London Borough of Hammersmith & Fulham

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

Agenda

Wednesday 26 April 2017
7.00 pm
Committee Room 1 - Hammersmith Town Hall

MEMBERSHIP

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

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Date Issued:18 April 2017

London Borough of Hammersmith & Fulham

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

Agenda

26 April 2017

Item		Pages
1.	**MINUTES OF THE PREVIOUS MEETING**	1 - 14

(a) To approve as an accurate record and the Chair to sign the minutes of the meeting of the Health, Adult Social Care and Social Inclusion PAC held on

(b) To note the outstanding actions.

2. APOLOGIES FOR ABSENCE

3. DECLARATION OF INTEREST

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

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

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

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

4. HEALTHWATCH 15 - 19

Healthwatch Central West London is an independent charity and membership organisation, supporting people who live, work or use health and social care services in Hammersmith & Fulham, Kensington & Chelsea and Westminster. The report provides a summary of its existing work, its progress and findings.

5. END OF LIFE CARE 20 - 32

This report summarises the work and findings of the JSNA on End of Life Care, including recommendations for key partners. The report also summarises the local direction of travel for End of Life Care in Hammersmith and Fulham, and continuing progress made against the JSNA recommendations since publication of the report.

6. IMPERIAL COLLEGE HEALTHCARE NHS TRUST: ACCIDENT & EMERGENCY SERVICE PERFORMANCE NOVEMBER 2016 - MARCH 2017 33 - 44

This report is provided by Imperial College Healthcare NHS Trust and covers the performance and activity of the Accident & Emergency service during the winter period November 2016 to March 2017.

7. WORK PROGRAMME 45 - 46

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

8. DATES OF FUTURE MEETINGS

The date of the next meeting will be Tuesday, 13th June 2017.

The dates of meetings for the remainder of the new municipal year are as listed:

Tuesday, 4th July 2017
Tuesday, 12th September 2017
Tuesday, 14th November 2017
Tuesday, 12th December 2017
Tuesday, 30th January 2018
Tuesday, 13th March 2018
Tuesday, 24th April 2018

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 (Disabilities Rights Campaigner)

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: Bathsheba Mall
Committee Co-ordinator
Governance and Scrutiny
☎: 020 8753 5758
E-mail: bathsheba.mall@lbhf.gov.uk

London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE & SOCIAL INCLUSION POLICY & ACCOUNTABILITY COMMITTEE** **26 APRIL 2017**	
HEALTHWATCH UPDATE	
Report of the Cabinet Member for Health and Adult Social Care	
Open Report	
Classification - For Policy & Accountability Review & Comment **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Director of Delivery and Value	
Report Author: Helen Mann (Healthwatch) Helen Rowbottom (Policy and Strategy Officer)	**Contact Details:** Tel: 020 753 5711 E-mail: helen.rowbottom@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. Healthwatch Central West London is an independent charity and membership organisation, supporting people who live, work or use health and social care services in Hammersmith & Fulham, Kensington & Chelsea and Westminster.

1.2. Hestia Housing and Support (Hestia) is currently the parent charity to Healthwatch Central West London. As agreed in their contract, Healthwatch are currently working towards full independence from Hestia and novation of the contract during 2017.

1.3. Healthwatch has provided a summary of its existing work, and has offered to present a quarterly update about its progress and findings to the PAC for review and scrutiny.

2. RECOMMENDATION

2.1. That the Policy and Accountability Committee requests quarterly update reports from Healthwatch in the future.

3. HEALTHWATCH UPDATE

3.1. Background

3.1.1. Healthwatch Central West London (CWL) is an independent charity and membership organisation supporting people who live, work or use health and social care services in Hammersmith & Fulham, Kensington & Chelsea and Westminster. A dedicated outreach worker in H&F ensures that Healthwatch collects residents' views of these services, and provides feedback about these insights to the Council.

3.1.2. Healthwatch has Articles of Association which clearly lay out its approach to governance. These are overseen by a Board of Trustees, who meet regularly and include representatives from each of the three local boroughs as well as representatives with the required skills mix, e.g. human resources, finance and fundraising.

3.1.3. In addition to the Board, there is a Local Committee structure in each borough. This structure ensures local authority area sovereignty for Healthwatch functions, enables local decision-making and ensures local voices are heard. Each borough maintains its own membership of people who live, work or use services in that area to support the work of these local committees.

3.1.4. A major staffing re-structure took place at Healthwatch CWL during 2016, with key priorities to ensure there are sufficient resources available to properly support the three different borough areas, reflect the identify of each borough and ensure that local membership is maintained. There are now 10 members of staff working across 3 boroughs, with one dedicated Engagement and Volunteer Coordinator in H&F.

3.1.5. Through a dedicated worker for H&F and members of the local committee acting as authorised representatives, Healthwatch works with key stakeholders in the Borough across health and social care building key relationships to input into key decisions. Healthwatch has engaged with:

- Sobus (umbrella organisation for third sector)
- Voluntary organisations (particularly to ensure that the views of the underrepresented and disadvantaged groups are sought and heard)
- GP Federation
- CCG (particularly via involvement in the public and patient engagement strategy)
- Quality and patient experience groups
- Safeguarding

- Adult social services
- PPG (Patient Participation Groups)
- Hospital Trusts (Imperial, West London Mental Health Trust, Central London Community Healthcare)
- Neighbourhood forums

3.1.6. The work plan for 2016/17 includes representation at meetings with all the stakeholders above. In addition to this and in line with the priorities the local committee and H&F residents have chosen the organisation is exploring the following priorities:

3.2. STP (Sustainability and Transformation Plan)

3.2.1. Healthwatch aims to ensure that local stakeholders are aware of and consulted on the STP and that the local voice is included in its development. Healthwatch recently conducted a survey in H&F around the STP with 66 responses: 68% of people were not aware that new plans for healthcare were being introduced and 94% of people had not attended a public event on the future plans for health and care in the last 6 months. Ninety-nine per cent of people said that they would like to know more about new plans.

3.3. White City and Edward Woods Estates

3.3.1. Healthwatch has been gauging current issues that impact on the health and well-being of young people and the corresponding initiatives that are in place to address these issues.

3.3.2. Work to date has involved extensive engagement with a range of organisations working in White City; demonstrating many local initiatives in place.

3.3.3. The White City Neighbourhood Forum, hosted by White City Enterprise (WCE), brings 25 of these organisations together, and a sub group has just been set up specifically addressing health and wellbeing. Healthwatch has received feedback that, although significant work is happening across White City, organisations based there are not always aware of which organisations have been commissioned and what their remit is. White City-based organisations feel it would be helpful for all stakeholders to have access to and share data and information to inform tendering processes and future work. The WCE is happy to look at hosting this with the help of the Neighbourhood Forum.

3.3.4. Various stakeholders have commented that a mapping exercise or flow diagram to inform local stakeholders of how the different fora/decision-making mechanisms overlap and interlink would be helpful. This would be especially good if it was tailored to the Borough's delivery landscape (meetings and personnel), including CCG/ LBHF key processes.

3.4. Mental Health issues

3.4.1. Healthwatch has been working with providers of mental health services including Mind, the West London Collaborative and the West London Mental Health Trust (WLMHT). Current issues service users face include a shortage of IAPT (Improving Access to Psychological Therapies) provision, difficulty accessing care plans for inpatients and a lack of knowledge about the single point of access (SPA) that exists in the Borough.

3.4.2. Local service users have also identified that those working in services that overlap with mental health (e.g. housing and benefits-related services) would benefit from mental health awareness training.

3.4.3. Healthwatch will be liaising closely with the CQC lead for WLMHT to decide how best to deploy Dignity Champions – volunteers who are trained to visit people in their own homes or in care homes to elicit their views and experiences of care – to visit services requiring independent monitoring. This may include sheltered housing and residential and care homes offering mental health-related services.

3.5. Homecare

3.5.1. Healthwatch is working with homecare commissioners to ensure that the user voice is embedded within the contract monitoring mechanism.

3.5.2. Currently, the monitoring of user experiences of homecare in the borough is inconsistent. Healthwatch's work with providers and commissioners will ensure that the experience of users is captured through a variety of ways, including surveys and one to one interviews with Dignity Champions.

3.6. Supporting Patient Participation Groups (PPGs)

3.6.1. Healthwatch has supported 27 of the 31 PPGs in Hammersmith and Fulham and has just published a report on this work.

3.6.2. A key finding is the barrier that those who speak English as a second language face in participating in their PPG. Healthwatch has relayed these findings back to the CCG and the GP Federation which funded this work until November 2016.

3.7. Signposting

3.7.1. Healthwatch is undertaking a review of signposting across the three boroughs to identify duplication and gaps in service provision. This is being done in collaboration with other signposting organisations including POWhER, Peoplefirst and the Citizens Advice Bureau and with service users to

understand their experiences. Findings will be relayed to commissioners to improve current provision.

3.7.2. Healthwatch maintains its own signposting function, providing local, current information through working in partnership with other “directories” and groups. The new Healthwatch website will feature an interactive map where providers can add details of their services.

3.8. Resident engagement and volunteering

3.8.1. Healthwatch’s remit is to collect user experiences of health and social care and engage residents to support Healthwatch’s work through a range of volunteer opportunities including as Community Listeners, Dignity Champions and as members of the Local Committee

3.8.2. Work to date has demonstrated a need to engage people via multiple channels, including online engagement and more traditional face-to-face events. Over the coming months Healthwatch will host a series of engagement days, building on the success of the first successful engagement day in January at St Paul’s Church in Hammersmith.

3.9. Contract novation

3.9.1. Hestia Housing and Support (Hestia) is currently the parent charity to Healthwatch Central West London. As agreed in Healthwatch’s contract, they are currently working towards full independence from Hestia and novation of the contract during 2017.

3.9.2. The due diligence submission has been made and, as at 12th April, Healthwatch is awaiting formal comment on this from the lead commissioner for Healthwatch Central West London in order for due diligence to take place, informing the timeframe for governance to be completed. Governance structures around the local committee will allow focused work to take place at a borough level, reflecting the individuality of H&F.

3.9.3. In working towards independence, Healthwatch has already put many processes in place including independent IT systems and HR processes, and a recent office move. Other processes are lined up and ready to be put in place once novation has taken place, and these have been outlined in the due diligence submission.

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

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

London Borough of Hammersmith & Fulham **POLICY & ACCOUNTABILITY COMMITTEE** **26 April 2017**	
END OF LIFE CARE	
Report of the Director of Public Health	
Open Report	
Classification - For Policy and Accountability Review and Comment **Key Decision: No**	
Wards Affected: All	
Accountable Director: Mike Robinson, Director of Public Health	
Report Author: Colin Brodie, Public Health Knowledge Manager Toby Hyde, Head of Strategy, H&F CCG Matthew Mead, Integrated Care Programme Manager, H&F CCG	**Contact Details:** 020 7641 4632 Email: cbrodie@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1. This report summarises the work and findings of the JSNA on End of Life Care including the recommendations for key partners. The JSNA was presented for discussion and approved by the Hammersmith and Fulham Health and Wellbeing Board on 21 March 2016.

1.2. The report also summarises the local direction of travel for End of Life Care in Hammersmith and Fulham, and continuing progress made against the JSNA recommendations since publication of the report.

2. RECOMMENDATIONS

2.1. The Policy and Accountability Committee are invited to consider and endorse the End of Life Care JSNA report and recommendations

2.2. The Policy and Accountability Committee are invited to note progress made against the recommendations.

3. END OF LIFE CARE JSNA

Background to the JSNA

3.1. People approaching the end of their life experience a range of physical symptoms, and emotional and spiritual needs. To manage these issues effectively requires integrated and multidisciplinary working between teams and across sectors regardless of whether the person is in their home, in hospital, a care home, or hospice.

3.2. Families and carers of people at end of life also experience a range of challenges and will have their own specific needs which must be addressed before, during and after the person's death.

3.3. While some people experience good and excellent quality end of life care, many people do not. In order to address this variation and identify local issues for end of life care a request for a JSNA was submitted and approved by the JSNA Steering Group, a sub-group of the Health and Wellbeing Boards, July 2014.

3.4. The JSNA provides a comprehensive evidence base to inform local strategic and commissioning approaches to end of life care. It draws on a range of information and data, both quantitative and qualitative, including national and local data, policy and strategy, literature, as well as views of patients, service users and the public. It provides an opportunity to understand the whole landscape for people approaching end of life, and their carers' and to highlight areas of improvement to be addressed in joint strategic planning.

JSNA Findings and Recommendations

3.5. The overarching theme emerging from the JSNA is the need for a whole scale 'culture shift', for all practitioners that may come into contact with dying people to consider End of Life care as 'everyone's business', not just a service provided by specialist palliative care.

3.6. The recommendations were drawn from the evidence contained in the JSNA and in development with key stakeholders. Many of the recommendations cut across a number of different themes and service areas, and were presented in a format for commissioners to consider whether they are appropriate for local implementation.

3.7. Recommendation 1 refers to an ambition for the local delivery of high quality, person- centred end of life care designed to improve the experience of the dying person and their families, carers and friends. Recommendations 2 to 5 describe the culture, governance, processes and systems that need to be in place in order to achieve this ambition.

3.8. The detailed recommendations are presented in the End of Life Care JSNA Key Themes document but are also summarised below.

Recommendation	Summary
Recommendation 1: Maximise choice, comfort and control through high quality effective care planning and co-ordination	Everyone with a life limiting long term condition should have care plans which address their individual needs and preferences, particularly as they approach the last phase of life. Their care must be coordinated, with a clear oversight of the respective roles and responsibilities of all health, social care and third sector service providers.
Recommendation 2: Promote end of life care as 'everybody's business' and develop communities which can help support people	The overall focus of end of life care must be a community model, with input from specialist services when needed. Local leaders, commissioners, professionals and our populations should generate a culture where talking about and planning for the last phase of life is 'normal', and all practitioners are willing and able to give end of life care.
Recommendation 3: Identify clear strategic leadership for end of life care across both social care, health and the independent sector	A lead organisation should be identified with responsibility for ensuring developments are cohesive. Leadership should reflect a community based model across a range of services, with a clearly articulated end of life care vision and ambitions.
Recommendation 4: Develop a coordinated education and training programme for practitioners, the person dying, carers and for family and friends (if they wish)	Formal and informal training and education programs for all frontline practitioners needs to be coordinated, systematic, visible and evaluated, in line with good practice guidelines.
Recommendation 5: Everyone should have easy access to evidence and information	More information needs to be easily available. Accessibility in terms of language, style, culture and ability should be reviewed. Evidence and information must be available to commissioners and providers and used to actively improve services.

4. END OF LIFE CARE IN HAMMERSMITH AND FULHAM/CURRENT WORK PROGRAMMES

4.1. **Recommendation 1: Maximise choice, comfort and control through high quality effective care planning and co-ordination**.

Hammersmith and Fulham utilise the Co-ordinate My Care (CMC) system along with the other 31 CCGs across London to record the care plan of those identified as being at the end of life. The CMC platform has been updated to facilitate the creation and updating of records and the Three Borough End of Life Care Steering Group regularly review the reports and discuss what additional support can be provided to increase the number of patients whose care information is shared on the system.

Central London Community Healthcare (CLCH) have convened six working groups, closely aligned to the recommendations of the JSNA with three groups looking at:

- High quality, relationship centred, compassionate care
- Advance care planning/risk stratification
- Assessment and care planning

The individual working groups report back on the progress of achievement against each of the outcomes, to the newly formed End of Life Care Operational Group.

Royal Trinity Hospice have sourced 3 years' funding from City Bridges Trust to recruit a Community Dementia Nurse to provide support to dementia patients approaching the end of life and their carers living in Hammersmith and Fulham and Kensington and Chelsea. The nurse was appointed in March 2017 and will address inequalities in end of life care for people with dementia through assessment, providing information and advice, advance care planning, and co-ordination of care.

4.2. **Recommendation 2: Promote end of life care as 'everybody's business' and develop communities which can help support people**

Supporting people in the Last Phase of Life (LPOL) has been identified as a priority area in the North West London (NWL) Sustainability and Transformation Plan (STP) submitted in October 2016. The shift to consider people in the last phase of life rather than those at the end of life recognises the more gradual functional decline that characterises the progression of various long term conditions and increasing frailty. This reinforces the need to recognise when people are in the last phase of life and to have discussions at an early stage with them and their families regarding their preferences and what support is required. This will allow a shift from an existing hospital-based model of care, often through emergency services, to a new community and person-focused model of delivering care with input from specialists when needed.

The CCG are also working with the new provider of the Community Independence Service to consider how the service can work alongside local hospices, district and community nursing, primary care practitioners and specialist palliative care teams to provide support to those in the last phase of life.

Trinity have run events in 2016 and 2017 for Dying Matters week. Dying Matters is a coalition of 32,000 members across England and Wales which aims to help people talk more openly about dying, death and bereavement, and to make plans for the end of life. For Dying Matters Week this year (8-14 May 2017), Trinity have organised a packed schedule of events to encourage people including week-long engagement activities hosted by the Hammersmith and Fulham Trinity charity shops, as in 2016, and other events held at the hospice will be widely promoted in Hammersmith and Fulham.

4.3. **Recommendation 3: Identify clear strategic leadership for end of life care across both social care, health and the independent sector**

In the NWL area, a programme of work is being undertaken as part of the Sustainability and Transformation Plan (STP) to improve the quality of care for people who are in their 'last phase of life'. This includes patients in Hammersmith and Fulham.

Providers working across Hammersmith and Fulham have end of life care strategies with key leaders within the organisations identified and governance mechanisms in place for monitoring progress.

Imperial College Healthcare NHS Trust (ICHT) and Chelsea & Westminster NHS Foundation Trust both have organisational end of life care strategy documents. The CLCH End of Life Care Strategy (2015-2018) was launched in March 2015 and sets out plans to improve end of life care and the experience for people and carers using CLCH services at the end of their lives. This encompasses improving access to end of life care services, improving choice and the coordination of services to reduce inequalities of service provision and increasing the proportion of patients who are cared for and die in their preferred place of care.

The strategy covers generalist and specialist palliative care, including care given in all settings of CLCH (at home, all community based services, in-patient, specialist in-patient palliative care services, day Hospice, specialist community palliative care services, prison health, nursing and residential care).

The Health and Wellbeing Board approved the End of Life Care JSNA at their meeting on 21 March 2016 and agreed to take on a leadership role for End of Life Care, providing a steer for local implementation.

4.4. **Recommendation 4: A coordinated education and training program for practitioners, the person dying, carers and for family/friends (if they wish)**

The NWL LPOL programme has identified consistent training and education across the NWL Collaboration of CCGs as one of the six key interventions and discussions have been initiated with HEE NWL to agree a funding mechanism.

The CLCH EOLC Strategy includes a working group dedicated to training and education which categorises staff groups and supports the delivery of appropriate training in relation to the end of life care components of their jobs.

ICHT and CLCH have delivered end of life care training to staff including difficult conversations training.

Trinity's Community Dementia Nurse will support other professionals to improve the quality of end of life care for dementia patients more widely, through joint assessments, training, and providing specialist advice over the phone and at multi-disciplinary meetings.

4.5. **Recommendation 5: Everyone should have easy access to evidence and information**

One of the interventions which has been recommended and prioritised by the North West London Last Phase of Life programme is to deliver a **telemedicine clinical support facility**, to help staff in care homes (initially) to be able to access generalist healthcare and end of life care advice and support. The next phase of the programme will then be to focus on the wider cohort of residents, including those people being cared for by district nursing, intermediate care services, and by formal and informal carers.

The service will be staffed by experienced clinical professionals who are capable of providing rapid triage and advice / guidance to both clinical and non-clinical staff. Best practice from elsewhere has shown that this model allows professionals and carers to better facilitate the wishes of patients at the end of their life, and support them to die in their preferred place, and can also reduce inappropriate A&E attendance and hospital admissions.

5. CONSULTATION

5.1. A workshop was held at the BME Health Forum in June 2015. Feedback from the workshop was incorporated into the findings, particularly the Policy and Evidence Review (Supplement 2).

5.2. A workshop was held at the End of Life Care Steering Group in September 2015 to inform the development of the recommendations. The End of Life

Care Steering Group consists of CCG and GP End of Life Care leads as well as community and secondary care providers.

5.3. The JSNA was presented to the Hammersmith and Fulham CCG Governing Body Seminar on 03/11/2015. In addition, CCG and GP End of Life Care leads were interviewed for the JSNA.

5.4. The draft JSNA was disseminated to key stakeholders in November 2015, including colleagues in Local Authority, Adult Social Care, CCGs, Central London Community Healthcare, Hospices, Specialist Palliative Care Teams, Healthwatch, and Community and Voluntary organisations. Feedback was collated and reviewed by the Task and Finish Group and informed the final report.

6. EQUALITY IMPLICATIONS

6.1. JSNAs must consider the health, wellbeing and social care needs for the local area addressing the whole local population from pre-conception to end of life.

6.2. The “local area” is that of the borough, and the population living in or accessing services within the area, and those people residing out of the area for whom CCGs and the local authority are responsible for commissioning services.

6.3. The “whole local population” includes people in the most vulnerable circumstances or at risk of social exclusion (for example carers, disabled people, offenders, homeless people, people with mental health needs etc).

7. LEGAL IMPLICATIONS

7.1. The JSNA was introduced by the Local Government and Public Involvement in Health Act 2007. Sections 192 and 196 Health and Social Care Act 2012 place the duty to prepare a JSNA equally on local authorities (LAs), Clinical Commissioning Groups (CCGs) and the Health and Wellbeing Boards (HWB).

7.2. Section 2 Care Act 2014 imposes a duty on LAs to provide or arrange for the provision of services that contribute towards preventing, delaying or reducing care needs.

7.3. Section 3 Care Act 2014 imposed a duty on LAs to exercise its Care Act functions with a view to ensuring the integration of care and support provision with health provision to promote well-being, contribute to the prevention or delay of care needs and improve the quality of care and support.

7.4. JSNAs are a key means whereby LAs work with CCGs to identify and plan to meet the care and support needs of the local population, contributing to fulfilment of LA s2 and s3 Care Act duties.

7.5. Implications verified by: Kevin Beale, Principal Social Care Lawyer, 020 8753 2740.

8. FINANCIAL IMPLICATIONS

8.1. There are no financial implications arising directly from this report. Any future financial implications that may be identified as a result of the review and re-commissioning projects will be presented to the appropriate board & governance channels in a separate report.

8.2. Implications verified/completed by: (Name, title and telephone of Finance Officer).

9. IMPLICATIONS FOR BUSINESS

9.1. None identified.

10. OTHER IMPLICATION PARAGRAPHS

10.1. None identified.

11. BACKGROUND PAPERS USED IN PREPARING THIS REPORT

None.

12. LIST OF APPENDICES:

Appendix 1: CLCH End of Life Care Operational Update August 2016

Appendix 1

Central London Community Healthcare NHS
NHS Trust
Your healthcare closer to home

END OF LIFE CARE STRATEGIC GROUP July 2016	
Report title:	The review of the End of Life Care Strategy
Agenda item number:	
Report of:	Hilary Shanahan; Compassion in Care Coordinator and End of Life Care Nursing Lead.
Contact officer:	Hilary Shanahan; Compassion in Care Coordinator and End of Life Care Nursing Lead.
Relevant CLCH priority (delete as appropriate)	1. **Quality.**
Freedom of Information status	Report can be made public.

Executive summary:

The Trust End of Life Care Strategy (2015-2018) was launched in March 2015 and through the End of Life Care Model of Care and work programmes, it sets out plans to improve end of life care and the experience for people and carers using CLCH services at the end of their lives. This encompasses improving access to end of life care services, improving choice and the coordination of services to reduce inequalities of service provision and increasing the proportion of patients who are cared for and die in their preferred place of care.

The End of Life Care Strategy includes the provision of end of life care for children and adults with any advanced, progressive or chronic illness regardless of diagnosis. It focuses on generalist and specialist palliative care, including care given in all settings of CLCH (at home, all community based services, in-patient, specialist in-patient palliative care services, day Hospice, specialist community palliative care services, prison health, nursing and residential care).

The End of Life Care Operational group is responsible for implementing the Strategy supporting incremental improvements and the continued spread of high quality, competent, compassionate end of life care to all those who need it. The Strategy is supported by a robust programme of work delivered through a number of different work streams. Considerable progress has been made in all of the work streams.

The End of Life Care Nursing Lead is now undertaking a review of the End of Life Care Strategy to ensure it encompasses current National guidance, patient and staff involvement and commissioners intentions.

This report provides an update on the Strategy and the actions being undertaken within the Operational End of Life Care group.

Assurance provided: The End of Life Care Strategy is supported by a robust work programme to provide assurance against the delivery of the Strategy; the work programme is reported to the End of Life Care Operational Group, the End of Life Care Strategic Group and the Quality Committee.

Report provenance: The Strategy was developed with the involvement of key clinicians, stakeholders and specialist palliative care providers. The Strategy was approved by the End of Life Care Steering Group.	
Report for:	Decision ☐ Discussion ☐ Information ■
Recommendation: For the End of Life Care Strategic Group to be updated on the actions that will be taken for the review of the End of Life Care Strategy.	

1 Purpose

1.1 The purpose of this paper is to provide an update on the actions that will be taken for the review of the Trusts End of Life Care Strategy.

2 Introduction

2.1 The Trust End of Life Care Strategy (2015-2018) was launched in March 2015 and through the End of Life Care Model of Care and work programmes, sets out plans to improve end of life care and the experience for people and carers using CLCH services at the end of their lives. This encompasses improving access to end of life care services, improving choice and the coordination of services to reduce inequalities of service provision and increasing the proportion of patients who are cared for and die in their preferred place of care.

2.2 In order to achieve the aims of the Strategy, the Adults work programme currently focusses on six objectives, based on the End of Life Care model and outcomes for CLCH. These are:

- High quality, relationship centred, compassionate care
- Advance care planning/risk stratification
- Assessment and care planning
- Symptom management, comfort and well-being
- Support for families including bereavement care
- Education and training

2.3 The six work streams of the End of Life Care Strategy are led through individual working groups, which report back on the progress of achievement against each of the outcomes, to the newly formed End of Life Care Operational Group.

2.4 The current model for End of Life Care for Children in CLCH is delivered against the core care pathway for children with life limiting and life threatening conditions, which is divided into three stages, comprising of six standards which specify the level and quality of care that every family should expect.

2.5 There is also an End of Life Care Working Group for Children's Services. The working group is representative of staff working in End of Life Care within the Division. The purpose of the group is to take forward the six standards of the End of Life Care for Children. The working group reports to the End of Life Care Operational Group and meets bi-monthly.

3 Adult objective work stream update

3.1 High quality, relationship centred, compassionate care

3.1.2 The CLCH Compassion in Care model, patient outcomes and staff competencies have been taken

forward through 'Knowing you Matter and 'Leading with Compassion' sessions across the Trust. There were a number of sessions in June and July 2015 for all Trust staff. A specific 'Knowing you Matter' and 'Leading with Compassion' Programme has taken place on Jade ward and with the Quality Leadership Team. The sessions have been extremely well evaluated and a final report and recommendations regarding the sessions were presented to the Compassion in Care Board meeting on January 15th 2016. Further funding from Health Education North West London, to implement a Train the Trainer programme for the delivery of 'Compassion in Care- it starts with us' sessions within the Trust and with other neighbouring organisations to create a Compassion in Care Community Provider Network has been recently approved. The delivery of the Train the Trainer sessions commenced in April 2016 and a number of sessions have taken place. The first Compassion in Care Provider Network meeting is being held in September 2016 in partnership with Chelsea and Westminster Hospital and Trinity Hospice. A Compassion in Care outcomes dashboard has also been developed and is due to be piloted in one of the clinical areas in September 2016.

3.1.3 The Patient Experience Team is also introducing the concept of patient stories and dynamic patient stories within palliative care services.

3.2 Advance care planning/risk stratification

3.2.1 Two national Advance Care Plan documents are being implemented within the Trust and initial Advance Care Planning teaching sessions took place in July 2015 in each Borough. The sessions have been facilitated by The Royal Marsden Hospital through commissioned education funds.

3.2.2 Further Advance Care Planning teaching sessions have taken place in each Borough in June and July 2016, facilitated by The Royal Marsden Hospital. The Advance Care Plan documents have been uploaded onto System One and Cross Care and are also available on the End of Life Care section on the hub.

3.3 Assessment and care planning

3.3.1 A review of documentation related to end of life care assessment and care planning has taken place and a working party was convened to re- develop the end of life care assessment and care planning documentation. An individual plan of care and support for the dying person in the last days and hours of life document has been developed for use across the Trust from November 30th 2015. This has been fully implemented at The Pembridge Palliative Care Centre. Care planning guidance and a patient/relative information leaflet has also been developed to be used in conjunction with the individual plan of care and support for the dying person in the last days and hours of life. A Train the Trainer one day education programme for staff, regarding care and support for the dying person in the last days and hours of life, and the use of the individual plan of care and support for the dying person commenced in February 2016. One hundred and sixty staff in the B staff grouping have been trained to date and further training dates are available until September 2016. The individual plan of care and support for the dying person document has been uploaded onto System One and Cross Care. The documents are also available on the End of Life Care section on the hub.

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3.4 Symptom management, comfort and well-being

3.4.1 End of Life Care symptom control guidelines for prescribing/symptom management have been agreed and circulated throughout the Trust. The guidelines will also be presented in a leaflet format for CLCH staff use. The Syringe Driver Policy was approved at the Medicines Management Committee in November 2015.

3.5 Support for families including bereavement care

3.5.1 Staff focus groups have taken place across the Trust to understand the bereavement support that is available for staff and patients. From the focus group findings, Schwartz rounds are now being taken forward across the Trust for all staff. The first Schwartz facilitators were trained in November 2015 and the first Schwartz round took place in March 2016. A specific End of Life Care Schwartz round is taking place in July 2016 at The Pembridge Palliative Care Centre. The bereavement information on the End of Life Care section of the hub has also been reviewed.

3.6 Education and training

3.6.1 Recommended End of Life Care Education Standards document, linked with the Priorities for Care for the Dying Person, for all staff has been approved. This outlines the behaviours, attitudes, competencies and skills for staff who work in any care setting of the Trust where dying people and their relatives receive care. A paper detailing the implementation of the end of life care standards document was presented and approved at the Education Committee in November 2015. Divisional End of Life Care Champions are now in place for each of the divisions to work with the Compassion in Care Co-ordinator and End of Life Care Nursing Lead. They will support the Train the Trainer educational programme for staff regarding care and support for the dying person in the last days and hours of life, and the use of the individual plan of care and support for the dying person. The education programme commenced in February 2016. One hundred and sixty staff in the B staff grouping have been trained to date and further training dates are available until September 2016.

4 Children's objectives update

4.1 The core care pathway for children with life limiting and life threatening conditions, which is divided into three stages, comprising of six standards which specify the level and quality of care that every family should expect are in use within the Trust.

4.2 Recommended End of Life Care Education Standards for staff working within the Children's Division are being developed.

5 Review of the Strategy

5.1 In order to review the End of Life Care Strategy, the following actions will be taken by the end of October 2016 by the End of Life Care Nursing Lead-

- A review of current National End of Life Care policy will be incorporated into the reviewed Strategy
- The current objectives of the End of Life Care Strategy will be benchmarked against the six ambitions of the Ambitions for Palliative and End of Life Care Framework(2015-2020) and incorporated into the reviewed Strategy objectives as appropriate
- Current End of Life Care Strategies from relevant stakeholders will be reviewed and incorporated into the reviewed Strategy objectives as appropriate

- An Adult patient /carer co-design event is planned in September with adult patient group representatives to inform the review of the Strategy
- A Children's patient /carer co-design event is also being discussed to inform the review of the Strategy
- A staff co-design event is also being discussed to inform the review of the Strategy

6 Recommendations

6.1 For the End of Life Care Strategic Committee to be updated on the review of the Trusts End of Life Care Strategy and approve the actions as the process for review.

London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE & SOCIAL INCLUSION POLICY & ACCOUNTABILITY** **26 APRIL 2017**	
IMPERIAL COLLEGE HEALTHCARE NHS TRUST: ACCIDENT & EMERGENCY SERVICE PERFORMANCE NOVEMBER 2016 - MARCH 2017	
Report of the Executive Director for Adult Social Care and Health	
Open Report	
Classification - For Policy & Accountability Review & Comment **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Executive Director for Adult Social Care and Health	
Report Author: Mick Fisher, head of public affairs, Imperial College Healthcare NHS Trust	**Contact Details:** E-mail: mick.fisher@imperial.nhs.uk

1. EXECUTIVE SUMMARY

1.1. The attached report to the Health, Adult Social Care and Social Inclusion Policy and Accountability Committee from Imperial College Healthcare NHS Trust covers the performance and activity of the Accident & Emergency service during the winter period November 2016 to March 2017.

1.2. The report provides information on monthly performance against the national waiting time standard both Trust wide and for each hospital site over the winter period November 2016 to March 2017.

1.3. Further information is provided on the levels of activity (numbers of patient attendances and breaches of the national waiting time standard) both Trust-wide and for each hospital site, comparing November 2016 to March 2017 with the same period in 2015/16.

1.4. In order to help address the challenges created by extra winter demand for A&E services, the Trust has an on-going programme of developments to improve its

whole urgent and emergency care pathway as well as major refurbishment works. The report also outlines the refurbishment and expansion of capacity in the A&E departments and other improvements to its urgent and emergency care services.

2. RECOMMENDATION

2.1. The Committee is asked to review and comment upon the report.

3. BACKGROUND

3.1. Imperial College Healthcare NHS Trust provides acute and specialist healthcare for a population of nearly two million people in North West London, and more beyond. It comprises of five hospitals – Charing Cross, Hammersmith, Queen Charlotte's & Chelsea (all located in the London Borough of Hammersmith & Fulham), St Mary's and Western Eye – as well as a growing number of community services.

3.2. The Trust's A&E services include emergency departments (EDs), urgent care centres (UCCs) and specialist emergency centres.

3.3. EDs are located at St Mary's and Charing Cross hospitals. The Trust also operates UCC services at Charing Cross and Hammersmith hospitals. Additionally, there is a UCC at St Mary's Hospital, which is run by Vocare Ltd (since April 2016).

3.4. The Trust's hospitals are also the home to some of London's specialist emergency centres:

- Major trauma centre at St Mary's Hospital
- Hyper acute stroke unit at Charing Cross Hospital
- Heart attack centre at Hammersmith Hospital
- 24-hour ophthalmic emergency service at the Western Eye Hospital.

4. LIST OF APPENDICES

Appendix 1: Report from Imperial College Healthcare NHS Trust to the London Borough of Hammersmith & Fulham Health, Adult Social Care and Social Inclusion Policy and Accountability Committee
Appendices 2 & 3: Accident & Emergency Service Performance November 2016 – March 2017

Imperial College Healthcare NHS Trust

Accident & Emergency Service Performance November 2016 to March 2017

Report from Imperial College Healthcare NHS Trust to the London Borough of Hammersmith & Fulham Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

1. Summary

This report to the Health, Adult Social Care and Social Inclusion Policy and Accountability Committee from Imperial College Healthcare NHS Trust (the Trust) covers the performance and activity of the Accident & Emergency service during the winter period November 2016 to March 2017.

As in previous years, the Trust experienced an increase in demand for our A&E services - particularly for adult type 1 patients at Charing Cross and St. Mary's hospitals during the winter period November 2016 to March 2017.

Despite our efforts to plan ahead and manage these extra winter pressures, the increased demand on the Trust's urgent and emergency care services had an impact on how quickly we could see and treat patients and on our capacity for planned, elective care.

2. Imperial College Healthcare NHS Trust overview

The Trust provides acute and specialist healthcare for a population of nearly two million people in North West London, and more beyond. We have five hospitals – Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and Western Eye – as well as a growing number of community services.

With our academic partner, Imperial College London, we are a founding member of one of the UK's six academic health science centres (now expanded to include Royal Brompton & Harefield NHS Foundation Trust and the Royal Marsden NHS Foundation Trust), working to ensure the rapid translation of research into better patient care and excellence in education. We are also part of Imperial College Health Partners, the academic health science network for North West London, spreading innovation and best practice in healthcare more widely across our region.

Map of Imperial College Healthcare NHS Trust

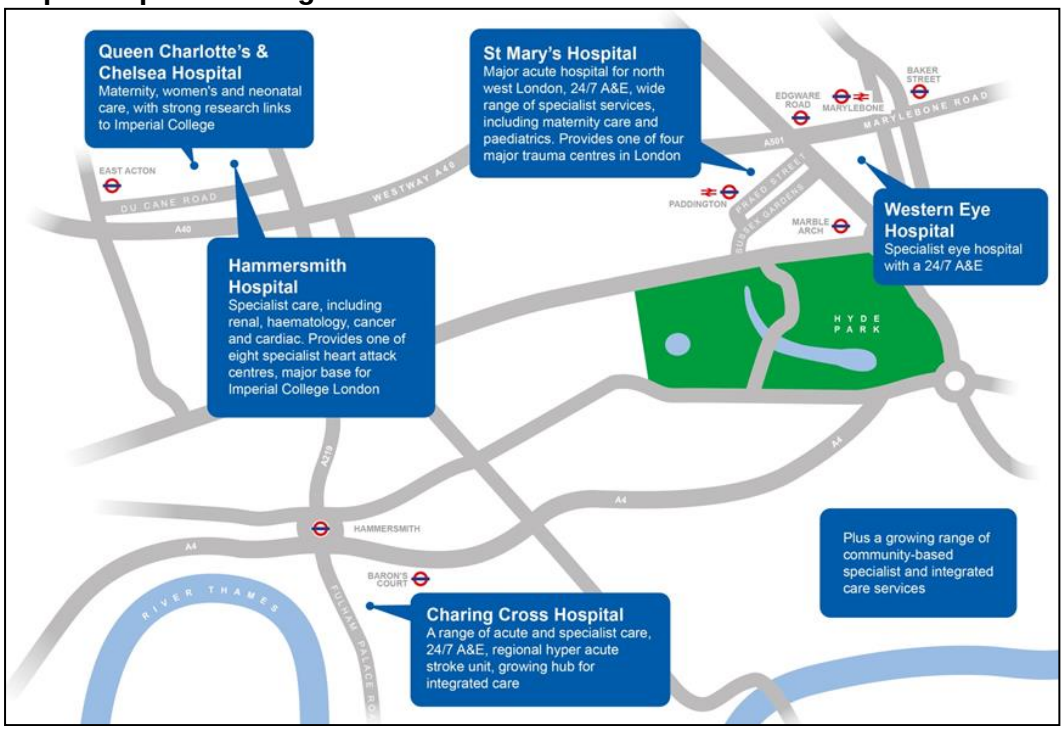

Figure 1 – Map of hospitals in Imperial College Healthcare NHS Trust

3. Emergency Departments and Urgent Care Centre Services

Accident & Emergency (A&E) services in England broadly consist of two types of service:

- **Emergency Department (ED)** – which provides care for a medical emergency, when life or long term health is at risk, for examples: loss of consciousness; persistent, severe chest pain; breathing difficulties; choking; severe non-stop bleeding; having fits; badly broken bones etc.
- **Urgent Care Centre (UCC)** – which can be based on a hospital site or stand-alone in the community, are often GP-led and provide patients with urgent advice or treatment in cases that are not life-threatening or life changing, for examples: sprains and strains of ankles, wrists and knees; minor burns (small area); cuts, including those that need stitches; infections that GPs commonly treat (e.g. sore throats and earache); minor broken bones such as toes, fingers and collarbone; x-rays where needed etc.

The Trust's A&E services include emergency departments (EDs), urgent care centres (UCCs), and specialist emergency centres.

EDs are located at St Mary's and Charing Cross hospitals. The Trust also operates UCC services at Charing Cross and Hammersmith hospitals. Additionally, there is a UCC at St Mary's Hospital, which is run by Vocare Ltd (since April 2016), and commissioned directly by Central London Clinical Commissioning Group

The Trust's hospitals are also the home to some of London's specialist emergency centres:

- Major trauma centre at St Mary's Hospital
- Hyper acute stroke unit at Charing Cross Hospital
- Heart attack centre at Hammersmith Hospital
- 24 hour ophthalmic emergency service at the Western Eye Hospital.

We report on the total waiting time performance in our EDs, as well as the emergency service at Western Eye Hospital and all of the UCCs located on Trust sites.

Definitions of A&E waiting time, national standard and patient types

Total waiting time in the A&E department: measured from the time of arrival and registration on the hospital information system to the time that the patient leaves the department to return home or to be admitted to a ward bed (including the A&E department observation beds).

National waiting time standard: national minimum threshold is 95 per cent of A&E patients seen in four hours.

Patient types:

- **Type 1** A consultant-led 24-hour service with full resuscitation facilities; applies to emergency departments (EDs) at Charing Cross and St Mary's hospitals
- **Type 2** A consultant-led single specialty A&E service (e.g., ophthalmology) applies to emergency department (ED) at Western Eye Hospital.
- **Type 3** Minor injury units/Urgent care centres: applies to urgent care centres (UCCs) at Charing Cross, Hammersmith and St Mary's Hospitals.

Figure 2 – A&E national waiting time standard and patient Type 1, Type 2 and Type 3

4. Performance and activity

4.1 A&E monthly performance for November 2016 to March 2017

During the winter period, Trust wide performance (i.e. all sites and all types) was below the 95% national waiting time standard, averaging approximately 86.7%, but with demonstrable improvement from December 2016 to March 2017, as shown in Figure 3.

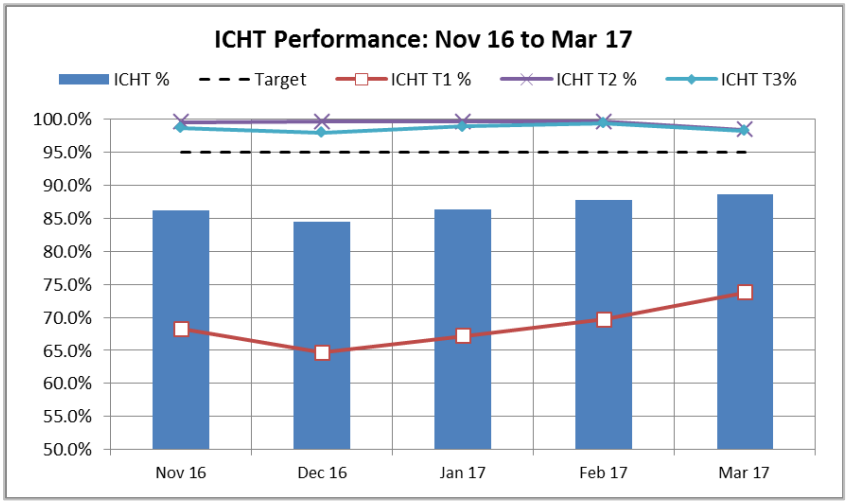

Figure 3 – Imperial College Healthcare NHS Trust A&E performance: All Types, and Types 1, 2 and 3

A&E performance for the Trust by type was as follows:

- Type 1 performance (St Mary's and Charing Cross hospitals) was below the standard, but steadily improved from 64% in December to 73% in March
- Type 2 performance (Western Eye Hospital) met the national standard during winter, averaging 99.4% and throughout the reporting year
- Type 3 performance (St Mary's (Vocare), Hammersmith, Charing Cross Hospitals) met the standard throughout the winter period.

A&E performance for the Trust by site was as follows:

- St Mary's overall performance (type 1 adults, type 1 paeds, and type 3) was below the standard, averaging approximately 82.3%, but with demonstrable improvement from December 2016 to March 2017
- Charing Cross performance (types 1and 3) was below the standard, averaging approximately 81.2%, but with steady improvement from December 2016 to March 2017.

Figure 4 shows Trust A&E performance for the national waiting time standard compared to the performance across the London region as a whole for 2016/17.

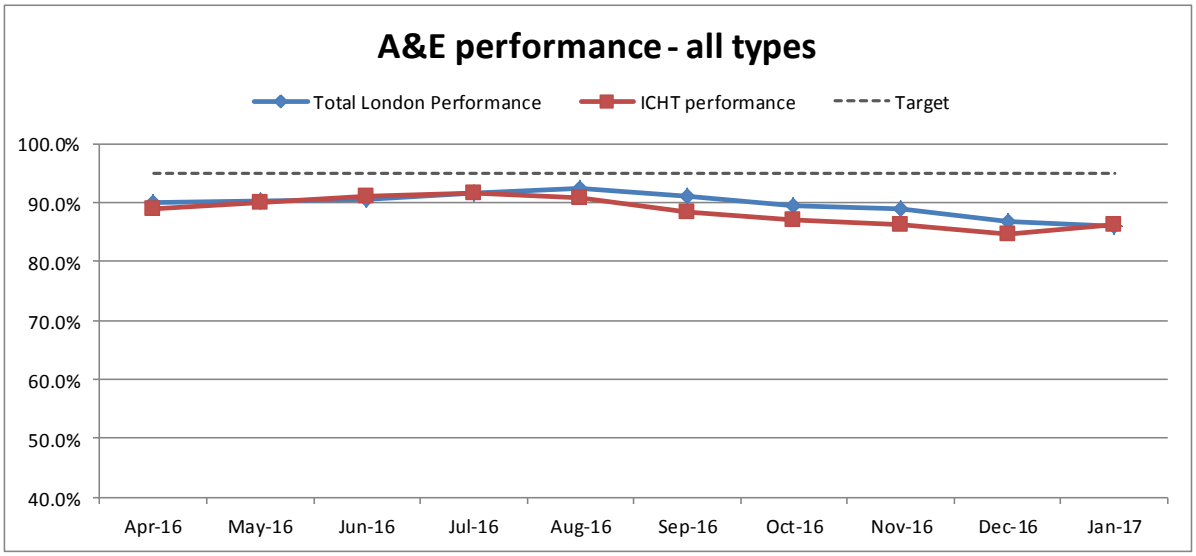

Figure 4 – London region and Trust A&E performance for all patient types 2016/17

(For further analysis please refer to Figures 6 to 8 in Appendix 1 of this report).

4.2 A&E activity and performance November 2016 to March 2017 compared with November 2015 to March 2016

As Figure 5 shows, Trust performance (i.e. all sites and all types) against the 95% national waiting time standard this winter showed an improvement in February and March 2017 compared with the same period in 2016.

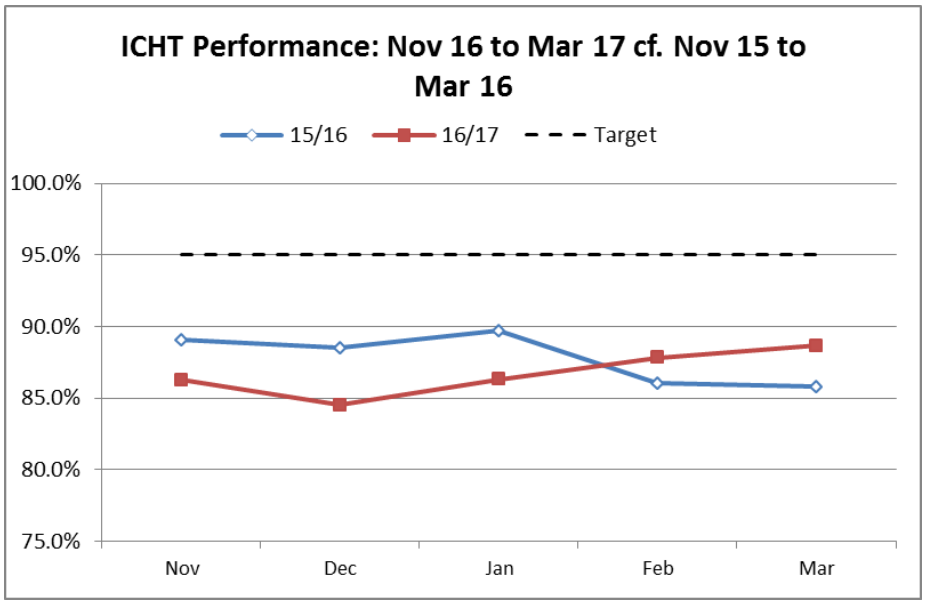

Figure 5 – Imperial College Healthcare NHS Trust performance Nov to Mar 16/17 cf. 15/16

Whilst total attendances across our A&E services did not increase in the period November 2016 to March 2017 when compared with the same period last year, there was a significant variation between types of attendance. There was a 5.4% increase in type 1 adult attendances at St. Mary's Hospital and a 9.3% increase at Charing Cross Hospital during this period. In addition to this, there were also increases in the numbers of patients arriving at the EDs by ambulance and in the number of admissions.

(For further analysis please refer to Figures 9 to 16 in Appendix 2 of this report).

The challenge of managing this additional demand during this period was exacerbated by problems with the pathway from the UCC at St. Mary Hospital and delays for patients presenting with mental health related complaints.

4.3 Mental Health

Following a change to legislation designating emergency departments as safe places to accommodate those in crisis, the number of patients attending the emergency departments at St. Mary's and Charing Cross hospitals with a mental health related complaint increased and remains high. Waiting times for this group of patients continue to rise and, in addition, patients requiring admission to a mental health bed, particularly those needing Child and Adolescent Mental Health Services (CAMHS), routinely experience long delays. These issues have a negative impact on both experience and quality of care for mental health and all other patients, as well as for the staff working in our emergency departments.

The Trust is working with commissioners and the mental health trusts to improve the pathway for mental health patients and has taken the following actions:

- Augmenting the nursing establishment in both emergency departments with registered mental health nurses
- Establishing a dedicated consultant lead for mental health in both emergency departments.

4.4 Pathway from St. Mary's Hospital UCC

Vocare assumed responsibility for the operation of the UCC at St. Mary's Hospital in April 2016. A new service model was put into place at this point and following this the service experienced difficulty with managing waiting times for streaming, delivering a consistent streaming service and maintaining adequate staffing levels, particularly overnight.

The operational issues associated with these difficulties have resulted in longer than usual waits for patients to be streamed to the UCC and to the ED, an increase in patients streamed to the ED that could have received treatment in the UCC and an increase in the number of late referrals (adult type 1) from the UCC to ED.

The commissioner of the UCC service, Central London Clinical Commissioning Group, and Vocare have agreed and implemented a recovery plan to address these issues which has resulted in number of improvements.

5. Refurbishment and expansion of capacity

The increase in levels of activity and acuity has also been particularly challenging to accommodate due to major refurbishment work taking place at both Charing Cross and St Mary's hospitals. These exciting developments will improve patient experience and strengthen the quality of clinical care delivered across the emergency pathway.

5.1 Charing Cross Hospital

Works have been completed as part of a £2.5 million investment in urgent and emergency care services and theatres at Charing Cross Hospital. This involves co-locating the acute assessment unit and the Marjory Warren acute medical unit on the ground floor of Charing Cross Hospital near to the A&E department, and closer to the imaging department on the first floor. The purpose of this is to enable patients to have quicker and easier access to the treatment that they need.

New South Green acute assessment unit (AAU)
The new acute assessment unit (AAU) at provides space for 13 emergency patients. This specialist unit provides a dedicated area for patients who require further assessment or treatment by doctors either before discharge or onward care in the hospital.

Marjory Warren acute medical unit (AMU)
The acute medical unit (AMU) is a 36 bed unit which has been formed on the ground floor from two wards formerly in the hospital's tower block. It cares for patients who need further specialist assessment once they have been stabilised in the ED and those patients who need more intensive monitoring and are not yet stable enough to go to a general medical ward. The unit offers a potential stay of between around 48 hours and five days.

Intensive treatment unit
Four new high dependency beds were opened on the intensive treatment unit (ITU) to care for the most seriously ill patients.

Lady Skinner rehabilitation unit
There has also been related works to transfer the Lady Skinner rehabilitation unit from the ground floor to Ward 5 West.

5.2 St Mary's Hospital

The £3.2 million programme of works to refurbish the ED at St Mary's Hospital, funded by Imperial Charity, started in June 2016 and is due to be completed by June 2017. While the ED has remained open and operational throughout the refurbishment, capacity has been reduced during some phases of the work.

The St Mary's Hospital ED improvements include:

- Remodelling the resuscitation and paediatric areas
- Creating a new clinical decision unit within the paediatric emergency department
- Refurbishing and expanding resuscitation from four to six beds
- Creating a new combined assessment space for ambulance and self-presenting patients.

6. Improving our urgent and emergency care services

The Trust has developed an on-going and extensive programme to improve the whole urgent and emergency care pathway with the aim of reducing waits, improving patient flow, and managing increased demand.

From January 2017 the new role of Patient Flow Co-ordinator was introduced in the ED at St. Mary's Hospital to support delivery of rapid and efficient treatment pathways. This role will be introduced at Charing Cross Hospital in April 2017.

The Trust has also extended the opening hours of the ambulatory emergency care (AEC) service at St Mary's and Charing Cross Hospitals. The AEC service is closely integrated with the medical and surgical take and provides specialist diagnostics and treatment for patients who have urgent needs but are well enough to go home in between procedures or

consultations and, essentially, to be cared for on an urgent outpatient basis. The AEC service has been operating since 2012/13 when it started as a small scale pilot, and has been running successfully on weekdays ever since. It now operates extended opening hours of 08:00 to 22:00, Monday to Friday, and 08:00 to 20:00 at weekends. A permanent staffing model is in place, supported by the A&E and the acute medical and surgical teams on rotation.

In addition, the Trust has created a 12-space surgical assessment unit in the Paterson building at St. Mary's Hospital to enable faster access to a specialist surgical opinion where required. The unit has been operational since January 2017.

To support further improvements in performance over the coming months the Trust has launched a programme of immediate and longer term developments. The programme focuses on the following work streams:

1. Streaming and avoiding unnecessary hospital admissions – this includes increasing the number of AEC attendances as a proportion of all emergency attendances, and the treating of emergency patients through alternative pathways.
2. Improving emergency department operations – this includes the introduction of "point of care testing", which will enable rapid diagnosis, monitoring and treatment of patients.
3. Efficient specialist decisions and pathways – this work stream will focus on streamlining pathways for specialist care.
4. Improving capacity availability through more effective management of inpatient beds – this includes the implementation of a 'real time' bed state dashboard.
5. Improving our ward processes – this workstream will embed the principles of the SAFER flow bundle on each of our wards
6. Improving discharge processes – this workstream aims to reduce delays in planning for discharge, working in partnership with community and social care.

Each work stream is led in partnership by a senior clinician and a senior manager.

To ensure that the actions associated with the programme remain on track the Trust has established a 4 Hour Performance Steering Group. This group, chaired by the Director of the Division of Medicine and Integrated Care and attended by the Chief Executive Officer, meets weekly.

7. Summary

The Trust is currently failing to achieve the national standard to see, treat and discharge 95% of patients that present to an urgent or emergency care setting within 4 hours. The key drivers of this underperformance are rising demand, high levels of inpatient bed occupancy and on-going difficulties with the performance of the Vocare Urgent Care Centre at St Mary's Hospital.

In response to these pressures we have developed an on-going programme of developments to improve the whole urgent and emergency care pathway. The priority of this plan is to reduce waits, improve flow and capacity and manage additional demand. The plan is supported by a trajectory for improvement, agreed with our commissioners and approved by NHS Improvement, that will bring the Trust to the 95% standard by the end of March 2018.

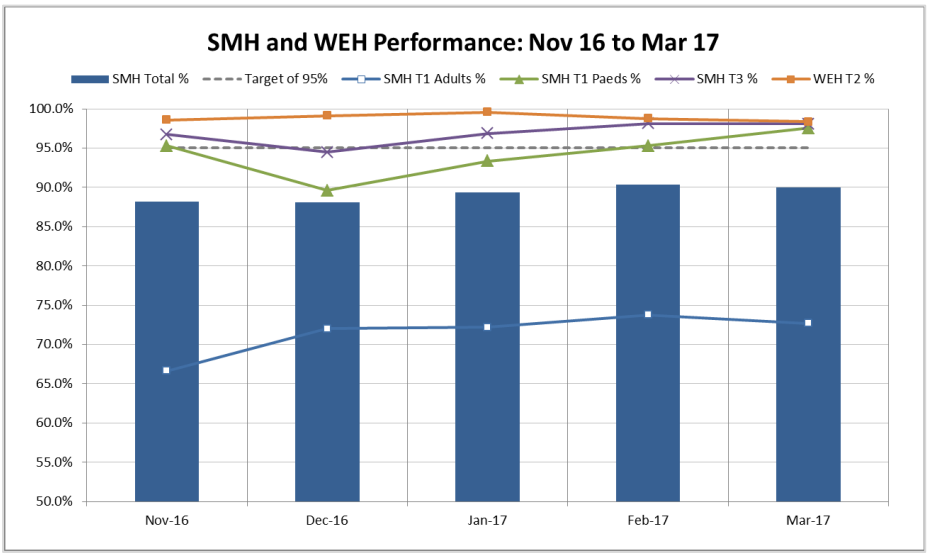

Figure 6 – St Mary's Hospital and Western Eye Hospital A&E performance: All Types, Type 1, Type 2 and Type 3

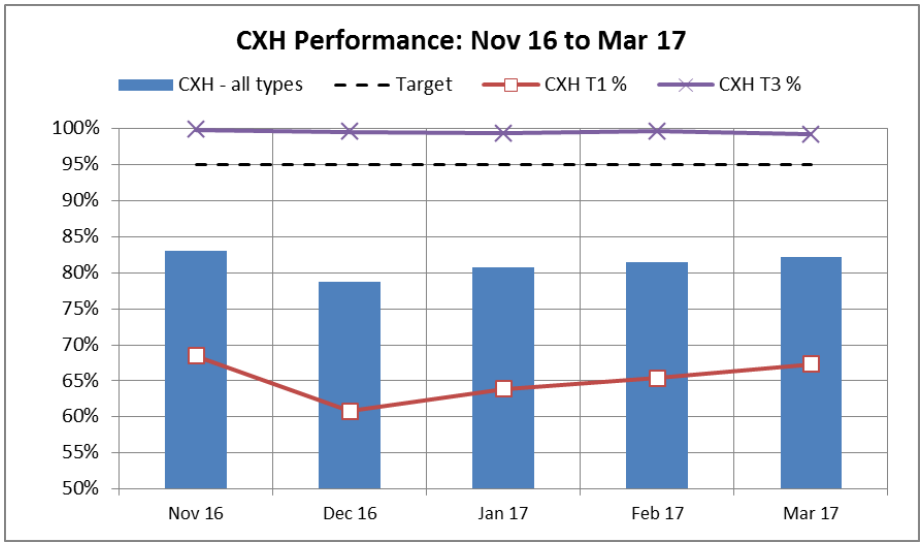

Figure 7 – Charing Cross Hospital A&E performance: All Types, and Types 1 and 3

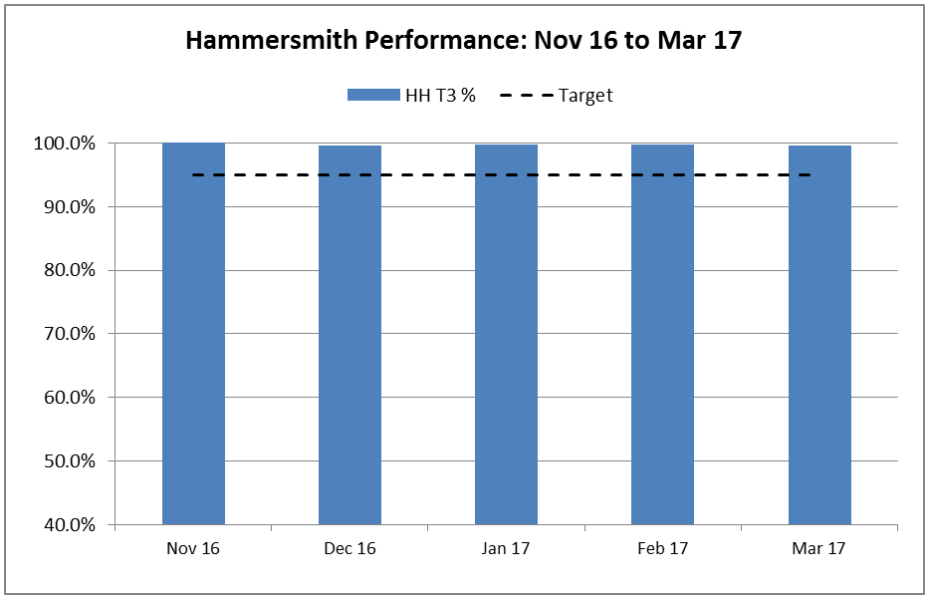

Figure 8 – Hammersmith Hospital UCC performance: Type 3

Reporting period: November to March	ICHT Attends	ICHT Breaches	ICHT %
16/17	119,364	14,604	87.77%
15/16	119,605	15,863	86.74%
% variance	**-0.20%**	**-7.94%**	**1.0%**
# variance	**- 241**	**- 1,259**	

Figure 9 – Imperial College Healthcare NHS Trust A&E activity and performance variance: All Types 2016/17 cf. 2015/16

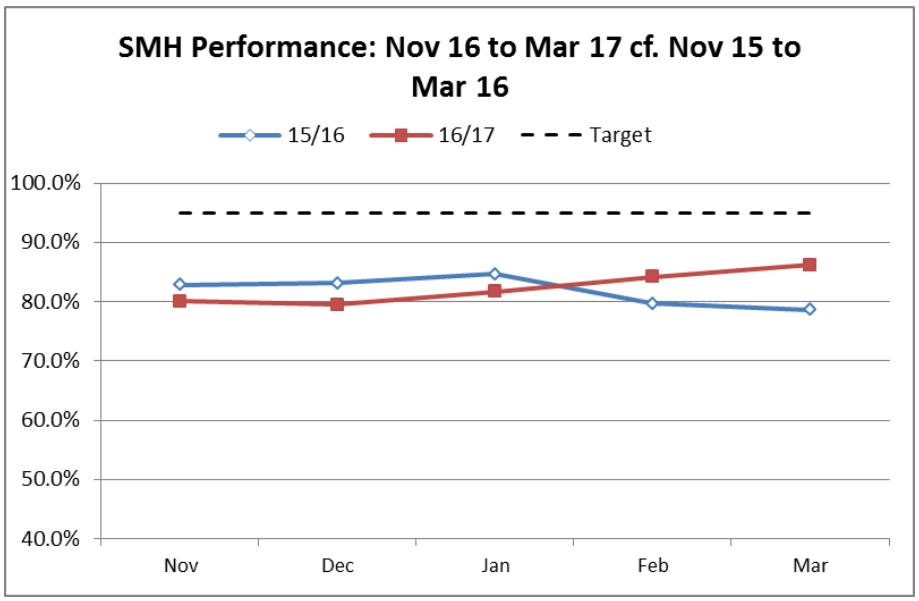

Figure 10 – St Mary's Hospital activity and performance 2016/17 cf. 2015/16: All Types

Reporting period: November to March	SMH T1A Attends	SMH T1A Breaches	SMH T1A %	SMH T1P Attends	SMH T1P Breaches	SMH T1P %	SMH T3 Attends	SMH T3 Breaches	SMH T3 %	SMH all Attends	SMH all Breaches	SMH all %
16/17	20,879	7,843	62.44%	8,404	670	92.03%	22,254	602	97.29%	51,537	9,115	82.31%
15/16	19,804	7,677	61.24%	12,173	995	91.83%	20,637	930	95.49%	52,614	9,602	81.75%
% variance	**5.43%**	**2.16%**	**1.2%**	**-30.96%**	**-32.66%**	**0.2%**	**7.84%**	**-35.27%**	**1.8%**	**-2.05%**	**-5.07%**	**0.6%**
# variance	**1,075**	**166**		**- 3,769**	**-325**		**1,617**	**-328**		**- 1,077**	**-487**	

Figure 11 – St Mary's Hospital A&E activity and performance by type - 2016/17 cf. 2015/16

Reporting period: November to March	WEH T2 Attends	WEH T2 Breaches	WEH T2 %
16/17	18,744	124	99.34%
15/16	17,697	300	98.30%
% variance	**5.92%**	**-58.67%**	**1.0%**
# variance	**1,047**	**- 176**	

Figure 12 – Western Eye Hospital A&E activity and performance variance - 2016/17 cf. 2015/16

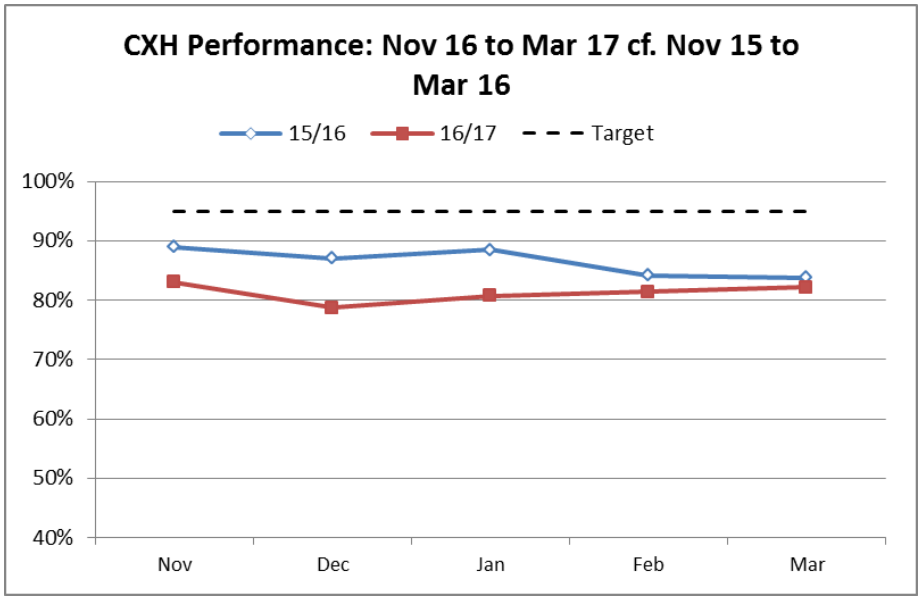

Figure 13 – Charing Cross Hospital A&E activity and performance 2016/17 cf. 2015/16: All Types

Reporting period: November to March	CXH T1 Attends	CXH T1 Breaches	CXH T1 %	CXH T3 Attends	CXH T3 Breaches	CXH T3 %	CXH all Attends	CXH all Breaches	CXH all %
16/17	18,670	6,505	65.16%	16,372	81	99.51%	35,042	6,586	81.21%
15/16	17,075	4,689	72.54%	17,622	6	99.97%	34,697	4,695	86.47%
% variance	**9.34%**	**38.73%**	**-7.4%**	**-7.09%**	**1250.00%**	**-0.5%**	**0.99%**	**40.28%**	**-5.3%**
# variance	**1,595**	**1,816**		**- 1,250**	**75**		**345**	**1891**	

Figure 14 – Charing Cross Hospital A&E activity and performance variance 2016/17 cf. 2015/16

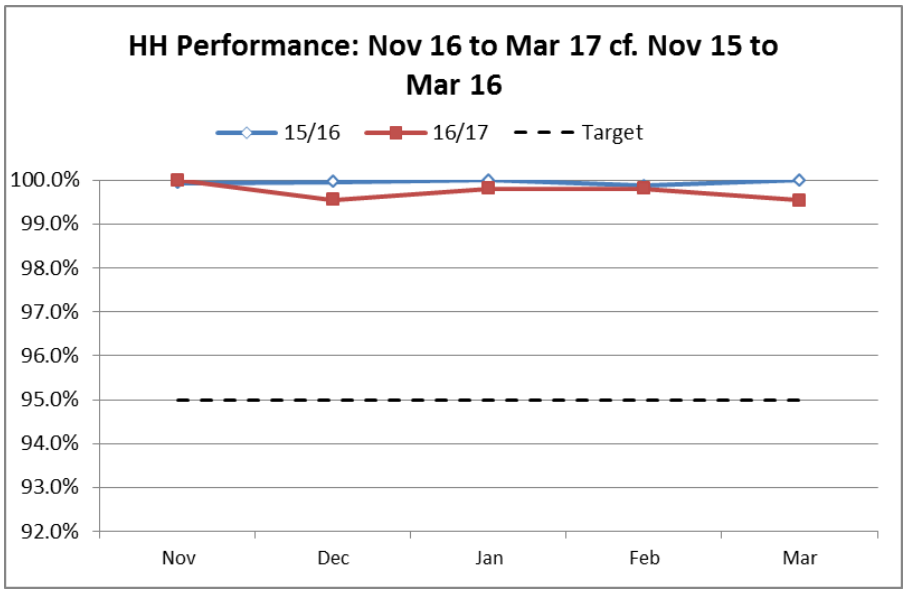

Figure 15 – Hammersmith Hospital UCC performance 2016/17 cf. 2015/16

Reporting period: November to March	HH T3 Attends	HH T3 Breaches	HH T3 %
16/17	14,040	38	99.73%
15/16	14,598	38	99.74%
% variance	**-3.82%**	**0.00%**	**0.0%**
# variance	**- 558**	**-**	

Figure 16 – Hammersmith Hospital UCC activity and performance variance 2016/17 cf. 2015/16

London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY & ACCOUNTABILITY COMMITTEE** **26 APRIL 2017**	
WORK PROGRAMME 2016-17	
Report of the Chair	
Open Report	
Classification: For review and comment **Key Decision:** No	
Wards Affected: All	
Accountable Executive Director: Kim Dero, Director of Delivery and Value	
Report Author: Bathsheba Mall, Committee Coordinator	**Contact Details:** Tel: 020 87535758 E-mail: bathsheba.mall@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1 The Committee is asked to give consideration to its work programme for the municipal year 2016/17.

2. RECOMMENDATIONS

2.1 The Committee is asked to consider the proposed work programme and suggest further items for consideration.

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

None.

LIST OF APPENDICES:

Appendix 1 – Work Programme 2016/17

Appendix 1

Health, Social Care and Social Inclusion Policy and Accountability Committee

Item – Report Title	Report Author / service	Status
26th April 2017		
End of Life Care	PH / CCG / CLCH	Confirmed
NHS Trust winter resilience	Imperial College NHS Trust	Confirmed
13th June 2017		
Immunisations update – 2017*	PH/CCG	TBC
West London Mental Health Trust: Update*	CCG	TBC
Disability Commission*	LBHF	TBC

(*suggested items)

Items for future agenda planning:

- Meal Agenda
- Commissioning Strategy: Providers
- Customer Journey: Update
- Equality and Diversity Programmes and Support for Vulnerable Groups
- H&F CCG Performance
- Immunisation: Report from the HWB Task and Finish Group
- Integration of Healthcare, Social Care and Public Health
- Listening to and Supporting Carers
- Self-directed Support: Progress Update
- Antibiotic prescriptions
- Tuberculosis
- CAMHS update
- Sports and leisure strategy
- Physical exercise strategy