Health, Inclusion and Social Care Policy and Accountability Committee

Minutes

Wednesday 11 September 2019

PRESENT

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

Co-opted members: Victoria Brignell, Jim Grealy, Keith Mallinson and Jen Nightingale

Other Councillors: Ben Coleman

Officers / guests: Vanessa Andreae, Vice-Chair, H&F CCG; James Benson, Chief Operating Officer, CLCH; Juliet Brown, Health and Care Partnership Director, NWL Collaborative of CCGs; Janet Cree, Managing Director, H&F CCG; Anita Parkin, Director of Public Health; Lisa Redfern, Strategic Director of Social Care; Andrew Ridley, Chief Executive Officer, CLCH; Dr Paul Thomas**;** Lesley Watts, Chief Executive Officer, Chelsea and Westminster Hospital NHS Foundation Trust

22. MINUTES OF THE PREVIOUS MEETING

RESOLVED

The minutes of the previous meeting held on 25 June 2019 were noted as an accurate record and agreed.

Actions and Matters Arising - Clinical Commissioning Groups: Merger and the Case for Change

Janet Cree reported that the Governing Body of H&F CCG had considered a report which set out details about the potential merger and case for change.

Unfortunately, H&F Save Our NHS had been omitted from the list of organisations which had provided feedback and that this would be amended.

The Governor Body of the CCG had discussed and considered a recommendation to merge in April 2021. This contrasted with prevailing views regarding an earlier merger and considered feedback and changes to the current financial situation of the North West London CCGs. A more realistic timeline for the merger had been agreed. The CCG would remain a statutory body, be reviewed and strengthened financially. The schemes of delegation would also be reviewed, and the CCG would continue to work with the local authority. It was explained that this was the direction of travel, not a decision to merge but one step in the process of moving towards a merger. Further and regular reports would offer further details and assurance at future governing body meeting to ensure local accountability, focus and transparency.

Councillor Richardson said that the Council welcomed this news and the opportunity to contribute towards a process that would shape the future of the CCG of North West London. In response to a question from Victoria Brignell regarding consultation and engagement, Janet Cree confirmed the CCG would ensure transparency throughout the engagement process. Councillor Richardson enquired about specific dates and timelines for consultation. Lesley Watts responded that the decision to postpone the vote had considered the current financial difficulties for CCGs in North West London and that these would need to be prioritised ahead of reorganisation. A sensible timeframe would be discussed with the governing bodies and that a finalised timetable would be provided as soon as this was determined.

ACTION: CCG to provide the Council with a timetable for the proposed merger

Councillor Caleb-Landy enquired about the potential impact of the merger on residents in terms of local accountability. Janet Cree responded that a move towards a single CCG would benefit residents through collective work to achieve economies of scale and deliver a more sustainable financial position over a greater primary care footprint. In a follow up question, Councillor Caleb-Landy asked if any modelling work had been undertaken with a comparative sized organisation. Lesley Watts explained that in her previous experience as a Chief Executive of a large, primary care trust (PCT), it was necessary to undertake local analysis to understand how patient pathways operated. Multiple care pathways hindered the ability to provide health care for patients and this would be balanced with the need to drive forward efficiencies.

Jim Grealy commented that the proposed changes had been previously been presented as administrative and not patient-facing. He felt that this was no longer the case and that there was fewer opportunities for the patient voice to be heard or engaged with. It was important that residents formed part of the decision-making process. Lesley Watts agreed and confirmed that the type of consultation or engagement would depend upon the nature of proposed patient service changes, in line with the requirement to follow protocols.

Lesley Watts concurred with Jen Nightingale's analogy of undervalued and skilled secretarial services being lost and projected cost efficiencies being valued more highly than experience and local knowledge, removing quality of care. Janet Cree added that there would be a local focus and that feedback highlighting concerns would be monitored.

Councillor Richardson agreed to allow Councillor Coleman to present a brief statement to the Committee regarding the CCG merger and case for change. Councillor Coleman recounted how the Council had held grave concerns about the approach taken by the Collaboration of CCGs. The West London Alliance (WLA) had met to discuss and share concerns about this, and the financial and democratic deficits. Mark Easton (Accountable Officer, Collaborative of North West London CCGs) had also attended the meetings. It was felt that proposals for the merger had been flawed and inadequate, and that consultation and engagement had been equally insufficient.

Councillor Coleman explained that legal advice had been sought, and a letter setting out concerns had been sent. The subsequent delay of the merger to April 2021 was therefore welcomed as it did not comply with NHS guidance. The case for change was flawed and did not address or justify claims that savings would be achieved. This was confirmed by Mark Easton to be about £1 million. It was acknowledged that the CCGs were under considerable pressure to reform but that there were many issues left unaddressed. The case for change lacked critical details such as what the reconfiguration of CCGs could look like and therefore could engender a proper response.

In response to a query by Councillor Lloyd-Harris who welcomed the CCGs news of the delayed merger, Councillor Coleman explained that administrative savings formed a small part of the overall financial savings and that more information was required. Lesley Watts agreed that initial savings could be £1 million but that this would increase going forward, with the aim of spending less on administrative services and more on patient care. An assurance was given that if there were significant changes to patient services consultation would be undertaken.

23. APOLOGIES FOR ABSENCE

Apologies for absence were noted from Councillor Bora Kwon.

24. DECLARATION OF INTEREST

None.

25. PRIMARY CARE NETWORK

Janet Cree explained that this report informed members about the development and structure of Primary Care Networks (PCNs) and the aspiration to deliver direct enhanced services. PCNs were evolving and development plans for this closely aligned to deliver the goals set out in the

NHS Long Term Plan. Details about the impact of this would be provided at a future meeting.

Victoria Brignell asked what difference would be noticed by patients following the establishment of PCNs. Vanessa Andreae explained that this was currently being considered. PCNs would be more patient facing and that it was hoped that this would lead to improved standards of care.

Councillor Coleman enquired whether any of the promised additional funding from central government would be directed to support social prescribing, to help GPs in directing patients to local services. The success of such an approach lay with a properly resourced and supported third sector.

RESOLVED

That the report was noted.

26. NHS LONG TERM PLAN UPDATE

Juliet Brown briefly outlined that the response to the NHS Long Term Plan (LTP) took a collective approach that was structured to ensure both a strong PCN and a local focus. The LTP included how the NHS was working towards improving mental health services and access to local care for long term conditions such as diabetes.

This was a strategic response to the LTP setting out where the CCGs were currently, how they intended to work together and engage locally. The response deadline was 15 November 2019 and it was explained that they had working on preparing a draft for some time, aiming for it to be available by the end of September. It was explained that the H&F integrated care partnership (ICP) offered the delivery of borough based local services. It was noted that a joint meeting of council leaders, led by Sean Harris, Chief Executive of the London Borough of Harrow, was arranged for 24 September 2019.

Lisa Redfern expressed concern that she had not received any formal communication about the work being undertaken by the care partnership board (which comprised of the North West London local authorities but did not include H&F and Ealing) or been consulted about the response to the LTP. The only communication received had been regarding workforce strategy. Lisa Redfern explained that she had also not been contacted in her statutory capacity as Director of Social Care or been asked to contribute to the formulation of the draft response, which she had requested sight of several times earlier in the year.
The Council's Better Care Fund had been drafted in the absence of any information about the LTP response.

Juliet Brown said that 'system boards' had been established and it was recognised that H&F did not currently form part of this. Lisa Redfern reiterated that the lack of engagement was very disappointing.

Councillor Coleman reported that Mark Easton had previously given assurances that the Council would be fully involved and engaged. It was noted that this would be rectified at the earliest opportunity. The Council would have wished to have been included at the start of the process in producing the draft response, working jointly with NHS and local authority colleagues. In terms of governance, Councillor Coleman pointed out that Sean Harris was not a democratically elected representative or a director of social care and that he would raise the issue with members of the WLA.

Lesley Watts offered an assurance that the Council would be fully engaged going forward and confirmed that a timetable of engagement and joint working will be provided, commencing with a formal invitation to attend the meeting taking place on 24 September.

ACTION: NWL Collaboration of CCGs to provide a timetable for engagement regarding the preparation and submission of their response to the NHS LTP

Councillor Lloyd-Harris referred to page 22 of the Agenda pack and commented that H&F had a great deal of knowledge and expertise on undertaking local engagement and asked how the CCGs expected to engage with the Council and stakeholders. Councillor Caleb-Landy also enquired about the groups that the CCG had consulted with and whether they were H&F residents. Juliet Brown confirmed that they had consulted with Healthwatch and conducted engagement events within each borough and offered to share further details about the events and the findings.

ACTION: Details about the engagement work undertaken to be shared with the Committee

Councillor Caleb-Landy highlighted also concerns about the lack of engagement with hard to reach groups such as those with learning disabilities. It was explained that the NWL response to for example diabetes care, was in line with the LTP in terms of the engagement undertaken. Dr Tim Spicer, former Chair of H&F CCG, had led a patient and carers group which looked at how care for older people was shaped and delivered with improved accessibility. It was pointed out that the LTP outlined a priority to engage with hard to reach groups. Juliet Brown indicated her agreement with this approach combined with the need to continue to develop cohesive plans with such groups.

Jim Grealy commented on the growing local population which contained enormous local demographic differences within North West London, and which would require the careful calibration of contract, commissioning and governance arrangements. It was pointed out that while there was information available about stroke and diabetes care, there was little clarity about the hierarchy of the CCG, how they co-existed and how they incorporated the local patient voice when commissioning services.

Greater complexity within the NHS meant that it became harder to hear the “local voice” and it would be helpful to understand how the PCN and CCG

linked together. In considering local, place-based care, Lesley Watts commented that London had benefitted greatly with the boroughs benefitting from, for example, the reforms in stroke care.

Lesley Watts provided a brief overview of the what the LTP hoped to achieve nationally. The integrated care system would exist as an overarching structure, covering the same geographical footprint of the Sustainability and Transformation Partnership. It was explained that the system had not yet been secured and will need to identify its own lead clinicians. Beneath this would be the CCG, with collaboratively work between CCG commissioners and providers. It was observed that within NWL, this was more refined and better established largely because of the commitment of the chief executives of the provider organisations to improving the health of residents.

Lesley Watts offered to provide the Committee with details about the prospective governance arrangements once these were completed. Jim Grealy responded that that there had been little time to consider the proposals and that this was difficult to do without a governance map in place. Lesley Watts took the view that treatment services had progressed and that they were committed to communicating more clearly, responding to the need for greater levels of scrutiny.

Lisa Redfern reiterated that the draft response had been requested repeatedly since the publication in January 2019 of the LTP. The timetable for this required a local systems response and it was unclear why it had taken this length of time to reach this stage. Juliet Brown explained that the technical guidance for the response was published in the last week of August.

Prior to this, it was explained that CCG colleagues had met to consider the initial shape and format of the response and how it could be structured. Juliet Brown recognised and accepted the view that this had been a protracted process particularly given its transformational nature, however the technical guidance was prescriptive with a short timetable for a document response that covered a period of five years.

There followed a brief discussion about the timetable and when the draft would be provided to the Council, with time to incorporate any comments by the submission deadline of 15 November 2019. Lisa Redfern emphasised that it was critical for the Council to review the draft at the earliest opportunity with a structured approach to engagement. It was accepted that a timetable for engagement with the Council would be agreed as soon as possible.

RESOLVED

1. That the CCG prepares and communicates its timetable for engagement on the draft LTP response and that the Council was given time to review and input into the draft the response; and
2. That the report was noted.

27. HEALTHWATCH

Olivia Clymer provided a brief overview of the recent activities undertaken by Healthwatch. It was noted that appendices and data was also available and would be circulated to members of the Committee. Much of the work had highlighted new ways in which the patient experience could be better understood, for example, providing forms in local chemists as well as surgeries.

Councillor Caleb-Landy enquired how H&F CCG had engaged with Healthwatch and how they had responded. Olivia Clymer explained that they had been commissioned by Healthwatch England to undertake national consultation, with a requirement to run consultation workshops. The consultation survey provided had not been "people friendly" so members of Healthwatch had gone out and about to help improve the number of responses. This had been undertaken in a tight timescale in March 2019, with a report produced in May. Healthwatch had worked with colleagues at NWL level and the H&F director of communications team to share information as widely as possible and this had been incorporated as the foundation to the CCGs own engagement work.

Councillor Richardson asked if work on mental health, young people and learning disabilities would inform the LTP response. Olivia Clymer hoped that this would be the case and that it would reference not just services but issues such as patient transport. She felt encouraged that further work would be undertaken on this.

Jim Grealy commended the report and commented that the marketing aspect had been positive. He referred to the work of the patient reference group and the causal factors underlying the low take up of cervical smear tests by young women. It was important to understand how North West Londoners accessed and engaged with health care.

The report also made a strong point about the loss of local voices, an increasingly important concern given the clarity of information that people required in order to make informed health care choices about the services they used. He felt that there was a recurring theme about the lack of information about services. Olivia Clymer welcomed the positive comments and explained that the use of postcards had been undertaken locally although the materials had been provided by Healthwatch England.

Councillor Coleman referred to the CCG merger and case for change and asked about Healthwatch's views on this. It was explained that Healthwatch interpretation of the LTP was to see a strengthened local voice, which was already very strong in H&F. Olivia Clymer hoped that this would be further nurtured by the CCG and was concerned that this might not continue.

RESOLVED

That the report was noted.

28. PEMBRIDGE HOSPICE

James Benson provided a brief overview which set out the background details. The service had been suspended temporarily and was now permanently closed and that a decision to cease recruitment had been taken. They had continued to support staff and residents and were proud to report that no staff had been lost although some had retired. Paragraph 3.7 of the report outlined planned next steps.

Janet Cree added that the CCG independent review had been published in June 2019. Engagement had been undertaken with patients and the palliative care working group. The aim was for the engagement to progress, to be followed by an agreed service specification which was currently being outlined. Formal consultation would commence once the service specification was completed. It was confirmed that information and papers would be circulated to the Council and to all stakeholders as part of the engagement process.

Councillor Richardson invited Dr Paul Thomas to provide the Committee with his personal experience of palliative care services, balanced with his professional expertise and understanding as a clinician. Dr Thomas extensive background of over thirty years included the development of what was now regarded as Primary Care Networks for collaborative working in Liverpool (1989 and 1995) and again in Ealing (2010, where he was the Clinical Director for Ealing PCT). He was presently a full-time carer for his wife who was being looked after by the Pembridge Unit.

Dr Thomas explained that his work in Liverpool's PCT was similar to what was being currently replicated with the LTP, with interlinked and multiple services delivered from surgeries. It was vital that palliative care remained on the LTP agenda, it was not possible to disentangle this from integrated care as one led to the other. Dr Thomas referred to "community orientated integrated care" and how it was important to understand how multiple systems connected and fitted together. Dr Thomas supported the view that palliative care services be continued at Pembridge and opposed any bed closures at the unit.

In thinking about what constituted a "healthy" death it was helpful to also consider what was disease. A successful system must integrate primary care and personal care which should work in tandem. The question to ask was how this work could and what were the different approaches to health care, and, how could primary care teams work to improve patient care hand overs. Dr Thomas was of the view that a healthy death was as important as a healthy death. A support network of friends and family was essential, as were the components of achieving a healthy life. Dr Thomas offered three points for the Committee and CCG colleagues to consider:

1. There will be a need for more palliative care beds in future. There will be an increased number of isolated elderly people and fewer cancer patients and part of the integrated care system approach is to keep

people out of hospital. The role of the Pembridge unit was not just to offer beds, but it could have the potential to be a centre for learning.

2. It was important to really understand the need to manage deficits and a whole systems approach to learning was invaluable. He acknowledged that there was a need for future planning within NWL but there was a need for more palliative care units, not less, given the geographical locations of other units at St Johns (WCC) and St Lukes' (Harrow). In his view, Pembridge could be developed into a hub where people understood integrated care.

3. Skilled end of life care practitioners offered an understanding of death. If the aim was to have successful community integrated care that worked, then the skills of palliative care practitioners were essential. Dr Thomas suggested that the unit could form an alliance with other units such as St Marys and St Lukes' and work collectively.

Councillor Richardson thanked Dr Thomas from his enlightening approach and invited further comments and views from members of the public in attendance.

A member of the public recounted her personal experiences with friends and family and the end of life care that they had received. As a resident of H&F for thirty years who had worked in palliative care, she explained that the experience had been transformative. In her view, there was a substantial lack of palliative care beds within NWL and a paucity of palliative care provision. It was important to maintain and pass on palliative care expertise.

Another member of the public shared similar experiences about the different end of life experiences that her friends and family members had received. Two neighbours had gone through very different experiences, one of whom had received little support and had unfortunately died without palliative care support that was unfortunately offered too late.

Dr Joanne Medhurst explained that she had worked for thirty years as a GP and was responsible for co-chairing the design group. 52% of residents did not get access to palliative care services. There was an aging population and the causes of death were different to what they were when the hospice movement was set up. Hospices were set up to deal with disease and it was important to understand this. Dr Medhurst gave a clear assurance that financial factors had not influenced the permanent closure of palliative care beds at the Pembridge. The aim was to manage end of life care provision for all.

Councillor Richardson thanked everyone for sharing moving and personal accounts of palliative care.

Jim Grealy agreed that it was important that people had a support network, particularly given that many who lived in the area did not have family members who lived locally. Pembridge was in one of the poorer areas between Brent, RBKC and H&F. There were many on low incomes who would find it difficult to travel to other boroughs to visit family and friends who

needed end of life care. He encouraged the CCG to consider a more creative solution for Pembridge rather than the permanent loss of palliative care beds and that the consultation should be wide ranging.

James Benson said that the decision to close the palliative care beds had not been an easy one. The vast majority of people were supported by end of life care at home. He continued that they would be considering different models of care, leadership and accommodation. The prime aim of suspending the service was to maintain community beds.

Lisa Redfern sought clarification about the way in which the decision to first suspend temporarily and then permanently close the provision had been progressed. Initial discussions had centred around the difficulties in appointing a suitably qualified palliative care consultant. It was advocated that if bed closures were being considered, a full and vigorous consultation would be required. Facilitating good, end of life care required a great deal of skill and huge network of support and care and it. It was important to understand what was being proposed by the review so that residents properly understood what they were being consulted upon.

Lisa Redfern referred to a recent CQC rating for Pembridge which had been "good" but information was later offered to indicate that there were problems about standards of care. She continued that she found it difficult to identify the direction of travel for the service and queried why support could not be sourced from Imperial College Healthcare NHS Trust. She explained that her understanding was that supervisory support from a hospital would be possible if there was a palliative care doctor in post at Pembridge.

RESOLVED

That at 8.55pm, the meeting be guillotined until 9.30pm

Janet Cree responded that the direction of travel was based on the events that had occurred and following the independent review. An assessment of H&F services had identified some gaps in provision and that the next step was to identify a service specification. This was an opportunity to check and reflect to ensure that the services being commissioned are meeting the required need. There was a difficulty in recruitment and the current model was not sustainable. The decision to suspend the service was because they had been unable to make a suitable appointment. The CCG was committed to ensuring that the service was fit for purpose and this work was currently underway. Lisa Redfern responded that to move from a suspended service because of a recruitment issue to one which had resulted in a permanent closure and a wide-ranging review was a challenging position that was difficult to sustain.

As a registered practitioner Dr Medhurst assured the Committee that the recruitment issue meant that there was not the right staffing structure in place and that there was not a doctor in post with palliative care experience. There was a specialist palliative care lead consultant, but this individual lacked sufficient experience and did not have capacity to supervise Pembridge staff. In response to Councillor Colemans suggestion that the Council offer to assist

in recruiting a suitable clinician, Janet Cree explained that the purpose of the review was to identify what the future service would look like and that is was not possible to accept or decline the offer of assistance while the review process was on-going.

In response to a query from Victoria Brignell regarding the percentage of those dying at home, Dr Medhurst explained that this would be considered by the working group, to develop a high-level service specification, followed by a month-long period of consultation. The working group would consider what the outcomes should be and how carers could be supported during bereavement. Janet Cree categorically stated that there was no financial incentive driving the process and that it was about ensuring that palliative care services were provided to residents and their families. Vanessa Andreae added that H&F CCG will be making the same level of investment, but it was not possible to specify at this stage what the outcome of the consultation would be.

Councillor Richardson invited Councillor Robert Freeman, RBKC to contribute his views to the discussion given that most patients came from RBKC. Councillor Freeman recognised the complexity of the current commissioning arrangements and encouraged the CCG and CLCH colleagues to find a suitable solution at the earliest opportunity. There was good relationship with CLCH but there had been little progress on this issue and there was an urgent need to address the problem.

Councillor Coleman commented on the need to consult as set out in NHS guidance and reiterated his view that there was much the Council could offer in terms of expertise about engagement and consultation. He sought further clarification about the aims and objectives of the consultation. Janet Cree responded that the aim was to develop the service specification and the outline of this would be informed by the outcomes of the consultation. She indicated that the CCG would welcome input from the Council on this.

RESOLVED

That the report was noted.

29. WORK PROGRAMME

Janet Cree and Vanessa Andreae jointly informed the Committee that the CCG had taken a decision to close the Parsons Green walk in centre. It was reported that the CCG had sought special dispensation from NHS England to keep the walk-in centre open until the end of March 2020 and were awaiting the outcome of that request. Formal notice of the closure would be made by the end of September. Janet Cree explained that core standards for an urgent treatment centre included being open throughout the day, access to a doctor, access to urine testing facilities and routine appointments and these could not be met at Parsons Green. Janet Cree added that the CCG had initially thought that with slight changes the Centre could continue. The CCG had carried out a review in December 2018 which concluded that the Centre offered high quality services and value for money. NHS England determined that it was not acceptable to continue to offer services from the walk-in centre

and that there would be no other walk-in centres nationally. It was noted that this was also the case in other parts of London such as Barnet.

Janet Cree continued that the CCG had looked at ways to fit the walk-in centre to the new standards or find an exemption that was sufficiently robust. The majority of the activities undertaken at the walk-in centre included ear irrigation and wound care, with most patients living in the vicinity of Parsons Green. These were also services that could be provided by other GP surgeries and the CCG regarded this as an opportunity to work with the Primary Care Network.

ACTION: That the CCG will provide more detailed information about this to the Committee

RESOLVED

That the Work Programme was noted.

30. DATES OF FUTURE MEETINGS

The date of the next meeting was noted as Monday, 11 November 2019.

Meeting started: 6pm
Meeting ended: 9.30pm

Chair .....

Contact officer: Bathsheba Mall
Committee Co-ordinator
Governance and Scrutiny
☎: 020 87535758 / 07776672816
E-mail: bathsheba.mall@lbhf.gov.uk