London Borough of Hammersmith & Fulham

h&f hammersmith & fulham

Health, Inclusion and Social Care Policy and Accountability Committee
Agenda

Tuesday 4 December 2018 at 6.00 pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

Administration	Opposition
Councillor Lucy Richardson (Chair) Councillor Jonathan Caleb-Landy Councillor Bora Kwon Councillor Mercy Umeh	Councillor Amanda Lloyd-Harris
Co-optees	
Debbie Domb, Disabilities Campaigner Victoria Brignell, Action On Disability Jim Grealy, Save Our Hospitals Bryan Naylor, Age UK	

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Date Issued: 26 November 2018

London Borough of Hammersmith & Fulham

Health, Inclusion and Social Care Policy and Accountability Committee
Agenda

4 December 2018

Item		Pages
1.	**MINUTES OF THE PREVIOUS MEETING**	5 - 12

(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 Monday, 17th September 2018; and

(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

The Committee is asked to agree the new appointment of the following co-opted member for 2018-19:

Jennifer Nightingale

5. HEALTHWATCH HAMMERSMITH AND FULHAM (HWCW) 13 - 19

This report provides an overview of the work undertaken by Healthwatch; raises awareness about local health issues; and the concerns of Hammersmith and Fulham residents.

6. 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 20 - 24

This report aims to outline circumstances that led to a decision to suspend all admissions into the in-patient beds of Pembridge Hospice, describe the service that is currently provided and to provide an update on the current situation.

7. ROYAL BROMPTON HOSPITAL TRUST Verbal Update

This item is to discuss a proposed joint bid for Royal Brompton Hospital by Imperial College Healthcare NHS Trust, and, Chelsea and Westminster Hospital NHS Foundation Trust.

8. PRIMARY AND URGENT CARE PROPOSALS - HAMMERSMITH AND FULHAM CLINICAL COMMISSIONING GROUP 25 - 82

This paper from Hammersmith and Fulham CCG looks at the urgent care and out of hours primary care provision in the borough and makes proposals about the hours of those services. This includes the case for change, the current usage of the two urgent care centres and the out of hours services as well as the public and stakeholder engagement to date and plans for consultation.

9. FINANCIAL RECOVERY PLAN - HAMMERSMITH AND FULHAM CLINICAL COMMISSIONING GROUP 83 - 103

This paper provides a briefing to the Committee on the 2018/19 financial position of the Hammersmith and Fulham Clinical Commissioning Group.

10. WORK PROGRAMME 104 - 107

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

11. DATES OF FUTURE MEETINGS

Tuesday 15 January 2018 (additional meeting date)
Monday, 11 February 2019
Tuesday, 26 March 2019

London Borough of Hammersmith & Fulham

Health, Inclusion and Social Care Policy and Accountability Committee

Minutes

Monday 17 September 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: Dominic Conlin, Director of Strategy and Business Development, Chelsea and Westminster NHS Trust Hospital; Mick Fisher, Head of Public Affairs, Imperial College Healthcare NHS Trust; Helen Mangan, Associate Director Local Services, West London Mental Health Trust; Prof. Tim Orchard, Chief Executive Officer, Imperial College Healthcare NHS Trust; Lisa Redfern, Strategic Director of Social Care and Interim Director of Public Services Reform; Sarah Rushton, Executive Director Local Services, Parminder Sahota, Safeguarding Adult Named Professional – Trust wide, West London Mental Health Trust; Prof. Janice Sigsworth, Director of Nursing, Imperial College Healthcare NHS Trust;

199. MINUTES OF THE PREVIOUS MEETING

The minutes were agreed as an accurate record, subject to a spelling correction, under minute 191, Declarations of Interest, which should be “Lygon” Almshouse. It was also noted that Councillor Lloyd-Harris’ question about social housing and wheelchair adaptations had received a detailed response and had not been recorded in detail.

200. APOLOGIES FOR ABSENCE

Apologies for absence were received from Debbie Domb.

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

201. DECLARATION OF INTEREST

Councillor Mercy Umeh declared an interest in respect of Agenda Item 4.

202. HEALTHWATCH

It was noted that Healthwatch's Annual General Meeting unfortunately coincided with the date of the PAC meeting, an update will be provided at the next meeting in December.

204. STAFF ENGAGEMENT, SATISFACTION, RECRUITMENT AND RETENTION

AND (combined)

205. 203. WORKFORCE: CAPACITY, DEVELOPMENT, ENGAGEMENT AND SUPPORT - CHELSEA & WESTMINSTER HOSPITAL NHS FOUNDATION TRUST - APPENDIX 2 WORKFORCE PERFORMANCE REPORT - MONTH 04 1819

A presentation was given by Professor Tim Orchard and Professor Janice Sigsworth. Professor Orchard acknowledged that recruitment and retention of staff had been a primary focus for a significant period. Imperial was a large organisation with over 7500 staff working across several sites, responsible for delivering high quality care. Imperial was ranked in the top three Trusts nationally with one of the lowest mortality rates in the UK, and had worked hard at staff engagement across a large workforce. Staff engagement was a challenge and the organisation had struggled with some key issues, particularly how senior staff were seen. Measures to address this included rotating meetings and increased frequency of ward visits. Professor Orchard acknowledged that they also needed to use tools such as social media more effectively to develop a presence with staff.

Staff turnover was a national challenge and in terms of metrics vacancy rates for London were 2.9%, with voluntary turnover rates at 9%, although they were aiming for 10%. Additional challenges also included how the organisation dealt with poor behaviour and performance. A premium for recruitment had been introduced, for example, for care of the elderly wards and acute, and the Trust recruited internationally where necessary. Recruiting well was key to achieving deliverables and to move forward from the Requires Improvement rating for CQC (Care Quality Commission). Focusing on people and culture, the Trust had three years previously engaged with 4000 staff, to better understand the values and manage expectations.

Professor Orchard stated for the record his deep regret regarding Staff Nurse Amin Abdullah who had ended his life, following a formal disciplinary hearing which had resulted in his dismissal. Professor Orchard acknowledged that Mr Abdullah should not have been dismissed and hoped that the experience would help the Trust to change its procedures for the benefit and protection of staff. He expressed concern that the use of less informal processes to address poor performance had declined and that there was a reactive response to deal with matters more formally. Professor Orchard introduced Kevin Croft, who had

recently been employed by the Trust as an interim measure. A new protocol had been introduced so that a senior manager from another site would review cases prior to a decision being reached, to ensure consistency, objectivity and impartiality. To date, 31 cases had been reviewed, eight had been returned for either more information to be obtained or for informal action to be taken.

Professor Orchard assured Councillor Richardson that Mr Abdullah's case should not have been the subject of a formal disciplinary hearing. Mr Croft's investigation and performance framework protocols had been implemented and there were now the tools in place for dealing with all forms of poor performance. There was a need to train staff in how to deal with some performance issues informally and for the performance evaluation processes to align for both doctors and other medical professionals. Finally, it was important to take full account of equality and diversity issues, and it was acknowledged that there were notably higher rates of BAME (black and minority ethnic) staff subjected to disciplinary procedures. Councillor Richardson commended Professor Orchard for the open and transparent way that the Trust had responded.

Dominic Conlin provided a perspective from Chelsea and Westminster NHS Trust Hospital (ChelWest), extrapolating key points from the report. The age of the workforce was significantly younger (although this had slightly increased, following the merger with West Middlesex), by comparison to Imperial or University College London (Hospitals NHS Foundation Trust), with a higher proportion being new to the work, looking to specialise once they had completed their critical care work. Many of the younger staff were not on the traditional career track of education, job, house, marriage. They had different priorities, highlighting the prohibitive cost of housing in London. The Trust aimed to improve the culture and wellbeing of staff with initiatives such as the healthy workforce charter, recognising that there was a duty of care toward staff and the wider population, with the aim of making a healthier workplace.

Staff engagement represented a linear link to better patient health outcomes. The data set out in the report provided a sense of the Trusts metrics and whether there were any wider incentives that could be considered such as housing, transport and key worker accommodation which were some of the root causes for the Trust.

With reference to the report (page 19 of the Agenda), Councillor Caleb-Landy expressed his concern regarding the reported 29% of staff who experienced abuse or harassment (staff survey). Professor Orchard acknowledged that this figure was high but expected it to reduce. He reported that such incidences usually arose during critical periods such as patient handovers. The Trust aimed to stamp out bullying behaviours and to ensure that all staff understood what was expected in terms of accepted values and behaviours. He explained that the way to avoid a "knee-jerk reaction resorting to formal disciplinary action was to create a more supportive environment and to equip staff with the tools to make this possible. Trust had also taken steps to ensure that there was an increased of amount of security in Accident & Emergency (A&E), to ensure the safety of staff and patients safety.

Professor Sigsworth added that the staff survey was anonymous and although harassment was a grave issue, this was a challenging concern throughout any

organisation. Regarding cases that she had been involved in, she had taken care to listen and acknowledge a complaint as a valid concern and not deny it. As a corollary, she added that it was important to be seen to take action. If the behaviour continued, a way should be found to feedback and to address a concern, without breaking confidentiality and that this was a critical matter of trust.

It was explained that it was critical to have a two-way relationship of trust. Monitoring and support for staff experiencing these issues was important and could sometimes affect more than one staff member, in any given situation. Professor Orchard stated that staff would be able to confide in designated 'guardians", one based on each of the Trusts sites and who would be able to report to the Trust's Board.

Jim Grealy welcomed the report but noted that 35% of staff had experienced bullying. He asked what had been done to counteract and address this, particularly in cases of abuse by members of the public. Additionally, he enquired about any causal factors as to why BAME staff found it difficult to pass appraisals and how these could be identified. Professor Orchard explained that dealing professionally with patients who were vulnerable and ill, was at times difficult and a necessary part of the job. There had been an increase in number of very disturbed patients held in A&E for extended periods, usually following Saturday night excess. It was important that staff felt safe in the workplace and the department was small for the number of patients treated. With regard to BAME staff appraisals. Professor Orchard recognised that while the organisation reflected the diversity of the local community, this decreased significantly at the top of the organisation. Professor Sigsworth explained that there were BAME midwives who had not accessed training opportunities and could be encouraged and better supported in managing their careers. An offer to support the Trust in its to efforts to recruitment overseas by writing to government was welcomed.

ACTION: PAC to write a letter of support to the Home Office (UK Visas and Immigration) on the issue of recruitment visas for overseas staff

Councillor Lloyd-Harris described the report as impressive, honest and brave and asked about the qualifications of the senior investigator and the process of appointing them; and, the human resources review, considering the high number of failings highlighted by the case of Amin Abdullah. Professor Orchard reported that having trained staff was essential, with a duty to ensure that investigators received training and support commensurate with the challenging requirements of undertaking investigations. He accepted failings had occurred and explained that the Trust had implemented proposals as to how future investigations would be conducted and supported. The Trust had plans to restructure Human resources, with staff being trained or retrained.

Victoria Brignell observed that there was no mention of affordable childcare for staff. Professor Sigsworth that there were nursery facilities accessible for staff, utilised and accessed as suitable around varying shift patterns. The provision was convenient and staff had reported positive feedback. The Trust was also considering improvements to a voucher scheme.

Bryan Naylor highlighted the issue of clinical staff performing administrative duties, with particular emphasis on discharge planning such as arrangements for patient transport. Professor Orchard explained that they had experienced difficulties with the patient transport contract. He concurred that this was partly an issue of discharge planning. Patient turnover was vast, with the length of stay reducing. Discharge planning was a concern, the shorter the length of admission, the harder it was to plan. The Trust was currently engaged in rolling out a series of interventions at ward level to better understand the estimated discharge time. Each time a patient was seen, staff should be thinking of when that patient could be discharged. He agreed that Imperial had not been as good in doing this as other trusts. It was necessary to consider practical elements: did the patient have clothes, keys etc; information to help forward plan for example, to book transport or support at home. Most problems arose when patient transport was booked on the day it was required. An external person had been asked to liaise with external organisations to ensure that care packages were in place. For this to work, confidence was required that if a patient was sent home, they would be assessed within two hours and a care package put in place.

Councillor Ben Coleman welcomed both reports which he felt addressed the issues differently, welcoming the breadth of the report of the Imperial report. Mr Conlin clarified that a broader perspective could be provided, with similar figure allowing for further comparisons. As part of the general ethos and culture of the organisation, staff must perceive that responsible and assured action was being taken on their behalf. ChelWest had an initiative which allowed senior managers to spend one day on a ward, once a month. This allowed greater dialogue and engagement with staff, to get the bigger picture rather than patient simply symptoms.

Councillor Coleman (on behalf of Councillor Patricia Quigley) asked why there was of no reference to ancillary staff, and if they had been included in the survey. In addition, Councillor Coleman asked if any staff with disabilities (according to a breakdown by gender) had been included in the survey. If not, how would ChelWest ensure that their needs were being met appropriately. Mr Conlin responded that ancillary staff were not directly employed by ChelWest. He acknowledged that this did not help unify staff culture and the Trust would consider how to be more inclusive of staff employed by Sodexo. The importance of this was recognised, particularly in terms of the positive impact all staff could have on patient care by encouraging greater inclusivity.

Mr Conlin observed that the contracted out ancillary staff bought into the culture of the organisation more than medical staff. They were also included staff award to celebrate this. The percentage of staff with disabilities led staff, were below national levels and it was acknowledged that most disabled awareness training was directed at patients rather than staff. It was explained that this was undertaken with a more implicit focus on patients, rather than staff and, always undertaken by new staff as part of their induction process, in accordance with the organisations equal opportunities policy.

Professor Sigsworth explained that the Trust had data on self-declared disabled staff, although the number was low. There were staff for whom reasonable adaptations had been made and all staff received disability awareness training.

She acknowledged however that Imperial could be quicker in resolving some staff issues and conceded that they were not always as sensitive as they could be. Professor concurred with Mr Conlin, much of the focus was in how staff should engage with patients and about making reasonable adjustments within the work place.

205. WEST LONDON MENTAL HEALTH TRUST UPDATE

The Chair welcomed Sarah Rushton, Operational Director for WLMHT. It was explained that the there was an on-going CQC inspection of the trust and that it would be helpful to report on the outcomes of the reviews at a future meeting. In terms of beds, WLMHT was always running to full capacity. There was a lack of seclusion facilities in the psychiatric care unit, with one for older people, with 20 beds per ward which therefore exceeded guidance for ward mental health patients. Since an earlier CQC inspection, sustained improvement had been noted and the Trust was currently running at 85% capacity (as noted in paged 55 of the Agenda pack). The Trust planned improvements included the relocation of a number of wards to the ground floor, and alterations that offered better physical and mental health care facilities. In terms of suspended beds, there were plans to permanently move to 20 bedded wards, and have suitable facilities to support disabled patients.

Parminder Sahota reported that the Safeguarding Adults Executive Board (SAEB) would shortly be meeting for the first time but during the interim, the LBHF continued to be members of the triborough SAEB. Many changes were planned and the Trust would work with the local authority to ensure communication was fluid.

Councillor Richardson asked about younger patients and isolation. It was explained that the trust provided support across the three boroughs, but the trust did not have individual care plans for each patient that came through the Trust and would not mix people in a way that would cause an issue. However, the trust did not have the facility to accommodate younger people.

Jim Grealy asked how many beds the Trust believed it needed and what was the time delay between referral and getting a bed, and, what was the level of returns following a discharge. Sarah Rushton responded that they were developing a model of the total patient flow. The Trust was also considering an initiative involving community treatment at home, to use less beds, which was about to commence. It was confirmed that readmission rates had been within targets and there was not currently no time gap between referral and admittance. Work around improving patient flow had ensured that beds were now available according to need. The Trust could also accommodate sectioned patients and Helen Mangan confirmed that patients could be detained under the statutory mental health regulations, which could be done immediately, comparted to previously years.

Councillor Kwon enquired about the recent publicity indicating that the police lacked capacity for out of hours provision. Ms Rushton took the view that there was a professional duty of care towards people with mental health and was disturbed by news the police would be reluctant to assist. Part of the role of the police was to undertake safeguarding work collaboratively with colleagues across

social care and health services. There was increased joined up working and the police were in regular contact with mental health professionals.

Councillor Lloyd-Harris referred to page 53 of the Agenda and the "requires improvement" rating. Change was required and Councillor Lloyd-Harris asked what could be done. Citing the example of female genital mutilation (FGM) Councillor Lloyd-Harris also asked what the Borough doing to address the issue and what support schools were given in dealing with the issue. Ms Rushton explained that the Trust had an adult rating and the poor rating related to bed flow, which the CQC would be returning specifically to review. Progress since the initial CQC had been remarkable and the Trust had worked very hard to deliver quality services.

Ms Sahota that with regards to FGM, NHS colleagues were trying to embed knowledge and use smart technology to capture data and it was anticipated that this would be rolled out next month, and included raising awareness of the issue with staff. They were also working with the Violence Against Women and Girls network to progress the issue and influence change. Councillor Richardson encouraged

Councillor Caleb-Landy echoed concerns raised regarding the Trusts ratings. Considering the baseline, he observed that there might be families with patients being housed outside the Borough and this was a concern. Additionally, he asked about the reasons given for a discharge.

Following the CQC inspection, Ms Rushton explained that the Trust had reviewed patient flow and discharge data, and had worked to develop a whole system approach. A more detailed response was assured in the next report to the Committee. There was patient flow, but this not as well-developed in LBHF compared to the other boroughs. Ms Rushton confirmed that the Trust did not currently have any LBHF patients in out of area private bed facilities.

Councillor Richardson asked the Trust how they monitored patient satisfaction. Ms Rushton explained that the Trust Board received regular patient satisfaction reports and worked closely with patient advocate services and a report on this could be provided to the Committee.

In response to a question regarding young people's access to care, particularly the 18-25 age group. Ms Ruston explained that units for older people were relocated on the ground floor was more appropriate (page 57 of the Agenda), with a more secure psychiatric unit located on the 2nd floor. It was noted that there was adolescent mental health provision with a facility in Chelsea. There was a lack of provision for adolescents under 18. The whole of North London had never had beds commissioned for them. CNWL were developing a general facility for adolescent beds and for patients with eating disorders. Children with other issues would not currently have a facility. Direct funding from NHS England rather than from commissioners was being considered which was positive progress.

Councillor Richardson welcomed assurance that the Trust would return to the Committee to report on progress following the next CQC inspection. She expressed particular interest in the community based provision which was briefly

covered in the report and what the aftercare provision was like, and what was available. Ms Rushton confirmed that she would be happy to report back and discuss community services, in addition to safeguarding, FGM bed capacity and the impact on community responses.

In terms of bed flow, Ms Rushton reported that there was no impact on community responses because patient flow was much better, utilising one bed more times in a year therefore using it more but more modelling work was needed. It was noted that the Trust involved service users at every point in developing the service. What was required was a 24hr crises team, and not be fixated on beds for patients as the answer. The key question to ask was what was the best care possible.

In response to a question about about red / green bed days, Helen Mangan explained that this system was in development so that it would be possible to identify at a glance, a value-added day. Noting a comment that the report lacked patient insight or indicated engagement,

Ms Rushton explained that 'red days' meant that the person was marking time, and that the patients stay was longer than necessary. Councillor Richardson responded that a red day equated to no clinical intervention but that this did not mean no interaction. Ms Rushton explained that this was not the measure used in understanding patient satisfaction. The Trust had also received sponsorship from The Kings Fund for a piece of work on co-production, which would also be reported back to the committee.

206. <u>WORK PROGRAMME</u>

Several items were noted for inclusion for work programme which included a report from the Older Peoples Commission and the SAEB annual report. The inclusion of an additional date would also be explored.

207. <u>DATES OF FUTURE MEETINGS</u>

An additional meeting date will be confirmed for January 2019.

Meeting started: 7pm
Meeting ended: 9pm

Chair ....

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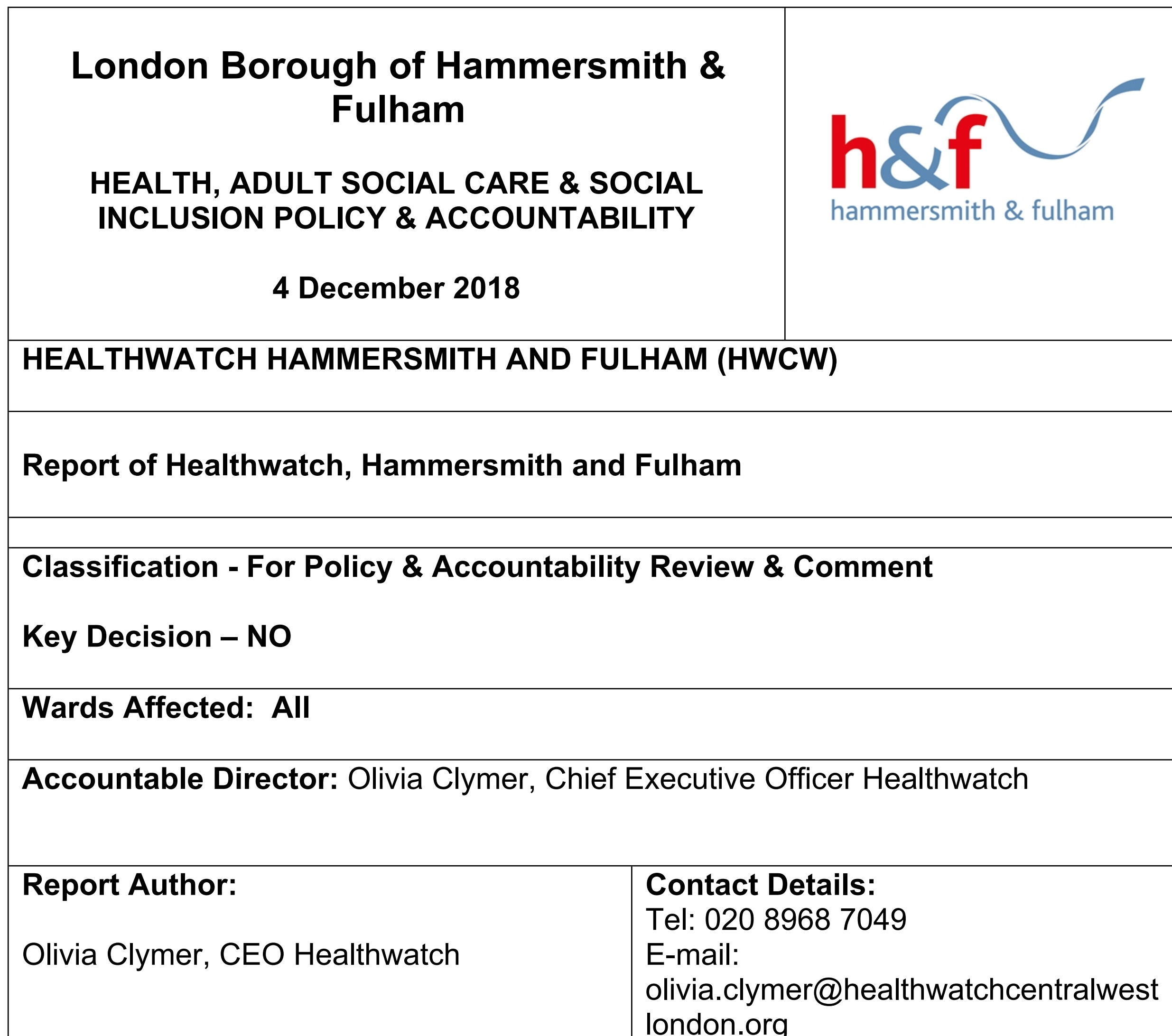


London Borough of Hammersmith & Fulham HEALTH, ADULT SOCIAL CARE & SOCIAL INCLUSION POLICY & ACCOUNTABILITY 4 December 2018	h&f hammersmith & fulham
HEALTHWATCH HAMMERSMITH AND FULHAM (HWCW)	
Report of Healthwatch, Hammersmith and Fulham	
Classification - For Policy & Accountability Review & Comment **Key Decision – NO**	
Wards Affected: All	
Accountable Director: Olivia Clymer, Chief Executive Officer Healthwatch	
Report Author: Olivia Clymer, CEO Healthwatch	**Contact Details:** Tel: 020 8968 7049 E-mail: olivia.clymer@healthwatchcentralwestlondon.org

1. EXECUTIVE SUMMARY

This report is to provide an update on recent work undertaken by Healthwatch in Hammersmith and Fulham and to notify the Committee about health and care matters and concerns that we have heard from talking to patients and the public.

1.1. RECOMMENDATIONS

1.2 That the Committee note the matters reported by Healthwatch.

2. SIGNIFICANT CROSS BOROUGH ISSUES

2.1 Pembridge Hospice & Palliative Care

2.1.1 In October, members of the community voiced concerns to HWCWL that Pembridge Hospice was closing. Healthwatch CWL had not been notified of any change.

2.1.2 Healthwatch CWL visited the hospice and asked staff if they were closing. Other services provided at Pembridge, such as day care and community services, will continue. Staff reassured us that the hospice was not closing. However, due to staff changes, they were unable to admit new patients to the 13-bed palliative care unit until they had recruited a new Palliative Care Consultant to provide the clinical expertise. It is referring people who need to stay to other hospices for their care. This update was shared with Healthwatch Central West London members on the website.

2.1.3 Healthwatch CWL attended WLCCG Quality and Safety Committee, an update on Pembridge was provided. Information to share with the community and via the website to provide clarity on the current position and next steps was requested. Central London CCG are the lead commissioners for the contract, Healthwatch concerns have been shared via the CCG. Healthwatch has requested a communication from CLCCG.

2.1.4 Pembridge inpatient unit is still closed. CLCH have, as yet, been unable to recruit a permanent Palliative Care Consultant post or find a suitable locum consultant. They are still trying to recruit but can't re-open until the consultant is in place. Patients continue to be diverted to the other hospices in the area. West London CCG have raised Healthwatch concerns with the CLCH Director of Operations and Healthwatch will be communicating directly.

2.1.5 Healthwatch CWL attended Central London Community Healthcare Inner Division Quality Stakeholder Reference Group and requested that we be formally advised of developments at Pembridge Hospice.

2.1.6 The current uncertainty is causing concern for local people and some are worried that it will mean that the Pembridge Hospice will close permanently.

2.2 Royal Brompton

2.2.1 NHS England's Specialist Commissioning, Engagement Lead on Chronic Heart Disease, Claire McDonald briefed the Healthwatch London regional meeting on 12th September 2018 on the proposals of the Royal Brompton. Engagement at this point and to date has been with specialist patient groups and groups with particular conditions that use the Royal Brompton.

2.2.2 Healthwatch CWL met with Claire McDonald on 11th October 2018 to voice concerns and request further information on a wider engagement or consultation process.

2.2.3 Healthwatch CWL raised the concerns of local people regarding the impact on communities in the local area, the loss to North West London provision and the impact to other specialist providers in the area such as the Royal Marsden. Healthwatch CWL outlined that any engagement planning would need to take this on board.

2.2.4 Healthwatch CWL Chair and CEO met with the CEO of Imperial on 15th October 2018 and the CEO of Chelsea & Westminster NHS Trust on 13th

November 2018. Imperial and Chelsea & Westminster are developing a business plan to respond to NHS England with an alternative to the proposal to move to St Thomas's Hospital.

2.2.5 Healthwatch will continue to challenge NHS England to broaden the scope of consultation and engagement on the implications of changes to the Royal Brompton.

2.3 Hammersmith and Fulham CCG Finances 4th July

Healthwatch Hammersmith and Fulham Local Committee members attended the Financial workshops delivered by H&F CCG regarding their financial position. Local Committee members examined the supporting material and found it challenging to understand. On the 4th July a delegation of Hammersmith & Fulham local committee members met with H&F CCC Managing Director Janet Cree and Chair Tim Spicer to; share their experience, raise with them the challenge and the need to make the information provided at the workshops more understandable to support a more effective engagement in the current challenges they face. The value of a timeline for proposed changes to services in North West London was raised and a communication plan to go alongside this.

3. UPDATE ON HEALTHWATCH CENTRAL WEST LONDON (HWCWL) PROJECT WORK ACTIVITY IN H&F

3.1 We enabling young people in H&F to have a say on:

a) how an if they want to engage digitally for their access to healthcare and
b) which of their healthcare needs (if any) could be covered by digital healthcare and how this might look like.

3.2 The project was launched in mid-July with a variety of different activities to be delivered until the end of November. A report will be written in January.

How are we going to work for this project?

- Engage with partner organisations from the voluntary sector, businesses, colleges and schools
- Go where young people are to talk with listen to their experiences and ideas
- Run a variety of different activities from focus groups to surveys.
- Provide a platform for young adults to run their own project of engagement activities on engagement about digital access and digital healthcare

What are we going to do with the information gathered?

- Information gathered from the project to provide recommendations to CCG and Council for engagement with young people around their healthcare

- Influence and support future commissioning of digital offers in the Borough and across NW London
- Contribute in the wider discussion about digitisation that is taking place in the NHS

4. DIGNITY CHAMPIONS ENTER AND VIEW VISITS

4.1 At the end of September, Healthwatch Dignity Champions visited Hammersmith Hospital Urgent Care Centre to listen to patients feedback and identify issues important to them.

4.2 The results of the visit will be used to inform the upcoming review of the Urgent Care Centres that will be conducted by H&F Clinical Commissioning Group.

5. PATIENT LEADERSHIP TRAINING

5.1 Healthwatch in H&F has been working with H&G CCG and the GP Federation to support the delivery of leadership training designed for patients in H&F. The purpose of the training is to a) equip patients with the knowledge and tools to understand the NHS system and b) empower them to get involved to influence positive change. The main target group is patients that are already involved or want to be more involved in their Patient Participation Group (PPG). As PPGs are currently underrepresented in the Borough, it was hoped that this would eb a vehicle to encourage participation.

5.2 The workshop took place on the 15th November and was very well received by patients, GPs and NHS staff. Approximately 30 patients attended and an abundance of positive and constructive energy. The event doubled as an opportunity to get a valuable range of views into primary and urgent care. The coaching approach proved popular and effective, with attendees so galvanised by the experience that by the end of the day they were pledging to commit to developing their GP Practice's PPG, joining the CCG's PRG, and even asking for selfies with the presenters and coaches. One patient attendee remarked: “I had no idea what patient participation was, but if it is like this, I am in!” while another tweeted: “Brilliant training day, loads of positive comments and ideas.” A volunteer and speaker on the day, told us why she volunteers with the NHS and Healthwatch: "My time is my currency, and I use it in the best ways I can." Ben Westmancott, Director of Compliance, who attended as a coach on the day commented: "It was amazing! So many positive people and contributions, so much energy."

6. MENTAL HEALTH AND EMPLOYMENT

6.1 Hammersmith and Fulham CCG has commissioned Richmond Fellowship to set up a new Employment and Wellbeing Service starting from 1st October

2019. According to the H&F CCG “frequently asked questions” document “the new service will be available to anyone with a mental health condition, and the offer will include structured employment support, advice and signposting, peer support, and befriending. It will have a single point of access, and will accept referrals from GPs, health care professionals and self-referrals”.

6.2 Healthwatch H&F Local Committee members made a comparative analysis to see if the patient feedback gathered at the Healthwatch mental health event in October 2017 has influenced the new service. Healthwatch CWL is pleased that most of the comments have been used to inform the new service. However, we have concerns about the following:

a) The efficiency of the transition period with the collaboration of all different stakeholders. For example, are GPs aware that they need to signpost to Richmond Fellowship instead of Mind?

b) If patients are aware of the new service, what it can offer and where it is based.

c) The potential gaps in the services, especially about complex cases.

d) The need for a H&F CCG strategy plan with employers and mental health. This has clearly identified at the Healthwatch Mental Health event in October 2017, as the aspiration from the CCG was to provide a holistic approach.

6.3 Healthwatch H&F Local Committee and staff will continue to discuss the matter.

7. ISSUES ARISING LOCALLY

7.1 HWCWL has been focusing on improving its engagement feedback mechanisms, tools and identify places for wider engagement. As such, it has produced a new engagement form that has been tested during the summer in different settings in H&F varying from Better Gym to the Lyric Square with great success.

7.2 Healthwatch will intensify the use of the engagement feedback forms in the upcoming months, including adding it to the website. This will help identify trends and themes important for H&F residents to provide information to the PAC Committee and to support future areas for project work for Healthwatch.

LIST OF APPENDICES:

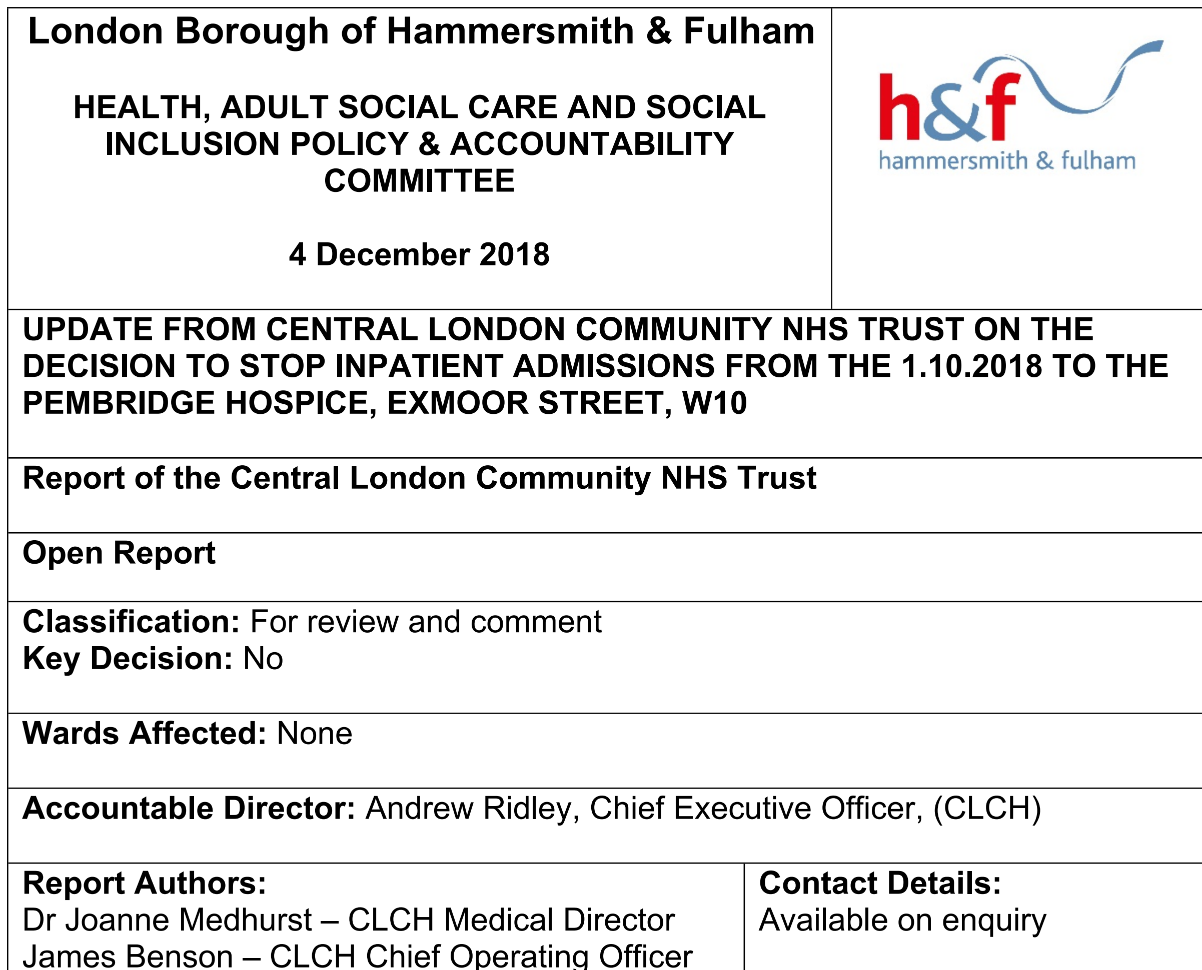
Appendix 1 - Table of local issues captured by Healthwatch

Overview of Patient Stories (June/July/August)

Service	Issue / Theme	How many times was this reported
H&F Social Care	Struggling to access social services in the borough	1
Parkview Practice	Poor waiting times for appointments at the practice – one recoded waiting four weeks for an appointment	2
Specsavers opticians Shepherds Bush	Patient was diagnosed with cataracts but not told what this was, how this will affect their sight, and limited details about the care they would need going forward.	1
Charing Cross Hospital	Carers not able to attend appointments at Charing Cross. Keep being referred back to their GP as they have to cancel the appointment, and the process beings again.	3
Parkview Health and Wellbeing Centre (dental care)	Excellent dental care at Parkview, treated as whole person.	1
Richford Gate Medical Practice	Person needed a doctor's note for their client who is homeless. Both reception staff and GP were very understanding and quick to arrange.	1
Charing Cross Hospital and St Marys Hospital	Person had to wait 6 months for an appointment with the neurology department. At the appointment the doctor rushed the appointment and they were running late.	1
H&F Social Care	Person's mother is elderly but not ill. There is a gap in services for these people.	1
Parkview Health and Wellbeing Centre (podiatry)	Good podiatry service from CLCH	1
University College London Hospital Trust	Poor administration. Appointments given to the wrong patients, or times given to the wrong patients.	1
Charing Cross Hospital	Cancer care has been good	1
Hammersmith Hospital	Waiting times for appointments has got worse	1
Hammersmith Surgery	Waiting times for appointments has got worse	1
Dr. Jefferies and Partners	Patient needed a diabetes review. Felt it took a long time to get one because the receptionist decided he didn't need one yet.	1
CLCH podiatry	Caller has been struggling to access podiatry services. Originally given an appointment in two months' time at St Charles, but wanted to access a closer service, such as that based	1

	at Parkview Health and Wellbeing Centre. Waiting to see GP to be referred there instead.	
Charing Cross Hospital	Long waiting time for an appointment	1
Charing Cross Hospital	Community respiratory team at Charing Cross delivered excellent care	1
The Westway Surgery	Doctor refused to prescribe painkillers for arthritis, to cut costs for the NHS, even though patient is in severe pain.	1
Charing Cross Hospital / H&F social care	Hospital staff wanted to send person's father into a care home or assisted living as they said that he had dementia. The family want him to return home, but were not being listened to by hospital staff. They were told that they did not have power of attorney. Eventually a doctor did listen. At this point social services could get involved and were empathetic and listened to the family and patient. The patient was allowed home, and is now seeing a private psychologist.	1
N/A	Good diabetes care	1
N/A	Good neurology care	1

Agenda Item 6



London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY & ACCOUNTABILITY COMMITTEE** **4 December 2018**	h&f hammersmith & fulham
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	
Report of the Central London Community NHS Trust	
Open Report	
Classification: For review and comment **Key Decision:** No	
Wards Affected: None	
Accountable Director: Andrew Ridley, Chief Executive Officer, (CLCH)	
Report Authors: Dr Joanne Medhurst – CLCH Medical Director James Benson – CLCH Chief Operating Officer	**Contact Details:** Available on enquiry

1. EXECUTIVE SUMMARY

1.1 The purpose of this update is to explain to the Overview and Scrutiny Committee the circumstances that led to a decision to suspend all admissions into the in-patient beds of the hospice, describe the service that is still provided and to describe the current situation.

2. RECOMMENDATIONS

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

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

None.

LIST OF APPENDICES:

Appendix 1 – 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

Central London Community Healthcare NHS Trust

London Borough of Hammersmith and Fulham Overview and Scrutiny Committee

Report title:	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.
Agenda item number:	
Lead director responsible for approval of this paper	Andrew Ridley – Chief Executive Officer
Report author	Dr Joanne Medhurst – CLCH Medical Director James Benson – CLCH Chief Operating Officer
Freedom of Information status	Can be made public

Executive summary:

The purpose of this update is to explain to the Overview and Scrutiny Committee the circumstances that led to a decision to suspend all admissions into the in-patient beds of the hospice, describe the service that is still provided and to describe the current situation.

1 Purpose

This report sets out the issues that have led to Central London Community Trust's (CLCH), inability to safely provide care to end of life patients within an inpatient setting at the Pembridge Hospice situated at St Charles Centre for Health and Wellbeing, Exmoor Street, W10 which has meant that the Trust temporarily closed the unit to admissions on the 1.10.2018.

2 Background

The Pembridge Hospice has been operational on the current site since 1996 and is only one of two hospices provided by a NHS Trust in the England. The service is commissioned by Hammersmith and Fulham CCG through the lead commissioner, Central London CCG. The service is made up of an in-patient bedded unit at the St Charles Centre for Health and Wellbeing and a community service comprising of a domiciliary service, an outpatient's service via the day hospice and a pain clinic.

The service delivers a multi-disciplinary service which includes two specialist palliative care consultants and a number of junior doctors, able to offer complex symptom management to patients at the end of their lives. All registered clinicians make treatment decisions regarding the care of their patients but the medical workforce has ultimate responsibility for clinical decisions. The seriousness of illness of patients on this unit requires that this ultimate decision maker is a

consultant level doctor with experience and qualification in specialist palliative care.

The inpatient service has 13 beds delivering consultant –led complex palliative care and has average bed occupancy of 63%.

The average usage by patients of Hammersmith and Fulham is set out below.

- Inpatient Unit- the unit admits on average 5 patients per month
- Community domiciliary service-the service has 257 patients registered with the service.
- Day hospice-there are 74 day care attendances per month

3 Description of key issues

In 2018 the substantive inpatient consultant, also the lead clinician, resigned and after a notice period left the unit on the 13.09.2018. The Trust initiated a standard HR process which involved advertising for a replacement but also advertising for a locum doctor to cover the period before any new substantive doctor would start. There was no interest in the substantive post and the Trust came to learn there was also no temporary workforce suitable for this post. The Trust widened the search, increased the rate of pay and offered accommodation. The Trusts' clinical leaders also reached out informally across the palliative care networks to colleagues in other London units. There were some CVs presented by agencies but none of the doctors had the level of expertise required to deliver safe and effective care on this unit.

As a result of this inability to source medical expertise and on the advice of the Medical Director of the Trust, Dr Joanne Medhurst, the Trust has no choice but to suspend admissions from the 1.10.2018.

At this point in time there were 5 patients remaining on the unit, one of which was a resident of Hammersmith and Fulham. Two of the patients required transfer to St Johns Hospice. One patient was discharged and two followed their normal course of life and died on the unit. For the two transferring patients, the Trust ensured that the patients and their families were fully informed about the reasons behind this transfer and the CCG quality lead visited both patients and they and their family reported that this had not caused distress.

The Trust continued to try and recruit a suitably qualified medical practioner and one CV was thought to have some of the experience required. The doctor was interviewed by a senior doctor in the trust with palliative care experience, the medical director discussed the appointment with NHSI- the Trust's regulator, the doctor's Responsible Officer and with a senior clinician from Health Education England, who agreed that a trial period would be reasonable. The Trust mitigated risk with significant checks and balances. Unfortunately after two weeks of induction the Corporate Clinical Director reported back that this colleague was not sufficiently experienced to be the responsible clinician for the unit and the Trust was not able to re-open.

The Trust has continued to advertise for a substantive medical practioner and will continue to do so, however to date, there have been no suitable applicants and therefore the Hospice remains closed to inpatient admissions.

The Community service remains fully operational and is consultant led ensuring high quality care to people who are remaining at home as they live their lives with life limiting diseases and enabling borough residents to have the choice to die at home.

4. Support to Patients

Community patients, who had chosen Pembridge Hospice as part of their care plan, have been individually met with by clinical staff to explain the current position and discuss alternatives to care. Those patients who require an inpatient hospice admission are being referred to neighbouring hospices to receive their care.

5. Support to Volunteers

The Trust is extremely fortunate to be working with a team of committed volunteers. Our volunteers are embedded across all areas of our service. There are currently 34 regular volunteers visiting the hospice every week to provide support for wellbeing activities, administrative and fundraising functions. A high proportion of our volunteers provided support to our inpatient unit. All of our volunteers are being supported by the Volunteer Manager and continue to provide support to the other parts of the Pembridge service, in particular the day care centre.

6. Support to Staff

Since the suspension of admission to the unit, staff have been supported and the Trust has openly communicated with them as to the next steps. The Trust recognised that there was a high risk that staff who only want to work in a palliative care service may choose to leave and work closer to their home. Therefore the following steps have been taken to support staff:

- The Pembridge nurse manager and ward manager have had 121 meetings will all inpatient staff to discuss preferences for redeployment areas. Staff have been redeployed as per choice to either the Athlone or Princess Louise Rehabilitation units, or to the community palliative care service. All staff are being supported by the leadership team and HR.
- HR clinics have been set up for staff to discuss concerns or raise issues
- The trust recruitment team continue to map-out vacant posts across the organisation to offer a variety of roles within the Trust, maximising opportunities and ensuring valuable skills are kept within the Trust and the wider health economy.

No member of staff had as yet resigned from the Trust as a result of the suspension to admissions

7. Communication to Stakeholders

Following the suspension, a letter dated 3rd October 2018 was circulated to acute and primary care referrers and other local hospices. An updated letter dated 24th October was also sent. A message is placed on our external web site and on twitter for our patients.

In addition to this several joint meetings have taken place between CLCH, St Johns, Marie Curie, St Luke's and the CCG.

8. Other Pembridge Services

Community Palliative Care

The Community Palliative Care Service continues to be fully operational. It provides advice and support for people in their own homes. The team focus on quality of life and keeping patients in

their own home, offering advice on pain control and symptom management as well as emotional and practical support for patients, their families and carers. Where patients are assessed as requiring a higher level of clinical intervention, the community team can also refer patients for an inpatient stay at other hospices.

At present there are on average 275 contacts with Hammersmith and Fulham patients per month.

<u>The Day Hospice</u>

The Day Hospice continues to be fully operational. It provides treatment, support and complementary therapies for patients who are able to visit from home.

At present there are on average 80 attendances/sessions for Hammersmith and Fulham patients per month.

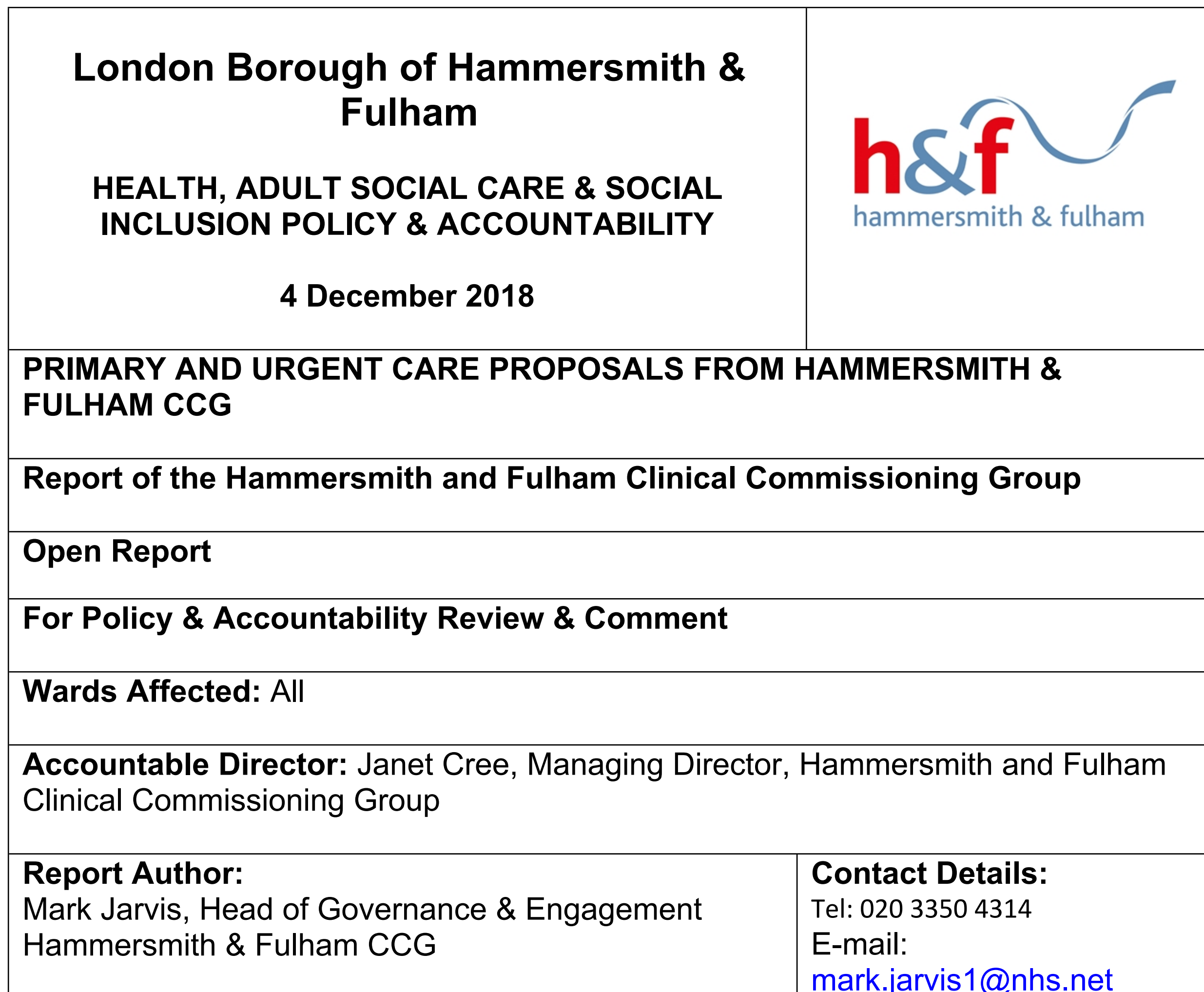
9. Consultant Recruitment

The Trust is continuing with our efforts to actively recruit into the substantive and locum posts. Both posts were advertised on NHS jobs with the substantive post also advertised in the British Medical Journal. Despite the advert being opened for more than 6 weeks, there was only 1 applicant who was rejected as not suitable. Rolling recruitment for specialist posts like these can sometimes create a negative impression on the recruiting unit. It is usually best to pause between recruitment campaigns. It was therefore agreed at our Executive Leadership Team meeting to pause the advert for a few weeks, re-advertising during the Christmas and New Year period.

The Trust leadership team will however continue to reach out to known networks for support in identifying suitable candidates.

10. Next Steps

The workforce for the provision of Specialist Palliative Care within the North West London Health and Social Care system is fragile. All partners recognise that to secure the future of continuing to deliver high quality specialist palliative care in our system we need to join up efforts and approach. We are therefore engaging with the CCG and other local hospices in wider system review. The CCGs are leading on this piece of work, engaging providers and obtaining expertise as necessary.



London Borough of Hammersmith & Fulham HEALTH, ADULT SOCIAL CARE & SOCIAL INCLUSION POLICY & ACCOUNTABILITY 4 December 2018	h&f hammersmith & fulham
PRIMARY AND URGENT CARE PROPOSALS FROM HAMMERSMITH & FULHAM CCG	
Report of the Hammersmith and Fulham Clinical Commissioning Group	
Open Report	
For Policy & Accountability Review & Comment	
Wards Affected: All	
Accountable Director: Janet Cree, Managing Director, Hammersmith and Fulham Clinical Commissioning Group	
Report Author: Mark Jarvis, Head of Governance & Engagement Hammersmith & Fulham CCG	**Contact Details:** Tel: 020 3350 4314 E-mail: mark.jarvis1@nhs.net

1. EXECUTIVE SUMMARY

1.1 This paper from Hammersmith and Fulham CCG looks at the urgent care and out of hours primary care provision in the borough and makes proposals about the hours of those services.

1.2 Included is the case for change, the current usage of the two urgent care centres and the out of hours services as well as the public and stakeholder engagement to date and plans for consultation. Plans for consultation have taken into account best practice identified through The Consultation Institute and by looking at the Councils own approach. Hammersmith and Fulham CCG would like to work with the Council to develop the consultation approach further.

1.3 The proposals, set out in chapter 4, are:

- To make no changes to the Urgent Care Centre at Charing Cross
- To change the hours of the Urgent Care Centre at Hammersmith Hospital to close it overnight from Midnight to 8am when it has a low volume of attendances and the majority do not require the services of the UCC.
- To reduce the number of GP appointments available outside the core hours of 8am to 6.30pm by 155 GP appointments a week in line with demand

- To look at the number of hubs providing weekend plus services to all H&F residents registered with any GP in the borough.

1.4 The consultation is currently expected to start in mid-late January, subject to appropriate assurance and decision making. It will cover the whole borough and neighbouring boroughs where there is a regular flow of activity to Hammersmith UCC. We are proposing a six-week consultation period. We would develop printed materials and a section on our website for all the information on the proposals. Translations would be available online or on request. More information on this is set out in chapter 5.

2. RECOMMENDATIONS

2.1. The CCG is seeking the views of the Council on the proposals and plans for consultation. With regard to the consultation process, we would ask:

- Is there any additional activity you feel should be included within our consultation plan?
- With your knowledge of your own particular wards and communities, what events and/or groups do you feel should be included in our engagement?
- What is your advice on suitable venues for public events during the consultation?
- Are their council communication channels you would allow us to use to raise awareness of the consultation?

3. REASONS FOR DECISION

3.1. The CCG seek scrutiny of their proposals and input into their consultation plan.

4. INTRODUCTION AND BACKGROUND

4.1. The case for change and status quo of Hammersmith UCC, Charing Cross UCC and GP appointments in the borough are set out in chapters 1 and 2 of the report.

5. PROPOSAL AND ISSUES

5.1. The proposals, with rationale, are set out in chapter 4 of the report.

6. OPTIONS AND ANALYSIS OF OPTIONS

Not applicable.

7. CONSULTATION

7.1. Details on the public involvement and pre-consultation engagement to date is set out in chapter 3 of the report.

7.2. Plans for further engagement and our proposals for consultation are set out in chapter 5 of the report.

8. EQUALITY IMPLICATIONS

8.1. The CCG equalities screening tool has been used to assess the impact of the proposals. No adverse impact on those in any protected characteristic. Addressing overnight safety issues will also help to address health inequalities that arise from this.

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

None.

LIST OF APPENDICES:

Appendix 1 – Primary and urgent care proposals, Hammersmith and Fulham, Clinical Commissioning Group

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Primary and urgent care proposals

Hammersmith & Fulham CCG submission to the Hammersmith and Fulham Council Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

22 November 2018

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Executive summary

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1. Case for change

1.1 About the London Borough of Hammersmith & Fulham

Hammersmith & Fulham is a London borough to the West of London and is bordered by the Thames to the South. Covering an area of 6.33m^2, the borough has around 183,000 residents making it one of the smallest boroughs in London. It is part of the NW London Collaboration of CCGs which includes eight London Boroughs and is also part of the NW London Health and Care Partnership (or STP).

The borough has 41 pharmacies, 29 GP surgeries with a total registered population of 252,357[1], two hospitals – both with an urgent care centre - and one ED.

It is a diverse London borough and a large proportion of the population are young working age residents with a low proportion of residents aged 65 and over (although this is increasing), and the fifth lowest number of children of any London borough.

- The area has high levels of migration in and out of the borough, and significant ethnic and cultural diversity.
- 32% of the population is from Black, Asian and Minority groups (BAME).
- Levels of affluence vary widely, creating inequalities within small geographical areas.
- Life expectancy for men is 79.1 years and 83.3 years for women.
- Around a third (29%) of children under 16 in H&F were classified as living in poverty in 2011, higher than London (27%) and England (21%) according to official definitions.
- Foreign-born residents made up 43 per cent of the Borough's population in 2011 - up from 34 per cent in 2001 (London 37 per cent and England & Wales 13 per cent); this is the tenth highest level of any local authority in England & Wales.
- 14.5 per cent of households have no people that speak English as a main language; this is the thirteenth highest proportion in England & Wales.

1.2 Digital vision – right care, right place, first time

Hammersmith & Fulham CCG's vision for digital innovation is simple - to make it easier for residents to access the care they need and to increase choice.

At a time where over 91% of people aged between 16-54 have a smartphone and wish to access services at a time convenient for themselves, it is essential for the local NHS to respond to that demand and ensure that healthcare, where appropriate, can be provided in a way that harnesses the advantages offered by modern technology.

[1] NHS Digital, October 2018

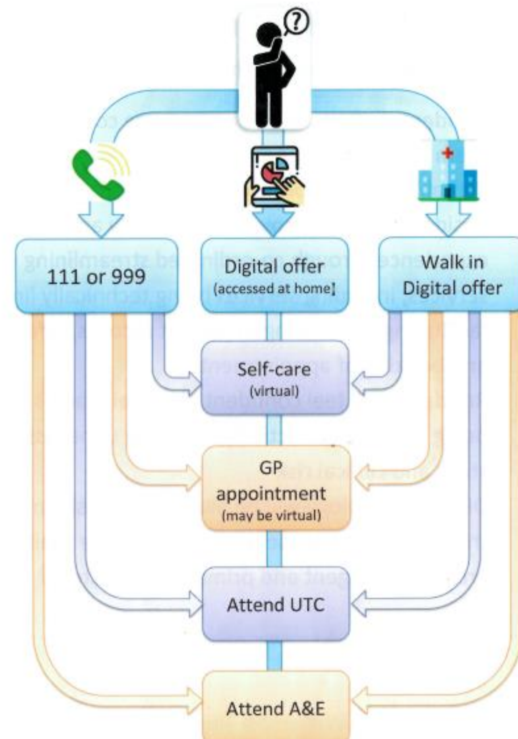
As well as providing convenience for patients, the implementation of the digital vision will lead to greater efficiencies for our staff. In addition, making it easier for patients to access the information they need will increase understanding of the appropriate setting of care for their concern and reduce mis-use of services such as ED, leaving them more able to focus on those who need life-saving treatment.

The benefit also extends to those who may prefer more traditional routes of accessing information and appointments as there will be fewer people using those routes meaning it should be quicker to do things like get through to your GP surgery on the phone.

Hammersmith & Fulham CCG's vision is that an individual's first point of contact would be through a digital channel, creating a single point of access for patients to access Primary or Urgent Care via an integrated digital model. Unlike models such as GP at Hand, the digital offer being developed by the CCGs for Hammersmith & Fulham will not affect a patient's registration with their practice.

Hammersmith & Fulham CCG have set four principles for their digital vision:

- Residents will be able to access care convenient to themselves at a location of their choice (this may be digital, telephone or face to face)
- Residents have improved accessibility and patient experience through coordinated streamlining of services, including being technically linked facilitating the sharing of patient records, referrals and booking of appointments
- Residents will feel confidence that their care is being managed effectively, reducing unnecessary steps and clinical risk
- Digital technology will be available to resident that wish to make use of this to navigate their way around the urgent and primary care system.



1.3 Financial challenges

Hammersmith & Fulham CCG is in a challenged financial position. Like other CCGs, it has a limited amount of money to spend and needs to ensure budget is used as effectively and fairly as possible for all patients and residents. It is therefore appropriate to regularly look at the services we provide, their effectively and utilisation and consider how we can best provide services for everyone.

1.4 Primary and urgent care

We have an opportunity to consider how we harness technology to improve our offer for those who would benefit from digital access, and to free up capacity within more traditional access routes for those who prefer these.

The contracts for urgent care centres at Hammersmith Hospital and Charing Cross are coming to an end and, in line with national guidance, we are implanting Urgent Treatment Centres.

As UCCs/UTCs form the urgent end of primary care access, it was also deemed necessary and appropriate to review our wider GP appointment access outside of core hours, and how this should look in the future.

Hammersmith & Fulham CCG is taking this forward by looking at the status quo to understand the utilisation of these services, whether the current operating hours are the most appropriate and how a modern digital offering can enhance the primary and urgent care provision in the borough.

2. Status quo

2.1 Hammersmith Urgent Care Centre (UCC)

Hammersmith UCC is currently open 24/7 and based at Hammersmith Hospital in the north of the borough. The UCC has been standalone since the ED closed in September 2014. It was at this point that it became a 24/7 service as part of the implementation of Shaping a Healthier Future.

The UCC is adjacent to one of the most deprived wards in the borough according to Indices of Multiple Deprivation data.

Hammersmith UCC is a contract held by Imperial and operated by London Central & West Unscheduled Care Collaborative (LCW).

2.1.1 Current attendance levels

Hammersmith UCC saw nearly 33,000 patients in 17/18, an average of 629 a week. Just under 8% of all attendances occurring in the period between midnight and 8am.

Table 1: Hammersmith UCC: Average number of attendances – by time of day and day of the week, 17/18

Hammersmith - 17/18 - average per week

Time	Mon	Tue	Wed	Thu	Fri	Sat	Sun		
00:00-01:00	1	1	1	1	2	2	1	10	48
01:00-02:00	1	1	1	1	1	1	1	6	
02:00-03:00	1	1	0	0	1	1	1	5	
03:00-04:00	1	0	0	0	0	1	1	3	
04:00-05:00	0	1	0	0	0	1	1	3	
05:00-06:00	0	1	0	0	0	1	0	3	
06:00-07:00	1	1	1	1	1	1	1	6	
07:00-08:00	2	2	2	2	2	2	1	11	
08:00-09:00	5	4	4	4	3	3	3	26	581
09:00-10:00	7	6	6	6	6	5	5	40	
10:00-11:00	7	6	7	7	6	7	6	46	
11:00-12:00	7	7	8	6	6	7	7	48	
12:00-13:00	8	6	6	6	6	7	6	45	
13:00-14:00	7	6	6	6	5	7	7	42	
14:00-15:00	7	6	5	5	5	6	6	41	
15:00-16:00	6	6	5	5	5	7	5	39	
16:00-17:00	6	5	5	5	5	6	5	37	
17:00-18:00	6	6	6	6	6	5	4	40	
18:00-19:00	6	6	6	6	5	5	4	39	
19:00-20:00	6	5	6	6	5	5	4	37	
20:00-21:00	5	6	5	5	4	4	4	33	
21:00-22:00	5	5	4	4	4	4	4	30	
22:00-23:00	3	3	3	3	3	3	3	22	
23:00-00:00	2	2	2	2	2	2	2	15	
	98	93	91	88	84	91	83	629	100%

Hammersmith - 17/18 - total in year

Time	Mon	Tue	Wed	Thu	Fri	Sat	Sun		
00:00-01:00	73	68	69	60	92	85	69	516	2,527
01:00-02:00	45	49	43	37	45	61	52	332	
02:00-03:00	35	44	21	23	34	42	45	244	
03:00-04:00	29	26	23	21	18	30	33	180	
04:00-05:00	20	27	21	26	14	30	31	169	
05:00-06:00	23	32	22	20	21	31	25	174	
06:00-07:00	42	50	40	35	47	62	51	327	
07:00-08:00	81	80	84	90	87	87	76	585	
08:00-09:00	243	212	191	217	180	158	166	1,367	30,269
09:00-10:00	349	309	328	288	290	260	266	2,090	
10:00-11:00	360	337	348	350	337	355	296	2,383	
11:00-12:00	385	339	398	328	327	363	346	2,486	
12:00-13:00	399	314	318	292	321	351	336	2,331	
13:00-14:00	352	289	297	321	267	346	341	2,213	
14:00-15:00	343	333	279	281	278	327	314	2,155	
15:00-16:00	302	307	268	285	243	349	278	2,032	
16:00-17:00	303	285	258	284	245	326	245	1,946	
17:00-18:00	324	331	322	338	292	252	220	2,079	
18:00-19:00	312	333	326	311	276	261	228	2,047	
19:00-20:00	317	285	324	294	262	248	220	1,950	
20:00-21:00	268	306	279	248	225	206	208	1,740	
21:00-22:00	239	237	231	195	225	197	217	1,541	
22:00-23:00	166	153	151	162	154	180	156	1,122	
23:00-00:00	125	114	103	98	125	127	95	787	
	5135	4860	4744	4604	4405	4734	4314	32,796	100%

There is an average of seven visits a night and, although this can vary, 90% of all night times have between three and 11 attendances.

Graph 1: Hammersmith UCC: Number of night time attendances by date, 17/18

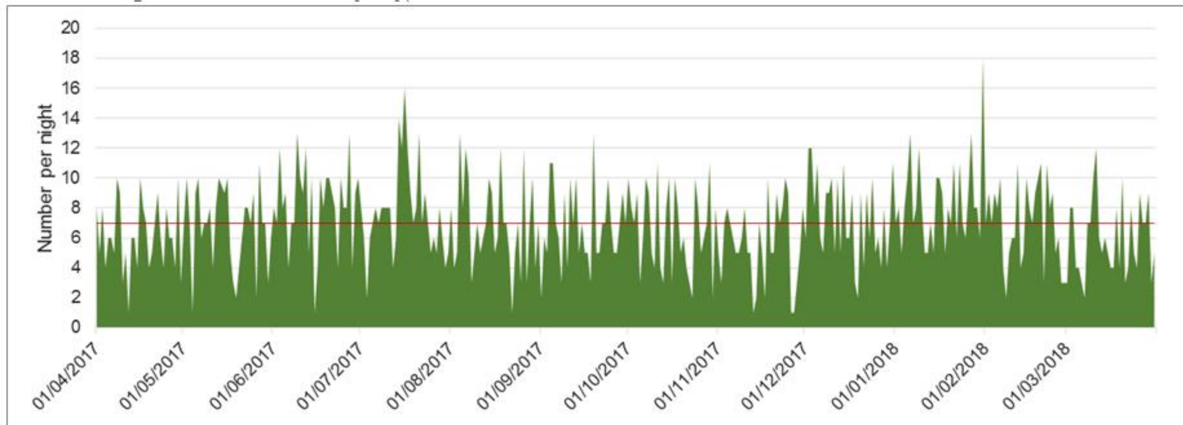


Table 2: Hammersmith UCC: Typical daily volume of attendances in a night-time (Midnight to 8am)

	Attendances
Average per night	7
Most common per night	5
Lowest per night - in year	1
Highest per night - in year	18

A third of people who use the service at night also use it during the day. However, repeat night time attendance is quite rare with only one in 10 patients coming at night more than once in the year.

Eight out of 10 night time attendances are for working age adults, with the rate of visiting higher for this group than for children and older people.

Table 3: Hammersmith UCC: Night-time attendances by age, 17/18

	Per week	Per month	Per year	%
0-4	3	11	131	5%
5-19	5	21	257	10%
20-44	30	129	1,550	61%
45-64	9	40	474	19%
65+	2	10	115	5%
Total	**48**	**211**	**2,527**	**100%**

The gender split at night is representative of the general population, unlike during the day, where women outnumber men. More information on the social-demographic breakdown of attendances is available in appendix 2.

A third of night time attendances are for people living in Hammersmith & Fulham (H&F), followed by a quarter from Ealing. Over a half are from a 3km radius, such as East Acton and White City. This area tends to be more deprived than average for London. People from these areas may have slightly higher rates of illness and disability than typical. Maps showing the location of attendees and average distance travelled are in appendices 3 & 4.

2.1.2 Clinical summary of attendances

Arrival

Overnight, 98% of attendees (which is on average 47 a week) to Hammersmith UCC self-present with the remaining 2% (on average 1 a week) sent by 111.

Table 4: Hammersmith UCC – Number of attendances by mode of attendance, 17/18

	Average daily number		Average weekly number		Percent of total	
	In night	In day	In night	In day	In night	In day
Walked In	7	82	47	577	98%	99%
Sent by 111	0	0	1	3	2%	1%
London Ambulance Service	0	0	0	1	0%	0%
Other	0	0	0	0	0%	0%
Total	**7**	**83**	**48**	**581**	**100%**	**100%**

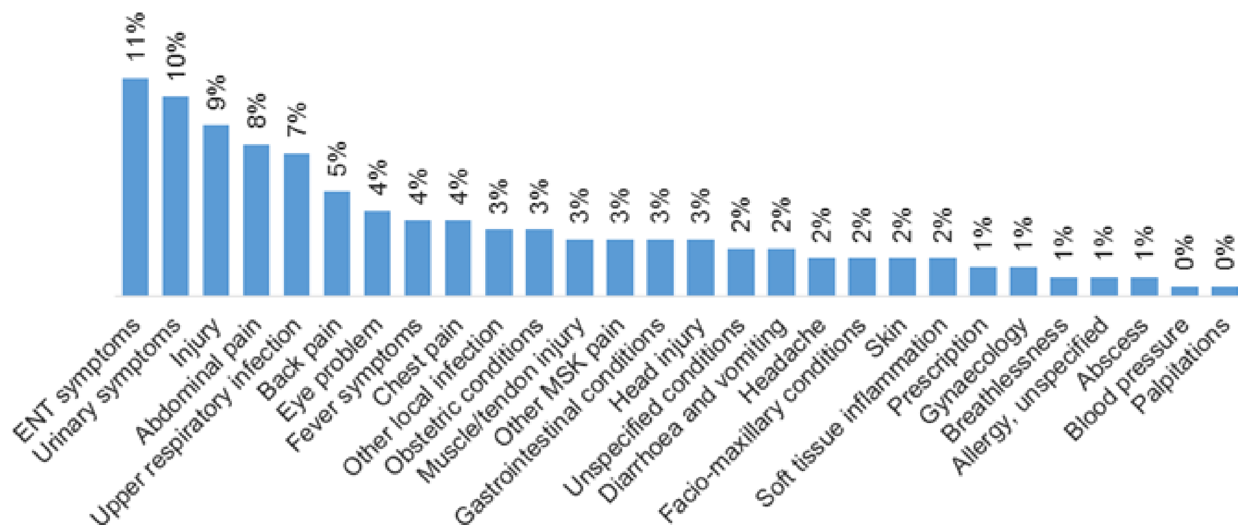
Reason for attendance

A clinical audit was carried out by Hammersmith and Fulham CCG of 250 records of 17/18 night time attendances with sufficient detail available on 238 of these records.

The 250 records were a random 10% sample of 17/18 night time attendances.

The graph below summarises the results of the clinical audit with regard to the presenting complaints/diagnosis of those attending Hammersmith UCC overnight.

Graph 2: Hammersmith UCC – Presenting complaint/diagnosis from audit of night time attendances



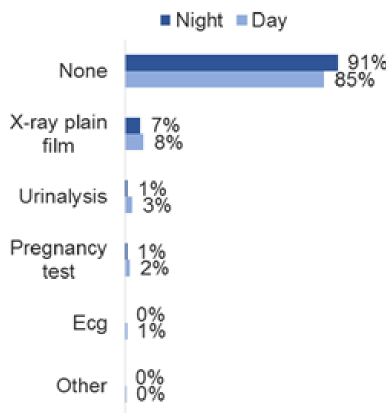
Treatment and investigations

For around three quarters of attendances, the treatment provided was advice and/ or simple medication. Most other attendances were given wound care/ dressing or simple MSK care such as slings/ tubigrips.

The graph below shows the investigations undertaken for those attending the UCC in 17/18, showing that the majority are discharged with no investigation. The data identifies 9% of patients needing investigation/ treatment at night, compared to 15% during the day.

On average, this equates to just 4 patients a week needing investigation or treatment overnight, compared to 85 patients per week during the day

Graph 3: Hammersmith UCC – investigations by day and night, 17/18



Outcomes

Routine data from the provider identifies an average of seven patients attending per night, of whom around six were discharged and one (15%) was referred to an emergency department (ED) which equates to seven per week.

Table 5: Hammersmith UCC – Number of attendances by outcome of attendance, 17/18

	Average daily number		Average weekly number		Percent of total	
	In night	In day	In night	In day	In night	In day
Discharged	6	70	41	492	85%	85%
Referred to Emergency Dept	1	13	7	89	15%	15%
Total	**7**	**83**	**48**	**581**	**100%**	**100%**

Data matching of NW London UCC and hospital admissions data (17/18) shows around 6-7% of patients attending the UCC at night time go on to be admitted as a non-elective admission the same day or following day after the attendance – around three a patients a week.

The clinical audit of 250 attendances at Hammersmith UCC between midnight and 8am identified 29% of night time attendances requiring UCC/ED attendances that

night (12% UCC; 16% ED). Applied to daily numbers, this would equate to two of the seven current night time attendances requiring care in UCC/ED that same night (or 14 per week).

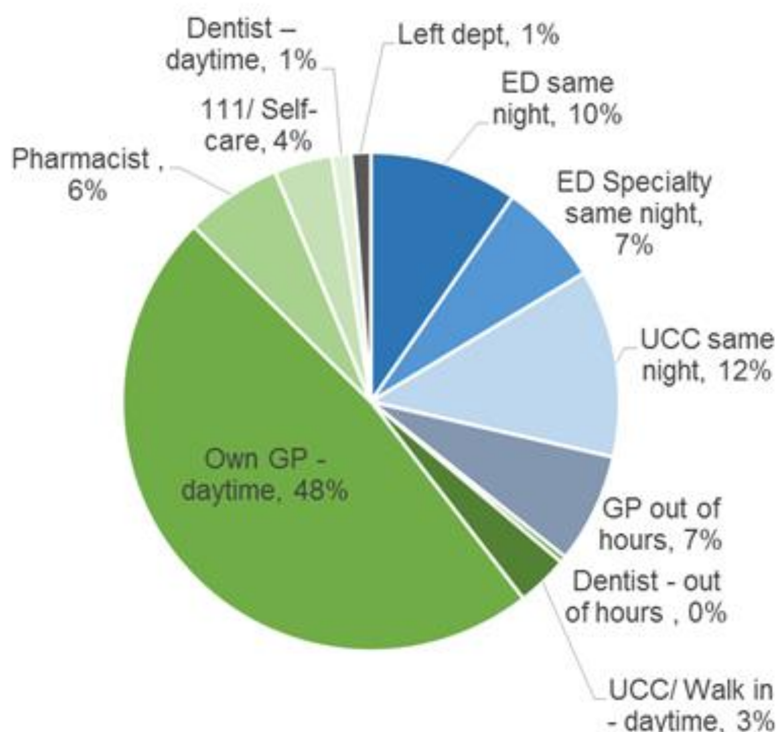
Table 6: Hammersmith UCC – Estimated number of night time attendances requiring UCC/ED same night (Audit percentage applied to attendance data)

	Average number per night	Average number per week	Percent of total
Need ED/ED Specialty same night	1	8	16%
Need UCC same night	1	6	12%
Need 'other' same night	1	4	8%
Need care next day	4	31	64%
Total	**7**	**48**	**100%**

Alternative care pathway

As reflected in table 6 above, the clinical audit found that suitable care for close to half (48%) of those attending at night would have been a GP appointment the following day. For those who do require an ED, the further onward transport required from a standalone UCC does increase clinical risk.

Graph 4: Hammersmith UCC – Outcome of clinical audit, appropriate presentation for those who came to UCC overnight



2.1.3 Workforce

Overnight, there are four staff in the urgent care centre:

- 2 Receptionists (shift 10pm – 8am)
- 1 GP (shift 11pm – 8am)
- 1 ENP (shift 8pm – 8am)

The provider is not reporting any issues filing these shifts as they are able to mitigate any emerging issues within their organisation. However, it is not without difficulty – the Provider has flagged that often shifts are harder to fill due to the clinical safety risks felt by staff of operating a standalone UCC overnight.

2.1.4 Financial cost of service

When the service moved to 24/7 in 2014, the additional contract value for the overnight hours was approximately £600,000 per year.

2.1.5 Performance

Hammersmith UCC has been fully compliant with the contractual five clinical quality indicators. We are moving towards reporting against the 14 NW London KPIs from 19/20 which are outlined in appendix 1.

Table 7: Hammersmith UCC – performance against five clinical quality indicators.

		Hammersmith UCC		
	target	July	Aug	Sept
Unplanned re-attendance at UCC within 7 days of original attendance	< 5%	3.3%	4.2%	3.5%
95th Percentile wait above 4 hours	95%	99%	99%	99%
Percentage of patients who left without being seen.	<5%	3.6%	2.3%	2.8%
Service Experience/FFT	>75%	99%	100%	100%
Median time to treatment (<60mins) minutes wait	50%	64.5%	76.3%	72.3%

2.1.6 Friends and family

The friends and family results from quarter two 2018/19 show that 99.6% would recommend the service at Hammersmith UCC to friends and families. This was out of 918 responses.

2.1.7 CQC

The February 2018 CQC inspection of Urgent and Emergency Care at Imperial did not include Hammersmith UCC.

Hammersmith and Fulham Clinical Commissioning Group

2.2 Charing Cross UCC

Charing Cross UCC is currently open 24/7 and is co-located with Charing Cross Hospital ED in the south of the borough. The ED at Charing Cross does not see children.

Charing Cross UCC is also operated by London Central & West Unscheduled Care Collaborative (LCW).

2.2.1 Current attendance levels

Charing Cross UCC saw just over 47,000 patients in 17/18, an average of 908 patients a week. Just under 11% of all attendances occur in the period between midnight and 8am with 4% occurring between 2am and 6am.

Table 8: Charing Cross UCC – Average number of attendances, by time of day and day of the week, 17/18

Charing Cross - 17/18 - average per week

Time	Mon	Tue	Wed	Thu	Fri	Sat	Sun		
00:00-01:00	3	2	2	3	2	3	3	18	99
01:00-02:00	2	2	2	2	2	2	2	14	
02:00-03:00	2	2	1	2	1	1	2	10	
03:00-04:00	1	1	1	2	1	2	1	9	
04:00-05:00	1	1	1	1	1	1	1	7	
05:00-06:00	1	1	1	1	1	1	1	9	
06:00-07:00	2	2	1	1	2	2	2	12	
07:00-08:00	3	3	3	3	3	3	3	20	
08:00-09:00	6	5	6	6	5	5	5	38	809
09:00-10:00	10	8	9	9	9	8	7	59	
10:00-11:00	11	10	9	9	8	10	9	66	
11:00-12:00	11	9	8	9	9	10	10	65	
12:00-13:00	10	8	8	8	7	10	9	62	
13:00-14:00	9	8	8	8	8	10	9	60	
14:00-15:00	9	8	8	8	7	10	8	59	
15:00-16:00	9	8	8	8	8	8	8	56	
16:00-17:00	8	8	7	8	8	8	7	54	
17:00-18:00	9	8	8	7	7	7	7	53	
18:00-19:00	9	8	8	8	7	7	6	53	
19:00-20:00	8	8	7	7	7	6	6	48	
20:00-21:00	7	7	7	7	6	6	6	45	
21:00-22:00	6	5	5	6	5	5	6	38	
22:00-23:00	4	5	4	4	5	4	4	30	
23:00-00:00	4	3	3	3	3	3	3	23	
	144	131	126	129	122	131	126	908	100%

36 attendances per week in **2am-6am** slot

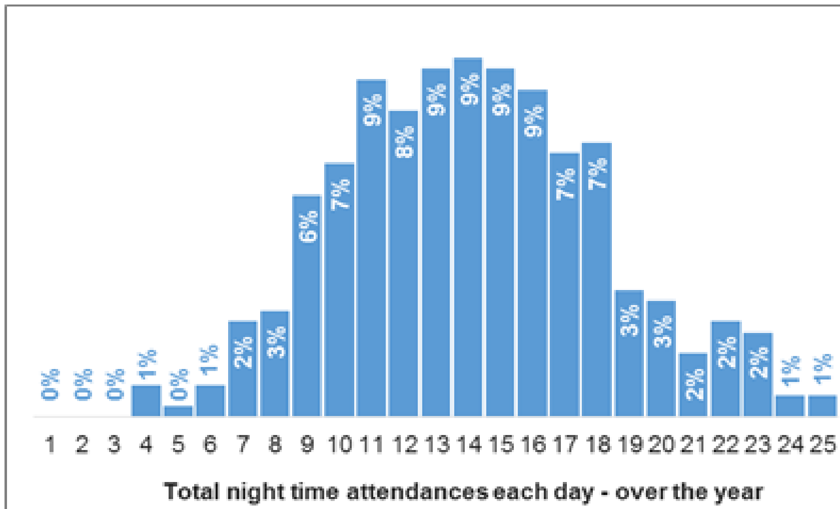
Charing Cross - 17/18 - total in year

Time	Mon	Tue	Wed	Thu	Fri	Sat	Sun		
00:00-01:00	132	126	123	143	124	139	138	925	5,150
01:00-02:00	97	112	98	102	94	111	92	706	
02:00-03:00	87	80	66	79	66	74	84	536	
03:00-04:00	66	61	54	80	74	80	71	486	
04:00-05:00	47	59	57	50	49	52	77	391	
05:00-06:00	75	47	72	65	59	58	71	447	
06:00-07:00	99	90	74	71	85	83	101	603	
07:00-08:00	173	155	142	141	151	158	136	1,056	
08:00-09:00	330	274	295	311	248	274	246	1,978	42,180
09:00-10:00	510	438	462	458	453	416	361	3,098	
10:00-11:00	589	508	460	481	421	496	485	3,440	
11:00-12:00	548	475	441	463	464	503	507	3,401	
12:00-13:00	547	427	419	422	388	516	491	3,210	
13:00-14:00	494	439	415	402	407	513	484	3,154	
14:00-15:00	468	427	412	437	391	496	436	3,067	
15:00-16:00	446	405	419	425	404	437	401	2,937	
16:00-17:00	401	429	388	397	397	419	364	2,795	
17:00-18:00	448	413	424	357	366	387	355	2,750	
18:00-19:00	462	441	397	418	370	343	323	2,754	
19:00-20:00	392	395	375	372	344	297	324	2,499	
20:00-21:00	349	369	342	351	306	315	315	2,347	
21:00-22:00	305	262	278	301	254	268	288	1,956	
22:00-23:00	231	242	206	232	242	213	222	1,588	
23:00-00:00	197	165	159	144	181	179	181	1,206	
	7493	6839	6578	6702	6338	6827	6553	47,330	100%

1,860 attendances per year in **2am-6am** slot

There are typically around 14 visits a night, although this can vary considerably. 90% of all night times (midnight to 8am) have between 8 and 20 attendances.

Graph 5: Charing Cross UCC – Night time attendance count, 17/18



Graph 6: Charing Cross UCC – Number of night time attendances by date, 17/18

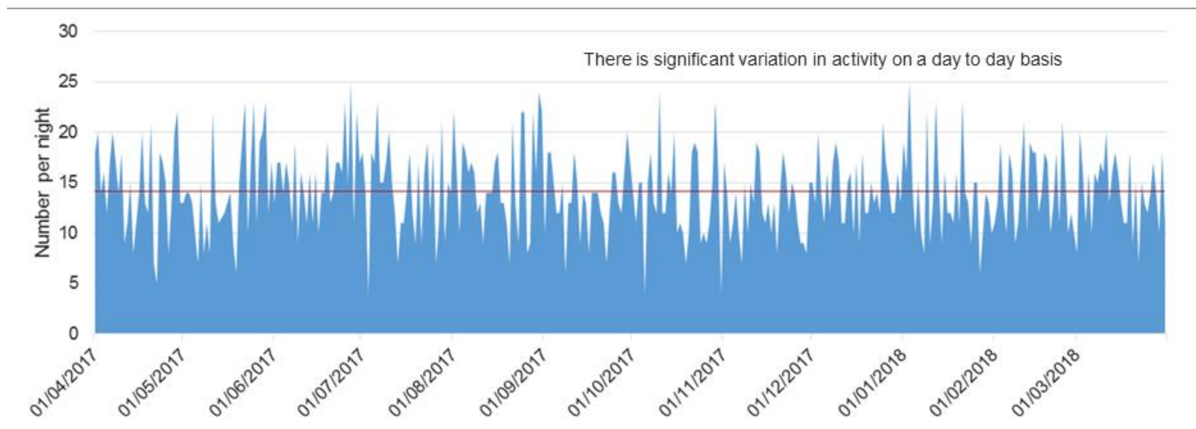


Table 9: Charing Cross UCC – Typical daily volume of attendances in a night-time (Midnight to 8am)

	Attendances
Average per night	14
Most common per night	14
Lowest per night - in year	4
Highest per night - in year	25

A quarter of people who use the service at night also use it during the day. Repeat night time attendance is quite rare with only one in 10 patients coming in at night more than once in the year.

85% of attendances between midnight and 8am are for working age adults, with the rate of visiting higher for this group than for older people and much higher than for children.

Table 10: Charing Cross UCC – Night-time attendance by age, 17/18

	Per week	Per month	Per year	%
0-4	1	5	64	1%
5-19	6	26	317	6%
20-44	60	259	3,110	60%
45-64	25	107	1,280	25%
65+	7	32	379	7%
Total	**99**	**429**	**5,150**	**100%**

Men are over-represented at night compared to the general population, unlike during the day, where women outnumber men. More socio-economic information on Charing Cross UCC overnight attendees can be found in appendix 5.

Half of night time attendances are for people living in Hammersmith & Fulham (H&F), followed by 1 in 10 from Ealing. The majority are from a 3km radius, such as Hammersmith/ Shepherd's Bush.

People from these areas may have slightly lower rates of illness and disability compared to London and deprivation is broadly similar. More location information on Charing Cross UCC overnight attendees can be found in appendices 6 & 7.

2.2.2 Clinical summary of attendances

Arrival

Overnight, 91% of attendees (around 90 a week) to Charing Cross UCC self-present, with 7% (7 a week) being sent by 111 and the remaining 2% (2 a week) arriving by ambulance.

Table 11: Charing Cross UCC – Number of attendances by mode of attendance, 17/18

	Average daily number		Average weekly number		Percent of total	
	In night	In day	In night	In day	In night	In day
Walked In	13	110	90	773	91%	96%
Sent by 111	1	4	7	27	7%	3%
London Ambulance Service	0	1	2	8	2%	1%
Other	0	0	0	1	0%	0%
Total	**14**	**116**	**99**	**809**	**100%**	**100%**

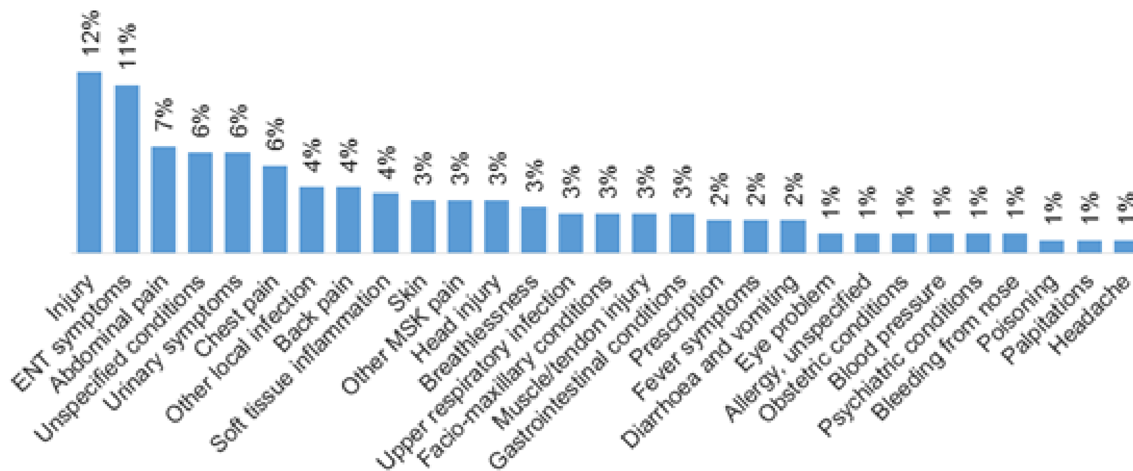
Reason for attendance

A clinical audit was carried out by Hammersmith & Fulham CCG on 250 records of night time attendees at Charing Cross UCC. There was sufficient detail available on

245 of these records. The sample for the clinical audit was a completely random sample of 5% of overnight attendances in 17/18 (comparable to the Hammersmith Hospital sample size).

The graph below summarises the presenting complaints/diagnosis of those attending Charing Cross UCC overnight.

Graph 7: Charing Cross UCC – Presenting complain/diagnosis from audit of night time attendances



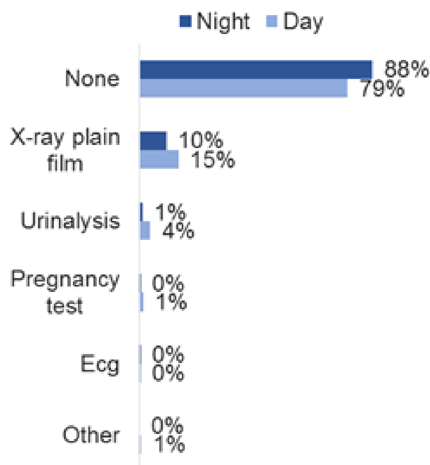
Treatment and investigations

As with Hammersmith UCC, for around three quarters of attendances, the treatment provided was advice and/ or simple medication. Most other attendances were given wound care/ dressing or simple MSK care such as slings/ tubigrips.

Routine NW London data identifies 12% of patients needing investigation/ treatment at night, compared to 21% during the day.

On average, this equates to just 12 patients a week need investigation or treatment overnight, compared to 170 patients a week during the day

Graph 8: Charing Cross UCC – investigations by day and night, 17/18



Outcomes

Routine data from the provider identifies around 14 patients attending per night, of whom around 11 were discharged and 3 (25%) were referred to an emergency department (24 per week).

Table 12: Charing Cross UCC – Number of attendances by outcome of attendance, 17/18

	Average daily number		Average weekly number		Percent of total	
	In night	In day	In night	In day	In night	In day
Discharged	11	87	74	611	75%	76%
Referred to Emergency Dept	3	28	24	198	25%	24%
Total	**14**	**116**	**99**	**809**	**100%**	**100%**

Data matching of NW London UCC and Hospital admissions data (17/18) shows around 5% of patients attending the UCC at night time go on to be admitted as a non-elective admission the same day or following day after the attendance – around 5 a patients a week.

The clinical audit found that 35% of those attending Charing Cross UCC between midnight and 8am required an ED or UCC that night. Applied to nightly numbers, this would equate to 5 of the 14 night time attendances requiring care in UCC/ED that same night (or 34 per week).

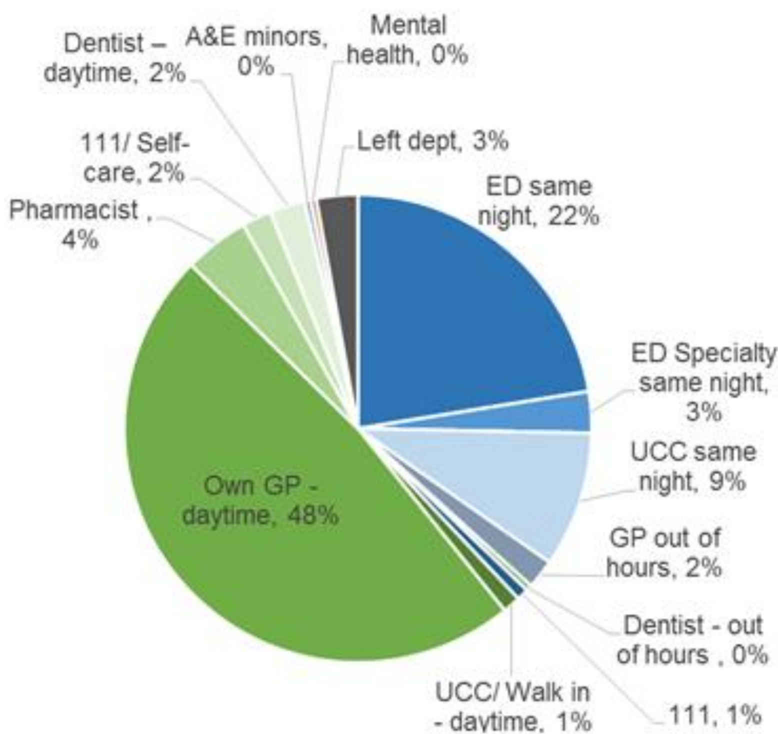
Table 13: Charing Cross UCC – Estimated number of time time attendances requiring UCC/ED same night (audit percentage applied to attendance data)

	Average number per night	Average number per week	Percent of total
Need ED/ED Specialty same night	4	25	25%
Need UCC same night	1	9	9%
Need 'other' same night	0	3	3%
Need care next day	9	61	62%
Total	**14**	**99**	**100%**

Alternative care pathway

As reflected in table 13 above, the clinical audit found that the suitable care for close to half (48%) of those attending at night would have been a GP appointment the following day.

Graph 9: Charing Cross UCC – Outcome of clinical audit, appropriate presentation for those who came to UCC overnight



2.2.3 Workforce

There are five staff in the UCC overnight:

- 2 Receptionists (shift 10pm – 8am)
- 1 GP (shift 11pm – 8am)
- 1 ENP (shift 8pm – 8am)
- 1 Health Care Assistant (shift 8pm – 8am)

2.2.4 Performance

Charing Cross UCC has been fully compliant with the contractual five clinical quality indicators. We are moving towards reporting against the 14 NW London KPIs from 19/20 which are set out in appendix 1.

Table 14: Charing Cross UCC – Performance against five clinical quality indicators.

		Charing Cross UCC		
	target	July	Aug	Sept
Unplanned re-attendance at UCC within 7 days of original attendance	< 5%	4.4%	4.9%	4.5%
95th Percentile wait above 4 hours	95%	99%	99%	99%
Percentage of patients who left without being seen.	<5%	4.3%	3.2%	3.4%
Service Experience/FFT	>75%	99%	97%	98%
Median time to treatment (<60mins) minutes wait	50%	52.2 %	54.1%	51.1%

2.2.5 Friends and family

The friends and family results from quarter two 2018/19 show that 98% would recommend the service at Charing Cross UCC to friends and families. This was out of 1147 responses.

2.2.6 CQC

The February 2018 CQC report on urgent and emergency services at Charing Cross had an overall rating of requires improvement. It is worth noting that the actual report makes no reference to the UCC at Charing Cross Hospital.

https://www.cqc.org.uk/news/releases/imperial-college-healthcare-nhs-trust-rated-requires-improvement-cqc

2.3 GP appointments

2.3.1 Overview

There are 29 GP practices in Hammersmith & Fulham with a broad range of registered patient numbers.

- Largest practice – GP at Hand (raw 34,030, weighted 34,259)
- Second largest – North End Medical Centre (raw 19,602, weighted 17,048)
- Smallest practice – Salisbury Surgery (raw 1,182, weighted 1,171)

It should be noted that GP at Hand is a practice which offers digital-based services which, whilst based at a practice in H&F, has a high number of registered patients from outside the borough which skews the numbers.

H&F CCG provides appointments for patients between 8am and 8pm, seven days a week. 765 additional GP appointments a week are currently commissioned through two schemes, extended hours and weekend plus.

2.2.2 Extended hours

Extended hours is about providing additional clinical capacity outside of core hours (8am-6:30pm). There are currently two schemes operating in Hammersmith & Fulham to deliver these appointments:

Local scheme: Under the locally commissioned services, (LCS) this is about individual GP practices providing the additional appointments to their own patients. 19 practices signed up to deliver the service in April 2018. The exact opening hours are flexible according to patient requirements but must be provided before or after core hours and any time over the weekend. Practices are not required to maintain service provision during Bank Holidays.

National scheme: Five practices in Hammersmith & Fulham are signed up to deliver extended hours as part of the national directed enhanced service scheme (DES). The national scheme mandates the number of extended hours that practices must provide per week based on a practice's list size.

2.2.3 Weekend plus

The service is aimed at providing additional clinical capacity outside of core hours for all patients registered in Hammersmith & Fulham to access and use. The CCG commission three Hubs; Brook Green Medical Centre, Cassidy Road Medical Centre and Parkview Practice. Each Hub is required to provide 1.5 hours per weekday and 12 hours over the course of a weekend. Whilst these appointments are available to all registered with a GP in the borough, it particularly ensures access to the patients

of the five practices who currently do not provide extended hours services for their patients.

2.2.4 Current attendance levels

Average weekly utilisation of the appointments outside the core hours at the 19 practices operating the local extended hours scheme (LCS) is 82%.

Table 15: Utilisation of extended hours (LCS) at 19 sites in Hammersmith & Fulham (Weekly average)

Practice Name	Appointments offered	Appointments Booked	Appointments Attended	Utilisation
North End MC	43.7	43.2	38.7	**89%**
82 Lillie Road	62.6	59.7	56.3	**90%**
Richford Gate	27.5	27.0	22.7	**82%**
Brook Green MC	50.7	50.1	42.6	**84%**
Dr Jefferies	47.1	45.9	40.5	**86%**
Hammersmith Surgery	30.9	30.9	25.7	**83%**
Palace Surgery	27.5	24.6	22.4	**82%**
The New Surgery	32.3	31.3	28.0	**87%**
Bush Doctors	66.8	65.2	53.9	**81%**
Brook Green Surgery	36.1	35.3	28.9	**80%**
Sands End Clinic	50.5	49.3	39.4	**78%**
Dr Uppal	24.2	23.3	21.0	**87%**
Park Medical Centre	50.1	48.7	42.5	**85%**
Fulham Cross	19.7	17.5	15.7	**80%**
Dr Kukar, Parkview	13.8	10.0	8.8	**64%**
Salisbury Surgery	17.1	9.7	8.3	**48%**
Ashville Surgery	34.6	34.2	31.8	**92%**
Dr Kukar, Medical Centre	57.7	51.5	44.3	**77%**
	693	**657**	**572**	**82%**

Average utilisation of the appointments outside the core hours at the three practices operating the national extended hours scheme (DES) is 83%. Although three practices have signed up to this scheme, only two have submitted returns to NHS England, meaning one signed up practice is not currently participating.

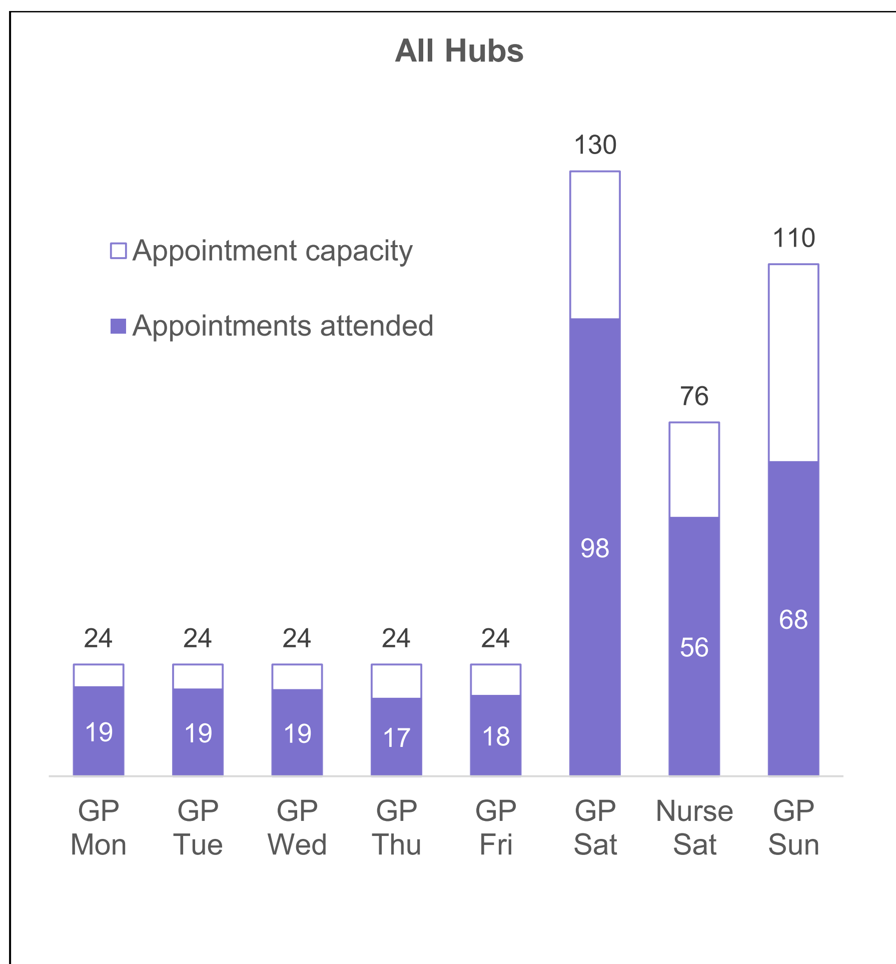
Table 16: Utilisation of extended hours (DES) at two sites in Hammersmith & Fulham (Weekly average)

Practice Name	Appointments offered	Appointments Booked	Appointments Attended	Utilisation
Lilyville Surgery	12.7	10.0	9.2	**72%**

Fulham Medical Centre	16.2	16.0	14.7	**91%**
	28.9	26.0	23.9	**83%**

Weekend plus – Average weekly utilisation of the appointments outside core hours at these three hubs is 72%.

Graph 10: Utilisation of weekend plus appointments at three hubs in Hammersmith & Fulham (weekly average)



2.2.5 Financial cost of service

- **Extended Hours Local Scheme (LCS)** funded from core CCG budgets (£614k)
- **Extended Hours Directed Enhanced Services (DES)** providing around eight hours a week funded from delegated budgets (£29k)
- **Weekend plus Services** providing 8am to 8pm, 7 day access to all patients registered and resident in the borough at three sites. Nurse appointments are

available on a Saturday. This scheme is funded from core CCG budgets (£692k) and supplemented by General Practice Access Funding (GPAF) from NHS England (£480k).

3. **Involvement**

3.1 Principles & overview

Hammersmith & Fulham CCG have principles of engagement and co-design which have been developed with our patient partners. This sets out the importance of involving our residents and stakeholders from the start and listening to all views in the development of our plans.

That approach has been followed on this project and our engagement work is on-going.

3.2 Workshops undertaken

To date, the CCG has engaged with members of the public on primary and urgent care access at a number of local workshops/focus groups/patient engagement events.

The engagement built on a spread sheet of previously collated feedback from community groups from which the relevant information has been filtered out. Much of the previous feedback pertained to accessibility of primary care, whilst the remainder was drawn from a NW London wide survey on extended hours and weekend plus services

Event	Date	Number of patient, public, Lay Member and CVS attendees
Patient Reference Group	Thursday 2 August	19
Primary and urgent care access workshop	Tuesday 21 August	15 + 5 GPs and Practice Managers
Patient Reference Group	Thursday 4 October	15
Session with Action on Disability group	Friday 5 October	9
Healthwatch Enter and View at Hammersmith Urgent Care Centre	Thursday 20 September, 5-8pm Friday 5 October, 11am-1pm	4 patients 11 patients
Stall at Age UK event	Friday 19 October	Handed out literature and discussed ideas for change with local people. Main focus was on recruiting participants for

		PPG Leadership training (participants will be surveyed).
QPR Community Trust's weekly older people's club	Wednesday 7 November	10-15
PPG Leadership training	Thursday 8 November	30

3.3 Stakeholder engagement

3.3.1 Local Authority

On 1 August a conference call took place to brief Cllr Coleman (Cabinet Member for Health and Adult Social Care) and Martin Calleja (Head of Health Partnerships) from the London Borough of Hammersmith & Fulham Council on plans to engage around possible changes to extended hours and weekend plus provision in the borough. On Thursday 9 August the CCG responded to a subsequent letter from Cllr Coleman detailing the CCG's decision to engage and consult on the extended hours, weekend plus and Urgent Care Centre contracts at the same time. The letter proposed that a paper be taken to their health scrutiny committee – PAC- in September. The paper is now being taken to PAC on 4 December. Cllr Patricia Quigley (Assistant to Cabinet) has been involved in subsequent discussions at the CCG's Patient Reference Group in August and October.

On the 12 October, the H&F Managing Director, Head of Engagement and Director of Communications met with the Chair of the local Scrutiny panel and the Lead Councillor for health to outline the proposals, the clinical assurance process and agree the outline for the Scrutiny meeting item in December

3.3.2 Healthwatch

On Wednesday 25 July the CCG's engagement lead and Deputy Managing Director met with Healthwatch representatives to discuss engagement with young people. As part of this discussion, the intention to review and engage on current primary and urgent care access was shared. Healthwatch offered to undertake an "enter and view" on Hammersmith Urgent Care Centre to help gather engagement data and this was agreed on 31 August.

3.3.3 GP practice staff

Information on the primary and urgent care access review was shared with GP practice staff via the CCG's weekly newsletter on 13 August 2018. Initial discussions took place at the members' meeting and at network meetings on 8 August 2018 (North), 20 August 2018 (Central) and 23 August 2018 (South).

3.3.4 Imperial College Healthcare NHS Trust

The Chief Operating Officer at LCW and the General Manager for Emergency Medicine and Urgent Care at Imperial have been fully sighted on the UCC element of the review. It was discussed at a performance meeting on 25 October 2018.

On the 2 November the H&F Managing Director updated the senior Partners for Health team in a telephone conference. The plans and timeline were covered and the data set has been shared with them. Attendees included the Divisional Director of Operations, Medicine & Integrated Care ICHT, Interim Clinical Director, Division of Medicine & Integrated Care ICHT, Clinical Director for LCW and CEO of LCW.

3.4 What we've heard so far

A summary of what we've heard through our engagement to date and how that has fed into our planning is outlined in appendix 10.

3.5 Further pre-consultation engagement planned

Event	Date	Estimated numbers
Bayonne and Field Road Community Champions yoga event	Wednesday 14 November	15
Community Champions winter health event	Wednesday 21 November	15-30
Youth Take Over Day	Friday 23 November	15
HeadsUp (mental health service user involvement panel)	Thursday 29 November	15-20
Addison Community Champions winter event	Wednesday 5 December	15-30
In-depth review and feedback of pre-consultation engagement documents from patient representative	Early- to mid-November	1
Solution workshop 1	Tbc	
Solution workshop 2	Tbc	
Options appraisal workshop	Tbc	

4. Draft proposals

4.1 Draft proposal for Charing Cross UCC

It is not proposed to make any changes to the Charing Cross UCC opening hours.

We looked at the volume of patients, their acuity and the impact any change in hours would have on staff, patients and other services.

We considered a closure of Midnight to 8am and also a shorter closure of between 2am and 6am. Both were discounted as it was not felt to be clinically appropriate.

Volumes at Charing Cross UCC are higher overnight than at Hammersmith. Based on attendance levels and acuity, the CCG considered a closure between 2am and 6am. At this time, there are low numbers of attendances and most are low acuity patients, with a high number of patients leaving with no investigation and minimal treatment.

However, any closure in night time hours after midnight would impact shift patterns and ability to recruit staff to work overnight. Additional difficulty accessing the wider public transport system for staff may incur cost of alternative transport home (e.g. taxi).

In addition, it is anticipated that many of those seeking care overnight will continue to do so which is most likely to result in additional pressure on the co-located ED.

Finally, an overnight closure at Charing Cross UCC would increase the impact of patients currently attending Hammersmith UCC if that unit were to close overnight.

4.2 Draft proposal for Hammersmith UCC

It is proposed to change the Hammersmith UCC opening hours by closing overnight from midnight to 8am.

4.2.1 Rationale for plan and evidence base

As highlighted by the 17/18 data and clinical audit results which were outlined in section 2.1.1 and 2.1.2, there is a low attendance of patients with low levels of acuity at Hammersmith UCC between midnight and 8am, with 91% of patients attending leave with no investigation and minimal treatment.

Closing the standalone unit overnight moves us to a safer urgent and emergency care offering in Hammersmith and Fulham by reducing the entry points to out of hours services to improve the ease in which patients get to the right place, quicker.

4.2.2 Workforce modelling

If an overnight closure were to be put in place, overnight shifts would not be required; shift patterns could be changed to cover 8pm-midnight.

4.2.3 Impact on patients
The clinical audit showed that from the average of seven patients attending per night the following would be the appropriate course of action if Hammersmith UCC were to close overnight:

- 16% (1 per night) would continue to require ED either urgent treatment or referral to specialty review
- 12% (1 per night) would need to attend an alternative UCC such as Charing Cross or St Mary's
- 8% (less than 1 per night) could access an alternative night service such as GP out of hours or dentist
- 64% (4 per night) could access alternative provision, including their own GP, the next day

It is recognised that whilst, on average, five patients a night attending Hammersmith UCC do not need to attend a UCC or ED, they have already chosen to do so and so it is prudent to assume they would continue to seek help overnight. That is addressed in the following section on impact on neighbouring trusts.

The digital offering being implemented by the CCG will aim to drive down those inappropriate attendances, helping to provide choice and direction to those seeking advice and care. The majority of attendees overnight are between 20 and 44, the age group most likely to have internet access at home, or own a smartphone, and therefore be best place to benefit from digital signposting.

4.2.4 Patient transport implications
Charing Cross is the closest alternative UCC.

- By car, it takes approximately 9-16 minutes (at 2am based on data from google maps).
- By public transport, both the 72 and 220 go from Hammersmith Hospital to Charing Cross hospital and take approximately 22 minutes, accounting for waiting time, overnight.

If the CCG were to progress with the proposals, impact on transport and access times would be a key part of the consultation.

4.2.5 Impact on neighbouring Trusts/EDs/UCCs
The impact is most likely to be on Charing Cross UCC due to its proximity. Whilst the clinical audit showed approximately two patients a night would need to attend a UCC, we are assuming all seven patients who currently choose to attend Hammersmith overnight would defer to Charing Cross UCC.

Due to the low numbers of attendees at Charing Cross UCC, especially between 2 and 6am, this patient flow could be absorbed within current staffing levels.

Any patients currently attending Hammersmith UCC overnight and needing to be transferred to ED are currently most likely to be transferred to Charing Cross (subject to specialist needs) due to proximity. Therefore there is not expected to be any additional impact on Charing ED.

If the CCG were to progress with the proposals, detailed modelling of likely patient flow would be a key part of the consultation.

4.2.6 Financial implications

This will be confirmed during contracting but it is anticipated that the cost of commissioning the UCC service would reduce by approximately £600,000 a year.

4.1.7 Risks and mitigations

The key risk relates to Hammersmith UCC being a standalone unit meaning there is no alternative service on site during the proposed closure hours. Whilst there is a low volume of patient attending Hammersmith UCC, the following mitigations would be discussed as part of the consultation process:

- Clear clinical pathways for all patients arriving at the UCC – with specific reference to pathways for patients arriving close to closing time.
- Clear on-site signposting for those arriving outside opening hours
- Road signage changes around the hospital and on approaching roads
- Consideration of overnight patient transport service based on-site between midnight and 8am for a set period of time after the change of hours
- Consideration of free-phone outside the UCC which goes straight through to 111 between midnight and 8am.
- Communications campaign in the areas where most attendees come from

There would be an on-going review of patient numbers at both UCCs and the ED. Any expected changes to patient flow would be addressed within the contracting for the updated UTC specifications.

During consultation, we would also undertake equalities assessments to identify any specific health inequalities in the local area or groups with protected characteristics who would be adversely impacted.

4.3 Draft proposal for GP appointment volumes

Extended hours - Following a robust options appraisal, the CCG are proposing to decommission local extended hours scheme and transfer all practices to DES. The changes in extended hours provision we are proposing will see a reduction of 155 GP appointments a week. We currently commission 765 a week (19 practices providing the LCS and three signed up to provide the DES) and we would reduce that down to 610 through only commissioning the DES.

Weekend plus – A series of options have been developed, from do nothing to changing the number of hubs to changing the number of commissioned hours. This is still under consideration. The full list of options is available in appendix 9 for information.

4.3.1 Rationale for plan and evidence base

The changing digital landscape and Hammersmith & Fulham CCGs commitment to their digital vision means patients will have the choice of a digital first offer for accessing advice and care options.

There are currently around 10-25% average underutilisation across these appointments. The commissioned appointments outside core hours would be in line with current demand.

The proposal would ensure a more consistent offering to all patient across the borough.

4.3.2 Financial implication

Moving all practices to the national extended hours scheme (DES) will deliver financial savings:

- £298,994 for part year affect in 2018-19.
- £597,998 per annum

There will also be fairer distribution of extended access funding based on registered list size rather than historic data.

4.3.3 Workforce modelling

This will be for practices to discuss at a local level.

4.3.4 Impact on patients

Appointments will still be available 8am-8pm, seven days a week, for all patients across the borough and the proposal is to commission within the current level of demand.

Not all appointments will be at the patient's own practice and this may have travel implications for some.

4.3.5 Risks and mitigations

- Large drop in income in short period of time for 4 practices who will lose over £60k however this can be mitigated.
- Reduction of appointments offered across the borough by 39 hours per week although there is currently under utilisation of extended hours appointments. We will aim to increase utilisation of all extended availalbilty including weekend plus hubs
- Patient satisfaction decreases as a result of reduced level of access. The introduction of a digital first platform will enhance access

- Practices may not sign up to the DES (as the scheme is less financially favourable and inflexible) which may further reduce access. CCG will facilitate sign up. Introduction of a digital first platform will enhance access

4.4 Wider NW London picture

Shaping a Healthier Future, in 2012, set out the NW London vision for improving care across the eight boroughs. It looked at improving out of hospital provision, centralising key services and ensuring that people had access to the right care at the right time and in the right place.

A significant number of improvements have been made across NW London as a result of SaHF and the vision is continued in the NW London STP.

One element of SaHF related to making the nine urgent care centres 24/7. It created a specification for UCCs that was higher than the national specification and agreed that a consistent 24/7offering to all residents would ensure a more efficient and equitable service.

For safety reasons, the ED at Hammersmith Hospital was closed. The UCC onsite increased to 24/7 as part of the mitigation to the closure.

Hammersmith and Fulham is the only borough in NW London to have two UCCs, only one of which is co-located with an ED. It is now over four years since the closure of Hammersmith ED and there is awareness of the lack of ED service at the site.

H&F CCG are clear that the proposals outlined in this paper remain in line with the clinical vision of SaHF. The borough continues to provide a 24/7 UCC services in the borough and infact provides an increased UCC provision to its residents, compared to other boroughs, during the day time. A map of all current urgent and emergency care provision in NW London is in appendix 8.

5. **Next steps**

5.1 Further engagement

We are currently engaging through workshops to seek feedback and solutions to the challenges we face around primary and urgent care. We are also asking about how we should approach a consultation. This will include working the local authority, Healthwatch and colleagues across the CCG and wider NHS to identify suitable venues for public events during the consultation.

We are engaging on scenarios to better understand patient decision making and to also gain insight into where patients would go if a service wasn't in place.

We will then run options appraisal workshop to consider whether any solutions or evidence have been provided to suggest an alternative to our draft proposals. This stage will include consideration of advice and assurance from London Clinical Senate.

5.2 Further assurance

Following the response from the London Clinical Senate, Hammersmith and Fulham CCG will consider any points made before progressing to the NHS England assurance process.

5.3 GB decision making

Upon the completion of the assurance process, the pre-Consultation Business Case will be developed, options will be developed in partnership with patient representatives and stakeholders before being presented to the Governing Body.

The Governing Body will make a decision in public about whether to move to consultation.

5.4 Consultation

It is proposed to start a consultation in mid-late January 2019 on the proposals in this document. The consultation would be six weeks long.

5.4.1 Target audience

- Patients & public:
  - Those who are registered with a GP in Hammersmith & Fulham
  - Those in the core area of users of Hammersmith UCC
  - Those with protected characteristics
  - Seldom heard groups
- GPs/staff in Hammersmith & Fulham
- Stakeholders across Hammersmith & Fulham

5.4.2 Objectives

- Deliver an open and transparent consultation

- Ensure the public voice helps shape the development of these plans
- Develop clear public materials
- Keep stakeholders updated on the issues and hear their views
- Support provision of information through the scrutiny process
- Reach a wide and representative sample of the population with a good geographical spread

5.4.3 Timeline

There are three phases of communications and engagement activity:

1. Pre consultation engagement (Sept – December 2018)
2. Consultation & engagement (Jan – March 2019)
3. Outcomes & implementation (April 2019 onward)

5.4.4 Audience involvement

- We will work closely with our lay partners and local Healthwatch
- We are working with the equalities team to ensure that any engagement and consultation addresses any issues or gaps identified.
- Focus groups with members of the public will test communications materials

5.4.5 Engaging on our pre-consultation and consultation approach

At engagement events to date we have received useful feedback from patient, community and voluntary sector representatives on: what information should be included in our consultation and engagement document; how the information should be presented; and how we should engage and get the message out. All feedback received is being given due regard as we pull together our plan for consultation.

We also co-produced the questions for our pre-consultation engagement with local residents, CVS representatives and Practice Managers at our 21 August workshop.

You said	We did / proposed
“In favour of having multiple access routes to care (telephone, walk in, face to face, digital) with one patient representative noting that ‘one size does not fit all.’”	Proposals cover a digital offer to cover UCCs and primary care, to expand access options.
“We need to know why people are going to the UCC rather than making a GP appointment.”	Pre-consultation engagement questions include asking whether people have tried making a GP appointment before using UCC, and why they use the UCC
“Not happy for NHS 111 to be the main access point into extended hours as it doesn’t operate well enough”	Added a question about 111 into our pre-consultation engagement questions and linked in with 111 procurement

	engagement piece
"North of the borough has greatest health inequality and services should reflect this e.g. ED in north of borough"	Engagement strategy includes ensuring that we engage at plenty of events located in the north of the borough and cover a range of outreach activities including homeless hostels, St Mungo's
"Should expand online content so that you can get video consultations from your own GP practice, or in a way which does not require de-registering from your current GP practice. Have this be accessible via app. Shouldn't have to de-register from your own practice and join GP @ Hand to get this service."	Proposals cover possible development of a digital offer in all H&F practices.
"How confident are we that technology will improve experience, safety and accommodate different demographics?"	Proposals for the digital offer include testing out models with patients via PPGs and wider engagement.
"What services are available locally need better promotion as people don't know about it – via PPGs and other routes."	Proposals cover the need for a less confusing, more integrated and streamlined offer in Hammersmith and Fulham. Advertising what is available will be supported by a local signposting campaign the CCG is planning for early 2019 with the Queen's Park Rangers FC, to raise the profile of local services and 111. The CCG is also delivering leadership training to PPG and potential PPG members.

5.4.6 Printed materials and translation
Similar to the approach taken by local Trusts and H&F Council, we will not be printing all materials. The current proposal is to print summary materials to raise awareness of the consultation and key issues which direct people to the website and support our engagement team. We will provide printed translated materials on request.

All information will be available on line where they can be automatically translated.

5.4.7 Equalities analysis
The CCG equalities screening tool has been used to assess the impact of the proposals.

No adverse impact on those in any protected characteristic. Addressing overnight safety issues will also help to address health inequalities that arise from this.

5.4.8 Consultation activity

Audience	Channel	Detail
Public	Social media Website Media GP screens Posters/leaflets Engagement GP practice patient groups Locations across the borough (libraries, cafes, sports centres etc). Ensure engaging in north of borough	Consultation document online Printed feedback form to support engagement activity Summary consultation materials (printed) Detail on website Online feedback form Frequent social media directing people to where they can find out more and have their say Short animation to provide overview of issue and options for feedback Town Hall style events Attendance at public meetings where there will be high footfall Engagement at GP surgeries and UCC sites Town centre stalls Outreach to key local groups and community centres Posters in locations across the borough (GP surgeries, hospitals, community centres, libraries etc) Information on GP screens Focus groups Press releases Media briefings Workshops with BAME groups, facilitated by local CVS organisations able to interpret where needed

		Attend Community Champion events locally Engage with PPGs, PPE network and PRG Homeless hostels, St Mungo's
Specific patient groups – patients using the services in question	Direct contact Leaflets/posters in situ	Summary leaflet in Hammersmith UCC Leaflets available for patients using evening and weekend services
Healthwatch, lay reps	CCG lay rep meetings ILPG Meetings with HW	Copy for websites and newsletters Request for support in distributing consultation and engagement material Regular updates to HW and lay partners on progress Meeting with Healthwatch to get formal response to consultation and engagement
Community, voluntary and third sector organisations*	Newsletters Engagement	Copy for websites and newsletters Request for support in distributing consultation and engagement material Attend meetings/events to reach more people Direct engagement and focus groups where appropriate
GPs and their surgery staff	Network and federation meetings Practice Manager forums Staff room posters Extranet information	Attend meetings to provide update on work Share consultation and engagement materials along with feedback forms. Copy for GP surgery websites Letter summarising engagement and consultation approach we will be taking so they are able to reassure patients and direct them to the relevant place for information
Pharmacists	Letter	Letter outlining plans and how to feedback

CCG staff	Octopus Intranet Staff briefing Mark's Mail	Briefing note to all H&F staff and all NW London engagement leads Update to all staff via usual internal communications channels Regular briefing to JSMT and Programme Exec especially on any cross cutting issues being raised
Specific staff groups eg UCC staff	Staff meetings Staff room information Intranet	Continued engagement Briefing materials to respond to patient enquiries HR side reassurance/Q&A
Political stakeholders – MPs, Councillors, Assembly Members	Stakeholder newsletters Meetings JHOSC/PAC	Letter at start of consultation/engagement providing key information, materials and links to further information Gain feedback on consultation plans as well as the detailed proposals Attend key meetings as requested

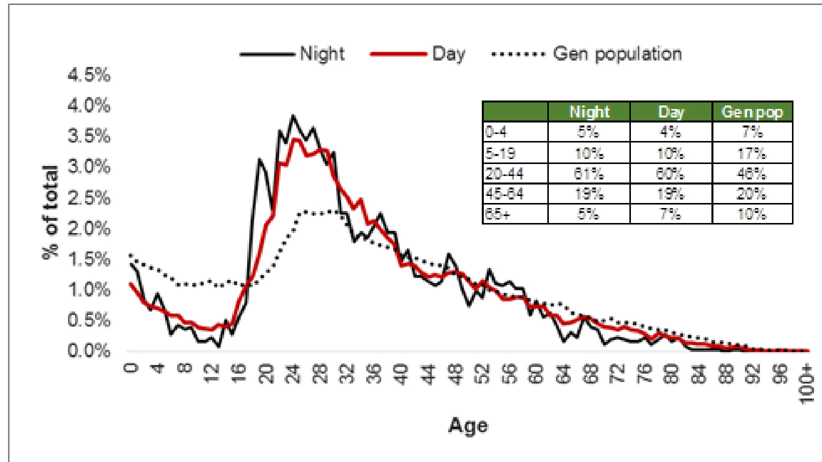
6. Appendices

Appendix 1: Draft NW London UTC KPIs

No.	KPI	Definition	Proposed Target	Proposed Baseline
KPI 1	Ambulance Handovers	Percentage of non-emergency handovers by ambulance service within 15 mins	**100%**	**95%**
KPI 2	Adult Clinical Assessment	Percentage of adult patients who have their initial brief clinical assessment and navigation within 20 minutes (15 min?)	**98%**	**90%**
KPI 3	Child Clinical Assessment	Percentage of paediatric patients who have their initial brief clinical assessment and navigation within 15 minutes	**98%**	**90%**
KPI 4	A&E 4 Hour Wait	Number/ percentage of patients referred from UTC to ED within 2 hours. Baseline of 70% to allow for complex patients to be managed longer in UTC	**98%**	**70%**
KPI 5	A&E 4 Hour Wait	Number/ percentage of patients treated and discharged from UTC within 4 hours	**98%**	**95%**
KPI 6	A&E 4 Hour Wait	Patients referred to ED from UTC	**>5%**	**7%**
KPI 7	Patient Redirection	Percentage of patients assessed for UTC who are deemed suitable for primary, community care or out of hospital service that are then redirected to primary care or out of hospital service	**info only**	**info only**
KPI 8	Prescribing	Adherence to CCG formulary	**98%**	**90%**
KPI 9	Unregistered patients helped to register	Percentage of non-registered patients helped to register with a GP	**98%**	**90%**
KPI 10	GP Information Transfer	Percentage of patients registered with a GP, who have information regarding their access of UTC services sent to their GP by 8am the next working day (where the patient consents to this.)	**98%**	**90%**
KPI 11	Unplanned re-attendance	Number/percentage of patients who have an unplanned re-attendance at UTC within 7 days of original attendance	**0%**	**2%**
KPI 12	Left without being seen	number/percentage of patients who leave the UTC without being seen	**0%**	**2%**
KPI 13	Expected Activity	Seen, treated and discharged or redirected by UTC	**60%**	**55%**
KPI 14	Wait time	Percentage of routine patients seen within 30 of their scheduled appointment	**90%**	**70%**

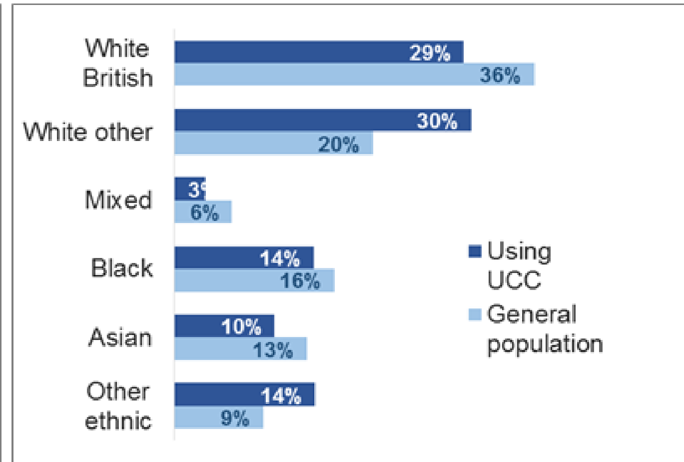
Appendix 2: Hammersmith UCC - Socio-economic characteristics of attendees, 17/18

Attendances by age – % of total by night and day and gen pop*

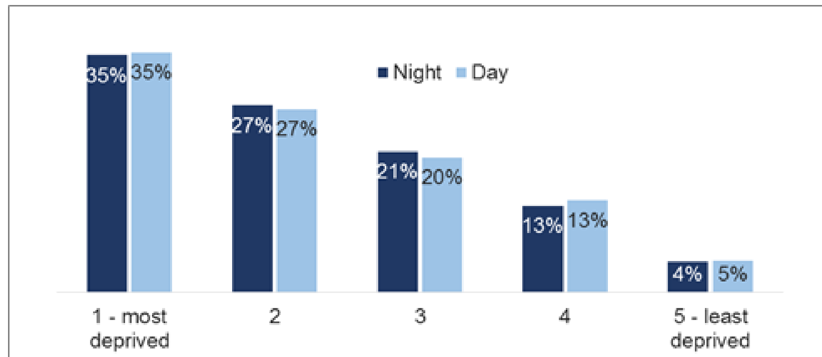


	Night	Day	Gen pop
0-4	5%	4%	7%
5-19	10%	10%	17%
20-44	61%	60%	46%
45-64	19%	19%	20%
65+	5%	7%	10%

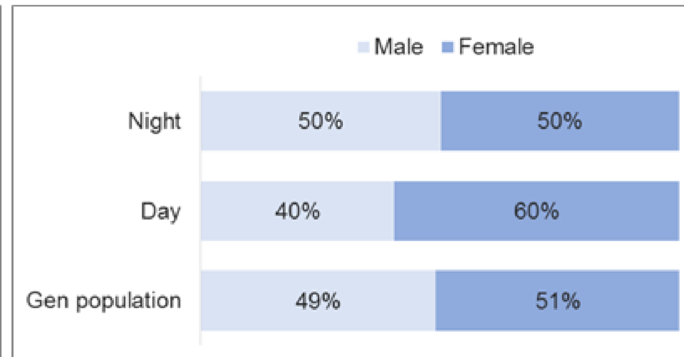
Night attendances by ethnicity Ethnic profile of day very similar to night



Attendances by area deprivation (IMD 2015) – night and day

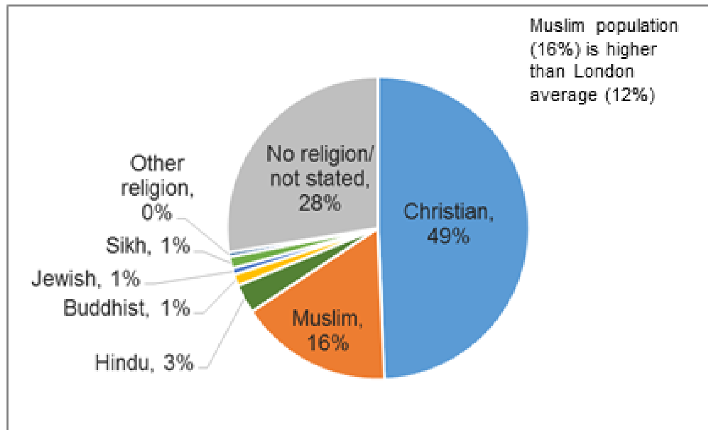


Attendances by gender – by night, day and gen pop* NWL

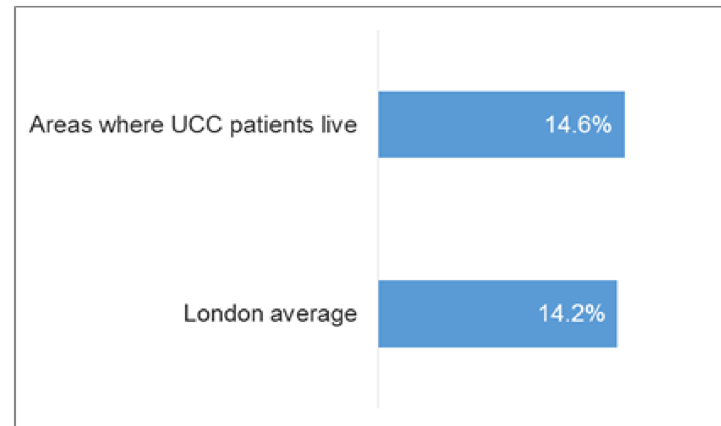


*General population figures have been calculated by taking the 2011 Census profile of LSOAs where there were attendances in 17/18. This was then weighted to account for volume of attendances in those LSOAs

Estimated* religion of patients attending
Based on 2011 Census data applied to location of attendances



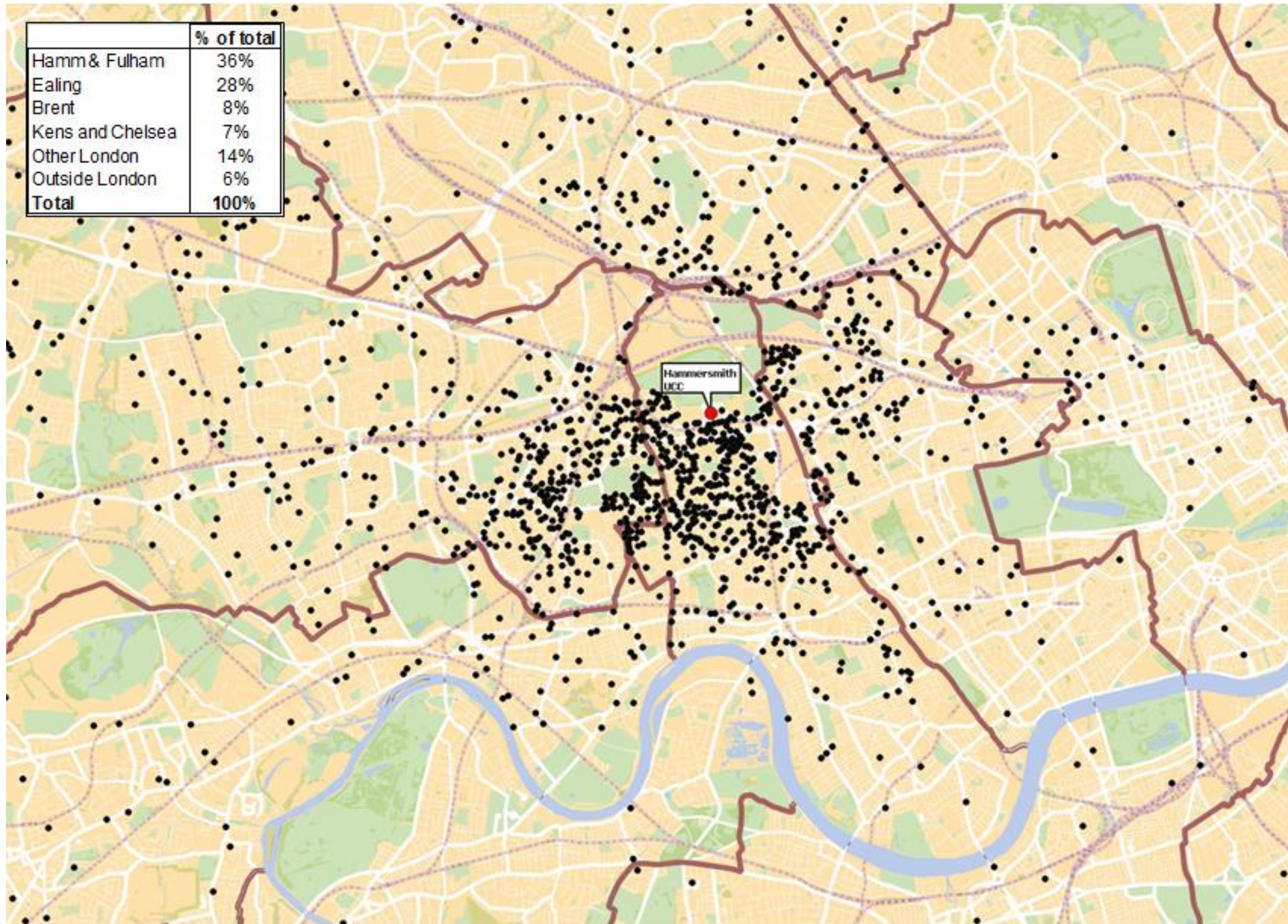
Estimated* limiting long-term illness of patients attending
Based on 2011 Census data applied to location of attendances. CAUTION: this does not account for the age mix of those attending and is an area estimate only



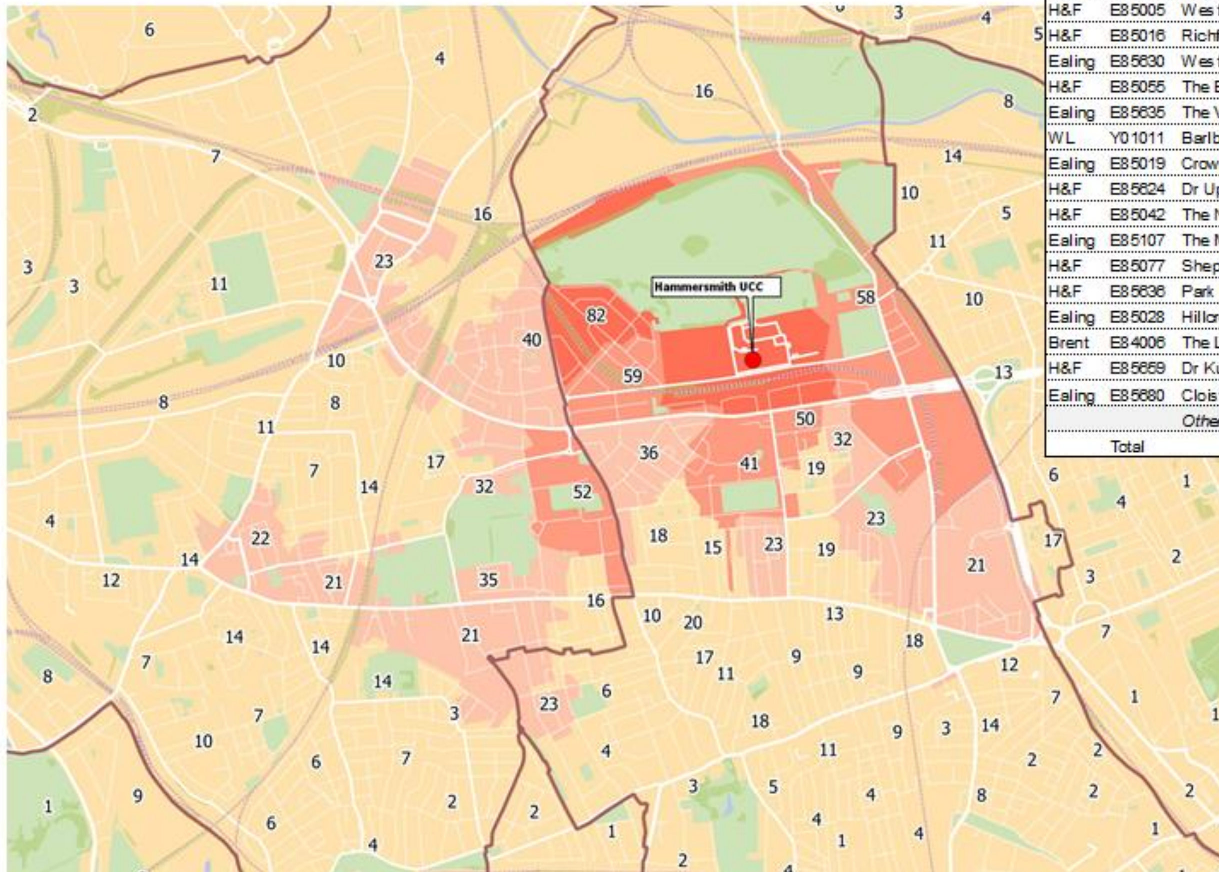
*No data was available on religion or long term illness/ disability of those attending the UCC. Therefore, ethnicity and limiting long-term illness were estimated, based on taking the 2011 Census profile of LSOAs where there were attendances in 17/18, which was then weighted to account for volume of attendances in those LSOAs.

It is important to note that this is an estimate based on an area profile ; ethnicity and disability of actual attendees may differ from these estimates if the UCC attracts particular cohorts of patients not typical of the areas they live in.

Appendix 3: Hammersmith UCC – Location of night attendances, 17/18



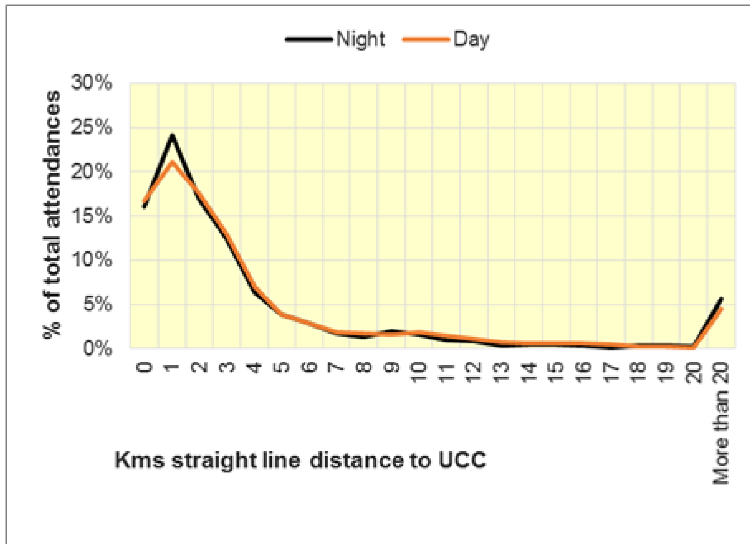
Count of night time attendances over 17/18, by LSOAs closest to site



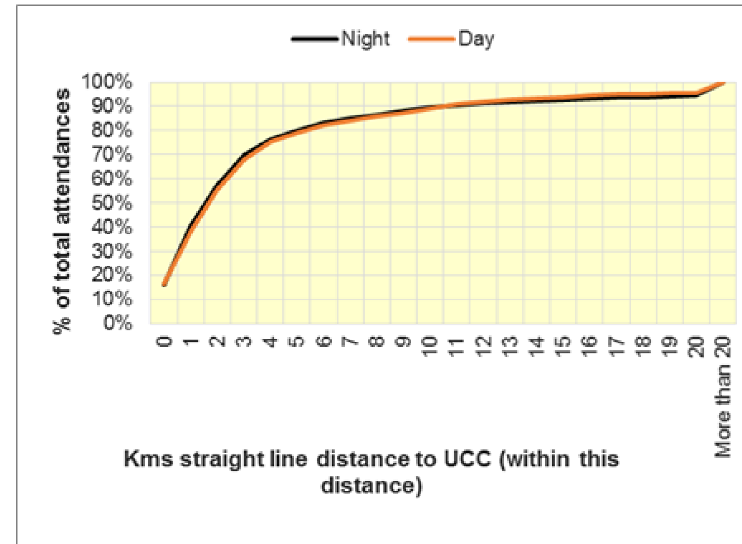
Top 20 highest GP Practices			
CCG	Code	GP Practice	% of total
H&F	V81999	Practice not known/ not reg	15.3%
H&F	E85048	Park view Practice	4.5%
H&F	Y02589	H&F Centres for Health	4.4%
H&F	Y02906	Canberra Practice, Parkview Ctr for H&W	3.3%
H&F	E85748	The Medical Centre (Dr Kukar)	3.0%
H&F	E85005	Westway Surgery (Dr Dasgupta & Partner)	3.0%
H&F	E85016	Richford Gate Medical Practice	2.9%
Ealing	E85630	Western Avenue Surgery	2.9%
H&F	E85055	The Bush Doctors	2.6%
Ealing	E85635	The Vale Surgery	2.2%
WL	Y01011	Barlby Surgery (AT Medics)	2.0%
Ealing	E85019	Crown Street Surgery	1.8%
H&F	E85624	Dr Uppal & Partners, Parkview	1.7%
H&F	E85042	The New Surgery	1.6%
Ealing	E85107	The Mill Hill Surgery	1.3%
H&F	E85077	Shepherd's Bush Medical Centre	1.3%
H&F	E85636	Park Medical Centre	1.3%
Ealing	E85028	Hillcrest Surgery	1.2%
Brent	E84006	The Law Medical Group Practice	1.1%
H&F	E85659	Dr Kukar, Parkview	1.1%
Ealing	E85680	Cloister Road Surgery	1.1%
		Other practices	40.5%
	Total		100.0%

Appendix 4: Hammersmith UCC – Night attendances by distance to UCC, 17/18

Proportion of attendances by distance from home to UCC
Where postcode known. Straight line distance (Kms)



Proportion of attendances living within a certain distance from UCC Cumulative. Where postcode known. Straight line distance (Kms)



Night	% of Attendances
Less than 1km	16%
Less than 3km	57%
Average (median)*	*2.5 km*

Day	% of Attendances
Less than 1km	17%
Less than 3km	55%
Average (median)*	*2.7 km*

*Median has been used rather than mean to avoid the impact of a small number of attendances a considerable distance away e.g. Scotland

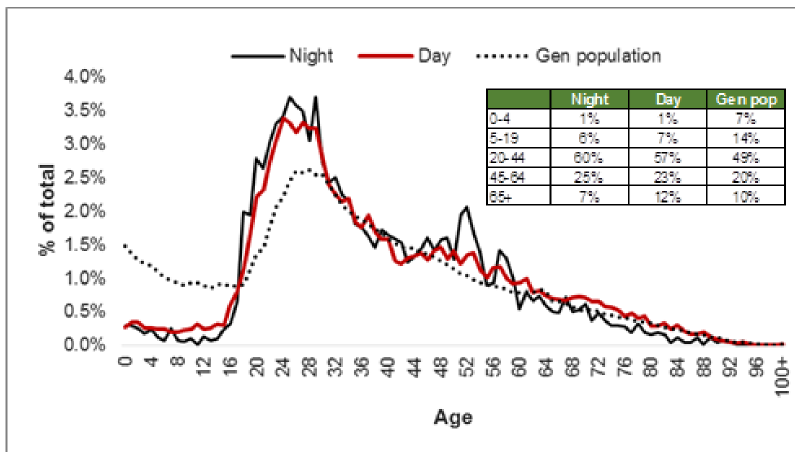
Night - by age	0-4	5-19	20-44	45-64	65+
Less than 1km	16%	27%	15%	14%	17%
Less than 3km	62%	69%	56%	55%	57%

Repeat attendances (within 7 days) which occur at night time show a similar pattern of geographical coverage to total attendances:

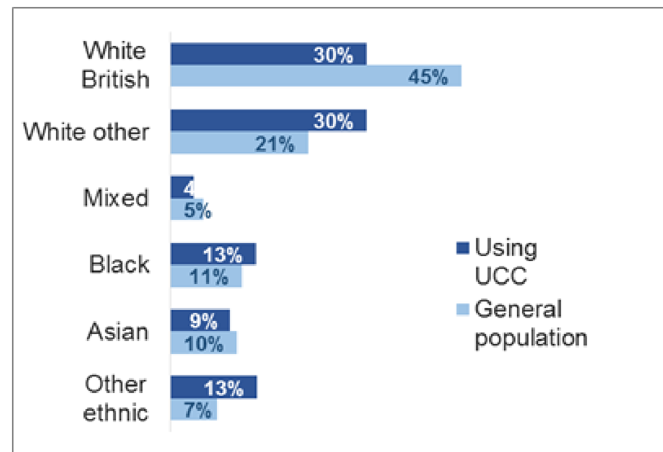
- 45% H&F
- 26% Ealing
- 6% K&C
- 23% other

Appendix 5: Charing Cross UCC – Socio-demographic characteristics of attendances, 17/18

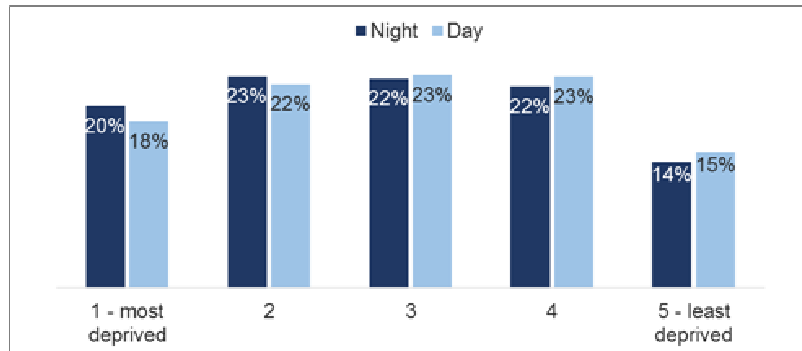
Attendances by age – % of total by night and day and gen pop*



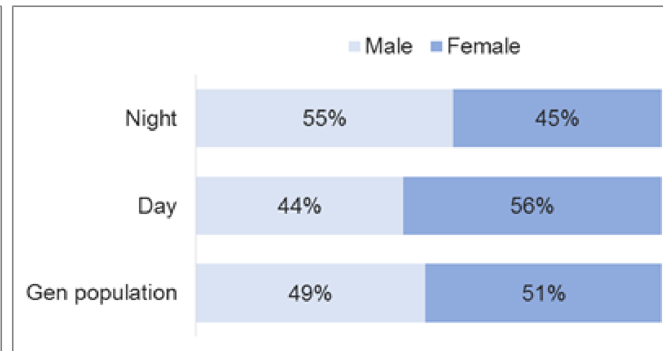
Night attendances by ethnicity Ethnic profile of day very similar to night



Attendances by area deprivation (IMD 2015) – night and day

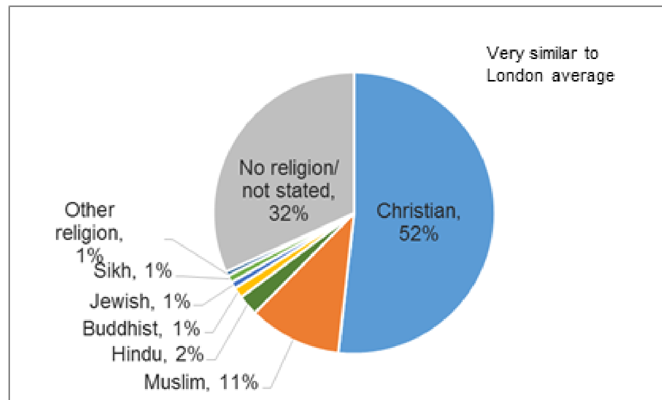


Attendances by gender – by night, day and gen pop* NWL

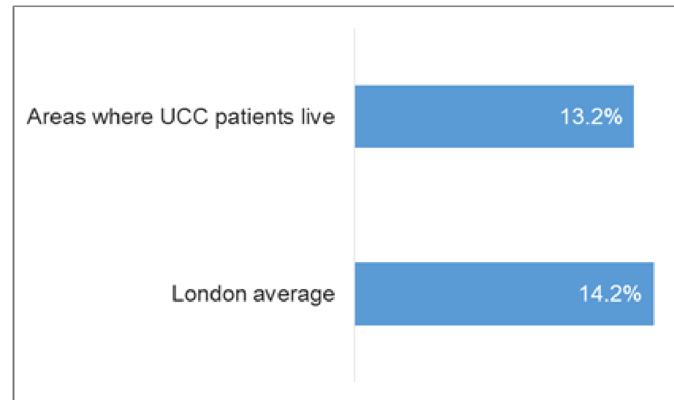


*General population figures have been calculated by taking the 2011 Census profile of LSOAs where there were attendances in 17/18. This was then weighted to account for volume of attendances in those LSOAs

Estimated* religion of patients attending
Based on 2011 Census data applied to location of attendances



Estimated* limiting long-term illness of patients attending
Based on 2011 Census data applied to location of attendances. CAUTION: this does not account for the age mix of those attending and is an area estimate only



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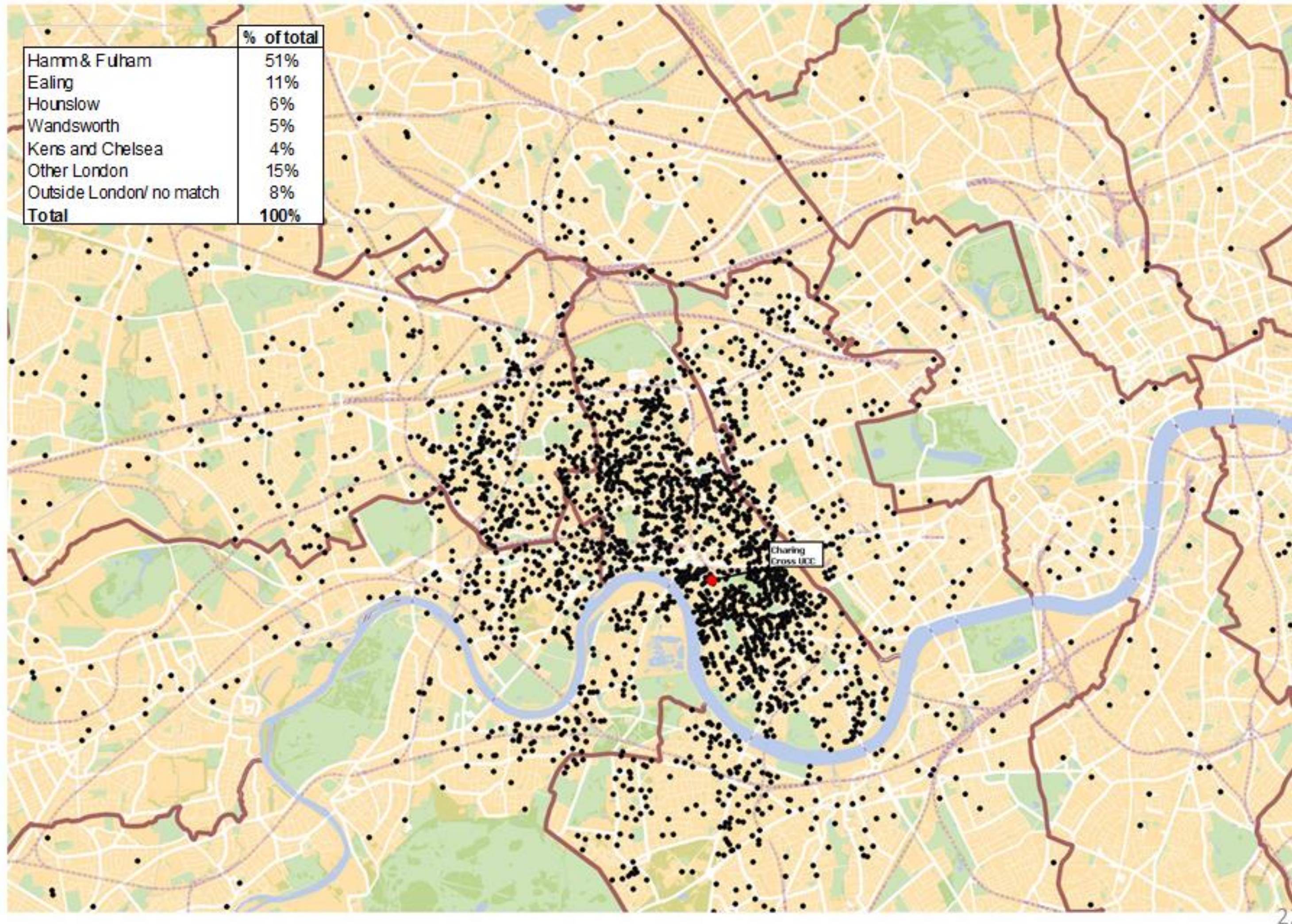
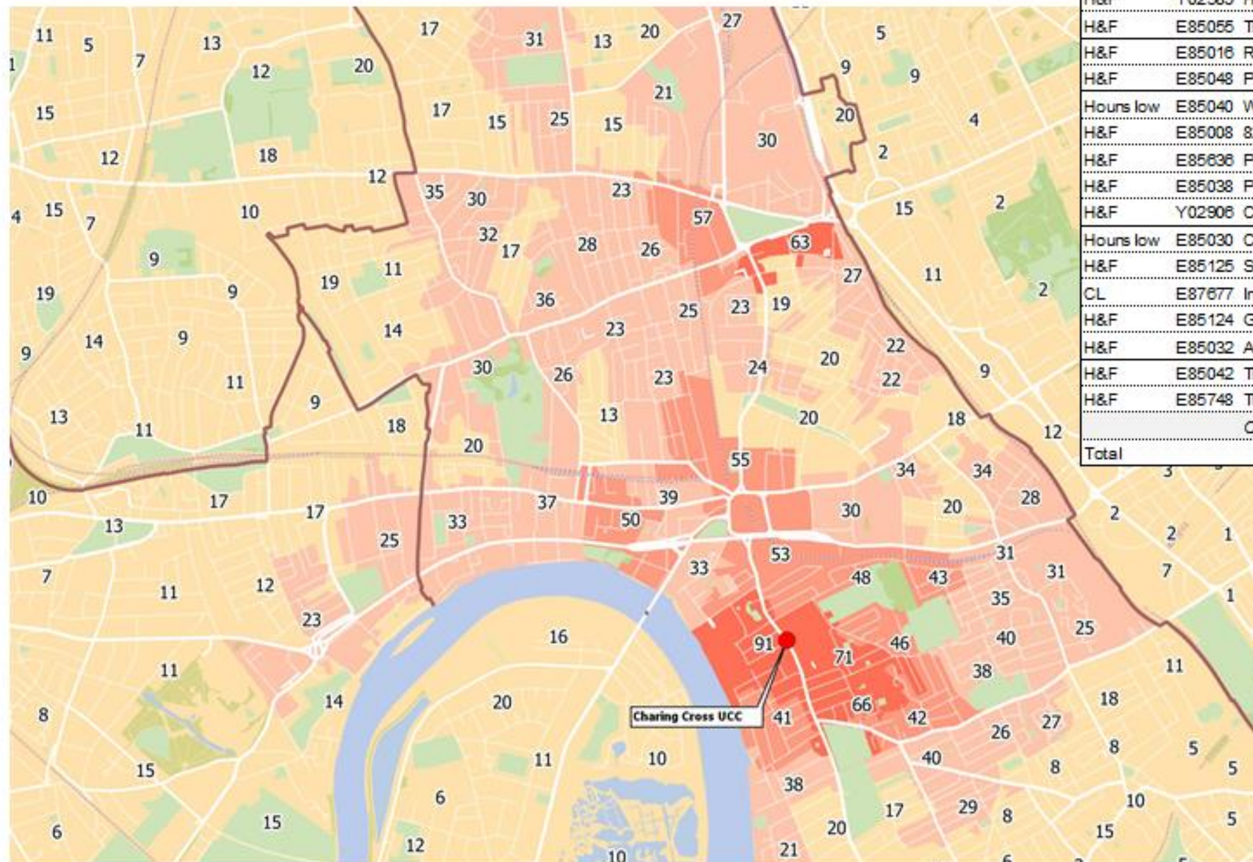
It is important to note that this is an estimate based on an area profile ; ethnicity and disability of actual attendees may differ from these estimates if the UCC attracts particular cohorts of patients not typical of the areas they live in.

Appendix 6: Charing Cross UCC – Location of night attendances, 17/18



	% of total
Hamm & Fulham	51%
Ealing	11%
Hounslow	6%
Wandsworth	5%
Kens and Chelsea	4%
Other London	15%
Outside London/ no match	8%
Total	**100%**

Count of night time attendances over 17/18, by LSOAs closest to site

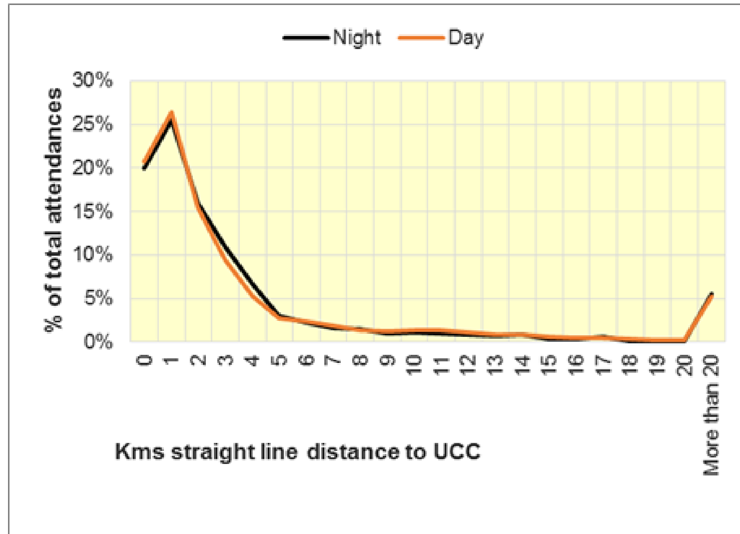


Top 20 highest GP Practices - NWL only, 17/18

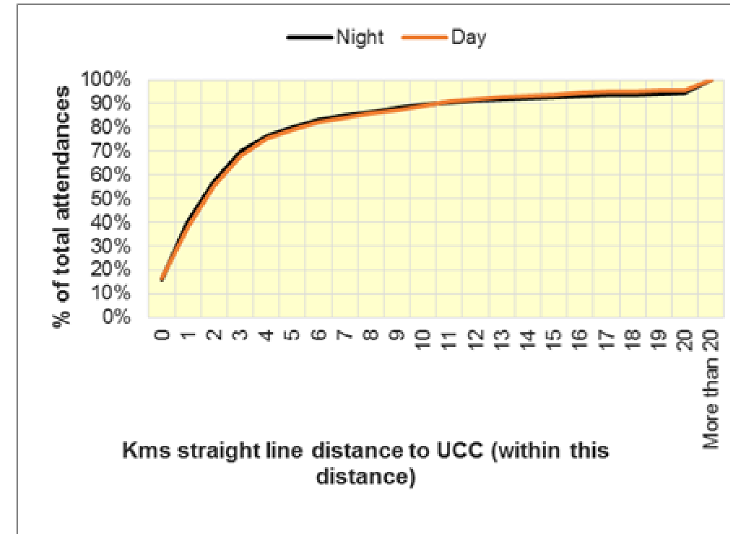
CCG	Code	GP Practice	% of total
H&F	V81999	Practice not known/ not reg	12.8%
H&F	E85003	North End Medical Centre	6.0%
H&F	E85020	Brook Green Medical Centre	4.6%
H&F	E85029	Dr Jefferies, 292 Munster Road	4.6%
H&F	E85033	Hammersmith Bridge Surgery	4.6%
H&F	Y02589	H&F Centres for Health	4.6%
H&F	E85055	The Bush Doctors	4.4%
H&F	E85016	Richford Gate Medical Practice	2.7%
H&F	E85048	Parkview Practice	1.9%
Hours low	E85040	West4GPs	1.8%
H&F	E85008	82 Lillie Road Surgery	1.7%
H&F	E85636	Park Medical Centre	1.7%
H&F	E85038	Palace Surgery	1.5%
H&F	Y02906	Canberra Practice,Parkview Ctr for H&W	1.4%
Hours low	E85030	Chiswick Health Practice	1.3%
H&F	E85125	Sterndale Surgery	1.3%
CL	E87677	Imperial College Health Centre	1.2%
H&F	E85124	GP at Hand	1.2%
H&F	E85032	Ashchurch Surgery	1.2%
H&F	E85042	The New Surgery	1.1%
H&F	E85748	The Medical Centre (Dr Kukar)	1.1%
		Other practices	37.5%
Total			100.0%

Appendix 7: Charing Cross UCC – Night attendance by distance to UCC, 17/18

Proportion of attendances by distance from home to UCC
Where postcode known. Straight line distance (Kms)



Proportion of attendances living within a certain distance from UCC Cumulative. Where postcode known. Straight line distance (Kms)



Night	% of Attendances
Less than 1km	20%
Less than 3km	61%
Average (median)*	*2.3 km*

Day	% of Attendances
Less than 1km	21%
Less than 3km	63%
Average (median)*	*2.2 km*

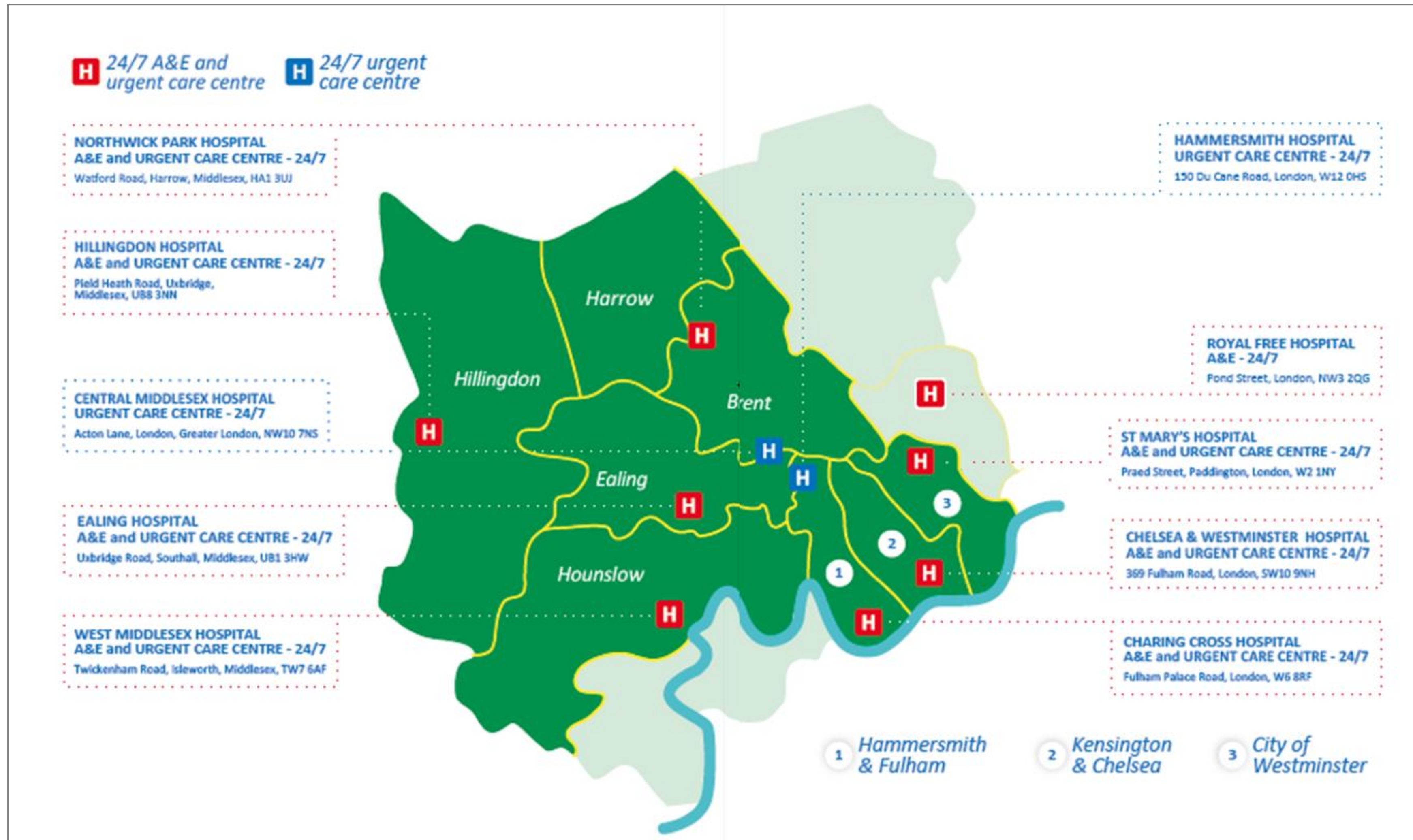
*Median has been used rather than mean to avoid the impact of a small number of attendances a considerable distance away e.g. Scotland

Night - by age	0-4	5-19	20-44	45-64	65+
Less than 1km	16%	18%	21%	20%	18%
Less than 3km	59%	59%	60%	63%	68%

Repeat attendances (within 7 days) which occur at night time show more concentration in H&F than total attendances:

- 62% H&F
- 13% Ealing
- 6% Hounslow
- 19% other

Appendix 8: 24/7 services in NW London



Appendix 9: Weekend plus options

Option	Benefits	Risks
Option 1 Do nothing	1 hub per network, evenly distributed across the borough	No financial savings Inequitable utilisation of appointments (C.50% of appointments are used by the hubs own patients)
Option 2 Reduce number of commissioned hubs	Financial savings Reduce number of appointments available to be utilised by a hubs own patients Less contracts for the CCG to manage.	Demand could exceed capacity of 1 or 2 hubs and so activity may increase in other areas such as UCC, WIC, ED Reputational risk to CCG of changing number of delivery sites
Option 2a Reduce number of commissioned hubs from 3 to 2	Financial Savings: £184,387 per annum	98 fewer GP appointments per week 26 fewer nurse appointments per week
Option 2b Reduce number of commissioned hubs from 3 to 1	Increased financial savings: £359,036 per annum	196 fewer GP appointments per week 52 fewer nurse appointments per week
Option 3 Retain three weekend plus hubs but reduce number of commissioned hours	Financial savings Maintains current distribution of hubs across the borough, with 1 hub in each network. Increased utilisation of appointments	Inequitable utilisation of appointments (some appointments are reserved for the hub practice's registered patients) Reduced number of appointments
Option 4 Include the commissioning of the weekend plus hubs within the scope of the urgent treatment centre/APMS Practice future specification	Financial savings Takes into account all patient access, not just Weekend plus Simplifies patient pathway Potential to improve resource utilisation	Potential reduction in number of sites providing Weekend plus .

Appendix 10: Feedback from involvement activity

General views

- North of the borough has greatest health inequality and services should reflect this e.g. ED in north of borough
- Travel issues need to be looked such as age, children, mobility / disability
- Scepticism around technology and how confident are we that it will improve experience, safety and accommodate different demographics
- Patient education and signposting is key (including via PPGs) – make sure people know what is available to them. Information provided to patients needs to be simpler and clearer
- GP receptionists should be trained so that they are very clear on what is available to patients
- Expand online content so that you can get video consultations from your own GP practice, or in a way which does not require de-registering from your current GP practice. Have this be accessible via app.
- It was noted by a patient representative that GP @ Hand works well but that the issue with it is the fact you have to de-register from your own GP Practice in order to access their service and video consultations
- Technology needs to be used appropriately; patient education may be required, and having an effective clinical triage process is essential. Important to have clear guidelines around what requires a video consultation and what requires a face to face appointment
- Introduce interactive SMS system so you not only get an appointment reminder, but can respond with 'Y/N' to indicate whether you can still attend
- Effective triage process to ensure no time is wasted, so you are seeing right person at right time
- Consider where we place services: currently we have several services in close proximity to each other, offering similar things. This can cause duplication as well as confusing people
- Previous engagement over the past year has identified a number of accessibility issues in general practice, including: difficulty getting through to make an appointment; language and privacy barriers for BAME and LGBT communities;

Urgent Care Centres

- Ensure an integrated service and take lessons from impact of Vocare on UCC performance

- Take into account Hammersmith UCC demographics of users and that it is a deprived area
- Need to know why are people going to the UCC rather than GP appointments?

Walk in Centre

- Convenient and used as an alternative to GP appointments
- Confusion about what services are offered: lack of joined up thinking, need better signposting
- Would be interesting to see a sample of what people go to WiC for and do they get what they need
- UCC and weekend hubs seem to duplicate provision: this creates confusion for patients especially of the service offers are close together
- Greater access to telephone advice and digital services
- If GP number increased then may not be a role for WiC
- Agree with need for digital option to triage what service people are best to access

Weekend Plus

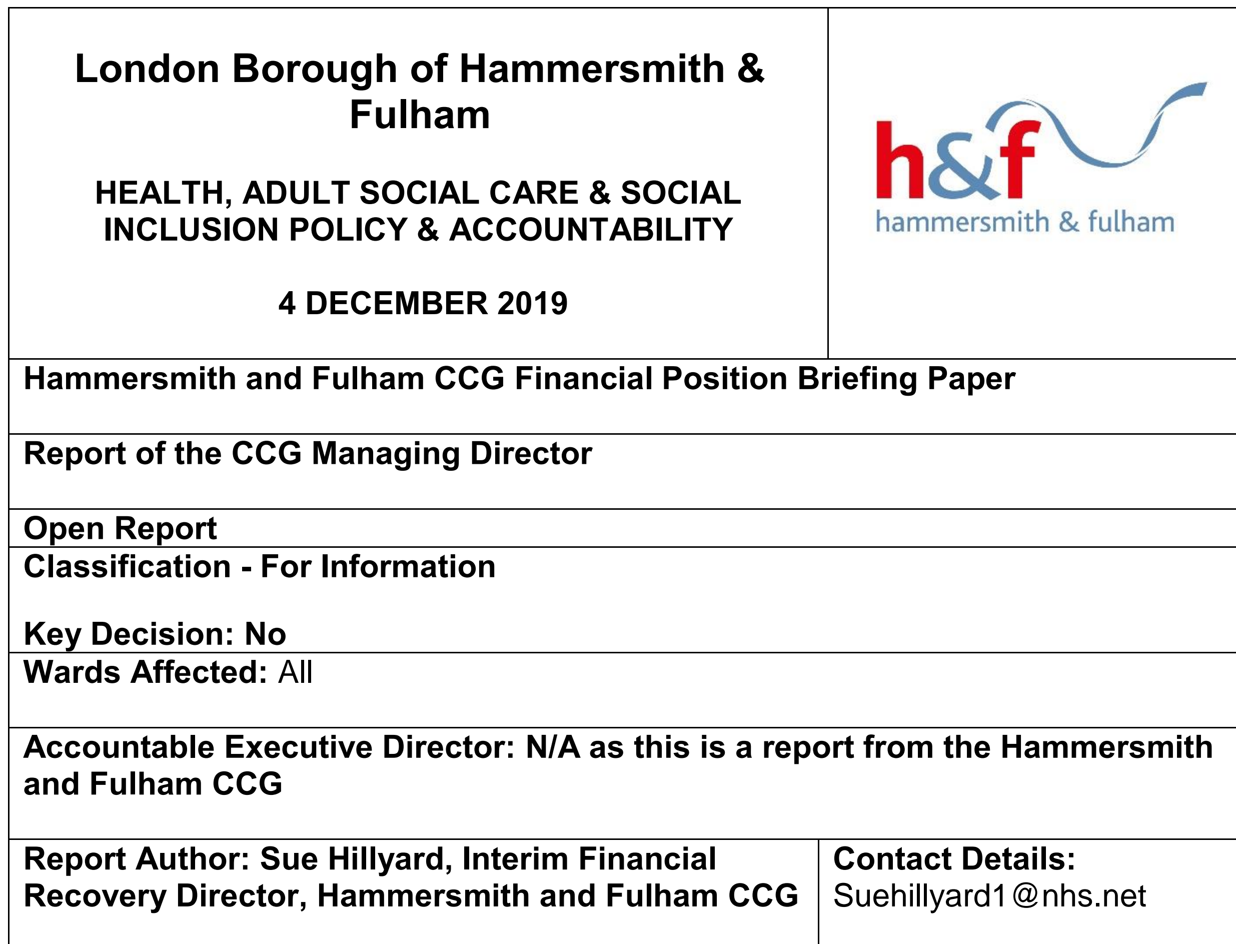
- Need more promotion
- Allow direct self-referral into Weekend Plus
- Online: can be confusing, hard to access, can be useful to book online. Prefer telephone to book appts – but only if you can get through. Opening hours: would be more likely to be used if patients could call hub directly, depend on person
- Mixed views on how helpful weekend appointments are
- Need good directions if not your surgery – text confirmations
- Difference in view on continuity of care – patients with LTCs wanted usual doctor
- Would be helpful to be able to get blood tests, health checks, BP with HCA

Extended hours

- Not happy for NHS 111 to be the main access point into extended hours as it doesn't operate well enough
- In favour of having multiple access routes to care (telephone, walk in, face to face, digital) with one patient representative noting that 'one size does not fit all.'
- approval from GPs, Practice Managers and patient representatives of the idea of having other professionals, such as pharmacists and practice nurses, available at your GP practice during extended hours

- Ensure we improve what we have, rather than reducing what we have – though some duplication can be looked at and avoided
- Some patient representatives said they would want to see the same doctor consistently within their own practice. Ensure enough resource in extended hours to provide continuity of care
- Some patient representatives expressed a willingness to travel to other practices for appointments provided that these were within a reasonable distance. Others said they prefer to see their regular doctor for routine appointments, and only use out of hours provision at other practices when it is urgent
- People who access out of hours GP appointments can't get a referral from these appointments
- Not getting the exact same treatment via extended hours appointments as they would at a regular routine appointment

Agenda Item 9



London Borough of Hammersmith & Fulham HEALTH, ADULT SOCIAL CARE & SOCIAL INCLUSION POLICY & ACCOUNTABILITY 4 DECEMBER 2019	h&f hammersmith & fulham
Hammersmith and Fulham CCG Financial Position Briefing Paper	
Report of the CCG Managing Director	
Open Report	
Classification - For Information **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: N/A as this is a report from the Hammersmith and Fulham CCG	
Report Author: Sue Hillyard, Interim Financial Recovery Director, Hammersmith and Fulham CCG	**Contact Details:** Suehillyard1@nhs.net

1. EXECUTIVE SUMMARY

1.1. This paper provides a briefing to the PAC on the 2018/19 financial position of the Hammersmith and Fulham Clinical Commissioning Group. The paper provides details of the level of savings that have been delivered as at month 6, as reported to the Governing Body meeting held in public on 13 November 2018. The paper also describes the approach being taken to managing financial recovery in year and the work being undertaken to develop the long-list of expenditure reduction options in 2019/20 in order to meet the anticipated £27m savings requirement.

2. RECOMMENDATIONS

2.1. This paper is for information and briefing only.

3. Introduction and Background

3.1 At the beginning of the 2018/19 financial year the CCG identified the need to deliver expenditure reduction of £17m. The CCG's current internal plan is c£20m in order to ensure delivery of the required target. This is what the CCG identified as its Quality, Improvement and Productivity Plan (QIPP) savings plan. This was required as a result of an underlying deficit position that had been building up over previous years and a change in the CCG's capitation position following decisions by NHS England to adjust the national funding formula so that under capitated CCGs reached their capitation more quickly than had previously been anticipated. As an over capitated CCG, Hammersmith and Fulham saw their distance from target position expedited, resulting in an overall reduction in funding in 2018/19. The financial position across a number of the NWL CCGs has been deteriorating over the last few years. Hammersmith and Fulham, as part of the NW London system, is working with the other seven CCGs to ensure the delivery of a sustainable long term financial system-wide position going forward.

3.2 As a result of a deterioration of the financial position over recent months a review of all areas of expenditure has been carried out including comparison of the CCG's spend on key programme areas. In order to comply with the legal requirement placed on the CCG to deliver a balanced position at year end a detailed Financial Recovery Programme (FRP) has been put in place. This has been agreed by the CCG Governing Body and is overseen by the Finance and Performance Committee. The Hammersmith and Fulham plan forms part of a wider NWL response.

3.3 The Governing Body of the CCG has received reports and briefings on the financial position as the year has progressed. Formal reports have been presented to the meetings of the Governing Body in public.

4. 2018/19 Plans and Assumptions

4.1 At the beginning of the year the CCG identified a long list of schemes that the Governing Body agreed should be worked up as possible areas to achieve cost reductions. These were made up of:

- transactional schemes- those things that could be described as internal housekeeping activities or actions that require a change in system and process but which delivers a cost benefit. These are mainly one off rather than recurrent savings
- schemes resulting from contractual changes – where contracts have ended or been handed back
- schemes that are transformational – where services might be reviewed and changes made to improve efficiency, effectiveness and value for money

4.2 Having worked these schemes up to a point where their potential value could be assessed it was identified that taking them forward could potentially only deliver cost reductions of c£11m. It was agreed that these schemes would be taken forward. Further work within the CCG and the Governing Body membership identified further opportunities, stretching our target to £20m. Details of these schemes were presented at two workshops earlier in the year with local residents.

4.3 At month 6 of the current financial year the schemes identified have so far delivered cost reductions of £3.2m. As a result the CCG has been looking to identify other schemes that could deliver cost reductions within the year. This is part of the CCG's financial recovery plan (see section 5 below). As indicated above, the overall financial position of the CCG has deteriorated since the beginning of the year and it has been recognised that further programmes need to be implemented in order to deliver the balanced position that the CCG is required to achieve by year end.

4.4 At the November Governing Body meeting, held in public, the month 6 position was presented. The summary cover report is attached at appendix A. Whilst this indicates that the CCG is on plan to deliver a break even position this is only being achieved by the use of historic drawdowns. The CCG has an underlying deficit of between £10m and £15m. The CCG has been advised that failure to deliver an acceptable FRP could lead to the imposition of Legal Directions and the removal of staff and/or powers from the CCG. This is a position that the Governing Body wishes to avoid.

4.5 Attached at appendix B is a briefing note on the month 7 position. This indicates that:

- the year to date position is £0.5m off plan as a result of under delivery of QIPP
- the year to date QIPP delivery has increased to £3.3m
- forecast QIPP delivery is at the level of £14.2m against a plan of £17.3m
- all reserves have been released to support the forecast position

5. FINANCIAL RECOVERY PROGRAMME

5.1 In light of the month on month deterioration of the financial position work has been undertaken across the CCG to determine where further opportunities for cost reductions exist and to analyse areas of overspending. All cost reduction schemes and contract opportunities have been reviewed for 18/19 and those where we can accelerate the pace or increase the impact have been brought into the 18/19 recovery plan actions. The recovery plan process is set out in an update paper in appendix C which is the paper that was presented to the Governing Body meeting, held in public, in November 2018.

5.2 To further support the delivery of the year end position the Governing Body approved a set of cost control measures at its meeting in November 2018. The Financial Recovery and Control of Investment Principles for Decision Making paper (included as part of appendix C) aims to support the CCG to manage overspend and halt any further deterioration. The impact of implementing this measure is that some planned investments may need to be put on hold for this financial year.

5.3 The CCG has established an internal, Managing Director led, financial recovery group to oversee and ensure all actions are delivered in a timely way and to commence the planning for 19/20. This group reports formally to the CCG's Finance and Performance Committee which is overseeing the delivery of the financial recovery.

6. 19/20 POSITION AND WORK TO DATE.

6.1 The CCG Governing Body has recognised that delivery of a sustainable financial position that ensures a year on year balanced position cannot be achieved in a single year. The recovery programme is, therefore, seen as a two year programme. All teams within the CCG have been asked to develop cost reduction proposals for 2019/20. Agreeing these now will enable us to commence delivery as quickly as possible from the beginning of the financial year. The anticipated level of cost reduction required in 2019/20 – upwards of £27m - means that we must consider all options for cost saving.

6.2 The planning guidance is likely to reinforce the need for a system led approach to planning, encompassing activity, finance and quality. The long term plan and planning guidance are expected to confirm that all STPs will develop into Integrated Care Systems with single financial control total (budget), agreed priorities and objectives, in line with national objectives and plans to enable the system to operate within the budget available.

6.3 Set out below are some of the areas being considered. All proposals will be signed discussed by the Finance and Performance Committee before being formally signed off by the Governing Body.

- Review all Community-based acute services where there is an equivalent hospital based service in place. The aim is to eliminate duplication of service provision
- Halt all planned investments unless they provide a clear invest to save option. This will ensure that the CCG only invests in services that can demonstrate a return on investment in line with the investment principles at appendix D
- Return all statutory budget contributions to the minimum level required in accordance with national guidance
- Cease any funding or commissioned services outside of statutory duties
- Review all contracts with local pricing agreements with the view to negotiating a reduction in costs for 19/20. This is to ensure that the CCG is achieving value for money from these contracts

6.4 Any proposals that are considered formally for approval will include a robust Equality/Quality Impact Assessment. This will provide information on the potential impact on protected characteristic groups within the local community and provide commentary on the wider impact of implementing any given proposal on the community. As proposals develop, they will go through the appropriate process which may include PAC to determine next steps for engagement and consultation.

7. ENGAGEMENT AND COMMUNICATIONS WITH PARTNERS AND STAKEHOLDERS

7.1 The CCG recognises that some proposals may have an impact on partners, stakeholders and potentially on services. In line with the CCG's agreed communications and engagement strategy there will be on-going engagement with local residents and stakeholders through a number of different established and developing processes.

7.2 The CCG has already undertaken two working sessions with local residents and stakeholders specifically on the financial position this year and will hold further meetings going forward. The schedule of these meeting will be finalised in the coming weeks and publicised widely. The sessions will continue to focus on the financial position and the actions we will be required to take. [The Committee will already be aware that the CCG has started the process of discussions on urgent care services and primary care access models with residents as part of the pre-consultation engagement on the design of future services which more effectively meet their needs.]

7.2 Discussions on whole system financial challenges are taking place with partners through the Hammersmith and Fulham Integrated Care Partnership (ICP) Board in recognition of the significant deficits in most organisations across the local health and social care economy. The ICP is a body formally constituted to consider the strategy for future services. This includes looking at how the financial challenges in the system can be addressed collectively whilst ensuring the delivery of better, more integrated services that are sustainable, affordable and meet the needs of local residents.

8. NEXT STEPS

8.1 The CCG is continuing to review cost reduction opportunities. Where appropriate this includes working closely with other NWL CCGs to ensure alignment of approaches to minimise differing approaches across boroughs.

8.2 The FRP is monitored both internally and reported on as part of the recovery regime put in place by NHS England. The financial position continues to be reported to Finance and Performance Committee on a monthly basis and to the Governing Body at its meetings in public.

Appendix A

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Item 11 (i)

Date	Tuesday, 13 November 2018

Title of paper	**Financial Position M6**

Presenter	Neil Ferrelly, Chief Financial Officer, NWL CCGs				
Author	Owen White, Interim Head of Finance H&F CCG Bahi Jayadevan and H&F CCG Finance Team				
Responsible Director	Neil Ferrelly, NWL CCGs CFO				
Clinical Lead	None				
Confidential	**Yes**	☐	**No**	☑	Items are only confidential if it is in the public interest for them to be so
Assurance Level Agreed by Responsible Director	**Good** ☐	**Adequate** ☐ **YES**	**Limited** ☐	**Unsatisfactory** ☐	

The Committee is asked to:
Discuss the finance and activity position reported for H&F CCG at month 6, also debated in detail at the H&FCCG Operational Group and Finance and Performance Committee

Summary of purpose and scope of report

- To update and inform the Committee about the financial and activity performance of the CCG at Month 6.
- The paper highlights the achievement of statutory duties and any material variances from plan :
  - Year to Date: At month 6 the CCG is reporting breakeven overall, but worse than plan by £0.5m YTD.
  - Although forecast outturn is on plan, that position is effectively an in-year deficit of £5.1m : the forecast of a £0.4m surplus includes the following critical items:

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- £1.6m of repayable NWL support
- £3.8m of historic drawdown
- £12.6m of in year QIPP – with an increase of over £6m between the first and second halves of the year

- Key concerns include:
  (i) All £4.6m of reserves have been utilised to offset pressures, which are mainly related to QIPP non-delivery.

  (ii) The underlying position of the CCG is a deficit ranging from c£10m to £15m depending on the delivery of future recurrent QIPP.

  (iii) The estimated £27m QIPP requirement for 2019/20 and implementation of a moratorium on investment cases which do not payback in year.

  (iv) The net Risks/Opps position is a Risk position of £2.8m – even allowing for a stretch to FRP schemes of £4.2m.

  (v) The likely outturn appears to be in the region of a £6.5m deficit against plan, and that assumes significant future non-recurrent QIPP delivery

  (vi) GP at Hand pressures are assumed fully mitigated, with a value of £4.7m YTD and £11.3m full year (vs plan of £6.5m and £18m respectively).

  (vii) Cash utilisation is £3m above plan and may present a risk to the end of the year.

Quality & Safety/ Patient Engagement/ Impact on patient services:
None

Finance, resources and QIPP
None

Equality / Human Rights / Privacy impact analysis
None

Risk	**Mitigating actions**
Captured in the CCG Corporate Risk Register and main report	

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Supporting documents		
H&F M6 Finance Report F&P		
Governance and reporting (list committees, groups, other bodies in your CCG or other CCGs that have discussed the paper)		
Committee name	Date discussed	Outcome
Ops Group	16.10.18	Discussed summary position
Finance and Performance Committee	23.10.18	Discussed in detail by F&P members

Healthy Future

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PAC Briefing Note

Month 7 Hammersmith & Fulham CCG Finance Report

Appendix B

4 December 2018

Summary

Overall Summary	Commentary	Status
Overall Summary	**IN YEAR :** The Forecast Outturn position has been maintained and no new net pressures have materialised in month. There has been an increase in Mental Health spend, however, driven by the introduction of higher local tariffs at CNWL (£0.4m) and placement pressures (£0.3m); however these have been offset by the recognition of lower cost expectations in Primary Care in relation to the DDRB settlement; non-recurrent projects and rates. Following development of the in-year Financial Recovery Plan, which reviewed the key forecast components and other mitigating actions, a number of the components of the forecast have changed from Month 6 to 7. The result is a forecast that remains on plan, but which no longer includes support from other NWL CCGs (impact -£1.6m) but does include greater reliance on a specific contract challenge (impact +£1.9m). In line with the above, QIPP expectations are for the delivery of £14.2m of QIPP (increased from £12.6m). At that level the forecast is 82% of plan, a shortfall of £3.1m. The QIPP runrate is for an outturn of c£6.6m - meaning the step-change requirement is c£7.6m. There are 2 key transactional items which are forecast to yield £7.2m which generates that increase, which are covered in detail within the FRP. The Forecast of a £0.4m surplus (ie a true deficit of £3.5m offset by £3.9m of historic drawdown) is currently seen as the best case scenario and includes a number of key deliverables which are in the process of being actively managed and negotiated. The reported net Risks/Opps position is a net risk of £10.8m, and this is seen as the Worst case scenario outturn (ie a variation to plan of £10.8m). The mid case scenario is a variance to plan of £5.6m. The YTD position is a deficit of £2.3m, £0.5m worse than plan - due to QIPP under-delivery. £3.3m of a planned £4.6m QIPP has been delivered year to date (72%), partly offset by reserve releases.	Red
	FORWARD LOOK : There is a increase in QIPP forecast for the second half of the year. The two most material schemes are Contract Challenges (£5.9m) and BCF (£1.25m). Due to the nature of those items they remain a significant risk to the year, albeit actions agreed with the CCG MD are being taken forward to negotiate those positions. Risks relating to these are included in the Risks/Opps position. Notwithstanding the above, the underlying position of the CCG is a deficit ranging from £10m-£15m. The range indicates the value of future forecast recurrent QIPP savings not yet secured but are reasonably expected to be delivered. Further acute/other pressures will of course make this position worse where they arise, as will any under-delivery of forecast QIPP. Given the above, and the degree to which in year QIPP forecast is transactional and non-recurrent, the initial view is that £27m of QIPP will be required for 2019/20, however this remains subject to future Guidance. FRPG is continuing, now on a weekly basis, to identify QIPP for future periods, and will look to advance schemes to 18/19 where possible. Given the size of the challenge, however, the CCG will need to include options that relate to reduced access to/decommissioning of services. A moratorium on investments which do not yield an in year return has been implemented supported by a policy now ratified at Governing Body. GP at Hand pressures are assumed fully mitigated in both YTD and FOT positions.	

Summary

	Commentary	Status
Overall financial position	The **YTD position is £0.5m off plan driven by QIPP under-delivery.** **The Forecast position is on plan and is an in-year deficit of £3.5m** (offset by £3.9m of historic drawdown). GP at Hand costs are assumed mitigated fully both YTD and the year as a whole. £14.2m (82%) of QIPP remains in forecast for the year - and is significantly back-ended, with material risk present given the dependency on external negotiations for the required step up from QIPP run rate levels. There are significant apparent variances on a gross service line basis but many relate to GP at Hand costs where so far we have seen 70% of anticipated costs materialising (£5.7m vs £8.2m).	Red
Risks and opportunities	**Net Risks/Opps position is a £10.8m Risk. This is a fully reworked position following the completion of the FRP and reflects the view of the worst case outlook scenario.** This no longer includes any NWL Support and the key risks relate to QIPP and Acute outturn positions.	
Underlying position	The **underlying deficit is in the range from £10m to £15m**, and dependent on the future delivery of recurrent QIPP.	
QIPP	**YTD QIPP achieved is £3.3m against the plan of £4.6m (73%)**. In the FOT the CCG anticipates delivery of £14.2m, 82% of the financial plan requirement. This forecast should be seen in conjunction with Risks/Opps.	
Reserves	**All reserves (£4.6m) have been released to support the Forecast position**, including the 0.5% required by Business Rules, agreed with the NWL CFO prior to closure of the M4 results.	
Service Line Highlights (Net of GP at Hand)	**Acute Contracts :** FOT shows an overspend of £5m, or 3.4%, after allowing for £7.3m of GP at Hand costs. The driver of this pressure is reduced QIPP schemes of which the Non Elective scheme is the largest deficit to plan (FOT is £2.2m below plan). Whilst there are some small areas of overperfomance, acute contracts are below plan in aggregate once GP at Hand costs are accounted for : ie acute overperformance is driven by QIPP non-delivery.	
	Mental Health : FOT shows an overspend of £1.2m, or 3.4%, after allowing for £0.3m of GP at Hand costs. This position has worsened by £0.7m this month resulting from an increase in tariff at CNWL (£0.4m) and £0.3m of placement pressures.SWLStG and CNWL are the additional drivers of this overspend.	
	Continuing Care : FOT shows an overspend of £2.2m, or 11.4%. This relates to under delivery of QIPP. The £0.2m worsening forecast this month is driven by the recognition of cost for Childrens care, previously shown as a risk.	
	Prescribing : FOT has improved by £0.1m vs plan following recognition of £0.1m of anticipated price reductions. Unplanned pressures of £0.7m remain within the forecast.	
	Community : FOT is off plan by £0.3m despite non-delivery of £0.8m of QIPP - the majority of the deficit being made up by lower activity levels within MSK and non contracted activity areas.	

Current QIPP Position- Overall

Overall Summary: M7

£000	Plan	Forecast	Risk	Net Forecast	Non-ISFE Opportunity	Non-ISFE Risk	Non-ISFE Net Risk FOT
QIPP Schemes: Identified at Time of Plan Submission	£11,106	-	(£643)	£10,463	-	-	£10,463
QIPP Schemes: Now Identified							
Transactional	£8,337	£8,810	(£6,123)	£2,687			
Transformational	£12,654	£5,398	(£2,328)	£3,070			
Total QIPP Schemes	£20,991	£14,208	(£8,451)	£5,757	£0	(£8,451)	£5,757

QIPP Plan

- CCG needs to push to deliver the maximum net opportunity of £14.21m
- Relying on delivery of 77% (£10.8m) of FOT from M8 onwards
- In year recovery plan and 19/20 planning is discussed at FRPG, NWL CFO level

Current QIPP Position: Top 12 Schemes

Scheme ID	Scheme Description	YTD Plan	YTD Actual	YTD Var	Variance %	Q1 Plan	Q2 Plan	Q3 Plan	Q4 Plan	FY Plan	FOT	FY Variance	Variance %	Risk Assessment to FOT
HF025	UCC Contract Management	£0	£0	£0	N/A	£0	£0	£0	£3,168	£3,168	£5,877	£2,709	86%	£5,877
HF001	Better Care Fund Transformation Programme	£729	£105	(£624)	-86%	£313	£313	£313	£313	£1,250	£1,250	£0	0%	£840
HF005	Primary care prescribing	£522	£837	£315	60%	£183	£244	£296	£275	£998	£1,173	£175	18%	£300
NWL25	NWL25 - Continuing care placements	£322	£380	£58	18%	£63	£187	£215	£214	£679	£828	£149	22%	£200
HF026	Milson road viability / ecomonic case	£0	£630	£630	N/A	£0	£0	£0	£630	£630	£630	£0	0%	£0
HF006	MH placements efficiency	£343	£343	£0	0%	£156	£147	£103	£19	£425	£425	£0	0%	£100
HF028	UCC Charge Rates	£256	£175	(£81)	-32%	£110	£110	£110	£110	£439	£350	(£89)	-20%	£0
HF004	Estates- Milson Road Void	£184	£184	£0	0%	£79	£79	£79	£79	£315	£315	£0	0%	£0
HF021	Budget Efficiencies	£165	£169	£4	3%	£71	£71	£71	£71	£282	£290	£8	3%	£0
HF014	Non-elective Admissions Programme	£1,153	£1	(£1,152)	-100%	£244	£623	£873	£881	£2,621	£282	(£2,339)	-89%	£200
HF002	Estates- Stamford Brook Void	£257	£257	£0	0%	£110	£110	£37	£0	£257	£257	£0	0%	£0
NWL20	NWL20 - Operating cost reductions	£0	£137	£137	N/A	£0	£0	£81	£243	£324	£246	(£78)	-24%	£60
Total of Top 12 Schemes		**£3,931**	**£3,219**	**(£712)**	**-18%**	**£1,328**	**£1,883**	**£2,177**	**£6,001**	**£11,388**	**£11,923**	**£535**	**5%**	**£7,577**
Overall CCG Plan		**£7,241**	**£3,320**	**(£3,921)**	**-54%**	**£2,144**	**£3,244**	**£5,761**	**£9,842**	**£20,991**	**£14,207**	**(£6,784)**	**-32%**	**£8,451**

RAG Rating : RAG rating follows the following convention regarding FOT variance to plan

- GREEN : FOT is at, above or within -5% of plan
- AMBER : FOT is between -5% and -25% of plan
- RED : FOT is -25% or less than plan

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Date	Tuesday, 13 November 2018

Title of paper	**H&F Financial Recovery Programme**

Presenter	Janet Cree, Managing Director				
Author	Sue Hillyard, Interim Financial Recovery Director				
Responsible Director	Janet Cree, Managing Director Approved report **Yes** ☐ **No** ☐				
Clinical Lead	Chair of F&P				
Confidential	**Yes**	☐	**No**	☑	Items are only confidential if it is in the public interest for them to be so
Assurance Level Agreed by Responsible Director	**Good** ☑	**Adequate** ☐	**Limited** ☐	**Unsatisfactory** ☐	

The Committee is asked to:
Note the current position and support the work programme as detailed and to **endorse** appendix A.

Summary of purpose and scope of report

This paper provides an update on the latest position in relation to the work associated with the H&F Financial Recovery Programme and must be read in conjunction with the month 6 finance report which is included on the Governing Body agenda.

Background:

The Governing Body will be aware of the deteriorating financial position across the NWL CCGs highlighted in regular briefings and the detail of H&Fs overall position within this.

In response to this NW London has instigated a Financial Recovery Programme (FRP) within which H&F and other CCGs have developed a routemap with clear actions and

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dependencies detailing the steps needed to halt the in-year deterioration and improve the end of year position, sufficient to deliver plan outturn without requiring NWL support.

Whilst this plan focusses on delivery in 18/19, it is also mindful of the scale and size of savings required in 19/20. The likely QIPP requirement will be in the region of £27m in 19/20 which is highly challenging. Any recovery instigated in 18/19 will improve this position going forward.

Work to date:

Work has been undertaken by all teams to date to analyse the drivers of overspend in each of the programme areas and understand where the opportunities lie.

There are a number of areas where the CCG must now focus and these are as follows :

- Where investment has significantly exceeded nationally set minimum requirements
- Where the CCG benchmarks as an outlier in areas of activity or costs for service provision
- Where the CCG cannot demonstrate value from current contracts in line with best practice
- Where the CCG is funding activity which is not part of its statutory duties

All QIPP schemes and contract opportunities have been reviewed for 19/20 and those where we can accelerate the pace or increase the impact have been brought into the 18/19 recovery plan actions.

A number of these remain at risk particularly where they are dependent on successful negotiations in year with various third parties.

A review of the Financial Recovery Programme Group (FRPG) has been undertaken and the meeting is now taking place weekly, tracking progress on 18/19 actions and overseeing pipeline development for 19/20 to ensure we have a robust and deliverable plan.

In addition for 18/19 the usual expected set of cost control measures are being put in place, such as the management of any underspends. In addition the Finance and Performance Committee (F&P) has considered and approved measures for financial recovery and control of investment. These are set out in appendix A. The Governing Body are asked to **endorse** these.

Current position:

2018/19 Recovery Routemap :

A routemap for 2018/19 which achieves the financial plan whilst not requiring support from within NWL has been developed, and the major elements of that will be reflected within Month 7 financial reporting.

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The routemap does carry significant risk, in relation to which a range of potential outcomes has also been modelled, which are summarised below :-

Scenario Summary Table			
£'000	Best	Likely	Worst
Forecast surplus/(deficit)	387	(5,217)	(10,417)
Variance to Plan	0	(5,604)	(10,804)

2019/20 Longlisting Process :

The longlisting process has commenced for 19/20 and the first drafts of this have been discussed at the Governing Body seminar. Given the CCGs financial position, no scheme proposals were ruled out at this stage but work is ongoing to work through the detail, timings and associated risks. This will be brought to F&P and the Governing Body for final sign off once completed.

The total sum of current proposals falls short of the required QIPP target for 19/20 and therefore the CCG will need to consider further options in order to cover the gap. This will now include:

- A full review of all Community-based acute services where there has been no corresponding drop in HRG activity at acute trusts since go live
- Halt all planned investments in line with the Control of Expenditure proposals
- Review all services where there is an equivalent service already in existence and consider decommissioning
- Return all statutory budget contributions to the minimum level required in accordance with national guidance
- Cease any funding or commissioned services outside of statutory duties
- Review all non tariff contracts with the view to negotiating pricing reductions for 19/20

The options in relation to the above are currently being costed and there will need to be a clear and robust quality impact assessment carried out in relation to decision making and sign off.

Communications and Engagement:

A number of sessions have been held with the public through established engagement groups to outline the financial position and commence discussions on the proposed approach that the CCG will need to take.

These conversations will need to continue and will need to widen to include all our stakeholders in the health economy. The CCG is committed to joint working with our partners and stakeholders to find collective solutions to the financial position across the

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health and social care economy as the financial challenges are impacting on all organisations and there will need to be a system wide set of solutions to address the financial pressures.

Next Steps and Recommendations:

The Governing Body are asked to note the severity of the current financial position and support the proposed steps above in order that further work can be carried out and more detailed proposals developed for further sign off.

The Governing body is asked to **endorse** the financial recovery and control of investment measures set out in appendix A.

Quality & Safety/ Patient Engagement/ Impact on patient services:
• Any proposed changes will require a full Quality and Equality Impact Assessments to be carried out. • Any significant service changes will require patient involvement and may require formal patient and public consultation.

Finance, resources and QIPP
• As detailed.

Equality / Human Rights / Privacy impact analysis
None at this stage.

Risk	**Mitigating actions**
Risks will be captured and detailed as part of the review of each proposal.	

Supporting documents
Appendix A

Governance and reporting
Previously discussed at:

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Committee name	Date discussed	Outcome
Governing Body Seminar	16/10/2018	Support for outline direction
F&P Committee	23/10/2018	Support for outline direction
Joint F&P and Quality Committee	23rd October 2018 26th October 2018 30th October 2018	Document at appendix A considered by members. The F&P Committee requested that the document be revised to incorporate the proposed changes agreed at the meeting. The document was recirculated for any final comments to be incorporated, prior to obtaining Deputy F&P Chair approval. The document was approved by Dr James Cavanagh, Deputy F&P Chair

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Appendix A

Financial Recovery and Control of Investment

Principles for Decision Making

Background to Principles

The financial position of Hammersmith & Fulham CCG is such that we reasonably expect we will require in excess of £27m of savings in 2019/20 in order to break even.

This figure is worse than the equivalent for 2018/19, the main driver being an increase in the under-delivery against identified savings schemes in 2018/19, and the extent to which non-recurrent benefits will be delivered in 2018/19 without which the in-year deficit would be worse than the c£5m currently forecast.

The ultimate consequence of a failure to deliver a balanced position, as referenced in the recent NHSE letter to Mark Easton, NWL AO, will be the imposition of Legal Directions and the removal of staff and/or powers from H&F CCG.

Given that the resources of the CCG are limited, we need to ensure that all resources are focused productively on addressing the financial position of the CCG as this is the biggest challenge facing the organisation currently.

In light of all the above, any planned new or continuing investments must be reviewed and severely limited as part of ensuring we meet the financial requirements placed upon us.

It was on this basis that Governing Body requested a clear proposal to set out the rules for approval of any Investment Cases, contract extension requests and service development proposals. These are set out below for approval:

Guiding Principle

It is natural that over time a number of clarifications may be required to the proposed actions, as questions arise in relation to a range of specific circumstances. In circumstances where there are proposals which fall outside these principles, F&P will be asked to consider the evidence for investment going forward.

It is proposed that these principles are agreed will be in place for the duration of 18/19 with a review on 31st March 2019.

Decision Making Principles

The principles for decision making are as follows:-

The CCG may only approve Investment Cases under the following conditions, which will apply to all areas of commissioning responsibility:-

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New Investments

1) All invest to save requests for 2018/19 must deliver a positive return on investment. Recognising where we are in the financial year, it is unlikely that we will see in year returns from any investment, therefore the starting position will be to delay any expenditure into 19/20. For areas where delaying is not feasible, the expected return in 19/20 will be as set out in 2 below;

2) All invest to save schemes for 2019/20 will be judged against a ratio of 1-3 (i.e. if the scheme requires £100,000 as an investment, it must deliver a required level of savings in 2019/20 of £300,000 or more, so the net benefit is twice as large as the initial investment);

3) All savings estimates must stand up to scrutiny and be evidence based with benchmarked systemwide data to demonstrate deliverability, coupled ultimately with the required actions to ensure wider system activity reduces to support the investment case;

4) The only possible exceptions to the above are where the CCG may be failing in delivering against a formal, legal requirement, requiring investment to remedy, in which case only the smallest possible investment may be made for compliance purposes;

Review Post Implementation:

Given the risks of benefit realisation, all schemes will need to include, where taken forward, the ability to stop or reverse the investment subject to evidence of delivery. All cases that fail to deliver the anticipated benefits should expect to be terminated.

Existing Contracts and Investments

5) In cases where existing contracts/investments may be expiring and due for potential extension/re-procurement, each contract will require re-evaluation to ensure that they yield a net benefit to the CCG in line with the terms outlined above, failing which it is to be expected that they will not be continued in their current form, if at all;

6) Where contracts/investments may be in place to and beyond the end of 2019/20, they will be reassessed for value in line with the same terms. This reassessment will take account of whether there has been a corresponding reduction in the same activity in other

healthcare settings. If this was the intention and it cannot be demonstrated then then consideration will be given to decommission the service;

7) Where specific sums have been invested in contracts to fund specific posts, all such investments will cease where the investment sits within a tariff based contract. All other such investments will be treated as per 4 above.

8) Where the CCG has funded services or functions for which it has no statutory duty to do so, a review will be undertaken with a plan to divest, transfer or decommission those services.

9) The timing of contractual and service reviews need to allow for any formal requirements to consult in line with national principles and this will be built into the review timelines going forward.

10) Where the above principles and processes lead to a decision to decommission/disinvest on the grounds of a lack of financial value/value for money, the necessary impact assessments and engagements will be taken forward.

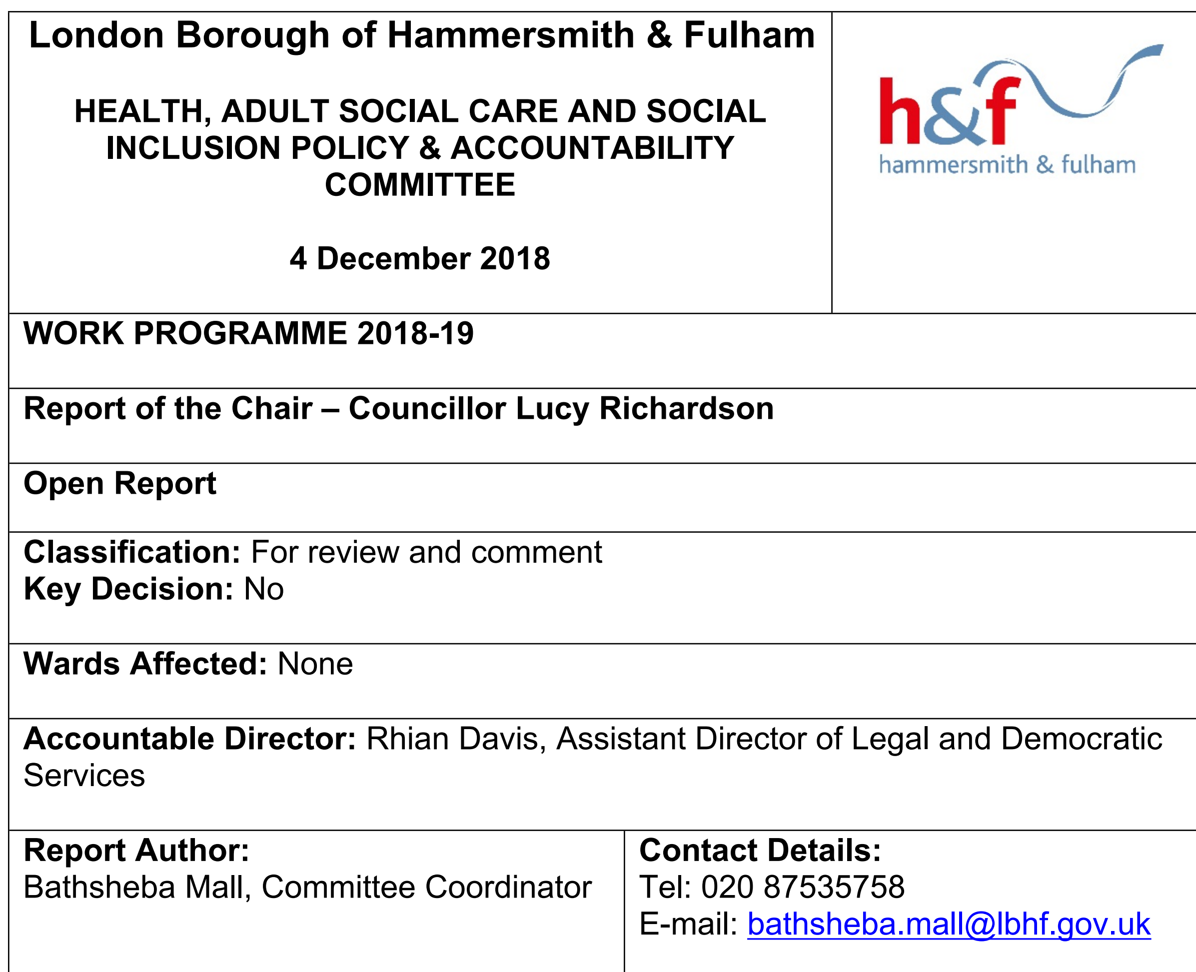
Evidence Base and Foundations of Decisions

11) When reviewing all proposals the practicality of implementation, including contractual notice periods/variations etc, will be taken into account when assessing the likelihood of benefit realisation. The basis of measurement will also be required to be agreed in advance of formal approval of any case.

This paper and the recommendations were approved by the Deputy Chair of the Finance and Performance Committee on Tuesday 30th October 2018 following deliberation at the 23rd October committee meeting, therefore the Governing Body is being asked to ratify the decision taken, and accept the content of the document.

Author: Sue Hillyard, Interim Financial Recovery Director

Date: Thursday 1 November 2018



London Borough of Hammersmith & Fulham HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY & ACCOUNTABILITY COMMITTEE 4 December 2018	h&f hammersmith & fulham
WORK PROGRAMME 2018-19	
Report of the Chair – Councillor Lucy Richardson	
Open Report	
Classification: For review and comment **Key Decision:** No	
Wards Affected: None	
Accountable Director: Rhian Davis, Assistant Director of Legal and Democratic Services	
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 2018/19.

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 2018/19

Appendix 1

Health, Inclusion and Social Care Policy and Accountability Committee
Work Programme Development Plan 2018/19

Item / working title	Overview / Development	Report Author / service
02 July 2018		
Housing Independent Living Strategy	This will be a draft report that members will have an opportunity to shape at PAC	Labab Lubab
Disabled People's Draft Housing Strategy	Building on the recommendations and actions arising from the DPC report	Labab Lubab
17 September 2018		
Safeguarding / MH	Interpreting the appropriate safeguarding thresholds and the subsequent management of safeguarding within the treatment and therapeutic setting.	Officer Lead Helen Mangan, WLMHT
NHS Workforce Recruitment and Retention	What provisions and strategies are being implemented to address the difficulties in recruiting and retaining staff; what protocols are in place to facilitate the reporting of patient concerns by staff. • Working conditions – including terms, engagement, support; • Staff consultation, involvement and engagement • Training, development and retention	NHS service providers

04 December 2018		
Pembridge Hospice	To understand the background to the decision to temporarily close the hospice.	H&F CCG and CLCH
The Royal Brompton Hospital - Bid	Information about a joint bid between Imperial College Healthcare NHS Trust, and, Chelsea and Westminster Hospital NHS Trust	Joint report from Imperial and Chelsea and Westminster
H&F CCG Primary and Urgent Care Proposals for Consultation	Report of H&F CCG on plans to locally consult on primary and urgent care proposals.	H&F CCG
H&F CCG – Financial Recovery Plan	Report of H&F CCG regarding the CCG's financial recovery plan.	H&F CCG
15 January 2019 (additional meeting date)		
Budget	Corporate, ASC and Public Health	LBHF
Aids and adaptations	Challenge to consider the terms and conditions and the provision of services	ASC / HSG
Housing impact on health and inclusion	Development of housing support services that help alleviate or prevent health conditions from deteriorating	ASC / HSG / PH
11 February 2019		
Older Peoples Commission	Report of the findings of the Older People's Commission.	
Community Champions	To consider current provision and support, following disaggregation of the service and what this means for LBHF residents; to consider the further development and support of the service.	

26 March 2019		
CQC Draft Quality Accounts	Imperial	Imperial
Listening to and Supporting Carers	To review current support for LBHF carers; to consider ways in which this could be developed; to understand the impact of caring on the health and wellbeing of carers themselves.	Older Peoples Commission
Access to Leisure Services for the learning disabled and vulnerable groups	To consider the access to and the provision of local leisure services for the learning disabled and any groups that may experience social isolation and loneliness.	

Suggested items – included for information

- Immunisation: Report from the HWB Task and Finish Group
- CAMHS update
- Report back from WLMHT