London Borough of Hammersmith & Fulham

Health, Inclusion and Social Care Policy and Accountability Committee

Minutes

Tuesday 4 December 2018

PRESENT

Committee members: Councillors Lucy Richardson (Chair), Jonathan Caleb-Landy, Bora Kwon, Amanda Lloyd-Harris and Mercy Umeh

Co-opted members: Victoria Brignell (Action On Disability), Jim Grealy (Save Our Hospitals) and Bryan Naylor (Age UK)

Other Councillors: Ben Coleman

Officers: Vanessa Andreae, Vice-Chair, H&F CCG; Martin Calleja, Head of Health Partnerships; Janet Cree, Managing Director, H&F CCG; Rory Hegarty, Assistant Director of Communications, H&F CCG; Lisa Redfern, Director of Adult Social Care and Public Services Reform

208. MINUTES OF THE PREVIOUS MEETING

RESOLVED

That the minutes of the previous meeting be agreed as an accurate record.

209. APOLOGIES FOR ABSENCE

There were no apologies for absence.

210. DECLARATION OF INTEREST

Councillor Amanda Lloyd-Harris declared an interest as a former Chair of Hammersmith and Fulham MIND.

211. APPOINTMENT OF CO-OPTEE

The Committee considered the nomination of a new co-optee. This was proposed by the Chair, Councillor Lucy Richardson and seconded by the Vice-Chair, Councillor Bora Kwon.

RESOLVED

That Jennifer Nightingale be appointed as a co-optee to the Committee for the municipal year 2018/19.

212. HEALTHWATCH HAMMERSMITH AND FULHAM (HWCW)

Olivia Clymer presented a brief update on current priorities, the key points of which were addressed in the report. There were concerns around The Pembridge Hospice, about the handling of communications about the temporary closure and the way in which people had been informed of this, which had been reported to H&F CCG and the Royal Borough of Kensington and Chelsea (RBKC). The future for the provision of services from the Royal Brompton Hospital were highlighted as of interest to the wider community. Healthwatch had received briefings and initial observations were that that there needed to be greater consultations with specialist groups. Healthwatch commended H&F CCG for the recent finance workshops they had facilitated, recognising that they were operating under increasingly difficult financial pressure.

RESOLVED

That the update from Healthwatch be noted.

213. UPDATE FROM CENTRAL LONDON COMMUNITY NHS TRUST ON THE DECISION TO STOP INPATIENT ADMISSIONS FROM THE 1.10.2018 TO THE PEMBRIDGE HOSPICE, EXMOOR STREET, W10.

The Chair welcomed Andrew Ridley, and Dr Joanne Medhurst, from CLCH, supported by Janet Cree. Mr Ridley briefly explained the circumstances that had led to a decision to suspend all admissions into the in-patient beds of The Pembridge Hospice. Staffing levels at the Hospice had been maintained and provision for day patients had continued, so it remained open in all other respects.

Co-optee Victoria Brignell asked about the wider context and whether other hospices had experienced similar difficulties. Dr Medhurst reported that she had spoken to several other hospices in the London area, all of which had reported difficulties in recruitment. It was confirmed that this was also a national experience. CLCH had tried to offer improved remuneration and had made informal enquiries through medical and professional networks. One application had been received but this had been unsuitable, and a review commissioned by the CCG. Dr Medhurst commented that the model of care outside of London was nursing led, by contrast to the model operated at Pembridge, which was consultant led, which indicated a need for more creative solutions. In response to a follow up question, Dr Medhurst confirmed that the issue had been escalated to the Department of Health and

that she had been unaware of the recent private members bill to improve palliative care.

Co-optee Jim Grealy commented that a member of his family had received palliative care and that this was an issue that would not be resolved quickly or easily. It was a strain on family members to have loved ones placed in hospices located outside their boroughs. Janet Cree confirmed that the CCG had no intention to reduce the provision of palliative care from a commissioning perspective but needed to ensure that the provision remained clinically safe. Dr Medhurst added that the Pembridge was not just a hospice but also included day and community units. The community service aspect of the whole provision was very important. Many people hope to end their lives peacefully, in their own homes. The Trust had redeployed hospice staff and reconfigured services around community focused provision.

Dr Medhurst expressed her concern about the possible loss of highly valued and skilled nursing staff, who may choose to leave the service, because of the temporary closure. They would have to consider the clinical strategy and look at staff models. The impact on the wider system was that patients had been transferred to St Johns and that The Pembridge was closed to new admissions. Patients had been diverted elsewhere to minimise the number of transfers, and this was currently being managed. Ms Cree reported that she was not aware of patients experiencing delays in care, but recognised that there had been increased flow. It was acknowledged that the demand for palliative care could be variable, which had been included in the forecast of projected need.

Co-optee Bryan Naylor enquired about the anticipated length of the temporary closure. Dr Medhurst replied that the Trust will re-advertise the New year and were working with provider commissioning boards to find a solution. The CCG had appointed a chief nurse as a clinical expert to help with the modelling. It was accepted that given the difficulties, a suitable appointment might not be made until the end of February, given the lack of suitable candidates.

Lisa Redfern queried the shift in the model of care from being nurse to consultant led. It was observed that the Trust may have had early awareness of the difficulties and asked why the CCG received late notice of the situation. Ms Redfern expressed further concern regarding the mixed messages about the refurbishment of Pembridge, and the implication that the hospice was closing due to the need for redesign. Given the added pressure on acute beds, Ms Redfern was unconvinced that there would be no corresponding impact, although the lack of a suitable appointment was noted.
Dr Medhurst responded that they had spoken to all the professional, medical leads in the palliative care network, with no result. They had considered appointing a doctor in training, however, this was a position for a lone, lead consultant. It was important to recruit a person with the appropriate level of expertise. Dr Medhurst admitted that they were in a tenuous position and had not fully appreciated the issue of the notice period being so critical. Patients had complex care needs and the opportunity to refurbish the facility and restructure the service was timely. As they went through the redesign, the

Trust would consider how to mitigate and make provision for wider end of life care cohort.

Councillor Richardson commented that this was an end of life pathway and that to consider closing the unit, while simultaneously considering changes to it sounded ambitious. Councillor Richardson added that she had also received reports about the poor fabric of the building and asked whether an impact assessment had been conducted, before the closure had been determined. Dr Medhurst reiterated that the unit had been closed on safety grounds. Mr Ridley added that it was not possible to change the model and move it away from being medical. This was a complex provision and he stated categorically that there was no plan to close the unit permanently. The assumption that the closure was because of the refurbishment was incorrect.

Councillor Richardson invited members of the public to provide details of their personal experiences of using the palliative care provision provided by Pembridge.

Members of the public recounted shared, collective experiences. They presented overwhelming support for the service, recognising that The Pembridge offered a unique form of care that extended beyond clinical treatment. It was about having a safe, peaceful, and caring environment, that provided support to not just the person who was reaching the end of their life, but their family and loved ones, who wanted to support them throughout the process. The expertise and knowledge offered by units such as The Pembridge was essential for ensuring this. It was also clear that the stress of travel (including distance) was an important factor in keeping The Pembridge. Palliative care needed to be provided locally, and it was important to have a qualified consultant in post, so that the service could be re-opened as soon as possible. There was significant concern that the loss of beds would continue, leading to additional pressure on local hospitals such as Charing Cross.

The comments were based on real life experiences and were particularly evocative, advocating strong support for the service to be reinstated.

In identifying some of the points raised, Dr Medhurst clarified that it was not possible to have a visiting consultant. They had tried to appoint one candidate, who worked for two weeks before it had become apparent that they did not have sufficient experience or expertise and could not prescribe the specialised drugs. The Pembridge Hospice was a facility to be extremely proud of, but safety assurances were necessary for the protection of both staff and patients.

Ms Clymer highlighted the quality of the communication undertaken by CLCH. The lack of communication had caused distress and serious concern. She explained that Healthwatch, was part of the regulatory care framework and Healthwatch was able to help address this and form part of a working group, that would work with the CCG.

Ms Cree recognised that communication was a concern and as part of a review going forward, the CCG wanted to ensure that engagement with the

right stakeholders was undertaken. A steering group would offer an opportunity to do so.

Councillor Sue Fennimore asked at which point the CLCH and the CCG had recognised that it would be difficult to recruit. Given the chain of events, she questioned whether the residents of Hammersmith & Fulham were being best served. Councillor Fennimore understood that there were service pressures, but having relatives end their lives in noisy hospitals, in an undignified fashion was unacceptable. Councillor Fennimore challenged the quality of the Trusts communications and queried if the potential impact on Charing Cross hospital had been considered. It appeared extraordinary that the Trust should find itself in such a position, with little urgency in its actions and no information provided about who would be represented on the steering group.

Councillor Lloyd-Harris observed that in addition to the lack of communication, it was fundamentally wrong to not have an appropriate forum in which the issue could be discussed, in advance of the Committee's meeting. Councillor Coleman confirmed that the Council members and officers met regularly with NHS colleagues but the key point to note was that this was a public meeting of the Committee and therefore played an important part in safeguarding the democratic process.

Councillor Caleb-Landy enquired about how the CLCH would mitigate against the risk of impact on other services. This would be particularly unacceptable as the difficult winter pressure period commenced. Dr Medhurst replied that most staff at CLCH were recruited through multiple ways but that the current situation at The Pembridge was unusual. Hospices had hugely fragile systems and Dr Medhurst gave an assurance that they would try to resolve this as quickly as possible.

Councillor Coleman enquired about the land that The Pembridge was situated on, given that the NHS was nationally trying to sell off land. He asked if anyone had considered what the Trust would do with the land, should The Pembridge unit be closed, what the possible value of the land would be and how much would the CLCH save if the unit was closed.

Mr Ridley confirmed that NHS estates owned the land on which The Pembridge was situated and that he did not know of its value. CLCH had paid rent on the unit, which had now been closed for two months. In addition, the Trust had also met the cost of recruitment. The Trust was currently losing money but if the unit closed, this would be cost neutral. Mr Ridley's primary concern however, was the loss of experienced, committed staff, and the loss of the service contract commissioned by the CCG.

Ms Brignell asked about whether consultant training was an issue that the Trust could address, possibly through overseas recruitment. Dr Medhurst explained that the Trust was considering how to address the shortfall in consultant training. In early 2019, the Trust will be trying to encourage signposting of The Pembridge overseas and registering this with recruitment agencies. Applicants will still need to meet regulatory requirements.

In summarising the key points of the discussion, Councillor Richardson welcomed the Trusts intention to not reduce or reconfigure the service during its hiatus and noted that the day patient provision would continue unimpeded, for the time being. Councillor Richardson looked forward to hearing more about how the recruitment process was progressing after Christmas, following re-advertisement; and about Healthwatch' s involvement in the work of the steering group. Councillor Richardson thanked members of the public, who had shared their personal stories, recognising that these collective experiences indicated whole-hearted support for maintaining local, palliative care provision for the residents of Hammersmith & Fulham.

ACTION: CLCH and the CCG to keep the PAC informed as to the future provision of palliative care services from The Pembridge Hospice and provide an update on the recruitment following re-advertisement

RESOLVED

That the report be noted.

214. ROYAL BROMPTON HOSPITAL TRUST

Professor Tim Orchard briefly explained the background to the report, which had considered options at a meeting in September. Proposals had been submitted by Kings Health partners, which proposed to move most of the services from the Royal Brompton Trust (RBH) to a site on the St Thomas hospital campus (part of Guys and St Thomas NHS Foundation Trust). This would be an expensive proposal, involving the transfer of congenital paediatric heart surgery services. Professor Orchard explained that the proposed joint bid (Imperial College Healthcare NHS Trust; and Chelsea and Westminster Hospital NHS Foundation Trust) would provide similar services, without moving them out of the NW London area, building on existing networks, utilising local expertise in both Imperial, and Chelsea and Westminster. High level documents had been produced which set out how these services could be provided more efficiently. The proposal had been submitted to NHS England, which would be meeting next week to discuss the joint bid. Professor Orchard indicated that when they had first approached NHS England, their preferred option had been for services not to be removed from RBH, however, they would aim to work as a collective of providers, to ensure that services remained local. Professor Orchard made the following points:

- An adult cardio-respiratory unit on the Du Cane Road site would be established. There was currently an empty block, available and this had been submitted as part of the proposal to NHS England. An in-patient care facility would also have to be built;
- New cardio service on Chelsea site;
- National heart and lung service would become part of the Hammersmith hospital; and
- Combined paediatric services, to maintain a unified approach.

Professor Orchard considered that this was the beginning of the process and further consideration as to how this would fit in with the options for public consultation, was required. He was hopeful that the first response from NHS England would indicate what proposals could be consulted upon. This would also offer an opportunity to further discuss with other providers.

Councillor Kwon asked if there was capacity at St Thomas's to accommodate services moving from RBH and the possible impact on their reputation. Professor Orchard explained that there would be a new build and confirmed that there would be capacity at St Thomas's. He speculated that there would be some reputational impact on RBH services moving to another NHS trust.

Councillor Caleb-Landy asked about the possible timeline for the transfer of services and what the plans were for consulting Hammersmith & Fulham residents about the changes. Professor Orchard confirmed that this was a significant decision and that there would be a special remit for consultation, which was complex. As most of work at RBH was commissioned by NHS England, there needed to be a mechanism for the whole the service to be consulted on. It was critical to get the right input.

In a response to a question from a member of the public, Professor Orchard confirmed that co-operation between Imperial, Chelsea and Westminster and St Thomas's was good. He clarified that this was not a "takeover bid" and did not think it would impact on the relationship. The link between the trusts was positive and extended to sharing expertise and collaborative work, for example, patient record sharing. Professor Orchard concurred that residents in Kensington and Chelsea were well served by RBH, as a specialist hospital.

A representative from Save Our Hospitals sought further information and clarity about the planned consultation and was concerned that no information had been provided about the new bid by RBH. Professor Orchard said that in terms of the consultation proposals, it was not a simple matter of residents engaging with the consultation process. The responsibility of developing consultation rested with statutory organisations, and not RBH. It was important to consider the breadth of the consultation, so that all views could be collected, and for this to be shared with NHS England and the CCGs.

Councillor Robert Freeman, Chair, Health and Adult Social Care Overview and Scrutiny Committee, from the Royal Borough of Kensington and Chelsea explained that the Committee was the designated scrutiny lead with a statutory remit to report to the Secretary of State as to whether any proposal for variations in services was in the best interests of residents. If RBH services moved to the South Bank, Councillor Freeman was of the view of the that this would mark the eventual end of RBH. It was difficult to see how two trusts could be based on one site. Equally, it was likely that RBH would not survive the transfer of services to Imperial, and Chelsea and Westminster. RBH had strong links with Chelsea and Westminster and worked closely with the Royal Marsden. Many residents and stakeholders had worked hard to support RBH and its closure would be a great blow.

George Doughty, Lead Governor, Council of Governors, RBH, gave an assurance that neither governors or staff had anticipated being in this position. RBH was unique in providing treatment that spanned an individual's lifetime. In his view, NHS England had tried to undermine RBH for many years and had unfortunately wanted to impose regulations for the operation of neonatal clinical units, which RBH was unable to comply with. Mr Doughty explained that NHS England had determined that the distance between the Chelsea and Westminster site and RBH was too far (although to date, Mr Doughty reported that he was not aware of a single fatality). Pericardial and paediatric respiratory services were delivered well, together but RBH had been forced in November to close the paediatric service.

Mr Doughty was of the view that this was very much an issue of colocation and hoped for a solution. RBH was a centre of excellence that dealt with patients from all over the UK and whose services warranted protection. It was confirmed that the all cardio-respiratory patients would have to be moved from the RBH site by April 2022. It was feasible that the Westminster site might still be under construction and that was unrealistic. Mr Doughty was adamant that the trusts would not merge. The financial drive will be heavily dependent on how RBH was able to fund raise.

Professor Orchard clarified that the Imperial, and Chelsea and Westminster joint bid was a reaction to a proposal which would see services moving out of the locality and stated that he would welcome the opportunity to form a working group to consider other proposals.

Councillor Coleman asked Mr Doughty if he felt fettered by NHS England. Mr Doughty explained that RBH as a site had been in place for 110 years and some buildings were not fit for purpose. He welcomed the possibility of the Trust remaining on the site as RBH was equipped with phenomenal equipment, but the physical structure was inadequate. The conundrum was how to support patients during a refurbishment, while ensuring that they continued to receive the best possible care.

Professor Orchard said he was familiar with the issue and commented that Imperial had considerable experience of providing services out of poor-quality buildings. He explained that he had not had the opportunity to discuss proposals with providers but that this would be helpful. Councillor Coleman suggested that if this was the case, then NHS England should be invited to attend a meeting of either the scrutiny committees or the health and wellbeing boards.

Dr Richard Grocott-Mason, Medical Director, RBH, reported that there had been many conversations with Imperial; and Chelsea and Westminster, in addition to discussions with NHS England, without consensus. He reported that the Imperial / Chelsea and Westminster proposal had not been discussed with RBH, before making it public. Dr Grocott-Mason stated that he would have welcomed the opportunity to attend the Committee's meeting and present his views on behalf of the Trust. He maintained that inaction was not an option, given the condition of the buildings and existing staff structures. Current services would be even less sustainable, if children's services were to

be removed and suggestions as to how the current impasse could be addressed were welcomed. It was reiterated that the fragmentation of RBH services was unacceptable.

Professor Orchard replied that the proposal from Kings Health had not been made public. He explained that interaction with RBH, had not led him to believe that there was any appetite to discuss the proposals. He did not have a suggestion, but that there was potential to discuss relationships within the sector. Professor Orchard confirmed that he would be happy to meet and undertake discussions as a working group, with the aim of keeping services within the North-West London area. There had never been any intention for the joint proposal to be regarded as a hostile takeover bid.

Councillor Richardson commended providers for managing to retain the facility, which was clearly an indication that providers were keen to put patients first.

ACTION: Imperial and Chelsea and Westminster to provide and update of the progress of the joint bid for RBH services

RESOLVED

That the report be noted.

215. PRIMARY AND URGENT CARE PROPOSALS - HAMMERSMITH AND FULHAM CLINICAL COMMISSIONING GROUP

Councillor Richardson welcomed Janet Cree, Dr James Cavanagh, Rory Hegarty and Vanessa Andreae, who would jointly speak to the report. Ms Cree explained that that the report outlined primary care and urgent care centre (UCC) proposed changes. It also addressed the implementation of digital plans, the offer of increased choice, responding to patients to match demand. Ms Cree referred to details in the report about UCC, focusing on Hammersmith Care Centre, where just under 8% of usage occurred between midnight and 8am. Commonly, five people attended the centre overnight, most of whom were discharged without further treatment. Routine data indicated that around six patients would be discharged, and one transferred to A&E. Clinically, only two patients per night were treated. There was no proposal to change the UCC at Charing Cross Hospital.

In H&F, 765 additional GP appointments were currently commissioned weekly through two schemes, extended hours and weekend plus. Demand was met across the 29 practices in total; 19 practices were locally commissioned and 5 delivered in accordance with the national criteria. The CCG had met with NHS London Clinical Senate on 20 November 2018, and had outlined proposals and presented the clinical data that they hoped to consult upon. The Clinical Senate had sought further details about the transfer of patients to Charing Cross and about how consultation would take place. The Clinical Senate had confirmed that the proposals were clinically safe, compared to the current model, and that changes would not impact on the provision of primary

care services. Chapter 5 set out an overview of the consultation and presented feedback, responding to some of the questions raised.

ACTION: CCG to provide information about patient transfers to Charing Cross, and, how the consultation would take place. CCG to forward this information to the Strategic Director of ASC and PSR.

Lisa Redfern expressed concern, and contextualised the impact of the proposed changes on residents. The commentary provided, in her view, a complex and inadequate narrative and appeared to be trying to achieve too much, in a short period. The intention to reduce services and, simultaneously introduce changes, was hugely challenging and would have a major impact. Ms Redfern recognised that there was logic in the proposals for reducing UCC services, but there was no compelling argument for the parallel reduction in GP out of hours provision. This, together with the reduction in practice hubs, held little logic. The introduction of digital based services such as GP at Hand, was also difficult to understand. Drawing a comparison with mobile banking services, Ms Redfern cautioned that the CCG were trying to phase in a significant change over a short timeframe, against a backdrop of additional, significant primary care service variations. The process also failed to recognise that while part of the population would be able to adapt, other groups would need longer to adjust. Any consultation questions would need to be set in this context. A final concern was the fact that these reductions in services had all been introduced at the same time, within the same setting.

Councillor Caleb-Landy echoed Ms Redfern's comments and expressed similar concerns. The report was complex and needed to be understood in the context of the CCG financial report (Agenda Item 8). He questioned if the changes were motivated by the financial difficulties that the CCG were experiencing. Ms Cree responded that the changes were about matching availability of demand, while at the same time meeting a duty of care to provide efficient services. Current provision was underutilised and clinical resources needed to be used effectively. Feedback from patients had indicated that it had been complicated to navigate UCC care pathways. The aim of the proposals was to try and achieve greater clarity, maintain clinical safety, and improve patient pathways. These were not financially driven; although it was accepted that this was conjoined with ensuring efficiencies.

Ms Cree continued that they had consulted with the provider, who had joined them at the Clinical Senate. One of the difficulties was that Hammersmith UCC was not situated in a co-located facility, which was frustrating. The proposed changes would help move provision towards co-located services. Councillor Caleb-Landy welcomed this approach but expressed concern that residents had not been consulted about the options that they would like to see and to decide for themselves as to what they wanted. In his view, this constituted an important part of the consultation. Ms Cree responded that feedback from the Committee was helpful, as part of the consultation. It was explained that one of the key factors driving the need for change was that the Hammersmith UCC contract was due to end and would need to be re-contracted. The CCG had tried to be clear about the proposal, without predetermining the outcome.

Councillor Kwon observed that the CCG report appeared to be an amalgamation of three different reports. It was hard to envisage what services would be available, following the implementation of the changes. The proposals offered a reduction in services, however, Councillor Kwon commented that she would have welcomed more solutions being offered in the report. Councillor Richardson supported Councillor Kwon's comments, and added that it was difficult to see the logic in reducing out of hours appointments, at the same time as reducing UCC provision. Ms Andreae responded that the digital offer addressed some of these concerns and would ensure that provision was future proofed. Broad consultation on all the proposals was necessary to ensure transparency and openness. Ms Andreae acknowledged that some of the changes were financially driven, however, if residents indicated that this was not wanted, then some uncomfortable financial decisions would need to be made. Ms Cree reiterated her earlier point in response to Councillor Kwon's comments, that out of hours practice appointments had been underutilised and that there was an urgent need to match need to resource.

Co-optee Jen Nightingale asked about how successful the digital offer was expected to be and Ms Cree explained that this was difficult to report. There was a cohort of patients that would benefit from this type of access. The vision was that H&F residents would all have access to a GP. Ms Andreae expanded that there were different tiers within digital care and that the level of this kind of service would vary in different practices. They hoped to mirror the NHS 111 offer, in addition to offering an appointment. It was important to identify what would work well for residents, according to individual practice requirements.

Co-optee Jim Grealy commented that the changes were cuts. Referencing previous CCG communications which informed residents about A&E services moving to UCCs, Mr Grealy pointed out that people had not been properly signposted. He suggested that the CCG reviewed current provision and reconsidered their approach. The CCG needed to be honest, open and upfront up about having a cost-cutting agenda. The key point to note was that out of hours care was being reduced, with fewer GP appointments being offered. He added that it was not the responsibility of members of the Committee to endorse a cuts agenda. Ms Andreae admitted that this was partly about finance, particularly given the UCC contract renewal. H&F CCG was the only CCG that offered this level of out of hours service, which was outstanding compared to the national offer. Ms Cree added that the report set out proposals for discussion and had not predetermined the outcome.

Mr Naylor said that it was nonsense to put the document forward as a consultative document, when it was clearly about cuts. It was implied that local, older people were aware of the local offer, however, most were confused, not knowing when to contact NHS 111, or go to the UCC. The assumption that residents were informed, was an error in judgement and it was suggested that the CCG needed to communicate the current offer, and how to access it, before they determined whether services should be

reconfigured. The CCG welcomed the comments and reiterated that this was not the final consultation document.

Councillor Umeh endorsed comments made by Ms Redfern and pointed out that the Northern part of the Borough was not well served. To consider the closure of the Hammersmith UCC was a concern. Residents could access services at Charing Cross, if they could reach it, and that this lack of provision was unacceptable. It was also insulting to residents to imply that most did not understand the digital offer. In response, Ms Andreae said that most people would self-select in terms of how they accessed services, but those who sought the digital offer were largely older. Patient pathways could be confusing, if consulted on separately, which was why they had chosen to consult on all aspects.

Ms Redfern sought confirmation that an analysis of patients transferring to A&E would be included as part of the consultation process. The current data did not indicate whether the patient would be able to manage the journey. Ms Cree clarified that some patients were transferred to A&E, dependent on their condition and the treatment needed. Councillor Coleman described the report as confusing, and that it was not clear what questions were being consulted upon. The report offered little clarity about the questions being asked in the context of reconfiguring out of hours services.

RESOLVED

That the meeting be extended for a further thirty minutes.

Ms Cree referred to the front page of the covering report, and chapter 4 of the report which outlined questions for the consultation. The bullet points were clear and specific, and the aim was to ensure proper scrutiny as to the quality of the consultation. The CCG sought feedback as to how this could be improved. Councillor Coleman referred to page 33 of the report and enquired if the policies were in line with Shaping a Healthier Future (SaHF) and how this could be married with the possible, increased burden to Charing Cross Hospital. Ms Cree responded that the CCG ensured that patients were provided the right care, in the right place, complying with clinical safety standards. The proposed overnight closure was endorsed by Imperial and would not impact on performance at Charing Cross.

Councillor Coleman sought confirmation about the information in the report and references made to information that would come out of the consultation. He asked if this was sufficient for further analysis or if more information would be required. Ms Cree confirmed that they had sufficient information on which to go out to consultation and receive feedback from residents.

Councillor Lloyd-Harris referenced the report and noted that 64% of patients could access alternative provision. She asked if there was a procedure in place to ensure that individuals could access a GP appointment. Ms Cree confirmed that more accurate information was available about the type of presentation that might be treated at UCC. If the proposals were accepted, the CCG would have to consider how to advertise them. At the same time,

they would have to consider the how patients would navigate the digital offer. Finally, if Hammersmith UCC closed, they would also have to consider how patients could access Charing Cross UCC. Councillor Lloyd-Harris pointed out that groups with protected characteristics (Equalities Act 2010) might find it difficult to access services. Ms Cree replied that she was aware of this, and additionally, groups without protected characteristics, who are also less able to access services. Mr Hegarty confirmed that the CCG wanted to reach as many groups as possible, across the Borough and welcomed advice from the Borough on how to do so.

Ms Brignell commented that the out of hours offer suggested that the service was needed and used by the majority of patients. Ms Cree explained that the proposal was to change the way in which this service was commissioned, and not cease commissioning it. Some practices made additional provision under a local offer, and all practices delivered Direct Enhanced Services (DES) under a national scheme. Both were offered with different rates of pay. The proposal was that all practices moved from the local offer to the DES (national scheme). Ms Brignell understood the distinction but reiterated that patients valued the flexibility that the local offer provided.

Merrill Hammer, Save Our Hospitals, challenged the idea that the aim was to match the availability of services according to demand. Hammersmith UCC was in one of the most deprived parts of the Borough, with a high percentage of BAME (Black and Asian minority ethnicity) groups. Yet there was no data to indicate the attendance of groups within the protected characteristics cohort. The data was based on only one year's attendance at A&E and there was little to indicate that information about UCC services had been given to residents. Ms Hammer questioned how well the CCG had communicated information. She suggested that the CCG needed information about how well residents knew what was on offer. Less deprived residents in the South of the Borough understood the local offer better and the CCG needed to address the imbalance. Ms Hammer also pointed out that formulated plans about the digital offer were not provided.

Councillor Caleb-Landy commented that it was difficult to perceive any consideration or thought behind the planned consultation and that a wider, strategic narrative would have been helpful. There was no indication as to the cost of the UCC, or, the possible back office savings. He was concerned that withdrawing the service could have an adverse impact on other services.

In summarising the key points of the discussion, Councillor Richardson highlighted the lack of information to patients and asked if it was possible to have data that extended further than a year, and in addition, what publicity had been provided by the CCG communicating details of the UCC local offer. The Committee requested further details about the viability of the proposals and the nature of the consultation and Councillor Richardson confirmed that she would be writing to the CCG to request further clarification.

ACTION: The Chair to write to the CCG, requesting information about the viability of the service change proposals and the nature of the consultation about the proposed changes

RESOLVED

That the report be noted.

216. FINANCIAL RECOVERY PLAN - HAMMERSMITH AND FULHAM CLINICAL COMMISSIONING GROUP

The Committee had requested a report from the CCG setting out the current financial position. It provided detailed information about months 6 and 7, 2018/19. The paper had also been presented to the governing body of the CCG. This set out how the CCG would manage its financial recovery, and targets for expenditure reduction. Ms Cree confirmed that they had not had notice of funding for 2019/20, and, any impact from the implementation of NHS long term plans would not be known until after Brexit.

The aim for the 2018/19 plan was to deliver reduction, and targets were factored to allow for any slippage. The H&F CCG allocation had remained either the same or had been cut and historically, had been overallocated. The month 6 position indicated a release of all the reserves available to the CCG and it was likely that by the end of the financial year, there would be a £5 million overspend. Ms Cree confirmed that she had received an assurance that NHS England would help mitigate.

Ms Redfern referred to section 6.3 of the report, page 86. The cuts being proposed were brutal and not clearly discernible from the report. The report did not offer a clear narrative about the local priorities. It was critical that a local commentary should clearly explain the proposals, and that this should be set out strategically. Ms Redfern stated that it was incumbent upon the CCG to clearly set out the detail, which was absent from the scenario outlined in page 86.

Ms Redfern pointed out that that there was a critical piece of information that was missing, and referred to a letter that had been sent to the Council by the CCG, which had advised that £1.25 million was being withheld from the Council. This would impact on services delivered through Adult Social Care. Ms Redfern challenged the legality of this, given that there was no formal notice given of the decision to withhold funds, and that the issue had not been discussed by the Health and Wellbeing Board.

RESOLVED

That the meeting be extended by a further thirty minutes.

Councillor Kwon asked what the risk was of driving up demand for services across the Borough; what was the cost of making cuts and whether these were sustainable. Ms Cree referred to section 6.3 of the report, and explained that the proposals will be used as a basis for the review, which would then be followed by an impact equalities assessment. The detail was absent from the report as this had not yet been determined. Ms Cree said that there was a framework that would be followed and it was confirmed that some services

might be downgraded and rationalised, and that non-statutory duties would cease.

Mr Grealy expressed disappointment that the CCG was unable to provide a list of services to be discussed and the impact of reducing these. Section 6.3 referred to only statutory provision. It was clear that all planned investment would stop and funding reduced in line with national levels and statutory duty. Mr Grealy was of the view that the local provision would be decimated and that it was critical to understand which services would be cut. Mr Grealy also challenged the CCG to provide details about the cost of maintaining the bureaucracy required to support the North-West London Collaboration of CCGs.

Martin Calleja clarified that the report provided the level of detail requested by the QIPP (quality, innovation, productivity and prevention) plan. The indication was that the plans proposed in section 6.3 had to be immediately implemented. The possible financial and reputational repercussions were a serious concern. Ms Cree responded that the CCG had been asked to set out a financial position, which combined figures for 2018/19 and 2019/20 and a reduction in the operating cost was included. The CCG would also be required to meet national requirements to further reduce costs in the budget by 10%, sought across the whole of the organisation. Ms Cree felt that the CCG had been clear about the process in which they had been engaged, and had considered what information was needed to make those decisions. The CCG intended to fully involve residents and key stakeholders, to ensure transparency.

Councillor Coleman said that the CCG met regularly with Council members and officers, and yet had failed to raise the issue. Without warning or notice, the CCG had determined that it would withhold Better Care Funding of £1.25 million. Ms Cree responded that the issue had been discussed in many conversations, particularly about QIPP plans. Councillor Coleman pointed out that the letter failed to offer reasons, or provide sufficiently transparent explanations as to why the funds would be withheld. Councillor Coleman recognised that there existed severe financial pressures arising from austerity measures. However, the letter from the CCG had been unhelpful, and he challenged the CCG to be more co-operative and transparent in their future communications and interactions with the Council.

Councillor Coleman asked if the CCG planned to consult on cuts to services. Ms Cree responded that there might be a need to consult on some of the service changes, but clarified that this would only be undertaken if there was a statutory requirement to consult.

Councillor Fennimore commented that there was no reference to the potential impact on residents. While Councillor Fennimore concurred with Ms Andreae's comment that £1 could only be spent once, there was a need to work with others to achieve the best expenditure for the benefit of residents.

Councillor Richardson said that the report raised serious concerns, and lacked detail about the possible implications for residents. There was no

sense of Borough-wide priorities, and no clear explanation about the reason for the hole in the budget. A more detailed report that offered a response to the concerns raised by the Committee, was requested.

ACTION: CCG to keep the PAC informed of their plans for financial recovery and how they plan to consult with stakeholders, and provide a further update.

RESOLVED

That the report be noted.

217. WORK PROGRAMME

The Committee considered the Work Programme and noted that an additional meeting had been included in mid-January.

RESOLVED

That the Work Programme be noted.

218. DATES OF FUTURE MEETINGS

The next meeting of the Committee was noted as Tuesday, 15 January 2019.

Meeting started: 6pm
Meeting ended: 9.48pm

Chair .....

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