London Borough of Hammersmith & Fulham

hammersmith & fulham

Health, Inclusion and Social Care Policy and Accountability Committee

Agenda

Monday 17 June 2019 at 7.00 pm
The Stephen Wiltshire Centre, Queensmill Road, SW6 6JR

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 Keith Mallinson, Healthwatch Jen Nightingale	

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Date Issued: 07 June 2019

London Borough of Hammersmith & Fulham

Health, Inclusion and Social Care Policy and Accountability Committee
Agenda

17 June 2019

Item		Pages
1.	**APPOINTMENT OF VICE-CHAIR FOR 2019-20 AND COMMITTEE TERMS OF REFERENCE**	5 - 8
2.	**APPOINTMENT OF CO-OPTEES**	

The following co-optees have been nominated for the municipal year 2019/20:

Victoria Brignell (Action On Disability)
Jim Grealy (Save Our Hospitals)
Keith Mallinson (Healthwatch)
Jen Nightingale

3. **APOLOGIES FOR ABSENCE**

4. **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.

5. MINUTES OF THE PREVIOUS MEETING 9 - 17

(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 24 April 2019.

(b) To note the outstanding actions.

6. UPDATE FROM THE STRATEGIC DIRECTOR OF SOCIAL CARE

Verbal update from the Strategic Director of Social Care, Lisa Redfern.

7. UPDATE FROM HEALTHWATCH 18 - 23

This report provides an update on Healthwatch activities.

8. UPDATE FROM NORTH WEST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE 24 - 32

9. UPDATE FROM SAVE OUR HOSPITALS

Verbal update from representatives of Save Our Hospitals.

10. WORK PROGRAMME 33 - 34

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

11. DATES OF FUTURE MEETINGS

11 September 2019
11 November 2019
27 January 2020
24 March 2020

12. 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.

13. EXEMPT MINUTES OF THE PREVIOUS MEETING 35 - 39

To agree the exempt minutes of the meeting held on 24 April 2019.

London Borough of Hammersmith & Fulham HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY & ACCOUNTABILITY COMMITTEE 17JUNE 2019	h&f hammersmith & fulham
COMMITTEE MEMBERSHIP 2019/20, APPOINTMENT OF VICE CHAIR AND TERMS OF REFERENCE	
Report of the Monitoring Officer – Rhian Davies	
Open Report	
Classification - For Information **Key Decision: No**	
Wards Affected: All	
Accountable Officer: Rhian Davies	
Report Author: Kayode Adewumi – Head of Governance and Scrutiny	**Contact Details:** Tel: 020 8753 2499 Email – kayode.adewumi@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. This report sets out the new membership of this Committee and its terms of reference, as agreed at the Annual Council on 15 May 2019.

2. RECOMMENDATIONS

2.1. The Committee is asked to note its membership and terms of reference.

2.2. To note the Committee's terms of reference and membership and to appoint a Vice-chair for the 2019/20 municipal year.

3. INTRODUCTION

3.1. The Council agreed the membership and terms of reference at the Annual Council Meeting held on 15 May 2019.

4. MEMBERSHIP

4.1. The membership of this committee is as follows:

Councillor Lucy Richardson, Chair
Councillor Jonathan Caleb-Landy
Councillor Bora Kwon
Councillor Amanda Lloyd-Harris
Councillor Mercy Umeh

5. TERMS OF REFERENCE

5.1. Policy & Accountability Committees (PACs) will develop key policies for the Council on behalf of and with residents and community groups and hold the Executive to account.

5.2. All PACs will discharge the relevant statutory functions within the scope of the Committee.

5.3. All PACs will have the following key responsibilities:

- To hold the Cabinet to account
- To be a critical friend to the Cabinet and to challenge the assumptions behind the policies and actions of the Council and other local service providers
- To amplify the voice and concerns of local residents and to give residents a mechanism to comment on, participate in and determine Council policy
- To improve the Council's services by listening to residents and user groups
- To scrutinise decisions made by partner organisations in the interest of the residents of the Borough
- To be independent of party politics and ensure an informed evidence-based approach to policy development

5.4 PACs may also co-opt non-voting additional members to ensure residents and users' groups are fully represented. Only statutory co-optees will have voting rights. All co-opted members will be able to participate fully in all meetings and have the same access to information as elected members.

5.5 Each PAC will maintain a work programme of policies and issues identified by the PAC members to be investigated, analysed and understood prior to making recommendations to decision-makers. PACs may receive evidence from experts and user groups either in writing in advance or verbally at meetings.

5.6 All PACs may compel Council officers and Executive members to attend meetings as required and can expect to receive written evidence as requested.

5.7 Where appropriate, PAC members may conduct research outside of formal meetings and make site visits as required.

5.8 When considering major cross-cutting issues that impact upon the work of more than one PAC, PACs may meet concurrently to receive evidence in a joint session. Following such meetings, reports may be published as joint reports or as separate responses. Alternatively, for major cross-cutting issues that impact the work of more than one PAC or require detailed attention, PACs may appoint sub-committees or task groups to examine the particular issue.

5.9 Overview and Scrutiny Committees will be known in Hammersmith & Fulham as the PACs.

5.10 Health, Inclusion and Social Care Policy & Accountability Committee, Terms of Reference are as set out below and are taken from the Council Constitution, as agreed a Full Council, 15 May 2019:

Members
5 voting Councillors

Quorum
3 Members of the Committee

Political proportionality
4 Administration Members
1 Opposition Members

Co-opted Members
Up to 5 non-voting members

Principal Functions
All the powers of an Overview and Scrutiny Committee as set out in section 21 of the Local Government Act 2000 and Local Government and Public Involvement in Health Act 2007, in particular:

- To discharge functions under the Health and Social Care Act 2001
- To discharge any functions under the Health and Social Care Act 2012 and any subsequent regulations
- To develop policy within the scope of the Committee and make recommendations to the Cabinet
- Monitor the administration and spending in services within its scope
- To review the impact of decisions and policies implemented by the Council
- Lead responsibility for scrutinising the relevant Cabinet Members(s).

Scope:
- Health of both children and adults (including public health)
- The provision, maintenance and improvement of primary and acute NHS services in the borough
- The provision of mental health services in the borough
- Adult social care services in the borough, including the exercise of statutory responsibilities in relation to the scrutiny of health as set out in Article 6 and also the voluntary and community sector

- The Council’s equalities and diversity programmes and support for vulnerable groups.
- Council and other out-of-school services for youth in the Borough
- The Council’s Voluntary Sector strategy
- Increasing access to opportunity in all aspects of social and economic life in the borough
- Other policies and initiatives supporting social inclusion in the borough
- Commissioning
- Any other matter allocated by the Finance, Commercial Revenue and Contracts PAC

BACKGROUND PAPERS USED IN PREPARING THIS REPORT - None

London Borough of Hammersmith & Fulham

Health, Inclusion and Social Care Policy and Accountability Committee

Minutes

Wednesday 24 April 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), Bryan Naylor (Age UK) and Jen Nightingale

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

Officers: Toby Hyde, Integrated Care Programme Director (Interim), Imperial College Healthcare NHS Trust; Lisa Redfern, Strategic Director of Social Care; Shona Maxwell, Chief of Staff, Office of the Medical Director, Imperial College Healthcare NHS Trust; Professor Julian Redhead, Imperial College Healthcare NHS Trust; Elaine Sheerin | Acting Clinical Service Lead, Outpatients, Therapies, Imperial College Healthcare NHS Trust

1. MINUTES OF THE PREVIOUS MEETING

That the minutes of the previous meeting held on 26th March 2019 be agreed.

2. APOLOGIES FOR ABSENCE

None.

3. DECLARATION OF INTEREST

Councillor Ben Coleman expressed a declaration of interest in respect of Agenda Item 5, as a former school governor of Jack Tizard Primary School.

4. IMPERIAL COLLEGE HEALTHCARE NHS TRUST - DRAFT QUALITY ACCOUNT 2018-19

Discussion of this item was entirely exempt and appears in the exempt minutes of the meeting.

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.

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

Councillor Richardson welcomed Toby Hyde and colleagues from Imperial. Imperial employ 140 qualified and unqualified physiotherapists, across the Trusts five sites. An inpatient and outpatient service is provided, ranging from acute care, to rehabilitation, hand therapy, musculoskeletal, for all age groups. The hydrotherapy pool was part of the outpatient's service and had approximately 22 staff members (an exact figure would include part-time staff).

It was explained that the referral process worked in two ways. Within the hospital, a patient could be referred by their consultant. Outside the trust, a patient can be referred by their GP. If a patient's condition was urgent it could be red flagged, for example rheumatoid arthritis or a musculoskeletal condition. Such referrals would be to a consultant, with a recommendation to the outpatient service. The service could only accept patients through the referral process, and not a direct referral from a GP.

All patients received an initial assessment at their first appointment. Following assessment, a treatment plan was agreed. There were several types of treatment. "Land based" exercises included fitness classes, exercise using weights and work with physiotherapists. The hydrotherapy service was based at Charing Cross with 3 part-time staff members. There were three half-day sessions per week, which equated to one full-time staff member*.

The hydrotherapy service predominantly treated post-operative patients who usually experienced chronic pain from conditions such as fibromyalgia. The Trust indicated that there were benefits to patients in terms of pain relief, improved range of movement, improved muscle tone and improved quality of life. However, while this was difficult to evidence as the true benefit of the of the therapy could not be ascertained; it was found that there was no discernible difference in benefit between the two different types of provision.

The Trust proposed that the staff members that currently work in pool be redeployed. They could be assigned an increased number of patients, and there could be a corresponding increase in the number of classes. This would also allow for a smoother transition in terms of post-operative care and greater consistency in treatment.

The intermittent closure of the pool resulted in an increased rate of cancelled appointments because of issues with the pool. The rate of cancelled appointments had increased from 7% to 18%. This had an impact on patient care, so that it could take longer to reach improvement targets, given the inevitable gaps between appointments, which became more staggered as a consequence.

The Trust reported that it had gone through assurance and governance protocols. The consultation had been agreed, a quality improvement programme assessment had also been undertaken. The Trust had written to the Chair of the PAC in March, to inform of her of the intention to engage with

stakeholders. The Trust had publicised the consultation using social media and leaflets and planned to hold patient focus group meetings. The Trust had also written to private pool users and planned to meet with them over the coming weeks.
Councillor Coleman reported that the trusts CEO Prof. Tim Orchard had confirmed that that the consultation could be extended and that a final decision could be reached in June.

Councillor Amanda Lloyd-Harris observed that there were clearly some benefits to hydrotherapy and asked if this had changed and the evidence for this. This would suggest that there were insufficient metrics to clearly indicate the benefits. In which case, was the proposed change attributed to maintenance issues and cost-cutting.

Elaine Sheerin explained that there was evidence to indicated that hydrotherapy was beneficial but of poor quality, so that the results were limited. For the benefits to be properly evaluated, highly controlled, robust and rigorous trials were required. Globally, there were hydrotherapy services in the departments of some trusts, but not available in all, which may reflect the lack of robust evidence. Toby Hyde confirmed that the closure of the service would save little money, as there was no proposed change to the number of staff as they would be redeployed. It would cost approximately £400,000 to renovate the facility to the required standard (exact figures to be provided).

Lisa Redfern felt that the content of the papers was unclear in terms of what outcomes were being sought from the consultation. She enquired about what was the Trust seeking to achieve and what the focus of the consultation was. On the one hand, the Trust was trying to close the pool, and had commented on how ineffective it was. She asked if the Trust was trying to improve the service, and if so, this needed be more clearly articulated. The figure of approximate £400,000 for renovation required further context. The Trust had not commented about making savings, but it was suggested that residents will naturally reach this conclusion. If the Trust was not planning to make savings, then this needed to be more clearly articulated in the report, given the complexity of the issues being presented. If the Trust was saying that hydrotherapy had no benefits, then it was felt that this point should have been highlighted much earlier. This was not a new service. This issue was about service improvement, savings and estates.

Commenting further, Lisa Redfern expressed concern about the terminology used to describe physiotherapy such as “land-based”, which she felt was inappropriate and dated terminology. It was also unclear how many people were aware of the facility, the evidence of usage and context. The report required clearer language as it was unclear what was being communicated.

Toby Hyde welcomed the feedback and explained that the terms used were intended to make the service distinguishable from hydrotherapy. He stated that the key issue was a question of the estate. The Trust had some fantastic physiotherapists and wanted to make the most efficient use of this resource. The issue was also about how many staff were needed in the pool, and, partly

about redeploying them to other physiotherapy services. This would allow the pool facility space to be repurposed.

A local GP commented that there was confusion about the proposed closure and the evidence base, although he recognised that it was difficult to evidence benefits. Hydrotherapy did help with giving better pain relief, with shorter hospital stays, being able walking further, walking up staircases, were positive outcomes. He asked about the percentage of patients that made it to hydrotherapy. He reported that he had never had a patient offered this service since 2009. He said that he would be interested in hearing about the numbers who had received hydrotherapy, the conditions treated and who these patients were. Elaine Sheerin explained that shed did not dispute that there was evidence, just that it was not superior to “land-based” physiotherapy. The issue was linked to the building estates. Pool was not fit for purpose, and the Trust did not want to enforce closure. The pool was currently closed for a month due to issue with a pump. The question of closing the pool was weighted against other priorities in the estate. Post-operative patients with hip replacements used the hydrotherapy pool and hydrotherapy was not offered to all patients. The service received approximately 6000 referrals, with 20-30% of patients being treated, amounting to 320 patients in the past year.

Lisa Redfern sought more detail about patient numbers and observed that the figure had declined from the previous financial year. It was explained that there had been staff changes and repeated pool closures and that staff did not have confidence in the condition of the estate. LR felt the figures given were misleading and that there was demand for the service. The presentation of the report does not clearly explain what the service offers.

The local GP commented that Trust appeared to be winding down service. He reported that he had a list of ten patients who would benefit immediately from the service. Toby Hyde confirmed that the Trust had no intention to wind down the service. The current issue was to do with concerns about the estate and the unplanned, cancelled appointments that resulted. Fewer referrals were made for this reason, offered with the caveat that the appointment may be cancelled without notice.

Jim Grealy commented that the Trust had indicated that they did not want to lose estate space and asked what the plans were for the space, if the pool was to be closed. Toby Hyde explained that the pool, located on the ground floor, was prime real estate. This offered a whole range of potential options, which would be reviewed and considered. It was unlikely to be repurposed as a ward but could be used to provide an outpatient clinic. The Trust will need to consider all the options, and individual departments would need to bid for the space, which will be determined by the Trusts Board. Jim Grealy responded that this would not be a cost neutral exercise, money would divert to setting up a new department or clinic. It was explained that the pool cost £100,000 to maintain, and that it would cost an estimated £90,000 to refurbish.

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Keith Mallinson outlined the case of a client who was referred for hydrotherapy, and who was informed that the consultant could not refer him as the pool was closed. He was advised that he should attend Northwick Park. This will be difficult, given the distance he will need to travel. He asked what alternative, local provision might be available and referred to the views in European countries such as Hungary and Czechoslovakia, as to the positive benefits of hydrotherapy. Elaine Sheerin responded that the Trust had initiated discussions with a local sports club to use their facilities. The water temperature however, was slightly cooler. They also hoped to make referrals to Chelsea and Westminster Hospital NHS Trust and were also trying to engage with Jack Tizard primary school. It was also confirmed that they could only accept referrals from within the Trust and not externally.

Keith Mallinson clarified that his client was an outpatient at Charing Cross, and reminded the Trust that the local GP had indicated that he was not aware of what was available due to the lack of information about the service. Northwick Park was clearly a very difficult option for those in pain. It was accepted that there might be patients who will want to continue to use the pool and this was being explored. The Trust also hoped to find a warmer pool for the mother and toddler private pool session.

Councillor Coleman commented that residents will be losing a valuable resource despite the alternatives that the Trust was exploring. Given the benefits of hydrotherapy, he asked if there was a strategy to map out alternative provision. Elaine Sheerin responded that the redeployment of staff would allow the creation of more appointment slots for patients and reduce waiting times from 8 to 6 weeks. In terms of follow ups, certain new patients may have to wait 3 weeks. It was hoped that this would be reduced to two weeks, with an increased number of general classes introduced, again to reduce waiting times.

Victoria Brignell reported that she had received hydrotherapy for five years, which had been a huge benefit. Paid users would indicate that there was some value to the facility. Guys and St Thomas NHS Foundation Trust maintained a facility, and she queried why the Trust was unable to do the same, and that this essentially came down to a matter of costs. Toby Hyde said that the fundamental issue was around the condition of the estate, which was in a poor state of repair. Guys and St Thomas had better maintained estates and facilities. He confirmed that to have the pool open and reliable, would cost approximately £400,000 and would also intensely utilise physio staff. It was reasonable that the staff be redeployed.

Bryan Naylor commented on the beneficial aspects of hydrotherapy, about which there was a wealth of information. Hydrotherapy was invaluable for a particular cohort. For some older, disabled patients, water therapy offered a short period of being pain free. The therapy helped slow down the onset of the issues that older people were likely to experience. This made life bearable for older and disabled people with long term conditions. He asked the Trust to explain the work undertaken to ensure that this particular group was not adversely affected, compared to the rest of the community. Elaine Sheerin confirmed that the Trust did not specifically look at the elderly, as a

group. They had considered patients that were at Charing Cross, those with e.g., fibromyalgia etc. It was recognised that for certain patient groups, hydrotherapy was very beneficial, and that this was not disputed. There was some reported benefit, but the key outcome was improved quality of life measurement, rather than an analysis of patient benefit. In considering this, there was no obvious advantage.

Councillor Caleb-Landy also indicated confusion as to the proposed service changes. There was no strategic context provided to understand where the service was going and no indication as to what the benefit to patients might be. The facility had been neglected in recent years and the estate management needed to be looked at. The report should have considered the benefit and the context, and Councillor Caleb-Landy struggled to see the proposals as anything other than another attempt to cut services. Toby Hyde welcomed the feedback and accepted that the Trust needed to understand how to better frame the proposals. The intention had been to improve the utilisation of existing staff and make more effective use of the staff resources.

A member of the public who had used the hydrotherapy services explained that it was very difficult to access but was of great benefit to her in terms of alleviating her condition. There were in her view, not enough hydrotherapy pools accessible in London. There were however, many places to access physiotherapy and so the proposal would further restrict access. Elaine Sheering clarified that Guys and St Thomas offered hydrotherapy and were able to justify retaining the service, and Councillor Caleb-Landy echoed earlier points, questioning why Imperial were unable to make the same commitment when there was clearly a case for keeping the pool. He suggested that the service could be self-funding and that Imperial should further explore commercial options in order to make the service sustainable and viable from a cost perspective. Elaine Sheering responded that the Trust had tried for five years to make the service self-funding, hiring out the pool privately, publicising paid sessions and so on. However, due to repeated closures and cancellations, the service struggled to generate income and self-supporting

A member of the public countered that if the facility was refurbished, it would require lower maintenance costs. There was a long waiting list for private sessions. A cost benefit analysis would demonstrate the value of continuing the service and help develop options for an outline business case. Councillor Richardson commented that there was a need for greater detail and clarity around the figures in order to properly respond to the consultation.

Olivia Clymer (Healthwatch) expressed concern about the capacity of the service and the patient journey. Healthwatch had received a number of calls about the possible pool closure and about not being able to access the pool. She sought clarity about whether the key issue was capacity or commissioning related. Toby Hyde responded that all therapies were commissioned by CCG on a block basis and was not paid for on a case by case basis. Altering this would have implications about how the Trust could use the facility in future.

Jim Grealy invited the Trust to maintain an open mind about the financial and business case options being suggested. The pool required money to bring up to standard. There was a valuable benefit in having the service, but no connection was made with what this meant for a service user. Why would someone in pain, be sent such a distance, unless it would benefit them. There was nothing specific or evidence based in the report that would make sense. The report needed to explain that people were being sent a long way to use alternative pools. Otherwise there was a failure to present a strong enough case. The lack of clarity arose from the fact that two different cases were being presented, one was financial and the other focusing on the medical benefit, and these did not match. Toby Hyde responded that there was a finite cost to supporting the hydrotherapy service and that needed to be balanced against the cost of intervention, and against value for money. The Trust would not propose this without thinking through evidence base and would think that the physiotherapy would benefit from the changes being proposed.

Cllr Amanda Lloyd-Harris commented that the evidence was subjective. The NHS was now prepared to accept Cognitive Behaviour Therapy as a valid therapy of choice, and this was deemed to be evidenced in terms of success rates. She therefore queried why this was acceptable for one part of the NHS but not the other and asked if this was an issue of take up and referral. Elaine Sheering confirmed that there was a link between the evidence base and finance. Toby Hyde added that there may be an additional demand for hydrotherapy but that the key issue was whether this was the best use of finite physiotherapy resources. The waiting list had increased, and pool closures were largely attributed to issues with the pump and microbe levels in the water, so the pool could not be used safely.

Councillor Coleman sought clarity on the figures provided. It was noted that £100,000 cost of maintenance would be redirected into physiotherapy services and the staff redeployed. Currently, there were 22 members of staff (it was later clarified that a portion of the 22 staff had additional, specialised roles, which equated to 15 full time equivalents). The Trust touched on staffing issues, waiting times. The paper had provided a starting point however, Councillor Coleman felt that for purposes of the discussion this did not go far enough. The quality of the paper lacked depth and did not provide sufficient evidence. The Trust had tried to shut the pool in 2013 and it was subsequently reopened in 2014 and he expressed the view that the Trust had run the service down. Councillor Coleman recommended that the Trust rewrote the paper and that the consultation be withdrawn. It was suggested that the Trust returned to the committee with a revised paper which would address the absence of information about physiotherapy. If this was a commissioning issue or a matter of finance, then the Trust needed to make this argument more clearly. Councillor Coleman sought confirmation that the Trust would return to the Committee with more detailed proposals that aimed to explain the cuts in hydrotherapy services. Toby Hyde welcomed Councillor Colemans comments and feedback. He indicated that they would consider the report and presentation and would be considering next steps.

Councillor Coleman commented that the proposed service change constituted a substantial variation and therefore required the NHS to consult the Council on whether this was the case, before any formal consultation, in accordance with NHS guidance. He requested reassurance that the Trust will return to the Council to form a view on any proposed changes in future, as to whether a service change constitutes a substantial variation. Professor Julian Redhead responded that he held a strong belief that the way forward was to continue to engage in joint dialogue and that he would feed this back to the Board.

Councillor Richardson felt that there was insufficient evidence provided to reach an informed conclusion. More detailed evidence was needed to help determine whether the cut in service constituted a substantial variation. It was noted that Councillor Richardson would write to the Trust on behalf of the Committee and anticipated that Trust would for further discussion about this issue.

Councillor Richardson thanked residents for supporting Charing Cross and that the Committee and residents must ensure that they continued to fight for services.

RESOLVED

1. That the Chair of the Committee write to the Trust setting out the Committee's response to the consultation; and

2. That the report be noted.

6. DATES OF FUTURE MEETINGS

The date of the next meeting was noted as 17 June 2019.

7. EXCLUSION OF THE PRESS AND PUBLIC

RESOLVED
That 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)

Discussion of this item was entirely exempt and can be found in the exempt minutes.

Meeting started: 6pm
Meeting ended: 9.30pm

Chair ....

Contact officer: Bathsheba Mall
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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.

London Borough of Hammersmith & Fulham HEALTH, INCLUSION AND SOCIAL CARE POLICY & ACCOUNTABILITY 17 June 2019	h&f hammersmith & fulham
HEALTHWATCH UPDATE - HAMMERSMITH AND FULHAM	
Open Report	
Classification: External Report for Policy & Accountability Review & Comment **Key Decision: No**	
Wards Affected: ALL	
Accountable Executive Director: N/A **Keith Mallinson Chair Healthwatch Hammersmith & Fulham**	
Report Author: Olivia Clymer Chief Executive officer, Healthwatch,	**Contact Details:** Tel: 0208 968 7049 E-mail: olivia.clymer@healthwatchcentralwest london.org

1. EXECUTIVE SUMMARY

1.1 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.

2. Healthwatch CWL and Healthwatch H&F Local Committee Response to H&F CCG Primary and Urgent Care Consultation that closed on 24th May.

2.1. Healthwatch H&F Local Committee had input in the design of the consultation document during the pre-consultation period through meetings with CCG representatives. The meetings aimed to ensure that the document is written in clear and simple language, jargon free, provides the necessary information and its design is user friendly. We welcomed that H&F CCG took our recommendations into account in the final consultation document.

Healthwatch CWL and its Committee put together a formal response to the consultation. Key points included:

a) Opposition to the suggested changes for specific reasons such as a lack of knowledge of how to access GP Hubs and the Urgent Care Centre
b) Need to address the bureaucratic existing system of accessing GP Hubs services. Patients have raised time and time again the difficulty of booking a GP appointment in general.
c) Concerns about how the suggested changes will fit into the wider healthcare landscape both locally and nationally with the upcoming changes with the reconfiguration of the Primary Care Networks.

3. Healthwatch Central West London (HWCWL) Engagement on the NHS Long Term Plan

3.1. HWCWL were asked to engage the public in shaping the local delivery of the NHS Long Term Plan through raising awareness of the changes that are due to take place in the NHS and by encouraging members of the public to share their views and ideas by completing the 'WhatWouldYouDo' survey designed by Healthwatch England.

3.2. HWCWL were also commissioned to undertake 6 discussion groups (2 in each Borough) to gather feedback from local people across six key topics that were outlined in the NHS Long Term Plan.

3.3. The tables below show key points from the 2 discussion groups that took place in Hammersmith and Fulham (one general and on specific on mental health) according to patient experience. Further information and comments are available on request until a full report is compiled.

Table 1: Sharing Good, Average or Poor Experiences with local Mental Health services

Good Experiences	*OK Experiences*	*Poor Experiences*
Staff efficiency: • Reception staff and duty officer at Claybrook centre considered to be constructive and knowledgeable. • Personal touch from GPs – one participant said: "she hugged me". However, ultimately was unable to help in any meaningful way, see 'OK' experiences.	Digital Technology: Digital technology was seen as a good way to make online appointments but there is not enough direct marketing of the service.	Assessment and treatment • Ten minute consultation period not sufficient • Staff are cold towards families and carers on the wards • Wards lack quiet space for recovery and respite • Little or no structure in group therapy sessions for the most vulnerable Coordination of services • Since 2013, patients have been referred for Cognitive Behavioural Therapy then to secondary care and then on to primary care – there seems to be an issue with information not being

• Reports of attentive and thoughtful psychiatrists at the Child and Adolescent Mental Health Services (CAMHS) • GP admitted gap in Mental Health knowledge and expressed willingness to learn more and also in alternative therapies such as music therapy.		sorted/archived correctly. • Postcodes lottery for treatment of mental health conditions is very difficult when dealing with it within the family, for example, an individual living in a particular borough not being able to access services in other boroughs. • **Misinformation:** removing Urgent Care Centres – there is a perception that authorities don't want people to know that they are primary care.
Access to services • Able to access Crisis Team very quickly and staff were knowledgeable and offered constructive help. • 'Back on Track' self-referral allows service users to take control of their own care.	Engagement and Information Access to Single Point of Access (SPA) considered to be a necessary lifeline in times of crisis for patients but it isn't enough by itself.	Crisis • No place of safety in moments of crisis • No access to peer support in moments of crisis. Lack of services • When Claybrook centre closes at the weekend, there is no other option for care, other than A&E. • Two-year training courses and online talks - all that is available, and only in certain boroughs.
Public Sector Training Schools and councils are taking it more seriously and Police training has improved. There is tangible evidence that officers have more awareness in relation to Mental Health.	Mental Health: There was a perception that Hammersmith & Fulham was providing inferior Mental Health, recovery and college best practices to surrounding boroughs, with Camden, Westminster, RBKC and Brent cited as examples.	Lack of training: There seems to be a lack of consistency in expertise, perhaps due to an issue with training

Proactive collaboration Service users have worked together to create a network to seek out help from charities where there are gaps in the NHS.	**Ongoing care** Recovery hub is brilliant, but they haven't done anything else. There was also regret expressed for the lack of funding for Mind services like 'Heads Up'.	**Priorities** • Not obvious that the public's health and wellbeing is number one priority for commissioners. • There have been calls for more focus on Mental Health in physical care , but health professionals need to buy in to the idea in order for progress to happen.
		Power imbalance Huge cultural issue – Mental Health still stigmatised by the government and people in powerful positions and these are the people who determine outcomes for marginalised people.

Table 2: Sharing Good, Average or Poor Experiences with local health and social care services

Good Experiences	*OK Experiences*	*Poor Experiences*
Digital Technology: Considered to be a positive element of NHS services, although there was also consensus that technologies are being under-utilised in local NHS services (see "OK" experiences).	**Digital Technology:** Digital Technology was considered to not be meeting its full potential: *"Algorithms are double edged"*, with the current focus on monitoring still missing the opportunity to proactively use the data to target or treat certain conditions. GP Online was considered a good service, but there were frustrations that this was *"the only way of getting an appointment."*	**Communication:** • Lack of communication between health professionals puts the onus on carers to connect different members of a care support network. • Staff are pushed for time and are using the facilities at a basic level rather than expertly **Time Constraints:** • Assessments often made after a snapshot appointment • Patients and NHS staff need to better understand and communicate treatment pathways
The recent response to the proposed closure of **Charing Cross Hospital** was celebrated, and participants also gave examples of positive experiences with accessing **Moorfield**	**Feedback and Listening:** Receptiveness of healthcare professionals (Head of Services) when addressing concerns for autism, learning disabilities and bipolar disorder.	**Marginalised groups still overlooked:** • No mention of rough sleepers in the LTP • People from socially deprived groups "lost in the system" • Wide-reaching implications when a service user is someone who is a danger to herself

services.		• Lack of support for relatives of with depressed/anxious/suicidal people can exacerbate their belief that they are a burden. **Lack of Support:** • Poor or non-existent post diagnostic support for ADHD, bipolar, autism etc. • Nobody wants to volunteer/do unpaid care work for MH or complex needs; pressure on unpaid carers. • Patients have been "told to their faces" that the reason for being denied care was the financial cost
In an example of non-local best practice, **SLaM (South London and Maudsley NHS Foundation Trust)** was suggested as a model of effective street triage that recognises the parity of mental and physical health that the NHS LTP seeks to reflect.	**Mental Health:** There was a perception that Hammersmith & Fulham was providing inferior Mental Health, recovery and college best practices to surrounding boroughs, with Camden, Westminster, RBKC and Brent cited as examples.	**Lack of Continuity:** • The central booking system should offer parents and their children a "true choice" for the right treatment, and that she found it to be insufficient and incompetent. • Different health professionals "all ignore each other" and "no one follows the plan."

3.3. HWCL was commissioned to lead this piece of work across North West London. The engagement took place during March-May 2019. We are in the process of collating all the evidence gathered and a report will be published in June/July 2019. It will be available via our website and will be sent to all stakeholders.

4. Update on Healthwatch Central West London (HWCWL) project work activity in H&F

4.1 We worked on a project to enable young people in H&F to have a say on:

a) how and 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.

4.2. Methodology:

a) We launched the project of "what do young people want from digital healthcare" in summer 2018, by testing out a series of questions that we put together based on the information gathered at the desktop research. We tested one single question each two weeks in different places such as (Parsons Green Fair, Phoenix Gym etc).

b) This has led to the construction of a baseline survey that was circulate via partner organisations and through outreach at West London College in autumn 2018. We received 72 responses with most responses from 16-21 years old.
c) We have conducted 4 focus groups with the Youth Council, Youth Action on Disability, local group organised by Community Organiser at Sobus and St Andrews Fulham Church with a total of 32 participants aged 11-21 years. We used a creative visual approach for the focus groups that was mainly focused on two “exercises”: a) discussing pictures of health issues and b) drawing health journeys. For the picture exercise we used photos selected by 2 students aged 16 from Kensington Academy that did their one-week work experience with us in autumn 2018. We found that for the young people we engaged with using pictures to discuss health issues was a fun and engaging way to collect their views. For the second exercise on “drawing health journeys” we provided young people with pens and post-it notes, as well as pictures of possible health places to use to stick to show us the steps they take when they have a health issue. This worked specifically well for the young people with disabilities and for the young people that were more interested in accessing health services.

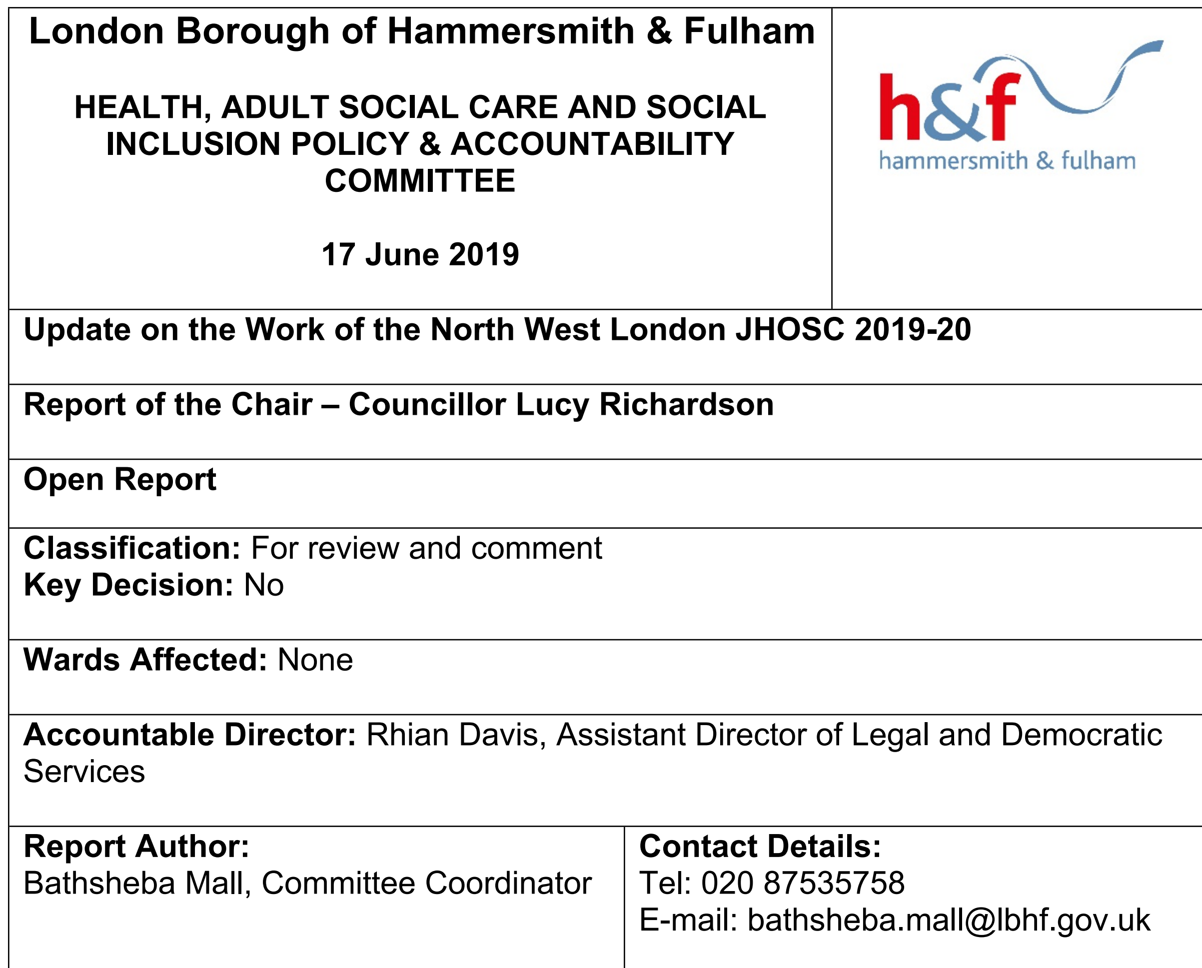
4.3 Initial findings show that the young people that we spoke to show that:

a) The use of digital technology is not necessarily linked with health
b) Self-care and patient empowerment through knowledge and information provide opportunities for digital interventions.
c) A combination of traditional and digital approaches is needed to address wider healthcare needs.
d) There are concerns about receiving wrong information when searching online (i.e. symptoms checking) and providing personal information.
e) A series of great ideas of how specific needs can be supported by using digital technology through applications have been identified.

4.4 Current and next steps**:**

a) We presented the initial findings of our project work to the Digital Health and Care Congress in May 2019 at Kings Fund and received very good comments. The presentation is available on our website.
b) The full report will be ready in June/July 2019 and will be sharing it with key partners to influence and support future commissioning of digital offers in the Borough and across NW London
c) Along with the report we will be publishing an engagement toolkit on how to involve people in discussions around digital health that was developed throughout the course of this project and was further tested at the NHS Long Term Plan workshop in Westminster with young people.

Agenda Item 8



London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY & ACCOUNTABILITY COMMITTEE** **17 June 2019**	h&f hammersmith & fulham
Update on the Work of the North West London JHOSC 2019-20	
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 consider the feedback provided to the North West London JHOSC, as attached in Appendix 1. The Appendix covers a range of topics considered by the JHOSC in the previous municipal year, how affective scrutiny has been and potential areas for discussion for 2019/20.

2. RECOMMENDATION

1.2. The Committee is asked to consider the proposed draft 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 – NW London JHOSC Annual Review Workshop

JHOSC Annual Review Workshop: NHS North West London CCGs submission

This document answers the seven questions put to NHS North West London CCGs to feed into the JHOSC Annual Review Workshop 2019.

1. In your opinion, how has the JHOSC worked this year? To what extent has it been outcome focused and looked at cross-cutting issues, including general health improvement, wellbeing and health inequalities?

- The JHOSC has worked relatively well over the past year. Mark Easton feels we are building an open dialogue where there is a **degree of trust** between the members and the senior representatives of the NHS.
- Regarding the second part of the question, Mark does not recall these three issues as being a particular focus for the committee because there has been a lot to discuss in terms of new commissioning arrangements and joint committee, Shaping a Healthier Future (SaHF), and financial challenges.

2. What could we change or do differently?

- We do feel that health scrutiny in North West London would be more effective if the committee frames its business in a way that is **more clearly defined around NHS priorities**.
- We recognise that there are occasions when individual members with particular areas of interest will sometimes wish to scrutinise NHS commissioning decisions in relation to these issues at a pan-North West London level. While the committee can seek to scrutinise any area of health commissioning policy it wishes, we would suggest that it may be more fruitful in terms of obtaining the right information to approach local **CCG leadership in the first instance**, or raising **local issues at the borough-level Overview and Scrutiny Committees** (or equivalent forums) when they are not in reference to Joint Committee and/or transformational programmes of work.
- While we do recognise that under national guidance, local authority health scrutiny committees have a "legitimate role in proactively seeking information," it is our view that the committee itself isn't always the most suitable forum for information-seeking. It is always worth considering c**arefully whether in each instance it is likely to be the most effective channel** through which to obtain the particular information you need. In the instances where JHOSC is indeed the most appropriate forum to request factual and/or detailed answers, advance notice would be likely to produce a more informed response.
- It would be useful to have greater **clarity in how the discussions from JHOSC feed back into each of the participating borough councils**.

3. How effective are the JHOSC committee meetings in getting to the heart of issues and problems in health policy?

- Generally the meetings achieve this.
- It is useful that the national scrutiny guidance explicitly calls upon scrutiny committees to consider the i**mpact of NHS proposals on sustainability as well as quality and safety**, as it means that the local authority and the NHS are measuring/assessing our work against the same objectives.

4. Are the lines of questioning and discussion helpful in clarifying issues?

- On the whole, yes.
- The role of the Chair as a trusted mediator is essential in ensuring that this aspect of JHOSC remains productive.

5. Have the JHOSC topics been relevant and timely?

- Yes.
- In terms of timescales, the Joint Committee will agree a future work programme for the year at our July meeting. We will share this with the JHOSC and look forward to **aligning our two work programmes**. Although our full work programme is not yet available, in our answer to question seven, we have suggested topics based on the month they are likely to be discussed by the Joint Committee.
- In terms of topics, we acknowledge that the JHOSC (and local OSCs) are explicitly given the power to scrutinise CCG finances. There are some financial challenges which are unique to the NHS, and some which the local authorities will, to a certain extent, share. At present, it does seem as if we often **receive impromptu or reactive requests for finance information**. Where our scrutiny partners wish to scrutinise CCG finances, we are open to discussing ways of developing a **more systematic approach** to this. As the CCGs in NWL work ever-more closely together, it would be sensible for the JHOSC to be involved in the scrutiny of our NWL finances, as well as local OSCs

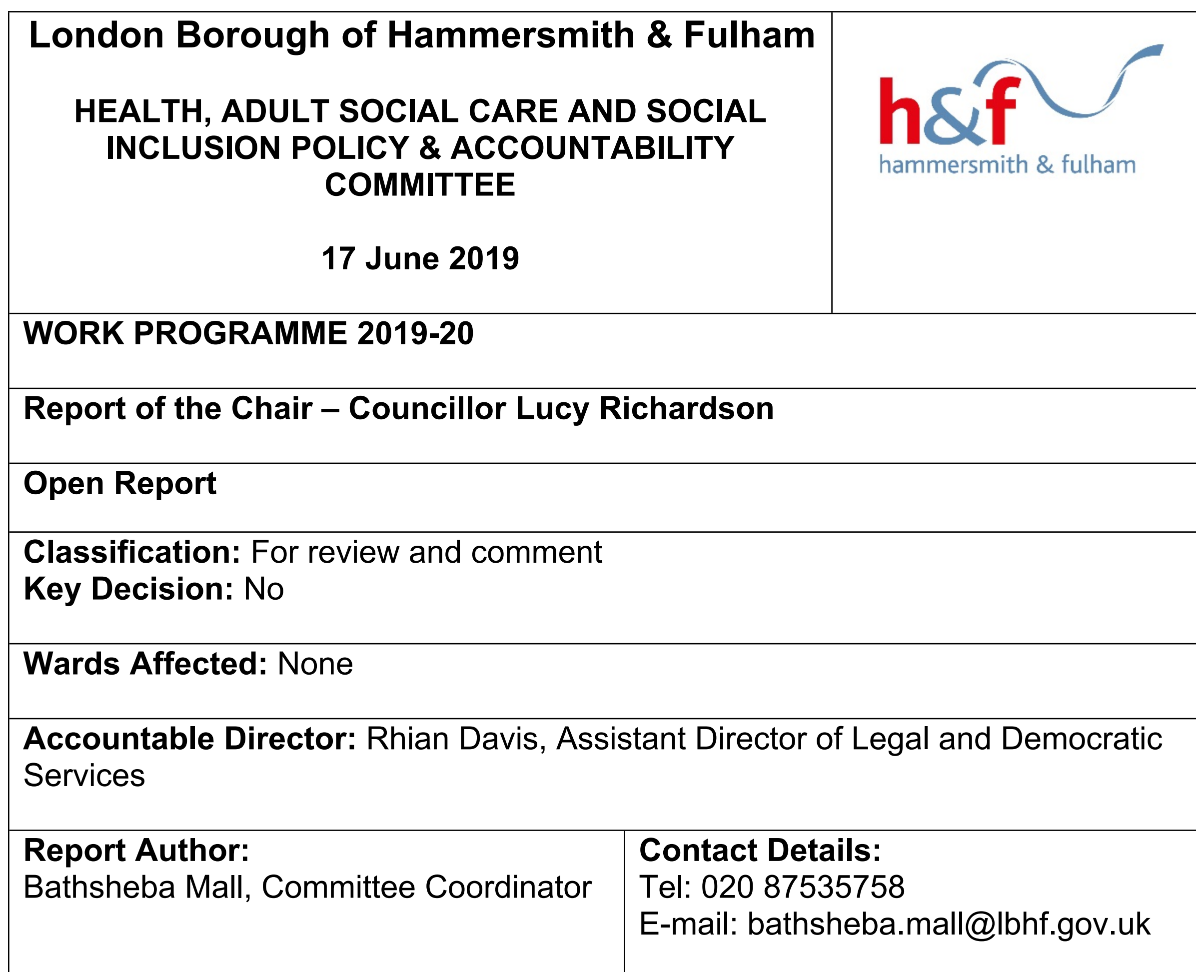
6. Has the JHOSC assisted your organisation to develop, change your work or do things differently?

- The independent challenge has been useful and helped to test our thinking outside of an NHS bubble.
- We always **welcome the submission of evidence-based advice** or proposals for consideration by North West London commissioners.
- We note the national guidance stipulation that health scrutiny reports or recommendations always be **evidence-based.**

7. What topics do you suggest might be useful for Scrutiny next year? (Please also suggest timings)

- Long-Term Plan submission (September)
- Development of integrated care (anytime)
- Case for a single CCG and borough arrangements (May)
- North West London financial recovery (July onwards)

Agenda Item 10



<table>
<tr><td colspan="2">London Borough of Hammersmith & Fulham

HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY & ACCOUNTABILITY COMMITTEE

17 June 2019</td><td>h&f hammersmith & fulham</td></tr>
<tr><td colspan="3">WORK PROGRAMME 2019-20</td></tr>
<tr><td colspan="3">Report of the Chair – Councillor Lucy Richardson</td></tr>
<tr><td colspan="3">Open Report</td></tr>
<tr><td colspan="3">Classification: For review and comment
Key Decision: No</td></tr>
<tr><td colspan="3">Wards Affected: None</td></tr>
<tr><td colspan="3">Accountable Director: Rhian Davis, Assistant Director of Legal and Democratic Services</td></tr>
<tr><td>Report Author:
Bathsheba Mall, Committee Coordinator</td><td colspan="2">Contact Details:
Tel: 020 87535758
E-mail: bathsheba.mall@lbhf.gov.uk</td></tr>
</table>

1. EXECUTIVE SUMMARY

The Committee is asked to consider its work programme for the municipal year 2019/20

2. RECOMMENDATION

2.1 The Committee is asked to consider the proposed draft 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 2019/20

Appendix 1

Health, Inclusion and Social Care Policy and Accountability Committee
Draft Work Programme Development Plan 2019/20

Item / working title	Overview / Development	Report Author / service
11 September 2019		
Primary Care Network	Discussion and comment on the development and implementation of the Primary Care Network	
Immunisations / measles		
17 November 2019		
Supported Employment	To look at the opportunities for improving the provision of supported employment placements within the Borough and that development of guidance for this.	
27 January 2020		
SAEB	Presentation of LBHF, Safeguarding Adults Executive Board by the Chair, Mike Howard.	SAEB
24 March 2020		
Budget	MTFS ASC and Public Health	LBHF

Suggested items – included for information and discussion

- CAMHS update
- WLMHT update
- Health Based Places of Safety
- 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.
- Health and Public Transport for older residents
- The Digital Development of Primary Health Services – GP at Hand

Agenda Item 13

By virtue of paragraph(s) 3 of Part 1 of Schedule 12A
of the Local Government Act 1972.

Document is Restricted