London Borough of Hammersmith & Fulham

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

Draft Minutes

Wednesday 8 March 2017

PRESENT

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

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

Other Councillors: Stephen Cowan, Sue Fennimore and Vivienne Lukey

Officers: Clare Parker, Accountable Officer, CWHHE, Janet Cree, Managing Director, H&F CCG, Christian Cubitt, Director of Communications, NW London CCGs, Susan LaBrooy, Medical Director, SaHF and Bathsheba Mall

120. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on Tuesday, 31st January 2017 were agreed as an accurate record.

121. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Hannah Barlow. Apologies for lateness were received from Co-optee Debbie Domb.

122. DECLARATION OF INTEREST

A declaration of interest was received from Councillor Joe Carlebach in respect of Agenda Item 3, in his role as Vice-chairman of the Board of Trustees for the Royal National Orthopaedic NHS Hospital Trust.

123. NW LONDON SUSTAINABILITY TRANSFORMATION PLAN AND STRATEGIC OUTLINE CASE PART 1

Councillor Rory Vaughan, Chair, welcomed members of the public and officers to the meeting. He introduced Clare Parker, Accountable Officer, from the collaboration of clinical commission groups covering Central London, West London, Hammersmith and Fulham, Hounslow and Ealing, accompanied by Christian Cubitt, Director of Communications, North West London CCGs, Susan LaBrooy, Medical Director, SaHF (Shaping a Healthier Future) and Janet Cree, Managing Director, Hammersmith & Fulham CCG. Cllr Vaughan explained that the presentation would be provided in two parts, the first covered Delivery Areas 1-4 (public health, primary care) of the Sustainability Transformation Plan (STP), followed by questions. The second part of the presentation, would examine acute services and the Strategic Outline Case (SOC) Part 1, and, the planned consultation, on SOC Part 2, which was currently being developed and included Charing Cross Hospital.

Clare Parker briefly set out the background to the STP and the SOC Part 1, the supporting documents for which had been included in the Agenda. As part of NHS England's Five Year Forward View (FYFV), the CCGs in the North West London area had been required to develop local plans which demonstrated how they would deliver improved health and care services that addressed three aims: improve people's health and wellbeing, the quality of care received and address the financial gap. This new approach brought together local government and the NHS for the first time in terms of actively planning public health provision.

The recent budget announcement of additional funding for social care was welcomed, which could help address the £1.4 billion shortfall and close the financial gap between funding for social care and health. During April 2016, it was explained that they had worked with partners to agree a set of nine priorities set out across five delivery areas (DA 1-5), to model demand against financial provision and which would allow them to be more radical and innovative, in terms of the way in which people could be supported in maintaining better health.

Janet Cree set out how the DAs would look at a North London level, mapped alongside the Joint Health and Wellbeing Strategy (JHWS) priorities areas for Hammersmith & Fulham, as identified by the Health and Wellbeing Board (HWB). She explained that at a recent development day workshop, the members of the HWB discussed joint working arrangements to develop the delivery plan. The synergy between the priorities, in the evolution of both the STP and the JHWS, was a result of collaborative working and reflected local need. The reference to the Strategic Commissioning Framework and the FYFV under DA2 was clarified. This would ensure that there was sustainable primary care as part of the national strategy, delivered at a local level.

Details about the priorities under the different delivery areas and the implications for residents in terms of delivering change were highlighted, in particular under DA1, ensuring that children and young families get the best possible start (also supporting prevention). The Child Health GP scheme,

had recruited seven GPs to an education and leadership development programme, who would act as local champions for child health. This was an innovative piece of work, ensuring that knowledge was cascaded to local colleagues.

Expanding on DA1 to 4, Janet Cree made reference to a sustained programme of health supporting diabetic patients. This was an area that H&F CCG was leading on across North West London, highlighting the clinical work of Dr Tony Willis, a local GP based in Shepherd Bush, from which there had already been notable improved outcomes for patients. This would ensure that there was consistency in the quality of care for diabetic patients and clear, clinical pathways. With reference to DA3, ensuring good mental health for all, it was reported that H&F CCG were also leading on the last Phase of Life programme on behalf of NW London CCGs. Initially, this focused on improving the support provided to residents living in care homes, through the introduction of a telemedicine support function. This was due to go live early in 2017/18, the benefits of which were anticipated from June onwards and would be reported (to the PAC) once operational. Finally, on DA4, improved support for residents with complex common, severe and long term mental health conditions via their registered GPs. It was reported that a 24/7 mental health crisis support line in North West London would allow residents in crisis to directly access appropriate specialist support via 111 without having to redial.

Clare Parker elaborated on the areas that they had primarily focused on since October 2016. There were a number of projects sitting under each of the delivery areas and these would be prioritised according to need. DA1 was taken as an illustration, as they had been considerable work on it by Directors of Public Health. The recommended priority area for 2017/18 was to focus on alcohol misuse, which could have a fundamental impact on health and care services, and, the most opportunity for benefit to local people. Clare Parker reported that there had not been the anticipated release of transformation funding at this stage, but in January 2017 they had been invited to submit bids for specific health projects around cancer, mental health and diabetes, which primarily fell under DA2 and long term health conditions.

Focusing on the governance arrangements, Clare Parker explained that they had established Delivery Area Boards and fully representative enabler and project groups. The Joint North NW London Health and Care Transformation Group (JHCTG) had been also been constituted, the membership of which consisted of a broad mix of representatives from both NHS and Local Government, including commissioners, providers, councillors and officers. While this was not a decision-making group, it would be overseeing the delivery of the STP. This was supported by a programme board for each of the delivery areas and would be co-chaired by a Senior Responsible Owner (SRO) from the NHS and Local Government. The exception to this was DA5, which would be co-chaired by a senior NHS provider and commissioner representative. The five DA's will be supported by three enablers: workforce, digital and estates, which will also be joined by a number of other specialist bodies including the NWL Clinical Care Board, in advising the JHCTG.

Co-optee, Patrick McVeigh, with reference to page 26 of the Agenda and the Executive Summary, commented on implied caveats in the wording of the document. Specifically, the word “could”, in the context of bringing forward the acute configuration changes described in DA5c, was cause for concern as it indicated uncertainty. Clare Parker apologised for the wording but offered assurances that the acute configuration changes would be addressed and be further elaborated on in the second part of the presentation on acute services. Currently, the plans for configuration would be beyond the period of the STP, which was why it was not built in to the current finances, as set out.

Co-optee Bryan Naylor expressed concern that there was little in the STP that indicated how the aims would be achieved, such as providing treatment closer to home and out of hospitals. He continued that GPs had articulated the difficulties in the training, recruitment and retention of GPs and support staff, which the STP had not addressed. Clare Parker concurred, recognising the current workforce challenges in North West London in respect of retiring GPs and other medical and specialist staff groups, which they also struggled to retain. She explained that one of the enabler workstreams would focus on workforce challenges, and that they hoped to address this in a range of ways, one of which included increasing the amount of patient-facing time available to GPs, releasing them from administrative tasks. She continued that the introduction of the role of physician associate would also provide further support for GPs, to see patients who did not necessarily need to see their GP. It was acknowledged that a key part of this would be to ensure that there was the right mix of skills sets so that patients would see the most appropriate clinician. Clare Parker reported that they were working with Health Education North West London to address this. She acknowledged that while there a number of training opportunities, it was recognised that many people left the area within two years of concluding their training, exacerbated in part by the lack of affordable housing.

Susan LaBrooy, Medical Director, SaHF, continued, acknowledging the difficult challenges of maintaining a robust workforce. Alternative methods of supporting patients were suggested, such as using email to provide information, if appropriate. Considering the patient experience of limited time with their GP’s, who then restricted consultations to specific issues, Susan LaBrooy accepted that this was inadequate and viewed as unacceptable by both patients and GPs. To illustrate further, it was reported that diabetic and asthmatic patients were now better equipped to maintain greater control and understanding of the treatment and management of their own care. One outcome of changes to paediatrics services, with the introduction of an assessment unit and greater consultant input, was a decrease in paediatric nursing vacancies, a specialist position that was difficult to recruit. A similar approach was being developed for radiographers, who could be trained to cover the work of radiologists. Offering the right training and developing career pathways, would help address many workforce challenges, attracting and retaining staff long term.

Bryan Naylor responded that while NHS colleagues recognised the problems and demonstrated a willingness to resolve them, the STP did not address the fundamental issue of how to deliver the solutions. He commented that GPs

set their own work patterns and could not be pressurised into adopting changes required by the STP. In his view it was overly ambitious, considering that the timeframe required for implementing workforce changes, such as training, would exceed five years. Clare Parker clarified that the STP was a high level strategic document and that a development plan containing detailed information would be available for further scrutiny. She continued that the workforce examples that referred to earlier had already been launched, such as the career framework for radiographers. Finally, she pointed out that the workforce challenges would continue to exist, regardless of whether a new model of care was implemented. Clinicians would continue to experience pressure, but new care models would attract more staff to work in the area.

Councillor Natalia Perez enquired if the implementation of the STP framework would result in any job losses. Clare Parker replied that there was no expectation that jobs would be reduced. The amount of money being spent on health would increase during the period of the STP, but not sufficient to cover the demand. However, with the anticipated retirement of large numbers of GPs, there would be a requirement to reconfigure existing skills sets to ensure provision, for example, the development of physician associates.

In a follow up question, Councillor Perez referred to a press release issued by the Save Our Hospitals Campaign (SOH), which reported that in response to a Freedom of Information (FOI) Request to Brent Council, it had been revealed that up to 8000 NHS jobs would be cut, as part of the North-West London STP delivery plan, with 3658, by 2017/18, and, 7053, by 2020/21. Clare Parker indicated that they had responded to this. It was explained that the figures reported in the FOI had been contained in a spreadsheet, which was incorrect. The spreadsheet had not been checked and provided only a partial picture across North-West London. Clare Parker apologised for the mistake and recognised that, in this context, this had been unhelpful. She confirmed that they were not planning to make 8000 health staff job cuts.

Co-optee Debbie Domb, commented that, as a disabled person, she was at the sharp end of the current situation and that, post-Brexit, health and social care services will be decimated, given the potential loss of EU staff from the NHS. Clare Parker acknowledge the potential risk and impact of Brexit on the workforce and hoped to put in place measures to mitigate against this.

Councillor Joe Carlebach observed that the aims of the STP were wonderful but the test lay in the execution, which would be difficult. While he welcomed the GP education and leadership initiative, he expressed concern about the difficulty accessing primary care, referencing the study by Dr Ingrid Wolfe (Why children die: death in infants, children and young people in the UK, May 2014), with the UK having one of the highest mortality rates in Europe, of one child death per day in London. Councillor Carlebach queried the emphasis on the introduction of physician associates, expressing concern that this remain untested within the UK. The identification of problems such as late diagnosis was a fundamental issue causing further pressure. Susan LaBrooy concurred that the higher mortality rates for cancer in the UK, compared to Europe (in many cancers), were attributable to late diagnosis and referrals. There was a large piece of work on-going around early intervention and screening with The

Cancer Vanguard about raising awareness as to value of early diagnosis by providing GPs with better access, together with understanding the management of cancer as a long-term condition, given the higher rates of survival that were now achievable. Susan LaBrooy continued that she would be happy to share information about this.

ACTION: CCG

Councillor Carlebach responded that it was more than a perception that it was hard to access GPs, particularly for older, vulnerable people. The difficulties extended beyond access to services and were also about reducing variations between the way in which different surgeries operated. Clare Parker explained that one of the workstreams in the STP was to reduce variations in the provision of out of hospital services, for example, diabetes, where they were working with the H&F GP Federation on identifying a small number of key elements, which, if avoided, would improve outcomes.

Councillor Andrew Brown welcomed the STP but queried the overall direction of the NHS locally. He also queried the metrics used, observing a lack of movement towards increased out of hospital provision, as promised to residents. Clare Parker responded that while there were no real metrics, the details about provision would be contained in the business case. She referred to the downward trend in the number of non-elective admissions per 100,000 and the number of occupied bed days per 100,000 of the population, contrary to London-wide trends. The movement to out of hospital care was slow and contributed to pressures on social care. She explained that in supporting projects such as diabetes, they had identified clinical indicators which would allow them to monitor the impact of a particular intervention on a group of patients. While acknowledging the need to share details of general metrics more widely, Clare Parker added that the whole country was struggling on these measures and offered to provide a more detailed report for the Committee on, for example, workforce or diabetes.

ACTION: CCG

In response to a comment from Councillor Brown, Clare Parker responded that one of the commitments of the STP was to focus on out of hospital care and that they were not currently planning changes to A&E during this period of the STP. She stated that it was not possible to close a bed that was occupied and therefore still required. Their primary focus was on ensuring that there was appropriate capacity and that the models of care were working.

Councillor Brown enquired about the JHCTG membership and who were the representatives, in particular those from local government. Clare Parker confirmed that the following representatives from local government were: Councillor Sachin Shah, LB Harrow; Councillor Steve Curran, LB Hounslow; Councillor Nickie Aiken, Westminster City Council; and Councillor Phillip Corthorne, LB Hillingdon. Senior officer local government officers included the Chief Executive Officers of the London Boroughs of Brent Hillingdon, Harrow, RBKC and Westminster.

In the context of Brexit, Patrick McVeigh enquired about the impact of workforce challenges and the movement from a 5 to 7 day working week. He asked if not moving to a 7- day model had been considered and further, what the impact was of an extended working week. Susan LaBrooy explained that variation on shift hours and rotas had been tried before. It was not the case that staff were moving from 5 to 7 working days, the issue was about what services were being provided at weekends; the aim was not to deliver the same services at the weekend, but to consider what services could be delivered throughout the 7-day period in order to achieve good patient outcomes. It was reported that this approach has subsequently been adopted by NHS England.

Debbie Domb referred to an earlier comment about post-Brexit, and the possible impact on health and social care, which depends upon EU citizens working in hospitals, as being a "risk". She expressed concern about the comment being insulting, as the support provided by health and social care staff to disabled people, enabled them to live their lives. Clare Parker clarified that it had not been her intention to cause offence, contending that this was an observation about the unknown outcomes of Brexit. There was no guidance as to whether EU staff would be allowed to remain in the country or what kind of system will operate in the future. Individual organisations were doing their best to reassure and retain staff, until definitive guidance was provided.

In response to a comment and question from a member of the public, Clare Parker explained that they had made the same commitment for Ealing (hospital) as they had for Charing Cross, that there would be no changes to A&E services until they were satisfied that there was sufficient capacity in the receiving sites, in either acute hospitals or out of hospital, to enable the safe management of care for patients. It was explained that the Ealing site offered a different set of workforce challenges but there was currently no intention to make any changes, as other acute hospitals would not be able to manage that demand. This was would be outlined in the business case, with the aim of securing the capital to fund the expansion of receiving hospitals.

With reference to the further question about the FOI released workforce figures, Clare Parker reiterated her earlier comment, admitting that in order to be transparent and open, they had confirmed that the figures were not validated, correct or representative, and offered an incomplete picture, with no planned reduction anticipated. They were planning to reduce the number of out-patient and the number of non-elective admissions, the underlying aim being prevention. Clare Parker continued that there were many specialities where up to 80% consultations did not need to be face to face and that they were exploring new models of working to alleviate demand, such as email. Responding to a point raised regarding funding, Clare Parker confirmed that there would be increased funding on healthcare in North-West London over the next five years but this would not meet the cost of care currently being delivered. They were confident that they would not be considering large cuts in workforce, in anticipation of the increased funding.

With regards to the FOI information, Clare Parker confirmed that to her knowledge, the figures had not been submitted to the Department of Health (DH), although the plans were submitted to NHS England. It was clarified that the figures were contained in an Appendix to the STP, which was subsequently released in response to the FOI. The STP was a strategic document and that the work that had been undertaken during the course of its preparation had been complex and fast paced. Work on staff numbers for clinical models was still progressing, but did not provide a complete picture as yet. Clare Parker reiterated that the figures were incorrect, had been withdrawn and that there were no substitute figures that had replaced them. She offered to share any new data once it had been compiled.

Councillor Brown briefly followed up an earlier question regarding local government representation commenting that there were no representatives from Ealing and Hammersmith & Fulham. Clare Parker responded that the reason why they were not represented on the JHCTG was because this body would oversee the delivery of the STP and that the two boroughs had chosen not to actively support the STP and therefore could not be included in its governance structures. She confirmed that if the councils chose to support the STP, they would be included in the governance group.

Responding to a question from a member of the public, Clare Parker reiterated that they could evidence the impact of the clinical strategy for out of hospital care. There were other factors affecting demand on A&E services that need to be better understood and evidence suggested that at a lot of the growth was in different groups to the ones that they had previously considered, for example, the over 65s group. Clare Parker confirmed that they were not cutting beds, but were trying to help people remain healthy in their own homes. Beds would close only once demand for them had reduced. She reiterated that, as with Ealing hospital, they would not be making any changes at Charing Cross until alternative capacity was in place. The proposed changes to A&E at Ealing would be made by 2022, earlier than at Charing Cross. Clare Parker stated that this was a clinically led programme which would not countenance any changes that would impact of the safe management of care of patients. On a final point, Clare Parker explained that they had not planned on closing the Hammersmith and Central Middlesex A&Es earlier than anticipated. This was based on the recommendation of the Independent Reconfiguration Panel. There were no emergency medicine consultants in post on the Hammersmith site. Service changes at Ealing would not necessarily result in the large-scale changes anticipated by residents.

In response to a comment and question from a member of the public, Clare Parker made reference to previous responses and speculated that a deep dive analysis over a longer period might be more helpful than the broad-brush approach presenting both the STP and SOC Part 1, together. The NHS was a large, complex organisation providing a huge range of services, that they were systemically working through, modelling new care provision. Accordingly, they could not provide a precise figure for the number of staff across multiple, acute, mental health hospital staff and community groups. A number of GP practices had significantly changed their skill mix, including for

example, clinical pharmacists, a change welcomed by patients. While there had not been the same use of physician associates in the UK, compared to Europe, Clare Parker confirmed that this was being trialled and had been evidenced in other European countries. While the precise level of detail had not been brought to this meeting, Clare Parker expressed intention to be open and transparent about the STP plans.

Councillor Vaughan briefly summarised the main points of the discussion, many of which had been identified for more detailed scrutiny at a later date*:

- Concern about the release FOI figures on workforce job loss numbers, which had been confirmed to an unfortunate error, both in terms of their inclusion in previous iterations of the STP and accompanying documents, and, their accuracy*;
- Composition of workforce, was something that required further discussion, the introduction of physician associates and the reconfiguration of skillsets;
- Better understanding of the impact of Brexit;
- Better understanding of the impact of the lack of affordable housing;
- The Committee welcomed a number of initiatives, particularly those relating to long term conditions;
- Access to primary care and the slow progress around the movement to out of hours' services
- Development of the STP delivery plan*;
- The changes to acute services such as Ealing, only being progressed once clinicians were satisfied that there was sufficient capacity at the receiving sites, for care to be managed safely and without compromise;

ACTION: *CCG

Proceeding to the second part of the discussion, Clare Parker explained that this would address acute service provision and consultation. SOC Part 1, published in December 2016, set out the business case for the implementation of the STP, and SaHF vision. This included plans for Ealing hospital and out of hospital estates but excluded hub sites. Highlighting the need for capital investment in primary and community estates in North-West London, the expectation was that this would help attract key staff, improve A&E provision and support critical care beds at Imperial.

SOC Part 2 related to the changes to Charing Cross and the Chelsea and Westminster site. The separation between Parts 1 and 2 was due in part to the on-going development work at Paddington, which meant that there were wider opportunities for Imperial, which would allow them to address fundamental estate issues. Clare Parker explained that the no changes to Charing Cross would be made during the course of the next 5 years. The intention was to implement changes as set out in the SaHF plan. Christian Cubitt briefly described the pre-engagement plans for consultation across the 8 boroughs. He explained that they had tried to ensure that consultation communication methods were appropriate to ensure affective engagement. Given the identified preferences, these events would most likely be early

evening public meetings. The Committee welcomed the offer to view and comment on the draft engagement strategy, once drafted.

In response to a question from Councillor Vaughan, Christian Cubitt confirmed that next stage of consultation would be on Charing Cross and the funding of capital investment for services in the borough in advance of the publication of SOC Part 2.

Councillor Perez referred to A&E figures recorded for November 2016, with 3712 attendances, a significant increase. Of these, 889, or 40%, waited for more than 4 hours and for that same week, 350 waited in excess of 4 hours. The figures also showed a 29% increased demand over a two-year period. In light of these statistics, Councillor Perez asked why the STP had not been rescinded. Clare Parker responded that they had no plans to make changes at Charing Cross in the next 5 years. The need to do more to move services out of hospital was recognised. She continued, that the value and benefit of consolidating services on a smaller number of sites had been evidenced which will allow for the concentration of specialist staff. There was also evidence that a population of half a million people was required to maintain optimum activity and to support training.

Councillor Brown observed that the plans were dated, particularly given the pace of medical advances. Referring to the comment in the plans that no planned change will be made to A&E services during the period of the STP, implied that there would be changes in the future. He suggested that a line be drawn under the plan, while still focusing on the service improvements, and revisit the proposal at some future point. Referring to the parity of care for mental health care alongside physical care as an example, had this been considered in 2012, provision for mental health would be very different. Councillor Brown urged NHS colleagues to reconsider the plans and suggested that if that if this were possible, to work alongside the borough, with cross-party support, it would help deliver the changes and desired improvements.

Clare Parker responded that they to new and innovative ways to improve service outcomes but that they have yet to find an alternative approach to consolidating services on a smaller number of sites. Clare Parker concurred with Councillor Brown on the issue of mental health care parity and indicated that she would welcome further discussion about improvement of such future services in A&E at Charing Cross. She reiterated previous points stating that the move away from generalist to more specialised services had been evidenced, with demonstrably better outcomes for major trauma, heart attacks and strokes.

Councillor Brown referred to the capital requirement figure which was excess 530 million and the earlier reference to the recent £325 million investment in the STP budget announcement. Clare Parker explained that the figure of £530 million was to be spread over a period of 7 years, so the actual value was lower and that they would be bidding for NHS capital. For the £325 million, there was national capital allocation which they would also be bidding

for. It was further explained that they would be applying for loans which would be repayable, depending on the terms.

In response to a question from a member of the public regarding the STP plans being a political vehicle for allowing greater privatisation, Clare Parker explained that officer decisions were apolitical and further pointed out that while services had always been provided by a mixture of both private and publicly funded NHS organisations, they have always been free at the point of use for patients.

In response to a query from a member of the public regarding funding and the concern that efficiency cuts were being prioritised over the provision of quality services, Susan LaBrooy responded that medical staff and clinicians aimed to provide the best services they could. While recognising that greater funding of NHS services was needed, she also acknowledged the duty of care over managing existing public health funding.

In response to a question from a member of the public, Susan LaBrooy highlighted the need to foster greater trust and to improve communications to facilitate the required improvement outcomes and ensure that people did not feel that were receiving lower value services. It was not helpful to ask a person to use an app, if they did not understand how it worked. Similarly, with reference to her earlier point, she commented that this was about providing, timely and appropriate care, observing that most people would prefer to die at home. Councillor Vaughan added that the issue of end of life provision would a scrutiny item at the next meeting of the Committee.

In response to a question from a member of the public, which asked if any of the panel had made any decisions, which actively opposed the STP plans, or, made a decision prioritising funding over need. Susan LaBrooy responded that as a medical director, she had never sanctioned any approach that sought to cut services on the basis of funding, and stressed the importance of selectively exercising authority. It was explained that nationally, care of patients was becoming so specialised, that A&E services were to be specialist, with a specialist hospital supporting it, to illustrate, there were two specialist heart hospitals serving North London. Susan LaBrooy recommended caution in selecting which services are chosen for saving, given the way in which they were currently provided. Clare Parker elaborated, referring to Councillor Carlebach's earlier comment. An A&E consultant who was able to treat greater frequency of patients presenting with the same issues, was more likely to be able to offer practiced and innovative solutions and improved outcomes.

In response to a comment and question from a member of the public, Clare Parker explained that they had not yet received a formal acknowledgement of their submission of the STP from NHS England. It was understood that the intention might be for each STP to undergo an assurance process. The CCGs had been asked to develop the local? delivery plan that would underpin the STP, particularly for 2017/18, and that was what they would be seeking to monitor it against.

In response to a statement and question from a member of the public, Clare Parker confirmed that there was no intention to cut spending on the NHS. The £22 billion figure was notional, demonstrating the difference between current funding demand based on the current model of care, and, the actual amount of money coming in the NHS. If nothing was done, there would be a £22 billion shortfall and if the model of care did not change, cuts would be required. Clare Parker believed that they could achieve better outcomes for patients and improved models of cares, better than existing care models. If changes to the model of care resulted in the avoidance of cuts that might impact on the quality of health care, or if this evidenced a return to two year waiting lists, then this was an approach she was willing to implement. She continued that the Mansfield Commission report did not set out a "do minimum" option, the intention was to improve outcomes for patients within the funding provided by tax payers.

In response to a question and comment from a member of the public, Susan LaBrooy replied that there were a number of issues in respect of specialisms. To illustrate, in relation to sepsis, haemorrhage and renal failure, the right specialist surgeon was required, to enable the right sort of intervention, in the right hospital location. She concurred with views expressed about frailty services. The 'frail elderly' was not a bar to treatment. The elderly may also experience strokes, heart attacks and renal failure, and would be treated for the primary condition, with input from a geriatrician. She hoped that the nursing home project would continue to be rolled out as this would improve the quality of care available.

A member of the public recounted a recent experience regarding the illness and subsequent treatment of an elderly parent. They had delayed seeking treatment, reluctant to be a burden. Clare Parker acknowledged with sympathy, the experience of the patient, whose care delayed had unfortunately resulted in further complications. Clare Parker commented that at the heart of this patient's experience, it was clear they were still not getting things right, not communicating to people about how to best use services, and not supporting people, which she admitted were fair criticisms. The fact that this person had spent three weeks in hospital and had visibly deteriorated over the course of this stay, was one reason why out of hospital services were needed.

Bryan Naylor expressed concern that the number of elderly and vulnerable people requiring ophthalmic treatment will increase, without a corresponding increase in staffing levels. Susan LaBrooy responded that one of the ways in which pressure on services could be alleviated was to reduce the number of non-attendance for appointments. Similarly, with return or follow up appointments. Bryan Naylor observed that this did not provide a suitable response to how increased demand will be managed, particularly in cases which cannot be delegated to a GP. Clare Parker responded that funding for the workforces was limited, increased to funding would not sufficiently affect the issue. She observed that another demand was the fact that people were living longer but having to manage long term conditions, so not necessarily living in good health.

Councillor Carlebach enquired about the role of specialist hospitals, which he felt had been excluded from the proposals. Residents with complex needs, or elderly people, had felt vulnerable in navigating specialist clinical pathways, where you would want to access the most appropriate care. Councillor Carlebach sought further clarification about the pathway and escalation routes, noting that residents struggle to navigate the system, and that even GPs cannot locate patients within it, particularly in cases involving treatment at more than one site. Susan LaBrooy described the work of Tim Briggs, who had been asked to examine more specialist pathways, other than orthopaedics, and whose mantra was that clinicians should only be doing work that they are specialists in. Councillor Carlebach reported that residents who, had they not been referred to the Marsden, would not have received specialist cancer treatment that saved their lives. Susan LaBrooy replied that they were working with The Cancer Vanguard to address this. She recognised the difficulties experienced by patients who get lost in the system and the importance of not being moved around, between wards and sites.

With reference to bullet point 5.6.18 (page 243 of the Agenda), "no service will be moved until the required capacity is available at all receiving sites…and can be safely transferred." Patrick McVeigh asked who would determine the level of capacity and if this was sufficient. Clare Parker explained, and illustrated her response using Ealing, where some changes had been made, most recently to maternity and paediatrics. They had mapped out existing activity and undertaken engagement at Ealing to establish new models of care. They had identified and contacted each patient and determined which sites they would be going to, establishing the number of beds required. In response to the second part of the question, Clare Parker explained that this was a matter of safety and that they were committed to ensuring the safe delivery of services, without compromise and subject to health scrutiny by local government representatives.

Councillor Brown observed that while the need for specialist treatments was accepted, there had been an increased trend towards specialisation and he emphasised the importance of retaining generalist skills, for which there was evidenced demand. He expressed the view that Charing Cross should be a place where such services could be provided, commenting that it served an area predicted to experience large population growth. He added that the London Ambulance Service (LAS) was not performing well enough to rely on a model requiring the management and movement of patients to different sites. Councillor Brown urged NHS colleagues to consider alternative plans for the benefit of Hammersmith and Fulham residents and indicated a willingness to work with residents, politicians and SOH campaigners, in order to achieve this.

Councillor Vaughan referred to page 271 of the report pack and enquired about the default position on what a local hospital or urgent care centre might look like. Clare Parker replied that this section was directly drawn from the business case. The Independent Reconfiguration Panel and the Secretary of State for Health had established that there should be a local A&E on the Charing Cross site, not just an urgent care centre. In the context of Ealing, they had listed a preferred set of services in the business case but this would

be subject to further engagement and consultation, and may well be adjusted. She explained that services may be constrained by the need to incorporate specialist services but much of this would require more detailed discussion. Their preferred approach was to work on providing frailty services or moving towards out of hospital services, as opposed to examining what a site might look like in the future. This approach would then be replicated and feed into discussions around what Charing Cross might look like in the long term.

In summarising the points raised during the second part of the discussion, Councillor Vaughan referred to the consultation and engagement process in terms of changes proposed to Charing Cross for the future. He observed that opposition to this approach still remained. In particular, there were underlying issues around trust and clear communication in terms of the proposals for the site.

124. WORK PROGRAMME

The Work Programme noted items planned for the next meeting of the Committee.

RESOLVED

That the report be noted.

125. DATES OF FUTURE MEETINGS

The Committee noted the date of the next meeting, to be held on Wednesday, 26th April 2017.

Meeting started: 7.05pm
Meeting ended: 10pm

Chair .....

Contact officer:

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