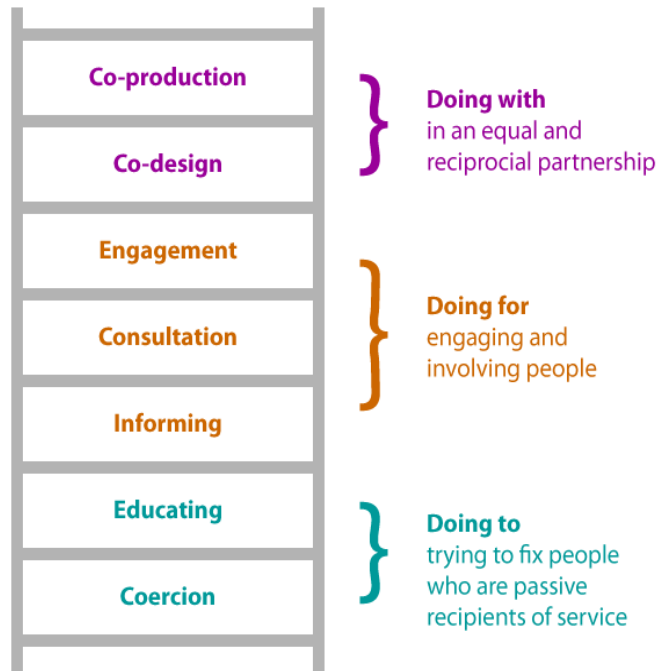
1. Transforming the perception of people, so that they are seen as equal partners in designing and delivering services - not as passive recipients of services and burdens on the system. (Asset based approach)
2. Altering the delivery model of public services from a deficit approach to one that provides opportunities to recognise and grow people’s capabilities and actively support them to put these to use at an individual and community level. (Building on people’s existing capabilities.)
3. Offering people a range of incentives to work in reciprocal relationships with professionals and with each other, where there are mutual responsibilities and expectations. (Reciprocity and mutuality)
4. Engaging peer and personal networks alongside professionals as the best way of transferring knowledge. (Peer support networks)
5. Removing the distinction between professionals and recipients, and between producers and consumers of services, by reconfiguring the way services are developed and delivered. (Blurring distinctions)
6. Enabling public service agencies to become catalysts and facilitators rather than being the main providers themselves. (Facilitating rather than delivering)

**Evidence**

*Public Services Inside Out* examines public services which are designed and delivered by the professionals who run them and people who use them. This ‘co-production’ approach is more effective at getting the public what they want out of public services and at a reduced cost compared to conventional top-down approaches.

For example, Scallywags in Bethnal Green, London is a childcare provision which involves parents and staff working together. It costs just £2.50 an hour, significantly lower than comparable childcare provision. In addition to making it affordable for parents to go to work, the children benefit from having their parents involved in their education.

Jonathan Kestenbaum, Chief Executive of NESTA, says: *‘The public is desperate to get involved in solving issues that affect them. Co-production offers people who have a strong sense of what’s needed on the ground the chance to act’.*



**Local context**

In mid 2015 Sobus organized a Leaders of the Voluntary and Community Sector (VCS) meeting. The meeting was attended by leaders of the VCS, Cllr’s Lukey, Fennimore and MacMillan and council officers. Everyone present recognised that due to previous funding cuts it was not going to be possible to apply further cuts to services without making them ineffective, unviable or potential dangerous. Therefore to be able to respond to future funding cuts a radical new way of working was going to be required where the starting point was no longer how much is currently spent on a service and how much needed to be saved but what is the need and how do we meet that need with the range of resources that all stakeholders have available to it.

Since then Sobus has been working with a range of partners including H&F Mind, Desta, H&F CAB, a local resident, H&F CCG and LBHF Adult Social Care Commissioners. The partnership working of the group has taken a lot of time and effort and has meant that 2 events were successfully run in September and October 2015. The events were attended by 50+ and 65+ people respectively and were made up of residents, service users, organisations and officers of the council and CCG. At the events we discussed what co-production was, how it works and applied it to developing a draft charter and selecting two services to apply the principles of co-production in pilots. Those pilots were democratically selected through a vote by everyone present which means that all stakeholders have bought in to the process and working in a co-productive way. So far we estimate that the partners have invested £22,000 of pro bono time to get the work to this stage of development.

The two services selected for the co-production pilots were Carers Services and Supported Employment Service. Feedback from the co-production work so far has been very positive with services users, providers and commissioners expressing that the co-production work has enabled fresh thinking on how to address the needs of local residents. The outcome of this work, so far is that we have been able to gain the genuine commitment of residents, commissioners and providers to work together to redesign Supported Employment Services and Carers Services. Since the two initial pilots were selected Sobus has also been appointed to use a co-production approach with Children’s and Families’ Universal Service.

To ensure that there is a common structure to the process a draft charter has been developed based on national and regional best practice and local experience.

#### Charter and its purpose:

A charter has been drafted that provides a clear framework in which partners can have a shared confidence in how their commitments, actions and behaviours can achieve joint objectives. It enables consistency for different groups that are using it across the borough. Partners can use the charter to hold each other to account based on what is included in the charter and its overarching principles.

The charter has key areas including:

- Vision for Co-production Partnership
- Principles of Co-production
- Co-production Group Membership
- Behaviours & Ways of Working
- Governance
- Inventory of key information
  - Resources – financial and non financial
  - Timescales
  - Decision making powers
  - Decision making process
  - Membership
  - Legal requirements eg Care Act

The charter is currently in its third iteration and when it has been further developed based on the pilots that are taking place and work with the Youth Partnership it will be presented as a final draft.

We propose bringing the final draft and recommendations to LBHF and H&F CCG to approve the charter and the principles of co-production as the way services are redesigned, procured and delivered in Hammersmith and Fulham.

#### Next steps

- There will be discussions between all stakeholders about the benefits of this approach and how it can be included in governance and resourced within existing resources.
- From the pilots a report will be written by September 2016 with recommendations which, may include:
  - Co-production best practice written into a charter
  - Allowing enough time for co-production to be successful
  - Training and mentoring for those involved in co-production including residents, VCS, commissioners and councillors
  - Changes to procurement process like questions in Invitations to Tenders which are developed with service users to ensure what is established as most important is prioritised in the procurement process
  - Changes to governance structures to ensure co-production is given the same level of importance as Equalities, Business and Risk.
  - All stakeholders including VCS, residents, council and CCG sign up to the co-production charter.

# Agenda Item 6

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

<b>Work Programme 2015/2016</b>
<b>3 June 2015</b>
Preparing for Adulthood: A Report About Young People Aged 14-25 with Disabilities Chelsea and Westminster Hospital NHS Foundation Trust: CQC Report The Francis Inquiry Recommendations: Responses by Chelsea and Westminster Hospital NHSFT and Imperial College Healthcare NHS Trust Chelsea and Westminster Hospital NHSFT: Integration with West Middlesex Hospital
<b>7 July 2015</b>
Addressing Food Poverty in Hammersmith & Fulham Chelsea and Westminster Hospital NHSFT: Integration with West Middlesex Hospital Primary Care Briefing: GP Networks Network Plan 2015-2016 and Out of Hospital Services
<b>14 September 2015</b>
Customer Satisfaction Immunisation Uptake New Home Care Service West London Mental Health NHS Trust: Development of Services
<b>4 November 2015</b>
Immunisation Uptake: Update CQC Inspections: Central London Community Healthcare NHS Trust and West London Mental Health NHS Trust Public Health: introduction to community services and strategy and in year Public Health savings
<b>19 January 2016</b>
Healthcare Commission Report Safeguarding Adults: H&F Report
<b>2 February 2016</b>
2016 Medium Term Financial Strategy Imperial College Healthcare NHS Trust: Winter Pressure and Outpatients PAS Update Care Act Part 1
<b>14 March 2016</b>
<ul style="list-style-type: none"><li>• Co-production in commissioning</li><li>• An update on Charing Cross revised</li><li>• Social isolation and loneliness in the borough.</li></ul>
<b>18 April 2016</b>
<ul style="list-style-type: none"><li>• Flu Vaccination: Update and Monitoring Data (to include CNWL)</li><li>• GP Access</li><li>• Meal Agenda</li></ul>

## **Future Meetings**

Digital Inclusion Strategy  
Impact of devolution on Local Health Services  
~~Care Act~~  
Chelsea and Westminster Hospital NHS Foundation Trust: Integration with West Middlesex Hospital  
~~Co-commissioning Work~~  
Commissioning Strategy: Providers  
Community Champions  
Community Independence Service  
Customer Journey: Update  
End of Life Care: JSNA and CLCH to Update on Action Plan  
Equality and Diversity Programmes and Support for Vulnerable Groups  
H&F CCG Performance  
H&F Foodbank  
Immunisation: Report from the HWB Task and Finish Group  
Integration of Healthcare, Social Care and Public Health  
Listening To and Supporting Carers  
Public Health Report  
Self-directed Support: Progress Update  
Vaccinations  
West London Mental Health Trust: Update