Joint Health Overview & Scrutiny Committee

Minutes

Monday 20 February 2017

PRESENT

Members Present:
Councillors Rory Vaughan
Councillor Mel Collins (LB Hounslow)
Councillor Sheila D'Souza (Westminster City Council)
Councillor Mary Daly (LB Brent)
Councillor Pamela Fisher (LB Hounslow)
Councillor Robert Freeman (RB Kensington & Chelsea)
Councillor Abdullah Gulaid (LB Ealing)
Councillor Anita Kapoor (LB Ealing)
Councillor Vina Mithani (LB Harrow)
Councillor Will Pascall (RB Kensington & Chelsea)
Councillor Ketan Sheth (LB Brent)
Councillor Victoria Silver (LB Harrow)
Councillor Rory Vaughan (LB Hammersmith & Fulham)
Ms Maureen Chatterly (Co-opted Member, LB Richmond)

NHS Representatives Present: Daniel Elkeles (Chief Officer, CWHH CCGs Collaborative and SaHF Senior Responsible Officer), Dr Mark Spencer (Associate Medical Director, NHS England and SaHF Clinical Lead)

1. **WELCOME AND INTRODUCTION**

The Chair invited Councillor Daniel Crawford of London Borough of Ealing to welcome attendees to Ealing Town Hall.

2. **APOLOGIES FOR ABSENCE**

Apologies were received from Councillor Jaeger (LB Richmond).

3. **DECLARATIONS OF INTEREST**

Councillor Sheth stated that he was the lead governor for the Central and North West London NHS Foundation Trust (CNWL).

4. **MINUTES AND MATTERS ARISING**

Consideration was given to the minutes of the previous meeting of the Committee which had taken place on 14 October 2016.

Councillor Arzymanow made reference to the request for consultancy spending on page 2 of the minutes, asking if these figures could be shared with the Committee. The Chair advised that the figures had not yet been received, but would arrange for them to be forwarded to all Committee members when available. Christian Cubitt (*Director of Communications & Engagement, NHS North West London Collaboration of CCGs*) stated that he would look into whether arrangements had been made to forward the information.

Resolved: That
(i) the minutes of the previous meeting of the Committee held on 14 October 2016 be agreed as a true and correct record; and

(ii) information on consultancy spending be forwarded to all Committee Members when available.

5. SHAPING A HEALTHIER FUTURE OUTLINE CASE PART 1

The Chair invited Clare Parker (*Accountable Officer, CWHHE CCGs*), Christian Cubitt (*Director of Communications & Engagement, NHS North West London Collaboration of CCGs*), Susan La Brooy (*Medical Director, NW London Shaping a Healthier Future*) and Neil Ferrelly (*Chief Financial Officer, Brent, Harrow and Hillingdon CCGs*) to update the Committee on the development of the Shaping a Healthier Future (SHaF) Strategic Outline Case (SOC) Part 1 released by the Clinical Commissioning Group (CCG) in December 2016.

Clare Parker provided background context, advising that the SOC was a business case detailing how £513m would be invested in the NW London primary care estate, out of hospital hubs, acute hospitals in outer NW London and the local hospital at Ealing, addressing the existing challenges faced in these locations and enabling the CCG to implement a new model of care to improve outcomes for residents.

Part 1 of the SOC was in place to secure the capital investment needed to deliver the next phase of the CCG's 'Shaping a Healthier Future' (SaHF) plans. At this stage it did not further develop any of the clinical or other service changes already set out in the SaHF. It did not explicitly consider transport, communications or equalities issues as these had been addressed in the Decision Making Business Case published in 2013 and would be addressed again as services were developed and more detailed business cases were produced.

Part 2 of the SOC was being prepared separately because of the opportunity to maximise the redevelopment potential at the St Mary's site as part of the wider Paddington regeneration. Rather than slow down other critical developments the SOC was instead split into two parts to enable both to progress at the fastest possible speed.

Due to the technicalities of the business case required by the Treasury, the SOC Part 1 had been divided into five sections, each of which was detailed separately.

Strategic Case

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

The strategic case stated that funding improvements to the GP practice estate would give the capacity to help patients be seen and treated quicker.
The development of out of hospital hubs would reduce unnecessary hospital appointments and use of hospital services, bringing care closer to home for people with multiple long-term conditions who required highly coordinated services.
It was stated that better outcomes would be achieved for patients through the consolidation of expert care for particular acute conditions onto fewer sites.

It was explained that the capital required would be divided into three pots:

- GP Practices (£69m) – The monies would be utilised to make it easier for patients to physically get in and out of practices, used to fund better waiting rooms and more provision for consulting rooms.

- Out of hospital hubs (£141m) – The monies would go towards building seven new hubs as well as modernising the eleven extant community hubs.

- Acute hospitals (£304m) – The monies would be used for supporting Ealing Hospital's move towards becoming an 'excellent local hospital'. The monies would also pay for the expansion of A&E and further beds at West Middlesex Hospital, expand A&E and the maternity unit at Hillingdon Hospital, provide more primary and community care services at Central Middlesex Hospital and provide more post-operation recovery and critical care beds at Northwick Park Hospital (with monies also going towards the improvement of some existing buildings).

Examples of progress made had also been used to justify the business case, such as the trend-bucking fall in non-elective admissions and the considerable reductions seen in non-elective bed days.

Economic Case

The economic case compared additional costs and benefits of SOC part 1 against a scenario without investment to test whether the proposed capital investment provided value for money.

Based on standard methodology and guidance, it was estimated that 334 lives could be saved per year through the capital investment. There would also be £94m 'Equivalent Annual Cost' (EAC) terms) in health benefits using the Quality Adjusted Life Year Approach used by the NHS to calculate health benefits.
It was also estimated that changes in capital and revenue costs of hub and hospital schemes would equate to £43m, with capital investment calculated to provide further economic benefits of £44m.

The total benefit expected from the investment was calculated at £181m. This would be a positive return of five times the capital invested based on EAC terms, excluding wider economic and health benefits, and sixteen times the capital invested based on EAC including the wider economic benefits and health benefits.

A range of scenarios had been tested through sensitivity analyses and had found that this approach represented best value for money.

Financial Case

The required level of funding was shown through a Comprehensive Spending Review (CSR) period and source, with exploration of affordable alternative funding options and an accelerated timetable.

CCG Finance and Performance Committees had been engaged to review financial modelling, including assumptions underpinning the 'do nothing' scenario and Quality, Innovation, Productivity and Prevention (QIPP) programme assumptions that drive the modelling.

Under the 'do-nothing comparator' all trusts would be in financial deficit, with a combined deficit of £114m by 2024/2025. This would improve to only an £18.4m deficit under the SaHF scenario before reconfiguration (with hub investment). After reconfiguration, trust financial projections demonstrated that trusts would have an income & expenditure surplus position of £27.6m by 2024/2025.

If capital investment were to be funded by loans, two of the trusts would have a below target Financial Sustainability Risk Rating (FSRR) and would be unable to meet the loan repayments.

The overall value of the investment to the NHS, over the period of the investment, was calculated at £828m, with a payback period of eight years for hubs and nine years for acute reconfiguration.

More detailed implementation plans were due to be produced during the next phase of business case development.

Commercial Case

Current provider arrangements would be utilised to identify the procurement implications of the capital proposals, supported by a central programme function to realise the benefits of economies of scale. Where staff would be affected by the changes taking place, retention within the NW London NHS would be sought.

Management Case

The next phase of SaHF would be delivered through a strong and effective Programme Management Office (PMO) with a Programme Executive in place. Strong relationships with stakeholders would be vital, as would wide engagement on proposals with patients and the broader NW London community.

Existing arrangements were being built upon and governance was being updated to ensure that it was fit for purpose in delivering the STP and the next phase of SaHF.

For the next phase of the business case development, clear project plans had been prepared, with established programme assurance and fully identified key risks.

Questions
The Chair thanked Officers for the presentation of the report on the SOC and invited Committee Members to comment and ask further questions.

The Chair opened the questions by making reference to a recent article in The Independent, which claimed that Ealing Hospital had actually been earmarked for full closure. It was asked if more detail could be given on the transition timeline. Officers stated that they “completely refuted” any reports which implied that Ealing Hospital would close. There was categorical insistence that there would be no closure of the site and that there needed to be accurate messages communicated to make sure that this was understood by concerned residents.

The business case had two timelines, and a request had been made to follow the accelerated timeline, part of the reason for this was that with 2022 still being some time away, an accelerated process would be preferable to help in assuaging staff concerns. However, the ability to ensure safe transition capacity would have to be in place before any such work could begin.

The Chair asked if contingency plans were in place should the full £530m requested not be received.

It was advised that no contingency plan was in place as the bid was for the full amount and the full amount only. This was needed to make the changes in full, there were no plans to fund ‘part changes’. The current estate was in the poorest condition of any STP area in the country, so a strong argument was in place to justify receipt of the full funding.

Councillor Arzymanow stated that there was no clarification in the business case on the position of the Samaritan Hospital site. Recent indications had stated that there was a covenant over the site which made it unavailable for sale. Officers advised that they would check with Imperial Trust on the current status. It was understood that current plans included the moving of the Western Eye Hospital to the St Mary’s site.

Councillor Arzymanow noted that organisations with similar covenants in the past had seen them overturned in court. Officers stated that they would expect Imperial Trust to have considered the legalities in detail.

Councillor Mehrban expressed concerns regarding overstretched services. GP practices rarely had appointments available for the same week, surgeries were busy beyond reasonable capacity and hospitals were so overstretched that people were being left on trolleys in hallways due to a lack of bed space, and yet some hospitals appeared to be removing bed space. Was there any confidence that the changes proposed within the STP could really alleviate such problems?

It was fully recognised that demands placed upon services in primary care had risen at a rate at which finances could not keep pace. The new capital would allow for increased capacity where it was needed, including improvement of the weekend offer. Digital solutions were also being taken forward, such as processes to expedite bookings through online solutions. Studies were taking place into ‘what people were attending for’ so that the public could better understand the assistance options open to them. Studies were also taking place into upskilling to free doctors from administration and relatively simple tasks which could be dealt with by others.

Due to GP practices being privately run businesses overseen by NHS England, there were currently no specific requirements in place around mandated opening hours and numbers of appointments taken. NW London CCG's were attempting to gain more control at a local level from NHS England.

With regards to beds, reductions were being seen in acute beds as lots of advances had reduced the need for beds in recent years (such as turnaround times in maternity wards). This opened up possibilities around expanding capacity for critical care. It was known that approximately 30% of people currently staying in hospitals were considered to be 'medically fit' and many of these could have their needs met better in their own home. There was an absolute need to ensure that acute beds were only being used by those truly in need. Officers only sought to remove beds when a permanent alternative solution was available.
Councillor Crawford made further reference to concerns around Ealing Hospital. The difference between a district general and a local hospital were significant and there was a vital need to know what local services would still remain in Ealing.
It was advised that district general hospitals in the traditional sense were evolving, with most hospitals now moving towards a specialist approach offering the highest level in particular areas rather than attempting a service which aims to provide every possible service.

Councillor Williams asked if the provision of community beds in North West London would increase.

It was advised that this was possible, work was taking place on a 'discharge to assess' programme and a lot of work had taken place with Hounslow and Richmond Community Trusts. These would not necessarily stop initial admissions, but could possibly offer quick alternative solutions.

Councillor Arzymanow asked if any hospitals were dealing with pressures better than others, and if so, were lessons being learnt from these?

Officers stated that all hospitals were currently struggling with pressures; however, examples of good performance were always sought and learnt from. As part of the 'discharge to assess' programme, models were being studied where such work had already begun. There was a concentration on looking for best outcomes for patients which would reduce the need for unnecessary bed capacity rather than just providing a blanket increase of beds.

Councillor Coombs made reference to the German health system, where policy had ensured that there were many more doctors, nurses and beds available per 1000 people of the population. He asked what kind of 'plan b' was in place, should it be found in five years that capacity was still an issue approaching unsustainability?

Officers reemphasised that they did not set health policy, and that their role was to find the best way to manage with the pot of money they were provided. This meant having a responsibility to join up services for patients, and working hard on the retention of quality staff.

Councillor Theresa Mullins requested that more information be provided on weekend appointments and the locations these would be available in. Officers advised that this information would be fed back.

The Chair then drew this section of the discussion to a close.

Resolved: That
(i) the presentation on the Shaping a Healthier Future Outline Case Part One be received by the Committee;

(ii) clarification on the current position regarding the Samaritan Hospital site at St Mary's be fed back to the Committee; and

(iii) further information on the locations and timings of weekend appointments be fed back to the Committee.

6. NORTH WEST LONDON SUSTAINABILITY AND TRANSFORMATION PLAN

The Chair invited officers still in attendance from the previous item to make a presentation concerning the North-West London Sustainability and Transformation Plan (STP).
The focus of the first two years of the STP would be to:

- Develop the new proactive model of care across North West London
- Address the immediate demand and financial challenges

It was reemphasised that no changes would be made at Ealing Hospital until there was sufficient alternative capacity elsewhere, and no changes were planned to the Charing Cross A&E service currently being provided during this STP period.
The STP identified a set of nine priorities that would help in achieving its vision and fundamentally transform the system. These were:

To support people who were mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves

- Improve children's mental health and physical health and wellbeing
- Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart disease and respiratory illness
- Reduce social isolation
- Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease
- Ensure people access the right care in the right place at the right time
- Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice
- Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population
- Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed

These priorities would be delivered within five separate delivery areas:

- Improve your health and wellbeing
- Better care for people with long-term conditions
- Better care for older people
- Improving mental health services
- Safe, high quality sustainable services

Since the October 2016 submission of the NW London STP work had focussed around the establishment of Delivery Area boards, enabler groups and project groups that were fully representative and had the skills and expertise required to successfully deliver the STP outcomes. Statutory bodies for discussion of the STP were being supported and STP governance arrangements were being strengthened across the board.

As part of the discussions ahead of the JHOSC meeting, CCG officers had been asked to address a number of questions on implementation timelines, governance, transport strategies and the inclusion of community pharmacies within the reconfiguration strategy. A series of detailed answers to these questions had been included within the Agenda, beginning at p340 (http://bit.ly/2nH6RlQ - Item 6d).

Questions

The Chair then invited Committee Members to comment and ask questions.
In relation to community pharmacies, the Chair asked about suggestions that minor-ailments services were to be withdrawn from 1 April 2017. If this was true, would it bring further pressures to bear upon GP practices?

Officers were not aware of such a plan as NHS England retained control over pharmacies, therefore a response would be provided in writing.

Councillor Sheth asked that if the NW London collaboration of CCG's were not to receive all the monies they requested, would they fund some elements themselves? It was advised that if it was something that could potentially save money, then it would still be considered regardless.

Councillor Sheth asked for more information on potential out of hospital hubs in the Wembley area, and asked if the STP had fully taken account of population increases.

It was advised that an indicative list of hubs was in place, officers would follow up with a list of probable services in the hubs. Detailed work had taken place on population projections, such as developments at Old Oak Common. Significant growth was expected and had been tested back with local planning departments.

Councillor Sheth then asked if any possibilities around devolution were being taken forward. It was advised that lots of conversations were ongoing considering possibilities around devolution of services, with officers being particularly open to conversation where the benefits would improve outcomes for residents.

Councillor Vaughan asked if inflation and other costs had been fully factored into the STP plans. He also expressed concern regarding staff modelling, with the cost of living and the exit for the European Union both potentially having a significant impact.

It was advised that risks around both costs and staffing had been fully taken into account. Inflation had been built into the financial numbers. A 15% contingency and a 25% optimism bias had been built in. There was a need to develop roles to bring strong staff into the service, offering clear and attractive career structures.

The Chair asked how local authorities would be built into the STP governance structure. He also asked how the Better Care Fund would be affected.

It was confirmed that the group overseeing the STP had local government representation on-board. The Better Care Fund was not being replaced by the STP in any way. Local Authorities were not expected to feel 'worse off' under the STP.

The Chair expressed concern that there was a perception that savings were being prioritised ahead of helping people in need. Officers strongly disagreed, stating that there was evidence that shorter bed stays actually aided the speed of health improvement in many cases.

The Chair then made reference to transport issues. A recent conference had taken place at Hammersmith which had brought good people together. Could results from the conference be circulated? And were they being brought into the strategy? Officers confirmed that they would circulated results, and that they had found it helpful and would form part of the work being done.

The Chair then expressed further concerns around the loss of bed capacity. Where were figures coming from to support these changes? It was advised that the plans had been fully tested. Clinical beds would not be reduced but it was expected that more capacity would be seen outside of the 'traditional hospital setting'. It was not expected that care settings overall would be reduced.

The Chair then drew the item to a close, thanking all present for their attendance and contributions to the meeting.

Resolved: That
(i) the presentation on the Strategic Transformation Plan be received by the Committee;

(ii) feedback be provided on the removal of minor ailment services from pharmacies and the potential impact upon general practices;

(iii) a list of services expected to operate from out of hospital hubs be forwarded to the Committee; and

(iv) results arising from the recent transport conference in Hammersmith be forwarded to the Committee

7. ANY OTHER ITEMS THE CHAIR CONSIDERS URGENT

Any Other Items the Chair Considers Urgent

8. ANNUAL GENERAL MEETING

As the meeting was not quorate at this point, the vote for the Chair and Vice-Chair of the Committee would be deferred until the next meeting.

9. DATE OF NEXT MEETING

Panel Members were advised that the date of the next meeting would be confirmed in due course.

Councillor Mel Collins
Chair.

The meeting ended at 4.20pm.