London Borough of Hammersmith & Fulham

Health, Inclusion and Social Care Policy and Accountability Committee Agenda

Wednesday 24 April 2019 at 6.00 pm
Small Hall - 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	
Victoria Brignell, Action On Disability Jim Grealy, Save Our Hospitals Bryan Naylor, Age UK	

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

Reports on the open agenda are available on the Council's website:
www.lbhf.gov.uk/committees

Members of the public are welcome to attend. A loop system for hearing impairment is provided, along with disabled access to the building.

Date Issued: 16 April 2019

London Borough of Hammersmith & Fulham

Health, Inclusion and Social Care Policy and Accountability Committee

Agenda - 24 April 2019

NOTE: Due to Item 4 being largely exempt, members of the public and press will have to leave the room. If you'd like to attend the meeting for discussion of Item 5 we would suggest arriving at 7pm.

Item		Pages
1.	**MINUTES OF THE PREVIOUS MEETING** To approve the minutes of the previous meeting and note any outstanding actions.	4 - 14 (6pm)
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.	**IMPERIAL COLLEGE HEALTHCARE NHS TRUST - DRAFT QUALITY ACCOUNT 2018-19** This report presents Imperial College Healthcare NHS Trust's Draft Quality Account 2018-19. The draft account document (appendix 1) is exempt at this time and can be found in the exempt part of the agenda. *NOTE: This item will be discussed in private session – we'd suggest members of the public arrive at 7pm for Item 5 on Physiotherapy Services.*	15 - 18 (6.10pm)

5. IMPERIAL COLLEGE HEALTHCARE NHS TRUST - SERVICE CHANGE FOR PHYSIOTHERAPY SERVICES 19 - 26

This report sets out the proposal to change the way physiotherapy services are provided at Charing Cross Hospital and asks for feedback before reaching a decision. (7pm)

6. DATES OF FUTURE MEETINGS

This is the final meeting of the municipal year. Dates of future meetings can be found on the Council's website: www.lbhf.gov.uk/committees

7. EXCLUSION OF THE PRESS AND PUBLIC

The Committee is invited to resolve, under Section 100A (4) of the Local Government Act 1972, that the public and press be excluded from the meeting during the consideration of the following items of business, on the grounds that they contain the likely disclosure of exempt information, as defined in paragraph 3 of Schedule 12A of the said Act, and that the public interest in maintaining the exemption currently outweighs the public interest in disclosing the information.

8. IMPERIAL COLLEGE HEALTHCARE NHS TRUST - DRAFT QUALITY ACCOUNT 2018-19 (EXEMPT ASPECTS)

This item presents the exempt aspects of Item 4 – Imperial College Healthcare NHS Trust's Draft Quality Account 2018-19.

London Borough of Hammersmith & Fulham

Health, Inclusion and Social Care Policy and Accountability Committee

Minutes

Monday 11 February 2019

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), Jennifer Nightingale (Senior Epilepsy Nurse Specialist), and Bryan Naylor (Age UK)

Other Councillors: Ben Coleman (Cabinet Member for Health and Adult Social Care)

Officers: Stephanie Bridger, Director of Nursing and Patient Experience, WLNHST; Dr James Cavanagh, Co-Vice Chair, H&F CCG Governing Body; Mark Easton, Chief Accountable Officer, NWL Collaboration of CCGs; Emily Hill, Assistant Director of Corporate Finance; Hitesh Jolapara, Strategic Director of Finance and Governance; Jane McGrath, CEO, West London Collaborative, (a community interest company or CIC); Anita Parkin, Director of Public Health; Lisa Redfern, Strategic Director of Social Care and Public Services Reform; and Sue Roostan, Deputy Managing Director, H&F CCG

226. MINUTES OF THE PREVIOUS MEETING

Councillor Amanda Lloyd-Harris raised a number of concerns regarding the contents of the minutes which she hoped would be addressed outside of the meeting.

RESOLVED
That the minutes of the previous meeting were agreed.

227. APOLOGIES FOR ABSENCE

None.

228. DECLARATION OF INTEREST

Councillor Lloyd-Harris declared an interest due to her involvement and interest in H&F Mind.

229. HAMMERSMITH & FULHAM CLINICAL COMMISSIONING GROUP - UPDATE

Councillor Richardson welcomed the CCG to the meeting. This item would contribute to the currently on-going discussion regarding the CCG financial position and help facilitate further dialogue. Councillor Richardson assured NHS colleagues that it was not the Committees intention to revisit points but to ensure that members clearly understood the CCGs rationale for resolving their current situation. A letter from the CCG in response to the chair's letter dated 15 January 2019 had been received but further clarity was sought around some of the issues raised.

The pre-consultation business case had a specific action on patient transfer but any changes could only be implemented following consultation, as part of the implementation plan. An assurance meeting with NSH England, Clinical Senate had reviewed the business case and was awaiting final sign off. A date for the consultation was expected and the CCG would return to the Committee as part of the Consultation. An engagement event had been held at the Irish Centre, facilitated by the CCG on 29 January 2019. There was a challenging target for savings to achieve, with £9 million identified to date. The intention was to continue with engagement and the financial recovery plan would need to be ratified by the governing body.

Anne Drinkell (Save Our Hospitals) asked a question about the proportions of people who died in hospital and in hospices. H&F did relatively well at enabling people to die at home and this was not reflected in the terms of reference. At the same time, statistics from the CCG indicated that there was a significant gap between how many people would like to die in a hospice and how many people do so. The inference was that there would be a reduction in the provision of palliative care.

Sue Roostan explained that a full strategic review of palliative care would be undertaken. They were still in the process of gathering evidence, and it was not yet envisaged what the shape of the provision would be for residents. She concurred that many residents wanted to die at home. The 2016 JSNA (Joint Strategic Needs Assessment) for H&F recognised that percentage of people dying at home was high, which indicated that the Borough was doing better compared to the national average (5.9% of H&F residents died in a hospice). Comments for the palliative care review were required by 13 February, and would be sought from members of the public, those directly affected, hospice staff and other stakeholders.

With reference to the planned savings figure of £17 million, Bryan Naylor pointed out that £9 million of this figure had been identified, with the

remainder being rolled into the following financial year. He raised very strong concerns about organisational under performance. He had observed that increasingly, the concept of a local provider had become diluted with a corresponding increase in management. The retention of senior management throughout this situation was questionable and open to challenge, given the need to identify savings. Further evidence was needed to provide assurance that the CCG was doing all that it could.

Mark Easton responded that across the NW London collaborative, a 20% reduction in management costs had been identified, as per NHS England planned guidance. He was confident that overall, a saving of £2 million was possible. The scale of the current savings required was significant. He recognised the importance of sound, financial structures and a balanced budget. The CCG still sought to maintain mental health standards, protect primary care budgets and achieve management changes within the NHS constitutional framework. Bryan Naylor expressed concern about the plans lacking credibility. In his view, services had been ill-managed and wasted resources.

Jim Grealy reported that information provided at the CCG facilitated events, offered little variation in the figures presented. Whilst he accepted the significant scale of the challenges presented, the Committees role was to scrutinise the delivery of local services. Over a period of seven months, no details about the changes to public services or information had been given, although financial headlines had been provided at the workshop on 29 January. There was no indication as to how cuts to services would be achieved without being damaged. There was little transparency and whilst the consultation would help provide this at the end of March, he asked when a comprehensive list of service reductions would be provided. Sue Roostan explained that CCG presentation at the 29 January workshop (circulated) provided details of the savings scheme, but a range of additional information would be required, which included an inequalities impact assessment. Work on this was on going and would be considered by the governing body. Responding to a follow up comment, it was accepted that substantive changes would require formal consultation and it was also recognised that residents felt frustrated with the information given.

Mark Easton assured the Committee that there was no intention to remove services without undertaking serious consultation. The CCG would continue to engage in dialogue, which would inform the ongoing development of the plans. He accepted that the process was frustrating and that it was difficult to see what reduced services would look like locally but that there was an obligation to comply with NHS requirements. The process was about finding opportunities within the budget to shape local services. The budget would increase in the next financial year. The current focus was a small sub-set of the wider CCG budget picture, and which would be increased in some areas.

Councillor Caleb-Landy commented that many residents were concerned about the level of savings required and struggled to understand the figures. The Committee needed assurance about the information provided and its wider context. Transparency of the figures was required, with clearer

explanations for non-medical people. Mark Easton responded that the long-term plan signalled the direction of the NHS and accepted the need for greater clarity.

Councillor Coleman expressed concern about the lack of local democratic accountability and the impact of having the CCG collaborative but thanked Mark Easton for coming to the Committee. Additional funding may be going into acute services but primary care was a concern. The temporary closure of the Pembroke had progressed to form part of a review of palliative care. There was a concern that everything that the CCG did now, would be viewed as cuts. Councillor Coleman asserted that CCG had tried to be strategic but needed to more overarching. It was essential to identify the impact of changes in one part of the primary care system on other areas and build a whole system, strategic case.

Mark Easton responded that the Long-Term NHS Plan was strategic. It considered partnerships and integrated care systems (ICS), with one CCG working in alignment with one ICS. A relationship with the Borough was essential, as was a borough based, NHS body. The plan required that the CCG collaborative formulated a response, with the intention to submit this in autumn 2019.

Councillor Coleman commented that the Council was not currently part of the current partnership arrangement because of the Shaping a Healthier Future (SaHF) consultation, and, the Sustainability and Transformation Plan (now known as the North-West London Health and Care Partnership). Councillor Coleman suggested that this should not prevent the Council from being able to continue to engage in dialogue, provided that the fundamental disagreement around changes to acute services could be removed from the discussion. The Council was not currently represented at the strategic transformation board and the SaHF was being remodelled and refreshed, the scope of which was currently being drafted. Councillor Coleman asked if it was possible to have early access to the remodelling and whether it was possible to meet to further discuss this.

Mark Easton confirmed that the Council could be involved in the formation of the response to the Plan, as part of local engagement. However, the specification for the SaHF remodelling was currently being drafted and would be finished within the coming two weeks, to be commissioned in April.

Merrill Hammer (Save Our Hospitals) commented that the engagement events had facilitated helpful discussion but that the reduction of management costs, with a target of 20% had not been factored into the financial recovery plan. She added that there had been very little information made available to the public and she asked if the figures had been compared like for like, given the higher inner London salary figures. The piecemeal approach in providing information was not sufficiently strategic to coordinate healthcare provision for residents in North-West London. Mark Easton clarified that management costs for NW London represented 2-3% of the overall cost and the reduction would not have a significant impact, although it would be helpful. It was explained that they had begun to streamline management structures in

advance of the Long-term NHS Plan recommendations and that the North-West London target recommendation was bigger than the national target. He continued that to devise a strategic plan at the same time as a financial plan would be problematic, as one would inform the other. The CCG was not alone in being financially challenged and in risking financial deficit.

Sue Roostan explained that the targeted savings not achieved for 2018/19 would be rolled forward to the 2019/20 savings plan. There were plans to decommission community services, for example, dermatology, which was 'double-running', with both community based and hospital provision operating at the same time. The CCG was committed to being open and transparent in sharing information, and to maintaining on-going dialogue and engagement and looked forward to bringing this back to the Committee. Councillor Coleman expressed support for CCG and was sympathetic to the situation that that CCG now found themselves in, particularly in respect of the financial burden of GP at Hand. He offered the Council's support in helping the CCG to resolve this with NHS England. Mark Easton confirmed that NHS England had provided an assurance that a solution will be found but admitted that their concern was increasing and had been flagged as a significant risk in the CCG's budget. They would soon have to reach a decision as to whether to indicate this as a deficit at the end of the year. Advice to date had been that the issue was being considered at a national level but he was not optimistic that there would be a quick resolution.

Councillor Richardson concluded the discussion and welcomed confirmation that the CCG would return to the Committee in March with the formal consultation document on the proposals for service change.

230. WEST LONDON MENTAL HEALTH TRUST - CQC INSPECTION FINDINGS AND UPDATE

Councillor Richardson welcomed Stephanie Bridger, Jane McGrath and Sarah Rushton from the West London Mental Health Trust. A full inspection of the Trust had been undertaken between August and November 2018 and the report had been compiled in two parts. The report had been published in December 2018 and the Trust had been moved from good to outstanding, for caring across all services. The Care Quality Commission (CQC) had commented on improvements but there remained some requirement notices in places and work was underway to ensure that these were resolved. The CQC had been particularly impressed with the Trusts work on co-production and partnership working. Considering the patient perspective was a radical approach, looking to build treatment plans that placed the patient at the centre.

Commenting on staff recruitment and retention, it was recognised that this was a London-wide pressure with specific challenges, it was noted that in other areas such as Harrow, a consultant psychiatrist was a member of the clinical team. By contrast, Hammersmith and Fulham did not have a similar, consultant led model and that this was a CCG funding issue.

Stephanie Bridger outlined the Trusts initiatives, which offered a varied range of staff training opportunities. Different educational pathways such as apprenticeships (including for occupational therapists), peer support; and encouraging retired nurses back into practice, would help to retain staff. The Trust was focused on service team specific recruitment events, rather than Trust wide events. The difficulty was not the lack of expertise, but around the mix of skillsets needed, for example a band 5 rather than a band 6 nurse based in the community. The pressures on recruitment were well recognised, particularly since the nursing bursary had been abolished. The Trust was investing in training their own staff, as part of its unique selling point.

Jen Nightingale asked if the funding training would be ringfenced and it was explained that the extra cost of investment was more financially efficient than resorting to agency staff and allowed the Trust to retain staff.

Councillor Caleb-Landy asked about what steps the Trust was taking to address patient seclusion. Stephanie Bridger explained that they had developed a matrix around seclusion but that there was a lack of seclusion facilities in Hammersmith & Fulham, which compromised the Trust's facility to safeguard an individual's privacy and dignity. This was being managed and the Trust's board had oversight of these concerns, particularly in sites such as Broadmoor, which the Trust also had responsibility for.

Councillor Richardson asked if work around developing community based services included support for suitable housing for those with specialised needs. It was confirmed that this provision was within the remit of the Council, not the Trust. Lisa Redfern explained that she chaired a weekly meeting board with a sensory housing officer to consider appropriate and supported housing, particularly around discharge to ensure that the correct provision was in place.

Councillor Richardson commended the work undertaken by the Trust to significantly improve ratings. The Trusts intent around recruitment and retention was also welcomed.

RESOLVED
The Committee noted the report.

231. 2019 MEDIUM TERM FINANCIAL STRATEGY (MTFS) - SOCIAL CARE

Hitesh Jolapara provided a corporate perspective on future public expenditure. National expenditure had continued to decline up to 2018-19, where there had been a slight uplift. General grant funding had reduced by £3.3 million, representing a 60% reduction in real terms. Each year, one-off funding allocation was provided to Children's Services and Adult Social Care and there had been a growth in business rates, as part of a pilot to divert funds direct to councils.

Comparatively, urban and city authorities had traditionally lost out to provincial needs, and this might be impacted by the governments fair funding

review. H&F was expected to achieve £34 million in savings, to maintain a balanced budget. Growth for 2019-20 included a council tax increase of 2%, accepting the social care precept; and the Council's share of business rates would be 48%, generating approximately £78 million but likely to be lower as the rates process was subject to appeal.

Lisa Redfern provided the Adult Social Care (ASC) financial overview. ASC prioritised enabling people to live independently at home, providing support for them and their carers. Underpinned by an approach that advocated co-production, ASC aimed to deliver integrated care. In terms of highlights, the Council had, for the fifth consecutive year, agreed not to impose homecare charges, and it was significant that it was the only authority able to do so. Similarly, the costs of meals on wheels (£2 per meal), and of providing the Careline (medical alert) facility would also remain static.

Despite these positive achievements, there remained significant challenges. Demand for ASC continued to increase. People were living longer and enjoyed a better quality of life but longevity varied from area to area. Local authority funding had decreased and the cost of care had continued to rise. The care market was volatile but the Council was committed to ensuring that all staff received the London Living Wage (LLW). Supporting 3100 residents, the discharge of patients had an impact on the ASC budget, with people leaving hospital with greater acuity of need.

ASC would deliver a balanced budget and achieve significant savings. Excellent feedback had been received from CQC, and the Community Independence Service, which now offered a blue print for providing community based services, had been highly commended. ASC continued to work hard to streamline and improve back office provision, looking for ways to be innovative and cost efficient. Consequently, the deployment of agency staff had been reduced by 50%.

The Transitions Into Adulthood service was an example of developing innovative services, designed to fit around need. Working jointly with Children's Services, the aim was to work with young people from the age of fourteen. Earlier intervention allowed a more bespoke, tailored support offer. Growth funding for this year was non-recurrent and there was no guarantee that the winter pressures grant funding would continue in future years. The Better Care Fund programme was also under review. Salary costs constituted the single, biggest budgetary pressure, exacerbated by the Councils commitment to LLW.

Councillor Lloyd-Harris commended the report and acknowledged the difficulties faced by the department and the needs of vulnerable people. Given the continued decisions to not charge for homecare services, meals on wheels provision and Careline support, she asked how sustainable this was. Lisa Redfern acknowledged the inherent challenges but pointed out that this was the approach taken by the Council Administration and a political priority to deliver the best possible services to residents. Councillor Coleman continued, that they had taken a decision to accept the ASC funding precept this year so that they could continue to fund these provisions. It was morally

and practically right to support individuals leaving hospital prematurely, with greater acuity of care. Meals on Wheels was subsidised but nutritious meals helped to maintain a healthy diet and could also tackle social isolation and loneliness.

Victoria Brignell commented that charging for homecare was a tax on being disabled. Charging for schools and roads would never be similarly contemplated and commended the Administration's decision to not levy a charge for this essential service. She asked what impact the £3.3 million in savings would have on services in practice. Lisa Redfern hoped that people would not see an impact on the services they received. This would be about how change could be affected in a way that would be transformative. They were now working more closely with the operations team and resolving issues more quickly. Identifying service improvements had also resulted in savings.

Councillor Umeh commented that this was a well-prepared budget, given the huge reduction in funding allocated by government and was satisfied that all the identified risks had been considered.

Bryan Naylor welcomed report and observed that over 40% of residents were satisfied with the services received however, this was not reflected across the Borough. Part of the issue was raising awareness about what services were available and that older people found this difficult. He asked if there were any plans to address this. Lisa Redfern concurred and acknowledged that how information was communicated to residents was a primary concern. She gave an assurance that the budget review process applied an equalities impact assessment for each possible saving. Nine years of austerity had meant fewer staff so making each contact count was critical. Last year, a list of 12 care standards was developed and included, for example, treating a person with dignity and respect.

Jim Grealy commended the report for its clarity and insight. He asked how the range of charges now being passed to ASC would be picked up, without destabilising the ASC budget. Lisa Redfern explained that the department had first considered this two years earlier. Greater acuity of need meant that people required increasingly more complex care packages, on being discharged from hospital. This high cost pressure and had been factored into future planning. Provision of social care had evolved and required a quantitative approach in collecting and analysing data. It was difficult to predict future need and how local demand could be sustained, given the expectations of the CCG. Councillor Coleman commented that there was no doubt that hospitals were asking people to leave earlier than they should be. This was a concern although the level of danger in each case varied. ASC was expected to meet the extra cost of providing much needed support where this arose, but this was difficult to evidence. Lisa Redfern explained that there was a need to adjust the perception as to who provided care. Nationally, there was a misconception that that it was the NHS, overlooking the care for adults provided by social care.

RESOLVED
That the guillotine be agreed and the meeting be extended to 21:30.

Commenting on the issue of early discharge, Jen Nightingale felt that this was a huge concern, particularly in the context of mental health provision. Lisa Redfern agreed and reported that the CIS was likely to receive an outstanding service award, which co-ordinated and brought together varied professional clinical staff groups. This was an excellent model of care and operated like a virtual ward, but was expensive and required continued investment. Referring to community neurological provision, there was a high cost in providing community based and in-patient care, and most NHS delayed discharge cases were patients with neurological needs which needed to be carefully managed. ASC funded a neurological doctor to provide support within CIS.

Councillor Kwon asked about homecare provision. Other than the fact that the service was free, she asked if there were any other limitations such as time, performance; and about performance monitoring measures. It was explained that there were regular reviews undertaken, the frequency of which correlated to the level of need. Homecare providers varied in terms of the quality of provision and contracts were monitored in-house. Homecare provision could be linked to issues around NHS recruitment and retention, highlighted earlier. Podiatry services for example, toenail clipping was a basic need, as long toenails could cause trips and falls. Podiatry services had been cut by 40% and this decision had been reached by factoring in clinical safety standards.

Councillor Richardson thanked officers for providing a strong strategic overview. They had prepared a detailed and insightful review of the current financial pressures, and potential ways in which these could be mitigated.

RESOLVED
That the Committee noted the report.

232. 2019 MEDIUM TERM FINANCIAL STRATEGY (MTFS) - PUBLIC HEALTH

Anita Parkin and Nicola Ashton provided an overview of Public Health and outlined the various ways in much Public Health allocated funds across the Council departments to ensure that health outcomes were supported. These included targets such as increasing life expectancy, smoking cessation or supporting rough sleepers; and acknowledged that people in different parts of the Borough often had different experiences. In addressing the wider determinants of health, Public Health worked with other departments across the Council. They worked particularly closely with ASC, supporting vulnerable adults and children, and facilitated prevention work, for example: health protection, working and responding to major incidents, healthcare and preventing mortality.

Understanding the financial picture, Public Health received £22 million to support locally, sensitive health priorities for Hammersmith & Fulham residents. Over 200 public health outcomes were provided within the Public Health Outcomes Framework 2017 and the issue was how to understand how this could be locally interpreted. Emily Hill set out the figures as to where the

Public Health grant was spent and reported that there was a reduction of 2.6%. The key point to consider was the positive impact of Public Health investment across the Council, contributing to meeting public health outcomes. The current funding trend indicated a downwards trajectory although a financial reserve had accumulated, counterbalancing that decrease and could ensure service continuity, if necessary. It was recognised that in terms of risk, future funding will eventually cease, excluding provision for essential services which would continue. There had been an increased and a review of the funding allocation would be undertaken.

Jim Grealy, in the context of the reduced Public Health grant, asked if Public Health worked to support children. Lisa Redfern explained that strategically, Steve Miley, Anita Parkin and herself, were members of the Health and Wellbeing Board, and worked closely to deliver on a range of early years. They also attended monthly meetings with the CCG to consider core and strategic, operational issues. Anita Parkin briefly outlined the healthy schools provision, and added that it was necessary to look at improved ways of working with schools to help young people build emotional resilience, and prepare them adequately for later life.

Councillor Coleman commented that Public Health operated right across the Council. He had requested to meet with all those who worked directly with young people to find ways in which the current range of outcomes could be improved upon. It was important to see the impact of preventative policies. He planned to meet with schools, parks and leisure services to address this and to ensure that Public Health funding was well spent.

In response to a query from Councillor Kwon, it was explained that the pie chart indicated the different portions of spend. The Council determined how to deliver on public health outcomes by investing in different departments. Much of this was apportioned to ASC and Children's Services and very little allocated elsewhere. Councillor Coleman added that Public Health was well placed to work alongside other departments. For Public health outcomes to be successfully delivered, departments would need to understand what was expected. The funding was to be paid quarterly and in arrears but it was important that they delivered the expected outcomes. Performance and monitoring will measure and demonstrate how departments are meeting the targets, how these were set and funding allocation would be contingent on targets were met.

In response to a query from Councillor Lloyd-Harris, Councillor Coleman clarified that discussions with parks and leisure would consider the service provision. They would work closely with residents, although it was accepted that engagement was self-selective and that this would require careful calibration in order to be inclusive.

Councillor Richardson thanked officers for the report and looked forward to hearing about further progress on delivering Pubic Health outcomes, in the future.

RESOLVED
That the Committee noted the report.

233. WORK PROGRAMME

It was noted that the CCG would be returning to the March meeting of the Committee, as part of the formal consultation. It was noted that because of timetabling difficulties, it was noted that Imperials Draft Quality Accounts 2019/19 could be considered at an extra meeting to be scheduled for the end of April.

234. DATES OF FUTURE MEETINGS

The next meeting of the Committee was noted as 26 March 2019.

Meeting started: 6.00 pm
Meeting ended: 9.22 pm

Chair .....

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

London Borough of Hammersmith & Fulham **HEALTH, INCLUSION AND SOCIAL CARE POLICY & ACCOUNTABILITY** **24 April 2019**	
DRAFT QUALITY ACCOUNT 2018/19 FROM IMPERIAL COLLEGE HEALTHCARE NHS TRUST	
Report of an External Partner – Imperial College Healthcare NHS Trust	
Open Report with Exempt Appendix *The appendix attached to this report is the first draft of Imperial College Healthcare NHS Trust's Quality Account and has been shared for feedback and consultation. It is an early draft and has not yet been reviewed or approved by their Board. The Trust therefore requested that it was not published as an open report. The final version will be shared with the Committee once it has been approved in May.*	
Classification: For Review & Comment **Key Decision: No**	
Wards Affected: N/A	
Accountable Director: Professor Julian Redhead, Medical Director, Imperial College Healthcare NHS Trust	
Report Author: Clementine Burbidge, Compliance and Assurance Improvement Lead	**Contact Details:** Tel: 020 331 21082 E-mail: clementine.burbidge@nhs.net

1. EXECUTIVE SUMMARY

1.1. Quality accounts are annual reports to the public from NHS healthcare providers about the quality of services they deliver. Their primary purpose is to encourage boards and leaders of healthcare organisations to demonstrate their commitment to continuous, evidence-based quality improvement, to assess quality across all of the healthcare services they offer and to explain their progress to the public.

1.2. Quality accounts are required by the Health Act 2009, and in the terms set out in the National Health Service (Quality Accounts) Regulations 2010 as amended ('the quality accounts regulations').

1.3. As part of the regulations, NHS providers are required to consult with their clinical commissioning groups, local healthwatch organisations and overview and

scrutiny committees. Statements provided by these organisations in response to the quality accounts are published in the final quality account.

1.4. The commissioners have a legal obligation to review and comment, while local Healthwatch organisations and OSCs are offered the opportunity to do so on a voluntary basis.

1.5. The attached document (appendix 1) is the Trust's draft quality account for 2018/19 for review by the OSC. This is being provided to allow members to review the document, and give feedback as part of the consultation process. Any comments and suggested amendments will be reviewed by the Trust and incorporated as appropriate into the final draft document.

1.6. The draft features data up to the end of January 2019. Year-end data will be incorporated into the final draft in May once available.

1.7. The final draft document will be circulated in early May following internal sign off to allow for the OSC to provide their final statement commenting on the quality account. This will be published in the final document on NHS choices before the end of June 2019.

2. RECOMMENDATIONS

2.1. The Committee is asked to review the document and provide feedback on the contents either by 19th April 2019 or at the meeting on 24th April 2019. Where possible, and appropriate, amendments will be made to the document in response ahead of the circulation of the final draft. This will be circulated following internal sign off on 7th May 2019.

2.2. The Committee is asked to provide a statement on the final draft quality account by 28th May 2019 for inclusion in the final document, which will be published at the end of June.

3. INTRODUCTION AND BACKGROUND

3.1. The Trust's annual quality account sets out the organisation's improvement priorities and metrics for the following year, and describes progress in delivering the priorities outlined in the previous document.

3.2. The draft quality account has been developed using the Department of Health Quality Account Toolkit and complies with the mandatory requirements, in the following structure:

- Part 1: Statement from the Chief Executive and About Our Trust.
- Part 2: Our quality improvement plan and priorities for 2019/20
- Part 3: Statements of assurance from the Trust Board
- Part 4: Review of our quality progress 2018/19
  - Progress with our 13 improvement priorities
  - Progress with delivery of the metrics in the IQPR under each domain and progress with other key workstreams which impact each quality domain

- Part 4: Performance against NHS Outcomes Framework indicators 2018/19
- Part 5: Statements from Stakeholders and independent auditor's assurance report
- Part 6: Appendices
- Part 7: Glossary

The contents of the key sections of the report are outlined below.

4. CONTENTS

4.1. **Part 1: Statement from the chief executive**
The statement will summarise our quality performance over the last year, and provides an introduction to the quality account. This will be written once year end data is available and the Trust's annual report has been drafted so that the contents align.

4.2. **Part 2: About our Trust and our quality improvement plans for 2018/19 (pages 6 – 24)**
This section provides some background to the Trust, including data regarding care e.g. patient contacts, which will be taken from the annual report when available. It also describes our governance framework, vision and objectives and some of the key strategies that are driving improvement in all areas across the organisation. It includes information about the organisational strategy, which was approved at Trust Board in March 2019, and how the quality priorities chosen for 2019/20 align with the plans set out in the strategy.

It then outlines our priority areas for quality improvement in 2019/20. This includes our eight priorities for 2019/20 which were approved at Trust Board in March. Most of these are being continued from last year. As this is the case, to avoid repetition we have not outlined these in detail in this section as progress and future plans with them are described in part 4. We are introducing a new priority for 2019/20 – to review our approach to inspection, accreditation and reviews. This section also contains the agreed metrics for our integrated quality and performance scorecard (IQPR) under each quality domain (safe, effective, caring, responsive and well-led).

4.3. **Part 3: Statements of assurance from the Trust Board (pages 25 – 33)**
In this section of the quality account, we are required to present mandatory statements relating to the quality of our services. This information is common to all quality accounts and can be used to compare our performance with that of other organisations. Some of this information is outstanding and will be included following year end in the final draft. This includes CQUIN performance, information governance toolkit compliance and new learning from deaths requirements.

4.4. **Part 4: Review of our quality progress 2018/19 (pages 34 - 99)**
This section begins with a review of our thirteen improvement priorities for 2018/19. The review includes a description as to why they were originally chosen

as a priority, what we have achieved in year, including outcome measures where available, and a brief outline of plans for next year.

Following this, we provide a summary of performance under each of the five quality domains, including key workstreams which impact on the domain and progress with delivery of the IQPR metrics. It also includes data and narrative on the 'use of resources' domain for the first time. The data included is up to the end of January 2019; final year end data will be added into the final draft in May.

This section also includes the NHS outcomes framework indicators for 2018/19. These are a core set of indicators mandated by NHS England which we must report against in the quality account in a standardised table format. Most of these indicators are already described in the document.

4.5. **Part 5: Statements from stakeholders**
Our external stakeholders are invited to provide a formal statement ahead of publication. These will be sought in May 2019 following circulation of the final draft and will be inserted in the document prior to publication in June.

The quality account will be subjected to both internal and external auditing, with the external auditors' statement also included in the published document.

5. CONSULTATION

5.1. Consultation with our external stakeholders (CCG, Healthwatch and Local OSCs) began in April 2019 with the circulation of the first draft of the quality account (appendix 1) for review following internal sign off. Stakeholders are being asked to review the document, and give feedback. Where appropriate, any additions or changes requested as part of this process will be included in the document.

5.2. The final draft will be circulated following internal sign off on 7th May 2019 with statements requested by 28th May 2019.

6. RISK MANAGEMENT

6.1 There are numerous risks associated with delivery of our improvement priorities and metrics. These are described in the Trust's corporate risk register. The annual quality account provides assurance to internal and external stakeholders that plans to improve quality in the Trust are robust.

LIST OF APPENDICES:
Appendix 1: Imperial College Healthcare NHS Trust – Draft Quality Account 2018/19 (Exempt)

London Borough of Hammersmith & Fulham **HEALTH, INCLUSION AND SOCIAL CARE POLICY & ACCOUNTABILITY** **24 APRIL 2019**	
IMPERIAL COLLEGE HEALTHCARE NHS TRUST: SERVICE CHANGE PROPOSAL FOR PHYSIOTHERAPY SERVICES	
Report of an External Partner – Imperial College Healthcare NHS Trust	
Open Report	
Classification - For Review & Comment **Key Decision: No**	
Wards Affected: N/A	
Accountable Director: Toby Hyde, interim director for integrated care programme, Imperial College Healthcare NHS Trust	
Report Author: Mick Fisher, head of external engagement, Imperial College Healthcare NHS Trust	**Contact Details:** E-mail: mick.fisher@nhs.net

1. EXECUTIVE SUMMARY

1.1. The attached report to the Health, Inclusion and Social Care Policy and Accountability Committee from Imperial College Healthcare NHS Trust (the Trust) sets out the proposal to change the way physiotherapy services are provided at Charing Cross Hospital and asks for feedback before reaching a decision.

1.2. The Trust has developed the proposal following a safety and effectiveness review prompted by the increasing challenge of maintaining and running the hydrotherapy pool at Charing Cross Hospital combined with evidence that land-based therapies produce very similar benefits to aquatic therapies.

1.3. The proposal has been developed by the Trust's physiotherapy team and is necessary in order to avoid unplanned and repeated disruption to patient care for health and safety reasons. A switch to all land-based therapies will enable the Trust to improve patient experience and reduce waiting times for all therapy patients, without impacting on clinical outcomes.

1.4. In early March, the Trust chief executive Prof Tim Orchard wrote to the Chair of the Health, Inclusion and Social Care Policy and Accountability Committee to

outline the proposal and the plan to seek the views of patients, carers, local residents and other stakeholders.

1.5. The Trust suggests that this proposal does not constitute a substantial development or variation to an existing clinical service which would be subject to a full formal public consultation. The proposal involves providing at least the same level of service, with the potential for additional appointment capacity, but in a different way on the same site location and stems from the safety, effectiveness and patient experience impacts of the unplanned, repeated and prolonged closures of the hydrotherapy pool.

1.6. The Trust is undertaking an engagement process raising awareness of the proposal and seeking comments and questions during March/April 2019 before reaching a decision, which subject to the feedback received, is expected in May 2019.

2. RECOMMENDATIONS

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

3. BACKGROUND

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

LIST OF APPENDICES:

Appendix 1 - Service change proposal for physiotherapy services: Report from Imperial College Healthcare NHS Trust to the London Borough of Hammersmith & Fulham Health, Inclusion and Social Care Policy and Accountability Committee

Imperial College Healthcare
NHS Trust

Service change proposal for physiotherapy services

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

1. Introduction

This report to the Health, Inclusion and Social Care Policy and Accountability Committee from Imperial College Healthcare NHS Trust (the Trust) sets out the proposal to change the way physiotherapy services are provided at Charing Cross Hospital and asks for feedback before reaching a decision. We have developed the proposal following a safety and effectiveness review prompted by the increasing challenge of maintaining and running the hydrotherapy pool at Charing Cross Hospital combined with evidence that land-based therapies produce very similar benefits to aquatic therapies.

2. Imperial College Healthcare NHS Trust overview

The Trust provides acute and specialist health care in north west London for around a million and a half people every year. Formed in 2007, we are one of the largest NHS trusts in the country, with over 11,500 staff. We have five hospitals – Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and Western Eye – as well as a growing number of community services.

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

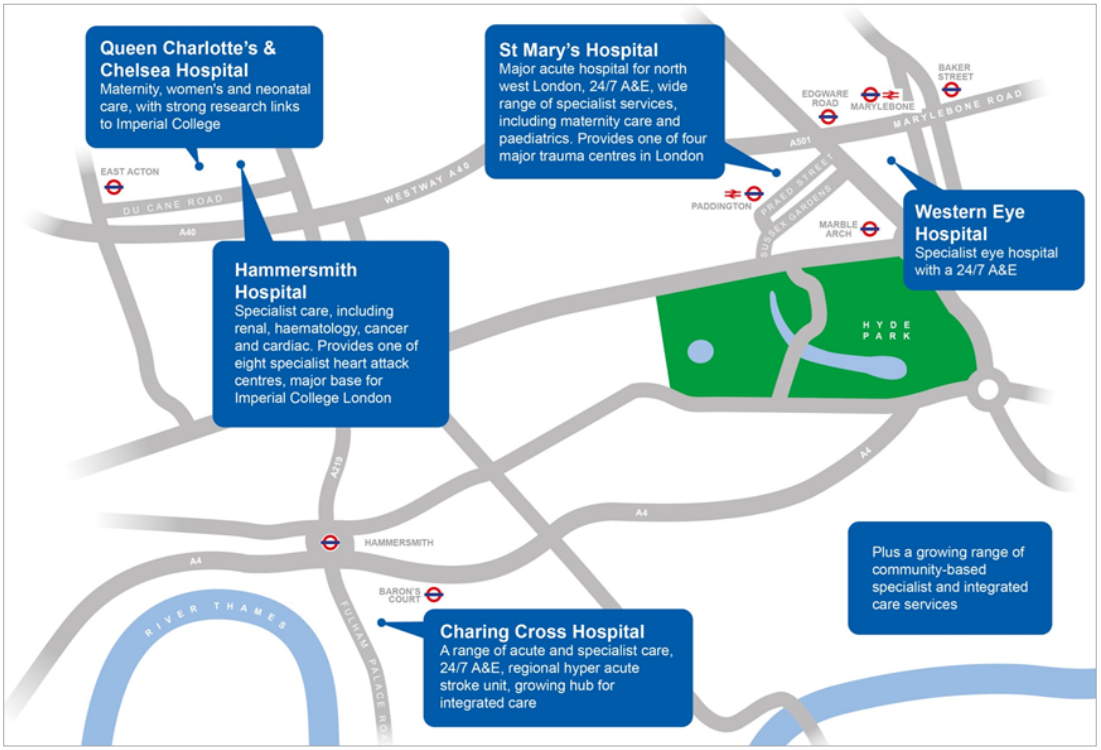

Figure 1 – Map of hospitals in Imperial College Healthcare NHS Trust

3. Our current physiotherapy services

Our Trust's physiotherapy services provide rehabilitation for inpatients and outpatients at Charing Cross, Hammersmith, Queen Charlotte's & Chelsea and St Mary's hospitals and various community locations.

The inpatient service provides expert physiotherapy assessment, treatment and advice for all inpatients that require physiotherapy to facilitate recovery following acute illness or surgery and to facilitate discharge home or onward referral for rehabilitation.

We offer inpatient physiotherapy services within all speciality areas provided by the Trust. Our physiotherapists are allocated to specific hospital wards according to the specialty skills of each therapist. All hospital departments can discuss the specific physiotherapy needs of a patient and referrals with their ward-based therapist. Our physiotherapists attend the board rounds and multidisciplinary team meetings on the wards to assist our medical teams in the planning of on-going inpatient care.

Referrals for physiotherapy services include inpatients with the following conditions:

- orthopaedics – trauma and elective surgery
- respiratory – acute and chronic respiratory disorders and critical care
- stroke and adult neurology/neurosurgery
- neuro-rehabilitation
- major trauma – head injuries and multiple fractures
- elderly medicine – patients that have fallen or have mobility problems
- obstetrics
- gynaecology
- cancer
- vascular and amputees
- renal
- children's services

The outpatient physiotherapy service receives referrals from our consultants within the Trust for patients requiring further expert assessment and treatment and for rehabilitation (we are unable to accept referrals directly from GPs). We offer outpatient services for:

- musculoskeletal conditions e.g. back and neck pain, other joint pain, soft tissue injuries
- post-orthopaedic surgery
- rheumatology conditions
- chronic pain
- vestibular disorders
- hand therapy
- intermittent claudication – classes
- amputees – prosthetic rehabilitation
- obstetrics – antenatal and postnatal assessment, treatment and advice for back pain, continence and urogynaecological problems
- gynaecology – conservative management for women with continence and urogynaecological problems
- advanced practitioner service in orthopaedic clinics, pain clinics, chronic respiratory care, and HIV clinics
- chronic pulmonary illness
- neurological conditions – expert opinion and signposting to appropriate services only

Treatment includes education, advice and exercise to maximise our patients' independence and self-management. The treatments we offer are:

- Postural and ergonomic advice and back care education

- Gait re-education to improve mobility
- Manual therapy to mobilise the joints and soft tissue
- Teaching specific exercises to improve strength or flexibility
- Joint management
- Self-management strategies and healthy lifestyle choices
- Aquatic/hydrotherapy
- Strength training regimes
- Functional task practice
- Respiratory and cardiovascular exercise regimes
- Group exercise sessions

4. Proposal to change our physiotherapy services

Following a safety and effectiveness review, we are proposing a planned and managed approach to the permanent closure of the hydrotherapy pool at Charing Cross Hospital in order to provide alternative forms of land-based therapy which safeguard the clinical care of our patients.

4.1 Patient impact

Currently, aquatic/hydrotherapy is one of several forms of treatment we offer patients referred to our musculoskeletal and pelvic health therapy service. The aquatic/hydrotherapy service at Charing Cross Hospital predominantly treats a mix of NHS patients, including those:

- with musculoskeletal conditions, for example, back and neck pain, other joint pain, soft tissue injuries
- recovering from post-orthopaedic surgery
- with rheumatology conditions
- suffering chronic pain.

In addition, a small number of women with pregnancy related pelvic or low back pain are treated in the hydrotherapy pool. Two private companies also hire the pool.

In 2018/19 we treated a total of 230 NHS patients in the hydrotherapy pool, compared to the 2017/18 total of 368 NHS patients. The majority of patients come from the eight north west London boroughs, although some patients are seen from outside north west London. On average, around 30 per cent of all patients are from the borough of Hammersmith & Fulham.

Clinical Commissioning Group	Patients	Contacts	New:Follow Up ratio
NHS BRENT CCG	28	107	1: 4
NHS CAMDEN CCG	1	2	1:2
NHS CENTRAL LONDON CCG	17	80	1:5
NHS EALING CCG	50	184	1:3.7
NHS HAMMERSMITH AND FULHAM CCG	72	254	1:3.5
NHS HARROW CCG	2	4	1:2
NHS HERTS VALLEY CCG	1	1	1:1
NHS HILLINGDON CCG	3	3	1:1
NHS HOUNSLOW CCG	23	83	1:3.6
NHS LEWISHAM CCG	1	7	1:7
NHS NEWHAM CCG	1	7	1:7
NHS RICHMOND CCG	4	16	1:4
NHS WANDSWORTH CCG	2	1	1:2
NHS WEST LONDON CCG	25	88	1:3.5
TOTAL	**230**	**837**	**1:3.6**

Table 1 – Charing Cross Hospital hydrotherapy pool patient numbers and contacts by CCG for 2018/19

However, the current evidence base for outcomes for patients of aquatic/hydrotherapy is inconclusive and, at best, supporting short term benefits only. Similar outcomes can be demonstrated when comparing aquatic/hydrotherapy with land-based therapy treatments and there is no evidence to suggest that aquatic/hydrotherapy is superior to land-based treatments.

4.2 Hydrotherapy pool standards
Hydrotherapy pools are required to operate to particular standards to ensure they are safe and effective. Recently updated national aquatic standards require pool air temperatures to be maintained at 25-30 degrees centigrade, as well as meeting stringent microbiology testing and providing a functioning hoist facility.

The Aquatic Therapy Association of Chartered Physiotherapists (ATACP) produced Guidance on Good Practice in Aquatic Physiotherapy (2015). The guidelines were reviewed in February 2018, with the following amended, based on Swimming Pool Water Treatment and Quality Standards (2017):

1.2 The ambient temperature in the pool hall is maintained within the range 25 to 30 degrees Celsius.
1.4 The atmospheric humidity level is maintained within the range 50 to 60% with a preferred maximum of 60%.
1.6 Disinfectant levels are maintained within the following parameters:
If disinfected using chlorine only:

- *Free chlorine within the range 0.5 to 3.0 parts per million (ppm) ideally 1-2ppm*
- *Total chlorine within the range 0.5 to 4.0 ppm*
- *Residual chlorine is never more than 1.0 ppm and is less than half the free level. 1.8 The total alkalinity is maintained within the range 80 to 200 ppm.*

1.9 The calcium hardness is maintained within the range 80 to 200 ppm.

4.3 Unplanned hydrotherapy pool closures
Over recent years, health and safety issues have led to repeated unplanned closures of the hydrotherapy pool, often at short notice and for prolonged periods, affecting the quality of care for patients and causing inconvenience to all users, resulting in increased complaints.

The root cause for these repeated closures is that, after many years of operation, the hydrotherapy pool is now in poor condition, making it very difficult to meet modern health and safety standards. Examples of specific reasons for recent closures and complaints include:

- failed microbiology tests resulting in the need for drainage and cleaning
- failed water analysis tests revealing water standards outside of safety parameters
- low air temperature poolside
- plant and pool equipment failure
- hoist failure.

4.4 Operational and financial impact
The impact of these issues has been that hospital-initiated rescheduling of appointments has increased, up from 7 per cent of all appointments in 2016/17 to 18 per cent in 2018/19. There continues to be a high risk of unplanned, repeated and indefinite closures of the pool on health and safety grounds in the coming financial year.

The service currently runs at a loss, even when the pool is fully functional, and the level of capital investment and on-going revenue required to bring the pool up to the required standard is very significant.

4.5 Our proposal

Our proposal therefore is to close the hydrotherapy pool at Charing Cross Hospital and replace the service it provides with land-based therapies. We have developed the proposal following a safety and effectiveness review prompted by the increasing challenge of maintaining and running the pool combined with evidence that land-based therapies produce very similar benefits to aquatic therapies.

We have undertaken a Quality Impact Assessment and Equality Impact Assessment which have raised no significant issues in terms of impact on quality, safety or groups with protected characteristics.

By closing the pool, our therapy staff will be able to provide more land-based therapy, increasing capacity and reducing waiting times across our wider therapy service for all patients. We will also be able to use the hydrotherapy pool space to provide expansion for other clinical services.

The land-based therapies which would be used to provide alternative, safe and effective care for hydrotherapy patients include:

- postural and ergonomic advice and back care education
- gait re-education to improve mobility
- manual therapy to mobilise the joints and soft tissue
- joint management
- strength training regimes
- teaching specific exercises to improve strength or flexibility
- functional task practice
- respiratory and cardiovascular exercise regimes
- self-management strategies and healthy lifestyle choices.

As noted above, the current evidence base for outcomes for patients of aquatic/hydrotherapy are inconclusive and, at best, support short term benefits only. Similar outcomes can be demonstrated when comparing aquatic/hydrotherapy with land-based therapy treatments. Thus therapy staff using the hydrotherapy pool to treat patients could re-allocate their time to provide land-based treatments, with the potential to create an additional 370 new patient and 2,500 follow up appointment slots per year. This additional capacity would help improve our routine waiting times for patients which currently involve delays of several weeks.

Two private companies also hire the pool in a private capacity each week: to teach babies/toddlers to swim; and to provide private aquatic/hydrotherapy for adults (see below). We would look to signpost these private users to alternative facilities, for example, baby swimming classes at Putney Leisure Centre or the hydrotherapy unit at Chelsea & Westminster Hospital.

A group of former NHS patients who have completed a course of hydrotherapy, and have been discharged from the service, use the hydrotherapy pool on a private basis weekly to continue exercising independently for a nominal fee We have contacted the Charing Cross Sports Club to inquire if this group can use their pool to continue exercising independently. Charing Cross Sports Club have responded favourably and are looking into suitable times to reserve an area of the pool weekly for this group. This pool operates at a water temperature of 29 degrees.

The key benefits to be gained from our proposal are to:

- increase physiotherapy outpatient capacity and reduce waiting times
- prevent poor service to both NHS and private users of the pool through repeated, unplanned and indefinite closures
- re-allocate the existing space occupied by the pool for alternative clinical space

- re-allocate estates resource from pool repairs to other important areas of hospital maintenance
- avoid recurring financial operating loss.

5. Summary and engagement activities

We believe this proposed change to our physiotherapy services is necessary in order to avoid unplanned and repeated disruption to patient care for health and safety reasons. A switch to all land-based therapies will enable us to improve patient experience and reduce waiting times for all therapy patients, without impacting on clinical outcomes.

The proposal has been developed by our physiotherapy service team and has gone through the required internal governance process before receiving assurance to proceed to external engagement by the Trust's executive team. Following discussion with the Hammersmith & Fulham clinical commissioning group (CCG), the proposal has also been considered at a meeting of the CCG's quality committee and the joint CCG-Trust clinical quality group.

As mentioned above, we have undertaken a Quality Impact Assessment and Equality Impact Assessment which have raised no significant issues in terms of impact on quality, safety or groups with protected characteristics.

In early March, our Trust chief executive Prof Tim Orchard wrote to the Chair of the Health, Inclusion and Social Care Policy and Accountability Committee to outline the proposal and the plan to seek the views of patients, carers, local residents and other stakeholders.

The Trust suggests that this proposal does not constitute a substantial development or variation to an existing clinical service which would be subject to a full formal public consultation. The proposal involves providing at least the same level of service, with the potential for additional appointment capacity, but in a different way on the same site location and stems from the safety, effectiveness and patient experience impacts of the unplanned, repeated and prolonged closures of the hydrotherapy pool.

We therefore planned our communications approach based on providing the necessary and appropriate level of information about the proposal to change the way the service is delivered, and to engage with patients, carers, local communities and other interested stakeholders over a period of at least four weeks.

We are raising awareness of our proposal and seeking comments and questions during March/April 2019 before reaching a decision, which subject to the feedback received, is expected in May 2019.

We are providing information via the Trust website, using social media channels, stakeholder emails and newsletters, distributing leaflets to patients explaining our proposal and organising four patient focus group meetings during April. We have also held meetings with our staff to explain the proposal and have written out to staff explaining the context and rationale, as well as the engagement process and timescales for reaching a decision.

We have also written to and organised meetings with the private users of the pool to inform them of the proposal and seek their feedback through the engagement process.

Following the conclusion of the engagement period, a further report to our executive team will provide a review of the engagement activities undertaken, the feedback we have received, and the outcomes of the engagement process on the physiotherapy proposal in order to enable a decision to be made.