London Borough of Hammersmith & Fulham

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

Information Notes
(Inquorate meeting)
Wednesday 26 April 2017

PRESENT

Committee members: Councillors 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: Vivienne Lukey

Officers: Helen Mann, Programme Manager, Healthwatch; Colin Brodie, Public Health Knowledge Manager, Public Health, LBHF; Craig Williams, Head of Health Partnerships, LBHF; Toby Hyde, Head of Strategy, H&F CGG; Matthew Mead, Integrated Care Programme Manager, H&F CCG; Holly Ashforth, Deputy Chief Nurse and Director of Patient Experience, CLCH; Darren Jones, Associate Director of Quality, CLCH; Anthony Clarke, Senior Social Work Practitioner, H&F CCG; Megan Veronesi, Head of Service Development and Communications; Trinity Hospice; Viv Whittingham, Head of Service Care and Assessment, Adult Social; Vanessa Andreae, H&F CCG; Dr William Oldfield, Deputy Medical Director; Claire Braithwaite, Divisional Director of Operations, Medicine and Integrated Care and Mick Fisher, Head of Public Affairs, Imperial College NHS Trust Hospital

126. MINUTES OF THE PREVIOUS MEETING

Meeting was inquorate therefore no formal business transacted.

127. APOLOGIES FOR ABSENCE

Meeting inquorate therefore no formal business transacted.

128. DECLARATION OF INTEREST

Meeting inquorate, therefore no formal business transacted.

129. HEALTHWATCH - INFORMAL NOTES

Councillor Vaughan welcomed Helen Mann, Programme Manager, Healthwatch to the meeting. As with neighbouring boroughs, the intention was that this would be a standing item for future meetings, to ensure that the organisation was able to provide regular input into health issues affecting Hammersmith and Fulham residents. It was understood that the organisation had gone through a lengthy period of transition and restructuring and that following this, a new Chief Executive had recently started. A new volunteer co-ordinator had also been appointed and had spent three months getting to know volunteers. Healthwatch aim to raise awareness of health issues such as the STP, was a primary goal. It was noted that 94% of people had not attended any public health event and the intention was to actively work jointly with the CCG to address this. The following key points of the discussion were noted:

- A recent signing posting event had encouraged attendance from across the three boroughs. It was noted that residents found it difficult to find information on social care provision and navigate the administrative process in order to access that care. This indicated the level of work still required to improve health advocacy;
- There was no indication as how long Healthwatch would continue to operate under Hestia Housing Support, its parent charity, and they were currently awaiting the outcome of the due diligence submission provided on 12th April;
- 66 responses had been received in response to a simple survey that Healthwatch had undertaken, with a decision taken to not ask respondents about their views on the STP. Healthwatch indicated that they would be happy to share this; and
- That better engagement could be facilitated through the removal of language barriers.

130. END OF LIFE CARE - INFORMAL NOTES

Councillor Vaughan welcomed a number of officers, both commissioners and providers: Colin Brodie, Public Health Knowledge Manager, Public Health, LBHF, Toby Hyde, Head of Strategy, H&F CGG, Matthew Mead, Integrated Care Programme Manager, H&F CCG, Holly Ashforth, Deputy Chief Nurse and Director of Patient Experience, CLCH, Darren Jones, Associate Director of Quality, CLCH, Anthony Clarke, Senior Social Work Practitioner, H&F CCG, Megan Veronesi, Head of Service Development and Communications, Trinity Hospice, Viv Whittingham, Head of Service Care and Assessment, Adult Social and Vanessa Andreae, H&F CCG.

This was a detailed, technical document which summarised the joint work undertaken by the local authority and the CCG on the JSNA on End of Life Care. It was signed off by the LBHF Health and Wellbeing Board in March

2016 and provided an overview of the provision of end of life care across the three boroughs. The following key points of the discussion were noted:

- End of life care was not simply care during the last few days or weeks, but could cover a period of months or years, usually following a serious long term condition. It should cover physical, emotional and social needs, cross cutting across a number of different sectors;
- Paragraph 3.8 of the report set out five key recommendations. This was primarily about a culture shift of moving on from the provision of palliative care to an open discussion, addressing issues such as individual choice, control and exploring broader options;
- There was a shift in terminology from "end of life" to "last phase of life", noting that there was now greater likelihood of functional or gradual, decline spanning a number of years;
- A primary recommendation was that each individual received an easily accessible and agreed care plan, that had been consulted upon with friends, family and clinicians;
- CLCH – it was important to support staff to enable them to have difficult conversations about last phase of life care;
- Events were planned throughout "Dying Matters" week, planned for 8-14th May. The 2016 event had been well received, however, it was also acknowledged that there needed to be improved communication and information provided about workshops and events;
- There was significant variation across the three boroughs in terms of raising awareness of the issue;
- A key issue was about empowering staff based in for example, sheltered housing accommodation and not just about offering palliative care. It was about how to facilitate a humanitarian and compassionate approach alongside professional care. This ought to be a shared and informed decision making process, making people feel comfortable and avoiding a fear of retribution culture;
- Recognising that cognitive decline often pre-empted last phase of life, it was acknowledged that not everyone was able to engage and that there was a need for earlier intervention, with preparation or planning being a prerequisite in much the same way as a funeral plan. This was not the same as simply having a conversation with your GP;
- The provision of last phase of life care was inclusive of all age groups, including young people, for whom tailored co-ordinated care plans could also be provided. It was important to not generalise about cultural or religious factors and again, these were difficult conversations to facilitate, making it important to ensure that staff were fully supported, particularly in dealing with young people;
- It was noted that the majority of GP practices have multi-disciplinary team meetings, to examine patient cohorts and to understand their future preferences. These were undertaken on rolling basis and contained inherent challenges, depending on the ability or cognisance of the individual. This progress development in LBHF has been organic over the past three years offering ample opportunities for sharing learning;

- It was noted that there were approximately 25,000 people the last phase of life, based on the current data, with only a small portion of that number having an agreed end of life care plan;
- It was acknowledged that carers perceived experience was also important to understand and contextualise;
- The 28 beds provided by Trinity, covering a 5th of Hammersmith and Fulham. The majority of people wanted to die at home. The issue was not about the number of beds but that 80% of care was provided in the community;
- The immediate focus of the JNSA was the need to ensure 24/7 access to clinical advice, with information as to who to go to and at what point in the day this should happen. There was recognition of the need for better co-ordinated care to reduce the variation in experience and a need to improve training;
- The challenges of moving resources and facilitate people's wishes to die at home; and
- The increase in extreme aging was highly challenging, requiring the co-ordination of different medical interventions and identified needs, ideally taking place with the least disruption.

131. IMPERIAL COLLEGE HEALTHCARE NHS TRUST: ACCIDENT & EMERGENCY SERVICE PERFORMANCE NOVEMBER 2016 - MARCH 2017 - INFORMAL NOTES

Councillor Vaughan welcomed Dr William Oldfield, Deputy Medical Director Claire Braithwaite, Divisional Director of Operations, Medicine and Integrated Care, Mick Fisher, Head of Public Affairs, from Imperial College Healthcare NHS Trust. The Trust managed a number of A& E services that included emergency departments (ED), urgent care centres (UCC) and specialist emergency centres, located at St Marys and Charing Cross hospitals. This had been a challenging winter period nationally but a month on month improvement had occurred through the period December 2016 to March 2017, with a new acute service commencing at Charing Cross. It was noted that a new UCC had become operational at St Marys in April 2016, operated by Vocare. Dr Oldfield explained that they were remodelling critical care facilities and that they were signs of improved quality of services. The following key points of the discussion were noted:

- This had been a challenging winter, with target of seeing 95% of patients being seen within fours not being met. On average, 87% of patients were seen within four-hour, however, there was demonstrable trajectory of improvement from December onwards;
- With reference to figure 5, in paragraph 4.2 of the report, it was noted that during 2017, the position showed much improvement, when compared with Feb-March of the previous year;
- In terms of key challenges, it was recognised that contrary to media reports, most patients presenting at A&E sites need to be there. There were increasing numbers arriving by ambulance, which also presented significant operational challenges;
- Remodelling of care at St Marys UCC had experienced short terms operational difficulties, with the result that that the streaming services

(to either UCC or ED) experienced difficulty with managing extended wait times, delivering consistent streamlining services and maintaining adequate staff levels, particularly overnight;

- There had been significant changes to improve UCC with an extending programme of work to improve resilience targeting not only A&E, but the range of service provision from when a patient first presents to discharge. Regular weekly meetings now monitored projects and required actions, with scrutiny and support from senior officers;
- The Trust acknowledged that they had not met the required standard but there was improvement;
- Dr Oldfield referred to a funnel affect, with large numbers of patients accessing service through single point. Remodelling to maximise available space, calculating demand and resources, particularly staff, accordingly would see this become more streamlined. Emergency medicine was hard, with staff requiring significant experience – taking up to 15 years to train an emergency consultant - in what was a highly pressurised, challenging environment;
- Difficulty in accessing other services could indicate a causal link to increased A&E attendance, particularly with some waiting periods of up to 18 weeks recorded for Referral to Treatment. Members of the Committee highlighted the point that vulnerable and elderly residents struggle to access GPs and how easy was it for people to access primary care in the community. Although it was noted that this was outside of the Trusts remit, it was understood that despite the wait, a patient who presented through an A&E service would eventually be seen within 14 hours by a consultant and receive a senior opinion on their condition; and
- Hospital based Social Workers were now accompanying consultants on their rounds, offering joined up patient care pathways, with discharge plans being formulated far early and sufficiently in advance of discharge to avoid delay.

An increase of Type 1 cases at Charing Cross was cause for concern, however, the Committee acknowledged that the level of demand caused significant pressure on the service, with the Trust unable to meet the national standard to see, treat and discharge 95% of patients that present to an urgent or emergency care setting within 4 hours.

Members of the Committee highlighted additional concerns around the length of waiting time, particularly at Western Eye Hospital, where waiting times of up to five hours had been experienced. The Committee would welcome closer analysis of public health education provision, which might potentially address this, together with a better understanding of how to achieve greater efficiencies around triage and initial assessments.

The Committee was disappointed that the waiting time targets had not been met. However, it welcomed the fact that the Trust had plans in place to improve its performance, particularly at the Charing Cross A&E. And members of the Committee commended the work of staff working in emergency care settings, understanding that the service had faced high levels of demand during this period. The Committee will be interested in

receiving a further report on A&E waiting times later in 2017 to see what impact these changes have made.

132. WORK PROGRAMME

Meeting was inquorate therefore no formal business transacted.

133. DATES OF FUTURE MEETINGS

Tuesday, 13th June 2017

Chair .....

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