London Borough of Hammersmith & Fulham

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

Agenda

Tuesday 30 January 2018
7.00 pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

Administration:	**Opposition**
Councillor Rory Vaughan (Chair) Councillor David Morton Councillor Mercy Umeh	Councillor Andrew Brown Councillor Joe Carlebach
Co-optees	
Debbie Domb, Disabilities Campaigner Jim Grealy, Save Our Hospitals Bryan Naylor, Age UK	

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Date Issued: 22 January 2018

London Borough of Hammersmith & Fulham

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

Agenda

30 January 2018

Item		**Pages**
1.	**MINUTES OF THE PREVIOUS MEETING**	1 - 11

(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. APPOINTMENT OF CO-OPTEE

A new co-option, to be appointed for the remainder of the municipal year 2017/18.

5. FUNDING OF GP PRACTICES IN HAMMERSMITH & FULHAM 12 - 17

The Committee is asked to consider a letter from Dr David Wingfield, Chairman of the Hammersmith & Fulham General Practice Federation (Appendix 1); and subsequent response from Clare Parker, Chief Officer, Hammersmith and Fulham Clinical Commissioning Group (Appendix 2).

6. A REPORT ON H&F COUNCIL'S EMERGENCY RESPONSE TO MAJOR INCIDENTS IN JUNE AND SEPTEMBER 2017 18 - 67

This report reviews the H&F response to two major incidents in and around Hammersmith & Fulham that required the authority to implement its emergency planning procedures. These were the fire at Grenfell Tower in North Kensington in June and an explosion on a tube train in Parsons Green tube station. The review also considered the views of local businesses and community organisations that participated in a 'hackathon' event convened by the council to examine the views of partners.

7. HEALTHWATCH UPDATE 68 - 128

This update will also include a Briefing On 'The Future of Charing Cross'' Healthwatch CWL Report.

8. 2018 MEDIUM TERM FINANCIAL STRATEGY (MTFS) – ADULT SOCIAL CARE 129 - 147

The Committee is asked to consider a letter from Dr David Wingfield, Chairman of the Hammersmith & Fulham General Practice Federation (Appendix 1); and subsequent response from Clare Parker, Chief Officer, Hammersmith and Fulham Clinical Commissioning Group (Appendix 2).

9. 2018 MEDIUM TERM FINANCIAL STRATEGY (MTFS) – PUBLIC HEALTH 148 - 160

This report sets out the budget proposals for the services covered by this Policy and Accountability Committee (PAC). An update is also provided on any changes in fees and charges.

10. WORK PROGRAMME

161 - 162

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

11. DATES OF FUTURE MEETINGS

Tuesday, 13th March 2018
Tuesday, 24th March 2018

London Borough of Hammersmith & Fulham

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

Minutes

Tuesday 12 December 2017

PRESENT

Committee members: Councillors Rory Vaughan (Chair), Andrew Brown, Joe Carlebach, David Morton and Mercy Umeh

Co-opted members: Jim Grealy (Save Our Hospitals), Patrick McVeigh (Action on Disability) and Bryan Naylor (Age UK)

Other Councillors: Ben Coleman and Sue Fennimore

Officers: Vanessa Andreae, Vice Chair, H&F CCG; Fawad Bhatti, Policy and Strategy Officer; Julia Copeland, Strategic Commissioner, ASC; Janet Cree, Managing Director, H&F CCG; Lisa Redfern, Director of Adult Social Care, Prof. Julien Redhead, Interim Chief Executive, Imperial College NHS Trust

160. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 13th November 2017, were agreed as an accurate record.

161. APOLOGIES FOR ABSENCE

Apologies for absence were received from Debbie Domb and Cllr Sharon Holder.

162. DECLARATION OF INTEREST

None.

163. REPORT OF THE HAMMERSMITH & FULHAM ROUGH SLEEPING COMMISSION

RESOLVED

That the order of business be varied, to take Agenda Item 7 as the first substantive Item.

Fawad Bhatti presented the report, together with Councillor Sue Fennimore, which set out the work of the Rough Sleepers Commission, commissioned and sponsored by the Council, in January 2017. Its remit was determined by what needed to happen to reduce rough sleeping in LBHF, with the key element being Prevention. This was an expert led commission and Chaired by Jon Sparkes, Chief Executive of Crises (who unfortunately had been unable to attend due to work commitments).

The Commission conducted wide ranging review, supported by the policy team at Crisis, gathering both written and verbal evidence from service providers, stakeholders. Peer led research was commissioned, with researchers speaking to 108 rough sleepers. Of those interviewed, 62% were currently rough sleeping, 23% were living on the streets in the Borough; and the remainder had slept rough in the past year. Local outreach organisations gathered the views of volunteers who worked with rough sleepers daily. The period of April 2016 to March 2017 had seen 246 rough sleepers. 61% were new to the streets, 28% were previously seen last year, during 2015/16. 11% were recognised as returnees, and known to the outreach teams.

Groundswell reported rough sleepers would not be on the streets, had they access to affordable housing or received help with work and to move on. For many, homelessness was extensive. Council and third sector staff were viewed as helpful but lacked the specialised expertise required to support rough sleepers with alcohol / drugs advice. 50% experienced difficulties with benefits and national numbers had increased over the past year. A peer led methodology for research was selected, i.e., those who conducted interviews had themselves experienced homelessness. 46% of those interviewed self-identified as having mental health problems, with 23% experiencing domestic violence, 17% having been in local authority care, 14% formerly in the armed forces and 12% with learning disabilities.

Key findings of the report were that rough sleeping could be significantly reduced in the borough, particularly in terms of outcomes. Welfare reform was making it hard to resolve the issue but with empowered outreach staff, specialist support could be more readily available. There were 30 recommendations aimed at the Council and the CCG, local and central government, detailed in the report and grouped into four sections:

1. Council implements stronger prevention framework across a range of partners and stakeholders.
2. Emergency response
3. Housing First and housing led approaches
4. Ensuring access and adequate supply of secure and affordable housing for rough sleepers or people at immediate risk of rough sleeping

In addition to greater collaborative working between the Council and health partners, a long-term approach was needed to ensure secure, affordable and sustainable accommodation. In Manchester for example, they were exploring options for housing first provision in new developments. There were 20 recommendations for the Council, which could not work in isolation.

Cllr Fennimore observed that it was appropriate this issue was being discussed on such a cold night, when there were significant numbers of rough sleepers on the streets of the Borough. The Commission had approached Jon Sparkes as a leading expert in this area, whom she thanked for chairing the Commission and to stakeholders and commissioners. The voice of rough sleepers, who were vulnerable and living in an appalling sense of isolation, was reflected in the report thanks to the peer led research, helping to produce a comprehensive and structured report.

Patrick McVeigh commended the report and enquired about what the public support and how the Housing First approach worked in in practice and implementation. Following the recommendations, they were now looking at costings and how to implement them. A fundamental part of the report was to help members of the public not just to walk past rough sleepers without acknowledgement. To illustrate, they could volunteer at Glass Door, who were overwhelmed with what needs to be done. There was a collective responsibility to offer support.

Julia Copeland explained that Housing First aimed to address a person's complex issues or traumas that culminated in causing homelessness. By putting you in home first, then help support your needs. Research commissioned by the Joseph Rowntree had indicated very positive outcomes.

Jim Grealy commented that the report was both thorough and remarkably bleak, observing that many more rough sleepers had been seen in the last few years than previously. He suggested that an outreach team be based at the CCG to ensure that rough sleepers have access to medical services. It was recognised that there were large numbers not on the GP practice lists; that there was a need for greater collaboration with between health partners and the Council; to avoid rough sleepers having to access A&E and to look at discharge issues; and work with WLMH NHS Trust to address mental health issues experienced by rough sleepers. Councillor Fennimore concurred, the national picture was that rough sleeping was increasing both within the Borough and across London. Addressing mental health concerns was a key element and required joined up work with A&E and the CCGs.

In response to questions from Bryan Naylor, Councillor Fennimore explained that while she did not have exact numbers, there was anecdotal evidence to indicate that rough sleepers came from various backgrounds and were not a homogenous group. Rough sleeping was transient and could not be viewed on a ward by ward basis but as people moving across the Borough. Groundswell indicated that there were North and South differences with more rough sleepers to be found centrally and south of the borough with cross over into RBKC and the St Charles Square boundary. Looking at the statistics, there was a rising number of pregnant woman rough sleeping.

Councillor Joe Carlebach commented that this was a troubling report and asked if the Commission had considered the Council's own processes, particularly evictions (not caused by anti-social behaviour). It was explained that care leavers, given the corporate parenting approach, meant that support would continue. Councillor Carlebach was concerned about older care leavers, recounting the experience of man in his 40's. Councillor Fennimore stated that we were all corporate parents and that a fundamental shift and sea change in our responsibility was required. When appropriate, councils should be helping young people.

Councillor Fennimore continued that the Administration was increasing the amount of accommodation available to young people, but this took time. It was understood that with regards to the eviction policy, this was actively and regularly reviewed. Measures such as ethical debt collection were also being implemented, to help genuinely vulnerable groups avoid eviction. S.8 eviction notices were used by many providers, which this Council did not. There were also early interventions, to prevent evictions happening. The introduction of Universal Credit policy may have led to 100% increase in the numbers of people using local food banks. Groundswell had undertaken great work being within Central London. 20% of the people approached had a history of leaving care, which sufficiently raised the risk of being a rough sleeper. Having a longer of duty of care may be a solution.

Councillor Ben Coleman commented that there were lots of positive things that the Council could do, referencing page 29 of the report. Councillor Coleman invited Groundswell to explain the positive impact the Housing First approach on the health costs. Homelessness had a significant impact on a person's health through chronic long-term health conditions. Groundswell worked in hostels to raise issues, acknowledging the difficulties in getting rough sleepers to engage with the need to address health issues or alcohol and drug problems, and accessing health care programmes. There was an advocacy programme in the borough, with collaboration between health partners and LBHF. Providing details of a recent case study, they had helped a woman at risk of rough sleeping, accompanying her to medical appointments and ensuring that she was supported throughout. By not addressing this, it became a potential, hidden cost to the NHS.

Julia Copeland explained that the Council was working hard to demonstrate those benefits, and quantify the cost of not intervening. They were working with the CCG, who understood the benefits of intervention better and the CCG had funded a nurse to go into the hostels. With reference to housing first, Janet Cree indicated that the CCG was willing to engage in dialogue, as set out in the recommendations, and would continue to work collaboratively on other initiatives.

Councillor Brown commented this complex issue required a multi-faceted approach from all parts of the government, partner agencies, stakeholders, and faith organisations. Recounting his own experience, Councillor Brown observed that there had been an increasing prevalence of rough sleepers in recent years and asked what was being done within the to test and treat

serious communicable diseases such as Tuberculosis (TB). Groundswell confirmed that this was a chronic issue, with 85% of rough sleepers being smokers compounded the issue. There were pan-London organisations that went out and identified people to treat for TB. They raised awareness of TB and ensured interventions were in place to combat it. It was recognised that TB significantly shortened life and rough sleepers with TB were offered accommodation and monitored to ensure that they are taking their medication.

Councillor Vaughan closed the discussion by summarising the key points of the discussion:

- The Committee commended the report; and endorsed its findings and recommendations;
- This was an ambitious, evidence led report with impressive, localised research, providing a voice to rough sleepers which added great weight to this report;
- The Committee expressed interest in the sequence of implementation, hoping that quick wins could be identified and actioned;
- There was a need for a collaborative, cross-cutting approach including health, housing, and the CCGs, and the Committee a commitment to achieve the ambition of zero rough sleepers;
- The Committee concurred that collaboration will see the benefit of cost savings to public purse; and
- This work was difficult and the committee wished those implementing it well and thanked those that had worked on it.

164. IMPERIAL COLLEGE HEALTHCARE NHS TRUST: INTERIM CHIEF EXECUTIVE ARRANGEMENTS AND CHARING CROSS HOSPITAL

Councillor Vaughan welcomed Prof. Julian Redhead, Interim CEO, who had replaced Ian Dalton, who had left to take a new post within the NHS. Prof Redhead explained in more detail the interim arrangements currently in place until a new CEO was appointed, and how this would impact on Trust. The Trust had a strong succession plan that would not change its direction of travel, so it would be 'business as usual'. Prof. Redhead had previously worked on the board. He expected to be in post 6 months, and would continue his role as a practicing clinician.

Bryan Naylor had received information suggesting that recruitment of the departing CEO had been costly and sought further clarification as to possibility that this expense was recoverable. Prof. Redhead responded that he was unaware of this and that they had followed accepted practice in using a recruitment agency.

Jim Grealy expressed surprise at the short tenure of the previous incumbent, who had offered an ambitious progress. Enquiring about the status of Charing Cross, he asked if it would remain open as an acute hospital. If the site was under pressure, he asked why not it could not be designated as an invaluable and sustainable resource in this part of London, to be retained.

Prof. Redhead responded that he would like to continue previous engagement, he explained that he had met with staff, and separately with stakeholders. The STP plan covered five years and that nothing would be done to put patient safety at risk.

Supporting Jim Grealy's remarks regarding the future of Charing Cross, Councillor Brown indicated that it had been made clear at public meetings that there had to be no change to the emergency provision at the site. Prof. Redhead reiterated the comments of Dr William Oldfield and Prof. Tim Orchard, with no changes intended until 2021. Councillor Brown stated there should be no doubt whatsoever over the future of Charing Cross because of the sheer pressure on it, and, the significantly increasing population in the Borough and West London.

Councillor Brown commented that he saw Charing Cross as a local community facility, anticipating investment; that the Council could support though either fundraising or help with the discharge of patients, from social care perspectives; help with workforce retention and nurture a more constructive relationship in future, moving forward. Cllr Carlebach commended staff at the Trust for their work throughout both the Westminster and Grenfell events.

The Borough was progressing, with radical changes, regeneration, investment, and housing development in Old Oak. Charing Cross was well placed to serve this increase. Prof. Redhead concurred that the message was to work together to improve care for patients.

Merril Hammer, Save Our Hospitals (SOH), asked what the criteria and evidence was for downgrading Charing Cross, for it to cease being viable; and commented that it would help the community to have a clearer understanding of the opposing arguments. Prof. Redhead confirmed that he would be delighted to continue to meet with SOH but responded that the issue of criteria would be difficult to answer.

Councillor Coleman asked if the increasing number of people and the increasing needs of an ageing population could be accommodated in the next seven years. Prof Redhead responded that these were questions facing all health economies and that there were new developments in treatments and technologies in treating patients, to assimilate what was happening in the future. In response to a follow up question regarding the likelihood of any reduction in A & E admissions, Prof. Redhead felt there was no clear answer but it was unlikely to reduce in the foreseeable future.

Councillor Coleman asked whether the Trust could make a decision about the number of bed reductions after 2021, in the context of the STP and whether this decision could be taken in partnership with the CCG. Prof. Redhead confirmed that Shaping a Healthier Future remained in partnership with the CCG.

In response to a question from a member of the public regarding oral maxillofacial services and possible backlogs, Councillor Brown requested that the Committee received a report on paediatric dental surgery and adult dental service.

Councillor Vaughan expressed interest in the investment in Charing Cross and enquired about the possibility of examining investment plans. Prof. Redhead explained that investment in Charing Cross to improve A&E, theatre suites and general infrastructure would continue.

Referring to the STP and the Ealing, SOC 1 (Strategic Outline Case), and SOC 2, which addressed changes to Charing Cross, Councillor Vaughan asked if the Trust was involved in those discussions, particularly given that SOC 1 now required revision. Prof. Redhead confirmed that SOC 1 did not affect the Trust. Imperial will be involved in SOC 2 but the timeframe for this had not been confirmed. It was also confirmed that the CCG was currently undertaking modelling work to assess the impact of the closure of Ealing and that discussions about this had taken place at the JHOSC meetings.

In response to a query from Councillor Coleman, Prof. Redhead confirmed that work had stopped on the business plan (SOC 2), regarding Charing Cross to allow for a national level assurance process. He explained that SOC 2 supported the business case, and that the Trust remained committed to supporting services such as out of hospital care. The Trust would focus on the work around the changes that they would like to implement to ensure high quality health care. Prof. Redhead confirmed that modelling work had previously been undertaken and would be refreshed, taking into consideration the impact of changes around the Borough.

Concurring with Councillor Vaughan's view, Janet Cree confirmed that SOC 2 would not be available until 2018, and she agreed to inform the Committee of the timeframe as it emerged.

Councillor Vaughan expressed disappointment regarding the short tenure of previous CEO. The Committee was aware of ongoing issues around Charing Cross and looked forward to further conversations about the future of this hospital. On behalf of the members of the Committee, Councillor Vaughan thanked Prof. Redhead and his dedicated team for all their support and work in responding to Grenfell.

RESOLVED

That the report be noted.

165. DEVELOPING FURTHER COLLABORATIVE WORKING ACROSS NW LONDON CCGS

Councillor Vaughan welcomed Vanessa Andreae and Janet Cree to the meeting. The paper provided an overview of collaboration and governance arrangements, about democratic accountability and how commissioning arrangements will operate across the eight North West London CCGs.

Janet Cree outlined on the collaborative working. The paper produced for the Committee was based on a paper submitted to the September meeting of the CCG Governing Body. The intention was to work better with the other CCGs, to ensure the best healthcare for residents in Hammersmith & Fulham, and remain accountable to the local community. It was important to note that the Borough boundaries and CCG boundary did not align and that approximately 50,000 H&F residents were registered outside the borough.

The CCG explained that easier and quicker decision making would benefit residents and help improve patient flows and commissioning. Working on out of hospital services, with GP practices and collaborative with other CCGs would facilitate this. Decisions being determined by clinicians in the borough across 8 CCGs was difficult so the aim was to create greater efficiencies and avoid duplication. This was an in initial paper to formulate what shape and form the joint committee would take and how decisions would be made. This would be further developed, to be considered at a governing body meeting in January 2018. The joint committee will meet in public, rotate in terms of its location in different boroughs; and may also be streamed.

Councillor Brown sought assurance that different channels of communications and use of technology were seamless across different NHS bodies. Vanessa Andreae confirmed that they were some way from this. Consent was needed to allow a patient records to be uploaded but this was increasing. Care plans were prepared but not always communicated or accessible, either as paper copies or digitally. All practices used SystemOne so that all patients, under community cardiology and respiratory care, had benefitted from improved patient record access during treatment.

Councillor Carlebach commented that the collaborative working arrangement was excellent and encouraging. He referred to a paper by Dr Ingrid Wolf highlighting significant gaps in the paediatric training of GPs. In response, Janet Cree reiterated that the paper's focus was the organisation of CCGs so that level of detail was not provided. One of the aims was to reduce unwarranted variation, and differential offers and provision across North West London. One of the key drivers was to have common standards and outcomes that could be expected for patients, for example, locally working to ensure training for specialist paediatric GPs, with cascaded training.

Co-optee Patrick McVeigh concurred that the combined CCGs would be better placed to collectively commission more efficiently but sought clarification regarding Accountable Care Partnerships (ACPs) and Accountable Care Organisations (ACOs), in relation to the Health and Social Care Act 2012 funding restrictions. Janet Cree clarified that ACOs were different organisations which merged to form one entity. In Hammersmith & Fulham, there was an Accountable Care Partnership, where partners worked together collaboratively.

Councillor Vaughan referred to joint commissioning arrangements and one data set and enquired how this would take place across 8 CCGs. Vanessa Andreae explained that existing data sets would form the basis of information used in different clinical systems. That information was already available, gathered from different systems and collated. Sector wide implementation would allow shared sets of information so that clinical activity can be identified. This was being considered at STP level through a collaborative working arrangement with providers. They needed to work together on the same set of data, to allow the CCG to make effective joint commissions. This was an on-going area of work.

Jim Grealy commended Clare Parker on pulling together 8 CCGs but commented that the new system was two-tier and engendered a crucial loss of accountability. In terms of representation, no councillors were involved, few clinicians, or Healthwatch. Highlighting concerns about the resolution of potential conflict between a patient and their GP, it was also pointed out that there was no assurance that agendas will be published in advance, public involvement or that councillors will be involved. Suggesting that the CCG should reconsider, he continued that only involving people post decision making was a concern. In response, Vanessa Andreae confirmed that councillors had never have been part of CCG and that while Healthwatch had been, they had no vote. It was reiterated that the September paper had not yet been finalised and that the proposed joint committee, will be a sub-committee.

Olivia Clymer (Healthwatch CEO) confirmed that they had submitted questions to CCGs. It was clarified that the 2012 Act required the CCG to submit commissioning intentions and while she acknowledged potential the efficiencies, Healthwatch would have one seat across 8 CCGs. There were also concerns that related to scrutiny and accountability; and timeframes for engagement. Vanessa Andreae explained that the currently, the Accountable Officer was required to go to five different meetings. The proposals were yet to be further developed and refined. There would be no change in the relationship between LBHF and the CCG, there will be some decisions will be delegated to the sub-committee but the H&F CCG governing body will remain the same statutory decision-making body.

Councillor Vaughan enquired that when a decision was being taken, who was subject to scrutiny. Clare Parker was the Accountable Officer for 5 CCGs, so that the relationship will remain the same but the collaboration will be extended to include 3 more CCGs. In response to a query from Councillor Coleman, Vanessa Andreae explained that they preferred a consensual approach to decision making.

Councillor Coleman referred to section 1.3a and commented that decisions for acute services meant decisions for acute providers should only be made once. Using Imperial as an example, Vanessa Andreae clarified that the CCG was much stronger working with the other CCGs, to get a larger portion of the Imperial budget. Greater leverage was possible working collaboratively but it was not possible to comment on decision making mechanisms in relation to the other CCGs at this stage.

In response to a question from Merril Hammer (SOH) regarding whether there would be further opportunities for the proposals to be scrutinised, Vanessa Andreae responded that there was no change to the CCG's accountability. It was pointed out that there was no mechanism to feed into the governing body process and that the accountability required greater clarity. Merril Hammer commented that ACOs created structures for long term contracts and who may sub-contract services, imposed without any legislative framework.

Noting a question from a member of the public regarding the specialist commissioning of services for high functioning adults with autism and the need for clear patient pathways agreed to provide a detailed response outside of the meeting.

Councillor Vaughan thanked the presenters, observing that the 8 CCGs, needed to clearly formulate the governance arrangements so that it was possible to understand who will be subject to scrutiny.

RESOLVED

That the report be noted.

165. UPDATE ON COMMUNITY PODIATRY SERVICES

Vanessa Andreae briefly explained that several people had said the service was well structured but acknowledged that there had been dissatisfaction about how the service was running, and issues around eligibility. It was noted that the service had not provided quality or value for money. There had been complaints about patients not being seen in a timely fashion and that people with low risk were no longer eligible for the service.

A member of the public commented that they had not been given information, and struggled to get appointments, without an evaluation as to their risk level and eligibility. The service had been changed to free up appointments but this had created a two-tier system.

It was explained that the review had been undertaken in October and that there was still a cohort of patients to work through. The CCG expressed disappointment at the decommissioning and were awaiting reports from CLCH. The CCG confirmed that they further review the podiatry service to see how the changes had progressed and concurred that it was not helpful to be told that the service would improve and it hadn't. Councillor David Morton commented that the central line booking system was problematic and that it was better to telephone St Charles direct.

Bryan Naylor commented that older people had been very disappointed with the podiatry service for a long time. The service was not working well and required further review. Vanessa Andreae apologised for the negative experiences resulting from poor service and agreed that there would be further feedback provided to the Committee.

In response to comments from Councillor Coleman regarding the quality and cost of podiatry services and feedback from residents at local engagement events, Vanessa Andreae explained that the CCG had signposted paid for services, pointing out that they could not specifically recommend these. It was acknowledged that the cost was relative to each individual and was an equalities issue, given the variation in fees.

Councillor Vaughan, in concluding the discussion, commented that there needed to be further engagement on podiatry services and welcomed the CCG's agreement to return to the Committee with more detailed information, following further discussions with the provider, CLCH.

RESOLVED

That the report be noted.

167. WORK PROGRAMME

RESOLVED

That the Work Programme be noted.

168. DATES OF FUTURE MEETINGS

The next meeting of the Committee would take place on Tuesday, 30th January 2018.

Meeting started: 7.00 pm
Meeting ended: 10.15 pm

Chair .....

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London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY & ACCOUNTABILITY COMMITTEE** **30 January 2018**	
Funding of GP Practices in Hammersmith & Fulham	
Report of the Chair – Councillor Rory Vaughan	
Open Report	
Classification: For review and comment **Key Decision:** No	
Wards Affected: All	
Accountable Director: Sarah Thomas, Interim Director for 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 consider a letter from Dr David Wingfield, Chairman of the Hammersmith & Fulham General Practice Federation (Appendix 1); and subsequent response from Clare Parker, Chief Officer, Hammersmith and Fulham Clinical Commissioning Group (Appendix 2).

2. RECOMMENDATIONS

The Committee is asked to consider the implications of the GP Federation's letter and the CCG's response for the healthcare provided to residents of Hammersmith and Fulham.

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

None.

LIST OF APPENDICES:

Appendix 1 – Letter dated 8th January, Dr David Wingfield, Chairman, H&F GP Federation
Appendix 2 – Letter dated 17th January, Clare Parker, Chief Officer, H&F CCG

8th January 2018

Clare Parker
Accountable Officer
Hammersmith and Fulham CCG

Dear Clare

Core funding of General Practice 2017/18.

It is with regret that I write on behalf of the GP federation to point out that the CCG plan for investing the available funding into General Practice has no credible chance of achieving its goals by 31.3.18

Hammersmith and Fulham residents have been chronically underfunded over many years on a per capita basis (£114 per patient) compared with those in neighbouring Boroughs such as Kensington and Chelsea (£135 per patient) and the England average (£130 per patient) and the uplift in funding over the next four years is meant to rectify this invidious position, which has deprived patients of their rights to equal funding and services.

The additional investable funding is £1.3m for 2017/18 and is referred to commonly as the 'Headroom Fund'. It must be spent by 31.3.17 or lost.

To date we understand that only £40k of the £1.3m has been allocated for spend.

No investment plans at all emerged from the CCG until November 2017 when a system requiring detailed and costed Project initiation documents (PIDs) to be produced across groups of GP practices prior to scrutiny at two layers of governance at the CCG.

In a remarkable period of 4-6 weeks leading up to Christmas GP Practices with support from the GP Federation have produced a large number of proposals to improve patient care. These include:

- Home care for frail elderly people
- Management programme for patients with complex medical conditions such as chronic kidney disease and heart failure
- Care navigators to direct patients rapidly to the part of primary care best suited to meet their needs
- New systems to improve the accuracy of disease coding in GP databases leading to better identification of patient needs
- New systems to improve the communications between GP and Hospitals to ensure best practice prescribing and specialist advice when needed.

- Integrated care for nursing home patients to bring together the best of nursing home carers and nurses, GP practices and care of the elderly consultants in the community.

The GP Federation of which I have been chairman for three years has worked consistently with the CCG before during and after the vote for primary care budget delegation from the NHSE to the CCG (which came into effect from 31.3.17) on how to invest this additional funding. We have jointly produced the Primary Care Strategy (enc) and have established a newly energised system of GP Networks bringing the prospect of significant benefits to patients in the North, Central and South of the Borough through integrated multidisciplinary working and Primary care at scale. These are key policies for the CCG, under the GP Forward View Programme and we have been wholly supportive throughout.

However, it has become clear over the many discussions and meetings that the CCG, GP Practices and Federation have had that the CCG plans to spend the Headroom Fund are destined to lead to a significant underspend. For example, partitioning money across 2017/18 vs 2018/19 financial years (and therefore under-spending in the current year) and partial allocation for projects pending review against undefined outcomes have been two recent moves. Some have suggested to us that the CCG's overspend against Hospital budgets are leading it to restrict allocation of the Primary Care Budget. Perhaps you could clarify this point.

The North West London Strategy and Transformation Plan (STP) requires significant and increasing investment in Primary Care and I have previously spoken publicly on the necessity to deliver on this. In Hammersmith and Fulham money is actually available in the Primary Care Budget but allocation is failing. Furthermore as the NHS falls back on emergency plans this winter Primary Care is not receiving the investment required to participate in the solution. These policy stances are inconsistent.

We at the GP Federation and General Practitioners as a body stand ready as we have over the past three years to work alongside the CCG in meeting this challenge but we have now reached the point where the CCG's handling of NHS funds is restricting patient care and **we are appealing for a major and rapid reversal of this policy**. In contrast to our local experience it is our understanding that in Ealing the full budget was allocated by the end of 2017 as is consistent with the duty of the commissioners of Primary Care services for patients.

Yours sincerely

Dr David Wingfield DM FRCGP
Chairman
Hammersmith and Fulham GP Federation
07711 141638

Healthy Future

NHS
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Clinical Commissioning Group

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By Email

Private and confidential

Dr David Wingfield
Chair
H&F GP Federation
Brook Green Medical Centre
Bute Gardens
London W6 7EG

17th January 2018

Dear David,

Re: Core funding of General Practice 2017/18

Thank you for your letter dated 8th January which I was disappointed to receive given the close working between the Federation and the CCG on this programme. At the meeting which you attended earlier on the 8th there was a detailed discussion and our approach to the proposed investments was restated. As you are aware, there are processes in place to allocate over £1 million of the estimated monies available this year.

I am also conscious that the letter has been shared widely so in responding I have sought to establish the broader context and facts relating to this matter before addressing the specific issues raised.

I wanted to reiterate our support for the partnership work done to date with the GP Federation and the absolute priority of investing in Primary Care as a means to improve the care delivered to our residents and registered patients in the borough. It is therefore disappointing to have received your letter suggesting that the process put in place by the CCG is somehow frustrating the realisation of this shared ambition.

We have welcomed the joint discussions with you and GP Federation colleagues in producing the business case agreed in October. This is the first year where the CCG has had full delegated responsibility for Primary Care commissioning and we have worked closely with our members and the GP Federation to ensure transparency as to the challenges associated with the transfer of these budgets and managing the financial risk associated with them (e.g. clarification of rent and rate commitments, list size growth). This has been a recurrent subject at our regular meetings and those of CCG and Federation colleagues. As you will be aware, the CCG is in a challenging financial position and we agreed that investment made in 2017/18 would need to result in tangible benefits for our patients and a return on investment to the local system and the CCG. This is consistent with decisions taken relating to all of our commissioned services.

After having reviewed progress on the Primary Care investment programme with the team, the following bullet points provide a summary of progress made to date:

- A business case was agreed by the CCG Finance & Performance Committee in October 2017, setting out a £1.3m investment in Primary Care between October 2017 and March 2018.

- In order to expedite this investment and provide opportunity for innovation at a practice and primary care networks level, a prospectus was issued on 5th November 2017 seeking bids against the £1.3m.

- As your email suggests, we had a fantastic response from our practices who (supported in part by the GP Federation and CCG teams) generated ten proposals across all three domains described in the prospectus by 7th December.

- Nine of the ten proposals received were approved by the Primary Care Commissioning Committee on the 12th December (which has overarching responsibility for investment in Primary Care and meets in public). However, the Committee sought clarifications on a range of issues relating to each of the proposals, the majority of which were minor queries requiring one or two-line responses.

- The agreement of transfer of funds has been contingent on receiving these final clarifications, which the CCG team have been actively pursuing and significant progress has been made and practices have received confirmation to this effect.

- As your email suggests, some of the activity relating to the proposals related to the next financial year (2018/19). As with any public sector organisation, we are legally bound to comply with accounting practice which means expenditure in the financial year has to come from that year's financial allocation. Therefore we are seeking approval for expenditure totalling £588,201 from next year's allocation at the Primary Care Commissioning Committee on the 16th January to enable these specific projects to continue into next year.

- As it stands, the status of all the various proposals is as follows:

    - Approved for transfer of funds and awaiting invoices for payment - £416,536
    - Awaiting clarification from practices - £153,210
    - Pending approval at Primary Care Commissioning Committee on 16th Jan - £206,582
    - Due for consideration at next PCDG on 22nd Jan - £250,381
    - **TOTAL (17/18 allocation) - £1,026,709**

As you can see from the above, although this is a complex programme, the progress made within a very short time period has been significant and does not reflect the position outlined in your letter of the 8th January. This is thanks to the hard work of the practices during what continues to be a very busy period in primary care, as well as the collective endeavours of our respective teams. Clearly there is work still to do, and the intention of all parties will be to ensure that we are making effective use of all available investment monies in year. At the meeting on 8th January, it was agreed that we would meet you and Federation colleagues at the end of January to review any underspend and agree how best to work with primary care networks to bring forward additional projects. However,

we will continue to do so acting within due process, ensuring we achieve our shared ambition of improving services and outcomes for our residents in Hammersmith & Fulham whilst also ensuring maximum value to the taxpayer.

I look forward to more constructive discussions going into 2018/19 and the next phase of our work to deliver the Primary Care strategy, building on the excellent progress made to date.

Yours Sincerely

Clare Parker
Chief Officer

cc: Dr Tim Spicer
Janet Cree
Andrew Slaughter
Stephen Cowan
Ben Coleman
Jane Betts
Trish Longdon

London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY AND ACCOUNTABILITY COMMITTEE** **30 January 2018**	
A REPORT ON H&F COUNCIL'S EMERGENCY RESPONSE TO MAJOR INCIDENTS IN JUNE AND SEPTEMBER 2017	
Report of the Chief Executive, Kim Dero	
Open Report	
Classification: For review and comment **Key Decision: No**	
Consultation: The author of the report has consulted extensively with H&F council officers from across departments who were involved in H&Fs immediate and ongoing responses to the Grenfell Tower fire and the Parsons Green terrorist incident.	
Wards Affected: All	
Accountable Director: Sarah Thomas, Director of Delivery and Value	
Report Author: Peter Smith, Head of Policy & Strategy	**Contact Details:** Tel: 020 8753 2206 peter.smith@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. In 2017 there have been two major incidents in and around Hammersmith & Fulham that required the authority to implement its emergency planning procedures. These were the fire at Grenfell Tower in North Kensington in June and an explosion on a tube train in Parsons Green tube station in September.

1.2. This report reviews the H&F response to those incidents through the experiences of H&F officers involved in the response to Grenfell and Parsons Green at both strategic and operational levels. The review has also considered the views of local businesses and community organisations that participated in a 'hackathon' event convened by the council to examine the views of partners.

1.3. The report identifies action taken to date to improve the council's readiness and response to major incidents and makes recommendations for additional

action to further improve this response. This report was submitted to Audit, Pensions and Standards Committee and Finance and Delivery PAC in December; to Economic Regeneration, Housing and the Arts PAC on 16 January and is being submitted to all remaining PACs on 29th and 30th January, before going to Cabinet in March.

2. RECOMMENDATIONS

2.1. The Health, Adult Social Care and Social Inclusion Policy and Accountability Committee is invited to discuss the findings and recommendations of the report and, should it see fit, make suggestions, including on implementing the recommendations, for the Council to consider in its response.

3. REASONS FOR DECISION

3.1. H&F Council has a duty of care to all of its residents and must ensure that it has appropriate plans and processes in place to deliver on that duty.

4. PROPOSAL AND ISSUES

4.1. The Health, Adult Social Care and Social Inclusion Policy and Accountability Committee is requested to consider and discuss the report's recommendations, and to refer its comments on to Cabinet.

5. OPTIONS AND ANALYSIS OF OPTIONS

5.1. The research that has informed the recommendations within the report has involved interviews with a variety of different officers, during which various options for improving planning and procedures have been examined and analysed.

6. CONSULTATION

6.1. The author of the report has been engaged in consultation with council officers and has examined feedback and proposals from an event that gathered the views of businesses and community organisations.

7. EQUALITY IMPLICATIONS

7.1. The implementation of these recommendations will have no direct equality implications.

8. LEGAL IMPLICATIONS

8.1. The Civil Contingencies Act provides a framework for Civil Protection in the UK. The Council is classified as category one. The "report" at appendix one sets out at paragraph 1.8 the full set of civil protection duties the Council has. The "report" makes a number of recommendations for action in relation to the Local Authority's response to future emergencies. The legal team can be

further consulted about the implementation of any of the recommendations, if the Council wishes to implement these.

8.2 Implications completed by: Hazel Best, Principal Lawyer 020 7641 2955

9. FINANCIAL IMPLICATIONS

9.1. The Government's Bellwin scheme provides emergency financial assistance to local authorities in England and is activated at the discretion of the Secretary of State. Bellwin funding is designed to cover uninsurable risk over a local threshold. It will recompense authorities for the costs of emergency measures undertaken to safeguard life or property, or to prevent further suffering and inconvenience locally, during exceptional circumstances. There are strict rules on the types of expenditure that are eligible for reimbursement. In relation to the Grenfell fire incident, RBKC will be making a claim under the Bellwin scheme which will include the additional costs incurred by Hammersmith and Fulham incurred in providing mutual aid.

9.2. In response to the wider lessons learned from the Grenfell Tower fire and Parsons Green incidents, on 4 September 2017, Cabinet approved a drawdown of £111,000 from the Community Safety Reserve to increase the resilience of the Emergency Planning Team for 18 months.

9.3. On 18 October 2017, Full Council approved amendments to the Four-Year Capital Programme 2017-21 to include £20m for the Fire Safety Plus Programme. Whilst the Department for Communities and Local Government have requested details of fire safety works from councils, no additional funding has been made available to date. Until further clarity on funding has been received, the programme will be funded from a combination of the use of reserves and internal borrowing. The detailed financial implications of the Fire Safety Plus Programme are included in the Full Council report.

9.4. Taking forward the recommendations for further actions identified in this report, will be subject to further decisions, the financial implications of which will be confirmed at that time.

9.5. *Implications completed by: Emily Hill, Head of Corporate Finance, 020 8753 3145.*

10. BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	Notes of interviews with officers	Peter Smith x2206	Delivery and Value/ HTH
2.	Notes from the hackathon on emergency planning	Peter Smith x2206	Delivery and Value/ HTH

LIST OF APPENDICES

Appendix 1: A Report on H&F Council's Emergency Response to Major Incidents in June and September 2017

A draft consultative report on H&F Council's Emergency Response to Major Incidents in June and September 2017

January 2018

Contents

1. Introduction

Purpose of the report

1.1 During 2017 London and the UK were affected by a range of major incidents including:

- the terrorist attack on Westminster Bridge in March;
- the Manchester Arena terrorist attack in May;
- the terrorist attack at Borough Market/London Bridge in early June;
- the Grenfell Tower Fire in mid June;
- the terrorist attack near Finsbury Park Mosque in June;
- the evacuation of residents from four tower blocks in Camden following fire safety testing in late June;
- the terrorist attack on a tube train at Parsons Green in September.

1.2 Two of these incidents required Hammersmith and Fulham (H&F) council to implement its emergency planning procedures. They were the fire at Grenfell Tower in North Kensington in June and the explosion on a tube train at Parsons Green station in September.

1.3 The purpose of this report is to present findings of a review that has examined H&F's experiences in implementing its emergency planning procedures, to determine the effectiveness of our response and any areas for improvement in the future. The report is draft for consultation with the Audit, Pension and Standards Committee and five Policy and Accountability Committees (PACs). Following consideration of the discussion and feedback at these forums, the findings of the review and consultative process will be presented to Cabinet in March 2018.

1.4 This version of the report has been fully updated following the discussions at the Audit, Pension and Standards Committee and Finance and Delivery PAC in December 2017 and the Economic Regeneration, Housing and the Arts PAC on 16 January 2018, adopting comments and additional recommendations made at those forums as well as tightening expressions and meaning following feedback. The report may be further amended following consultation with the other PACs over the course of January 2018.

Summary of the major incidents

1.5 The Grenfell Tower fire, which began in the early hours of Wednesday 14 June 2017, was one of the worst disasters in London and the UK in living

memory[1]. The impact of the disaster has reverberated far and wide. A public inquiry is currently under way and criminal proceedings may follow, so this review is not intended to influence or undermine the due legal process of that inquiry and those proceedings. With this in mind, the review purposefully does not comment on the Royal Borough of Kensington and Chelsea's (RBKC) response or affairs.

1.6 The Grenfell Tower Inquiry will cover issues relating to the response in the aftermath of the fire and is set to review:

(a) What policies, procedures and plans were in place on the part of central and local government for dealing with a major emergency such as the Grenfell Tower fire?

(b) What was the response of the Tenant Management Organisation, central and local government by way of the provision of emergency relief in the days immediately following the fire?

(c) Was the response adequate and, if not, in what respects was it inadequate?

1.7 H&F borough has been significantly affected by the fire, with the council, councillors, council staff and local residents, community organisations and businesses all contributing to the efforts to provide relief to the many hundreds of people directly affected.

1.8 In addition, at 8:35am on Friday 15 September 2017, an improvised explosive device was detonated on a tube at Parsons Green tube station[2]. H&F Council was the authority with responsibility for the response to that incident. The Parsons Green incident can not be compared in scale to the Grenfell Tower fire, in terms of the human tragedy and the duration of the impact on so many displaced families. However, like Grenfell, it was an incident that required an emergency plan to be implemented and for people to be evacuated from the area as a police cordon was put in place. It also attracted huge international media interest.

1.9 As a local authority, H&F council is classed as a Category 1 responder under the terms of the Civil Contingencies Act 2004[3]. This means that the Council is subject to the full set of civil protection duties and is required to:

- assess the risk of emergencies occurring and use this to inform contingency planning;
- put in place emergency plans;

[1] See Appendix 1 for a map of the Grenfell Tower local area
[2] See Appendix 1 for map of the Parsons Green local area
[3] See Appendix 2

- put in place business continuity management arrangements;
- put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- share information with other local responders to enhance co-ordination;
- co-operate with other local responders to enhance co-ordination and efficiency;
- provide advice and assistance to businesses and voluntary organisations about business continuity management.

1.10 The review process consisted of a series of interviews with H&F staff who played major roles in the Council's response to the Grenfell fire and its aftermath and to the Parsons Green terrorist incident, along with a 'hackathon'[4] style event to gather the views of businesses, local agencies and community organisations that also played a role in the relief efforts, especially that at Grenfell. This review is focussed on the lessons to be learned for H&F Council so it did not extend to interviews with RBKC staff nor to RBKC stakeholders. To do so might have compromised the process of the public inquiry.

1.11 This report is a follow up to the immediate H&F Emergency Planning Lessons Learned Report, which was presented to the Finance and Delivery PAC on 6th September 2017. At that meeting the Committee recommended that a second report be provided to a subsequent meeting addressing: communities, hotel work, reassurance, community resilience and housing in relation to emergency planning, and that officers provide further information on when local emergencies escalate to national emergencies.

1.12 The Grenfell Tower fire occurred across the H&F borough boundary in RBKC so the primary local authority with responsibility for delivering its civic protection duties was RBKC. Hence, that council's role, along with that of the Kensington and Chelsea Tenant Management Organisation is the central focus of the public inquiry. However, given the scale of the disaster and the proximity of H&F to North Kensington, the Leader of H&F Council asked the Chief Executive to offer immediate and compassionate support. This report examines the nature of that support, what worked well, what lessons have already been learned and what can be further improved for the future.

[4] A hackathon is an event consisting of focussed sessions with key stakeholders to consider complex problems in the pursuit of solutions

1.13 The report is structured around a number of thematic sections relating to different aspects of the council's implementation of its emergency planning procedures following both major incidents.

2. Command and Control

First 24 hours

2.1 The Grenfell Tower fire took hold in the early hours of Wednesday 14 June. The Chief Executive of H&F Council immediately established a Service Resilience Group (SRG) to plan and oversee the Council's response to the fire and its aftermath. The group was chaired by the Chief Executive and brought together senior officers at daily meetings for a period of two weeks.

2.2 In the first 24 hours, H&F was requested to send rest centre managers to three centres at Westway sports centre, Portobello and St Clements Church at about 11am on the Wednesday morning. The H&F emergency response team also provided assistance.

2.3 As the Parsons Green incident happened in H&F borough a Borough Emergency Command Centre (BECC) was established within ten minutes which led the H&F council emergency response.

2.4 The Grenfell Tower fire and the Parsons Green terrorist incident have raised interest, at all levels across the council, in H&F's emergency planning procedures and the command and control structure within it. There is now a much broader understanding of this structure as officers from across the authority have seen it in action. It is intended that this wider understanding will be maintained via broader communication networks and expanded training (see section 8).

2.5 Directors involved in the SRG for the Grenfell response confirmed that the H&F command and control structure was clear to them. However, those who were not part of the daily briefings (Children's Services and Adult Social Care) were less clear about the distinction between the H&F sovereign response and the response under the "tri-borough" shared services arrangements (i.e. RBKC, Westminster City Council and H&F). Some of the shared services officers interviewed as part of this review said the shared service arrangements with RBKC may have blurred the distinction between RBKC and H&F officer resources on the ground, where care workers and volunteers were operating. In turn, this created some confusion about how H&F resources were being allocated. The structure of any future SRG for an

incident of the scale and scope of Grenfell needs to include senior representation from all directorates. Additionally, it will be important that the work underway to disaggregate children's, adults and public health shared services arrangements considers H&F's sovereign capacity to respond to a major incident, including capacity to aid other boroughs in emergencies.

2.6 At Parson's Green, the council's command and control structure and management of a robust operation was commended by London's Local Authority Gold, the Metropolitan Police and London Fire Brigade (LFB).

First few days

2.7 On 17 June 2017, the Chief Executive appointed senior officers to set up two task groups in response to the Grenfell Tower fire – one to co-ordinate the provision of temporary accommodation and support for displaced Grenfell residents (the H&F Grenfell Outreach task force) and the other to address the concerns of H&F residents in tower blocks within the borough (the H&F Tenants' Reassurance task force).

2.8 The officers appointed to run these teams were clear as to their briefs and were given the necessary delegated authority to draw in other officers from across departments. One of the task group managers noted that it had been helpful that the role and authority of the task force has been set out in writing and circulated to all those who needed to know of it. He noted the value of the task force being a joined-up operation working across council services with named leads.

2.9 Some of those drawn in to manage the situation on the ground in the days following the Grenfell disaster (i.e. those dealing with donation management), were less aware of the command and control structures. This reflects the fact that a large number of volunteers had to be drafted in at short notice with limited previous training in emergency planning or knowledge of the borough's Emergency Management Plan. The extent to which officers working on the donations response needed to be briefed on the wider emergency response is, however, questionable. Indeed, as donations on the scale received were unprecedented, donation management presented new leadership and skills challenges (see section 7).

2.10 The experience suggests that the shared service arrangements had not foreseen the complexity of an incident such as the Grenfell disaster. Each borough in the "tri-borough" arrangement had its own sovereign BECC. For Grenfell, this caused confusion in the H&F command and control structure when H&F staff were allocated to support the emergency planning response

as part of the shared services arrangements rather than through the H&F BECC or H&F command and control structure.

Week by week

2.10 The H&F Emergency Planning team compiles and circulates, to selected senior officers and those on emergency response rotas, a weekly rota known as 'Weekly Orders'. This sets out which officers are responsible for different levels of command and control in the event of an emergency incident.

2.11 Following the experiences of 2017, challenges have been identified in how H&F council can effectively monitor operational activity and staff capacity and coordinate responses in shared service areas, which may be responding to dual reporting structures at the point of an emergency. The Moving On programme, to disaggregate key "tri-borough" shared services, will address this issue for the future, in some part.

Actions taken

- The circulation of the Weekly Orders has been expanded.

- The Chief Executive advised the Strategic Leadership Team to be on high alert and confirm capacity, resources and accuracy of communication channels in case of any further major incident over the summer months. This was agreed for July – September as L.B. Camden had evacuated four tower blocks due to safety concerns which, together with Grenfell residents and summer tourism, had reduced hotel availability locally.

Recommendations for further action:

- The circulation list for the Weekly Orders should be subject to a regular review, co-ordinated by the Chief Executive's office and Human Resources, to ensure that all officers who may need to respond to an emergency are included in its circulation.

- In the event of a disaster of the magnitude of the Grenfell fire there may be a need for a two-tier daily planning briefing – strategic and operational.

- That the expectations from membership of a Service Resilience Group be clearly set out and communicated to attendees and relevant Directors/Heads of Service.

- That the command and control and briefing arrangements should be built into emergency planning training and exercising.

- Accurate records of staff deployed should be kept from the start of a response.

- Continued shared services and any new partnerships or shared arrangements should be clear about 'first call' arrangements of H&F and H&F services to limit competing calls and under capacity at critical times of an emergency.

3. Communications

Internal/operational

3.1 The Emergency Communications Plan is updated regularly, in liaison with the Emergency Planning team. During both the Grenfell fire and Parsons Green incidents, the Communications division's liaison with the Emergency Planning team was via the Local Authority Liaison Officer (LALO) and the Borough Emergency Command Centre (BECC). Officers interviewed as part of this review advised that these internal communications worked well.

3.2 Outside of this, responsible H&F Directors managed the operational communications on a day-to-day basis, following the daily briefings given by the Chief Executive at the SRG. Communications with other staff was via the web, intranet and from those on the ground.

3.3 Intelligence on the Grenfell fire evacuees placed in H&F hotels was initially received anecdotally when West Kensington Tenants' and Residents' Association alerted the Leader of the Council that evacuees had been placed in a Fulham hotel and seemed confused and unsupported. This led H&F to respond immediately with emergency welfare assistance and small cash subsistence offers and led to the establishment of the H&F Grenfell Outreach team on Saturday 17th June.

3.4 In the absence of other information, H&F officers approached hotel managers across the borough directly to obtain details on whether any evacuees had been placed in their hotels. The media were keen to hear evacuees' stories so there were trust issues to overcome in winning the confidence of hotel managers and support them to protect the privacy of evacuees and those who had been evacuated from the surrounding are .

3.5 The limited information on who had been placed in which H&F hotels might have been partly overcome had there been an agreed protocol of information exchange between H&F Council and local hoteliers. This suggestion emerged from both the interviews with officers and from discussions with a hotel manager at the community hackathon event. The Council should consider future arrangements and establish a shared protocol with hoteliers in

the borough. It may be possible to agree a system of instant messaging of all hotels in the borough seeking offers of assistance in similar emergencies.

3.6 Communication with hotel staff during the Grenfell relief effort was mainly via leaflets, through face-to-face or telephone contact with the H&F Grenfell Outreach Task Force. A newsletter was produced for hotel residents telling them what support and services were available to them.

External/ public communications

3.7 After the Grenfell fire, the first external communication reassuring council residents in high rise blocks in the borough was sent on Thursday 15th June, the day after the fire. The H&F Tenants' Reassurance Task Force was formalised on Saturday 17th June. Advice sessions were held at the Charecroft estate on the 16th and 23rd June. Advice sessions were also organised on the Edward Woods Estate from Sunday 18th June. There were daily sessions at this estate which were well attended, with officers taking questions on fire safety issues. Information on safety and risk assessments, reassuring residents that H&F council tower blocks did not have the same cladding as at Grenfell and informing residents on processes underway to assess high-rise properties, were provided quickly via a wide range of communications channels.

3.8 A meeting took place with Tenants' and Residents' Association (TRA) Chairs, the London Fire Brigade and council representatives in the following week to the Grenfell fire. There were then public meetings with Edward Woods and Charecroft estate residents. The Leader of the Council attended the meetings, as did ward councillors and the Cabinet Member for Housing.

3.9 Some residents felt that there should have been visits to all of the TRAs. However, this would have stretched the small core group of officers, as they needed to be present at those meetings to answer the range of questions that residents were posing. The LFB offered to attend any TRA meetings on request. The Chief Executive had already held a meeting with the Borough Fire Commander early in her induction in June 2017 to ensure that good working relationships were formed with key partners. There was a Q&A document published on the H&F website which was regularly updated. It was noted that, on reflection, the circulation of Q&As to other TRAs not visited would have been helpful.

3.10 The Grenfell disaster is probably the first incident of that scale to occur in the UK in an age where social media plays such an important role in communications and in shaping the public response. Social media proved invaluable in feeding on-the-ground reports from local people into the council's

emergency response. The council's communications team maintained a round-the-clock social media operation throughout both incidents. There is a clear need for an effective social media strategy, given the increasing role it plays in emergency incidents and to get clear, coherent messaging out as widely as possible – through as many channels as possible. To assist, it is recommended that a pre-prepared, updated banner message is placed on the front page of the H&F council website in the event of another major incident.

3.11 External communication was also undertaken to promote the H&F Fire Safety Plus programme. This was launched following the Grenfell fire, and includes an extensive package of fire prevention measures and fire safety messages. A booklet on this package was sent to all high-rise residents of council properties first and then to all H&F council residents and made available on the council's website. (see section 5)

3.12 In relation to external communications at Parsons Green, it was suggested that more information was needed for those people unable to return to their homes because of the police cordon established. However, the bomb was not made safe until 5pm so it was difficult for the police to give early information as to when people might be able to return home.

3.13 Overall, this review has found that there was a joined-up approach to dealing with the media during both major incidents. H&F communications officers worked long hours to deal with media enquiries which were directly Grenfell-related, as well as general tower block fire safety enquiries. The main communications difficulty arising from the Grenfell fire was the Council's capacity to answer large volumes of wide-ranging and detailed questions from the media, government and the public about all aspects of fire safety in council properties. At a time when resources were stretched in dealing directly with the incident on the ground, capacity to meet information demand was also stretched. This is an area that all services should consider in their emergency planning.

Recommendations for action

- All services should receive guidance on how to manage large-scale information demand in their emergency plans.

- A social media strategy, including the use of the Next Door platform, should be prepared for an emergency incident communications response.

- Alternative arrangements should be identified for communicating with residents to enable communications to continue if one or more of the mobile phone system, internet or the council website failed during an incident.

- Single Points of Contact (SPOC) should be identified to deal with different types of communication enquiries in an emergency (e.g. media enquiries, requests from the emergency services, central government etc). This should be built into procedures, training and exercising.

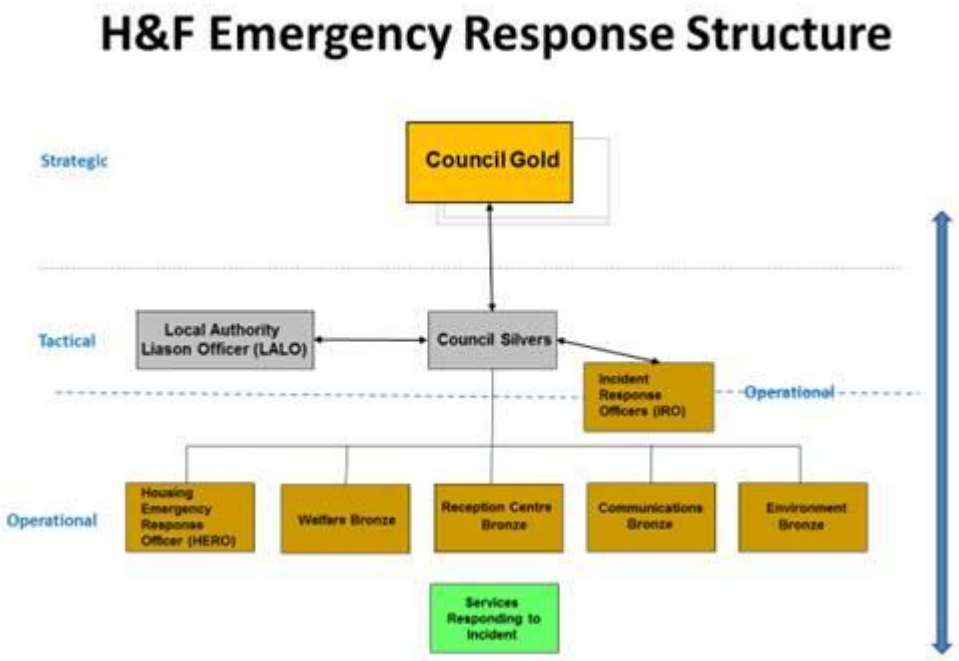
- Member briefings and training must make it clear who to contact in the event of an emergency so councillors can give information and feedback from the ground.

- All staff should be informed of the emergency contact number.

- A pre-prepared update banner message should be put on the front page of the H&F council website in the event of an incident.

4. Emergency planning

4.1 The emergency planning procedures in H&F are quite clear. This is set out in the figure below. In this structure, Gold is the strategic lead, the Chief Executive holds this role and was Gold at the time of both incidents; Silver is the tactical lead (a trained council officer); and Bronze are the operational leads (these are trained council officers, including a Welfare Bronze).



4.2 If an emergency requires an evacuation, a Welfare Bronze is appointed (historically from Adult Social Care) to identify any premises within the cordon that include vulnerable persons or people with particular needs. An LFB

trained LALO will also be deployed to a rendezvous point. The LALO attends all Silver meetings and reports back to the Duty Silver on what is required. The LALO then passes the information to the police, fire service and any other authorities providing emergency services.

4.3 This review has found that the emergency planning responses from H&F to the Grenfell Tower fire and Parsons Green incident implemented organisational plans and provided appropriate assistance to those affected. Whilst H&F has the necessary capacity to respond to a large scale emergency within the borough, it is likely to require additional resources (e.g. via mutual aid) to relieve an emergency support team over time.

4.4 Training is being expanded to increase the capacity of the authority to cope with an incident of the scale of the Grenfell fire in H&F. As identified elsewhere in this report, there needs to be a wider general understanding of key aspects of H&F's emergency management plan, through wider communications with staff, councillors and partners, as well as a specific need for a wider pool of trained officers for key emergency response roles. The pool of trained officers needs to be offered periodic refresher training.

4.5 Key insights from H&F officers supporting the Grenfell rest centre highlight the need for H&F to put in place pre-agreements with chemists, opticians, dentists etc for essential items (e.g. medications, glasses, dentures) for those displaced without their everyday items. Agreements could also be made with local foodbanks to offer other essential provisions such as food and toiletries.

Mutual aid

4.6 Under London's local authority Gold arrangements, any borough can request mutual aid when facing an emergency incident and there is a clear and agreed process to go through. A request has to go to the London Resilience Group (LRG) and be signed off by London Local Authority Gold (LLAG).

4.7 In the event of an incident requiring multi-agency regional strategic coordination, the steps below describe the process for activating the LLAG arrangements:

1. The Metropolitan Police or London Resilience Team (LRT) activate Golds from all agencies as required.
2. London Local Authority Gold is activated by the Metropolitan Police or LRT using contact details provided by London Fire Brigade Emergency Planning (LFB-EP).
3. LLAG activates a London Local Authority Coordination Centre (LLACC).
4. LLAG and Support Team (if there is a Strategic Coordination Centre (SCC)) travel to the designated meeting location.

5. LLAG and Support Team (if SCC) arrive at designated meeting location and are met by the Duty LLACC Manager or LFB-EP SCC Liaison Officer (if SCC).
6. LLAG establishes communications with the LLACC.

4.8 Once mutual aid had been called in for the Grenfell fire, the timing of rotas had to be managed as the London Resilience team rotas did not align those already set up for H&F staff. The response from the LRG was to allocate qualified social workers from every London local authority to work with the evacuees for an initial two-week period.

4.9 A lesson from Grenfell concerns the role of neighbouring boroughs affected by a large scale incident, where the emergency response is being led by another borough. Further work is required on how to involve neighbouring boroughs in these circumstances as part of London-wide responses. H&F Council has raised this issue with the Local Government Association (LGA), in order that the role of 'bystander' boroughs is better utilised. The Local Authority Panel (LAP), which acts on behalf of London's local government, is developing service level agreements to provide the commitment to mutual aid at a sub-regional level and provide London with consistent and effective resilience into the future.

Actions taken

- New H&F rest centre equipment has been purchased and is stored at Bagley's Lane depot in Fulham. There are enough beds and bedding for 145 people with provisions for a further 80 stored nearby.

- Tow bars have been added to new vehicles to ensure that they can transport trailers with bedding quickly to wherever they need to be – there had previously been only one vehicle with a tow bar. Emergency planning equipment is also stored in the Courtyard Room storage cupboard in Hammersmith Town Hall.

- A review of H&F's emergency planning procedures, following the Parsons Green incident, has been commissioned from an independent consultant.

- Additional lanyards and high visibility jackets have been purchased and are now to be worn by all emergency responders at an incident.

Recommendations for further action

- A review should be undertaken of the best means of registering and storing records of people displaced to a rest centre in an emergency incident.

- Consideration should be given to negotiating agreements with chemists, opticians, dentists and other local stores and suppliers to secure the emergency provision of essentials for any displaced residents in the event of a major incident.

- The list of potential premises in H&F for emergency use as rest centres should be updated, along with contact details for keyholders and means of access.

- Work should be undertaken to identify premises in H&F borough that might be used to provide emergency accommodation.

- Emergency Planning should review the corporate emergency planning response arrangements, structure and responsibilities in the event of an emergency.

- Additional emergency response and planning training should be provided for all senior staff and councillors.

- Media training should be provided for councillors.

- Information on emergency planning should be included as part of staff induction training.

- High visibility jackets and personalised name badges should be supplied to all members of the strategic leadership team.

- An annual Emergency Planning Report should be presented to Cabinet (in addition to any other papers required during the year) covering:

    1. Emergency planning progress across the Council

    2. Overview of emergency staffing levels

    3. Overview of training and exercising programmes and up-take.

- Further work should be undertaken on involving neighbouring boroughs affected by a large scale incident including their role as part of London-wide responses, in order that the role of ‘bystander’ boroughs is better utilised.

- It is noted that an independent peer challenge of London's regional resilience procedures has been commissioned by London Councils on behalf of London Local Government.

5. Housing

Temporary accommodation for evacuees

5.1 In August 2017, there were a total of 57 families, consisting of 108 people (including 18 children), displaced because of the Grenfell Tower fire, located in seven H&F hotels. By 8th January 2018, this had reduced to 29 families, made up of 43 people.

5.2 The families and individuals displaced required cash, food, clothes, health and care services, mobile phones and chargers, internet access and other supplies in the immediate days following the tragedy. Laundry also had to be organised.

5.3 One hotelier who took part in the H&F hackathon had a large number of the evacuees from Grenfell and the surrounding blocks staying at his hotel. His staff were not adequately trained to deal with the traumatised guests that were placed in the hotel. Once H&F had discovered that there were evacuees at the hotel, there were daily visits from the H&F Outreach team of support workers. This included Children's Services placing key workers with every family located in an H&F hotel within 48 hours of notification of their arrival. In the case of an emergency in Hammersmith & Fulham, the council's Housing Service places families in temporary accommodation and informs Children's Services immediately and a social worker is allocated and visits on the same day.

5.4 Hotel accommodation is the most obvious pool of temporary accommodation in H&F so a central database of such accommodation should be maintained by the Council. There may be other unexplored options to consider, however, such as Airbnb and using residents' spare rooms.

5.5 Some of the officers assisting with finding temporary homes for Grenfell fire evacuees in H&F hotels noted the lack of a clear policy at that stage from RBKC as to what impact the acceptance of an offer of temporary accommodation in H&F might have on the rights of the tenant to be rehoused permanently in RBKC. Some evacuees refused all offers of temporary accommodation from H&F due to fears that it would mean the loss of their entitlement to be rehoused in RBKC. There needs to be cross-borough

agreements between London councils in the event of a disaster of this nature, whereby acceptance of an offer of temporary accommodation by a neighbouring borough should not affect a tenant's rights to social housing in their own borough. H&F Council should agree such a policy for any social housing tenants of H&F Council that might be displaced by a similar incident in this borough.

5.6 Information from both major incidents confirms the need for staff who are coordinating or arranging emergency support at the front line to have immediate access to financial resources to pay suppliers and access goods and services. Moving forward, arrangements for corporate credit cards and their distribution within services should be considered within emergency plans. Efforts have been made to set up business accounts with H&F hotels to avoid the need to issue more corporate credit cards.

Action taken

- An additional corporate credit card has been issued to a third Housing Director to spot-purchase emergency accommodation and other essentials in the event families and individuals are displaced by an incident in H&F.

Recommendations for further action

- H&F Council should agree a lettings policy that assures that any social housing tenant who is displaced by an incident of this scale will retain their rights to permanent rehousing in the borough, irrespective of any acceptance of an offer of temporary accommodation from another borough.

- Cross-borough agreements should be laid down to ensure that tenants' rights to permanent accommodation in their borough of origin are not adversely affected by the allocation of temporary accommodation in another borough where this is due to an emergency incident causing displacement from the home borough.

- A data-sharing protocol should be drawn up to ensure that information on the needs of displaced residents from one borough can be shared with a neighbouring borough that is temporarily accommodating those families and individuals.

- Further attempts should be made to secure business accounts with other hotels located in the borough.

- Arrangements for corporate credit cards and their distribution within services should be considered within emergency plans.

Assurance for H&F residents

5.7 The new Chief Executive at H&F had initiated a review of the borough's fire safety regime upon appointment in March 2017, and was in the process of implementing more stringent fire safety checks prior to the Grenfell Tower fire.

5.8 Following the Grenfell fire, it was important to reassure H&F tenants and residents about their safety in tower blocks located within the borough. Understandably, Grenfell triggered discussions with tenants and residents on fire safety, especially at the Edward Woods Estate and at the Charecroft Estate. However, communication with residents in the days that followed Grenfell quickly provided reassurance that there were no H&F tower blocks with the same cladding as at Grenfell.

5.9 Urgent fire safety checks were carried out at Edward Woods, Charecroft and other tower blocks, with Fire Safety Advisers drafted in to visit all tower blocks. The Council also established the H&F Fire Safety Plus programme (see Appendix 4) to install sprinklers in all blocks where it would improve safety, replace fire doors and offer free safety checks and free replacement of faulty appliances. A Full Council meeting agreed to allocate £20m to this 'Fire Safety Plus' programme. [5]

Action taken

- Fire safety checks have been completed on all 71 H&F high-rise tower blocks (a tower block is a communal residential building with more than 6 storeys) and all blocks of five or less storeys

- Fire Safety Plus handbooks have been issued to H&F council residents, setting out the H&F offer of free safety checks for all homes and free replacement appliances and plug adaptors.

- Concierge staff have been increased at the Edward Woods Estate and are now located in all three tower blocks of the estate.

- Specifications for works to install sprinklers in all high-rise blocks, where this would improve safety, are being drawn up.

[5] See Appendix 4

- A residents' advisory group on fire safety is being set up to work with the Council on improvement plans.

- A Property Compliance Task Force, chaired by the Chief Executive, has been set up to ensure that H&F Council is meeting its full responsibilities as a landlord.

- The housing repairs emergency response service has been reviewed and enhanced and a new emergency response policy put in place.

Recommendations for further action

- The Council should set out in advance the range of outreach support and services that could be available to families and individuals placed in temporary accommodation in and outside of the borough as a result of a major incident

- Clear lists and contact details for all residents placed in temporary accommodation following an evacuation should be available and updated as necessary to key staff.

6. Welfare

6.1 Emergency welfare and support for those affected by major incidents is a critical element of any emergency response. Support arrangements need to ensure that social care, health care and other support services continue to be provided for those with previously identified needs, and also respond to the additional impact of the incident, or possible evacuation. Welfare arrangements should also be sympathetic to the cultural needs of local residents, and recognise the diverse nature of the local population.

6.2 For example, some residents evacuated following the Grenfell fire and placed in H&F Hotels were observing Ramadan, and their experience was that this could not easily be accommodated by the hotel catering service. Some residents were accommodated in hotels offering a bed and breakfast service with no other access to catering or food preparation. The H&F Outreach Taskforce arranged food delivery services and meal vouchers, with supportive assistance from a number of local restaurants and caterers. A pre-arranged protocol with local hoteliers to commission a specific catering response during emergencies or to sign up local restaurants willing to assist with providing meals to those affected may be helpful in future incidents. A food and meal voucher system might be agreed in advance with supermarkets and restaurants in the borough.

6.3 Some of those affected in both incidents had pre-existing health or social care needs, which required additional services to be available in both emergency centres and emergency accommodation (e.g. access to medication, social care support).

6.4 The impact of incidents such as the Grenfell fire and the Parsons Green incident may result in ongoing needs which are likely to continue beyond the immediate event, or may only be identified after a period of time. This may include trauma and post traumatic stress. Moving forward, specific training for staff to provide appropriate responses and ongoing access to psychological support for traumatised residents should be considered within emergency plans.

6.5 Support for children and young people with additional needs, such as those with learning disabilities, or families receiving social care support also needs to be addressed in emergency plans. As part of the emergency response to the Grenfell fire, children in the affected area who were already receiving social care support were immediately identified by Children's services.

6.6 At Parsons Green, the NHS was not able to respond to requests to obtain medication for people in the rest centre. Independently, a local pharmacist assisted the Rest Centre officers in liaising between residents and a local GP practice to provide medication for those that required it.

6.7 H&F provides an employee assistance programme throughout the year. The offer is enhanced for employees affected by a major incident to include telephone counselling and specific face-to-face support. In the immediate aftermath of Grenfell, the Council further enhanced the offer with on-site counselling sessions in the six weeks following the incident. In addition, regular communications about longer-term support available has been established, recognising some effects may be delayed. During the Parsons Green incident a similar response was provided although, given the relatively lower numbers of employees affected, the role of the line managers in establishing contact and support requirements was most beneficial.

Actions taken

- An enhanced counselling service has been put in place for H&F staff.

Recommendations for further action

- A process should be established to negotiate agreements with supermarkets and restaurants to provide food and meals to the victims and evacuees of

future incidents, perhaps by way of a voucher scheme administered by the Council or local charities.

- The offer of counselling to all staff involved in the Grenfell fire relief effort should be followed up over the coming weeks and months.

- Service commissioners with responsibility for mental health services should consider how access to counselling services for non-council staff who volunteer to be emergency responders could be made available, particularly where the Council funds counselling services in the community.

- Service commissioners with responsibility for mental health services should work with NHS partners to develop local plans to provide specialist support for trauma and post-traumatic stress disorder.

- Work should be undertaken with local NHS services to develop future plans to ensure that access to medication can be quickly provided to those affected by emergencies, such as those in rest centres or emergency accommodation.

- The Council should investigate whether 24-hour pharmacies can provide support in an incident where people require prescriptions in a rest centre.

7. Donations Management

7.1 On the evening following the Grenfell fire, Clem Attlee and Rocque Maton TRA and residents brought donations to Hammersmith Town Hall, then further donations began arriving spontaneously from 7pm and continued arriving over the following days. On the day after the fire, there was a call for volunteers to assist with the co-ordination of the influx of donations, which brought 450 offers of help from council staff and the wider community. Donations were also being delivered to, and collected at, various other community sites across the borough, which were then diverted to the Town Hall.

7.2 Some of the donations included perishable goods, which were stored whilst an assessment was made of the needs of evacuees of the fire. The majority of the perishable goods was provided to the local foodbank for distribution. Non-perishable donations were stored by H&F. Some of the donations were directly distributed to evacuee families in local hotels, including toiletries. Once the Red Cross became involved as part of the government task force, they coordinated donations for Grenfell from all areas. Consequently, the remaining donations stored by H&F were provided to the Red Cross for storage and distribution.

7.3 At the time of the Grenfell fire, H&F did not have a plan for the management of donations and volunteers as part of its emergency response plan and had to move quickly to put ad hoc arrangements in place. Key officers were taken off their day jobs and asked to develop a donations receiving centre. This quickly became full with thousands of donated items sorted, stacked, boxed and labelled by over 100 volunteers (both staff and residents). Officers leading on donations management for Grenfell had no experience of this work nor the scale of the operation and much can be learned from their direct experience and considerable fortitude over the initial 3 days at the height of donations.

7.4 Officers coordinating the donations stated that they would have benefitted from more internal communications and quicker updates. It might have been helpful to have had a visible screen constantly updating everyone and displaying important information across the locations where donations were being handled.

7.5 Moving forward, H&F emergency plans should be developed to anticipate large scale donations and work with community partners to coordinate activity to effectively manage this. A donations protocol should be developed to communicate guidance on donations management including how to separate new and used items, the importance of signage advising that donations can not be returned and the importance of logging items so that once boxed they could be more easily located.

7.5 The donation management plan needs to identify suitable storage sites (both temporary and longer term) to receive and process donations in different parts of the borough and local businesses identified that that can provide storage boxes. Volunteers brought in to manage the donations need to be appropriately briefed and supported to undertake the task.

Recommendation for action

- A donation management protocol should be drawn up and agreed by the council in discussion with community partners to help manage all aspects of donation management. The plan should form part of the Council's emergency management plan procedures. It should include a communications plan to ensure that, in the event of a future major incident, donors are well informed about the type of donations needed and where donations should be taken. The protocol should guide organisers on how to stack, store and allocate donations and engage volunteers and clarify to donors what will happen to their gift once received.

- Specific council staff should be nominated to be 'Donations Managers' in the event of any future incidents and briefed accordingly.

8. Training

8.1 H&F emergency responders report that the training they receive is excellent. To ensure there are sufficient numbers of staff trained to cope in the immediate period following an incident of the scale and duration of the Grenfell Tower disaster, additional training has been provided or is planned for roles within H&F's Emergency Response Structure (see 4.1). As of 5th January 2018, there are 105 H&F officers trained in emergency response roles. This number has increased since Grenfell, with additional officers trained as Council Silver, Welfare Bronze and Housing Emergency Response Officers. Further training is planned in January 2018, to form a new team of nine officers as BECC responders. Training will continue to be provided and updated across the emergency planning roles.

8.2 Staff across some shared services responding to the major incidents had inconsistent understanding of H&F specific emergency plans and procedures. There needs to be better awareness of H&F's emergency management plan across all service areas that may need to respond to an emergency incident and training offered if required. Crisis management training should be delivered to all directors and all councillors on a prioritised basis.

8.3 It is also proposed that training is needed for responders from the community as well as council staff. The community response to the relief effort for both major incidents was widely praised but most of those volunteers had little or no training.

Action taken

- Training provided to increase number of council officers in key roles in the emergency response structure.

- Strategic Leadership Team emergency planning training and briefing session held in December 2017.

Action to be taken

- Further emergency responders training to be provided to more staff.

- Wider staff awareness training or guidance to be provided on H&Fs emergency management plan and procedures.

- There will be at least eight trained officers to cover each of the key roles of Duty Silver (currently 8 trained officers), Welfare Bronze (currently 7 trained officers) and Rest Centre Manager (currently 7 trained officers).

Recommendations for further action

- Training on emergency response to be provided to community responders, TRAs and residents.

- Crisis management training should be provided for directors, cabinet members, shadow cabinet members and ward councillors, on a prioritised basis.

- Media training should be provided for councillors.

9. Work with Communities, Local Agencies and Businesses

9.1 The public response to the Grenfell fire was tremendous in demonstrating the widespread compassion that people feel for victims of a disaster of such magnitude. This compassion and drive to help resulted in a large number of volunteers, faith groups and local community organisations, residents and businesses all getting involved.

9.2 The strength of the community response in H&F to both major incidents provides an opportunity to consider how the volunteering offer can be better coordinated and harnessed and the array of skills that are available across the borough identified. There needs to be work done to build community resilience as part of an emergency response. This was considered as part of the 'Stronger Together: Building Community Resilience' hackathon event in September 2017. Future ideas for consideration include developing an emergency responder/volunteering database, identifying community go-betweens and undertaking more outreach and community development work.

9.3 Where there are to be significant numbers of displaced individuals located in a specific area, then a plan of action is required to inform and reassure the local community in which those individuals are going to be placed. This was required in the area around the location of a temporary school that had to be established on Wormwood Scrubs to relocate the pupils of Aldridge School, which had to be closed because of the Grenfell fire. It was rightly felt that it

was important to keep the Aldridge School pupils together. Some local residents expressed concern at the potential impact on the community of a large number of school pupils being relocated to their area.

Action taken

- A hackathon event, 'Stronger Together: Building Community Resilience', has been held with representatives of local businesses, local agencies and community groups. (A hackathon is an event with focussed sessions that brings stakeholders together to discuss complex problems and come up with possible solutions.)

Recommendations for action

- The proposals that came forward from the hackathon should be progressed – building up contact lists with details of possible roles and offers of available support from local organisations and businesses.

- Taining should be provided for community outreach responders.

- A database of volunteers should be considered.

- Where displaced individuals are to be relocated in new communities, advance information and reassurance should be given to those within the host community.

- Service level agreements with funded organisations should be amended to allocate duties and responsibilities for assisting in an emergency situation.

10. Regional and National Implications

11.1 There are lessons to be learned from the Grenfell Tower fire and the response to it for national Government, the LGA and regional government, as well as for local authorities. New guidelines are likely to be required, and are anticipated following the conclusions of the Public Inquiry and other reviews. This report has urged for new thinking and learning on 'bystander management' – namely the role and responsibilities of neighbouring authorities where an incident is close to an administrative boundary.

11.2 It is disappointing that central government has not made additional funding available to carry out the essential refurbishments and safety measures that have been identified as being needed. H&F has developed its own Fire

Safety Plus programme, utilising only council resources, in response to our review of fire safety across the borough.

11.3 DCLG has written to all councils with a request to actively ensure owners of private residential tower blocks are taking measures to ensure their residents are safe. The request of councils is to identify any private residential tower blocks that have ACM or similar cladding and to ensure adequate mitigation is in place. The Environmental Health/Corporate Health & Safety team is leading this work for H&F which is ongoing at the time of writing.

11.4 H&F Council was asked to submit a response to the consultation on the terms of reference of the Grenfell Tower Inquiry and proposed that the following questions need to be answered:

Training and resources

- Were enough officers trained in emergency response roles and tactics to be able to respond to an incident of this type and scale?

Decision making

- What was the decision-making process and who made those decisions and were the Gold arrangements adequate?

Wider implications

- Are the current arrangements adequate to respond to an incident of this scale?
- Should LLAG and LLACC have stepped up response, in any event, without being asked?
- There are no mutual aid agreements between London and the surrounding counties or other parts of the UK, other than those arranged locally. Does this need looking at, in light of the Grenfell tragedy?

Pastoral and other support provided

- Can the current mutual aid arrangements be re-visited for longer term recovery incidents?
- What improvements could be made on data/information sharing between agencies relating to affected families and individuals?

Donations management

- What additional training, resources and planning is needed to manage donations in major incidents?
- How can emergency response agencies work together with the voluntary and community sector and businesses to manage donations effectively?

Building fire safety management

- Are the current regulations and guidance for fire safety management in social housing and other types of residential property fit for purpose? Would

safety be enhanced by adopting an Approved Code of Practice for fire safety management for landlords?

- How effective are sprinklers compared with other measures as part of fire safety management? Should sprinklers be mandated for all properties over a certain number of storeys? Should a common prescribed standard be set to minimise ongoing maintenance liabilities?
- How can the practical challenges of managing the fire safety of high-rise buildings with a mixture of leasehold and tenanted properties be overcome?
- Is a national regulatory body needed for fire risk assessment, similar to that in place for the gas safety industry?

Recommendations for action

- An ask that new guidance is produced by national government, the LGA and London Councils on key areas of learning from the Grenfell fire.

- It is noted that an independent peer challenge of London's regional resilience procedures has been commissioned by London Councils, on behalf of London local government.

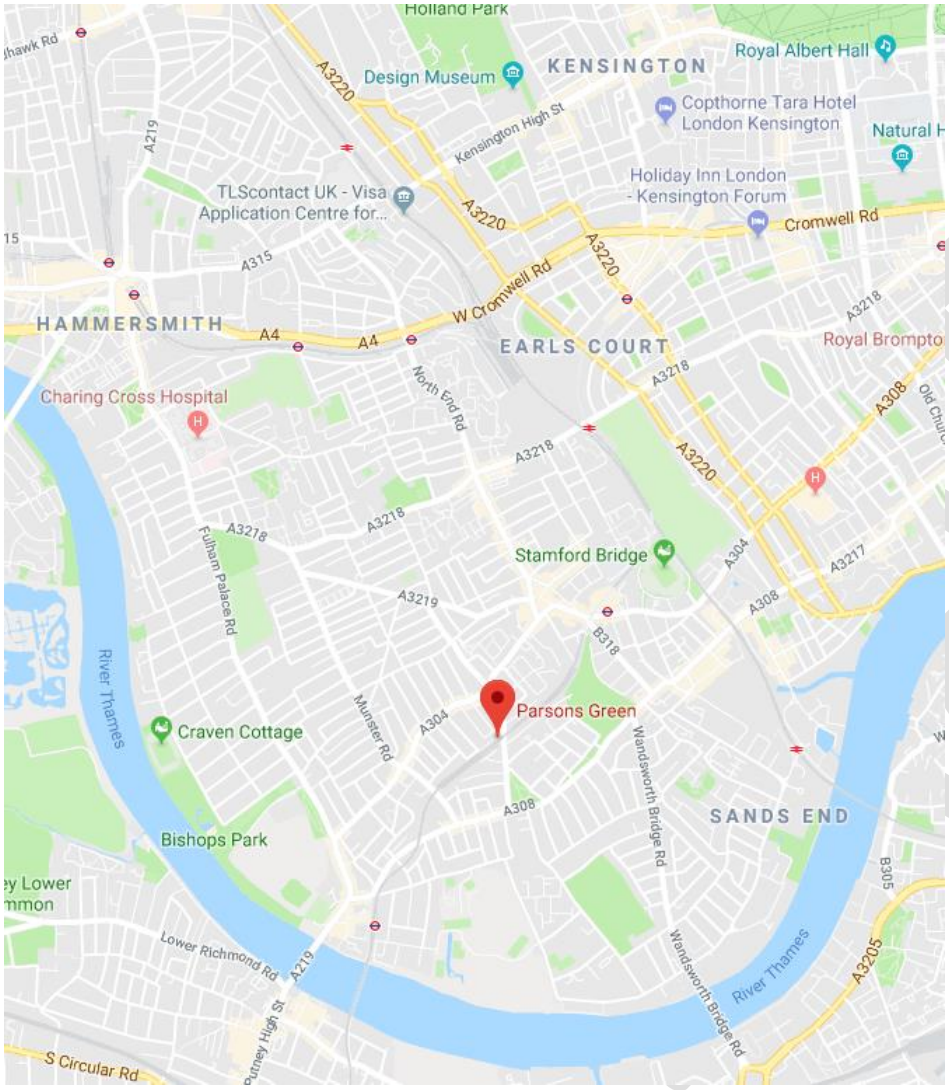
Appendix 1

Map of Grenfell Tower Local Area

Shepherds Bush and North Kensington

Location of Grenfell Tower

Map of Parsons Green local area



Appendix 2

EMERGENCY PLANNING REQUIREMENTS

Our emergency planning should aim, where possible, to prevent emergencies occurring, and when they do occur good planning should reduce, control or mitigate the effects of the emergency. It is a systematic and ongoing process which should evolve as lessons are learnt and circumstances change.

Organisations should aim to maintain plans which cover 3 different areas:

- **Plans for preventing an emergency**

In some circumstances there will be a short period before an emergency occurs when it might be avoided by prompt or decisive action

- **Plans for reducing, controlling, or mitigating the effects of an emergency**

The main bulk of planning should consider how to minimise the effects of an emergency, starting with the impact of the event and looking at remedial actions that can be taken to reduce effects. The evacuation of people may be a direct intervention which can mitigate the effects of some emergencies. Recovery plans should also be developed to reduce the effects of the emergency and ensure long term recovery.

- **Plans for taking other action in connection with an emergency**

Emergency planning should also look beyond the immediate response and long-term recovery issues and look also at secondary impacts. For example, the wave of reaction to an emergency can be quite overwhelming in terms of media attention and public response. Plans may need to consider how to handle this increased interest.

Emergency plans should include procedures when to activate the plan in response to an emergency. This should include identifying an appropriately trained person who will take the decision, in consultation with others, on when an emergency has occurred.

Exercising plans and training staff

Organisations should test the effectiveness of their emergency plans by carrying out exercises, and should ensure that those involved in the planning for or response to an emergency receive appropriate training.

Organisations should also ensure their plans give due consideration to the welfare of their own personnel.

Voluntary sector

Where appropriate, organisations should consider whether voluntary organisations may have capabilities which could assist in responding to an emergency.

The voluntary sector can provide a wide range of skills and services in responding to an emergency. These can include: practical support (such as first aid, transportation, or provisions for responders); psycho-social support such as counselling and helplines; equipment; and information services.

Appendix 3

Service Resilience Group:

Chief Executive

Lead Director of Regeneration, Planning and Housing Services

Lead Director Environmental Services (Director for Environmental Health)

Director of Housing Options

Director of Delivery and Value

Director of Adult Social Care

Director of Childrens Services

Director for Property Services

Director for Finance and Resources

Head of Emergency Services

Strategic Head of Communications

Head of Environmental Health (Residential)

Strategic Head of Development, Regeneration and Economic Growth

Appendix 4

Fire Safety Plus booklet

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h&f
hammersmith & fulham

WE'RE WORKING TO KEEP YOU SAFE

WE'RE WORKING HARD TO KEEP YOU SAFE

The fire in Kensington has made one thing clear – just meeting minimum fire standards is not enough. The regulations are clearly not good enough. So we've put together this H&F Fire Safety Plus programme, and we're going above and beyond what is required.

We want our residents to know that we care deeply about your safety, we understand your concerns, and we will do everything it takes to keep you safe.

All councils need to do more to make sure tenants' and leaseholders' homes are safe. We've got work to do here – that's why we've developed this H&F Fire Safety Plus programme, to make sure our properties meet higher standards. And we've set aside £20million to pay for it.

Tenants and leaseholders have been working with us to shape our Fire Safety Plus package. We've been visiting estates and hearing residents' concerns and suggestions for improving fire safety – and we're acting on that with a massive programme of works.

Cllr Stephen Cowan
Leader of Hammersmith & Fulham Council

OUR FIRE SAFETY PLUS PROGRAMME

Our Fire Safety Plus programme is about doing more than the minimum requirement to keep you safe. We've set aside the money to fund a major package of testing, building works and free equipment for our residents that live in council owned accommodation.

1 Replacement concierges

We are bringing back concierge staff to Edward Woods and Charecroft estates and looking to do the same at other estates where concierge staff have been removed in the past.

2 Sprinklers in tower blocks

We are working on a plan which is being discussed with the London Fire Brigade about the feasibility of fitting sprinklers in tower blocks. As we progress we'll be in touch with more details.

3 Better fire assessments

Independent experts are reviewing safety in all communal blocks. Current standards don't require assessments to check the outside of the building (cladding and external panels are not usually checked). Although we don't have the Grenfell fire cladding, we've raised the standards in H&F and asked our expert fire reviewers to look at all external panelling. They will also do much more detailed and thorough assessments than in the past.

❹ Free safety checks for every home

We are offering every resident an individual safety check visit, with priority for people in high-rise homes (six storeys or more). Depending on what your property needs, this could mean follow up visits to carry out a portable appliance test (PAT), if you want one and to remove and replace any appliance that fails. We aim to do this within 48 hours.

- **New fire doors** – We will work on checking the entire block you live in and organise a programme of works to ensure the block is safe. We will write with more details and updates.
- **Free replacement appliances** – If one or more of your appliances fails a PAT we will cut the plug off immediately and remove the failed appliance and replace it with a good quality, brand new one – for free. We aim to do this within 48 hours.

  The fire in Shepherds Court last year was started by a faulty Hotpoint tumble dryer. If you haven't yet checked whether your appliances are on the Hotpoint, Creda or Indesit recall list, please do so and book your upgrade with them. Check whether your tumble dryer is affected at: **www.lbhf.gov.uk/checkyourappliance**
- **Free heat detectors** – During our visit, we'll also install free heat detectors and check any detectors or alarms you already have to make sure they're working properly.

Book now

To book your Fire Safety Plus visit, please call the customer services centre on **0800 023 4499** or email: **firesafetyplus@mitie.com**

5 Free plug adaptors

The London Fire Brigade advise residents not to use cube-style plug adaptor/extensions. They say linear adaptors with circuit breakers built in are safer.

If you are presently using an adaptor which looks like this:

Then we will happily swap it for an extension lead which looks like this:

You can exchange your cube-style plug adaptors for FREE for a safer type of extension lead. All you need to do is bring your cube-style plug adaptors down to your local housing office and we will give you new linear adaptors for every cube you exchange. If you want more details on how to avoid fires caused by electrical equipment please visit:
www.london-fire.gov.uk/ElectricalEquipment.asp

BLOCKS WITH CLADDING

We have no council blocks in H&F that have cladding like that used on Grenfell Tower.

We have only three blocks that have cladding – all at the Edward Woods estate. We have had both the materials used and the installation tested by independent experts BRE, and the Edward Woods estate has passed these tests.

There are a few housing association blocks in the borough that have failed the cladding tests. None of these are council properties, and the housing associations that own them have notified their tenants and are working to make them safe.

EXTERNAL PANELS

The fire at Shepherds Court in Shepherds Bush on 19 August 2016 was caused by a faulty tumble dryer igniting. There was no loss of life or serious injury and initial fire reports showed the fire was well-contained. However, the fire brigade subsequently raised concerns about external panels below lounge windows.

We commissioned one of the leading firms in the field to carry out additional testing and assessment of these window panels.

We will be removing and replacing the window panels at Charecroft estate and we have round-the-clock fire patrols in all the Charecroft blocks to keep people safe while this work is being done.

We have commissioned a review of all our other communal blocks to check if these panels are used elsewhere, to check their safety, and, if necessary, to replace these too.

LISTENING TO RESIDENTS

One of the main lessons from the Grenfell fire is that councils should do more to listen to residents and act on their concerns. Here's what we've been doing to make sure residents' voices are heard:

- Fire safety officers have been visiting all our estates to talk to residents, and to check fire safety arrangements.
- We are setting up a residents' advisory group on fire safety, to work with us on our improvement plans.
- We have held advice and listening sessions at the Edward Woods and Charecroft estates in Shepherds Bush – some of our tallest tower blocks where there have been concerns about cladding and window panels.
- We've written to all residents in high-rise blocks in H&F to offer advice and reassurance where we can. We've also written separately to residents of Edward Woods and Charecroft estates about their specific concerns.
- We've met representatives from our tenants' and residents' associations to hear their views on actions we need to take, and will continue to work closely with local people.

PLEASE HELP KEEP YOUR HOME SAFE

There are some simple ways you can help keep your home and family safe. The following requests are based on fire brigade advice.

- Please keep communal areas and hallways clear of obstructions, such as furniture, bikes and boxes. It could save lives.
- Please don't smoke in bed or leave candles unattended.
- Please talk to your family about your fire plan – and make sure everyone knows what they should do, including children. Each block has its own fire safety procedures, but you can also find general advice from the London Fire Brigade at **www.london-fire.gov.uk**
- Please talk to your neighbours and help them with their fire plans if they need it, especially older people living alone or people who have recently moved to the area.
- Please don't remove or alter the external fire door to your flat. These are crucial to stopping the spread of fire in any block and give you the protection you need to stay safe until the fire brigade is able to put out any fire.
- We really need you to help us by allowing us access for fire and safety inspections so we can test equipment and fire doors.
- Please check if any of your white goods have been recalled by the manufacturer by using the link below. The manufacturer will replace appliances that have been recalled. **https://www.electricalsafetyfirst.org.uk/product-recalls/**

WHAT TO LOOK FOR IN YOUR BUILDING

Fire safety in all buildings also depends on good maintenance and housekeeping.

Here are some things to keep an eye on.

- All front doors of flats and doors on corridors and staircases must be 'self-closing' fire doors.
- Fire doors must 'self-close' properly, and not be held or wedged open. They are designed to stop the spread of fire.
- Things shouldn't be stored in corridors or staircases. This can block escape routes and stop firefighters doing their job. They can also feed the fire.
- Keep any storage on individual balconies to a minimum and do not use a BBQ on your balcony
- There should be signs that show you how to escape a fire.

If you're concerned about any of these things, please contact your local housing office for more details.

North Area Office

New Zealand Way
White City estate
London W12 7DE

Tel: 020 8753 4808
Email:
hammersmithnorth@lbhf.gov.uk

South Area Office

Clem Atlee estate
Lillie Road
London SW6 7RX

Tel: 020 8753 4327
Email:
fulhamnorth@lbhf.gov.uk

SHOULD I STAY PUT?

Below is the current advice from the fire brigade and their guidance remains the same after the Grenfell fire.

If your home is affected by fire or smoke and your escape route is clear:

- Get everyone out, close all windows and doors and walk calmly out of the building.
- Do not use the lift.
- Call 999, give your address, the number of your flat and state which floor the fire is on.

If there is a fire or smoke inside your home, but your escape route is NOT clear:

- It may still be safer to stay in your flat until the fire brigade arrives.
- Find a safe room, close the door and use soft materials to block any gaps to stop the smoke.
- Go to a window, shout *"HELP, FIRE"* and call 999.
- Be ready to describe where you are and the quickest way to reach you.

If there is a fire in another part of the building:

- You are usually safer staying put and calling 999. Purpose-built blocks of flats are built to give you some protection from fire. Walls, floors and doors can hold back flames and smoke for 30 to 60 minutes.
- Tell the fire brigade where you are and the best way to reach you.
- If you are in the common parts of the building, leave and call 999.
- Follow the fire safety instructions in your block.

WHY IS IT USUALLY SAFER TO STAY PUT?

The London Fire Brigade's guidance is to 'Stay Put' unless your flat is affected by fire or smoke.

This is because:

- Blocks of flats are usually built to prevent the spread of fire – 'compartmentalisation' includes fire breaks between flats and between floors.
- By leaving your flat, you may walk into smoke or fire in communal areas.
- Opening your fire door may allow the fire into your home and help spread smoke and flames.
- Staying put will also allow firefighters to tackle the fire safely and quickly without being delayed by many residents evacuating down the stairways.
- During the Shepherds Court fire in 2016, residents were advised to follow the standard fire brigade advice for tower blocks and to stay in their homes. Many families remained in the upper floors until the fire was brought under control. This action kept residents safe.
- This 'stay put' advice, together with the swift response to the fire and the building's good-quality fire-retardant systems, led to the initial fire report concluding there had been 'no rapid fire growth', and shows these combined measures can, and do, work successfully.

English

Information from this document can be made available in alternative formats and in different languages. If you require further assistance please use the contact details below.

Arabic

يمكن توفير المعلومات التي وردت في هذا المستند بصيغ بديلة ولغات اخرى. إذا كنت في حاجة إلى مزيد من المساعدة، الرجاء استخدام بيانات الاتصال الواردة أدناه.

Farsi

اطلاعات حاوی در این مدارک به صورتهای دیگر و به زبانهای مختلف در دسترس می باشد. در صورت نیاز به کمک بیشترلطفا از جزئیات تماس ذکر شده در ذیل استفاده کنید.

French

Les informations présentées dans ce document peuvent vous être fournies dans d'autres formats et d'autres langues. Si vous avez besoin d'une aide complémentaire, veuillez utiliser les coordonnées ci-dessous.

Portuguese

A informação presente neste documento pode ser disponibilizada em formatos alternativos e em línguas diferentes. Se desejar mais assistência, use por favor os contactos fornecidos abaixo.

Somali

Macluumaadka dokumentigan waxaa lagu heli karaa qaabab kale iyo luuqado kala duwan. Haddii aad u baahan tahay caawinaad intaas dhaafsiisan fadlan isticmaal xiriirka faahfaahinta hoose.

Spanish

La información en este documento puede facilitarse en formatos alternativos y en diferentes idiomas. Si necesita más ayuda por favor utilice la siguiente información de contacto.

Contact us:

www.lbhf.gov.uk/firesafetyplus-translate

London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE & SOCIAL INCLUSION POLICY & ACCOUNTABILITY** **30 JANUARY 2018**	
HEALTHWATCH CENTRAL WEST LONDON THE FUTURE OF CHARING CROSS HOSPITAL	
Report of: Healthwatch Hammersmith & Fulham (Central West London) for the Health, Adult Social Care & Social Policy & Accountability Committee	
Open Report	
Classification - For Information & Comment **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: External report	
Report Author: Eva Psychrani, Hammersmith and Fulham Healthwatch	**Contact Details:** Tel: 0208 968 7049 Email:Eva.Psychrani@healthwatchcentralwestlondon.org

1. EXECUTIVE SUMMARY

1.1 The continued uncertainty around the future of Charing Cross Hospital has been raised repeatedly by residents to Healthwatch Central West London. Discussions about future models of healthcare and what this means for Charing Cross Hospital have been dominant in the Borough of Hammersmith and Fulham and more widely for many years both on the ground and on a strategic level.

1.2 This report provides patient views on the future of Charing Cross Hospital and their experiences of using the hospital. We heard very strongly that residents want to be at the heart of the way health and care services are being shaped and delivered.

1.3 Healthwatch CWL carried out specific work around Charing Cross during October and November 2017 that included:

- Submission of questions to Hammersmith & Fulham Clinical Commissioning Group; Imperial College Healthcare NHS Trust; and North West London Collaboration of Clinical Commissioning Groups. A joint response to these questions was received on 9th November 2017.
- Outreach survey work to collect outpatients' experiences of using Charing Cross Hospital and their views on its future. In total, 218 surveys were collected over four full days, morning and afternoons: Friday 17th, Tuesday 21st, Wednesday 22nd and Thursday 23rd November 2017.

1.4 The report focuses on analysing the joint response from Imperial College Healthcare NHS Trust (ICHT) and North West London Collaboration of Clinical Commissioning Groups (CCGs), and the survey responses. The report aims to:

- Build a comprehensive picture of the current situation at Charing Cross Hospital, captured within the timeframes that our project work took place.

- Provide patients' views and experiences for key decision makers, responsible bodies, as well as residents and groups to inform their position and future actions.

1.5 Main themes explored are:

• Patient involvement in the future provision of Charing Cross Hospital.
• Patient experience of the hospital in terms of:
  a) treatment,
  b) communications with staff,
  c) waiting times, and
  d) travel distance.

• Evaluating the importance of Charing Cross Hospital for patients.
• Exploring patients' perceptions of ‘local hospital’ definition.
• Testing patient preference of using ‘out of hospital’ services.

2. RECOMMENDATIONS

2.1 To ensure that everyone who values Charing Cross Hospital as an important part of their community, or who has used, or may use, it in the future is able to have their say on its future, we recommend that:

A clear and robust communications and engagement strategy should be developed and implemented. This should clearly set out:

- The process by which decisions about the future of Charing Cross Hospital will be made;
- How this will be communicated to local people and others that use the hospital;
- How local people and others who use the hospital will be involved in the decision-making process;

- Clear routes for patients to have their say; and
- A timeframe for engagement.

2.2 That North West London Collaborative CCGs, Imperial College Healthcare NHS Trust and Hammersmith and Fulham CCG, should provide clear information about how, and by whom, decisions about the future of Charing Cross Hospital will be made; and who is responsible for local communication and engagement on its future.

3. CONCLUSION

3.1 The report provides a picture of the experiences of patients using Charing Cross Hospital and their views on its future.

3.2 Patients told us very clearly that Charing Cross Hospital is an important part of their local community and for some, it brought back memories of previous visits to the hospital for them and family members. We heard that patients want opportunities to be involved in shaping the future of Charing Cross Hospital and that they need more information so that they can understand plans for future service provision.

3.3 The report also takes into account the position of the North West London Collaborative CCGs, Hammersmith and Fulham CCG and Imperial College Healthcare Trust and we have included their position on patient information and involvement as outlined in their joint response to the questions we asked them.

3.4 We believe that this report provides stakeholders with an opportunity to look at how they are communicating with local people and others who use Charing Cross Hospital and to plan how they will involve people in any decisions that are made about the hospital's future.

3.5 Charing Cross Hospital is a very important part of the community for local people and others who use the hospital. They value the continuity of care that they have received from the hospital at different stages in their lives, recalling memories of significant moments when they were patients.

3.6 Local people and others who use the hospital are concerned about its future and want opportunities to be involved in decision making process.
responsible for local communication and engagement on its future.

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

None.

LIST OF APPENDICES:

Appendix 1 - Healthwatch Central West London: The Future of Charing Cross Hospital, Draft report January 2018

Healthwatch Central West London

The future of Charing Cross Hospital

January 2018

Contents

1. Introduction

The continued uncertainty around the future of Charing Cross Hospital has been raised repeatedly by residents to Healthwatch Central West London.

Discussions about future models of healthcare and what this means for Charing Cross Hospital have been dominant in the Borough of Hammersmith and Fulham and more widely for many years both on the ground and on a strategic level.

This report provides patient views on the future of Charing Cross Hospital and their experiences of using the hospital. We heard very strongly that residents want to be at the heart of the way health and care services are being shaped and delivered.

It is not the purpose of this report to either record or analyse the history of this debate, nor to explore its socio-political manifestations and implications but we hope that our findings will be used to inform these discussions.

Healthwatch CWL carried out specific work around Charing Cross during October and November 2017 that included:

- Submission of questions to Hammersmith & Fulham Clinical Commissioning Group; Imperial College Healthcare NHS Trust; and North West London Collaboration of Clinical Commissioning Groups. A joint response to these questions was received on 9th November 2017.
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Main themes explored are:

- Patient involvement in the future provision of Charing Cross Hospital.
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    - c) waiting times, and
    - d) travel distance.

- Evaluating the importance of Charing Cross Hospital for patients.
- Exploring patients' perceptions of 'local hospital' definition.
- Testing patient preference of using 'out of hospital' services.

2. Methodology

A key aspect of Healthwatch Central West London's work is to provide information to the public about healthcare and changes in local provision. We also listen to people's experiences of accessing healthcare and whilst doing this we have heard concerns about the future provision of Charing Cross Hospital from residents on a number of different occasions.

To help local people get the answers they need, we put forward questions regarding the future of Charing Cross Hospital to the relevant responsible bodies.

The questions were formulated in collaboration with the Healthwatch Local Committee in Hammersmith and Fulham. Local Committee members submitted their questions by e-mail and in a special meeting held on Friday 4th August 2017. Further changes to questions occurred through e-mail communications in which Healthwatch representatives at Imperial College Healthcare Trust were also included.

The questions covered the following themes:

- Communications and Involvement
- A&E and Wider Services
- Beds, community services and accessibility
- Charing Cross in the national context
- Funding
- Technical infrastructure

The questions were submitted directly in writing to Hammersmith and Fulham Clinical Commissioning Group; Imperial College Healthcare NHS Trust; and North West London Collaboration of Clinical Commissioning Groups on the 5th October 2017. By law organisations who plan, run, and regulate health and social care services must listen to our comments and respond within 20 working days.

On 6th November 2017 we received a joint response addressing most of the questions signed by Imperial College Healthcare Trust and North West London Collaborative of

Clinical Commissioning Groups. We received the outstanding responses on Thursday 9th November 2017[1].

Along with their response, Imperial College Healthcare Trust informed us that it was organising a public event on 27th November 2017 with special focus on Charing Cross Hospital. We believe that this was an immediate outcome of Healthwatch pointing out local concerns and uncertainty of the future of Charing Cross.

Following this, we designed a survey to collect people's experiences of using Charing Cross Hospital and their views on its future[2]. As a main reference point for the design of the survey we used the joint response received. We asked people to complete the survey during outreach at Charing Cross Hospital where we held a stall on the 1st floor for four full days: Friday 17th, Tuesday 21st, Wednesday 22nd and Thursday 23rd November 2017. We collected a total number of 218 responses from outpatients, with an average of 50 each day.

The survey focused on the following themes:

- Identifying patients geographical spread.
- Capturing patient experience of the hospital in terms of
    - a) treatment,
    - b) communications with staff,
    - c) waiting times, and
    - d) travel distance.
- Evaluating whether and why Charing Cross is important for patients.
- Testing patient preference of using "out of hospital" services.

[1] To read the questions and the joint response go to Appendix a, p. 28
[2] To read the survey questionnaire go to Appendix b, p. 48

- Exploring what turning Charing Cross into a “local hospital” means for patients.
- Identifying if patients want opportunities to be involved in shaping the future of the Charing Cross Hospital.

The survey statistics include “no answer” data, as in some cases patients chose not to respond to all the questions. When appropriate, this information has been included in the data, as it helps to build the picture of how patients currently view and experience Charing cross Hospital.

Most of the people we surveyed identified themselves as patients (85.4%), although a small percentage identified themselves as carers (6.85%) and visitors (7.3%). For the purposes of this report, when we refer to patients, we refer to everyone surveyed.

We have also collected demographics and these are available on request.

3. Summary & Key Findings

As outlined in the introduction, this report aims to build a comprehensive picture of the current situation for Charing Cross Hospital that will provide stakeholders with evidence about patients' views and experiences to help them inform their future decisions and actions.

The main findings that this report focuses on analysing in the following chapters are:

- **Patient Involvement:** Patients want more opportunities to be involved in shaping the future of Charing Cross Hospital.
- **Patient Experience of Charing Cross on the Day:** Patients are extremely satisfied overall with their experience, especially in terms of satisfaction of treatment and staff communication.
- **Patient Information:** Patients are confused about the definition of what a ‘local hospital’ might be and want more information to help them inform their position.
- **Patient Perception of Charing Cross:** Patients value Charing Cross Hospital for both its services and its role in the community.
- **Patient Preference on Out of Hospital Services:** Patients would prefer to continue using Charing Cross Hospital instead of their GP practice.

Our analysis also takes into consideration patient flow. It shows, where appropriate and possible, distinctions between all patients, those living in the STP North West London area and Hammersmith and Fulham residents.

When we refer to patients in this report, we are referring to outpatients. We acknowledge in both the introduction and methodology chapters that surveying inpatients or patients waiting for A&E treatment could provide different results.

The main finding of this report is the high number of people indicating that they would like opportunities to be involved in the future of Charing Cross Hospital and what type of provision it might be after 2021.

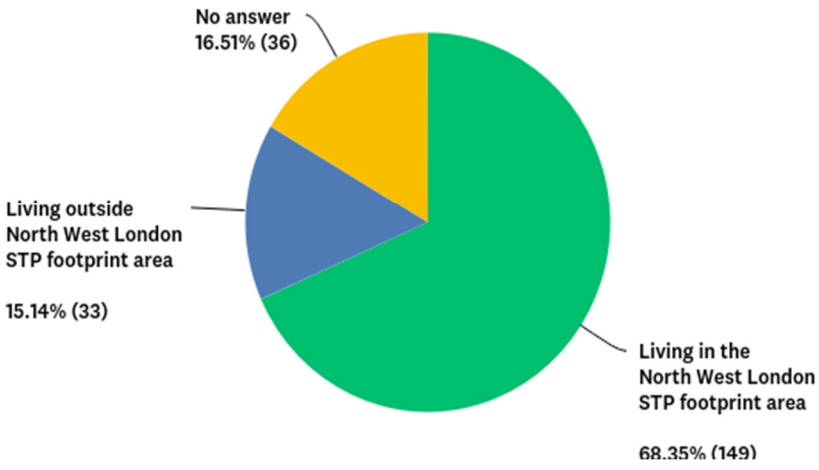
Further findings on a) positive patient experience, b) the importance that Charing Cross Hospital has for patients, c) the need to clarify what is meant by "local hospital", and d) further work on understanding patients' preference for out of hospital services provide useful information that stakeholders can explore to ensure patient involvement can happen at an early stage.

4. Patient Flow

Healthwatch Central West London's role is to capture patient experience of people using services in Royal Borough of Kensington and Chelsea, City of Westminster and Hammersmith and Fulham. This includes all patients that are using health or social care services that are based within these Boroughs, regardless of whether they are local residents.

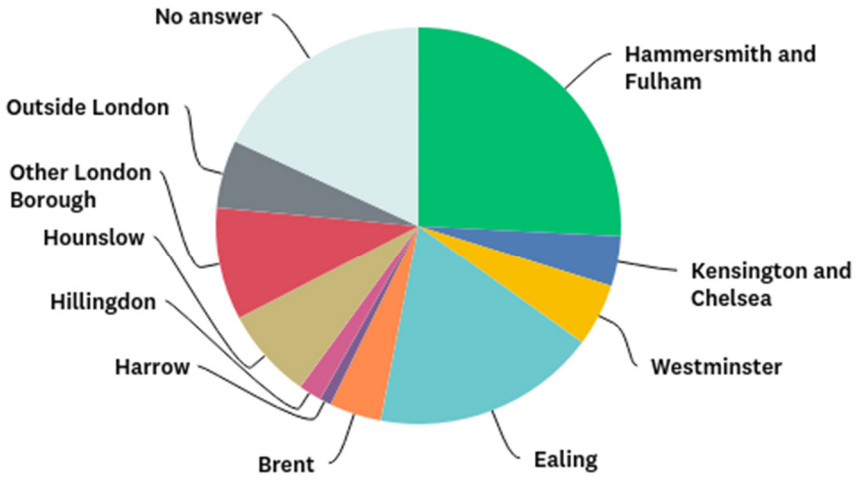
To get a better understanding of who uses Charing Cross Hospital, we asked the patients we spoke to provide us with their home postcode where possible.

As we can see in the pie chart, although most patients lived within the STP North West London area (68.35%), a significant number visiting Charing Cross Hospital on the days we were there, live either in other parts of London or across the country (15.14%).

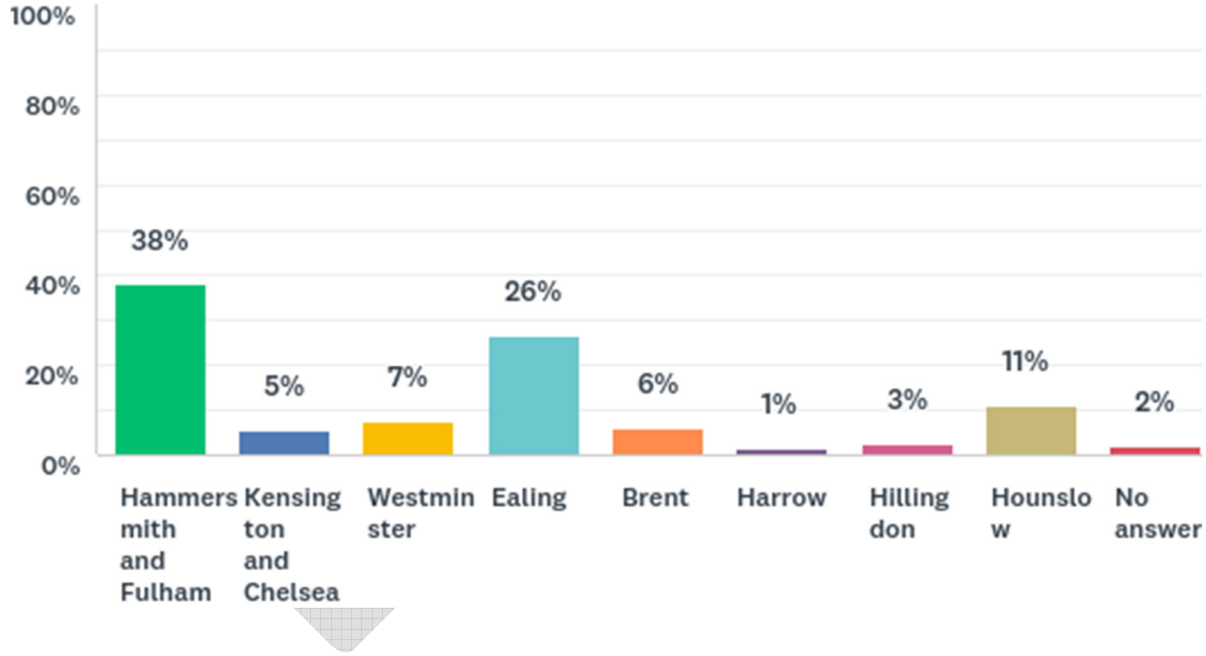


This could indicate that the future of Charing Cross Hospital will be of wider interest than local and North West London stakeholders.

The pie chart below provides a better sense of the geographical distribution of patients.



Breakdown of patient flow from within the North West London STP Area



This diagram, focused on patients from within the North West London STP area, shows that patients came mainly from Hammersmith and Fulham (37%), followed by Ealing (26%) and then Hounslow (11%).

The results of the survey do not change dramatically when we look at patient experience according to a breakdown of areas (Hammersmith & Fulham, North West London STP area and all patients surveyed). However, where appropriate the report breaks our findings down to different areas for comparison.

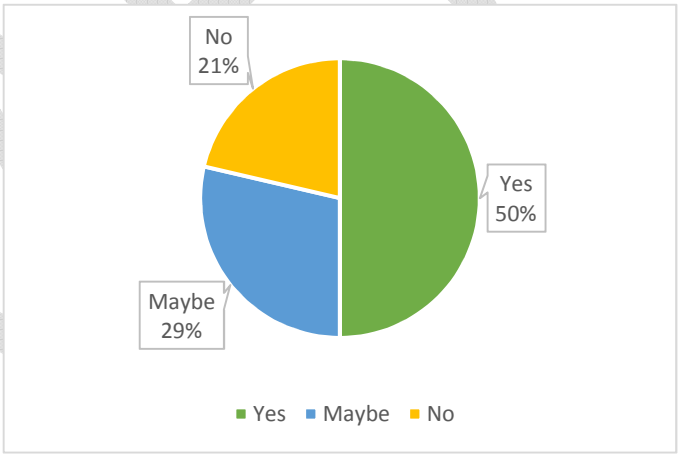
5. Analysis of findings –

a) Patients ask for Involvement

Our survey highlighted Imperial College Healthcare NHS Trust (ICHT)'s position that no changes are going to happen until 2021 and asked patients if they would like to be involved in shaping the future of Charing Cross Hospital. The main finding of this report is that a high number of patients responded yes and requested involvement opportunities[3].

What did patients tell us about involvement in the future of Charing Cross Hospital?

From the 218 people surveyed, of those who answered the question on whether they would like opportunities to be involved in the future of Charing Cross Hospital (206), 50% said they would like opportunities to be involved; 29% said maybe and 21% said no.

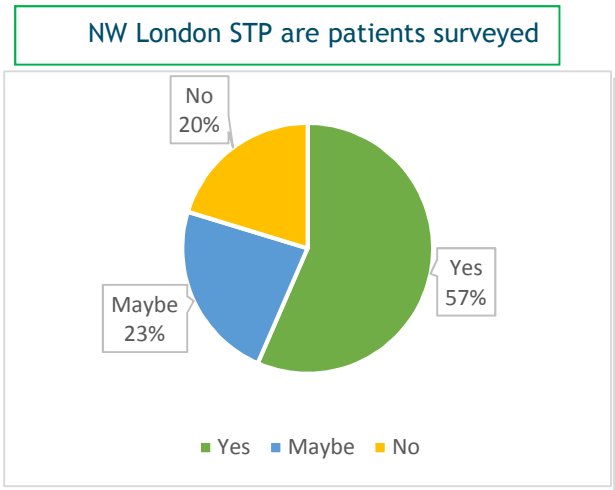


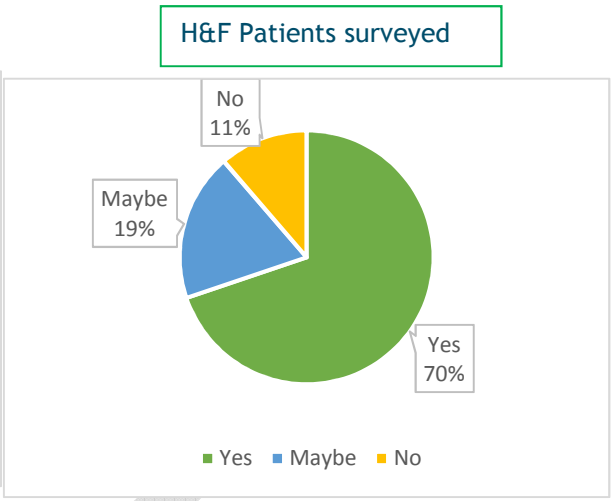
All patients surveyed

The numbers rise slightly when the question is applied to patients living in the STP North West London footprint area; 57% yes, 23% maybe and 20% no.

Looking specifically at the data from Hammersmith & Fulham, the request for involvement rises, with 70 % saying that they would like opportunities to be involved, 19% maybe, and 11% replying no.

[3] Appendix b, Question 8, p. 49





In addition, from the 218 people surveyed, 16% (35) said that they would be happy to be contacted by Healthwatch for a face-to-face or phone interview to talk more about their experiences of Charing Cross and share their views on its future.

What did ICHT and North West London Collaborative tell us about plans for public involvement in the future of Charing Cross Hospital?

In their joint response, ICHT and North West London Collaborative clearly stated that they want to engage and involve patients for future developments. ICHT organised an event on Monday 27th November 2017 to inform patients about their current position on Charing Cross and they said that a series of events will take place in 2018 to mark 200 years since the birth of Charing Cross Hospital.

The joint response emphasised a need for public engagement and referred to the communications and engagement plan that has been put forward by Hammersmith and Fulham CCG (Appendix a., p. 31). However, the response also pointed out that engagement with patients specifically around Charing Cross has been put on hold until plans are unveiled (Appendix a., p. 36).

In addition, Imperial is part of a collaboration of organisations – the Hammersmith and Fulham Integrated Care Partnership – that is working together to develop "a radically better way of providing care for the population of Hammersmith and Fulham through an integrated/accountable care approach" (Appendix a., p. 40). Healthwatch CWL is also represented part of this collaboration. Based on the data gathered through our survey, we suggest that more information is required to ensure that residents can be fully aware of this partnership, how it works and how people can be involved. In addition, patients from different sectors of the community should be invited to participate and help shape this partnership. The results from our outreach should encourage stakeholders to involve patients at this very early stage in the future of Charing Cross Hospital.

The following chapters provide more information on the elements that could be considered in a new patient involvement plan for the future of Charing Cross Hospital.

5. b) Patient Experience

We asked patients to share their experiences of using services in Charing Cross Hospital on the specific day that they visited the Hospital[4].

Patients were invited to tell us how satisfied they were with their experience of using the hospital in four different categories:

- the time they waited to be seen,
- the distance they had to travel to get to the Hospital,
- the treatment they received,
- the communication from staff members.

Most patients said they were "extremely satisfied" with their experience overall. This was followed by high levels of "very satisfied" or "satisfied". Very few people chose "not satisfied" or "not satisfied at all" in all cases.

The patients we met on the days of the survey were at the Hospital to use a variety of different services and specialist support, such as ENT, breast screening, neurology, audio-hearing, attending mainly regular or pre-scheduled appointments with different referrals times, varying from one day to more than 6 months.

Treatment and communication from staff

As is evident from the data shown in the table on the next page, the two areas that scored particularly highly in the "extremely satisfied" option are communication from staff (58%) and treatment received (59.36%).

Nearly 90% of patients said they were satisfied with their treatment and the communication they had with staff; whilst no patient chose the "not satisfied at all" option with regards to their treatment.

The results complement the Care Quality Commission (CQC)'s recent report[5] that found outstanding practices in Charing Cross Hospital: "*Without exception, patients*

[4] Appendix B, Question 4, p. 48

[5] Charing Cross Hospital Quality Report, Date of inspection visit: 7th-9th March 2017, Date of publication: 19/10/2017, p. 4

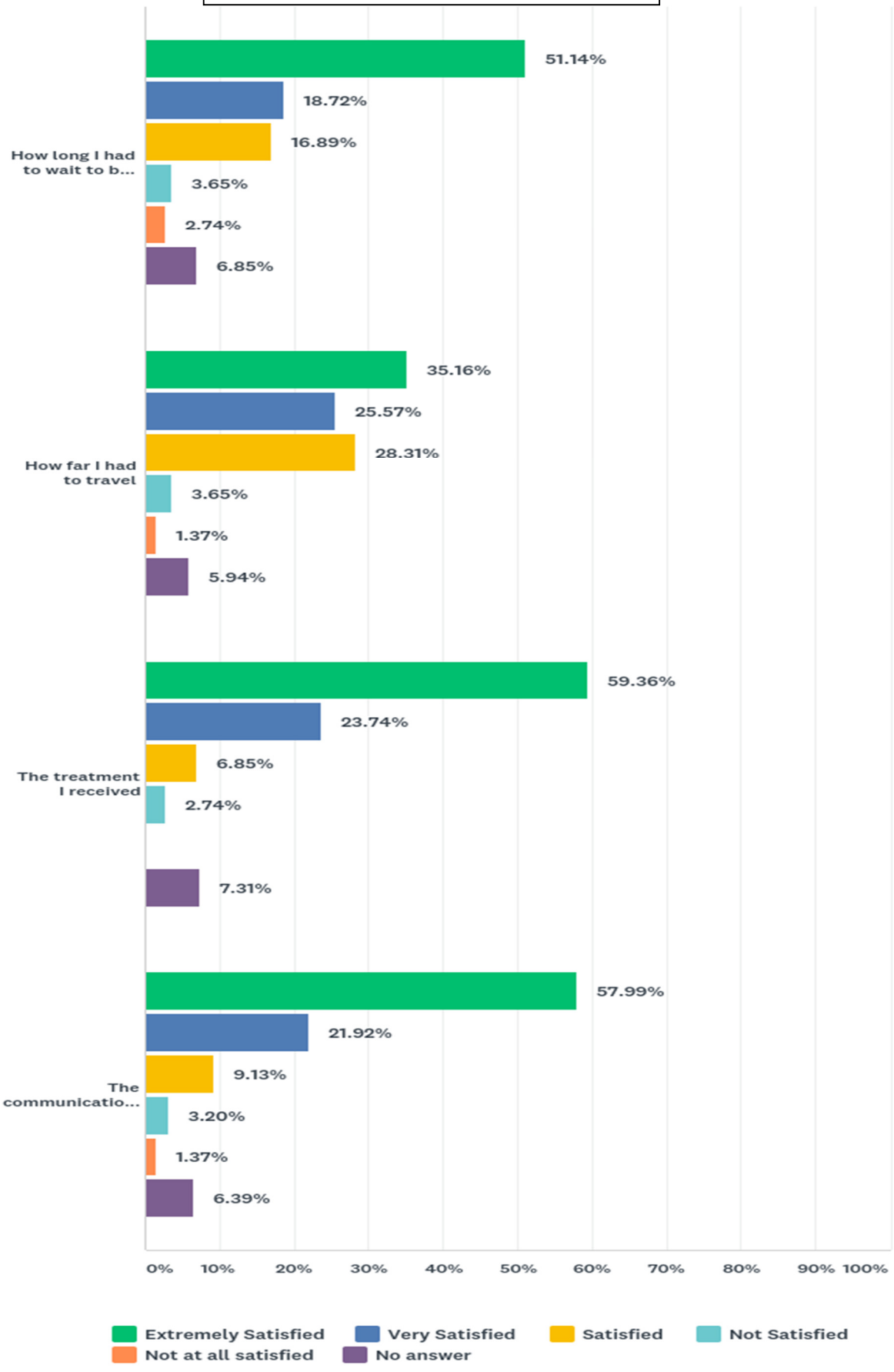
told us they were treated with kindness, dignity, respect and compassion. There was a high standard of care provided for patients on the medical wards, and we saw that staff went to great lengths to respect and accommodate the wishes of patients and their loved ones. There was a strong, caring and visible-centred culture, which was fully rooted on all the medical wards visited".

The quantitative data is complemented by comments made by patients, some of which are listed below.

Comments made by patients on treatment and staff:

- *"Very efficient, friendly staff and was seen immediately even though I was early".*
- *"The staff and doctors are always kind, courteous and helpful. Couldn't ask for more!"*
- *"Friendly, professional, approachable staff".*
- *"The atmosphere at Charing Cross is very nice, comforting".*
- *"The treatment care and expertise I have received through a really difficult time by the Neurology and stroke teams has been excellent".*
- *"The professionalism of the specialist nurse is superb".*
- *"Impressive and consistently high standard, well done Charing Cross".*

How satisfied are you with your visit?



Waiting times

In this report, patient satisfaction about the time waiting to be seen refers to the time from the moment they arrived at the hospital to when they were seen. As shown in the table on page 12, the levels of satisfaction are high, with 75% of patients saying that they were extremely, very or just satisfied. However, as we saw from our question on treatment received, most appointments were regular appointments or pre-scheduled, and this will have a bearing on responses. Further work and analysis on patient referrals could be done by ICHT to look at the waiting times for outpatients.

The only question for which the "extremely satisfied" option scores below 50%, at 35.16%, was about patients' feelings regarding the time they had to travel. Even for this question it was the highest scoring choice. The overall levels of satisfaction reach nearly 90%.

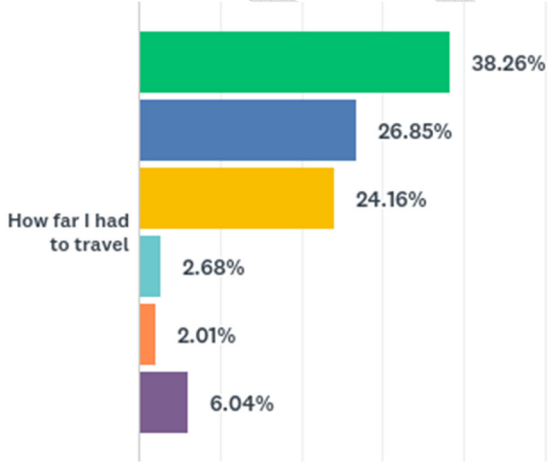
Travel distance

Looking at the data gathered for this question for within the North West London STP area and residents outside that area (other London Boroughs and across the country) separately, there is a slight difference but not as high as might be expected. This may imply that travel distance is not necessarily experienced according to miles, but rather is open to personal interpretation and may also be related to the quality of the experience.

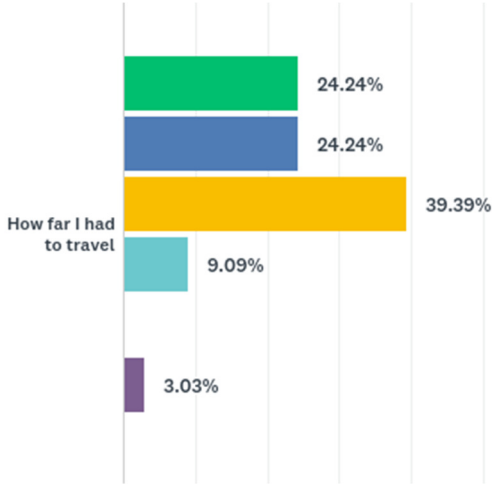
As one patient put it:

- *"It's so good. Oncology. Moved out of London and come 30 miles-that's how important it is".*

NW London STP patients surveyed



Outside NW London STP area, including other London Boroughs and across the country patients surveyed



However, there will always be room for improvement. Despite the high levels of patient satisfaction outlined in this chapter, we identified the following two areas that ICHT could look at more closely.

- **Concerns about levels of cleanliness in the inpatient units**

As we have already highlighted the survey was done with outpatients. However, we received a few comments and concerns from people who were either visiting a family member in the inpatient unit or have recently used the inpatient units about the levels of cleanliness.

- **Lack of appropriate signage for outpatients**

During our outreach, a high number of patients who completed our survey were people who had initially asked us for directions to the Clinic where their appointment was. This was due to a lack of proper signage on the 1st floor for outpatients.

5. c) Importance of Charing Cross Hospitals for Patients

The picture of positive patient experience demonstrated in the previous chapter is complemented by comments received by patients about their general experience of Charing Cross Hospital.

- *"Charing X is one of the best hospitals in the world. Expertise and the care was outstanding. It works to prevent and tackle the illness. Brilliant at coordinating treatment in the hospital"*

Patients were asked[6] to indicate what was important for them about Charing Cross Hospital. The could select as many options as they liked from the following categories:

- A&E Department
- Urgent Care Centre
- Outpatient services
- Impatient Services
- Charing Cross Hospital is an important part of my community
- Charing Cross Hospital is not important to me

[6] Appendix b, Question 6, p. 49

The combination of quantitative and qualitative results from the survey show high appreciation of specialist care, the variety of services offered, and a strong recognition of its importance for the community.

Comments reveal an attachment to Charing Cross Hospital that is based on previous treatment received, the continuity of care, and recalling memories of significant moments in their lives when they were patients.

Below, we have separated some of the comments received into different categories, giving an indication of where the patient lives for each, to build a full picture of Charing Cross Hospital and its importance for patients. It seems to have a historic significance that goes beyond geographical boundaries.

Part of the community and beyond:

- *"CXH is and have always been an important part of the community."* (H&F resident)
- *"I am 76 years old and I have lived in Hammersmith for 45 years. This Hospital has always been very good for me and my husband"* (H&F resident)
- *"Charing Cross not important to me -unthinkable. The spirit of ethos of Charing Cross Hospital was carried to this site by staff from the strand location -always the best."* (H&F resident)
- *"This hospital is very important to my community, Definitely"* (Hounslow resident)
- *"I have been coming to this hospital for many years, it is my hospital."* (H&F resident)

A&E

- *"It is important (vital for my condition) that there are good fast communications between A&E and my hospital consultant. This why I chose to come to A&E here."* (Kingston resident)
- *"Visited A&E and was an in-patient when I had pneumonia. Diagnosis saved my life and have used the resources here a lot!"* (Ealing resident)
- *"I attend regularly to see various consultants and have had bad asthma and lungs, so I need A&E and all the consultants in one Hospital."* (Hounslow resident)
- *"Hammersmith Hospital doesn't have an A&E only UCC but it isn't well equipped for emergencies such as asthma attack. When I had one I was sent to Charing X A&E."* (H&F Resident)

General and specialist services:

- *"I have used this hospital a lot for many services and it's brilliant" (Ealing resident)*

- *"There is a high stand of specialised multidisciplinary care at Charing X" (Hounslow resident)*
- *"My experience is (related) to my mum's treatment for cancer. I think the hospital does a good deal for the patient and its care and the staff and nurses go above and beyond."* (Westminster resident)
- *"Everything is well planned. I feel that everything is focused on me. I feel special!!" (no postcode provided)*

Specialist services such as cancer services, the stroke unit, as well as the A&E department and the value people give to the hospital as an important part of the local community and its historical significance, are key elements of the patient experience that should inform any future changes.

5. d) A Local Hospital?

The plans for Charing Cross to become a local hospital were set out in *Shaping a Healthier Future*[7] service reconfiguration for North West London document which was published in 2012. This document is a key marking point in the debate around Charing Cross Hospital.

Imperial College Healthcare NHS Trust (ICHT) and the North West London Collaborative of CCGs (NW London Collaborative CCGs) have repeatedly said, including in their answers to Healthwatch CWL, that Charing Cross will continue to provide A&E and wider services for at least the lifetime of the Sustainability and Transformation Plan (STP) for North West London[8] which runs until 2021.

STPs are part of governmental plans for changes to the healthcare system; their aim is to change the way healthcare is being designed and delivered, moving from a reactive approach to a more proactive model. They promote a increased focus on prevention and primary care to keep people healthy closer to where they live (i.e. GPs, community services and the voluntary sector) with the aim of reducing pressure on secondary care (i.e. inpatient units at hospitals). Consequently, future changes

[7] Shaping a Healthier Future: https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/Shaping%20a%20Healthier%20Future%20Consultation%20Document%20Updated%20August%202012.pdf

[8] The STPs, part of governmental plans, were published in 2016 aiming to provide a strategic framework of how healthcare is going to be designed across a big geographical area and they are planned to run until 2021. The STP for NW London footprint area: https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/stp_june_submission_draft.pdf

to Charing Cross Hospital's provision will be influenced by the way that the STP is delivered in North West London.

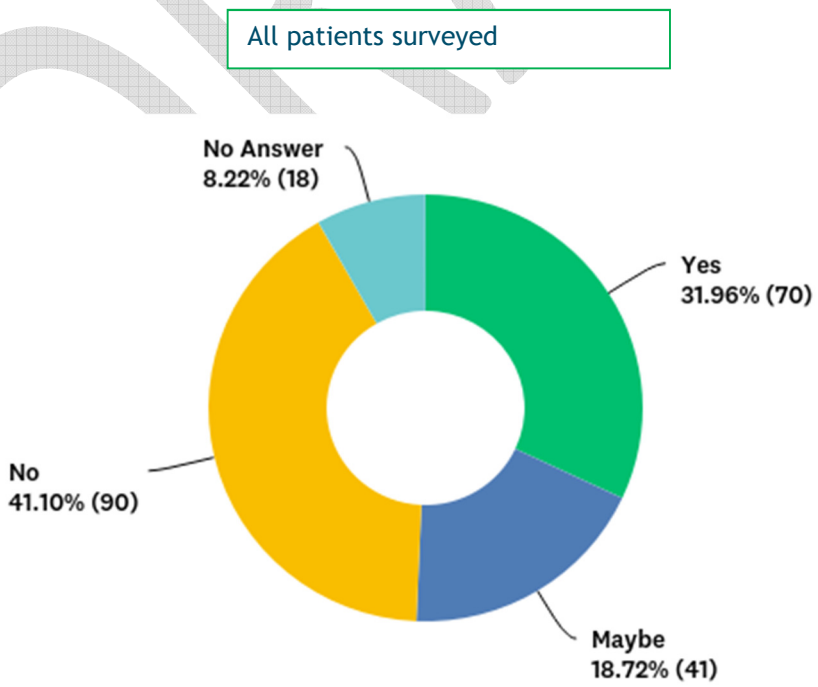
The definition of a "local hospital" which was set out in *Shaping a Healthier Future* (and repeated by ICHT and North West London Collaborative of CCGs in their response to Healtwatch CWL) is as follows:

"A type of hospital that provides all the most common things people need hospitals for, such as less severe injuries and less severe urgent care, nonlife threatening illnesses, care for most long-term conditions such as diabetes and asthma, and diagnostic services. It basically provides the kinds of services that most people going to hospital in NW London currently go there for."

What did patients tell us about turning Charing Cross into a "Local Hospital"?

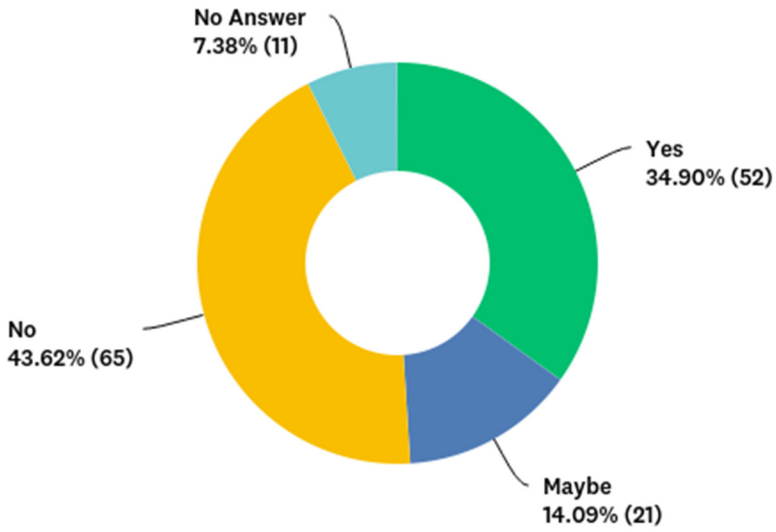
Our survey asked patients if they feel that their health needs and those of others in their local area, will be fully met by Charing Cross becoming a local hospital (after 2021) as described above[9].

As the three pie charts below show, there was no clear consensus about whether people felt that their health needs would be met by Charing Cross becoming a local hospital. When looking at all patients surveyed, **just over 40%** said that their health needs **would not** be met, **just over 30%** said that their health needs **would** be met and nearly 19% saying maybe, while around 8% did not answer this question.

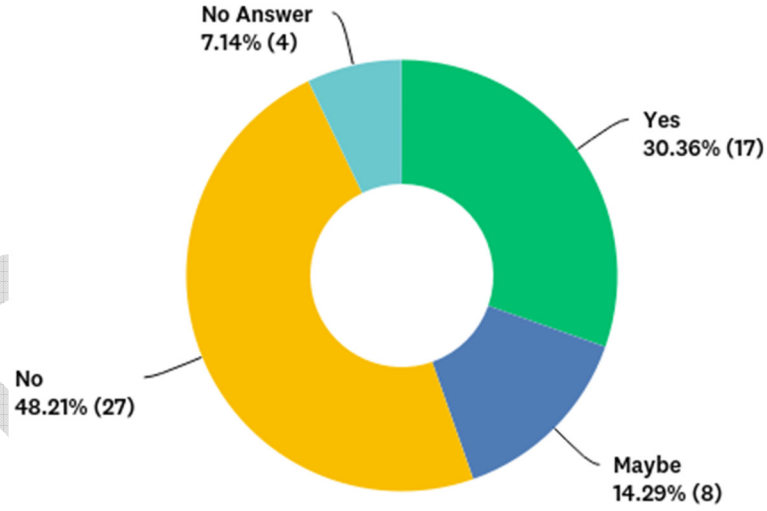


[9] See Appendix b, Survey, Question 7

NW London STP are patients surveyed



H&F Patients surveyed



The number of patients who do not think that their health needs will be fully met by Charing Cross becoming a local hospital gets slightly higher if we look at patients living in the STP North West London area, at just over 43% and slightly higher still when examining the data from Hammersmith and Fulham patients only, at about 48%.

Examining the comments received to this question gives us a fuller picture of the concerns that people have regarding changes to Charing Cross Hospital. Most show that people do not understand what a local hospital means and how this is going to affect the services they currently receive.

- *I do not know, if I don't know what local hospital is.*
- *It is a very vague statement. We need A&E, we need a cardiovascular ward, breast screening. As we live longer and develop more illness in later life we need a hospital to care for us.*
- *They want to change it into a clinic. That's how it sounds. What are they going to do with emergencies?*
- *The explanation is rubbish: not accurate, not informative.*
- *I will decide when plans are ratified. Things will change to meet changing needs and funding.*
- *It's not really clear what local hospital means; could be a bad or good thing.*

There were a number of comments from people that did not support Charing Cross becoming a "Local Hospital", expressing concerns about which services are going to be kept, raising doubts about the need for change and stating that Charing Cross should stay as it is.

- *"Local" suggest routine problems. Most people recognise Charing Cross as a centre of excellence.*
- *It should stay exactly like it is because it is an asset to this neighbourhood and other boroughs.*
- *The history and the medical standards and training at Charing X would not support this.*
- *Very big NO. Keep it like it is and A&E.*
- *Absolute rubbish. They should not be allowed. It is a major hospital for the community. Leave it alone. Disgraceful! I paid for 45 years. It's a government plan to privatize NHS-leave it alone!*

There were a few comments where patients stated that they would support a change under specific circumstances and for different reasons.

- *Yes, As long as they don't turn it into hotels/flats.*
- *Yes, but I have a more local A&E at St Georges.*

The combination of our quantitative and qualitative data indicates that the "local hospital" definition is open to interpretation.

All the comments received in this question can be found at Appendix 3.

What did ICHT and North West London Collaborative tell us about the future of Charing Cross Hospital?

At the ICHT event on Charing Cross on the 27th November 2017 the Trust representatives stated that they did not know what a local hospital is. However, they made it very clear that no changes will happen to the acute and inpatient units of Charing Cross until and unless there is evidence of reduced clinical need[10]. At the time of writing this report it was unclear what this evidence would include.

With 2021 only four years away, patients are confused as to **why** these changes are taking place and **what** is going to change exactly. This reflects gaps identified in the joint response[11] we received by Imperial and North West London Collaborative. Although the aim of making changes to future provision of Charing Cross has been set, a series of steps towards its implementation are yet to be taken. These include:

- **The Outline Business Case and Financial Business Care**. As stated in the response: *"As we progress from the SOC (Strategic Outline Case) to Outline Business Case and Financial Business Case, all details will be refined including the equality impacts and the actions required to mitigate these. Full equality impact assessments will be undertaken in line with best practice for all relevant programmes and projects as part of their development"* (Appendix a. p. 30).
- **Engagement work with residents.** As stated in the response: *"The subsequent work to engage patients and the public in the development of detailed plans for Charing Cross Hospital was paused as increasing demand for acute hospital services highlighted the need to focus first on the development of new models of care to help people stay healthy and avoid unnecessary and lengthy inpatient admissions. Our approach of actively not progressing plans to reduce acute capacity at Charing Cross Hospital unless and until we could achieve a reduction in acute demand was formalised in the North West London STP published in 2016. The plan made a firm commitment that Charing Cross Hospital will continue to provide its current A&E for at least the lifetime of the plan, which runs until April 2021. We also made the commitment to work jointly with staff, communities and councils on the design and implementation of new models of care. At this stage, therefore, before the engagement process with the residents of Hammersmith & Fulham, it is too early to specify the details of services Charing Cross Hospital would offer in the future."* (Appendix a. p. 36)
- **Staffing.** As stated in the response: *"Nothing has been 'set in stone' with regard to overall staff levels across the five years of the STP. Any changes in*

[10] The presentation and a video from the event can be seen here: https://www.imperial.nhs.uk/about-us/events/charing-cross-hospital-open-door-event
[11] See Appendix a, p. 28

workforce will be part of the detailed service plans that are developed at a local level". (Appendix a. p. 44)

- **Out-of hospital provision and reduction of demand on hospital services.** The joint response says that nationally there is evidence that supports the case for reduction in demand on hospital services through out of hospital provision. However, it states that: *"Locally, we have yet to secure the capital required for the majority of the hub developments. Of the hubs which we have developed the evidence is just emerging. We are in the process of compiling this and anticipate having this available later this year. We have a full strategy for this work".* (Appendix a. p. 35)

The lack of documentation along with the results of the survey and the comments people made about the lack of information provided to them raise inevitably questions regarding the future of Charing Cross provision, as the pieces that could reveal how it could look like after 2021 in the "Local Hospital" puzzle have not been revealed yet.

5. e) Testing Preference of out of hospital services

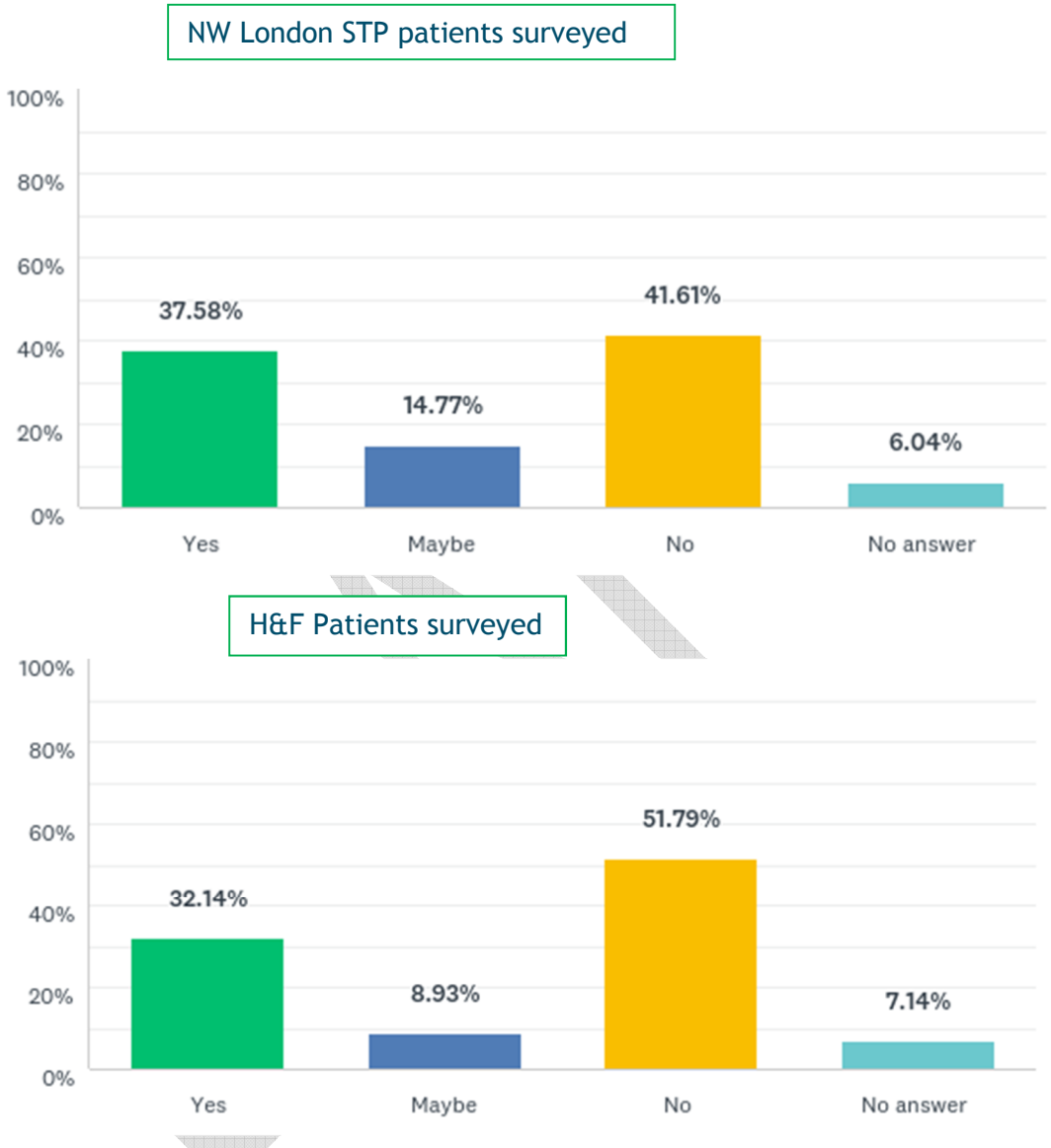
It is clear from the joint response and Imperial College Healthcare NHS Trust (ICHT) position at the event on the 27th November 2017 that no changes will be made to Charing Cross Hospital unless and until clinical need is reduced. A key component to this, as we saw at the end of the previous chapter, will be the evaluation of the out of hospital services. At the time of writing this report, there is no local evidence that the out of hospital services are decreasing hospital demand.

Taking into consideration the importance of out of hospital services for the future provision of healthcare and the implications this might have for Charing Cross Hospital, we thought it would be useful to test people's preferences. To get an understanding of how people feel about of hospital services, we asked patients if they would be happy to receive the service they used at Charing Cross Hospital at a different setting close to their home, for example at their GP surgery[12].

As shown in the following two diagrams, a slightly higher number of patients from the North West London STP area would prefer to continue receiving treatment at Charing Cross Hospital than would be happy to receive treatment somewhere else,

[12] See Appendix b, Survey, Question 5, p. 48

with 41.6% choosing “no” and just over 37% choosing “yes”. A greater number of patients from Hammersmith and Fulham would prefer to continue receiving treatment at Charing Cross Hospital than to receive treatment in a setting closer to their home, with just over half choosing “no” as a response and about 32% choosing “yes”.



The results are similar to the ones discussed in the previous chapter, with patients’ answers indicating mixed feelings regarding a transfer of services from hospital to their GP surgery.

The people that supported delivery of the service they used at Charing Cross Hospital in primary care, stated travel distance as main reason. However, a lot of people stated that Charing Cross is close to them.

- *If the service would be closer to home, I would prefer it*
- *I live nearby the hospital. The hospital staff had always been a great help.*

For those that would not support it, the main reasons stated are:

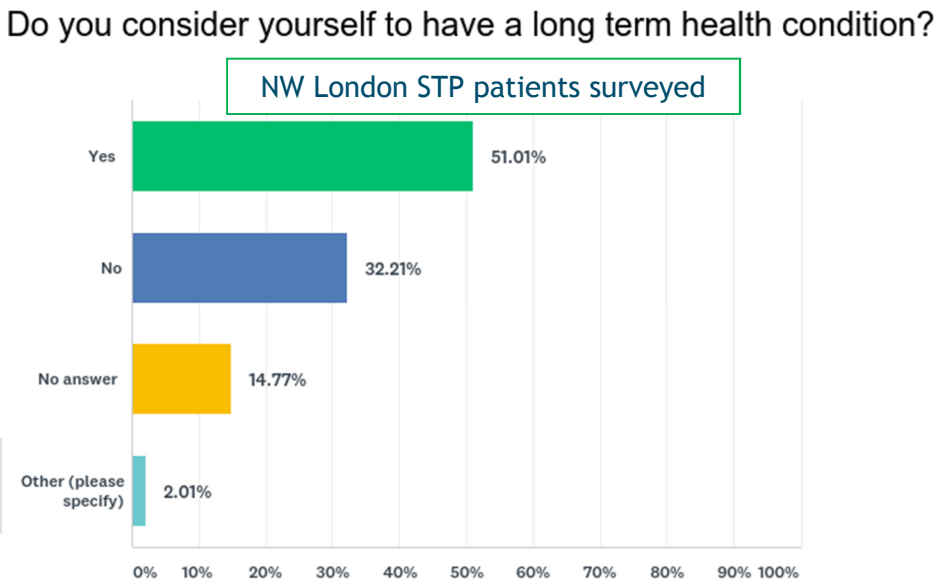
- the lack of expertise at GP surgeries.
- lack of equipment at GP surgeries.
- GPs are already overcrowded.
- The value of specialists at Charing Cross Hospital
- The relationship built with staff over their time of care and treatment.

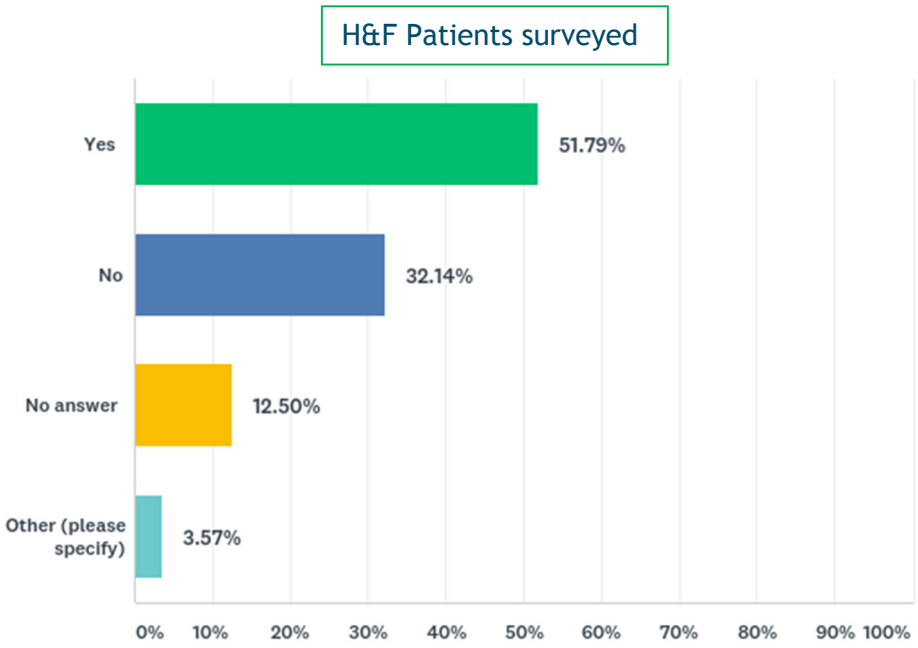
This is shown by the comments below:

- *Hermodialysis is very specialised and must be done in hospital setting*
- *I have confidence in the multidisciplinary offer at Charing Cross and I am under the rheumatology department.*
- *GP not specialist*
- *I prefer to visit Charing X, as I feel safe that the treatment I will get will be the best.*
- *Impossible for GP services, which I use and value to equal London teaching hospital standards.*
- *GP does not provide the same service a hospital can provide. For example dealing with emergencies.*
- *As long as people are qualified.*
- *I would rather have it here because I like the hospital.*
- *I have faith in CCH. They saved my life 9 years ago and have looked after me extremely well since then.*
- *I prefer to have it here because they are more efficient and they know what they are doing*
- *Charing Cross hospital is my hospital. I am happy coming here.*
- *The choice is not mine. I am here for breast cancer yearly check up.*
- *Can I pick up hearing aids batteries at my GP? I don't know*
- *I think the complexity of my case means hospital setting needed.*
- *Treatment is specialised. The GP is over subscribed and although uncertain I am sure the hospital is the best choice.*
- *Don't believe the GP could provide that level of service*
- *It makes sense to separate GP clinics from hospitals. Providing citizens with options is a sign of civilisation. GPs often get it wrong.*

- *The hospital is actually closer to my home than my GP Practice. Also, I am more comfortable in a hospital setting, more expertise etc.*
- *Hospital services are more specialized and staff have more experience of range issues as they see more patients.*

For further analysis, the above results could be looked alongside the tables below that indicate that the majority of patients surveyed identified themselves as having a long term health condition. As we saw at chapter 5.b on patient experience, patients were at Charing Cross Hospital to use a variety of different services. We asked patients to tell us about their preference of using out of hospital services based on the service the visited the hospital on the day of the survey. However, we are unable to tell if they were thinking of support and treatment needed for their long term health condition or the specific service they used on the day we met them when answering the survey.





Current and future plans for healthcare changes could benefit by looking more closely into patient's sentiments of out-of-hospital services to inform future work.

Conclusion and Recommendations

This report provides a picture of the experiences of patients using Charing Cross Hospital and their views on its future.

Patients told us very clearly that Charing Cross Hospital is an important part of their local community and for some, it brought back memories of previous visits to the hospital for them and family members. We heard that patients want opportunities to be involved in shaping the future of Charing Cross Hospital and that they need more information so that they can understand plans for future service provision.

The report also takes into account the position of the North West London Collaborative CCGs, Hammersmith and Fulham CCG and Imperial College Healthcare Trust and we have included their position on patient information and involvement as outlined in their joint response to the questions we asked them.

We believe that this report provides stakeholders with an opportunity to look at how they are communicating with local people and others who use Charing Cross Hospital and to plan how they will involve people in any decisions that are made about the hospital's future.

Conclusion

Charing Cross Hospital is very important part of the community for local people and others who use the hospital. They value the continuity of care that they have

received from the hospital at different stages in their lives, recalling memories of significant moments when they were patients.

Local people and others who use the hospital are concerned about its future and want opportunities to be involved in decision making process.

Recommendations

To ensure that everyone who values Charing Cross Hospital as an important part of their community, or who has used, or may use, it in the future is able to have their say on its future, we recommend that:

1. A clear and robust communications and engagement strategy should be developed and implemented. This should clearly set out:
    - The process by which decisions about the future of Charing Cross Hospital will be made
    - How this will be communicated to local people and others that use the hospital
    - How local people and others who use the hospital will be involved in the decision-making process
    - Clear routes for patients to have their say
    - A timeframe for engagement.

At the time of writing this report, changes are taking place in the governance structure across the North West London STP area. Some decisions about local health provision that will be implemented by Hammersmith and Fulham CCG are now taken by North West London Collaborative CCGs[13]. Healthwatch CWL has raised concerns and questions regarding the new governance structures and routes of accountability for local people with regards to decisions made at NW London Collaborative CCG level[14]. The lack of clarity about decision making structures and lines of responsibility and accountability adds to the confusion surrounding the future of Charing Cross Hospital.

Therefore, our second recommendation is:

2. North West London Collaborative CCGs, Imperial College Healthcare NHS Trust and Hammersmith and Fulham CCG should provide clear information about how and by whom decisions about the future of Charing Cross Hospital will be made and who is responsible for local communication and engagement on its future.

[13] North West London CCGs' Governing Body Paper: Developing further collaborative working across North West London CCGs: http://www.hammersmithfulhamccg.nhs.uk/media/116666/GB-26-Sept-North-West-London-Draft-Governing-Body-Paper-FINAL_v2.pdf

[14] Visit our website for our questions: https://healthwatchcwl.co.uk/

7. Appendices

Appendix a

The joint response signed by Imperial College Healthcare Trust and North West London Collaborative of Clinical Commissioning Groups to Healthwatch Central West London questions.

Dear Olivia

Thank you for your letter setting out a range of questions around the future of Charing Cross Hospital.

Before we get to the questions themselves, we think it useful to note the overall aim of the work we are doing here in Hammersmith & Fulham and across North West London. We want to flip the model of care from a reactive one, where we wait for people to get sick and then attend A&E, to a proactive one, which focuses on keeping people well and out of hospital, providing care in settings much closer to home wherever possible.

The *Shaping a healthier future* service reconfiguration for north west London, and the Trust's clinical strategy, set out plans for Charing Cross to evolve to become a new type of local hospital, offering a wide range of specialist, same-day, planned care, as well as integrated care and rehabilitation services, particularly for older people and those with long-term conditions. It would retain a 24/7 A&E appropriate to a local hospital.

However, we have been clear that we will not reduce acute capacity at the hospital, including within its A&E, unless and until we can achieve a sufficient reduction in acute demand. The Sustainability and Transformation Plan published in 2016 made a firm commitment that Charing Cross will continue to provide its current A&E and wider services for ***at least*** the lifetime of the plan, which runs until April 2021.

We have also made the commitment to engage with our local community, including with Healthwatch, as we start to develop the detail around the plans at Charing Cross. Your involvement in that process is essential and we look forward to continuing to work with you.

It's also worth highlighting that you raise a number of questions around the use of digital services within healthcare. Most people use health services in a local community setting where there has already been significant developments in the use of digital technology to improve patient benefits. Through the 'Care Information Exchange' Imperial College Healthcare is also leading a major initiative to build an online care record for patients and those providing their care across North West London.

Turning then to the questions themselves, please find detailed answers set out on the following pages. If you would like any further detail please let us know.

Clare Parker, Chief Officer – CWHHE, SRO – Shaping a Healthier Future

Ian Dalton CBE, Chief Executive, Imperial College Healthcare NHS Trust

A) COMMUNICATIONS AND INVOLVEMENT

Q1) What negative impacts for patients have been captured as part of your planning for this major change for example during an options appraisals?

A) The Strategic Outline Case (SOC) as the enabler for the North West London Sustainability and Transformation Plan (STP) offers an excellent opportunity to further address health inequalities and ensure a positive impact of any proposed service changes for our protected groups. We have a thorough understanding of the demographics and particular health challenges of our residents to support our inequalities work, and are of course working closely with our local authority colleagues to share and update our knowledge of specific groups and any emerging issues.

To date two Equality Impact Reviews have been completed. The first was undertaken when the Shaping a Healthier Future (SaHF) strategy was produced. This included, based on the available evidence to date, how the SaHF programme meets with the aims of the Public Sector Equality Duty.

The second was an STP-wide health inequalities impact screening analysis, which provides a framework for the detailed equalities impact assessments likely to be needed. This approach is in line with other STP regions.

The Equality Impact Reviews identify potential adverse impacts. These are all stated within the documents attached with indications of how these are or will be addressed. As we progress from the SOC to Outline Business Case and Financial Business Case, all details will be refined including the equality impacts and the actions required to mitigate these.

Full equality impact assessments will be undertaken in line with best practice for all relevant programmes and projects as part of their development.

It's also worth making the point here that there have been some really positive steps forward in the way we have transformed care across NW London as a part of the SaHF and STP plans – for example the maternity and paediatric transitions which have taken place have seen real benefits to our patients and residents. We continue to monitor and evaluate both of these transformations to ensure they remain successful. We are committed to ensuring that all service developments have effective and thorough monitoring and evaluation going forward.

Q2) Do you have evidence to demonstrate that patients and communities can be assured that possible negative impacts from future changes will be mitigated? If yes, please provide a copy of your evidence. If not, please provide us with information regarding how you are going to test and measure possible negative impacts.

A) As set out in the previous answer we have conducted Equality Impact Reviews which are available online at:

SaHF EIA
https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/Equalities%20Impact%20-%20Strategic%20Review%20%20vf.pdf

STP EIA
https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/stp_equality_impact_analysis_april_2017.pdf

Q3) What steps have you taken to communicate with the local population, your plans for Charing Cross hospital in a clear, accessible and easy to understand manner and how are you monitoring the progress? Please provide a breakdown of steps and monitoring mechanisms.

A) As indicated above, we have been very explicit about the fact that no major changes will take place at Charing Cross during the lifetime of the STP. This is a commitment that has been made publically and has not changed. At the 'town hall' style meeting held in October 2016, the CCG also committed to improving engagement with local residents more generally. To this end the CCG approved a new communications and engagement strategy at its meeting in September which sets out very clear objectives for future engagement with local people.

Additionally, the Trust uses its website and social media channels (eg Facebook and Twitter) to communicate with audiences about developments and issues regarding Charing Cross Hospital. We also use the Trust's electronic newsletters which are tailored to specific audiences: stakeholders; GPs; and patients and the public. Commissioners use the Healthier NW London website as well as the CCG twitter feeds to help keep people updated.

The Trust chief executive has regular meetings with local MPs and with Hammersmith & Fulham Council's Cabinet Member for Health and Health Scrutiny Committee Chair. The Trust chief executive also meets formally with representatives of the Save our Hospitals group. Similarly, senior officers from both Hammersmith & Fulham CCG and NW London routinely meet with the local MP, councillors and representatives from patients' groups to talk through our plans.

In addition, the Trust is planning a public event at Charing Cross Hospital at the end of November 2017 to set out the current position on Charing Cross and to share updates on recent and planned investments.

Q4) Will you be able to produce a briefing, for wide circulation, that explains what your plans are and what they mean for local people? The briefing should refer to policies from different documents to inform local people, but also provide them with the opportunity to track down the progress you are making moving forward.

A) We are happy to discuss an update which brings together all the plans (SaHF, Trust strategies and plans, STP etc) and explains where we are and the current position on Charing Cross. We would welcome involvement from Healthwatch in developing that update to ensure we make it as user friendly as possible for local people.

We will produce a concise briefing on the current position on Charing Cross and its future as part of the Trust's public event at Charing Cross being planned for November 2017.

Again, we also make the point that major change at Charing Cross is not planned until there has been sufficient reduction in acute demand, which will not be within the lifetime of the STP, that is not before April 2021. Any proposed changes will also include equalities impact assessments and opportunities for local people to be informed and involved.

Q5) How are you going to involve members of the public, as well as health professionals in the development of the plans for Charing Cross hospital? Healthwatch Central West London would like to be fully involved in the planning and consultation process and work with the Trust to ensure that any changes result in an enhanced level of healthcare provision for the local population.

A) As our plans for Charing Cross progress, we have been clear that we are committed to involving patients and the public in their development. We envisage that Healthwatch, as well as our own lay partners, will be integral to that process.

B) A&E AND WIDER SERVICES

Q1) What is the evidence that suggests that Charing Cross should become a local hospital and what is the definition of a local hospital? Please provide us with any supporting documents.

A) The case for Charing Cross to become a local hospital was set out in the SaHF consultation document. We believe that this will help us deliver services which are right for the people of Hammersmith & Fulham, matching their needs.

The consultation document (August 2012) for the plans to improve local NHS services in North West London as part of the SaHF programme, identified eight different settings for care. Section 10 of the consultation described a 'Local hospital' as follows:

"Local hospital – this type of hospital provides all the most common things people need hospitals for, such as less severe injuries and less severe urgent care, nonlife threatening illnesses, care for most long-term conditions such as diabetes and asthma, and diagnostic services. It basically provides the kinds of services that most people going to hospital in NW London currently go there for."

There is also further reference to this case within the SOC – Part 1. The strategic case in the SOC sets out a list of factors which point in the same direction:

1. Our current system is unsustainable. We cannot achieve our vision without major changes to how we deliver care, given the population health trends, coupled with

our current model of care and health infrastructure. This is therefore an opportunity for us to do something different and better for our residents.

2. We have a strategy to meet our residents clinical and social care needs in the right place at the right time. We will reconfigure health services so they are: localised where possible; centralised where necessary and in all settings integrated across health and social care providers to improve patient care.
3. We are confident that based on our experience of successfully delivering change and identified opportunities; our new model of care will address the key issues. Our strategy is to focus resources to keeping the population well through management of long term conditions, rapid access and treatment via local services with high quality acute specialist care when it matters most. This will achieve financial and clinical effectiveness.
4. Our new model of care requires major changes. Our SaHF proposals deliver much of this vision. Approved by the Secretary of State in 2013, SaHF is an inter-connected model of care which:
    - Retains activity in the community, enabled by out of hospital hubs where services are co-located and primary care is delivered at scale
    - Reconfigures our acute services to deliver high quality care and provide clinical and financial sustainability. This is principally achieved by concentrating valuable clinical capability across fewer sites

It is also important to recognise that in Hammersmith & Fulham, as well as across North West London as a whole, we face the following major challenges:

- An ageing population with increasingly complex and resource intensive health needs, with an increase in the overall population.

- Over 30 per cent of inpatient beds in acute hospitals are occupied by patients whose care would be better provided elsewhere in their own home or community. Clinical audits regularly show that over 30 per cent of patients in an acute hospital bed do not need acute care.[15] It is best for patients if they are able to return home at the optimal time for them, to be subsequently cared for in the most appropriate setting, preferably their own homes.

- Unacceptable variation in the quality and delivery of all services. There are variations in the quality of care and the proportion of patients who need to be readmitted after receiving a number of procedures varies considerably from one hospital to another. Senior doctors' availability in acute medicine and emergency general surgery at the weekends is more than halved at many sites compared to cover during the week.

- A reactive health service where resources are still focused on getting patients better rather than keeping people well to start with.

- Workforce capacity with shortages in supply expected in many professions and expected increases in demand, combined with the need for a skilled workforce to

[15] NW London Sustainability and Transformation Plan v01 21 October 2016.

deliver a 7-day service under the current model across multiple sites. The lack of skilled workforce to deliver a seven-day service under the current model across multiple sites is an issue in North West London. Workforce shortages are expected in many professions under current supply assumptions and expected increases in demand making the provision of services more fragile.

- We have more A&E departments per head of population than other parts of the country and insufficient capacity to meet demand as senior staff and resources are spread too thinly across multiple sites.[16]

- Poor quality estate in our hospitals and primary care which is increasingly costly to maintain, does not meet modern standards and is not fit for purpose for delivery of care. NW London has more poor quality estate and a higher level of backlog maintenance across its hospital and primary care sites than any other sector in London. For example, a detailed survey and compliance audit (called a six-facet survey) undertaken in 2015, suggested total investment / project costs of £1.3 billion to bring all the Imperial College Helathcare Trust estate to an acceptable condition (Source: Imperial College Healthcare NHS Trust Annual Report 2016/17, p49)

- Too many small hospitals resulting in a compromise of clinical productivity for the residents of North West London, with valuable clinical resources being spread too thinly and the inability to drive high quality specialist care which can be achieved by concentrating care into fewer large hospitals:

    - The total population in North West London is 2,086,000 as of 2015/16.[17] With a growing population in North West London it is increasingly hard to provide a broad range of appropriate specialist services at the existing nine acute hospital sites to the standards our patients expect and deserve.

    - This is because specialist teams gain skills as a result of the numbers of people they diagnose and treat. There is evidence that the more specialised doctors and other professional staff become, the better the results for patients.[18] If treated by a specialist, patients are at a lower risk of death, are likely to have fewer complications and are likely to benefit from shorter stays in hospital.[19]

    - Units therefore need to serve a sufficiently large population so they are busy enough for clinical staff in a variety of specialities and subspecialties to maintain their clinical skills for the best outcomes for patients.

[16] "Delivering High-quality Surgical Services for the Future", a consultation document from the Royal College of Surgeons reconfiguration working party, March 2006.
[17] Office for National Statistics (ONS) population estimates.
[18] Hall, Hsiao, Majercik, Hirbe, Hamilton, The impact of Surgeon Specialization on Patient Mortality; Annals of Surgery 2000.
[19] Chowdhury, Dagash, Pierro. A systematic review of the impact of volume of surgery and specialisation on patient outcome; British Journal of Surgery, 2007.

- For example, guidance from the Royal College of Surgeons[20] recommends that for emergency surgery to be of high quality, activity from a population of 500,000 needs to be undertaken on one site. Even with the current configuration of A&E services nationally, the seven A&E departments in North West London hospitals each have a catchment population smaller than average.

- And clinical evidence has highlighted that for emergency care services, early involvement of senior medical personnel in the assessment and subsequent management of many acutely ill patients improves outcomes.

- It is known that in North West London, our hospitals are only sometimes meeting the seven-day services standards guidelines of emergency general surgery admissions seeing a consultant within 14 hours.

Q2) What evidence is there that GP hubs and other out-of-hospital provision are reducing demand on hospital services?

A) There is national evidence from the work being undertaken by Vanguards which supports the case for reduction in demand. I attach an NHS presentation from the national new models of care team which is presenting early evaluation of vanguards. Slide 5 quotes 30% reduction in NEL admissions. Locally, we have yet to secure the capital required for the majority of the hub developments. Of the hubs which we have developed the evidence is just emerging. We are in the process of compiling this and anticipate having this available later this year. We have a full strategy for this work in enclosed in these two documents.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Q3) "No reduction of A&E and wider services" – this term has been used in the Trust's responses to concerns regarding a closure plan for Charing Cross Hospital. Please provide a breakdown of all services with clarification what is included and what is not in "wider services".

A) Charing Cross Hospital provides a range of acute and specialist care services, it also hosts the hyper acute stroke unit for the North West London region and is a growing hub for integrated care in partnership with local GPs and community providers. Information on all the services at Charing Cross Hospital is provided on the Trust website.

Our approach of actively not progressing plans to reduce acute capacity at Charing Cross Hospital unless and until we could achieve a reduction in acute demand was formalised in the North West London STP published in 2016. The plan made a firm commitment that Charing Cross Hospital will continue to provide its current A&E for at least the lifetime of

[20] "Delivering High-quality Surgical Services for the Future", Royal College of Surgeons, March 2007.

the plan, which runs until April 2021. We also made the commitment to work jointly with staff, communities and councils on the design and implementation of new models of care.

The Trust does consider specific proposals for service changes from time to time in response to quality, safety and/or efficiency issues. On these occasions we are very mindful of our duty to engage with patients, the public, their elected representatives and our other partners in order to develop the best proposals and reach the right decisions for patients. We followed this approach with the successful move of the stroke unit at St Mary's Hospital to Charing Cross Hospital in 2015.

We will continue to engage with people on specific service proposals and we will also undertake equality impact assessment related work for any such proposals.

Q4) If the Shaping a Healthier Future plans go through, please clarify: a) Will there be A&E and consultants on site at Charing Cross? And b) Will there be a blue light ambulance service at Charing Cross?

A) In 2012, the NHS published plans for a reconfiguration of health services across North West London to respond to rapidly changing health and care needs. A full public consultation set out plans for a more integrated approach to care, with the consolidation of specialist services onto fewer sites, where this would improve quality and efficiency, and the expansion of care for routine and on-going conditions, especially in the community, to improve access.

Charing Cross Hospital was envisaged as a local hospital within this network of services, building on its role as a growing hub for integrated care offered in partnership between hospital specialists, local GPs and community providers..

In October 2013, the Secretary of State for Health supported the proposals in full, adding that Charing Cross Hospital should continue to offer an A&E service, even if it was a different shape or size to that currently offered. He also made clear that there would need to be further engagement to develop detailed proposals for Charing Cross Hospital.

The subsequent work to engage patients and the public in the development of detailed plans for Charing Cross Hospital was paused as increasing demand for acute hospital services highlighted the need to focus first on the development of new models of care to help people stay healthy and avoid unnecessary and lengthy inpatient admissions.

Our approach of actively not progressing plans to reduce acute capacity at Charing Cross Hospital unless and until we could achieve a reduction in acute demand was formalised in the North West London STP published in 2016. The plan made a firm commitment that Charing Cross Hospital will continue to provide its current A&E for at least the lifetime of the plan, which runs until April 2021. We also made the commitment to work jointly with staff, communities and councils on the design and implementation of new models of care.

At this stage, therefore, before the engagement process with the residents of Hammersmith & Fulham, it is too early to specify the details of services Charing Cross Hospital would offer in the future.

C) BEDS, COMMUNITY SERVICES AND ACCESSIBILITY

Q1) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: a) How many beds will there be and what type will they be when compared to now?

A) As indicated previously it is too early to specify the details of services Charing Cross Hospital would offer in the future.

Charing Cross Hospital currently has just over 400 inpatient and day-case beds.

Successful programmes have shown that high-quality interventions that support patients before they become acutely unwell can reduce non-elective admissions and slow progression of a disease. This can contribute to a reduction in overall care costs through the removal of acute beds when out-of-hospital solutions are in place. It does not necessarily mean planning to treat fewer people – it means treating people in a different way or different place.

The NHS is already working closely with local residents and patients at CCG level as we implement new services that help people stay as healthy as possible, avoid unnecessary stays in hospital (especially older patients) and support patients to return home as quickly with the support they need. We will build on this engagement activity to engage further with stakeholders specifically about the services Charing Cross Hospital should offer in the future.

The Trust's current clinical strategy was published three years ago in 2014. We see each of our three main hospitals developing their own distinctive and interconnecting character: with Hammersmith continuing on its path as a specialist hospital with a strong focus on research; St Mary's being the acute/emergency hospital for North West London; and Charing Cross as a pioneering local hospital with planned/elective surgical innovation and integrated care services. All the Trust's main hospital sites will continue to provide local services as well as their particular unique function.

At the time of the clinical strategy being published the proposed number of beds at our main hospital sites by 2020 was shown (with the July 2014 numbers in brackets) shown in the table below:

Hospital	**Total**	**Inpatient beds**	**Day-case beds**
Charing Cross	150*	24 (360)	86 (41)
Hammersmith	466	427 (406)	39 (39)
St Mary's	540	507 (401)	33 (40)
Total	1,156*	958 (1,167)	158 (120)

* In the space requirements and costings for Charing Cross Hospital, we also allowed for a further approximately 40 beds to support a new integrated care offering.

Since then, the work to engage patients and the public in the development of detailed plans for Charing Cross Hospital has been paused as increasing demand for acute hospital services at the site highlighted the need to focus first on the development of new models of care to help people stay healthy and avoid unnecessary and lengthy inpatient admissions.

Our approach of actively not progressing plans to reduce acute capacity at Charing Cross Hospital unless and until we could achieve a reduction in acute demand was formalised in the North West London STP published in 2016.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: b) If there is a reduction of beds, how will demand be met and managed?

A) Demand will be met and managed through a combination of increased capacity at other local trusts, reduced demand for services through better management of long term conditions such as diabetes, earlier intervention when people become ill and new ambulatory models in hospitals so that less people are conveyed or admitted, and discharging people home at the right time with full community support becomes the norm.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: c) If there is a reduction of beds, how are you measuring safety issues given the high bed occupancy figures at ICHT hospitals?

A) NHS England Chief Executive Simon Stevens announced earlier this year that hospital bed closures arising from proposed major service reconfigurations will in future only be supported where a new test is met that ensures patients will continue to receive high quality care.

From 1 April 2017, local NHS organisations have to show that significant hospital bed closures subject to the current formal public consultation tests can meet one of three new conditions before NHS England will approve them to go ahead:

- Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
- Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
- Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme)

All bed reduction proposals will, therefore, be subject to being evaluated against these conditions. The assessments made against these conditions will form part of any documentation that is put forward to NHS England and will be included in documents considered at Trust Board and CCG Governing Body meetings in public.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: d) Are there any estimates as to how many in-hospital patient visits that requiring bed and clinic capacity will be replaced by community based services?

A). We have made estimates in the past, for example during the 2012 consultation, and we will be updating all figures once we have implemented and evaluated the out of hospital services so that they reflect real activity and demand in the future.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: e) How many of these community based services depend on the enhanced digital capabilities and interoperability strands referred to in Local Digital Roadmap – STP January 2017?

A) Full realisation of the integrated health and care services envisaged in the local area will require a shared digital patient record, which allows transfers of care between different settings to be automated. Where these settings use different clinical IT systems, the shared digital record is dependent on interoperability between those systems.

Community based services in the area are currently supported by TPP's SystmOne Community clinical IT system, which is a common platform with the GPs in the three local CCGs, all of which use SystmOne; so the shared record is already available between primary and community healthcare.

Between primary and acute care, there are some existing interfaces between SystmOne in primary care and the Cerner acute clinical IT system in use at Imperial College Healthcare (and due to be implemented at Chelsea & Westminster): referrals can be transmitted electronically from SystmOne using the NHS E-Referrals Service (e-RS) and discharge information at the end of acute episodes of care is sent electronically from Cerner to SystmOne.

However, full realisation of the shared digital patient record will require more comprehensive interfaces between community and acute services, either directly or via the NW London Care Information Exchange currently under development. These interfaces do not yet exist in SystmOne, but fortunately TPP has recently announced that it will develop an open interface capability, and we would expect links to Cerner to be developed and in place well before 2021.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: f) In Shaping a Healthier Future 2012, there were plans to develop a separate elective orthopaedic hospital on the lines of the one in Epsom. Is this still planned and how will it affect Charing Cross?

A) There are no plans in place to develop a separate elective orthopaedic hospital. The Provider Board considered the benefits of an orthopaedic centre(s) in April 2017 and made two recommendations. Firstly to approach the Elective Orthopaedic Centres (EOC) in two phases and not assess the feasibility of an EOC in 2017/18. The first phase will be to drive up productivity and quality within each Trust and to measure performance against a sector score card, informed by existing measures that Trusts use. It was noted that the MSK clinical network will be key to supporting delivery. Secondly it was agreed to review the data in April 2018 to assess the need for a NW London EOC. This two-part approach is driven in part by the need for capital funding for an EOC.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: g) How will Charing Cross, as a local hospital be complemented by integrated care and an Accountable Care Partnership

A) NHS commissioners across North West London have agreed that Accountable Care Partnerships are the preferred model for delivering an integrated care system. Accountable care approaches are a potential way of overcoming dispersed responsibility for the commissioning and provision of care.

Imperial College Healthcare is part of a collaboration of organisations - the Hammersmith & Fulham Integrated Care Partnership - working to develop a radically better way of providing care for the population of Hammersmith & Fulham through an integrated/accountable care approach.

The programme also involves lay partners in the co-design of all aspects of the emerging care model. Healthwatch representation in the programme structure is provided by Olivia Freeman, who is a member of the steering group and a valued lay partner.

During 2017/18, the partnership plans to test its shared principles in practice by redesigning a number of care pathways for a sample of the population. The partnership is also working closely with Hammersmith & Fulham social care services.

Q2) Given that we have a growing, ageing population who live longer with periods of chronic illness and disability how can you in practice reduce planned admissions without rationing access to operations such as cataract removal, knee and hip replacements? Isn't there now an additional pressure on the STP to limit access to these procedures given their inclusion on the list of areas whose finances are deemed to require increased control through the Capped Expenditure Process?

A. The Capped Expenditure Programme (CEP) is not about cutting services - but making sure we balance our books across the NHS in North West London. We have to reduce waste and cut inefficiency across North West London and it is important we do that in a sensible, planned way, so as to avoid any unplanned cuts at a later date. By taking this approach we can ensure that we continue to deliver high quality healthcare services. The overall approach we are taking to healthcare in NW London is all about better management of long term conditions and earlier interventions to ensure that we can deal sensibly with the growing and ageing population.

D) CHARING CROSS IN THE NATIONAL CONTEXT

164,000 disabled people this year in England have had some or all of their Personal Independence Payments withdrawn and Employment Support Allowances have been cut by 33.3%. Between 2010 & 2015 there was a 31% cut, i.e. £4.6bn in English social care budgets and 400,000 fewer people receive social care in 2015 compared to 2009-10 (Association of Directors of Social Services Budget Survey 2015).

Q) Given this context and how it is reflected in the areas served by Charing Cross Hospital please answer the following: a) Have you measured how these changes on a national level have impacted residents across North West London?

A) The planning work around the SOC has not addressed this in detail as the nature of the SOC is to focus on high level growth based on historic trends and the individual plans from each Trust and each provider. If this is addressed it would be in the detail of those plans rather than in the SOC. Plans for specific service change will be influenced by the analysis of local needs and services designed in ways that meet those needs.

Q) Given this context and how it is reflected in the areas served by Charing Cross Hospital please answer the following: b) How this national landscape has been taken into account to inform your plans for the future of Charing Cross hospital services?

A). Our planning is based on actual data and the use of past trends to influence future planning. The impact of social care cuts is reflected in our planning. Also its important to point out that integrated care gives us an opportunity to mitigate the impact.

Q) Given this context and how it is reflected in the areas served by Charing Cross Hospital please answer the following: c) Given this collapse in funding, how can you ensure that STP plans are realistic

A) It is not clear what impact, if any, the changes in national policy for Personal Independence Payments (PIP) and Employment Support Allowances (ESA) will have on health needs. As the STP is very much a high level document it is the detailed planning of individual services that will need to take account of the specific needs highlighted during the service design phase.

Q) Given this context and how it is reflected in the areas served by Charing Cross Hospital please answer the following: d) How have you tested the assumptions that integrating community health and social care can generate enough extra capacity to compensate for potential loss of services?

A) The integration of community health and social care involves changing the model of care from a reactive one, where we wait for people to get sick and then attend A&E, to a proactive one, which focuses on keeping people well and out of hospital, providing care in settings much closer to home wherever possible. This will require new funding and evaluation approaches which will require modelling and testing prior to rolling out. We have made real inroads in reducing our non elective admissions across NW London – which bucks both the London and the national trend – see the graph at Appendix II for more detail.

We are continuing to work with our social care partners to develop better integrated services. The joint strategic needs assessment outputs will support the decisions made about what services are provided and how best they can be delivered to ensure that those most in need receive the level of care and support that they require.

As mentioned earlier, through the Hammersmith & Fulham Integrated Care Partnership, in addition to social care and community services Imperial College Healthcare is working with other healthcare providers - West London Mental Health Trust, the Hammersmith and Fulham GP Federation and Chelsea and Westminster Hospital - on new models of care.

Q) Given this context and how it is reflected in the areas served by Charing Cross Hospital please answer the following: e) Have you measured the impact these changes at the national level will have in the local context regarding Charing Cross provision for people that are not in employment?

A) The planning around Charing Cross is in the very early stages. We are not planning on making any changes to Charing Cross within the lifetime of the STP.

E) FUNDING

Q1) According to this article http://www.nationalhealthexecutive.com/Health-Care-News/go-ahead-given-to-support-15-stp-areas-with-325m-capital-investment?dorewrite=false/Page-1345 from 19.07.2017, NW London STP is not going to participate in a share of the £325m, funding which NHS England has targeted to "strongest and most advanced schemes in STPs" How will losing out on this bid affect the delivery of

the STP and, in particular, Charing Cross hospital provision? What are the current steps taken to face the financial challenge?

A) The £325 million was the first cohort of STP capital funding which was for schemes due to be completed within the next twelve months. We are still progressing our bid for funding and understand further funds will be available. Our bid is following an approval process requiring regulator (NHS England and NHS Improvement approval) and Department of Health approval prior to being considered by the Treasury. This is still progressing. We are still anticipating our plans being funded in due course.

Q2) On page 42, Local Digital Roadmap January 2017 states in the last sentence: "Funding for the programme is still under discussion within NHSE, and full details of programme costs and the associated funding will be published in due course." Please clarify "due course" and inform us when you will be able to provide a timeline related to the funding. Which systems will be prioritised? What are the clinical and demand implications of not providing the technology systems that cannot be funded?

A) NHSE has clarified that there will be no funding for the Local Digital Roadmap (LDR) in 2017/18. It is expected that the funding for 2018/19 will be announced at some point after the Autumn Budget and that the bidding process will be clarified in February 2018. The North West London Digital Portfolio Board will be responsible for agreeing a list of prioritised projects within the context of the national investment levels available. The implication is that aspiration to be paperless by 2020 will not be realised.

Q3) Local residents are concerned that saving £1.3bn from NW London's budget over the next 5 years could lead to job redundancies or downgrading of skills. How are you going to measure labour cost against the budget and what are the steps you are taking to show that you mitigate possible negative impacts on the quality of healthcare?

A) In 2016/17, the Trust invested £600 million in staff benefits (pay and pension contributions) from a total annual expenditure of £1,091.5 million. Appendix 1 shows the annual growth in Trust staff benefits over the past three years.

The Trust's clinical staff (including consultants, doctors and senior nurses) often work across more than one of our hospital sites and so the Trust does not hold information for the number of clinical staff by specific hospital site.

The Trust currently employs nearly 11,000 staff in total, of which around 2,500 are doctors including consultants. Five years ago the Trust had a total headcount of nearly 10,000, of which around 2,000 were doctors including consultants.

As healthcare changes so the roles our staff perform will change and people will do their jobs in different ways. However while we expect the ways of working to change we would always ensure that we had the right numbers of staff to deliver safe care.

While the savings target is challenging, it is also recognised that changing the way services are delivered should achieve economies of scale that will enable significant savings to be made. North West London is looking at the experiences in other places where efficiencies have been achieved and service quality and levels maintained. Part of service reconfiguration does involve reviewing how services are delivered and the skill mix required. This will also happen across North West London in order to ensure that the right staff at the right level and in the right quantity are available. Some staff will almost certainly be doing things in different ways in the future which could mean that certain services require fewer people. Nothing has been 'set in stone' with regard to overall staff levels across the five years of the STP. Any changes in workforce will be part of the detailed service plans that are developed at a local level.

F) TECHNICAL INFRASTRUCTURE

Q1) How robust is the technical infrastructure being put in place, which the move to the community model of service provision relies upon. How can assurance be demonstrated to the community?

A) The NHS network (N3) provides a secure and robust means to enable teams working in community locations access to the Trust's full range of clinical systems. This is demonstrated through the existing community and acute services already provided across North West London.

Q1a) How many systems that need to, can share data now and how many will be able to by 2021?

A) Community healthcare services in the three boroughs covered by Healthwatch Central West London are currently delivered by Central London Community Healthcare (CLCH) and Imperial College Healthcare, mainly using TPP's SystmOne clinical system. Other care settings which will be relevant are Urgent & Emergency Care and federated primary care services; most of these settings are also served by SystmOne, including all practices in the tri borough

Cerner is the electronic patient records system in use at Imperial College Healthcare and being implemented at Chelsea and Westminster sites. It has an interoperability tool to enable sharing of data with other clinical systems. The providers of SystmOne, which is widely used in primary care, have recently announced that they will be enabling information sharing. This will allow us to build on the work already done to develop the Care Information Exchange to create an information sharing platform that incorporates clinical information from systems across all care settings in North West London.

Q1b) What are the implication for the STP if the underlying systems cannot share data? What will be the effect of removing the productivity tools required to provide to healthcare remotely?

A) Communication between care settings is less effective and efficient if it relies on manual processes to effect transfers of care. More effective working is dependent on the ability of systems to share data between acute (Cerner), community (mainly SystmOne) and primary care (SystmOne). This capability already exists between community and primary care. SystmOne does not currently share data with acute systems, but the supplier TPP has recently announced a commitment to develop open interfaces to SystmOne and we would expect interoperability to be developed in the next one or two years.

We are not entirely clear what is meant by the second part of the question. Clinicians in primary and community care are already able to work remotely via mobile devices such as laptops and tablets – this is what is normally meant by 'productivity tools'. These are not being removed.

Q1c) What is the state of cyber security across all systems?

A) Imperial College Healthcare remained free from virus infection during the global cyber-attack on 12 May 2017. The Trust continues to maintain and strengthen its ability to protect our systems against cyber security threats.

Q1d) What is the timeline for improving or rendering obsolete technology that can be economically improved?

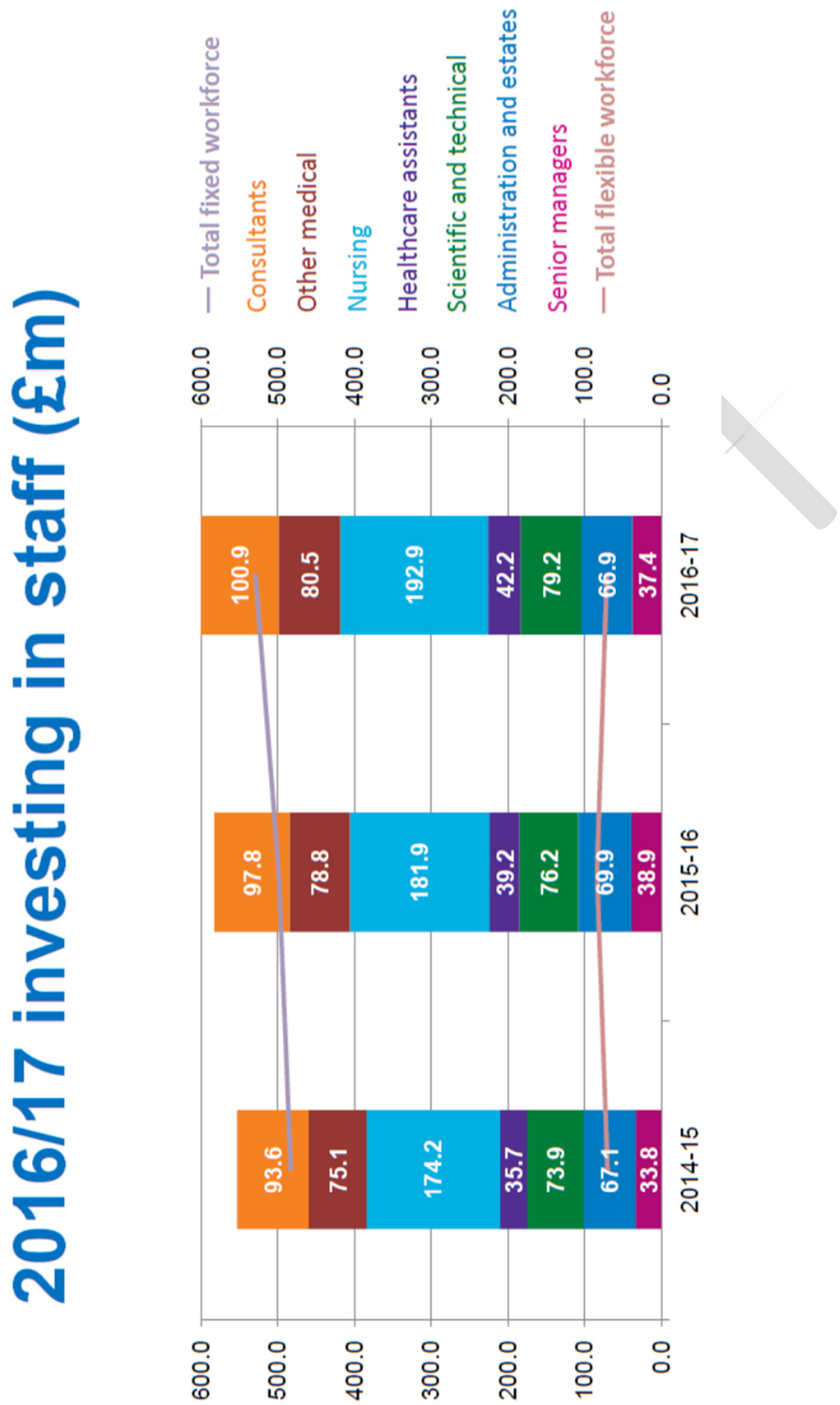
A) During 2016/17, Imperial College Healthcare invested a total of £6.1 million in Information, Communications & Technology (ICT) infrastructure. We are one of 16 acute Trusts that have been nominated Global Digital Exemplars with a commitment to drive digital innovation for our patients

Q1e) What are your plans for raising data standards to improve interoperability of the IT infrastructure?

A) To most effectively share information between systems the data must be recorded in a structured way that is common to all systems. Snomed is the coding standard that is being adopted across the NHS to facilitate this and is being implemented across North West London.

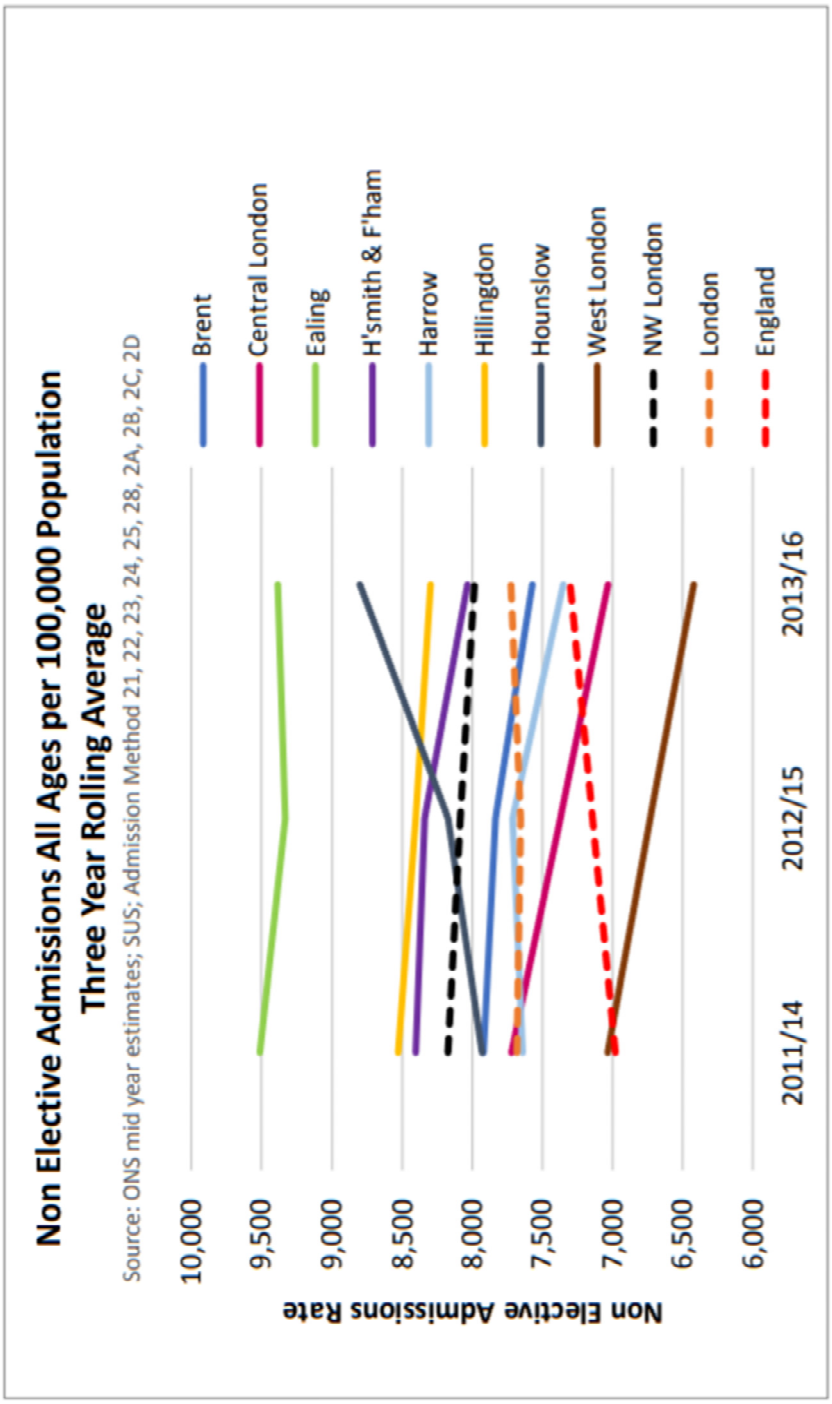
Appendix 1

Imperial College Healthcare NHS
NHS Trust



Appendix II

Figure 15: Non-elective admissions all ages per 100,000 population three year rolling average 2011/12 to 2015/16



Source: Strategic Outline Case (SOC) Part 1 – p.47

7. Appendix b – Survey

Questionnaire used to gather patients views and experiences, including demographics questions.

Tell us your experience to help shape the future of Charing

healthwatch Central West London

Healthwatch wants to learn more about your experience of using Charing Cross hospital and your views on the future on the hospital.

Your Postcode:

1. Why are you at the hospital today? Please tick ONE option or tell us more by writing in 'other'.

Patient ☐ Visitor ☐ Carer ☐

Other, please specify:

2. Which service are you visiting today?

Name of service:

3. How long did you have to wait to get a hospital appointment?

4. How satisfied are you with your visit? Please select the option that applies most by ticking the box in each line.

	Extremely satisfied	Very satisfied	Satisfied	Not satisfied	Not at all satisfied
How long I had to wait to be seen					
How far I had to travel					
The treatment I received					
The communication from staff					

Tell us more

Comment:

5. If the service you used today was available closer to your home in a different setting (for example at your GP practice) would you be happy to receive it there instead of Charing Cross Hospital? Please tick.

Yes ☐ Maybe ☐ No ☐

Please tell us more about why you made this choice:

6. Please tell us what is important about Charing Cross Hospital for you? Please select all that apply and use the comment box if you wish to tell us more.

A&E Department ☐ Urgent Care Centre ☐

Inpatient services (this is when you have to say in the hospital for a night or more) ☐

Outpatient services (this is when you visit a service but don't have to spend the night in) ☐

Charing Cross Hospital is an important part of my local community ☐

Charing Cross Hospital is not important to me ☐

Please tell us more about your choice/s

7. The NHS and Imperial Trust that run Charing Cross Hospital said that there are no plans to make any major changes at least until 2021. Plans are for "Charing Cross to evolve to become a new type of local hospital". They described a 'local hospital' as: ***"a type of hospital that provides all the most common things people need hospitals for, such as less severe injuries and less severe urgent care, nonlife threatening illnesses, care for most long-term conditions such as diabetes and asthma, and diagnostic services. It basically provides the kinds of services that more people going to hospital in North West London currently go there for."***

Do you feel that your health needs, and those of others in your local area, will be fully met by Charing Cross becoming a local hospital as described above?

Yes ☐ Maybe ☐ No ☐

Comment:

8. Would you like there to be opportunities for you to be involved in future plans for Charing Cross Hospital?

Yes ☐ Maybe ☐ No ☐

Demographics Monitoring

This section asks questions about you. The data you share with us will not be used to personally identify you, and will not be passed on to anyone else. **It is optional to complete this page.**

What is your age? (please circle)

0-15 16-25 26-45 46-59 60-74 75+

To which gender do you most identify with?

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Other: _____
- ☐ Prefer not to say

What is your sexual orientation?

- ☐ Bisexual
- ☐ Gay
- ☐ Lesbian
- ☐ Heterosexual
- ☐ Other: _____
- ☐ Prefer not to say

To which ethnicity do you most identify with?

- ☐ White British
- ☐ Black British
- ☐ Asian British
- ☐ Other non-white British
- ☐ Irish
- ☐ Gypsy or Irish Traveller
- ☐ White & Asian
- ☐ White & Black African
- ☐ White & Black Caribbean
- ☐ Any other mixed/multiple ethnic background, please describe
- ☐ African
- ☐ Caribbean
- ☐ Indian
- ☐ Pakistan
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Any other Asian background, please describe
- ☐ Arab

Please describe: _____

Do you consider yourself to have a disability? (please circle) Yes / No

Do you consider yourself to have a long term health condition? (please circle) Yes / No

Do you look after someone? (please circle) Yes / No

If you wish to be kept up to date from Healthwatch please leave us your contact details and we will add you to our mailing list. Your details will be kept separate from your answers. We can also arrange a face to face or phone call interview with you if you wish to tell us more about your Charing Cross views and experiences. Please tick all that apply.

I would like to be added to the Healthwatch Central West London mailing list ☐

I would like to tell you more about my views and experience of Charing Cross Hospital ☐

Name:

Email:

Telephone:

Address:

Postcode:

Borough:

7. Appendix c- All patients comments on “Local Hospital”

All comments received by patients in response to question 7 (See Appendix b).

- The explanation is rubbish: not accurate, not informative
- We need all facilitates under one roof
- We need this hospital as it is with all it's services and especially A&E
- It should stay exactly like it is because it is an asset to this neighbourhood and other boroughs.
- Very vague, don't know
- I will decide when plans are ratified. Things will change to meet changing needs and funding.
- I am not sufficiently qualified to know if this is a good description/plan.
- This is an excellent hospital. Keep it that way.
- The hospital should remain as it is.
- We need this Hospital, as I need most my consultants in one hospital.
- Charing Cross is a fine hospital. However, this is not our local hospital, so we don't feel qualified to comment on future needs.
- This hospital has major units to treat specific things and its saves so many people lives a day
- I live nearby and I used this hospital on many occasions. I want this hospital to carry on serving people of the UK
- I do not know if I do not know what local hospital is
- very close by, it meets our requirements as family
- Very important to keep services at Charing Cross Hospital and excellent staff
- A question in the future. It's a manufactured expression of cottage hospitals.
- Yes, As long as they don't turn it into hotels/flats
- Not sure I like the idea of a local hospital in general
- Yes, but I have a more local A&E at ST Georges
- We need more help

- I do not know what 'local hospital' services entail/include.
- Very vague
- I'm happy with the services I receive here and prefer it to stay as it is.
- What about cancer? What about operations?
- It is a very vague statement. We need A&E, we need a cardiovascular ward, breast screening. As we live longer and develop more illness in later life we need a hospital to care for us.
- Charing Cross should stay the way it is currently. There is a huge influx of people coming to live in the Borough. I personally umbellic tied to dialysis unit there.
- I am happy with my hospital and the service I get from.
- I had oncology and breast reconstruction at Charing Cross. I benefited from having experienced specialist plastic surgeons here.
- The facilities of the hospital is essential for the local communities.
- The history and the medical standards and training at Charing X would not support this
- It's not really clear what local hospital means; could be a bad or good thing.
- As we get older we may need more specific treatment and therefore travelling far from home will become difficult and expensive.
- "Local" suggests routine problems. Most people recognise Charing Cross as a centre of excellence.
- It has specialist departments which will be a shame to lose
- A cottage hospital by another name is inadequate to the current needs of the catchment area, people get really sick and need expert care. As if they would pay any attention (for involvement)
- IF what they say comes to fruition then it would be great.
- Please do not close vital services like A&E and the specialist cancer services
- I don't understand.
- They want to change it into a clinic. That's how it sounds. What are they going to do with emergencies?
- Leave it as it is.
- The halfway house described above is no good to patients and staff. This hospital should remain as a fully functional unit.

- It would be a shame to lose the excellent full service.
- As long as it stays as it is.
- Why would they do that/
- Concerned about A&E/more serious incidents.
- This area need a full hospital. Number of people in hospital is growing. We need hospital in this area.
- When something is successful don't change it.
- Will they do the screening? If yes, it will be ok. It is longer to go to Hammersmith.
- That would be useless for me. I use it for urgent health needs
- Every hospital needs A&E
- Leave things as they are!
- I had knee surgery and it was good. Every service is very good. I would like to keep it as it is. 12/4/2017 11:34 AM
- Leave the hospital the way it is. All my family coming here, it has good reputation. Why change?
- Are they keeping A&E?
- We need A&E, it is very important for this area
- I have kidney condition which requires a center with specialists
- Being leaders in the field in a specialist capacity must also be important?
- Less is WORSE for patients
- We need to have maternity, hart, strokes
- Where all the specialist can move to?
- It would be a real shame to be without the hospital, it would be greatly missed.
- They should continue to do operations, always seem brilliant. I don't quite understand. That could be a gray area.
- It is not clear if this new hospital will have my specialists
- The proposal to change to a local hospital is very disappointing. It is our local hospital and we need urgent care including A&E.
- I am happy if they add services. It's very important to keep the facilities that they have, because I already need to come from Harrow.

- It is important to have all the services
- We need more information
- I want present facilities to continue
- Absolute rubbish. They should not be allowed. It is a major hospital for the community. Leave it alone. Disgraceful! I paid for 45 years. It's a government plan to privatize NHS-leave it alone!
- I like it as it is now. We need urgent care places.
- No, it will not be a good idea becoming a local hospital. This hospital should stay as it is.
- What about cancer?
- It depends if other hospitals gave these services. We need all the facilities here.
- I don't really know
- What about Maggie and the treatment for cancer that people come all over the country for? Where are they supposed to go?!
- Need specialized input at times. Links with others need to result in a smooth transition.
- I cannot answer this question because my "local" A&E is at Kensington and Chelsea Hospital.
- I need Charing Cross Hospital to provide all the services of a big hospital.
- Better to keep it the way it is now.
- They should take care of the building and the staff because they work hard.
- This is an important hospital in the area which is very busy and big population, and close to transport links that is more accessible.
- If there are alternatives nearby for the services that are going to be moved then it's fine. But if those services are too far then it's not fine.
- With respect, don't trust what I have heard to date. Cost Cutting thinly veiled as transformation.
- This is my first referral to CXH ENT (recommended by A&E Register at CWH), so I don't have enough experience/exposure to CXH to comment further.
- I think the oncology department is vital.
- Don't know enough about the proposed changes.

- This is a general hospital and the only other nearest hospital is St Mary's (Paddington).
- I would expect to visit whichever Imperial hospital has a neurology clinic.
- We cannot tell what re-arrangements of services across the Trust may happen. Thereby keeping urgent care etc accessible in the area.
- More focus on elderly care
- Services such as cancer diagnosis and treatment will apparently no longer be available
- The statement above appears to imply a scaling down of service to exclude the most services of most urgent conditions.
- Urgent care and A&E must be local! The world being urgent.
- I have no idea what the blurb cited above actually means in real terms. Generally, I think the hospital should serve the needs of the community and there's no need to get clever about it.
- This Would mean travelling to St Marys or Charing Cross on a more regular basis, which is not always possible or practical for all.
- There are very few A&E units in the area. Long queues at Chelsea and Westminster. It has world class cancer care and is a vital teaching hospital.
- Stop cutting hospital services in West London.
- Read it, says no-urgent. It should have an A&E at all times. Sounds like the care is going to be reduced.

8. Contact us

Healthwatch Central West London

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	London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE & SOCIAL INCLUSION POLICY AND ACCOUNTABILITY COMMITTEE** **30 JANUARY 2018**
2018 Medium Term Financial Strategy (MTFS) – ADULT SOCIAL CARE	
Report of the Cabinet Member for Finance	
Report Status: Open	
Classification: For review and comment. **Key Decision:** No	
Wards Affected: All	
Accountable Director: Lisa Redfern - Director of Adult Social Care	
Report Authors: Corporate Overview Andrew Lord – Head of Strategic Planning and Monitoring Hitesh Jolapara – Strategic Finance Director Adult Social Care Department Prakash Daryanani – Head of Finance for Adult Social Care	**Contact Details:** Tel: 020 8753 2501 E-mail: hitesh.jolapara@lbhf.gov.uk Tel: 020 8753 2523 E-mail: prakash.daryanani@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. Cabinet will present their revenue budget and council tax proposals to Budget Council on 21st February 2018. A balanced budget will be set in accordance with the Local Government Finance Act 1992.

1.2. This report sets out the budget proposals for the services covered by this Policy and Accountability Committee (PAC). An update is also provided on any changes in fees and charges.

1.3. Government resource assumptions, that are used to calculate LBHF's Government grant, model the council increasing council tax by 6% in 2018/19. However, in line with the administration's policy of lowering the cost of the council to residents, this increase has not been proposed. Instead, the budget proposes to freeze council tax for the year.

2. RECOMMENDATIONS

2.1. That the Policy and Accountability Committee (PAC) considers the budget proposals and makes recommendations to Cabinet as appropriate.

2.2. That the PAC considers the proposed changes to fees and charges and makes recommendations as appropriate.

3. THE BUDGET GAP

3.1. The 2018/19 budget gap, before savings, is £14.6m, rising to £55.1m by 2021/22. The budget is based on several key assumptions regarding resources and expenditure.

Table 1: Budget Gap Before Savings

	2018/19	2019/20	2020/21	2021/22
	£'m	£'m	£'m	£'m
Base Budget	**155.0**	**155.0**	**155.0**	**155.0**
Add:				
- Inflation (includes pay)	5.2	10.6	15.8	21.1
- headroom	0.0	6.0	12.0	18.0
- Growth	6.8	7.2	7.2	6.9
Budgeted Expenditure	**167.0**	**178.8**	**190.0**	**201.0**
Less:				
- Government Resources	-10.1	-28.5	-25.4	-23.5
- LBHF Resources	-139.0	-115.3	-117.2	-119.1
- Use of Developer Contributions	-3.3	-3.3	-3.3	-3.3
Budgeted Resources	**-152.4**	**-147.1**	**-145.9**	**-145.9**
Cumulative Budget Gap Before Savings	**14.6**	**31.7**	**44.1**	**55.1**
Risks	**19.3**	**25.0**	**28.3**	**31.2**

Budget Assumptions

3.2. A continued reduction in the general grant receivable by Hammersmith and Fulham from **Central Government**. Grant funding[1] has been cut in each year since 2010/11. The total reduction since April 2010 to March 2018 has been £70m. In addition, there will

[1] After allowance for changes in funding between grant and business rates.

be a further reduction in 2018/19 of £8.6m and further £5.2m cut is forecast by 2021/22.

3.3. **A Council Tax freeze** is modelled with no use of the adult social care precept. Authorities can opt to levy a maximum adult social care precept of 3% in 2018/19 and up to 6% by 2019/20. A 3% precept would raise £1.7m for LBHF. Central Government grant assumptions are based on LBHF raising council tax and the precept by a combined 6% per year in 2018/19. 2018/19 is the third year of a four-year local government finance settlement that started in 2016/17. From 2016/17 to 2018/19 Government modelling has assumed an overall council tax increase of 13.3% of which 7% relates to use of the social care precept. The administration, however, has a commitment to reduce the cost of the council to residents and will not be increasing tax.

3.4. **Business rates** are modelled to increase with inflation with allowance made for an extra £2.2m from the opening of the Westfield extension in March 2018.

3.5. London Local Government has been working to take forward a **100% business rates retention** pilot for London from April 2018.

3.6 The pilot will pool business rates across the 33 London Boroughs and Greater London Authority (GLA).

3.7 Under such an arrangement London will keep 100% of any growth in business rates, though business rates valuations and levels would still be set by Government. Indicative modelling has suggested this may benefit Hammersmith and Fulham by £2.6m. In addition, £110m would be generated for a London wide investment pot.

3.8 At present Hammersmith and Fulham retains 30% of the business rates it collects with the balance paid to the Government and GLA. Under the proposed pilot the share retained by Hammersmith and Fulham would increase to 67% with the balance going to the GLA. The Council would not initially benefit from the increased share as there would be compensating reductions (through grant cuts and payment of a tariff to Government). These adjustments are shown in Table 2. The benefit to Hammersmith and Fulham would be receiving a share of London's future business rates growth.

Table 2 – Changes to Funding Streams from the Business Rates Pilot

	No-Pilot	With Pilot
Business Rates Baseline	77.9	157.8
Tariff payable to the Government	-18.8	-74.8
Funding Baseline	**59.1**	**83**
Revenue Support Grant	23.9	0
Total LBHF Funding	**83**	**83**

3.9 Table 2 sets out the sums assumed by the Government in the 2018 Local Government Finance Settlement. The current LBHF forecast, which will be updated in January, for business rates income is £80.4m. Under the pilot scheme there is a guarantee that no authority will be worse off than under the present scheme.

3.10 The 100% business rates retention pool:

- Is a pilot and may not continue after 2018/19.
- Uses modelling based on an aggregation of high level estimates.
- Will not confirm final income until October 2019 in relation to 2018/19

3.11 Greater clarity, after each Borough updates their 2018/19 business rates forecast, on the potential benefits from the pilot 100% business rates retention pool will be available in mid-February. No benefit is allowed for within the current LBHF resource forecast. Once confirmed the sum receivable will be added to Reserves.

3.12 **Property developments** have placed increased pressure on council services in recent years.

3.13 Section 106 agreements containing planning obligations are entered between developers and the Council as the Local Planning Authority. Legislation controls the use of such obligations, including regulation 122 of the Community Infrastructure Regulations 2010 which requires planning obligations to be:

- Necessary to make the development acceptable in planning terms;
- Directly related to the development; and
- Fairly and reasonably related in scale and kind to the development.

3.14 The Council has entered into a significant number of s106 agreements. Whilst S106 funds can only lawfully be applied in accordance with the terms of each specific agreement, as approved by the Planning Applications Committee, some approved funds are identified generally as being for expenditure on as yet unspecified “Social and Physical Infrastructure” or “Environmental Improvements” (although the agreements identify the types of projects/items the funds can be used for).

3.15 Provided the Council respects the obligation to maintain a reasonable relationship with the developments and complies with the specific terms of each of the s106 agreements giving rise to the funds, the Council has a degree of flexibility and discretion as to how it spends some of these funds. The council has analysed all its s106 agreements that may give a financial benefit to determine which should be relied upon for budgeting purposes and which have flexibility in how they may be applied. As is usual in these circumstances many areas of Council activity that have faced increased demand following new developments offer a good fit with

the purposes of some of the uncommitted s106 funds which can therefore be lawfully used to finance such activities.

3.16 The Council currently has section 106 receipts of £50.1m in hand with agreements in place for the receipt of future financial obligations of £201m. £72.4m of the future obligations are assessed as highly likely to be received by the close of 2021/22. The total amount of flexible funding in-hand, or highly likely to be received, is estimated to be a minimum of £72m by the close of 2021/22.

3.17 The 2018/19 budget assumes that £3.3m (an additional £0.7m compared to previous years) of expenditure will be funded from section 106 resources with such funding on-going over the MTFS period. In addition, contributions of £1.7m per annum are assumed towards the provision of policing.

3.18 **Inflation**. A pay award of 2% per annum is modelled compared to 1% in 2017/18. Inflation has also been provided, on a case by case basis, to meet external contractual requirements. Inflationary pressures have increased in the wider economy with the August Retail Price Index showing an increase of 3.9% compared to 1.8% last year. For 2018/19, the sum provided for overall inflation is £5.2m (£1.8m pay and £3.4m non-pay) compared to £2.9m in 2017/18.

4 GROWTH, SAVINGS AND RISKS

4.1 The growth and savings proposals for the services covered by this PAC are set out in Appendix 1 with budget risks set out in Appendix 2

Growth

4.2 Budget growth is summarised by Service Area in Table 3.

Table 3: 2018/19 Growth Proposals

Department	£m
Adult Social Care	1.3
Children's Services	1.8
Environmental Services	0.6
Corporate Services	0.3
Regeneration, Planning & Housing Services	1.4
Council Wide Budgets	1.4
Total Growth	**6.8**

Savings

4.3 The Council faces a continuing financial challenge due to overall Central Government funding cuts, unfunded burdens, inflation, and

growth pressures. The budget gap will increase in each of the next three years if no action is taken to reduce expenditure, generate more income through commercial revenue or continue to grow the number of businesses in the borough.

4.4 To close the budget gap for 2018/19 savings (including additional income) of £15.4m are proposed.

Table 4: 2018/19 Savings and Additional Income

Service Area	£'m
Adult Social Care	(2.9)
Children's Services	(2.1)
Environmental Services	(1.9)
Library Services	(0.1)
Corporate Services	(2.7)
Public Health	(2.0)
Regeneration, Planning & Housing Services	(0.2)
Commercial and Cross-Cutting	(3.5)
Savings	**(15.4)**

4.6 The Council will receive Public Health Grant of £21.8m in 2018/19. The savings of £2m in existing services will enable investment in Council services that deliver public health outcomes.

4.7 The saving proposals are categorised by savings area in Table 5.

Table 5: Categorisation of Savings and Additional Income

	2017/18 £'m	2018/19 £'m
Business Intelligence	(0.6)	(0.4)
Budget reduced in line with spend	(0.3)	(0.2)
Commercialisation	(2.9)	(3.4)
Estate Rationalisation	0	(0.1)
Income	(0.3)	(0.5)
Outside investment secured	(0.2)	(0.1)
Prevention	(0.6)	(1.6)
Procurement / Commissioning	(5.0)	(5.1)
Service reconfiguration	(2.7)	(3.1)
Staffing / Productivity	(2.2)	(0.9)
Total All Savings	**(15.0)**	**(15.4)**

Budget Risk and Reserves

4.8 The Council's budget requirement for 2018/19 is £152.4m. Within a budget of this magnitude there are inevitably areas of risk and uncertainty particularly within the current challenging financial

environment. The key financial risks that face the Council have been identified and quantified. They total £19.5m. Financial risks of £20.6m were identified when the 2017/18 Budget was set.

4.9 The level of balances and reserves are examined each year in light of the risks facing the Authority in the medium term. The latest position is set out in Table 6.

4.10 The Council has used reserves to fund investment in transformation and efficiency and other significant one-off costs pressures. Examples in 2016/17 included investments in ICT, Invest to Save schemes such as LED street-lighting and mitigating the impact of the Managed Services project.

4.11 The 2018/19 base budget includes planned contributions of £0.75m to the Efficiency Projects Reserve and £0.8m to the IT Enablers Reserve. In addition, the proposed savings for 2018/19 (£15.4m) currently exceed the budget gap (£14.8m). This will enable a further contribution to Reserves of £0.6m. The sum due from the London 100% Business Rates retention pilot (estimated at £2.6m) will also be put to Reserves. **In total, the estimated contribution to Reserves for 2018/19 is £4.75m**. Uses of Reserves in 2018/19 will include taking forward the Integrated Family Support Service, taking forward new arrangements for the outsourced managed services programme and funding the Landlord Incentive scheme to support the provision of temporary accommodation.

Table 6 – General Fund Balances and Earmarked Reserves

	31/03/14 actual	**31/03/15 actual**	**31/0316 actual**	**31/03/17 actual**	**31/03/18 forecast**
	£'m	£'m	£'m	£'m	£'m
General Balances	19.0	19.0	19.0	19.0	19.0
Earmarked Reserves	81.6	89.5	90.0	82.7	75.0
	100.6	**108.5**	**109.0**	**101.7**	**94.0**

5 FEES AND CHARGES

5.8 The budget strategy assumes:

- Adult Social Care, Children's Services, Market, Parking, Libraries and Housing charges frozen
- A standard uplift of 3.9% based on the August Retail Price index for other charges
- Case by case review for commercial services that are charged on a for-profit basis. These will be varied up and down in response to market conditions, with relevant Member approval.

5.2 There are no fees and charges exceptions to report for Adult Social Care.

6 2018/19 COUNCIL TAX LEVELS

6.8 The administration proposes to freeze the Hammersmith and Fulham's element of 2018/19 Council Tax at £727.81. This will provide a balanced budget whilst recognising the burden on local taxpayers.

6.9 The Mayor of London's draft budget is currently out for consultation and is due to be presented to the London Assembly on 25th January 2018, with final confirmation of precepts on 22nd of February.

6.10 As part of the Provisional Local Government Finance Settlement the government announced that authorities can charge a 3% adult social care precept. The Council does not wish to apply this tax to residents, so it does not form part of the 2018/19 budget proposals.

6.11 Following last year's council tax freeze, the current Band D Council Tax charge of £1,007.83 (LBHF element £727.81 and GLA £280.02) is the 3rd lowest in England. In cash terms, the Band D charge for the Hammersmith and Fulham element is at its lowest since it was £706.83 in 1999/2000.

7. Comments of the Lead Director for Adult Social Care on the Budget Proposals

7.1. Budget Context

There is much to be proud of about the Council's achievements in improving adult social care despite significant funding challenges exacerbated by major reductions in central government funding.

This administration is passionate and ambitious about its social care agenda. It is committed to supporting the independence of residents by offering genuinely personalised and independent options to those who need and want care services.

We are seeing increasing demand for our services as residents are living longer and have more acute social and health care needs. This pressure is being magnified by hospitals increasingly discharging patients early, which can require us to provide more intensive social care support, such as two carers per visit.

Working closely with residents and community partners, the administration is committed to reducing social isolation and loneliness. This is also a priority for the borough's Health & Wellbeing Board and for H&F's resident-led Older People's Commission. It will entail closer working with carers, among others, and co-producing new ways of delivering support.

A strengthened focus on co-production with residents will be at the heart of how the council develops and delivers all its adult social care services. Co-production is a core recommendation of the resident-led Disabled People's Commission, whose report has been accepted in full by the Cabinet. To take just one example, this approach will underpin implementation of the recommendations of the council's Working Group on improving transitions for young disabled people.

Despite huge pressures on the adult social care budget, this administration remains committed to high quality social care delivery and to mitigating where possible the financial pressures facing the borough's older people, most of whom are living on a limited fixed income.

This is the only council in the country to have abolished home care charges for older and disabled residents. We have also cut and frozen council tax, reduced the cost to residents of meals on wheels to only £2 and frozen the cost to residents of Careline.

7.2. **Care Market**

The care market across inner London is particularly fragile and work by the Association of Directors of Adult Social Services (ADASS) highlights inner London as having significant pressures across all care groups. The acuity and level of complexity of people's needs are increasing alongside demographic changes. Workforce pressures from future increases in the London Living Wage, the National Living Wage, sleep-in allowances and housing costs will affect the retention and quality of staff. As prices have been driven down over the last few year, a lack of investment has compounded the market's ability to rise to these challenges.

7.3. **Better Care Fund (BCF)**

The Council works with health providers to ensure that residents are discharged from hospital promptly and safely. Our performance levels continue to be excellent compared to other areas of the country and in the first half of this year we met our targets for delayed transfers of care. Pressures will increase over the winter.

Investment from Health in partnership with the Council is vital to the sustainability of adult social care. Additional government funding in the form of the Improved Better Care Fund (iBCF) was announced for adult social care over the three years 2017/18 to 2019/20 in the 2017 Spending Review. Hammersmith & Fulham Council's total funding of £21m over this three-year period was as set out below:

	2017/18	**2018/19**	**2019/20**
iBCF	£5.127m	£7.051m	£8.814m
Adult Support Grant	£0.923m	£0	£0
Total	**£6.050m**	**£7.051m**	**£8.814m**

Like all councils, we are in the difficult situation of not having been told by the government whether any additional funding will be available after 2019/20. The BCF includes "Social Care to Benefit Health" funding which local authorities have

received for the past five years and which is being used to sustain local social services.

Our BCF Plan sets out the direction of travel agreed by Cabinet and CCG Chairs. We are looking to improve the quality and experience of care in the borough across health and social care over the next five years. We are working to achieve reductions in emergency admissions to hospital and the demand for residential, nursing and home care to provide support to people in their own homes and communities wherever possible.

The new funding will also support price pressures as a result of living wage increases, continued demographic pressures and learning disability packages of care as residents transition from children's to adult services.

Our BCF Plan also aims to develop a joined up, whole systems approach to the delivery of health and social care services across the borough where this benefits our residents, and to implement a delayed transfers of care reduction plan to ensure the maintenance of target levels of delays in hospital discharge to support our acute hospitals.

7.4. **Adult Social Care Savings Strategy**

Our future savings plan aims to deliver change at a time of increasing demand, uncertainty, and risk. Many of the proposed savings require partnership working with local people, their families and friends, Health, housing and other community stakeholders.

Delivery will be supported by three programmes of work that focus on: our front door and demand management services (access to adult social care); commissioned care and support services; and further service integration. We will work to re-design services so that they more effectively support independence, prevent demand for high cost health and social care services and meet the outcomes that are most important to our residents.

Co-production with the local people we support and extending choice and control to more residents through Direct Payments are priorities. Please refer to Appendices 1 and 4 for further detail of each savings proposal.

<u>Front Door and Demand Management Programme – Savings of £0.897m.</u>

This is working towards a re- design and re-commissioning of our front door and prevention service portfolio. It will allow residents the appropriate access into adult social care services.

<u>The Commissioning Strategy Programme – Savings of £1.219m</u>

This aims to deliver better outcomes and maximise independence for those residents that need care and support services.

<u>The Whole Systems Integration Programme – Savings of £0.700m</u>

This will continue to work with the NHS on local Better Care Fund and health and wellbeing plans.

Other – Savings of £0.100m

A complete review of cost management will also be undertaken, particularly agency and interim provisions. The main opportunities to reduce staff costs have been undertaken through major restructures of back office, commissioning and operational services, and we will be looking at further opportunities as part of the Moving On redesign of services.

7.5. **Council-funded Growth**

Contractual inflation pressures of at least 3 per cent for a range of ASC services have led to an increase in prices from outsourced providers. Growth funding is required to bring ASC budgets in line with the anticipated 2018/19 contract prices and enable the service to cope with demand.

This will also help providers with staff retention and therefore ensure continuity of care for service users. It will also enable the department to stay competitive in the placement procurement market.

7.6. **Risks**

Highlighted and summarised below are some of the key risks of £4.411m already mentioned which could have a significant impact on the department. These risks have been partly mitigated by the additional resources of £1million from the improved Better Care Fund (iBCF). Other mitigations are set out in Appendix 2.

We continued to experience increases in numbers during this financial year. People are being discharged much earlier from hospital with a greater acuity of need. This and demographic pressures on adult social care services will continue to increase as the population gets older. There is also an estimated shortfall in the Section 75 Health Commissioning budgets which are under significant financial pressures. And we are continuing to receive requests for inflationary increases from providers above that which has already been built into the base budget.

7.7. **Fees and Charges**

Despite fierce central government funding cuts, this administration proposes to continue its commitment to making life more affordable for older and disabled residents by providing eligible home care free of charge, continuing to subsidise meals on wheels significantly and not increasing Careline charges

The cost of meals on wheels to residents is currently only £2, down from £4.50 in 2014/15. For 2018/19, the budget strategy proposes freezing charges for resident services. This would maintain the £2 charge for a third consecutive year and freeze Careline charges for a second consecutive year.

8. Equality Implications

8.1. A draft Equality Impact Analysis (EIA), which assesses the impacts on equality of the main items in the budget proposals relevant to this PAC, is attached as Appendix 3. A final EIA will be reported to Budget Council.

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		

Appendix 1 – Savings and Growth Proposals

Appendix 2 – Risks

Appendix 3 – Draft Equality Impact Assessment

Appendix 1 - Growth Savings

Adult Social Care

MTFS Growth			Budget Change			
Service	**Description**		**2018-19 Budget Change (£000's)**	**2019-20 Budget Change Cumulative (£000's)**	**2020-21 Budget Change Cumulative (£000's)**	**2021-22 Budget Change Cumulative (£000's)**
All	Departmental growth arising from demographic pressures and increased costs of social care		1,249	1,249	1,249	1,249
Total Growth			**1,249**	**1,249**	**1,249**	**1,249**

MTFS Savings			Budget Change			
Service	**Description**	**Delivery Risk (R-A-G)**	**2018-19 Budget Change (£000's)**	**2019-20 Budget Change Cumulative (£000's)**	**2020-21 Budget Change Cumulative (£000's)**	**2021-22 Budget Change Cumulative (£000's)**
Integrated Care	Promoting Independence through social work practice. Reduction in Community Care spend as the council facilitates individual care and support plans for residents. Forensic assessment of where payments are not aligned to services provided for residents.	Medium	(747)	(1,397)	(1,397)	(1,397)
Strategic Commissioning & Enterprise	Major re-commissioning projects in the areas of Learning Disabilities Accommodation and Support; Mental Health Accommodation and Support. Day Care Services and Extra Care Housing.	Medium	(505)	(505)	(505)	(505)
Strategic Commissioning & Enterprise	An in-depth value for money assessment of the councils in-house care and support service portfolio	High	(75)	(75)	(75)	(75)
Strategic Commissioning & Enterprise	Dynamic Purchasing System.	Medium	(100)	(100)	(100)	(100)
Integrated Care	Improved transition and promoting independence.	Medium	(310)	(465)	(465)	(465)
Strategic Commissioning & Enterprise	Review of supporting housing programme	Medium	(130)	(130)	(130)	(130)
Strategic Commissioning & Enterprise	Improved targeting of prevention services and increased emphasis on using community assets to deliver better services for residents	Medium	(150)	(150)	(150)	(150)
Director	The Whole Systems Integration Programme with the NHS.	Medium	(700)	(700)	(700)	(700)
All	Review of workforce costs moving into single borough arrangement	Medium	(100)	(100)	(100)	(100)
Asset Based Approach to Transport	Transport: Review transport provision and policy across care type and consider opportunities to promote independence wherever possible.	Medium	(99)	(110)	(120)	(120)
Total Savings			**(2,916)**	**(3,732)**	**(3,742)**	**(3,742)**

Departmental Risk/Challenges

		Risk				
Department & Division	**Short Description of Risk**	**2018/19 Value (£000's)**	**2019/20 Value (£000's)**	**2020/21 Value (£000's)**	**2021/22 Value (£000's)**	**Mitigation**
Adult Social Care						
Integrated Care	Demographic pressures on Adult Social Care services continue to increase as the population gets older. We continue to experience increases in numbers during future financial years.	1,321	1,321	1,321	1,321	The March 17 Local Government settlement announced a new improved Better Care Fund (iBCF) support for Adult Social Care. We will aim to mitigate the pressures from this funding.
Integrated Care	There is an estimated shortfall in the s.75 Health Commissioning budgets which are under significant financial pressures. Following discussions with Health, the LA have been advised the financial liability will rest with the organisation responsible for the resident.	1,800	1,800	1,800	1,800	The department has commissioned a piece of work to explore the health requirements of local residents to ensure these are being met and funded by the appropriate body.
Integrated Care	Commissioners are continuing to receive requests for inflationary increases from providers above that which has already been built into the base budget	190	190	190	190	The Commercial and Innovation team will negotiate with providers on the inflationary increases to be awarded and this will need to be managed through this process. The Care Market is particularly fragile with a number of factors which are affecting the price-service delivery model.
All	Year on year savings from Transformation Commissioning Programme are increasingly difficult to deliver	900	900	900	900	The department has a transformational programme review group which will review all saving programmes and check progress on delivery.
Integrated Care	Increased costs associated with the payment of the London and National Minimum Wage for care workers who work sleep-in shifts in the social care sector.	200	200	200	200	There is a risk that providers will require extra monies in order to cover the backdating of these payments. It is expected that backdating could go back as far as 6 years, costing ASC c. £200k - £1 million. In order to mitigate this we have made clear that ASC will not consider backdating any payments from before this financial year. We would, however, be happy to support providers lobbying position that central Govt who decided on this policy should make funding available to address the issue.
Adult Social Care Total		**4,411**	**4,411**	**4,411**	**4,411**	

DRAFT EQUALITIES IMPACT ASSESSMENT

Health, Adult Social Care and Social Inclusion

Budget Proposals 2018/19

4.1 Adult Social Care

Adult Social Care has a number of financial challenges, both locally and nationally. Since 2010/11, there has been a significant reduction in funding. Meanwhile, people are living longer and residents are being discharged from hospital much earlier. Both of these are very positive, however people are living longer with more complex needs, and those leaving hospital earlier have a greater acuity of need. Both cases require more intensive social care support for longer which has substantial financial implications.

4.1.1 Efficiencies, Growth and Fees and Charges

The 2018/19 proposals are detailed in this report. They are grouped departmentally into Front Door & Demand Management, Strategic Commissioning, Whole System Integration and other efficiencies. ASC delivered a number of efficiencies in 2017/18 totalling £1.9m. The proposals in 2018/19 of £2.9m are an extension of existing proposals without any anticipated adverse impact on people who use the services.

4.1.2 The Front Door and Demand Management Programme -Savings of £0.897m

Promoting independence through social work practice. Careful and creative facilitation of care and support planning. Forensic assessment of where payments are not aligned to services provided and/or residents £0.747m

This project relates to the consistency, quality, and creativity of social work practice so that the potential for independence is at the forefront of assessments and reviews. This ensures associated care and support costs are avoided.

As delivery of savings is increasingly challenging, the continuing approach is being supported by a range of additional provisions including the Front Door and Demand Management Programme, a strengthened approach to annual reviews, a review of the capability of the Learning Disabilities service to undertake this work and the extension of housing allocation and adaptations provisions.

Savings associated with this proposal are counterbalanced by growth plans so that unavoidable market and demographic cost increases are provided for. The changes are therefore considered to have a neutral impact.

Improved targeting of prevention services and increased emphasis on using community assets to deliver savings £0.150m

The Front Door and Demand Management Programme was established in July 2016 to join up and digitalise services and integrate commissioning budgets for front door and prevention services. Savings will be delivered through a combination of digital development, re-commissioning and contract management.

4.1.3 The Commissioning Strategy Programme – Savings of £1.219m

Major re-commissioning projects in the areas of Learning Disabilities and Mental Health Accommodation and Support; Day Care Services and Extra Care Housing £0.505m

The re-commissions will go to the market to seek re-designed services that better promote independence and personalised services moving away from the rigid and fixed approaches to providing care and support. Services will also be re-commissioned within the context of a wider review of care pathways. Co-production with key partners and residents will drive the process. There will also be continuing work to manage down costs with block contract and high-volume spot contract providers. This work is on track, although delivery of savings is dependent on the market response and cannot be assured until later stages of the retender process.

The procurement framework requires ASC to consider EIA implications of re-commissions in a proportionate way which will be done in due course. Savings for the recommission programme are counterbalanced by growth plans so that unavoidable market and demographic cost increases are provided for and a neutral impact is therefore expected.

Remodel In-House Service Portfolio £0.075m

In-depth value for money assessment of the Council's in-house care and support service portfolio of seven services including day care, respite and home visiting services.

The review will be undertaken to assess any remaining opportunities for improving efficiency and the long-term market position of in-house services. In year one, limited efficiency reductions which have no impact on the service offer were undertaken. An options paper for more substantive changes is currently in draft form.

Once a steer has been provided, associated EIA implications can be considered further.

Dynamic Purchasing System (DPS) £0.100m

The project focusses on the procurement and implementation of a DPS, an electronic mini tendering system for regular purchases of residential care placements. This improves access to a wider market and the best price in an automated way. Residents will be provided with a placement that will clearly support their assessed needs and agreed outcomes. This will be provided in a more transparent process as quotes will be provided electronically rather than being telephone based.

The proposal will have a neutral impact in terms of equalities regarding access, choice and control for a resident's care placement. It is hoped that the system will allow the Council to reach out to a greater number of homes than previously.

Review of Supporting Housing Programme £0.130m

Commissioners are currently exploring options to transfer the commissioning and contracting responsibilities and /or procure contracts.

Overall, the impact on vulnerable groups is adjudged as neutral or positive as service continuity will be maintained and there will be additional types of support available for people to access.

Improved Transition and Promote Independence £0.310m

It is essential that the process for young disabled people transitioning into adulthood is improved through the development of an integrated transition service between children's and adult's services and a more co-ordinated response. Early, multi-disciplinary co-ordinated planning from age 14 and improved case tracking will enable young disabled people to reach their life goals and aspirations locally, within a value for money framework.

This work considers diverse needs through all the key stages. Savings associated with this proposal are counterbalanced by growth plans so that unavoidable market and demographic cost increases are provided for resulting in a neutral impact.

Asset Based Approach to Transport £0.099m

This piece of work will review the transport provision and policy across care type and consider opportunities to promote independence wherever possible.

4.1.4 The Whole Systems Integration Programme – Savings of £0.700m

A joint commissioning and review of services with the NHS including people with a Learning Disability, Mental Health issue and intermediate care. Work to provide details of options to achieve savings is now being facilitated with a shared benefits delivery map that caters for 2018/19 requirements on both sides. Any potential equalities impact will be considered as part of this process.

4.1.5 Other - Review of workforce costs £0.99m

A complete review of cost management will be undertaken, particularly agency and interim provisions. Work is on target to finalise the savings plan as the service moves into a single borough. We anticipate that there would be a neutral impact on our staff as there will be no staff reductions.

4.1.6 Growth

4.1.6.1 Improved Better Care Fund (IBCF) £7.051m in 2018/19 (£1.001m increase from 2017/18)

In the 2017 spring budget, new money was announced for Adult Social Care through the Improved Better Care Fund totalling £7.051m. The purpose of the grant is to meet Adult Social Care needs and reduce pressures on the NHS.

The Improved Better Care Fund will have a positive impact on all Adult Social Care residents as:

- It will enable the Department to continue to implement the out of hospital strategy and this will impact residents positively as they are able to live independently for longer.
- It will enable the service to manage and meet increased demand and acuity of needs.
- It will help providers with staff retention and therefore ensure continuity of care for residents which will have a positive impact on their wellbeing.
- The additional budget received will be used to fund eligible young adults who transition into social care services.

4.1.6.2 Council Funded Growth for contract inflation- £1.249m

There are further contractual inflation pressures of at least 3% for a range of ASC services. This has led to an increase in prices from the market providers. Headroom funding is required to bring ASC budgets in line with the anticipated 2018/19 contract prices.

The additional funding will enable the service to manage this demand and continue to provide free Homecare services. It will also help providers with staff retention and therefore ensure continuity of care for people who use adult social care services, this will have a positive impact on their wellbeing. This will also enable the Department to stay competitive in the placement procurement market.

4.1.7 Fees and Charges

Meals on Wheels: No change in charge proposed

LBHF provides a meal service for residents of the borough and charges a flat rate contribution towards the service (£2 per meal). 59% of those receiving meals are female and BME ethnic groups account for 26%.

Meals services are provided to residents by the contractor Sodexo Ltd. This is part of a contract framework agreement with Sodexo Ltd and Hammersmith and Fulham Council is the lead authority. The contract commenced on 8th April 2013 and covers a five-year period. There is now six months remaining on this contract and the service is proposed to extend for a further 12 months to allow time to development of a new model for April 2019.

Maintaining the current price is expected to have a positive impact on BME user groups as well as other users as a price freeze will improve their financial position and overall wellbeing.

Careline: No change in charge proposed

There is no change proposed in the Careline charge for 2018/19, this will be the second year the carline charges will remain unchanged. This will have a positive impact as it will improve the financial position of residents in real terms.

	London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE & SOCIAL INCLUSION POLICY AND ACCOUNTABILITY COMMITTEE** **30 JANUARY 2018**
2018 Medium Term Financial Strategy (MTFS) – Public Health	
Report of the Cabinet Member for Finance	
Report Status: Open	
Classification: For review and comment. **Key Decision:** No	
Wards Affected: All	
Accountable Director:	
Report Authors: Corporate Overview Andrew Lord – Head of Strategic Planning and Monitoring Hitesh Jolapara – Strategic Finance Director Public Health Department Rachel Wigley – Director for Finance	**Contact Details:** Tel: 020 8753 2501 E-mail: hitesh.jolapara@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. Cabinet will present their revenue budget and council tax proposals to Budget Council on 21st February 2018. A balanced budget will be set in accordance with the Local Government Finance Act 1992.

1.2. This report sets out the budget proposals for the services covered by this Policy and Accountability Committee (PAC). An update is also provided on any changes in fees and charges.

1.3. Government resource assumptions, that are used to calculate LBHF's Government grant, model the council increasing council tax by 6% in 2018/19. However, in line with the administration's policy of lowering the cost of the council to residents, this increase has not been proposed. Instead, the budget proposes to freeze council tax for the year.

2. RECOMMENDATIONS

2.1. That the Policy and Accountability Committee (PAC) considers the budget proposals and makes recommendations to Cabinet as appropriate.

2.2. That the PAC considers the proposed changes to fees and charges and makes recommendations as appropriate.

3. THE BUDGET GAP

3.1. The 2018/19 budget gap, before savings, is £14.6m, rising to £55.1m by 2021/22. The budget is based on several key assumptions regarding resources and expenditure.

Table 1: Budget Gap Before Savings

	2018/19	2019/20	2020/21	2021/22
	£'m	£'m	£'m	£'m
Base Budget	**155.0**	**155.0**	**155.0**	**155.0**
Add:				
- Inflation (includes pay)	5.2	10.6	15.8	21.1
- headroom	0.0	6.0	12.0	18.0
- Growth	6.8	7.2	7.2	6.9
Budgeted Expenditure	**167.0**	**178.8**	**190.0**	**201.0**
Less:				
- Government Resources	-10.1	-28.5	-25.4	-23.5
- LBHF Resources	-139.0	-115.3	-117.2	-119.1
- Use of Developer Contributions	-3.3	-3.3	-3.3	-3.3
Budgeted Resources	**-152.4**	**-147.1**	**-145.9**	**-145.9**
Cumulative Budget Gap Before Savings	**14.6**	**31.7**	**44.1**	**55.1**
Risks	**19.3**	**25.0**	**28.3**	**31.2**

Budget Assumptions

3.2. A continued reduction in the general grant receivable by Hammersmith and Fulham from **Central Government**. Grant funding[1] has been cut in each year since 2010/11. The total reduction since April 2010 to March 2018 has been £70m. In addition, there will

[1] After allowance for changes in funding between grant and business rates.

be a further reduction in 2018/19 of £8.6m and further £5.2m cut is forecast by 2021/22.

3.3. **A Council Tax freeze** is modelled with no use of the adult social care precept. Authorities can opt to levy a maximum adult social care precept of 3% in 2018/19 and up to 6% by 2019/20. A 3% precept would raise £1.7m for LBHF. Central Government grant assumptions are based on LBHF raising council tax and the precept by a combined 6% per year to 2019/20. 2018/19 is the third year of a four-year local government finance settlement that started in 2016/17. From 2016/17 to 20181/9 Government modelling has assumed an overall council tax increase of 13.3% of which 7% relates to use of the socal care precept. The administration, however, has a commitment to reduce the cost of the council to residents and will not be increasing tax.

3.4. **Business rates** are modelled to increase with inflation with allowance made for an extra £2.2m from the opening of the Westfield extension in March 2018.

3.5. London Local Government has been working to take forward a **100% business rates retention** pilot for London from April 2018.

3.6 The pilot will pool business rates across the 33 London Boroughs and Greater London Authority (GLA).

3.7 Under such an arrangement London will keep 100% of any growth in business rates, though business rates valuations and levels would still be set by Government. Indicative modelling has suggested this may benefit Hammersmith and Fulham by £2.6m. In addition, £110m would be generated for a London wide investment pot.

3.8 At present Hammersmith and Fulham retains 30% of the business rates it collects with the balance paid to the Government and GLA. Under the proposed pilot the share retained by Hammersmith and Fulham would increase to 67% with the balance going to the GLA. The Council would not initially benefit from the increased share as there would be compensating reductions (through grant cuts and payment of a tariff to Government). These adjustments are shown in Table 2. The benefit to Hammersmith and Fulham would be receiving a share of London's future business rates growth.

Table 2 – Changes to Funding Streams from the Business Rates Pilot

	No-Pilot	With Pilot
Business Rates Baseline	77.9	157.8
Tariff payable to the Government	-18.8	-74.8
Funding Baseline	**59.1**	**83**
Revenue Support Grant	23.9	0
Total LBHF Funding	**83**	**83**

3.9 Table 2 sets out the sums assumed by the Government in the 2018 Local Government Finance Settlement. The current LBHF forecast, which will be updated in January, for business rates income is £80.4m. Under the pilot scheme there is a guarantee that no authority will be worse off than under the present scheme.

3.10 The 100% business rates retention pool:

- Is a pilot and may not continue after 2018/19.
- Uses modelling based on an aggregation of high level estimates.
- Will not confirm final income until October 2019 in relation to 2018/19

3.11 Greater clarity, after each Borough updates their 2018/19 business rates forecast, on the potential benefits from the pilot 100% business rates retention pool will be available in mid-February. No benefit is allowed for within the current LBHF resource forecast. Once confirmed the sum receivable will be added to Reserves.

3.12 **Property developments** have placed increased pressure on council services in recent years.

3.13 Section 106 agreements containing planning obligations are entered between developers and the Council as the Local Planning Authority. Legislation controls the use of such obligations, including regulation 122 of the Community Infrastructure Regulations 2010 which requires planning obligations to be:

- Necessary to make the development acceptable in planning terms;
- Directly related to the development; and
- Fairly and reasonably related in scale and kind to the development.

3.14 The Council has entered into a significant number of s106 agreements. Whilst S106 funds can only lawfully be applied in accordance with the terms of each specific agreement, as approved by the Planning Applications Committee, some approved funds are identified generally as being for expenditure on as yet unspecified “Social and Physical Infrastructure” or “Environmental Improvements” (although the agreements identify the types of projects/items the funds can be used for).

3.15 Provided the Council respects the obligation to maintain a reasonable relationship with the developments and complies with the specific terms of each of the s106 agreements giving rise to the funds, the Council has a degree of flexibility and discretion as to how it spends some of these funds. The council has analysed all its s106 agreements that may give a financial benefit to determine which should be relied upon for budgeting purposes and which have flexibility in how they may be applied. As is usual in these circumstances many areas of Council activity that have faced increased demand following new developments offer a good fit with

the purposes of some of the uncommitted s106 funds which can therefore be lawfully used to finance such activities.

3.16 The Council currently has section 106 receipts of £50.1m in hand with agreements in place for the receipt of future financial obligations of £201m. £72.4m of the future obligations are assessed as highly likely to be received by the close of 2021/22. The total amount of flexible funding in-hand, or highly likely to be received, is estimated to be a minimum of £72m by the close of 2021/22.

3.17 The 2018/19 budget assumes that £3.3m (an additional £0.7m compared to previous years) of expenditure will be funded from section 106 resources with such funding on-going over the MTFS period. In addition, contributions of £1.7m per annum are assumed towards the provision of policing.

3.18 **Inflation**. A pay award of 2% per annum is modelled compared to 1% in 2017/18. Inflation has also been provided, on a case by case basis, to meet external contractual requirements. Inflationary pressures have increased in the wider economy with the August Retail Price Index showing an increase of 3.9% compared to 1.8% last year. For 2018/19, the sum provided for overall inflation is £5.2m (£1.8m pay and £3.4m non-pay) compared to £2.9m in 2017/18.

4 GROWTH, SAVINGS AND RISKS

4.1 The growth and savings proposals for the services covered by this PAC are set out in Appendix 1.

Growth

4.2 Budget growth is summarised by Service Area in Table 3.

Table 3: 2018/19 Growth Proposals

Department	£m
Adult Social Care	1.3
Childrens Services	1.8
Environmental Services	0.6
Corporate Services	0.3
Regeneration, Planning & Housing Services	1.4
Centally Managed Budgets	1.4
Total Growth	**6.8**

Savings

4.3 The Council faces a continuing financial challenge due to overall Central Government funding cuts, unfunded burdens, inflation, and growth pressures. The budget gap will increase in each of the next

three years if no action is taken to reduce expenditure, generate more income through commercial revenue or continue to grow the number of businesses in the borough.

4.4 To close the budget gap for 2018/19 savings (including additional income) of £15.4m are proposed.

Table 4: 2018/19 Savings and Additional Income

Service Area	£'m
Adult Social Care	(2.9)
Children's Services	(2.1)
Environmental Services	(1.9)
Library Services	(0.1)
Corporate Services	(2.7)
Public Health	(2.0)
Regeneration, Planning & Housing Services	(0.2)
Commercial and Cross-Cutting	(3.5)
Savings	**(15.4)**

4.6 The Council will receive Public Health Grant of £21.8m in 2018/19. The savings of £2m in existing services will enable investment in Council services that deliver public health outcomes.

4.7 The saving proposals are categorised by savings area in Table 5.

Table 5: Categorisation of Savings and Additional Income

	2017/18 £'m	2018/19 £'m
Business Intelligence	(0.6)	(0.4)
Budget reduced in line with spend	(0.3)	(0.2)
Commercialisation	(2.9)	(3.4)
Estate Rationalisation	0	(0.1)
Income	(0.3)	(0.5)
Outside investment secured	(0.2)	(0.1)
Prevention	(0.6)	(1.6)
Procurement / Commissioning	(5.0)	(5.1)
Service reconfiguration	(2.7)	(3.1)
Staffing / Productivity	(2.2)	(0.9)
Total All Savings	**(15.0)**	**(15.4)**

Budget Risk and Reserves

4.8 The Council's budget requirement for 2018/19 is £152.4m. Within a budget of this magnitude there are inevitably areas of risk and uncertainty particularly within the current challenging financial

environment. The key financial risks that face the Council have been identified and quantified. They total £19.5m. Financial risks of £20.6m were identified when the 2017/18 Budget was set. There were no budget risks identified by the Public Health service.

4.9 The level of balances and reserves are examined each year in light of the risks facing the Authority in the medium term. The latest position is set out in Table 6.

4.10 The Council has used reserves to fund investment in transformation and efficiency and other significant one-off costs pressures. Examples in 2016/17 included investments in ICT, Invest to Save schemes such as LED street-lighting and mitigating the impact of the Managed Services project.

4.11 The 2018/19 base budget includes planned contributions of £0.75m to the Efficiency Projects Reserve and £0.8m to the IT Enablers Reserve. In addition, the proposed savings for 2018/19 (£15.4m) currently exceed the budget gap (£14.8m). This will enable a further contribution to Reserves of £0.6m. The sum due from the London 100% Business Rates retention pilot (estimated at £2.6m) will also be put to Reserves. **In total, the estimated contribution to Reserves for 2018/19 is £4.75m**. Uses of Reserves in 2018/19 will include taking forward the Integrated Family Support Service, taking forward new arrangements for the outsourced managed services programme and funding the Landlord Incentive scheme to support the provision of temporary accommodation.

Table 6 – General Fund Balances and Earmarked Reserves

	31/03/14 actual	**31/03/15 actual**	**31/0316 actual**	**31/03/17 actual**	**31/03/18 forecast**
	£'m	£'m	£'m	£'m	£'m
General Balances	19.0	19.0	19.0	19.0	19.0
Earmarked Reserves	81.6	89.5	90.0	82.7	75.0
	100.6	**108.5**	**109.0**	**101.7**	**94.0**

5 FEES AND CHARGES

5.1 The budget strategy assumes:

- Adult Social Care, Children's Services, Markets, Parking, Libraries and Housing charges frozen
- A standard uplift of 3.9% based on the August Retail Price index for other charges

- Case by case review for commercial services that are charged on a for-profit basis. These will be varied up and down in response to market conditions, with relevant Member approval.

5.2 There are no Public Health fees and charges to be reported.

6 2018/19 COUNCIL TAX LEVELS

6.1 The administration proposes to freeze the Hammersmith and Fulham's element of 2018/19 Council Tax at £727.81. This will provide a balanced budget whilst recognising the burden on local taxpayers. The Mayor of London's draft budget is currently out for consultation and is due to be presented to the London Assembly on 25th January 2018, with final confirmation of precepts on 22nd of February.

6.2 As part of the Provisional Local Government Finance Settlement the government announced that authorities can charge a 3% adult social care precept. The Council does not wish to apply this tax to residents, so it does not form part of the 2018/19 budget proposals.

6.3 Following last year's council tax freeze, the current Band D Council Tax charge of £1,007.83 (LBHF element £727.81 and GLA £280.02) is the 3rd lowest in England. In cash terms, the Band D charge for the Hammersmith and Fulham element is at its lowest since it was £706.83 in 1999/2000.

7. Comments of the Director of Public Health on the Budget Proposals

7.1. For 2018/19 the Public Health service will continue to be fully funded by the Department of Health's grant and thus will stay a nil cost budget to the Council.

7.2. The grant for 2018/19 shows a net decrease of 2.6% when compared with 2017/18 funding levels and the ring-fence on expenditure is being maintained. It is assumed that Public Health will in future be funded locally from business rates retention, but no further details are available regarding timescales for the implementation of this.

7.3. The table below shows the effects of this year's grant reductions.

PUBLIC HEALTH GRANT MOVEMENTS	
	£'000
Original 2017/18 grant	22,338
Reduction -2.6%	-581
Grant award for 2018/19	**21,757**

7.4. Public Health England has indicated that the Public Health Grant will continue to reduce for the foreseeable future, with 2.6% reductions for the next two years. In order to maintain a sustainable service there will be a further requirement to reduce spending on contracted Public Health services.

7.5. Reviews of the current service have been undertaken by the senior management team and commissioners. The following savings have been identified:

SERVICE	BUDGET 17/18 £'000	SAVINGS £'000	OTHER CHANGES £'000	BUDGET 18/19 £'000	% CHANGE
Substance Misuse	4,570	-809	0	3,761	-17.7%
Sexual Health	5,554	-751	0	4,803	-13.5%
Behaviour Change	2,395	-800	0	1,596	-33.4%
Families and Children	6,216	-916	0	5,300	-14.7%
Intelligence & Social Determinants	33	0	0	33	0.0%
Salaries & Overheads	1,220	0	0	1,220	0.0%
Public Health Investment	4,162	0	2,000	6,162	0.0%
Contribution from grant balances	-1,812	0	694	-1,118	0.0%
TOTAL COST / GRANT FUNDING	**22,338**	**-3,276**	**2,694**	**21,757**	**-14.7%**

7.6. Substance Misuse provision has been redesigned with the elimination of duplicated services and getting a better price for detox placements.

7.7. Sexual Health will complete the transformation which has occurred across London. The new tariff prices will be effective from 1st April 2018 and are the result of a shift to other testing approaches, such as self-testing at home, that are both more likely to be taken up and lower cost.

7.8. Behaviour Change has made savings from the Health Trainers contract which expired in 2017/18. This contract was operating below expected levels and as the uptake of Health Checks increased, a reduction in the use of this contract has been possible. Savings have also been found in smoking cessation.

7.9. Families and Children's services are integrating into the Family Support Service. As part of this, re-procurements of School Nursing and School Health have generated savings greater than anticipated.

7.10. The scale of savings above is such that Public Health will contribute a further £2 million towards the Public Health outcomes delivered in other areas of the Council. This additional £2 million will transform services across the Council and lead to improved health outcomes whilst providing better value for money. This takes the total PH investment to £6.162 million in council services that benefit public health of residents.

7.11. In 2018/19, Public Health will balance its funding requirement with a £1.118 million drawdown from public health earmarked reserves built up through public health underspends in recent years. This will give time for re-procurement of services to take place and bed in.

8. Equality Implications

8.1. A draft Equality Impact Analysis (EIA), which assesses the impacts on equality of the main items in the budget proposals relevant to this PAC, is attached as Appendix 3. A final EIA will be reported to Budget Council.

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		

Appendix 1 – Savings and Growth Proposals

Appendix 2 – Draft Equality Impact Assessment

Appendix 1 - Growth Savings

Adult Social Care

MTFS Growth			Budget Change			
Service	**Description**		**2018-19 Budget Change (£000's)**	**2019-20 Budget Change Cumulative (£000's)**	**2020-21 Budget Change Cumulative (£000's)**	**2021-22 Budget Change Cumulative (£000's)**
All	Departmental growth arising from demographic pressures and increased costs of social care		1,249	1,249	1,249	1,249
Total Growth			**1,249**	**1,249**	**1,249**	**1,249**

MTFS Savings			Budget Change			
Service	**Description**	**Delivery Risk (R-A-G)**	**2018-19 Budget Change (£000's)**	**2019-20 Budget Change Cumulative (£000's)**	**2020-21 Budget Change Cumulative (£000's)**	**2021-22 Budget Change Cumulative (£000's)**
Integrated Care	Promoting Independence through social work practice. Reduction in Community Care spend as the council facilitates individual care and support plans for residents. Forensic assessment of where payments are not aligned to services provided for residents.	Medium	(747)	(1,397)	(1,397)	(1,397)
Strategic Commissioning & Enterprise	Major re-commissioning projects in the areas of Learning Disabilities Accommodation and Support; Mental Health Accommodation and Support. Day Care Services and Extra Care Housing.	Medium	(505)	(505)	(505)	(505)
Strategic Commissioning & Enterprise	An in-depth value for money assessment of the councils in-house care and support service portfolio	High	(75)	(75)	(75)	(75)
Strategic Commissioning & Enterprise	Dynamic Purchasing System.	Medium	(100)	(100)	(100)	(100)
Integrated Care	Improved transition and promoting independence.	Medium	(310)	(465)	(465)	(465)
Strategic Commissioning & Enterprise	Review of supporting housing programme	Medium	(130)	(130)	(130)	(130)
Strategic Commissioning & Enterprise	Improved targeting of prevention services and increased emphasis on using community assets to deliver better services for residents	Medium	(150)	(150)	(150)	(150)
Director	The Whole Systems Integration Programme with the NHS.	Medium	(700)	(700)	(700)	(700)
All	Review of workforce costs moving into single borough arrangement	Medium	(100)	(100)	(100)	(100)
Asset Based Approach to Transport	Transport: Review transport provision and policy across care type and consider opportunities to promote independence wherever possible.	Medium	(99)	(110)	(120)	(120)
Total Savings			**(2,916)**	**(3,732)**	**(3,742)**	**(3,742)**

DRAFT Equality Impact Analysis (EIA) of main budget proposals for 2018/19 Public Health

The impact of 2018-19 efficiencies proposals is detailed in this report. They are grouped into transformation projects, procurement and contract efficiencies, reconfiguration of services and other efficiencies. With reconfiguration and procurement activity, detailed EIAs will be carried out at the time the proposals are in development when the potential impact can be fully assessed. For transformation projects, the savings will be re-invested into other council departments where Public Health outcomes are achieved. All expenditure and savings will be contained within the ring-fenced Public Health Grant Budget and earmarked reserves.

Sexual Health Services

2017-18 Budget	2018-19 Proposed Budget	2018-19 Savings
£5,554k	£4,803k	(£751k)

The majority of the saving is gained from the re-design and re-procurement of the genito-urinary medicine (GUM) contract, which will promote channel shift to online and postal sampling rather than clinical sampling. This will commence on 1st April 2018 with the savings arising from the channel-shift activity, in addition to lower tariff costs for testing.

The re-designed service will continue to offer open access and ensure that the services are accessible to all, therefore there should be no changes for those groups who hold protected characteristics.

Substance Misuse Services

2017-18 Budget	2018-19 Proposed Budget	2018-19 Savings
£4,570k	£3,761k	(£809k)

The newly procured detox placement contracts have coped with the levels of demand in the borough. Therefore, the £116K allocated from the risk and transformation fund (held to address any pressures from new contracts) is not required.

The remaining savings arise from redesigned services and elimination of service duplications, in addition to planned contract savings. The redesigned services provided the opportunity to strive for disabled friendly premises and will enable disabled friendly refurbishment: inclusion of ramps, wide door frames, info in braille, U-loop, lifts or wheelchair friendly design.

The most common age of service users is 30-40, with many having been in treatment for long periods of time. Re-commissioned services have renewed focus on engaging older drinkers, which is shown to be cost effective by avoiding long term care and health interventions later on.

The prevalence of substance misuse issues amongst some of the more marginalised ethnic groups, accompanied by cultural stigma and shame associated with substance misuse, has led to commissioned services which focus on engaging BAME substance misusers into treatment. Services are provided on an in-reach basis at venues best suited to meet the needs of this group and staff members will be knowledgeable in the cultures individuals are from. Service information and advice is available in a wide range of languages.

Behaviour Change

2017-18 Budget	2018-19 Proposed Budget	2018-19 Savings
£2,396k	£1,596k	(£800k)

Within Behaviour Change, an element of activity is for Health Checks, which are aimed at older residents within the borough. As part of efficiency proposals, the Health Trainers element of Health Checks has ended. This activity was operating below the levels anticipated and so a decision was taken to not renew the activity when the original contract ceased.

There is also a reduction to the funding of the nicotine replacement therapy within smoking cessation. This is open access and residents can access support and guidance through the successful Kick It smoking cessation programme,

There will be no adverse impact and residents accessing the service will not notice any difference.

Families and Children

2017-18 Budget	2018-19 Proposed Budget	2018-19 Savings
£6,216k	£5,300k	(£916k)

The majority of services within Families and Children's provide universal services to families with children. The efficiency proposals are related to Childhood Obesity contracts.

The proposal to not renew the contracts was made as the activity is delivered in schools by other services, therefore a more efficient approach to delivering obesity prevention activity in schools can be found.

Conclusion on impact on the budget for Public Health

The vast majority of the efficiencies proposals have a neutral equalities impact. The substance misuse services continuing to focus on greater engagement with BAME substance misusers has a positive equalities impact.

London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY & ACCOUNTABILITY COMMITTEE** **30 January 2018**	
WORK PROGRAMME 2017-18	
Report of the Chair – Councillor Rory Vaughan	
Open Report	
Classification: For review and comment **Key Decision:** No	
Wards Affected: None	
Accountable Director: Sarah Thomas, Interim Director for 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 2017/18.

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 2017/18

Appendix 1

Health, Social Care and Social Inclusion Policy and Accountability Committee

Item – Report Title	Report Author / service	Status
30th January 2018		
A Report On H&F Council's Emergency Response to Major Incidents in June and September 2017	Chief Executive	Confirmed
Annual Budget Report – ASC and Public Health (x2)	Finance LBHF	Confirmed
Funding of GP Practices in H&F	H&F CCG	Confirmed
13th March 2018		
GP Prescription Services	CCG	Expected
Transitions Task Group – Findings	Governance and Scrutiny	Expected
Digital Inclusion	Policy	TBC

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
- Integration of Healthcare, Social Care and Public Health
- Listening to and Supporting Carers
- Self-directed Support: Progress Update
- Tuberculosis
- Digital Inclusion (2018)