London Borough of Hammersmith & Fulham

Health, Inclusion and Social Care Policy and Accountability Committee

Agenda

Wednesday 11 September 2019 at 6.00 pm
Meeting Room 2 (2nd Floor) - Shortlands

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	

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

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

Shortlands

3 Shortlands,
Hammersmith,
London W6 8DA

Closest Underground Station
Hammersmith

Closest Bus Stop
Latymer Court (Stop G)

Date Issued: 10 September 2019

London Borough of Hammersmith & Fulham

Health, Inclusion and Social Care Policy and Accountability Committee

Agenda

11 September 2019

Item		Pages
1.	**MINUTES OF THE PREVIOUS MEETING**	4 - 10

(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 17 June 2019; and

(b) To note the outstanding actions.

2. APOLOGIES FOR ABSENCE

3. DECLARATION OF INTEREST

If a Councillor has a disclosable pecuniary interest in a particular item, whether or not it is entered in the Authority's register of interests, or any other significant interest which they consider should be declared in the public interest, they should declare the existence and, unless it is a sensitive interest as defined in the Member Code of Conduct, the nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent.

At meetings where members of the public are allowed to be in attendance and speak, any Councillor with a disclosable pecuniary interest or other significant interest may also make representations, give evidence or answer questions about the matter. The Councillor must then withdraw immediately from the meeting before the matter is discussed and any vote taken.

Where Members of the public are not allowed to be in attendance and speak, then the Councillor with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration. Councillors who have declared other significant interests should also withdraw from the meeting if they consider their continued participation in the matter would not be reasonable in the circumstances and may give rise to a perception of a conflict of interest.

Councillors are not obliged to withdraw from the meeting where a dispensation to that effect has been obtained from the Audit, Pensions and Standards Committee.

4. PRIMARY CARE NETWORK 11 - 19

This report provides an overview of Primary Care Networks and explains how they will be organised in Hammersmith and Fulham. For Information and noting.

5. NHS LONG TERM PLAN UPDATE 20 - 25

This report provides an update from H&F CCG about their response to the NHS Long Term Plan, published on 7 January 2019.

6. HEALTHWATCH 26 - 104

This report provides an update on Healthwatch activities.

7. PEMBRIDGE HOSPICE 105 - 107

This report provides an update from Central London Community Healthcare NHS Trust on the decision to stop inpatient admissions to the Pembridge Hospice.

8. WORK PROGRAMME 108 - 110

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

9. DATES OF FUTURE MEETINGS

11 November 2019 at 6pm
27 January 2020 at 7pm
24 March 2020 at 6pm

London Borough of Hammersmith & Fulham

Health, Inclusion and Social Care Policy and Accountability Committee

Draft Minutes

Monday 17 June 2019

PRESENT

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

Co-opted members: Victoria Brignell (Action On Disability), Jim Grealy (Save Our Hospitals), Jen Nightingale and Keith Mallinson (Healthwatch).

Other Councillors: Ben Coleman

Officers: Lisa Redfern, Strategic Director of Social Care
Anita Parkin, Director of Public Health

9. APPOINTMENT OF VICE-CHAIR FOR 2019-20 AND COMMITTEE TERMS OF REFERENCE

Councillor Bora Kwon proposed herself as Vice-Chair, Councillor Mercy Umeh seconded the nomination:

RESOLVED

That Councillor Bora Kwon be elected as Vice-Chair for 2019-20.

10. APPOINTMENT OF CO-OPTEES

That the following co-optees be appointed for 2019-20:

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

11. APOLOGIES FOR ABSENCE

Apologies for absence were received from Keith Mallinson.

12. DECLARATION OF INTEREST

None.

13. MINUTES OF THE PREVIOUS MEETING

RESOLVED

That the open minutes of the meeting held on 24 April 2019 were agreed.

14. UPDATE FROM THE STRATEGIC DIRECTOR OF SOCIAL CARE

The Strategic Director for Social Care provided a verbal update.

Scene setting, Vision, Achievements and Challenges
ASC provided services for 3,100 people with 234 staff, and Lisa Redfern outlined how the H&F vision was to support residents who were vulnerable to be enabled to live independently. Co-production of services offered real choice and control over residents own lives.

Quality
The Care Quality Commission (CQC) rated two H&F provided services as "outstanding": The Community Independence Service, (CIS), and the Riverside short breaks service. Lisa Redfern explained that they were very proud of these achievements as this meant that they were offering high quality services to H&F's residents. Ofsted and CQC had rated H&F SEND services as very good.

ASC was committed to improving quality of care, working more with primary care to prevent hospital admissions. The special disabilities service (Transitions) with the transfer to adult services commencing from 14 years and upwards was rated as "good".

Home Care
ASC continued to work very closely with all three main agencies and robustly manage and monitor provision. Quality was variable.

Performance
ASC performance on delayed discharges both for acute and non-acute service is very good. We address any quality issues through our quality assurance work and forums, including the Safeguarding Adults Board.

Budget
ASC achieved a balanced budget again for 2018/19, however, the social care budget continued to face significant challenges.

Sovereign Borough Progress
All social care services have been fully disaggregated We have two services, the hospital discharge and emergency duty services which continue to be shared.

The Borough's Safeguarding Adults Board was launched in September 2018 and was well attended by all relevant agencies and appeared to be working very well.

A weekly Footcare service/clinic was established. The cost for toenail cutting was heavily subsidised at £16.00, rather than £60.00. The option of a home visit was also being considered with a possible charge of £32.

The new direct payments service had been co-produced, and the new service was about to be launched.

Councillor Richardson thanked the Strategic Director for her overview and its emphasis on community provision and asked why the NHS did not engage more in similar provision. Councillor Coleman briefly provided context to the establishment of the footcare clinic, how following consultation the CCG had limited the provision of podiatry services to only those who had acute or severe medical conditions. Feetfirst had contacted the Council and this had been supported by the Strategic Director and the Mayor. Councillor Coleman felt that this was something that the CCG should have been able to pursue in partnership with the Council.

Footcare was important as it helped to prevent serious trips and falls and helped those who were too embarrassed about being unable to cut their own toenails. Councillor Kwon suggested that the availability of the service be highlighted to local diabetes charities and community groups as good footcare could help prevent amputations. Good footcare was essential, not just about grooming or appearance, but was much broader than this. Councillor Kwon also suggested that it might be possible to identify those who were not eligible for NHS podiatry services and it was noted that those with diabetes remained eligible.

Jim Grealy commented that the CCG needed to be reminded that health services were for residents and that how their provision impacted on residents. He asked if data could be provided by Feetfirst and hoped that this area of work could spark a conversation with people if they were already in receipt of hospital care. Good footcare was preventative medicine which could potentially save money and improve health and wellbeing.

Victoria Brignell enquired about annual surveys and whether the data and results were published. Lisa Redfern confirmed that these were undertaken each year and that the most recent results would be analysed with the results published soon.

ACTION: Strategic Director to provide this when it became available

Victoria Brignell asked about the proportion of people in receipt of direct payments. Lisa Redfern confirmed that approximately 500 people in residential and nursing care received direct payments.

In the context of homecare, Jen Nightingale asked if there was a correlation between pay and the quality of staff. All carers received a London Living Wage (LLW) however, Lisa Redfern explained that this was only one aspect as had been indicated by recent CQC and ADASS (Association of Directors of Social Services). It was important to recruit carers with the right attitude, who were caring and compassionate.

Councillor Lloyd-Harris reported that she had received complaints from residents about the poor quality of the home care that they had received and asked at what stage did the Council intervene. Lisa Redfern responded that the Council had significantly improved home care monitoring over the past year and that his was also being closely monitored through Councillor Coleman's weekly member briefing meetings.

Councillor Caleb-Landy suggested that it might be possible to identify pinch points through cross-departmental working where residents who have experienced anti-social behaviour or environment concerns could be further supported. He asked if there were plans to have further engagement and dialogue with residents. Lisa Redfern explained that there were several cross-cutting, strategic and operational service boards. Lisa Redfern outlined how the Public Services Reform agenda was to challenge siloed thinking and advocated new ways of working. Formal boards such as the Safeguarding Adults Executive Board, and, the learning disability and mental health executive boards had also been established.

Councillor Caleb-Landy enquired about short breaks and was one of the first services to go but also one of the most important. Lisa Redfern responded that the Council continued to fund short breaks, breaks for carers, day services, direct payment for carers and a range of other options. Councillor Coleman commented that there had been a programme of ring-fenced funding for disabled children services. This had been removed by the Conservatives (in power at the time). Financial challenges had worsened but the Council still provided the service. There were also charities such as Family Fund that were able to offer support. Further information about this was provided at ASC Lunch and Learn sessions which members were invited to attend.

ACTION: Strategic Director to send information to Cllr Caleb-Landy; and to confirm for members details of Lunch and Learn sessions

Councillor Richardson commented on the physiotherapy consultation which had been scrutinised by the Health, Inclusion and Social Care Policy and Accountability Committee (HISPAC). The consultation had concluded, and Professor Tim Orchard and Imperial colleagues would consider the feedback provided by HISPAC. Members would receive a further update following Councillor Coleman's next meeting with Imperial. A paper on physiotherapy

and hydrotherapy had been requested from the CCG for the Health and Wellbeing Board (HWB). It was acknowledged that this may be a CCG funding or contracts issue and Councillor Caleb-Landy suggested that it would be helpful to obtain data about which physiotherapy services can be provided, with a view to further scoping this at HWB.

RESOLVED

That the update provided by the Strategic Director was noted.

15. UPDATE FROM HEALTHWATCH

RESOLVED

That the Committee noted the report from Healthwatch.

16. UPDATE FROM NORTH WEST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Councillor Richardson provided a brief update on the work of the JHOSC. The member boroughs included Brent, Harrow, Hounslow, RBKC, Westminster and H&F, with Richmond as observers. There had been collective and unanimous agreement that the JHOSC should continue and a work programme was agreed. There was expected to be an additional meeting in July to discuss proposals to unify local CCGs in alignment with Integrated Care Partnerships and this was being currently explored. H&F would be hosting the September meeting, the key themes for which would be scrutiny of CCG financial long-term planning and the impact of GP at Hand and the cost of digital services.

17. UPDATE FROM SAVE OUR HOSPITALS

Jim Grealy confirmed that Save Our Hospitals had recently been renamed "H&F Save our NHS". He outlined priorities for the coming year, the first being the proposed health budget cuts and the impact on residents of H&F. A second priority was to look at GP at Hand. There was a need to recoup the cost of the service as the NHS continued to move increasingly towards digital services. It was important to address the natural injustice of this situation or the deficit would continue to accrue. The movement towards the merger of the eight North West London CCGs continued. This would affect eight boroughs, conducting approximately 40 CCG meetings per year. The merge will mean one CCG covering the needs of over two million people, with mixed income and diversity. It appeared illogical that one body could determine health needs and engage services for a wide geographical area. It was explained that HFSON would concentrate on working with residents and advocate the need for local democracy. Additional concerns included the low rate of immunisations in H&F.

Councillor Kwon referred to GP at Hand and observed that the digitisation of the NHS would become increasingly prominent as an issue, continuing privatisation by stealth. Historically, the NHS had a poor track record for this.

It was important to recognise that Council lacked the necessary expertise in understanding the issue, particularly given current the rate of progress, which could not be allowed to continue without proper scrutiny. It was noted that one of the key criticisms of GP at Hand was that while they had the technical knowledge, they lacked a critical understanding of local need and diversity.

Jen Nightingale observed that the variation in information technology (IT) varied in different trusts and that it would be helpful if this could be unified, with an overarching technical policy or strategy that could be universally adopted. This would also be more financially efficient, given the large number IT companies that a varied range of services to different trusts. Jim Grealy concurred, that it would be helpful to consolidate buying power to strengthen purchasing power.

Jim Grealy commented on the recent CCG consultation which he felt had not considered the different was in which people now lived their lives and advocated the need for long term integrated care service planning.

Councillor Coleman commented that one of the biggest injustices had been that funding for GP at Hand had come from H&F CCG but this project had benefited those that live outside the Borough. Councillor Kwon agreed and felt that this was the tip of the iceberg, referring to the Aviva Application initiative. She queried whether the App was any good or if it offered value for money, noting that a Tech company had been paid for this development work by the NHS. Merrill Hammer (H&FSON) added that this was an issue that could not be resolved locally, and that NHS England would need to be challenged. One important concern was that digital services such as GP at Hand had not been properly tested and had been implemented too quickly, without regard to residents or GPs and ultimately, has undermined the NHS.

Councillor Richardson thanked Jim Grealy for his update. The work of H&FSON had recently been recognised with a community award at the Borough's civic honours ceremony and welcomed their continued commitment to the work of the PAC and their expertise.

RESOLVED

That the Committee noted the verbal report from H&FSON.

18. WORK PROGRAMME

The Committee noted the draft Work Programme and in addition discussed potential items on measles and immunisations, and cervical cancer. A planned item for July on primary care network had been moved to September. Councillor Caleb-Landy suggested an item on supported employment and to identify opportunities for the co-creation of services, with a view to forming a small working group. Councillor Kwon suggested as link to

GP at Hand, an exploration of digitisation of services and patient experience, with the potential inclusion of Imperial College.

19. DATES OF FUTURE MEETINGS

The date of the next meeting was noted as 11 September 2019.

20. EXCLUSION OF THE PRESS AND PUBLIC

RESOLVED

That members of the press and public are excluded.

21. EXEMPT MINUTES OF THE PREVIOUS MEETING

RESOLVED

The closed minutes of the meeting held on 24 April were agreed.

Meeting started: 7.00 pm
Meeting ended: 9.20 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** **11 September 2019**	
Report title: NW London commissioning reform	
Open Report	
Classification: For Discussion **Key Decision:** No	
Wards Affected: All	
Accountable Director: Janet Cree, Managing Director Hammersmith and Fulham Clinical Commissioning Group	
Report Author: Mark Jarvis **Head of Governance Hammersmith and Fulham Clinical Commissioning Group**	**Contact Details:** **mark.jarvis1@nhs.net**

1. Introduction

The NW London CCG Governing Bodies are considering the proposals set out in the paper attached at September Governing Body meetings.

Hammersmith and Fulham CCG Governing Body are meeting on 10 September. A verbal update on the outcome of the discussion will be provided to the PAC on 11 September.

Meeting name:	Hammersmith and Fulham CCG Governing Body meeting
Date	Tuesday, 10 September 2019

Title of paper	NW London Commissioning Reform Programme: **Recommendations to September Governing Bodies**

Presenter	Mark Easton, Accountable Officer, NW London Collaboration of CCGs				
Author/s	Chloë Hardcastle, Head of commissioning reform, NW London Collaboration of CCGs				
Responsible Director	Mark Easton, Accountable Officer, NW London Collaboration of CCGs				
Clinical Lead	NW London CCG Chairs				
Confidential	**Yes**	☐	**No**	☑	Items are only confidential if it is in the public interest for them to be so

The Governing Body is asked to:

agree with the following recommendation:

1. In view of the feedback from our stakeholders to move to a single CCG in 2021, the need to focus on financial recovery, and the commitment of all Chairs to remain aligned as an eight borough collaboration, we recommend to CCG governing bodies that the merger to a single CCG for NW London takes place on 1 April 2021.

note the following consequence of recommendation 1:

2. This transition year will enable us to work with each governing body to focus on:
    a. System financial recovery
    b. Development of integrated care at PCN, borough and ICS level
    c. The development of a single operating structure across the commissioning system, and meet the expectations of NHSE that we would operate in 2020/21 under a single operating framework, with the associated reduction in management costs and streamlined governance
    d. To work with providers to develop alternative reimbursement structures from 2020/21 to support delivery of ICP/ICS.

Summary of purpose and scope of report

In response to the NHS long-term plan which suggested that all sustainability and transformation partnerships (STP) develop into an integrated care system (ICS), by April 2021 with, “typically a single CCG for each ICS area”, the NW London senior leadership decided to scope the implications of moving towards a single CCG, and have begun to explore key line of enquiry.
The case for change was launched on 29 May 2019 to engage and assess the implications and the impact of commissioning reform on our patients, our staff and our system.
Following extensive engagement of over 100 meetings and events with our stakeholders over the three month engagement period, the NW London Leadership are able to make recommendations to the governing body.

What are the benefits of this project?
Having worked together since their formation, the NW London CCGs were able to deliver many clinical priorities and were able to improve outcomes for patients and staff. Moving towards a single CCG within our STP footprint, will therefore not only put us in line with the national policy but will allow us to further develop our clinical strategies to improve the delivery of services and address our ever growing financial challenges.
Patient, staff and stakeholder engagement
Full engagement with key stakeholders launched on 28 May until 24 August 2019. Stakeholders include: Governing body members GP members Primary care networks CCG staff Local authorities Health and care providers Voluntary sector Patient groups, representatives and lay partners
Jargon buster
Commissioning reform: the NW London programme set up to support changes to commissioning form in NW London CCGs Sustainability and transformation partnership (STP): areas where local NHS organisations and councils drew up shared proposals to improve health and care in the areas they serve. Integrated Care System (ICS): partnership of health and care providers, working together to oversee joined-up care centred around the person. In NW London, this will be our health and care partnership (formally our STP) Integrated Care Partnership (ICP): borough/locality based alliance of providers to locally manage the delivery of health and care services Financial Framework: a financial structure in which our eight CCGs can manage money more effectively Operating model: An operating model is the blueprint for how resources are organised and operated to deliver the strategy. All elements of the operating model—structure, accountabilities, governance, behaviours as well as the way people, processes and technology get integrated to deliver key capabilities—must be explicitly designed to support the strategy.

Quality & Safety
Changes to patient facing services are not anticipated with this case for change. It is however predicted with the single CCG we will be able to streamline our commissioning approach and decision making processes which will allow us to address health inequalities across the boroughs.
Equality analysis
The thorough impact assessment is underway, the detailed report will be made available when complete.

Finance and resources
As well as improving outcomes and reducing variation, we also recognise that our financial challenges are significant and that only by working as a single CCG can we begin to address them.

Risk	Mitigating actions
If we do not engage sufficiently with	We are developing an engagement plan. Once it

stakeholders there is a risk that we may not realise the benefits for commissioning reform in North West London.	is agreed and implementation has commenced we envisage that it will be unlikely that there will be a moderate slippage to the timetable, reducing the risk.
If we do not develop an approach that is coherent across the ICS, single CCG, ICPs and Primary Care Networks then this could become just an administrative change that will not help us to address the underlying issues of financial and clinical sustainability resulting in intervention by regulators.	We have measures in place; however, we need to do more to meet national standards. By implementing improvements and evidencing success we can reduce the likelihood of regulator intervention.
If we do not merge into a single organisation with clearly articulated financial principles and flow, then we risk success to financial recovery and sustainability resulting in a lack of cohesive operations and delivery.	Until we have agreement from governing bodies to the merger and associated financial principles and flow, we cannot reduce the risk. With agreed principles we can implement, it is unlikely this risk will be of detriment to financial recovery.

Supporting documents
NW London Commissioning reform: Recommendations to September Governing Bodies

Conflict of interests
There are no conflicts of interest identified.

Governance, reporting and engagement		
Name	Date	Outcome and where in the report can you find out more
NW London Chairs & MDs meeting	15/08/2019	Collectively agreed to the recommendations to the Governing Body members.
NW London Commissioning Reform Working Group	21/08/2019	Developed the recommendation paper for governing body members.
NW London Chairs & MDs meeting	29/08/2019	Signed off paper of recommendation for discussion at the September governing body meetings.

NW London commissioning reform: recommendations to September Governing Bodies

September 2019

1. Background

In response to the NHS long term plan, which suggested that the number of CCGs will be significantly reduced to align with the number of emerging integrated care system (ICSs), NW London CCGs launched a case for change for commissioning reform on 29 May 2019.

The case for change recognised that there were questions on how the CCGs respond to the configuration issues raised by the long term plan which required exploration and resolution. The key areas for exploration identified were:

- Whether this change to the number of CCGs happens by April 2020 or later, in April 2021
- What functions should be delivered at a NW London level and what should be organised more locally;
- How would the finances work; and
- How the changes to our CCGs relate to: changes at NW London with the development of an NW London integrated care system, the development of integrated care partnerships (ICP), based on boroughs, current CCG footprints, or groupings of boroughs, and the development of sub-borough structures such as primary care networks (PCNs).

2. Our stakeholders

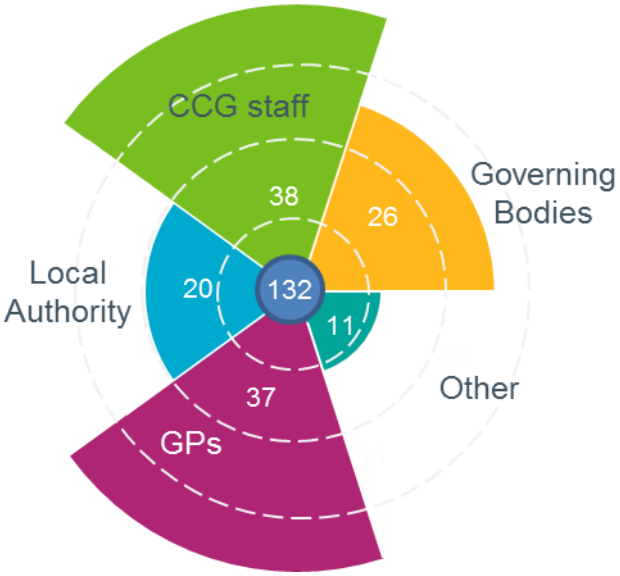
Our wide ranging stakeholders range from our staff across the NW London commissioning system, our providers of health and care, our voluntary sector, supporting bodies such as the Londonwide Local Medical Committees (LMC), Healthwatch, local government and our regulators.

3. Engagement

Our engagement period launched on the 29 May with the publication of the case for change. The engagement focused on the case for change and gave stakeholders the opportunity to input into the design of the future commissioning arrangements for NW London.

During the engagement phase, we carried out significant engagement with our range of stakeholders and subsequent information was disseminated, including FAQs and detail around the operating model and governance. We agreed to extend the engagement phase to 24 August, in order to give stakeholders further time to comment and input into proposals.

Collectively, we have now attended over 130 events, including 8 governing bodies in public and 18 governing body events In addition to this we have met with all local authorities, GP members, primary care networks and GP Federations, patient groups, the LMC, Healthwatch and most importantly, our staff.



Context in which engagement was conducted:

- NW London is the largest and most complex STP area in the country with multiple providers and eight local authorities. Our plans and reform proposals have been arguably scrutinised more thoroughly and generated greater debate than in some other areas of London and the rest of England. We are grateful for the time and effort people took to input into our plans and the responses received.
- The NHS in NW London is one of the most financially challenged in the country, and the need to get back into financial balance is a major priority which will dominate our work for the period of the financial recovery plan.
- The changes to CCG configuration are being discussed at a time when significant other changes are being proposed to the health and care system. The health and care partnership is making good progress with integrated care at system (NW London), borough (ICP) and sub-borough level (PCN); however, in order to ensure success, the interplay between these emerging arrangements and the role of a single CCG needs to be explained with a well thought out division of responsibilities at place and system level.

4. Key issues raised

The key points that emerged through the engagement were:

- **Drivers for change:** Stakeholders generally understood the need to change our current commissioning arrangements, especially those that reduce costs from transactional activities, reduce health inequalities, support front-line delivery and are supportive of our move to integrated care. They would like to see us move away from systems that can incentivise the wrong patient pathways, such as payment by results, and focus our commissioning effort on the integration agenda.
- **Concern around timing**: Although most respondents accepted the need to reduce the number of CCGs to align with the STP there was concern about whether we would be ready by April 2020. With ICS, PCN and ICP development, and the perceived lack of clarity to the system architecture and function of ICPs in the future, GB members particularly felt that the merger would land better when ICPs and PCNs further developed in 2020/21. There is much energy and focus on our integration agenda and the characteristics of each component, we must continue to keep our efforts focused and take more time to develop the form and structures to support these developments.
- **Surplus/deficit position**: Some CCGs were concerned about what financial position the new CCG would inherit and whether historic surpluses and deficits would be netted off into the new arrangement or if the CCG was starting with a clean balance sheet. Definitive guidance on this is still awaited at the point at which these papers are published.
- **Operating model[1]:** some stakeholders were unclear how the single CCG would function, how finance will flow and how responsibilities would be distributed between different levels. Some stakeholders suggested that a transition year will help us continue at pace, whilst we ensure risks are managed effectively.
- **Governance products**: some stakeholders expressed a desire to see and have time to effectively scrutinise the new CCG constitution, scheme of delegation and powers delegated to local committees before a decision is taken. There has been significant interest in our constitution, and we are now engaging more widely with the support of LMC colleagues. Maintaining clinical leadership and ensuring the empowerment of

[1] An operating model is the blueprint for how resources are organised and operated to deliver the strategy. All elements of the operating model—structure, accountabilities, governance, behaviours as well as the way people, processes and technology get integrated to deliver key capabilities—must be explicitly designed to support the strategy. https://www.bain.com/insights/design-principles-for-a-robust-operating-model/

members was raised multiple times as a very important point to emphasise in the new governance products and new arrangements.

- **Patient involvement and democratic scrutiny:** concerns were expressed as to whether there would be a loss of democratic accountability to local authorities and local residents in each area.
- **Justification for one CCG rather than more:** some comments were received that we had not clearly justified the proposal for one CCG rather than two or more. During the engagement phase it was explained that a single CCG would achieve the NHS Long Term Plan aim of aligning the CCG boundary to the STP boundary and that if we were to deviate from that a justification was required. We made clear that we were willing to consider arguments for more than one CCG, but none were put forward.
- **Staff:** the key response from staff was about the implications for them and whether there would be job losses. Clearly the required reductions in management costs will have an implication for jobs but given the number of vacancies and interim posts we currently have, we would not anticipate significant numbers of compulsory redundancies.

5. CCG Chairs Review

The CCG Chairs, the AO, and STP SRO met to review the position and consider the results of the engagement period, and to agree the recommendation to take to governing bodies.

It was noted that:

- Financial recovery is the number one priority in NW London;
- There is a strong desire for the collaboration to move forward as a partnership of eight boroughs and to work with providers to develop alternative payment and contractual arrangements from 2020/21 to support our collective desire of ICP and ICS delivery;
- Due to the significant interest and complexity in the system, a number of products remain in development, such as the CCG constitution and scheme of delegation;
- We are yet to receive finalised advice from NHSE on the financial surplus/deficit position;
- There is not an aligned view amongst governing bodies, CCG members, and stakeholders to support the earlier date for CCG merger; and that
- Not supporting a merger in 2020 did not mean no change, indeed a number of changes will still be required as we transition to formal merger in 2021.

There are a number of changes we need to make in preparation for 2021:

1. CCG Governing Bodies are expected to agree to a commitment to merge in April 2021.
2. CCGs will move to a transition year, working under a single operating model for 2020/21.
3. As part of this transition year, each CCG will require a clear plan to demonstrate the delivery of the equivalent financial and efficiency benefits to that of a formal merger from April 2020. This will need to include plans for the following areas:
    - Delivery of cost savings and organisational efficiencies to meet the 20% management cost reduction.
    - Developing the NW London-wide collaborative governance arrangements and reducing CCG governing body committee and governance meetings.
    - Rationalisation of governing body membership, in line with the arrangements that we have already been making to share roles and standardise and review clinical lead arrangements in line with the new operating model.
    - Developing a single operating model and new staffing structures to reduce duplication and support the development of integrated care arrangements at borough and ICS level.

The points above align with our regulators expectations of how a transition year would operate, and are consistent with other areas in London where merger is deferred until 2021.

6. Recommendation to the governing body

It is the CCG Chairs' and Accountable Officer's recommendation to the governing bodies is as follows:

The governing body is asked to agree with the following recommendation:

3. In view of the feedback from our stakeholders, the need to focus on financial recovery, and the commitment of all Chairs to remain aligned as an eight borough collaboration, we recommend to CCG governing bodies that the merger to a single CCG for NW London takes place on 1 April 2021.

The governing body is asked to note the following consequence of recommendation 1:

4. This transition year will enable us to work with each governing body to focus on:
    a. System financial recovery

b. Development of integrated care at PCN, borough and ICS level

c. Building closer working relationships with our local authorities

d. The development of a single operating structure across the commissioning system, and meet the expectations of NHSE that we would operate in 2020/21 under a single operating framework, with the associated reduction in management costs and streamlined governance

e. To work with providers to develop alternative reimbursement structures from 2020/21 to support delivery of ICP/ICS.

9. Next Steps

If the recommendations are agreed we will:

- Review our structures and implement our single operating model, in-line with financial recovery;
- Continue our engagement on the future CCG constitution and related governance documentation;
- Work together during the transition year, making our meetings more efficient and effective, while maintaining strong public engagement and effective scrutiny; and
- Continue to work with members to demonstrate benefits of merging as we prepare to vote in 2020.

Mark Easton

Accountable Officer

Appendix 1: Engagement activities

CCG/ NWL	Event	Date
Brent CCG	Governing Body Meetings	26/06/2019
Brent CCG	Governing Body Seminar	10/07/2019
Brent CCG	Governing Body Seminar	08/05/2019
Central London CCG	Governing Body Meetings	12/06/2019
Central London CCG	Governing Body Seminars	08/05/2019
Central London CCG	Governing Body Seminars	10/07/2019
Ealing CCG	Governing Body Meetings	19/06/2019
Ealing CCG	Governing Body Seminar	22/05/2019
Ealing CCG	Governing Body Seminar	24/07/2019
Hammersmith & Fulham CCG	Governing Body Meetings	11/06/2019
Hammersmith & Fulham CCG	Governing Body Seminar	07/05/2019
Hammersmith & Fulham CCG	Governing Body Seminar	16/07/2019
Harrow CCG	Governing Body Meetings	18/07/2019
Harrow CCG	Governing Body Seminars	21/05/2019
Harrow CCG	Governing Body Seminars	16/06/2019
Hillingdon CCG	Governing Body Meetings	05/06/2019
Hillingdon CCG	Organisation Development Seminars (GB)	08/05/2019
Hillingdon CCG	Organisation Development Seminars (GB)	24/07/2019
Hounslow CCG	Governing Body Meetings	11/06/2019
Hounslow CCG	Governing Body Seminar	14/05/2019
Hounslow CCG	Governing Body Seminar	09/07/2019
West London CCG	Governing Body Development session	07/05/2019
West London CCG	Governing Body Development session	04/06/2019
West London CCG	Governing Body Development session	02/07/2019
West London CCG	Governing Body Development session	06/07/2019
West London CCG	Governing Body Meetings	18/06/2019
Brent CCG	locality meeting	27/06/2019
Brent CCG	locality meeting	10/07/2019
Brent CCG	locality meeting	19/07/2019
Brent CCG	GP Engagement	June 2019 - July 2019
Central London CCG	Council members	26/06/2019
Central London CCG	Membership meetings (big conversation)	26/06/2019
Central London CCG	Practice visits	June 2019 onwards - Present
Central London CCG	Primary Care Network Boards	06/08/2019
Central London CCG	Primary Care Network Boards	15/08/2019
Ealing CCG	Council of members	15/05/2019
Ealing CCG	Council of members	24/07/2019
Ealing CCG	GP Practice	03/06/2019 (virtual

CCG/ NWL	Event	Date
		engagement)
Hammersmith & Fulham CCG	local LMC	13/06/2019
Hammersmith & Fulham CCG	local LMC	08/08/2019
Hammersmith & Fulham CCG	Members meeting	18/07/2019
Hammersmith & Fulham CCG	Practice visits offered	June - present
Hammersmith & Fulham CCG	Primary Care Networks meetings	July - sept
Harrow CCG	GP forum	19/06/2019
Harrow CCG	LMC	02/07/2019
Harrow CCG	Practice visits	May 2019 onwards - present *(August)*
Harrow CCG	Primary Care Networks meetings	July onwards - September
Hillingdon CCG	AGM	09/07/2019
Hillingdon CCG	locality meeting	05/07/2019
Hillingdon CCG	locality meeting	12/07/2019
Hillingdon CCG	locality meeting	27/07/2019
Hounslow CCG	Council of members	15/05/2019
Hounslow CCG	Council of members	17/07/2019
NW London meetings	NWL wide LMC	17/07/2019
NW London meetings	NWL wide LMC	30/07/2019
West London CCG	AGM	23/07/2019
West London CCG	Council members - plenary meeting	25/06/2019
West London CCG	Council members - plenary meeting	23/07/2019
West London CCG	Network meetings	11/07/2019
West London CCG	Network meetings	17/07/2019
West London CCG	Network meetings	18/07/2019
West London CCG	Network meetings	24/07/2019
West London CCG	Network meetings	25/07/2019
Brent CCG	Health & Wellbeing Board	23/04/2019
Brent CCG	Health & Wellbeing Board	15/07/2019
Central London CCG	Health & Wellbeing Board	03/07/2019
Ealing CCG	Health & Wellbeing Board	09/07/2019
Ealing CCG	Overview & Scrutiny Committees	20/06/2019
Hammersmith & Fulham CCG	Health & Wellbeing Board	25/06/2019
Harrow CCG	Health & Wellbeing Board	25/07/2019
Harrow CCG	Health & Wellbeing Board	04/06/2019
Harrow CCG	Overview & Scrutiny Committees	09/07/2019
Hillingdon CCG	Health & Wellbeing Board	25/06/2019
Hillingdon CCG	Overview & Scrutiny Committees	09/07/2019
Hounslow CCG	Health & Wellbeing Board	15/07/2019
NW London meetings	Joint Health Overview & Scrutiny Committee	21/06/2019

CCG/ NWL	Event	Date
NW London meetings	Joint Health Overview & Scrutiny Committee	23/07/2019
NW London meetings	Lay members meeting Accountable Officer	28/05/2019
NW London meetings	Local Authorities Meetings	20/05/2019
NW London meetings	Local Authorities workshop	24/06/2019
NW London meetings	Local Authorities Meetings	09/07/2019
West London CCG	Health & Wellbeing Board	04/07/2019
West London CCG	Overview & Scrutiny Committees	02/07/2019
Brent CCG	Brent CCG Patient Voice	24/06/2019
Hammersmith & Fulham CCG	H&F patient group	16/07/2019
Harrow CCG	Engagement and Equality Committee	16/07/2019
NW London meetings	Brent patient Voice	24/07/2019
NW London meetings	Ealing save our hospital	03/07/2019
NW London meetings	Lay partner meeting	04/06/2019
NW London meetings	NWL Clinical Quality Leadership Group	27/06/2019
NW London meetings	NWL Partnership board	27/06/2019
NW London meetings	NWL Partnership operations group	13/06/2019
West London CCG	Patient and public engagement committee	13/08/2019
West London CCG	Patient reference group	09/07/2019
Brent CCG	Staff meeting	08/05/2019
Brent CCG	Staff meeting	18/06/2019
Brent CCG	Staff meeting	16/07/2019
Brent CCG	Staff meeting	20/08/2018
Central London CCG	Staff meetings	05/06/2019
Central London CCG	Staff meetings	09/07/2019
Central London CCG	Staff meetings	12/07/2019
Ealing CCG	staff meeting	04/06/2019
Ealing CCG	staff meeting	11/06/2019
Ealing CCG	staff meeting	18/06/2019
Ealing CCG	staff meeting	25/06/2019
Hammersmith & Fulham CCG	Staff meeting	30/07/2019
Hammersmith & Fulham CCG	Staff meeting	06/08/2019
Harrow CCG	staff meeting	19/06/2019
Harrow CCG	staff meeting	17/07/2019
Harrow CCG	Staff meeting	21/08/2019
Hillingdon CCG	Staff meeting	21/05/2019
Hillingdon CCG	Staff meeting	05/06/2019
Hillingdon CCG	Staff meeting	01/08/2019
Hounslow CCG	Staff meeting	15/05/2019 onwards (weekly) till present
Hounslow CCG	Staff meeting	01/06/2019

CCG/ NWL	Event	Date
Hounslow CCG	Staff meeting	03/08/2019
Hounslow CCG	Staff meeting	01/07/2019
NW London meetings	NW London Live Staff Q&A	18/07/2019
NW London meetings	NW London Staff event	12/06/2019
NW London meetings	Informatics Staff meeting	20/08/2019
NW London meetings	Comms & Engagement staff meeting	25/07/2019
NW London meetings	Comms & Engagement staff meeting	20/08/2019
NW London meetings	Health and Care Partnership team meetings	17/06/2019
NW London meetings	Health and Care Partnership team meetings	01/07/2019
NW London meetings	Health and Care Partnership team meetings	15/07/2019
NW London meetings	Health and Care Partnership team meetings	29/07/2019
NW London meetings	Health and Care Partnership team neetings	12/08/2019
NW London meetings	Governance Staff meetings	24/05/2019
West London CCG	Staff meeting	15/05/2019
West London CCG	Staff meeting	12/06/2019
West London CCG	Staff meeting	10/07/2019
West London CCG	Staff meeting	14/08/2019

Appendix 2: Formal feedback received

Date received	Name	Organisation
23/08/2019	Cllr Heather Acton/ Cllr Sarah Addenbrooke/ Cllr Robert Freeman/Cllr Jonathan Glanz,	Westminster City Council & Royal Borough of Kensington & Chelsea
23/08/2019	Robin Sharp CB, Chair	Brent Patient Voice
23/08/2019	Primary Care leads	NWL CCGs
21/08/2019	Chris Corfield Head of Medicines Management	NWL CCGs
21/08/2019	Jenny Greenfield Director of Services, voluntary and community sector	Kensington & Chelsea Social Council
21/08/2019	Cllr Mel Collins	JHOSC
20/08/2019	Patient Reference Group Response	WLCCG
05/08/2019	Ealing Save Our NHS	Ealing Save Our NHS
02/08/2019	Hammersmith & Fulham Council	Hammersmith & Fulham Council
29/07/2019	PPIE committee	Hillingdon CCG

Date received	Name	Organisation
12/06/2019	Cllr Graham Henson, Chair of Health & Wellbeing Board	Harrow Council
06/06/2019	Lay Partners meeting	NWL CCGs
20/06/2019	Lesley Williams Assistant Director Primary Care Strategy	Londonwide LMCs and Londonwide Enterprise Ltd
24/08/2019	Elizabeth Gaynor Lloyd	Brent Patient Voice
23/08/2019	Carena Rogers	Central West London Healthwatch

London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **9 September 2019**	
Report title: Primary Care Networks	
Open Report	
Classification: For Discussion **Key Decision:** No	
Accountable Director: Janet Cree	
Update Author: Matt Mead, Integrated Care Lead	**Contact Details:** m.mead@nhs.net

1. EXECUTIVE SUMMARY

Primary Care Networks (PCNs) are groups of general practices providing population based health care to geographical groupings of between 30,000 and 50,000 people. PCNs are part of the wider changes to the GP contract, accompanied by additional investment to enable greater provision of proactive, personalised, coordinated and more integrated health and social care.

Following the release of the Network Contract Direct Enhanced Service (DES) in March 2019 practices in Hammersmith and Fulham have organised themselves into five PCNs based on existing relationships and organised around the physical geographical locations of the practices. The Network Contract DES, which practices have signed up to in addition to their core GP contracts, applied requirements for the PCN to collectively deliver from 1st July 2019 with additional elements being added over the lifetime of the contract which is expected to be in place until at least 31st March 2024.

Initially under the Network Contract DES the PCN is provided with funding to appoint a Clinical Director, core PCN funding to support the development of the network and for the delivery of extended hours access across the whole population alongside reimbursement for additional roles.

From April 2020 PCNs will also be required to deliver the first five of seven national service specifications designed to improve health, improve quality of care and help to make the NHS more sustainable. In April 2020 this will include obligations to provide structured medications reviews and optimisation; enhanced health in care homes; anticipatory care for high needs patients; personalised care; and to support early cancer diagnosis.

Under the Network Contract DES new funding is available to PCNs to support the diversification of the primary care workforce through the recruitment of clinical pharmacists, social prescribing link workers, physician associates, first contact physiotherapists and community paramedics. The introduction of these roles will be phased across the first three years of the Network Contract DES to allow the roles to become an integral part of the core general practice staffing.

In Hammersmith and Fulham several Clinical Pharmacists are already in post and working in practices under existing national schemes who would be eligible to transfer to the PCN roles. Work is also progressing to recruit Social Prescribing Link Workers with three PCNs progressing this through the GP Federation.

PCNs also require the member practices to reflect their existing obligations for patient engagement at a population level. The CCG has taken an active role in supporting this by providing training for existing and potential Patient Participation Group (PPG) members and facilitating network level PPG discussions.

In support of the ambitious aspirations for the PCNs work is underway across NWL to support the PCN development including the creation of a development plan accompanied by access to a menu of support in identified areas. The CCG is further supporting this work through collective and individual meetings with the Clinical Directors and by aligning teams to provide an identified lead for each PCN.

PCNs are also recognised as an important building block in integrated care with the expectation that the Clinical Directors play a role in shaping and supporting their Integrated Care System. Locally this has been responded too through the refocusing of Integrated Care Partnership work at the PCN level and inclusion of the Clinical Directors at Board and workstream meetings. The GP Federation has also revised the composition of it's Board to the five Clinical Directors to ensure that it represents primary care across the borough.

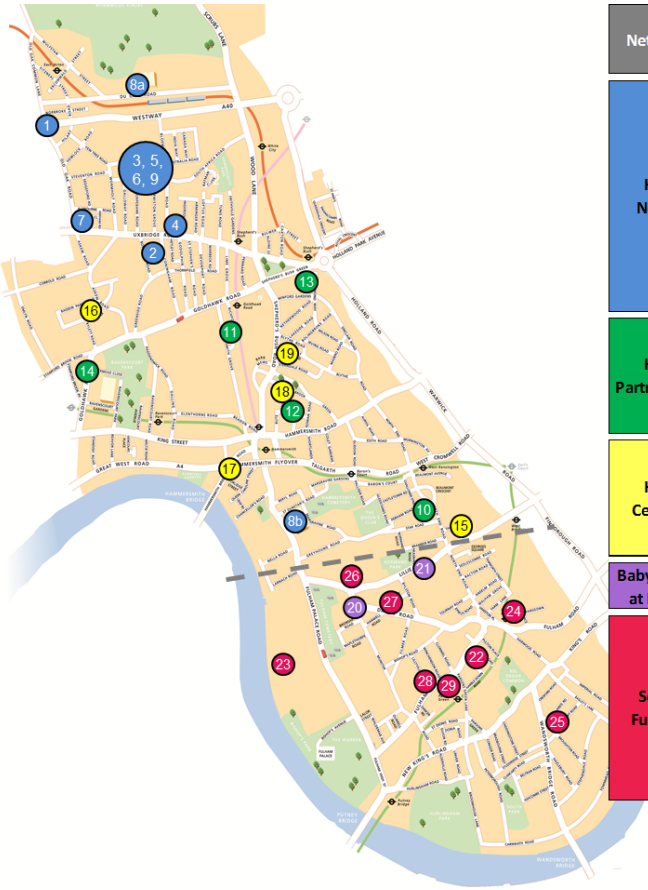
2. **INTRODUCTION**

Primary Care Networks (PCNs) are at their simplest level, groupings of local general practices and are intended to build upon the core of current primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care. Typically PCNs are expected to cover a population of between 30,000 and 50,000 people so that they are small enough to provide the personal care valued by patients and GPs, whilst being large enough to provide economies of scale through better collaboration between practices as well as with the wider health and social care system. Although these are the anticipated population sizes the upper limit is not a strict requirement providing that the PCN is able to organise itself operationally into smaller neighbourhood teams.

PCNs are part of the wider changes to the GP contract which provide access to extra investment in order to help address the challenges facing general practice and deliver new services. In order to do this the PCNs will enter into network contracts in addition to the core GP contracts of their member practices.

Practices in Hammersmith and Fulham have organised themselves into five PCNs, building on established relationships and organised around the physical geographical locations of the practices. The location of practices and population for each of the PCNs is shown below in Figure 1.

Figure 1: Hammersmith and Fulham Primary Care Networks



Network	Practice Code	Map No.	Practice Name	Raw List Size (Jul 19)	Weighted List Size (Jul 19)	Network List Size (Raw)
H&F North	E85005	1	Westway Surgery	3,480	3,421	51,140
	E85042	2	The New Surgery	5,476	5,278	
	E85048	3	Parkview Practice	7,347	6,967	
	E85077	4	Shepherd's Bush Medical Centre	3,449	3,440	
	E85624	5	Dr Uppal & Partners, Parkview	6,883	7,300	
	E85659	6	Dr Kukar, Parkview	1,874	1,754	
	E85748	7	Dr Kukar, The Medical Centre	6,640	5,442	
	Y02589	8a	H&F Centres for Health (Hammersmith)	9,159	8,197	
		8b	H&F Centres for Health (Charing Cross)			
	Y02906	9	Canberra Old Oak Surgery	6,832	6,439	
H&F Partnership	E85003	10	North End Medical Centre	19,515	16,998	67,739
	E85016	11	Richford Gate Medical Practice	10,562	10,687	
	E85020	12	Brook Green Medical Centre	14,747	13,866	
	E85055	13	The Bush Doctors	12,518	11,751	
	E85636	14	Park Medical Centre	10,397	9,975	
H&F Central	E85008	15	North Fulham Surgery	7,806	7,909	33,107
	E85032	16	Ashchurch Surgery	5,027	5,091	
	E85033	17	Hammersmith Bridge Surgery	10,751	10,411	
	E85074	18	Brook Green Surgery	4,857	4,362	
	E85125	19	Sterndale Surgery	4,666	4,228	
Babylon GP at Hand	E85029	20	Dr Jefferies & Partners	13,616	11,784	71,291
	E85124	21	Babylon GP at Hand	57,675	52,068	
South Fulham	E85025	22	Cassidy Road Medical Centre	7,482	6,789	56,727
	E85038	23	Palace Surgery	5,379	4,683	
	E85118	24	Fulham Medical Centre	6,974	6,301	
	E85128	25	Sands End Health Clinic	12,152	11,201	
	E85649	26	Fulham Cross Medical Centre	2,445	2,000	
	E85672	27	Salisbury Surgery	1,165	1,149	
	E85685	28	Lillyville @ Parsons Green	9,100	8,430	
	E85719	29	Ashville Surgery	12,030	9,951	
				280,004	257,871	

3. NETWORK CONTRACT DIRECT ENHANCED SERVICE

In order to register as a PCN a new Network Contract Direct Enhanced Service (DES) was published in March 2019. The CCG was required to offer the practices the opportunity to register a PCN from April 2019 to enable the PCNs to sign up to deliver the contract in advance of the application of the requirements on practices from 1st July 2019. The Network DES in intended to evolve over time with additional elements being added over the lifetime of the contract which is expected to be in place until at least 31st March 2024.

The focus of the Network Contract DES in 2019/20 is to support the establishment and development of the PCNs in preparation for their role as a key delivery vehicle for the ambitions articulated with the NHS Long Term Plan.

Alongside working on organisational development the PCNs are currently delivering extended hours access across their PCN, ensuring full population coverage, and recruiting to clinical pharmacist and social prescribing link worker roles.

The Network Contract DES is supported by financial entitlements which the PCN receive into a nominated payee account on behalf of the network.

Payments to the PCN reflect funding for:

- Clinical Director
  Funding: 0.25WTE per 50,000 registered population or £0.514 per registered patient
  The PCN are required to appoint a named accountable Clinical Director to provide leadership for the PCNs strategic plans and to work with members to improve the quality and effectiveness of the network services.
- Core PCN Funding
  Funding: £1.50 per registered patient
  This funding is for use by the PCN as required to deliver the ambitions of the Network Contract DES.
- Workforce
  Percentage Reimbursement based on actual salaries up to maximum amounts
  Under the Network Contract DES PCNs will be reimbursed to support the recruitment to new roles. Initially this is for Social Prescribing Link Workers and Clinical Pharmacists with other roles to be introduced from 2020/21.
- Extended Hours Access Appointments
  Funding: £1.45 per registered patient
  PCNs are required to provide additional clinical sessions outside of core contracted hours to all registered patients within the PCN.

In addition to the funding provided to the PCN, funding is also available for practices to support their participation and active membership of their PCN equivalent to £1.761 per registered patient.

4. FUTURE REQUIREMENTS

Following the initial period of development the PCNs will be required to deliver seven national service specifications with five starting in April 2020 and the remaining two starting in April 2021.

The seven specifications are focused on areas where PCNs can have a significant impact on improving health and saving lives; improving quality of care for people with multiple morbidities; or helping to make the NHS more sustainable. Each of the specifications will include national processes, metrics and expected quantified benefits for patients.

Table 1: Network Contract DES Service Specifications

	2020/21	2021/22
Structured Medications Review & Optimisation		
Enhanced Health in Care Homes		
Anticipatory Care		
Personalised Care		
Supporting Early Cancer Diagnosis		
CVD Prevention & Diagnosis		
Tackling Neighbourhood Inequalities		

The specifications are to be developed with the General Practitioners Committee England as part of the annual contract negotiations and have yet to be released. In preparation the CCG is working with PCNs to ensure their readiness to deliver the specifications including support through the Integrated Care Partnership (ICP) to develop multi-disciplinary teams. The CCG is anticipating providing additional support to the PCNs to prepare for delivery when the specifications are released.

5. WORKFORCE

The additional requirements for general practice under the Network DES are accompanied by new funding to support the diversification and recruitment to new roles to work across the PCN. Initially this is for clinical pharmacists and social prescribing link workers in 2019/20, expanding to include physician associates and first contact physiotherapists in 2020/21 and community paramedics in 2021/22.

These roles have been identified based on the demand for these roles within general practice and their ability to reduce the burden of the GP workload and improve practice efficiency. It is expected that over the course of the Network Contract DES that these roles will become an integral part of the core general practice.

The reimbursement available to PCNs will fund 70 per cent of these roles, with the exception of social prescribing link workers which are 100 per cent funded through the DES, up to maximum values. For 2019/20 this is the relevant percentage reimbursement of one Whole Time Equivalent (WTE) Clinical Pharmacist and one WTE social prescribing link worker per PCN. In most cases the reimbursement is required to fund new rather than existing roles with Clinical Pharmacists funded through alternative reimbursement schemes the only exception.

Table 2: Network Contract DES Additional Roles Reimbursement

	Funding	2019/20	2020/21	2021/22
Clinical Pharmacists	70%			
Social Prescribing Link Workers	100%			
Physicians Associates	70%			
First Contact Physiotherapists	70%			
Community Paramedics	70%			

From 2020/21 the network will be given greater flexibility to decide how many of each of the additional staff to recruit under the Network Contract DES with each network being allocated a single combined maximum reimbursement sum covering all five staff roles.

In Hammersmith and Fulham there already a number of clinical pharmacists in post working in a number of practices under existing national schemes who would be eligible to transfer to receive the Network Contract DES reimbursement. The CCG is working with practices and PCNs to discuss the potential transfer and to support them in developing new ways of working for the Clinical Pharmacists to deliver services across the PCN not for a single practice.

Work to recruit Social Prescribing Link Workers is also progressing locally with the recruitment for three PCNs being organised through the GP Federation and the remaining PCNs advertising independently. Opportunities to enhance and supplement these roles with additional funding are also being discussed as part of an ICP workstream to develop a Compassionate Communities model.

6. PCN PATIENT INVOLVEMENT

The PCNs are expected to reflect the existing patient engagement requirements of their member practices through their primary medical services contracts. In practice this means that the PCNs are required to engage, liaise and communicate with their collective registered population, including 'seldom heard' groups, in the most appropriate way to inform and involve them in developing new services or changes related to service delivery.

The CCG has been very active in supporting practices and PCNs with these requirements particularly in relation to the development of well supported Patient Participation Groups (PPGs). This has led the CCG to develop a coaching style PPG Leadership course, based on the London Leadership Academy model, to help residents develop the collaborative working skills required to be an effective PPG member. In developing this training the CCG has worked closely with some particularly active PPG Chairs which has supported them in developing networks with other PPGs in line with the PCNs.

Accessible communications about PCNs are also being coproduced with patient and voluntary sector representatives to ensure a wider understanding of the broader context of practice engagement.

7. NWL SUPPORT

Alongside the additional funding within the Network Contract DES, across NWL there is a clear programme of work to support the PCNs and help deliver the ambitious aspirations for PCNs as part of the wider system.

In order to support this the PCNs are being asked to undertake a maturity matrix assessment to establish development needs and have a clear idea of where they are aiming to get to through the implementation of a development plan. Having identified the goals and

development support for the PCN the networks will then have access to a menu of support based on a series of domains:

- PCN Set-up
- Organisational Development & Change Management
- Leadership development
- Collaborative working (MDTs)
- Population Health Management
- Asset based community development and social prescribing
- Clinical Director development

Support will be allocated on the basis of agreed principles that ensure that the success and progress against the PCN development plans are measureable, is targeted at achieving strong team-working with partners and enables the PCN to understand their population to reduce unwarranted variation.

Table 3: Timetable for PCN Development Support

Milestone:	**Completion:**
PCN & Community Partners undertake PCN assessment	August / September 2019
PCN Development Plan reviewed at Integrated Care Partnership	September 2019
PCN Development Plans submitted to Health and Care Partnership	October 2019
Development Support Mobilised	Late October 2019
Progress against PCN Development Plans reviewed and areas for additional support identified including sharing learning and best practice.	October 2019 – March 2020

As part of the support offer PCNs are also being asked to consider how their development could contribute to the Health and Care Partnership priorities particularly in achieving the improvement in clinical outcomes for:

- Urgent Care
- Outpatient Care
- Supporting people with frailty
- Diabetes
- Last Phase of Life and Enhanced Health in Care Homes
- Cardiovascular disease and respiratory disease
- Personalisation
- Mental Health
- Cancer
- Children's Health
- Musculoskeletal Health

In addition to the NWL level support we are also supporting the PCNs locally having met with the Clinical Directors to establish ways of working to ensure a collaborative relationship

between the CCG and PCNs. To further this collaborative approach we have also organised our Primary Care and Commissioning and Delivery Teams to align to the five PCNs with an identified lead from each team for each PCN.

8. PCNs AND INTEGRATED CARE

PCNs are recognised within the NHS Long Term Plan as an essential building block of every Integrated Care System with the expectation that the Clinical Directors play a critical role in shaping and supporting their Integrated Care System.

The importance of alignment of the work of the H&F Integrated Care Partnership (ICP) with the development and plans of the PCNs has been recognised with the clinical directors of each PCN invited to attend at both Board and workstream level ICP meetings. In further support of this the H&F GP Federation has revised it's constitution with the five PCN Clinical Directors now forming the Federation Board.

Progress has also been made to refocus partnership working activity at a network level, allowing the PCNs to focus of delivering care to reflect local need, and established workstreams to address priority areas. These priorities are based on steps towards a place based model of care, bringing together staff from across health and social care with the voluntary sector and the community.

- Social Prescribing – utilising the opportunity provided by the social prescribing link workers funded through the Network Contract DES, and potential additional investment from Macmillan to further increase the link worker workforce, this workstream is intended to support the development of a borough level architecture to effectively utilise community assets and support community activation and development.
- Integrated Community Teams – this workstream will look to accelerate the integrated working at PCN level through the creation of place based teams encompassing staff across health, social and voluntary sector organisations. Initially building the links between community health services the workstream will look to deliver improved outcomes for the patients alongside improving staff experience and improving the system efficiency.
- Integration of acute services with Primary Care Networks - building on the foundation of the other workstreams, this will look to fast-track the integration by bringing in acute services in order to draw resources out of hospital and avoid unnecessary acute activity.

The formation of the Primary Care Networks provides an exciting opportunity to support GP at scale working and deliver a standardised offer of primary care to the residents of Hammersmith and Fulham with practices working together, and with partners, to harness their respective strengths.

Appendix 1: NWL Primary Care Networks

Where we are now –Primary Care Networks

Hillingdon (317,104) – 45 practices
- Confederation (311,740)
- 9 Networks
  - HH Collaborative (72,981)
  - MetroCare (36,064)
  - North Connect (44,385)
  - Celandine Health (32,446)
  - Synergy (35,753)
  - Yiewsley, High St, Otterfield, Medical Centre (37,334)
  - First Care Group Network
  - LL Hillingdon and Uxbridge (34,384)

TBC

Harrow (270,605) – 33 practices
- 1 Federation (270,605)
- 5 Networks
  - Sphere PCN (63,362)
  - Health Alliance (52,873)
  - Harrow Collaborative Network (44,972)
  - Harrow East (28,619)
  - Healthsense (80,779)

Brent (389,177) – 56 practices
- 3 Federations
  - Harness (139,924)
  - Kilburn (79,328)
  - K&W (169,925)
- 10 Networks
  - Harness Temple (35,668)
  - Harness Stadium (35,392)
  - Harness North (37,207)
  - Harness Parks (31,657)
  - ConnectHealth Alliance (45,292)
  - Kilburn Partnership (34,036)
  - K&W South (36,876)
  - K&W North (39,592)
  - K&W Central (42,188)
  - K&W West (51,269)

Ealing (441,683) – 75 practices
- 1 Federation (441,683)
- 8 Networks
  - Acton (77,731)
  - Greenwell (37,319)
  - NGP (67,182)
  - North Southall (58,940)
  - Northolt (38,420)
  - South Central Ealing (50,662)
  - South Southall (51,824)
  - The Ealing Network (59,605)

Central London (236,816) – 34 practices
- 1 Federation (236,816)
- 4 Networks
  - Maida Vale and St. John's Wood (52,507)
  - Regents Canal and Paddington (64,894)
  - West End and Marylebone (44,017)
- South Westminster Primary Care Home (75,398)

Hounslow (320,152) – 46 practices
- 1 Consortium (320,152)
- 5 Networks
  - Brentford & Isleworth (59,566)
  - Chiswick (49,380)
  - Feltham (69,468)
  - Great Western Road (60,101)
  - Heart of Hounslow (81,637)

Hammersmith & Fulham (261,710) – 29 practices
- 1 Federation **(261,710)**
- 5 Networks
  - North Primary Care Network (49,984)
  - H&F Partnership (67,087)
  - Central Primary Care Network (33,059)
  - Babylon GP at Hand (55,569)
  - South Fulham Network (56,011)

West London (253,756) – 42 practices
- 1 Federation (253,756)
- 5 Networks New Names
  - NeoHealth (38,152)
  - North (33,449)
  - West-Hill Health (66,890)
  - Kensington and Chelsea South (59,474)
  - South (55,791)

London Borough of Hammersmith & Fulham **HEALTH, INCLUSION AND SOCIAL CARE POLICY & ACCOUNTABILITY** **11 September 2019**	
Report title: NHS Long Term Plan Update	
OpenReport	
Classification: For Discussion **Key Decision:** No	
Wards Affected: All	
Accountable Director: Janet Cree, Managing Director Hammersmith and Fulham Clinical Commissioning Group	
Report Author: Mark Jarvis **Head of Governance Hammersmith and Fulham Clinical Commissioning Group**	**Contact Details:** **Mark.jarvis1@nhs.net**

1. Summary

1.1 As a system we have worked together over the last year to refresh our strategy to ensure we give people the best start in life, ensure care and support is there when it is needed, and ensure people receive high quality care in hospital. These developments have been discussed through governing bodies and the joint committee.

1.2 Across NW London we have agreed a governance system that involves all our partners - partnership board, partnership operations group, clinical and quality leadership group, lay partners, and individual 'cog' programme boards - working across the system. These groups have developed our programmes of work to

ensure we deliver the long term plan commitments as well financial sustainability within NW London.

1.3 To be a successful integrated care system across NW London we need to ensure we have strong, local integrated care partnerships. Therefore, in our LTP submission a summary of each ICP plans and areas of focus will be included to ensure the plan is pertinent to local residents and resonates locally and across the system.

1.4 Our submission drafts will be discussed with the partnership operations group and partnership board before our draft submission to NHSE on 27 Sept. The final version will be agreed through the Joint Committee, in addition to our partnership governance.

1.5 Full and final guidance on what needs to be included in the submission is still awaited from NHS England. A “stocktake” submission needs to be made to NHS England on 27 September. A draft of the submission will be presented to the Health and Care Partnership Board for their meeting on 12 September and this will then have wide circulation amongst system partners to ensure that there is wide input into the final submission that has to be made on 15 November. A draft of the November submission will be brought to the 6 November Health and Wellbeing Board. It is important to emphasise that the final submission will contain high level information and be NW London focussed. It will not provide detailed information on how the strategic statements will be implemented locally. This is something that system partners will want to undertake further work on in order to reach agreement on the local processes. The Integrated Care Partnership (ICP) will have a central role in this.

2. Introduction

2.1 This paper sets out the arrangements in place for the NW London CCGs to respond to the Long Term Plan issued by NHS England at the beginning of this year. The NW London health and social care system is required to make a draft submission to NHS England on 27 September and a final submission on 15 November 2019. The paper cover the ways in which Local Authority partners are inputting into the process of developing both submissions and raises a specific point in relation to how the London Borough of Hammersmith would like to engage with the on-going process.

3. Current Governance Arrangements

3.1 The Health and Care Partnership Board (HCP) is the main system level meeting that is overseeing the development of the system response to the Long Term Plan. This is made up of representations from the Local Authorities, CCGs, health care providers, Healthwatch and other system partners. The HCP is supported by a Partnership Operations Group and a Partnership Leadership Group. Both these groups have system wide membership. At a programme specific level there are a number of integrated programme area programme boards (referred to as COGs) focussing on:

- Healthy communities and prevention
- Maternity children and young people
- Primary social and community care
- Urgent and emergency care
- Mental health
- Cancer
- Hospital care

3.2 Membership of the programme boards is drawn from the various Integrated Care Partnership configurations represented across the NW London system to ensure that there is a direct link with service delivery.

3.3 All parts of the governance system have been contributing to the development of the draft submission and will continue to play an integral part of finalising the system response for the November submission.

3.4 From a Local Authority perspective Sean Harrisss, Harrow Council, is the Local Authority NW London STP lead. Local Authorities have different representatives on the various Boards and Groups within the structure described above and set out in the appendix. Juliet Brown, Health and Care Partnership Director for NW London has offered to attend a future DASS meeting to explore and agree an approach to further engagement and we understand is awaiting an invitation for a suitable meeting date.

4. Update on the NW London Long Term Plan submission

4.1 The submission will be supported by a series of templates that detail finance and workforce ambitions. Colleagues across NW London have already started to engage with social care colleagues on the workforce issues. These discussions will continue. The outputs from these discussions will form part of both draft and final submissions. There are a number of other key areas to which the system will be responding and on which discussions with system partners will be important. These discussions may not all have be initiated by the time the draft needs to be submitted. However, there will be time for detailed discussion on these as we iterate the draft and produce the final version in November. Initial contact with system partners on how best to initiate these discussions will take place at the Partnership Board.

5. How Does the London Borough of Hammersmith and Fulham Want To Engage?

5.1 As indicated above the Local Authorities are represented at the different levels of the governance system. What is important is for the London Borough of Hammersmith and Fulham to be appropriately represented. The Borough representation may not have been as strong in terms of representation in some areas as other Local Authorities have been. The Borough therefore needs to determine whether it wishes to review its current membership and consider if this should be strengthened. Juliet Brown would be happy to have discussions with the Borough to explore this further.

6. NW London submission

6.1 There are two main focusses of the document, how we will work differently in the future, and delivering the health and care priorities of the NHS Long Term Plan.

7. How we will work differently

7.1 This section will include details of our timeline to move to an integrated care system and eight local visions for the development of integrated care partnerships. Within Hammersmith and Fulham the Integrated Care Partnership Board is well established and is making progress on identifying its priorities and outcomes. A summary of this will form part of the NW London submission, alongside the plans from other ICPs.

8. Delivering health and care priorities (Delivering the Long Term Plan)

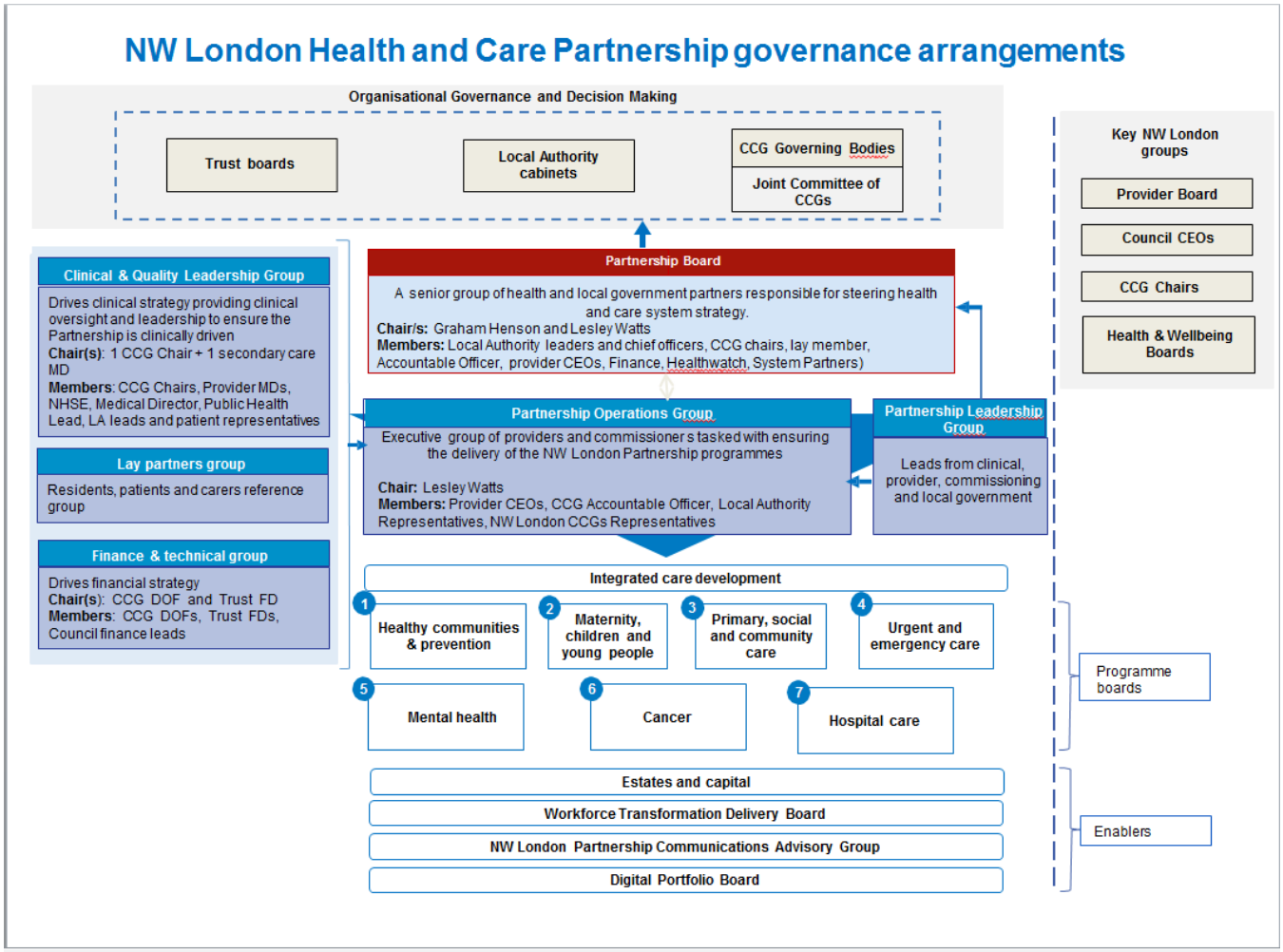
8.1 This section will form the bulk of the document and provide detail on programmes that are already being planned and undertaken through the integrated programme area programme boards listed above. It will focus on how the requirements of the LTP will be met in NW London. The final guidance and requirements for this are still awaited.

9. Engagement

9.1 As part of the commitment to engaging with local people on the system response more than 1500 people have been spoken to over the last four months to help shape our local response. NW London Healthwatches have held 18 events and spoken with 257 local people, ensuring that local issues, concerns and understanding of what is working well are captured in our plans for improving health and care services over the next five years.

9.2 Engagement teams across NW London have also asked local people for specific feedback on this plan. Twenty events, roadshows and public meetings have been attended with surveys completed by 450 people.

Appendix


NW London Health and Care Partnership governance arrangements
Organisational Governance and Decision Making
Trust boards
Local Authority cabinets
CCG Governing Bodies
Joint Committee of CCGs
Key NW London groups
Provider Board
Council CEOs
CCG Chairs
Health & Wellbeing Boards
Partnership Board
A senior group of health and local government partners responsible for steering health and care system strategy.
Chair/s: Graham Henson and Lesley Watts
Members: Local Authority leaders and chief officers, CCG chairs, lay member, Accountable Officer, provider CEOs, Finance, Healthwatch, System Partners)
Clinical & Quality Leadership Group
Drives clinical strategy providing clinical oversight and leadership to ensure the Partnership is clinically driven
Chair(s): 1 CCG Chair + 1 secondary care MD
Members: CCG Chairs, Provider MDs, NHSE, Medical Director, Public Health Lead, LA leads and patient representatives
Lay partners group
Residents, patients and carers reference group
Finance & technical group
Drives financial strategy
Chair(s): CCG DOF and Trust FD
Members: CCG DOFs, Trust FDs, Council finance leads
Partnership Operations Group
Executive group of providers and commissioners tasked with ensuring the delivery of the NW London Partnership programmes
Chair: Lesley Watts
Members: Provider CEOs, CCG Accountable Officer, Local Authority Representatives, NW London CCGs Representatives
Partnership Leadership Group
Leads from clinical, provider, commissioning and local government
Integrated care development
1 Healthy communities & prevention
2 Maternity, children and young people
3 Primary, social and community care
4 Urgent and emergency care
5 Mental health
6 Cancer
7 Hospital care
Programme boards
Estates and capital
Workforce Transformation Delivery Board
NW London Partnership Communications Advisory Group
Digital Portfolio Board
Enablers

Chapters to be covered in the submission:

- Our vision and priorities (cogs)
- What people have told us
- The London vision
- Our population
- New ways of working (ICS/ICP)
- Borough pages x8 (local ICP visions and priorities)

Delivering the NHS Long Term Plan

- Transformed 'out-of-hospital care' and fully integrated community-based care
- Reducing pressure on emergency hospital services
- Giving people more control over their own health and more personalised care
- Prevention
- Digitally-enabling primary care and outpatient care
- Improving cancer outcomes
- Improving mental health services
- Shorter waits for planned care
- Population health

Care and quality outcomes

- A strong start in life for children and young people
- Maternity
- Learning disabilities and autism
- Better care for major health conditions
    - Cardiovascular disease
    - Stroke care
    - Diabetes
    - Respiratory disease
- Research and innovation and Genomics
- Wider social impact

Enablers

- Workforce (volunteering)
- Digital
- Estates
- Finance

London Borough of Hammersmith & Fulham **HEALTH, INCLUSION AND SOCIAL CARE POLICY & ACCOUNTABILITY** **September 2019**	
HEALTHWATCH HAMMERSMITH AND FULHAM	
Open Report	
Classification - For Decision / For Information/For Policy & Accountability Review & Comment (delete as appropriate) **Key Decision: No**	
Wards Affected: ALL	
Accountable Executive Director: **Keith Mallinson Chair Healthwatch Hammersmith & Fulham**	
Report Author: Olivia Clymer	**Contact Details:** Tel: 0208 968 7049 E-mail: olivia.clymer@healthwatchcentralwestlondon.org

AUTHORISED BY: .....

.....

DATE: .....

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 H&F Local Committee partnership work with H&F Clinical Commissioning Group

2.1 Healthwatch H&F Local Committee had an input in the development of the H&F consultation document for Primary and Urgent Care Changes that closed on 24th May.

2.2 H&F Local Committee influenced the development of the final consultation material which was easy to understand by local people clear and simple language, jargon free, provides the necessary information and its design is user friendly. Its contribution was acknowledged at the CCG's decision-making business case that was discussed at the CCG Governing Body Meeting in June, as well as by individuals and publicly in other meetings such as the Patient Reference Group.

2.3 H&F CCG has now approached H&F Local Committee to ensure their public facing materials are as clear and accessible as possible, saying that "their feedback on the consultation documents was invaluable". We are currently working together on reviewing:

- a Summary version of Hammersmith UCC and Weekend Plus Hubs Decision Making Business Case
- Leaflet/booklet informing local residents of available services and how to access them

3. H&F Healthwatch Local Committee Response Digital-First Primary Care Policy: consultation on patient registration, funding and contracting rules by NHS England and NHS Improvement

3.1 H&F Healthawtch Local Committee welcomed the opportunity to provide a formal response to the consultation document that aims to address issues deriving from the quick expansion of digital providers.

3.2. Key points of the response included:

- Stressing the importance of assuring patients that traditional elements of accessing healthcare will not be lost and that NHS England should make it very clear when communicating any changes to patients that those who can't or don't wish to use digital services or tools will still be able to access general practise services in person.
- Supporting the principle of the "out-of-area registration" proposal to have a new local contract awarded to the provider in the "other area" once a specific number of patients has been reached in the condition that potential risks for patients will be identified and mitigations will be put in place.
- Highlighting the problems that the existing funding allocation system has created for the healthcare system in Hammersmith and Fulham that was evidenced by the financial uncertainty that the expansion of Babylon GP at Hand service has created.
- Asking for assurance that new digital providers will respond to what matters to patients under doctor areas by providing evidence they have engaged locally prior to their establishment with the wider community, people that don't want to use the internet and seldom heard groups.

The full response has been attached to this document and can be found on our website.

4. Healthwatch Central West London Response to the NW London Case for Change

4.1 As a local Healthwatch our role is to ensure that local people are actively involved in shaping the health and care services that they use, and that they have a say on how decisions about what health and care services are available for them. We also monitor local provision and hold commissioners and service providers to account for the quality of local publicly funded health and care services.

4.2 Healthwatch CWL have submitted a response to the Case for Change under our statutory powers to hold the NHS and Local Authority to account with the requirement for a response within 20 working days.

4.3 We know from our work that people receive better services when they can directly influence what health and care provision is available in their local area. We also know that people are better able to challenge what services are available locally if there are clear lines of accountability and routes for raising concerns with decision makers or publicly funded agencies and providers. To ensure that both can happen with regard to services provided through local NHS providers and commissioned through a single Clinical Commissioning Group (CCG) for North West London, our examination of this proposal has been carried out with three overarching questions in mind:

- **Patient voice:** "Will a single NWLCCG continue to enable local people to play an active role in shaping health and care services available to them in their local area?"
- **Local Accountability:** "Are there clear lines of accountability that will enable local people to challenge and influence decisions made about what health and care services are available to them in their local area?"
- **Quality of services:** "Will local people's experiences and views be central in how monitoring of quality of service provision is carried out in each area?"

We also consider the information needs of local residents and the types of engagement that are needed at these initial stages of change and as new commissioning routes are implemented in the future.

4.2 The response has provided Healthwatch in Hammersmith and Fulham with the opportunity to remind the NHS of its obligations to patient engagement, consultation and voice and the statutory position of local Healthwatch.

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

The NW London report is now complete. NW London CCG are planning to take the report together with engagement work they have completed to the NW London Lay Members group and Collaboration Board before they provide their STP response to NHS England on the Long Term Plan. Local Healthwatch are able to share the report now and use it to inform the development of local Integrated Care Partnership and local health services.

6. Pembridge Hospice provision

Healthwatch Central West London welcomed the call for evidence and work of clinicians on the provision around Pembridge. Local Healthwatch members across the boroughs have expressed concerns with the potential loss of provision and the vulnerability of depending

on community services for palliative care, in a climate where finances are challenged. There is particular concern about the provision of Continuing Healthcare Budgets and how these budgets, which can be vulnerable to cuts, balance with the provision of hospice at home or hospice beds, for example, would the existing Pembridge Hospice beds be available for respite or provision which does not require a palliative care consultant? Healthwatch would welcome greater engagement with local people on these and the wider concern about palliative care provision.

7. Healthwatch CWL General Engagement

7.1 Healthwatch Central West London monitors the quality of health and care services by listening to the experience of local people using services. We tell commissioners and service providers people's views so that they can work to improve local provision. For Healthwatch to fulfil its role it is important to engage with as many people as possible to increase the number of experiences received.

7.2 During summer 2019 we have redesigned our main patient feedback form to ensure that we cover three main areas: access, experience and solution. We will be encouraging a narrative approach to strengthen our qualitative benchmark.

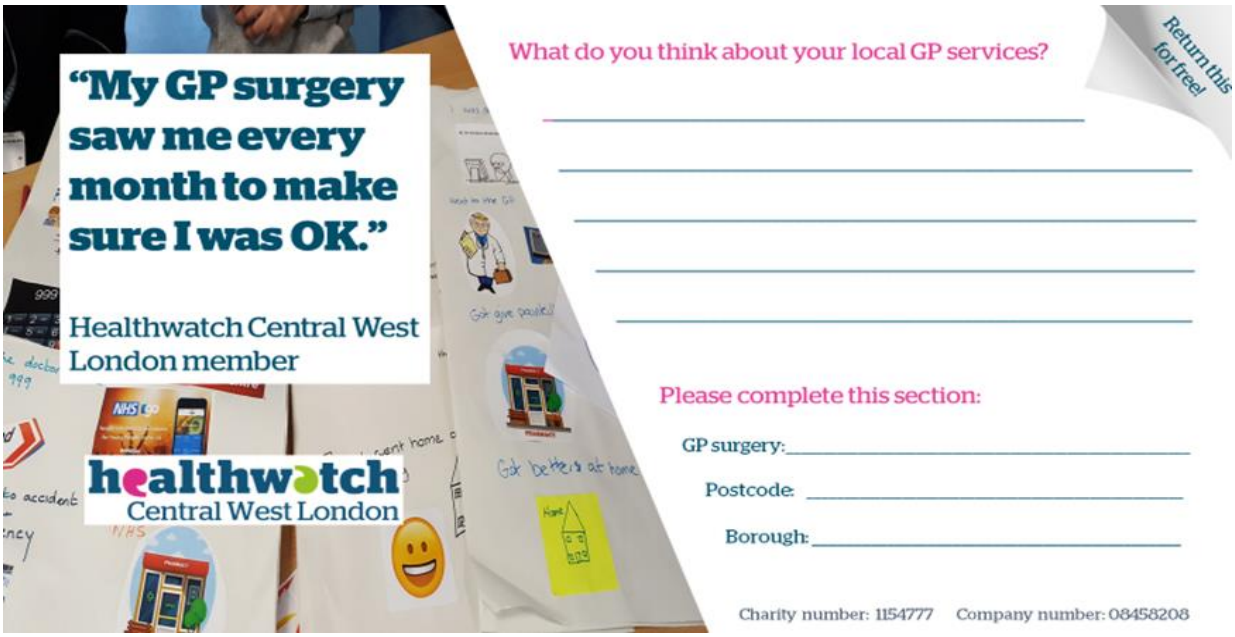
The development of this form follows from an internal staff review of a form that we produced last year and co-designed with a group at Dalgarno Trust.

We developed postcards with a quote from a previous "patient listening" and a picture to inspire comments.

7.3. We will be focusing in the next period in circulating these engagement materials at as many local settings as possible varying from GP practises to local community centres, pubs and hairdressers.

Both the feedback forms and postcards can be returned to Healthwatch Central West London by free post.

Below is a sample of the postcard. Attached with this document the feedback form that will be circulated along with a free post envelope.



NWL Case for Change – response from Healthwatch Central West London, August 2019

Healthwatch Central West London (Healthwatch CWL) welcomes the opportunity to comment on the NWL Case for Change documents.

As a local Healthwatch our role is to ensure that local people are actively involved in shaping the health and care services that they use, and that they have a say on how decisions about what health and care services are available for them. We also monitor local provision and hold commissioners and service providers to account for the quality of local publicly funded health and care services.

This response is submitted under our statutory power to hold the NHS and the Local Council to account. By law organisations who plan, run, and regulate health and social care services must listen to our comments and respond within 20 working days. If they are unable to respond within 20 working days, they must tell us a reason why and a timeframe for when a response can be expected.

An overview of the questions that need a response is set out at the end of this submission.

We know from our work that people receive better services when they can directly influence what health and care provision is available in their local area. We also know that people are better able to challenge what services are available locally if there are clear lines of accountability and routes for raising concerns with decision makers or publicly funded agencies and providers. To ensure that both can happen with regard to services provided through local NHS providers and commissioned through a single Clinical Commissioning Group (CCG) for North West London, our examination of this proposal has been carried out with three overarching questions in mind:

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We also consider the information needs of local residents and the types of engagement that are needed at these initial stages of change and as new commissioning routes are implemented in the future.

Introduction

The following comments and questions have been arrived at in consultation with Healthwatch members who sit on our Local Committees in Hammersmith & Fulham; Kensington & Chelsea; and Westminster.

There was an acceptance amongst our Local Committee members that a single NWLCCG could potentially bring about improvements, but our Local Committee members were clear that for this to be the case it needs to go further than joining up administration. It has to mean a consistent and excellent offer with transparent targets for the 2 million plus patients who will be part of the NWLCCG Sustainability and Transformation Partnership (STP) area.

As an expert in speaking to local patients and residents, and the lead organisation in a recent Healthwatch engagement on the NHS Long Term Plan with local people across the NWL STP area, we would welcome a conversation about how we might work together with the NWLCCG as it develops to ensure that local people are able to fully comment on proposed changes to local health systems and structures.

We would also welcome a discussion about how we might work together to ensure that local people have all the information they need to be able access the healthcare in their area.

Patient voice and quality of health care services

Duties to involve the public in NHS commissioning

Under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), CCGs and NHS England have duties to involve the public in commissioning, (under sections 14Z2 and 13Q respectively). To achieve this, patient and public engagement will need to be central to plans for a single NWLCCG going forward. Public involvement in commissioning is about enabling people to voice their views, needs and wishes, and to contribute to plans, proposals and decisions about services. As Healthwatch we are concerned about how well this will be carried out under the new structure of a single NWLCCG covering such a large area with diverse populations.

Question 1: How is the patient voice to be included at all levels of commissioning within the single NWLCCG commissioning framework?

Role of local Healthwatch

Local Healthwatch have an important role to play in ensuring that residents are aware of potential changes to local health systems and structures, and that they

have the opportunity to comment on changes and how this might affect them before they get implemented.

Part of the driver for creating a single NWLCCG seems to be to create consistency in access to treatment across the STP area covered. We know that this is important for patients. However, this should not be at the expense of basing commissioning decisions on local health needs, or on an understanding of the differing needs of locally diverse populations.

For the foreseeable future, Healthwatch will continue to be commissioned in alignment with local authority boundaries, and so we offer a potential for a partnership that would ensure that local voices are not lost in wider, more regional debates about health care provision. We are an integral part of the regulatory framework for NHS services and have a crucial role in local scrutinising the quality of services and the gaps in provision for local people.

Question 2: How will the single NWLCCG involve local Healthwatch in local commissioning decisions including supporting us to have conversations with local people about proposed changes and gathering their views?

At present there is a Healthwatch representative on the NWL Joint Quality Committee, who is from Healthwatch Central West London. We are pleased to be part of this important Committee and appreciate the changes that have been made as a result of what we have told you, especially around providing more information about the Committee and making its meetings accessible by video streaming them. However, going forward it is important to ensure that local Healthwatch are included in all conversations that affect local health and care provision, as your partner and critical friend. Our remit is to ensure that local people are informed about and get to have a say in decisions about local provision and quality of services provided.

Question 3: How are local Healthwatch to be further included in discussions about STP area future plans and commissioning decisions?

The three boroughs that we work across are ethnically and culturally very diverse. We know from our own work that it is essential to have a dedicated focus on ensuring that we speak to a diverse range of people in any of the work that we do. Our Local Committee members raised concerns about how well the NWLCCG will be able to talk to and create partnership opportunities with different cultural groups.

Question 4: How much attention has been paid to how the NWLCCG will talk to its diverse local populations and create opportunities for them to be a meaningful part of ongoing discussions and decisions about local provision?

Stakeholder engagement

An important question that many of our Local Committee members asked was whether there will be further opportunities after this initial discussion to engage and comment before April 2020. From the information currently provided this is not clear. As it seems that discussions are mostly at the stage of how the single NWLCCG is going to organise itself rather than the detail of the operational level, it is difficult for patients to fully comment at this stage.

Question 5: What further conversations about the change to a single NWLCCG and how this might affect local people are planned before implementation?

Our Local Committee members highlighted the importance of local people and patients receiving information about proposed changes, opportunities to share their views, and guidance on how the changes may affect them, their friends, family and neighbours.

Changes to Primary Care Networks are likely to be where patients first notice a difference in provision. They will need information and will be keen to share their views and experiences. Healthwatch has good links into many GP practices and PPGs across our three boroughs and could be a useful partner in getting information to patients and asking them to share their views.

Question 6: What plans are there for local Healthwatch to be included in plans for patient and public engagement, to ensure that all communications produced are clear, accessible and provide the information that patients and local people most need to hear?

Integrated Care partnerships

Integrated Care Partnerships are localised commissioning mechanisms that create the opportunity for whole systems joining up of provision. They offer the benefit of local ownership whilst offering economies of scale. Acute hospital services are an integral part of these local systems. However, the NWLCCG is also deigned to cover commissioning of acute and specialist health services across the STP area where it makes sense to do so.

Question 7: How will the NWLCCG ensure that it takes into account local health needs and sees that they are addressed through local Integrated Care Partnerships and does not remove close links with acute hospital services from the local level?

Question 8: As Integrated Care Partnerships are developed across the eight CCG areas can you provide more information on when and where patient feedback can be offered?

Patient Participation Groups (PPGs) and representation

PPGs are an important route for patients to be able to comment on availability and quality of GP services. As Healthwatch we have concerns about how well statutory obligations for PPGs are currently being adhered to. Our Local Committee members and wider Healthwatch membership report variable quality and

availability of PPGs in the GP surgeries they attend. We know from our work focused on supporting PPGs that not all GP practices provide the necessary commitment to the PPG in their practice and that this is not always a robust way for patients to comment on the services that they receive, or to work with their practice to make improvements.

We are currently working with CCGs across our three boroughs to find ways to support and improve PPGs, including at the Primary Care Network level as we recognise this as an important route for patients to comment on local availability and quality of services.

Question 9: How will the single NWLCCG ensure that GP practices support PPGs as an essential route of local engagement for patients, and to also ensure how the work that they do can affect positive change at GP Practice level for patients?

Local accountability and quality of local health care services

The primary aim of health scrutiny is to act as a lever to improve the health of local people, ensuring their needs are considered as an integral part of the commissioning, delivery and development of health services. It is essential that health scrutiny functions are also carried out in a transparent manner, so that local people have the opportunity to see and hear proceedings, in line with the transparency measure in the Local Audit and Accountability Act 2014. Guidance issued by the Depart of Health in 2014 clearly states that a failure to comply with duties for local scrutiny mechanisms set out in Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 would place the relevant NHS body or relevant health service provider in breach of its statutory duty and render it at risk of a legal challenge.

Local authority scrutiny of local health and care provision

As Healthwatch our focus is on how local people's views and experiences can help to improve health and care provision, and also to help identify where the gaps currently are. Being part of local scrutinising mechanisms, including reporting into and raising local health and care issues directly to local authority Overview and Scrutiny Committees, undertaking Enter & View visits into publicly funded health and care services, and commenting on NHS providers Quality Accounts are all important aspects of the work that Healthwatch undertakes. From this we see first-hand the power of residents and patient's voices to actively influence which local services get scrutinised and to be part of the evidence included in decisions made.

We are currently part of the NWL Quality Committee as a representative from the eight Healthwatch. It will also be important for Healthwatch to have good representation on all Quality Committees in NHS Healthcare Trust providers, as this will help us make good use of our links to local authority Overview and Scrutiny Committees. It will also put us in a good place to be able to get a local response.

At the moment, the links between locally commissioned health services and local authority Overview and Scrutiny Committees is clear but it is difficult to see how this might work in practice once a single NWLCCG is established, with its regional level responsibility for commissioning services that people will use locally.

Question 10: How will Healthwatch and local authorities in each area retain responsibility and power to use local patient experience to scrutinise and tackle poor performance or gaps in health services at a local level where those services are commissioned at a single NWLCCG level?

NWLCCG Governing Body and other committees

The current proposals suggest that there will be four lay members on the NWLCCG Governing Body. Our Local Committee members were concerned about whether this would be enough representation across the eight boroughs, each of which have quite diverse health needs. They stated that it is important local Healthwatch also have an active presence on the NWLCCG Governing Body and recommended that there should be at least two from across the eight Healthwatch. Not having this representation considerably weakens local patient voice in decisions made at the NWL STP area level that will impact people's health care locally.

Question11: Will local Healthwatch be offered places for at least two representatives on the NWL Governing Body?

Healthwatch currently have one seat at the NWLCCG Quality Committee; this has been an important avenue for us to achieve greater transparency of the workings of the Committee and to allow for better local scrutiny of proceedings. It is essential that we retain this seat.

Question 12: Will NWLCCG guarantee that local Healthwatch will continue to have one representative on the Quality Committee?

Commissioning responsibilities

Currently commissioners and providers work together at the local level in regard to 'commissioning intentions' about what should be provided in their local areas. There is still room for patients, residents, and user groups to have a greater say in which services should be commissioned and on the quality of services provided. As local CCGs are no longer responsible for commissioning acute hospital services, the need to involve local people in forward planning and quality assurance becomes even more important. There is an obligation for local commissioners to take account of local JSNAs and for commissioning intentions to be taken to Health and Wellbeing Boards and / or Overview and Scrutiny Committees.

Question 13: What plans are in place to ensure that conversations about future service provision are held with local people and patients, and for local people and patients to be involved in monitoring quality of local provision across the NWLCCG area?

Our Local Committee members appreciate that having a single NWLCCG may lead to improvements in consistency and access to services across the NWL STP area. However, there was some concern about how well innovation of services, or those services that emerge as a response to a very particular local need will be supported in future. To ensure that this can happen, the NWLCCG will need to continue to talk to local residents, community groups, Healthwatch, and local authorities about the health needs of the local population to fully understand the diverse health needs and potential service and localised responses needed.

Question 14: How will the NWLCCG ensure that the drive for consistency in health provision standards across the wider area does not drown out local people's needs for diversity of health support and the potential for innovative models to be developed at local levels?

Integrated Care Partnerships

We welcome the latest Case for Change documents statement that "Healthwatch to be involved with Integrated care partnership (ICP) development". We are keen to ensure that local people's views and experiences are included in all discussions about current provision and future changes to NHS systems and structures and the wider commissioning intentions that follow from that.

However, there a lot of potential changes happening alongside each other and as Healthwatch we can find ourselves stretched in being part of important conversations with a range of stakeholders. Local Healthwatch are commissioned to act locally and the conversations that we have with all stakeholders, and the critical friend challenges that we offer to service providers and commissioners are a core part of our work. Nevertheless, as more decisions are made at a more regional level, it is just as important to have Healthwatch as a partner at that level to ensure that local representation is not lost as health needs are looked at more broadly. Healthwatch England is currently recommending that appropriate resource is committed from health to ensure that Healthwatch is funded appropriately in order to provide patient voice as set out in the Health and Social Care Act 2012.

Question 15: How will the NWLCCG ensure that all local Healthwatch have the resources and support to fully represent local people's views and experiences in discussions on health and care provision that are happening within Primary Care Networks and Integrated Care Partnerships at a local level, as well as being part of conversations at the NWLCCG level?

Primary Care Networks

It is at the Primary Care Network level that most local people will begin to see changes in how their healthcare is offered. The changes are not just about sharing services between GP practices, they are also about changing locations for some services. This offers a really good opportunity for conversations with patients about how best to make primary care sustainable. Local issues about accessibility of services and how well public transport can help people get to their

appointments are important parts of the picture that can only be understood by talking to the people affected.

Currently it is not clear how Primary Care Networks will be monitored within the single NWLCCG body. There is an obligation on CCGs to engage with patients and it is important that this is continued as Primary Care Networks become established. Primary Care Networks will need help to engage with local people; guidance supporting this would be useful. Healthwatch has a lot of experience in talking to the public and local patients about health service quality, accessibility and gaps in services. We also have experience in developing guidance on best practice.

Question 16: How does the NWLCCG intend to work in partnership with local Healthwatch to ensure that the public and local patients have the opportunity to have their say on local changes and to report back on the impact these are having on their health and wellbeing?

Availability of treatment

Our Local Committee members recounted a number of examples of treatment that should be available but where patients currently encounter a gap. For example, the move to stop injections for back pain was based on achieving better / comparable results through having physiotherapy. However, there are not enough physiotherapists to offer this treatment, leaving patients in pain. When this change was first suggested, Healthwatch voiced the concerns of patients. This may be a localised issue across the eight CCG patch, but this is the type of gap in provision that can have a large and detrimental impact on patients' lives.

Question 17: How will patients be able to feedback on localised problems in quality of service or gaps in provision through the single NWLCCG mechanism?

Question 18: How will patient reported impact of changes to local provision be monitored and responded to, especially in situations where there may be variable outcomes as a result of a change across the larger area?

Questions raised by Healthwatch Central West London and our Local Committee members in Hammersmith & Fulham; Kensington & Chelsea; and Westminster

Patient voice and quality of local health care services

Question 1: How is the patient voice to be included at all levels of commissioning within the single NWLCCG commissioning framework?

Question 2: How will the single NWLCCG involve local Healthwatch in local engagement plans – including by commissioning us to have conversations with local people about proposed changes and gathering their views?

Question 3: How are local Healthwatch to be further included in discussions about STP area future plans and commissioning decisions?

Question 4: How much attention has been paid to how the NWLCCG will talk to its diverse local populations and create opportunities for them to be a meaningful part of ongoing discussions and decisions about local provision?

Question 5: What further conversations about the change to a single NWLCCG and how this might affect local people are planned before implementation?

Question 6: What plans are there for local Healthwatch to be included in plans for patient and public engagement, to ensure that all communications produced are clear, accessible and provide the information that patients and local people most need to hear?

Question 7: How will the NWLCCG ensure that it takes into account local health needs being addressed through local Integrated Care Partnerships and does not remove ownership of acute hospital services from the local level?

Question 8: As Integrated Care Partnerships are developed across the eight CCG areas can you provide more information on when and where patient feedback can be offered?

Question 9: How will the single NWLCCG ensure that GP practices support PPGs as an essential route of local engagement for patients, and to also ensure how the work that they do can affect positive change at GP Practice level for patients?

Local accountability and quality of local health care services

Question 10: How will Healthwatch and local authorities in each area retain responsibility and power to use local patient experience to scrutinise and tackle poor performance or gaps in health services at a local level where those services are commissioned at a single NWLCCG level?

Question11: Will local Healthwatch be offered a place for at least two representatives on the NWL Governing Body?

Question 12: Will NWLCCG guarantee that local Healthwatch will continue to have one representative on the Quality Committee?

Question 13: What plans are in place to ensure that conversations about future service provision are held with local people and patients, and for local people and patients to be involved in monitoring quality of local provision across the NWLCCG area?

Question 14: How will the NWLCCG ensure that the drive for consistency in health provision standards across the wider area does not drown out local people's needs for diversity of health support and the potential for innovative models to be developed at local levels?

Question 15: How will the NWLCCG ensure that all local Healthwatch have the resources and support to fully represent local people's views and experiences in discussions on health and care provision that are happening within Primary Care Networks and Integrated Care Partnerships at a local level, as well as being part of conversations at the NWLCCG level?

Question 16: How does the NWLCCG intend to work in partnership with local Healthwatch to ensure that the public and local patients have the opportunity to have their say on local changes and to report back on the impact these are having on their health and wellbeing?

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Healthwatch Central West London

NHS Long Term Plan Engagement

A focus on Mental Health

Shaping the future of our NHS in North West London

healthwatch

“I was able to access the Crisis Team very quickly.

Staff were knowledgeable and offered constructive help.”

Local resident and service user

Contents

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What is the NHS Long Term Plan?

With growing pressure on the NHS – people living longer, more people living with long-term conditions, lifestyle choices affecting people's health – changes are needed to make sure everybody gets the support they need.

The Government is investing an extra £20 billion a year in the NHS. The NHS has produced a 'Long Term Plan' setting out the things it wants health services to do better for people across the country.

This includes making it easier to access support closer to home and via technology, doing more to help people stay well, and providing better support for people with long-term health conditions.

Engaging Local People

Whilst the national plan has set some clear goals, it's up to local areas to decide how they're achieved – that means engaging with local people and listening to their experiences and expectations of current and future services.

Healthwatch organisations in North West London, alongside the national Healthwatch network has collected local views on the Long Term Plan through surveys, focus groups and events between April and June 2019, to give tens of thousands of people the opportunity to help local hospitals, GP surgeries and community services hear about the changes people would like to see.

In this report, we look at experiences and expectations associated with Mental Health.

What matters most to people in North West London?

Engaging with 46 people – service users, families and carers we found that:

Summary: Mental Health Services

GP Services
When talking about local GP services, people cite good levels of empathy from GPs, however treatment is not always effective. Some patients comment on feeling unsupported, with GPs showing 'little interest' in their personal or social circumstances – this can affect ongoing care and early intervention. One patient had to 'persuade' the doctor that he was ill, while others say that assistance is only offered in potentially suicidal cases.

Generally it is felt that mental health specialists at GPs 'are not best equipped' to help and it was also agreed that the ten minute consultation period was not sufficient. Long waiting lists are a common theme, with people receiving little or no support in the interim.

Digital technology was seen as a good way to make online appointments but there is not enough direct marketing of the service.

Community Mental Health Services
We heard reports of attentive and thoughtful psychiatrists at the Child and Adolescent Mental Health Services (CAMHS). People were also complimentary about community services and hubs.

Some people comment on a lack of personalisation, in some cases leading to social isolation. For counseling, it is reported that the number of sessions on offer is not always effective, particularly for those with 'complex needs'. Waiting times are also cited as an issue, with some services not responsive following referrals.

Hospitals
People commented on good levels of empathy and support, and timely services. However, we heard experiences of poor staff attitude, a lack of quiet space or privacy on wards and an environment not conducive to recovery.

It was also suggested that cuts to community services have increased demand on hospital beds. Waiting times are also cited as an issue, particularly for Psychiatric Liaison.

Being accompanied by a partner, family member or carer can make the experience more comfortable for all. Views about mixed-sex wards differ – some people prefer them while others do not, therefore a choice would be equitable.

Summary: Mental Health Services

SPA (Single Point of Access)
Many people commented that the service is 'not empathetic' and offers advice of little value - such as 'make a cup of tea, listen to music or go for a walk'. Telephone access and waiting times for callbacks are also noted as issues.

To improve understanding and empathy, it was suggested that staffing should include people who have had similar mental health illnesses.

Recovery Team
We heard accounts of compassionate staff, however people note the service is 'over stretched'.

Many people experience poor telephone access, with one person trying to make contact for one week. It is also reported that communication and liaison between services and GPs is poor.

Coordination between services
People commented on administrative problems, poor communication and liaison between services plus a 'postcode lottery' across boroughs. The complexity of referral pathways can also delay treatment.

Travel and Transport
In one experience, a journey to visit a partner involved 3 buses – each way. Other people cited financial cost and waiting times as issues. By one person, the Freedom Pass was regarded as 'a lifeline'.

Co-morbidities
When talking about co-morbidities we detected a sizeable theme on medication. People cite a lack of alternatives to medication, side effects and complications with other medication. Some people also comment on a lack of information and signposting from their GP.

Learning from Discussion (Checklist)

GP Services – local people would like:

- Good levels of support and engagement.
- To be listened to, respected and involved.
- Specialists that are knowledgeable and empowered/equipped to help.
- Timely access to services and support while waiting.
- Optimum use of digital technology.

Learning from Discussion (Checklist)

Community Mental Health Services – local people would like:

- Holistic treatment and care, with 'real choice'.
- Good levels of support (example increasing number of sessions).
- Timely access to services.
- Services that are responsive.

Hopsitals – local people would like:

- To be treated with dignity and respect.
- An environment conducive to recovery (with privacy and quite space).
- Timely access to services.
- Option of same or mixed-sex ward.

SPA (Single Point of Access) - local people would like:

- To be treated with dignity and respect.
- A good level of information and advice.
- Good telephone access.
- Services that are responsive.
- To be understood.

Recovery Team - local people would like:

- Adequate staffing levels
- Good telephone access.
- Good liaison and communication between services.

From Diagnosis to Ongoing Care

Assessment, Diagnosis and Treatment
It was felt that assessments should include a 'risk assessment', and that only Mental Health professionals should be authorised to diagnose. A good level of training was emphasised across the board – from school staff to GPs. People also stressed the importance of contact with peer workers who have recovered from similar conditions.

Follow-up treatment and support should be tailored and personal, and alternatives (such as laughter therapy, music therapy and exercise) included in the mix of options, as appropriate.

At one event, a number of people felt the 'only way to access emergency treatment' was through the police and that this was inappropriate.

From Diagnosis to Ongoing Care

Prevention and Early Intervention
Discussions emphasised the importance of education for new mums, children and young people, and school staff. People said that GPs should have a 'broader understanding' of mental health issues. There is also a need to educate the wider community so that people with mental health issues do not feel any different and can seek support (break down the taboo factor about mental health).

It was felt that good levels of specialist support are vital, including for continued access, and people should not be discharged prematurely.

Lack of community based projects, poor levels of information & signposting and use of 'jargon' were also cited as challenges.

Ongoing Care and Support
The ability to build relationships is considered important - a named, consistent contact (such as a care navigator) would be useful for both patients and families and volunteers could be trained to befriend and offer peer support. Carers also need greater levels of support – suggestions include drop-in centres and peer support groups.

People would also like subsidised travel, greater choice of treatment and therapies and practical support – such as assistance in applying for benefits or completing forms. It was felt that medication 'should not always be the go to approach'.

At one event, young people use the word 'frustrating' as it is felt that help 'simply isn't there' for them.

Learning from Discussion (Checklist)

Assessment, Diagnosis and Treatment – local people would like:

- Assessments that include a risk assessment.
- Diagnosis by Mental Health professionals.
- Training for medical and other professionals.
- Access to peer support.
- Holistic follow-up treatment and support, with alternative options.

Learning from Discussion (Checklist)

Prevention and Early Intervention – local people would like:

- Education for new mums, children and school staff.
- Training for GPs.
- Awareness within the wider community (break down the taboo).
- Good levels of specialist support.
- Appropriately timed discharge.
- Access to community based projects.
- Clear, and good levels of information.

Ongoing Care and Support – local people would like:

- A named contact (such as a care navigator).
- Befriending and peer support.
- Support for peer support carers.
- Subsidised travel.
- Choice of treatment and therapies.
- Practical support (such as help to apply for benefits).
- Alternatives to medication.

Communication and Engagement

Finally, we asked people how engaged they would like to be, and whether they would like to be involved in designing new services. As part of this, we asked them which aspects of communication and engagement could be improved.

It was felt that public meetings should be well communicated, to maximise turnout. Consideration should be given to having meetings at different times in the day, including evenings, so that people can attend.

Patients also need encouragement and support to get involved in engagement – Healthwatch could be useful, particularly in raising awareness, harnessing skills and building networks. Outcomes of meetings should be widely communicated and actions reported back – to keep people engaged.

Learning from Discussion (Checklist)

Communication and Engagement – local people would like:

- Good awareness of public meetings.
- Choice of times (morning, afternoon and evening).
- Good levels of engagement.
- Updates on how their feedback has/has not been used.

What did people tell Healthwatch?

Here, we take a more detailed look at the top themes emerging from discussion. Generally we asked people what they feel works well and what could work better.

1. GP Services

This section explores top themes around GP services.

1.1 What works well?

People comment on good levels of empathy from GPs, however treatment is not always effective.

GPs - what works well?

Selected comments:

"Reception staff and duty officer at Claybrook centre considered to be constructive and knowledgeable." [Hammersmith & Fulham]

"Personal touch from GPs - one participant said: "she hugged me". However, ultimately was unable to help in any meaningful way." [Hammersmith & Fulham]

"GP admitted gap in Mental Health knowledge and expressed willingness to learn more and also in alternative therapies such as music therapy." [Hammersmith & Fulham]

1.2 What could work better?

Patients comment on feeling unsupported, with GPs showing 'little interest' in their personal or social circumstances – this can affect ongoing care and early intervention. One patient had to 'persuade' the doctor that he was ill, while others say that assistance is only offered in potentially suicidal cases. Generally it is felt that mental health specialists at GPs are 'not best equipped to help' and it was also agreed that the ten minute consultation period was not sufficient.

Long waiting lists are a common theme, with people receiving little or no support in the interim.

GPs - what could work better?

Selected comments:

"Not taking early intervention seriously enough - Mental Health crises/eating disorders only addressed when they are extreme." [Westminster]

"You have to persuade the GP or doctor about that you are ill. You have to lie,

otherwise you are not taken seriously. I was really depressed, had anxiety, couldn't open my post, couldn't leave the house. I forced myself to go to the GP to get help, they asked if I was suicidal. I had not felt suicidal that week so I didn't get any help. Another time I had to lie and say I was suicidal and a danger to other people. If I didn't add any colour to my story nothing would happen." [Ealing]

"Services always ask if you are thinking about ending your life. It's the first thing they ask. If you say yes they take you seriously, If you say no you get nothing." [Ealing]

"One person had been transferred back to the mental health worker at their GP, who told them that they couldn't help with certain things because it was out of their jurisdiction. They felt like they didn't see the point of having someone there who was not equipped to deal with mental health issues." [Ealing]

"Waiting time from seeing the Dr to getting a proper diagnosis and specialised treatment can be a long time, some quoted 9 months and were not signposted to any help in the meantime." [Ealing]

1.3 What could easily be improved?
Digital technology was seen as a good way to make online appointments but there is not enough direct marketing of the service.

2. Community Mental Health Services

This section explores top themes around Community Mental Health services.

2.1 What works well?
We heard reports of attentive and thoughtful psychiatrists at the Child and Adolescent Mental Health Services (CAMHS). People were also complimentary about community services and hubs.

Community Mental Health Services - what works well?

Selected comments:

"Able to access Crisis Team very quickly and staff were knowledgeable and offered constructive help." [Hammersmith & Fulham]

"'Back on Track' self-referral allows service users to take control of their own care." [Hammersmith & Fulham]

"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'." [Hammersmith & Fulham]

2.2 What could work better?

Some people comment on a lack of personalisation, in some cases leading to social isolation. For counseling, it is reported that the number of sessions on offer is not always effective, particularly for those with 'complex needs'.

Waiting times are also cited as an issue, with some services not responsive following referrals.

Community Mental Health Services – what could work better?

Selected comments:

"Claybrook uses a model of therapy that doesn't work for all - it's based on Borderline Personality Disorder, but what if you don't have that? I've had to help myself and still find myself isolated." [Hammersmith & Fulham]

"Isolation is part of the illness, it is hard to approach someone who is depressed - inreach and outreach is the key." [Hammersmith & Fulham]

"There is 'little or no structure' in group therapy sessions for the most vulnerable." [Hammersmith & Fulham]

"The gap between in-patient and community support is too big/wide." [Brent]

"It would be much better to have fewer more highly functioning specialist mental health centres - I would be prepared to travel" [Hammersmith & Fulham]

"Counselling is seen as a negative (even though it is good that we have it) because the contracted periods are too short for people with complex needs. [Westminster]

"Long waiting times (no interim measures in place while waiting for appointments)". [Hillingdon]

"One participant mentioned that their GP had referred them to IAPT, who did not reply to them for two months and then failed to keep in touch." [Ealing]

2.3 What could easily be improved?

In one case, service users have been inspired to 'take the initiative' and forge support networks. This has including pooling of personal budgets to book particular actitivities.

Community Mental Health Services – what could easily be improved?

Selected comments:

"Service users have worked together to create a network to seek out help from charities where there are gaps in the NHS." [Hammersmith & Fulham]

3. Hospitals

This section explores top themes around hospital services.

3.1 What works well?

People commented on good levels of empathy and support, and timely services.

Hospitals – what works well?

Selected comments:

"Lakeside (mental health unit, Hounslow): I was in taken to Lakeside last year as there was no room at Ealing Hospital. A nurse stayed with me up until 11pm. She made time for me and sat with me to make sure I ate. I felt somebody cared." [Ealing]

"I had a voluntary admission. Help and support at the hospital was quick." [Ealing]

"PALS worked OK when they missed an appointment at Hillingdon Hospital." [Hillingdon]

3.2 What could work better?

We heard experiences of poor staff attitude, a lack of quiet space or privacy on wards and an environment not conducive to recovery.

It was also suggested that cuts to community services have increased demand on hospital beds. Waiting times are also cited as an issue, particularly for Psychiatric Liaison.

Healtwatch Ealing makes an observation about mixed sex wards (St Bernards Hospital). "Service users mentioned that some wards are mixed and some are same-sex, depending on the severity of people's illness. They mentioned that on one hand it can feel unsafe to be in a mixed ward and that they needed more support from the nursing staff than they were receiving as a result. On the other hand, some participants felt as if being in a mixed ward was better for them. They agreed overall that would like to have an option to choose what type of ward to be admitted into as part of their care plan."

Hospitals: what could work better?

Selected comments:

"Staff are cold towards families and carers on the wards." [Hammersmith & Fulham]

"Wards lack quiet space for recovery and respite." [Hammersmith & Fulham]

"Thought that it wasn't a good environment to recover in; there are no windows, it looks like a prison, is unhealthy." [Ealing]

"Having multiple people in consultation rooms could be very uncomfortable for some, and they often do not feel like they have a choice but to allow this - it's often student doctors. They feel as if there needs to be a relationship built with a person before they can divulge sensitive information around them. [Ealing]

"Mental Health in-patient service is like a revolving door when there is insufficient support in the community." [Brent]

"So demands for beds outstrips needs because the support in the community doesn't work. There are people who need to be hospitalised." [Brent]

"Psychiatric Liaison service at Ealing Hospital: I had to wait for 4 hours. Another person identified only waiting 20 mins recently." [Ealing]

3.3 What could easily be improved?

Being accompanied by a partner, family member or carer can make the experience more comfortable for all.

Views about mixed-sex wards differ – some people prefer them while others do not, therefore a choice would be equitable.

Hospitals: what could easily be improved?

Selected comments:

"One person said that they benefitted when their partner was transported there with them and was not separated from them." [Ealing]

4. SPA (Single Point of Access)

This section explores top themes around SPA (Single Point of Access).

4.1 What works well?

We heard one account of a good, helpful service.

SPA (Single Point of Access) - what works well?

Selected comments:

"SPA played a role in getting me the help I needed. The first call was not good. The second call was very helpful." [Ealing]

4.2 What could work better?

Many people commented that the service is 'not empathetic' and offers advice of little value - such as 'make a cup of tea, listen to music or go for a walk'. Telephone access and waiting times for callbacks are also noted as issues.

SPA (Single Point of Access) - what could work better?

Selected comments:

"Not very empathetic when people phoned up feeling suicidal, they were giving useless advice such as "watch TV, listen to your favourite music or go for a walk", therefore people questioned whether or not they are even trained. Some people have had experiences of being automatically signposted rather than SPAs helping them deal with the situation. Many people said they would rather use the Samaritans because they are more empathetic and supportive - "you get the feeling that they actually want to talk to you"." [Ealing]

"I had a 10 minute call. I felt rushed. She left me crying on the phone." [Ealing]

"Can't get through on the phone. Have to wait too long." [Ealing]

"They left me in a worse state when I got off the phone. They told me the clinician would call back in 20 minutes. 12 hours later they finally called back." [Ealing]

4.3 What could easily be improved?

To improve understanding and empathy, it was suggested that staff should include people who have had similar mental health illnesses.

SPA (Single Point of Access) - what could easily be improved?

Selected comments:

"It was suggested that the staff employed by phone services should be people who have had similar mental health illnesses to them because people who have not gone through it themselves do not understand their situation. This suggestion was a two-fold solution 1) to help recruit more understanding and helpful staff 2) Most mental health SUs do not have employment and this could be a way to help them regain confidence and self-respect, and therefore improve their mental health." [Ealing]

5. Recovery Team

This section explores top themes around Recovery Team services.

5.1 What works well?

We hear accounts of compassionate staff, however people note the service is 'over stretched'.

Recovery Team - what works well?

Selected comments:

"Staff are good and compassionate but people do not see them often, and the staff seem overstretched, which means that they lack a proper human connection." [Ealing]

5.2 What could work better?

Many people experience poor telephone access, with one person trying to make contact for one week.

It is also reported that communication and liaison between services and GPs is poor.

Recovery Team - what could work better?

Selected comments:

"Many phone call services do not pick up their phone lines - especially detrimental as people usually call when they are in a crisis. One SU called the Limes as we spoke and only got through to the answering machine." [Ealing]

"One person has been trying to contact for one week - impossible to get through!" [Ealing]

"Communication between Avenue House and the GP is poor." [Ealing]

"When you go and see the duty team at Avenue House the information does not get logged. I have no confidence in the service. I'm not being listened too." [Ealing]

"Staff are always rushing at Avenue House. It makes you feel like an inconvenience. There are not enough CPNs there. CPNs have been cut and the workload has gone up. They have no time. They have just paperwork and deadlines. Even getting allocated a social worker is difficult." [Ealing]

5.3 What could easily be improved?
It was felt that home visits for the housebound would be a good idea.

Recovery Team – what could easily be improved?

Selected comments:

"There should be a home visit service for people unable to leave home." [Ealing]

6. Co-ordination between services

Trends were also established on service coordination. We heard accounts of administrative problems, poor communication and liaison between services plus a 'postcode lottery' across boroughs.

The complexity of referral pathways can also delay treatment.

Co-ordination between services

Selected comments:

"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 sorted/archived correctly." [Hammersmith & Fulham]

"Postcode lottery for treatment of mental health." [Hammersmith & Fulham]

"Lack of coordination with/access to out-of-borough Mental Health services; lack of community support." [Westminster]

"Services not working in an integrated way (having to tell my story more than once)." [Hillingdon]

"Feeling that services were passing the buck and blaming each other." [Hillingdon]

"There is also a lack of communication between GPs and other services; GPs are not getting records from Avenue House - again this can cause a problem between medications." [Ealing]

"The layers that exist between you and getting help need to be removed. You go from the GP – consultant – psychiatric nurse – psychiatrist back to consultant etc. It takes months in between each appointment and every time it's a new person." [Ealing]

7. Travel and Transport

In one experience, a journey to visit a partner involved 3 buses – each way. Other people cited financial cost and waiting times as issues.

By one person, the Freedom Pass was regarded as 'a lifeline'.

Travel and Transport

Selected comments:

"My partner doesn't drive and it took him 3 buses to come and see me at West Middlesex hospital every day. The travel took a lot out of him (more so as he has back problems). The distance of treatment to where your family/support network is makes all the difference to your recovery and their ability to support you." [Ealing]

"The financial cost of travel for partner/family/support network limits the support they can provide." [Ealing]

"Ealing hospital transferred me to Lakeside. The longest wait was for the transport. They took my partner with me in the transport. This was a massive help and very reassuring. The services were quick, but the transport slow. This was a voluntary admission." [Ealing]

"The freedom pass is a lifeline." [Ealing]

8. Co-morbidities

When talking about co-morbidities we detected a sizeable theme on medication. People cite a lack of alternatives to medication, side effects and complications with other medication. Some people also comment on a lack of information and signposting from their GP.

Co-morbidities

Selected comments:

"People said they would rather get therapy than take pills, and felt that medication was overprescribed, however in some cases people have waited for over 2 yrs for a therapist." [Ealing]

"There is too much medication. Everytime you go they give you something new. There are too many side effects and too many problems caused by the medications." [Ealing]

"I am not getting my diabetes medicine as I am on too many other medications, 12 all together. My daughter is a doctor. She helps and advises me." [Ealing]

"The GP and Psychiatrist do not understand each other's medicine. It's dangerous." [Ealing]

"One person has learning difficulties as well, and therefore they find it hard to find information about services, and about their mental health. Therefore they need more support from Drs than they are getting, just someone to give them proper face-to-face information and signposting." [Ealing]

From Diagnosis to Ongoing Care

We talked about various aspects around assessment, diagnosis, treatment, early intervention and ongoing care and support.

9. Assessment, Diagnosis and Treatment

It was felt that assessments should include a 'risk assessment', and that only Mental Health professionals should be authorised to diagnose. A good level of training was emphasised across the board – from school staff to GPs. People also stressed the importance of contact with peer workers who have recovered from similar conditions.

Follow-up treatment and support should be tailored and personal, and alternatives (such as laughter therapy, music therapy and exercise) included in the mix of options, as appropriate.

At one event, a number of people felt the 'only way to access emergency treatment' was through the police and that this was inappropriate.

Assessment, Diagnosis and Treatment

Common themes:

Assessment:
An assessment should involve a comprehensive risk assessment before crisis point. Any non-specialist staff involved should be trained to spot the signs and this should be the protocol across the boroughs. School staff should be trained to spot the signs of mental health so that it could be identified before becoming a crisis. Training should also be provided to GPs and/or their staff to help identify issues and to have a better understanding of how to manage the person/patient.

Specialist Diagnosis
Only a Mental Health professional should be authorised to provide a diagnosis with a full evaluation of environmental and familial factors included with an emphasis on the cause, not the effect. These diagnoses should also be earlier rather than at crisis point - there is anecdotal evidence that incorrect assumptions by non-specialist staff can lead to misdiagnosis and unsuitable treatment.

Peer Support
Participants stressed the importance of contact with peer workers who have recovered from similar conditions.

Follow-Up
People agreed that follow-ups should be tailored to the case. For example, it may be necessary to follow up once a day for some patients and once a month for others. Isolation is often part of the illness in mental health cases, but attempting to contacting patients via various means of communications is important. One participant suggested follow-up calls should have a caller ID so patients know who the call is coming from even if they are unable to answer.

Alternative Treatment
Popular examples include laughter therapy, music therapy and exercise should be considered viable options for treatment.

Assessment, Diagnosis and Treatment

Summary of other popular themes:

- **GP Support:** The GP turns people away unless the situation is life threatening. It feels like this pushes people to hurt themselves.
- **Diagnosis:** Advice should be given at the point of diagnosis as well as guidance to how better to manage while waiting for appointments. This would help the patient to cope better.

- **Treatment:** Emergency metal health needs should be accessible without having to contact the Police. There needs to be a way of accessing treatment after the short-term Cognitive Behavioural Therapy (CBT) and Talking Therapy as when these have stopped it can have devastating effect for some people. More specialists are needed to resolve the waiting time issue.
- **Protocol:** Should be more awareness that some unwell patients are unable to manage schedule of appointments and travel to services and that this needs to be a joined-up, team effort between patient and service provider.
- **Gateway to Treatment:** Treatments other than CBT should be available, but a risk assessment and proper diagnosis are needed first.

10. Prevention and Early Intervention

Discussions emphasised the importance of education for new mums, children and young people, and school staff. People said that GPs should have a 'broader understanding' of mental health issues. There is also a need to educate the wider community so that people with mental health issues do not feel any different and can seek support (break down the taboo factor about mental health).

It was felt that good levels of specialist support are vital, including for continued access, and people should not be discharged prematurely.

Lack of community based projects, poor levels of information & signposting and use of 'jargon' were also cited as challenges.

Prevention and Early Intervention

Common themes:

Further Training
Discussions emphasised the importance of education for new mums, children and young people, GPs and school staff. Children should be educated to understand feelings and emotions and how to manage them. There is also a need to educate the wider community so that people with mental health issues do not feel any different and can seek support (break down the taboo factor about mental health). GPs should have a broader understanding of mental health issues e.g. triggers and support needs for different conditions.

Specialist Support
Having more specialists to reduce waiting time is crucial both in terms of treatment, early intervention and prevention. Within this aspect of the service having a continued access to the healthcare professional is crucial. Not being discharged too early from treatment is important.

Community
There is a 'dearth' of projects within communities. More accessible activities are needed to combat isolation and prevent crises recurring.

Service Signposting
There needs to be better mapping of available services in local areas and a directory of services in surgeries and practices, and in the community.

Jargon
Language of othering e.g. DNA (Did not attend) and 'flow' as a synonym for patients is not helpful and should be stopped – patients who do not attend appointments may not have been able to due to factors like severe isolation and fear so more teamwork is required in ensuring patients get the correct and timely treatment.

Prevention and Early Intervention

Summary of other popular themes:

- **Role of GPs:** There was a strong view that patients with health care should be informed of any GP/s in their practice with specific knowledge of mental health.
- **Tackling Conditions Early**: An early recognition apparatus needs to be instated for particularly complex/serious cases to trigger a package of services and care as early as possible.
- **Navigating Crises**: Crisis/recovery cafes in the community that are periodically staffed with mental health and peer support workers.
- **Monitoring:** For those people who don't meet the threshold would help people who are close to crisis point. Parents and carers should be trusted more when they report their concerns about an individual.

11. Ongoing Care and Support

The ability to build relationships is considered important - a named, consistent contact (such as a care navigator) would be useful for both patients and families and volunteers could be trained to befriend and offer peer support. Carers also need greater levels of support – suggestions include drop-in centres and peer support groups.

People would also like subsidised travel, greater choice of treatment and therapies and practical support – such as assistance in applying for benefits or completing forms. It was felt that medication 'should not always be the go to approach'.

At one event, young people use the word 'frustrating' as it is felt that help 'simply isn't there' for them.

Ongoing Care and Support

Common themes:

Trusted Connections
One point of contact (such as a 'trusted' care navigator) would help with on-going care and support and this should not be the GP. There should be a process of checking up on the clients so that it is not always the client chasing up issues related to appointments and medicine needs. This would help reassuring patients who are having to wait a long time for support. Patients need more regular monitoring that is currently available.

Volunteers and Befriending
Training for volunteers on how to befriend patients taking in to account their specific needs and triggers. Volunteers should commit to regular, timetabled interactions to provide consistency and continuity and build trust with the patient.

Family Guidance
Families need guidance and support on how to negotiate and manage certain situations – there is a massive divide between what family and patient understand to be real and how to communicate.

Support for Carers
We need more support for carers who are caring for long term mental health service users. There should be support groups for carers specifically focusing on mental health. There should be drop-in centres for people particularly for males who are 50+ after the meds have been prescribed. Support should also be available via websites which would also allow people to keep in touch. Families should be involved in on-going care of patients.

Flexible Travel
Subsidised travel should be available for most ill/vulnerable.

Choice
A more diverse selection of therapies should be available, such as music therapy, exercise and laughter therapy and more investment in social prescription.

Practical Help
Further help is needed with practical tasks like filling out PIP and benefits forms. Mind provided this service in the past but it has been cut – it should be an NHS service!

Medication
Need for specialist mental health pharmacist who understands the complexities of multiple prescribing and can offer a person-centred approach as medication should not always be the go-to response.

Ongoing Care and Support

Summary of other popular themes:

- **Pro Choice:** Established specialist centres - service users and care navigators should be given option to choose centre based upon Ofsted-like ratings.
- **Improved Outreach:** Peer support workers should be available around the clock to offer support advice to patients and their families when it is needed most.
- **Practical Considerations:** The standard twelve appointments for long term mental health conditions is not enough and should be person-centred.
- **Quality of Service:** There is a concern about the quality of services in different parts of the country (postcode lottery). One person was concerned about her impending relocation to another borough whether the care and support would be continuing, who to contact and the quality of communication between the services. Shortage of staff particularly when patients are seeing different professionals has an impact on the quality of care and support.
- **Admissions:** There is a need for more long-term beds for those with mental health particularly for teenagers. There needs to be some transport support to get people home from hospital particularly when they have been referred to out of Borough hospitals. There is a need for some form of support for teenagers who have been diagnosed with mild mental health conditions.

12. How could communication and engagement be improved?

Finally, we asked people how engaged they would like to be, and whether they would like to be involved in designing new services. As part of this, we asked them which aspects of communication and engagement could be improved.

It was felt that public meetings should be well communicated, to maximise turnout. Consideration should be given to having meetings at different times in the day, including evenings, so that people can attend.

Patients also need encouragement and support to get involved in engagement – Healthwatch could be useful, particularly in raising awareness, harnessing skills and building networks.

Outcomes of meetings should be widely communicated and actions reported back – to keep people engaged.

How could communication and engagement be improved?

Common themes:

Attendance and Representation
Meetings should be 'better communicated' so that patients and carers can attend. One 'critical meeting' was not communicated adequately to the people who need it most, therefore it was poorly attended - it was suggested that Healthwatch could be a vehicle for creating awareness of meetings. Consideration should be given to having meetings at different times in the day, including evenings, so that people can attend.

Closing the 'Feedback Loop'
Outcomes of meetings should be widely communicated and actions to be reported back. Some people wanted a follow-up event where they could get feedback on how the information and ideas they came up with during the focus group was used. They want to know whether or not their feedback has reached the right people and why/why not it was taken on board.

Decision Making
Those with mental illness and supporters of better care for mental health need to be more political in their approach to influencing policy and services – these are the people that should be part of any decision that is taken.

How could communication and engagement be improved?

Summary of other popular themes:

- **Meetings:** There should be more of these types of meetings with key decision makers in attendance (commissioners, services, police and social services and other Local Authority representatives). One group suggested three monthly meetings.
- **Database:** Should be available that shows what meetings are taking place, what these are about and who is attending.
- **Patient Power:** Need to be at the centre of the treatment, more focus groups are required and advocated with lived experience – service users should be involved at every level.
- **Using Skills:** Healthwatch should utilise skills of the Discussion Group and members, capturing their expertise and using them as expert contributors in future groups and discussions.
- **Community Forum:** Healthwatch should consider creating forums open to all with access to expert advice and services and an option to add friends in need.
- **Follow-Up:** People also wanted to be included in the write-up process before the report is disseminated to make sure that it is a proper reflection of their ideas and experiences.
- **Official Representation:** Some people would like to sit on official boards and committees, to be 'genuinely involved' in decisions.

13. Case Study on Good Practice – The Solace Centre

The Solace Centre is an out of hours community service in Ealing, and regarded as a centre of good practice.

The Solace Centre

Selected statements:

- Staff treat everyone like human beings, they feel as if they are a family unit. People can discuss problems and get help from staff. It is an environment in which everyone is respected.
- It's open 365 days a year, and long hours (4pm - 7.45pm and weekends). Its open on Christmas day and the staff drive around and pick people up to bring them here for Christmas when there are no buses running to get there by yourself.
- The centre provides many services including cooking, washing. There is a book club, a women's group, a men's group, a baking group, a wellbeing group, benefits help, advice around budgeting.
- The Solace Centre has Saturday meals and discussion which people find important especially if they do not have other family. The centre is open on Christmas for people to come to.
- The service gives you "the power and means to make connections" - very important as many people have lost touch with family and friends.
- Also because they see same people, do not have to repeat their story again and again, and risk triggering.
- Several service users highlighted the woman's forum, describing it as "empowering" and "refreshing".

Glossary of Terms

CAMHS	Child and Adolescent Mental Health Services
CPN	Community Psychiatric Nurse
CWL	Central West London
IAPT	Increasing Access to Psychological Therapies
NHS	National Health Service
LTP	Long Term Plan
PALS	Patient Advice and Liaison Service
SLaM	South London and Maudsley NHS Foundation Trust
SPA	Single Point of Access

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healthwatch Brent

3 Rutherford Way, Wembley, London, HA9 0BP

☎ 020 3598 6414
info@healthwatchbrent.co.uk
healthwatchbrent.co.uk

healthwatch Central West London

Grand Union Studios, 332 Ladbroke Grove, North Kensington, London, W10 5AD

☎ 020 8968 7049
info@healthwatchcentralwestlondon.org
healthwatchcwl.co.uk

healthwatch Ealing

45 St. Mary's Road, Ealing, London, W5 5RG

☎ 020 3886 0830
info@healthwatchealing.org.uk
healthwatchealing.org.uk

healthwatch Harrow

3 Jardine House, Harrovian Business Village, Bessborough Road, Harrow, London, HA1 3EX

☎ 020 3432 2889
info@healthwatchharrow.co.uk
healthwatchharrow.co.uk

healthwatch Hillingdon

20 Chequers Square, The Pavilions Shopping Centre, Uxbridge, UB8 1LN

☎ 01895 272997
office@healthwatchhillingdon.org.uk
healthwatchhillingdon.org.uk

45 St. Mary's Road, Ealing, London, W5 5RG
☎ 020 3603 2438
info@healthwatchhounslow.co.uk
healthwatchhounslow.co.uk

The project was supported by Healthwatch England.

151 Buckingham Palace Road, London, SW1W 9SZ
☎ 03000 683 000
enquiries@healthwatch.co.uk
healthwatch.co.uk

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Healthwatch Central West London, Grand Union Studios, 332 Ladbroke Grove, North Kensington, London, W10 5AD

☎ 020 8968 7049
info@healthwatchcentralwestlondon.org
healthwatchcwl.co.uk

“Young people with mental health issues feel life has no value.

We [the system] need to act to inspire them”.

Healthwatch official

NHS Long Term Plan Engagement

A focus on Learning Disabilities

Shaping the future of our NHS in North West London

healthwatch

“Medical professionals are informed, and we trust that they know what they are talking about.”

Local resident and service user

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This includes making it easier to access support closer to home and via technology, doing more to help people stay well, and providing better support for people with long-term health conditions.

Engaging Local People

Whilst the national plan has set some clear goals, it's up to local areas to decide how they're achieved – that means engaging with local people and listening to their experiences and expectations of current and future services.

Healthwatch organisations in North West London, alongside the national Healthwatch network has collected local views on the Long Term Plan through surveys, focus groups and events between April and June 2019, to give tens of thousands of people the opportunity to help local hospitals, GP surgeries and community services hear about the changes people would like to see.

In this report, we look at experiences and expectations associated with Learning Disabilities.

What matters most to people in North West London?

Engaging with 75 people – service users, families and carers we found that:

Learning Disability Services

GP Services
When talking about local GP services, people comment on feeling excluded or ignored, and not being able to understand written or spoken information. It was suggested that increased training and awareness could do much to address this.

Some people also felt that levels of support could be greater, for example longer appointments and shorter waiting times for people with a learning disability. It was suggested that the system could 'flag' disabilities so staff know when to make reasonable adjustments.

Hospital Clinics and Services
We heard accounts of good levels of involvement, communication and support from hospital doctors, nurses and other staff. Levels of expertise and knowledge are also particularly appreciated.

However, lengthy waits can be uncomfortable and problematic for patients, families and carers. It was suggested that use of Health Passports could help staff to prioritise. Some patients would also like more information in easy read format.

People were appreciative of specialist nurses and doctors, but question staffing levels (one particular nurse has a catchment of three major hospitals).

Learning from Discussion (Checklist)

GPs, Hospitals and Clinics – local people would like:

- Recognition of their disability or condition.
- To be included, involved and respected.
- Good levels of awareness (training for staff).
- Clear written and oral language and effective communication.
- A level of support that reflects their condition or need.
- Well resourced specialist nurses and doctors.
- Awareness and active use of Health Passports.

From Diagnosis to Ongoing Care

We talked about various aspects around assessment, diagnosis, treatment and ongoing care and support.

Assessment, Diagnosis and Treatment
People felt that assessment, diagnosis and treatment at the right time is very important. Most people agreed that it was more important to see a medical person who was qualified who was free immediately if it was urgent. However, if less urgent it helps if 'someone knows you and your history'.

Ongoing Care and Support
We heard accounts of good levels of support and communication. When asking what could work better, people are quick to comment on long waiting lists and lack of support overall. Some people suggested more emotional support for patients and carers, plus practical assistance (such as help to fill in a form).

We also asked people to consider what could be 'easily' improved. Suggestions included enhanced training and awareness, and clearer communication to patients, and professionals.

Learning from Discussion (Checklist)

Assessment, Diagnosis and Treatment – local people would like:

- Timely diagnosis and treatment.
- Continuity (choice of professional) if required.
- Timely access to specialists and support.
- Emotional and practical support for patients and carers.
- Good levels of awareness - training for staff and education for the general public.
- Clear communication, including professional-to-professional.

What did people tell Healthwatch?

Here, we take a more detailed look at the top themes emerging from discussion. Generally we asked people what they feel works well, what could work better, and what in their view could be improved 'easily'.

1. GP Services

This section explores top themes around GP services.

1.1 What works well?

People were complimentary about automated signing-in systems, choice of appointment times and in one case, accessible information.

GPs: What works well?

Selected comments:

"Signing in technology at appointments is accessible." [Harrow]

"I can go to the GP in the morning, afternoon or evening - that's a good thing."

"Doctor provides easy read (a carer)." [Brent]

"I have a good relationship with my GP and am involved in my treatment plan, though I accept that is 'quite rare'." [Hounslow]

1.2 What could work better?

People comment on feeling excluded or ignored, and not being able to understand written or spoken information. It was suggested that increased training and awareness could do much to address this. Some people also felt that levels of support could be greater, for example longer appointments and shorter waiting times for people with a learning disability.

GPs: What could work better?

Selected comments:

"Where medical professionals talk to the parent/carer rather than the person with a learning disability." [Harrow]

"Received a text and didn't understand the message, patient thought they would have to pay if they miss the appointment." [Brent]

"Information and forms not always provided in an accessible way - complex language (jargon) used." [Harrow]

"One person said that when he asked his doctor for more information on his medication, the doctor refused to sit down and explain as he was too busy." [Hounslow]

"Receptionists should be more sensitive on the phone and have a better understanding of learning disability." [Harrow]

"Reasonable adjustments not always made (double appointments not offered)." [Harrow]

"Patients with learning disabilities need more support and less medication."

[Brent]

"Appointments don't run on time - get anxious while waiting - don't get given an update on how long the delay will be." [Brent]

"Can't book appointments to be seen on the same day." [Brent]

1.3 What could easily be improved?
People want clearer written and oral communication and some cited greater levels of training and awareness. It was felt that the system could 'flag' disabilities so staff know when to make reasonable adjustments (such as shorter waiting times or double appointments).

GPs: What could easily be improved?

Selected comments:

"Information and forms being provided in easy read. Removing complex language and acknowledging the Accessibly Information Standard." [Harrow]

"GP's to break down the information and ensure it has been understood." [Brent]

"Medical professionals and staff receiving more training about learning disability." [Harrow]

"Inform patients if there is a delay and ensure people with learning difficulties have understood." [Brent]

"Some way of people knowing that you have a learning disability, so they know to make/offer reasonable adjustments such as double appointments at the doctors." [Harrow]

"Learning disability nurses having more time / resource so they are not spread too thin." [Harrow]

2. Hospitals and Clinics

This section explores top themes around hospitals and clinics.

2.1 What works well?
We heard accounts of good levels of involvement, communication and support from hospital doctors, nurses and other staff. Levels of expertise and knowledge are also particularly appreciated.

People were appreciative of specialist nurses and doctors, but question staffing levels (one particular nurse has a catchment of three major hospitals).

Hospitals and Clinics: What works well?

Selected comments:

"Good explanation while being treated." [Brent]

"Assistance from the nurses and staff is good." [Brent]

"There is a learning difficulties nurse that helps and supports patients - although one nurse for 3 hospitals - NPH, CMH and Ealing." [Brent]

"Staff listened to what the patients had to say and were patient." [Brent]

"Doctors - knowledgeable, helpful and we trust them." [Harrow]

2.2 What could work better?

Lengthy waits can be uncomfortable and problematic for patients, families and carers. Some patients would also like more information in easy read.

Hospitals and Clinics: What could work better?

Selected comments:

"A family member had to go A&E and waited for 5 hours. It was stressful, and no one gave any update to when we'd be seen." [Brent]

"There should be no waiting time for patients if they have Autism. Carers find it very stressful to manage the patient when they become restless and start to get aggressive or anxious and worried." [Brent]

"Two cases where people had to wait 24 hours to be seen in A&E, and another had to wait 8 hours." [Hounslow]

"Not enough information available in easy read." [Harrow]

"Health Passports aren't always recognised or used by some medical professionals." [Harrow]

"Concerned about patient confidentiality - their hospital passport is on display at the end of their beds and "nosey patients" might see them." [Hounslow]

2.3 What could easily be improved?
People felt that greater levels of training and awareness would enhance support, including while waiting. Active use of Health Passports could help staff to prioritise.

Hospitals and Clinics: What could easily be improved?

Selected comments:

"Take into consideration if a patient with autism is being restless and may need to be seen before other patients." [Brent]

"All staff need to have awareness on Autism and best way to manage and help patients." [Brent]

"All medical professionals to be aware of Health passports and know to use them." [Harrow]

"Difficult to remember where the hospital is or how to get there. May need a map printed out for them with directions." [Brent]

"West Middlesex Hospital should adopt a 'numbers system' for queuing." [Hounslow]

From Diagnosis to Ongoing Care

We talked about various aspects around assessment, diagnosis, treatment and ongoing care and support.

3. Assessment, Diagnosis and Treatment

People felt that assessment, diagnosis and treatment at the right time is very important.

Most people agreed that it was more important to see a medical person who was qualified who was free immediately if it was urgent. However, if less urgent it 'helps if someone knows you and your history'.

4. Ongoing Care and Support

We heard accounts of good levels of support and communication. When asking what could work better, people are quick to comment on long waiting lists and lack of support overall. Some people suggested more emotional support for patients and carers, plus practical assistance (such as help to fill in a form).

We also asked people to consider what could be 'easily' improved. Suggestions included enhanced training and awareness, and clearer communication to patients, and professionals.

4.1 What works well?

We heard accounts of good levels of support and communication.

Ongoing Care and Support: What works well?

Selected comments:

"Support from nurses and carers." [Brent]

"When appointment details are written down and explained." [Brent]

"Support to stay stable and mind positive." [Brent]

"Receive support for medication." [Brent]

4.2 What could work better?

When asking what could work better, people are quick to comment on long waiting lists and lack of support overall. Some people suggested more emotional support for patients and carers, plus practical assistance (such as help to fill in a form).

Ongoing Care and Support: What could work better?

Selected comments:

"Not enough support especially from mental health specialist." [Brent]

"Long waits to get support from a specialist." [Brent]

"Whilst they appreciate the support of their learning disabilities group, the staff do not always take the time to understand service user's individual needs. For example, one of the service users who is blind was not allowed on a trip and another with lymph edema was not given adequate physical support on an outing." [Hounslow]

"Not able to get appointments to see specialists, such as psychiatrists." [Brent]

"Some can't fill in forms and there is not always support available to help." [Brent]

"More emotional support for carers and those living with learning difficulties." [Brent]

"Do not understand information they receive from the NHS." [Brent]

"GPs and nurses do not understand learning difficulties needs." [Brent]

"The group agreed that they would like to receive home visits from district nurses after discharge." [Hounslow]

4.3 What could easily be improved?

We also asked people to consider what could be 'easily' improved. Suggestions included enhanced training and awareness, and clearer communication to patients, and professionals.

Ongoing Care and Support: What could easily be improved?

Selected comments:

"Extra training for nurses on how to deal with learning disability issues." [Harrow]

"Educating the users of on-going services about learning difficulties." [Brent]

"Less jargon from professionals and communication between carers and health professionals in simple English." [Brent]

"Not all disabilities are visible, but should all get equal care." [Brent]

"They would like their names called instead of being displayed in the banner." [Brent]

"Better if the appointment were running on time." [Brent]

"Being able to choose the gender of your doctor and option of treatment locally." [Hounslow]

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45 St. Mary's Road, Ealing, London, W5 5RG

☎ 020 3886 0830
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healthwatch Harrow

3 Jardine House, Harrovian Business Village, Bessborough Road, Harrow, London, HA1 3EX

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info@healthwatchharrow.co.uk
healthwatchharrow.co.uk

healthwatch Hillingdon

20 Chequers Square, The Pavilions Shopping Centre, Uxbridge, UB8 1LN

☎ 01895 272997
office@healthwatchhillingdon.org.uk
healthwatchhillingdon.org.uk

healthwatch Hounslow

45 St. Mary's Road, Ealing, London, W5 5RG

☎ 020 3603 2438
info@healthwatchhounslow.co.uk
healthwatchhounslow.co.uk

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151 Buckingham Palace Road, London, SW1W 9SZ
☎ 03000 683 000
enquiries@healthwatch.co.uk
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“I would never go to a teacher as you just get sent to the nurse and given an ice pack, whatever the issue!”

Local young person

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In this report, we look at experiences and expectations associated with Children and Young People.

What matters most to people in North West London?

Engaging with 10 young people, we found that:

Children & Young People's Services

Schools
Students have opportunities to volunteer in the community (for example supporting elderly people in care homes) and this is seen as good way to 'learn how to communicate with individuals who have health problems'.

Some students feel that care in school is not focused enough and there is not enough empathy from staff – the perception is that young people's health complaints are not taken seriously. It is also suggested that school nurses are 'not trained properly' and 'offer ice packs for everything'.

Communication is also noted as a problem – teachers will often send an email to the nurse about a student's health concern that is not picked up until the end of the day.

Mental health issues are addressed at assemblies, however students cite a shortage of named teacher contacts, and lack of follow up.

It was felt that schools could be more inclusive by appointing health prefects and monitors who are trained in Mental Health First Aid, so young people have someone to talk to of their own age.

Primary Care Services
Young people cite good support from NHS 111 and GPs, and a 'good atmosphere' at the pharmacy. However, it is noted that 'staff are overworked' and this impacts on quality.

Some people comment on a lack of information from their GP and poor liaison between GPs and Pharmacists.

Emergency and Acute Services
An example was given of 'a clear and supportive' service from 999, however some young people feel they 'won't be taken seriously' and this can be a disincentive.

Learning from Discussion (Checklist)

Local children and young people would like:

- A ‘focused’ approach to care within schools.
- To be respected and involved.
- Well trained school nurses.
- Timely communication between staff.
- Access to named teacher contacts.
- Good levels of support and peer support.

From Prevention to Support

We talked about various aspects around prevention and support.

Key themes emerging from a Westminster workshop include how to successfully promote healthy eating, how to utilise technology to engage young people, how to highlight the adverse health outcomes of smoking and how to create an inclusive and nurturing environment for open conversations about mental health.

Communication and Engagement

Finally, we asked people how engaged they would like to be, and whether they would like to be involved in designing new services. As part of this, we asked them which aspects of communication and engagement could be improved.

It was felt that…

- There was a preference for group forums over other types of engagement.
- Volunteering should be flexible, young people have different interests and ideas so some room for manoeuvre would be helpful.
- The desire to be involved in the co-design and production of solutions for problems with NHS healthcare.

What did people tell Healthwatch?

Here, we take a more detailed look at the top themes emerging from discussion. Generally we asked people what they feel works well and what could work better.

1. Schools

Students have opportunities to volunteer in the community (for example supporting elderly people in care homes) and this is seen as good way to 'learn how to communicate with individuals who have health problems'.

Some students feel that care in school is not focused enough and there is not enough empathy from staff – the perception is that young people's health complaints are not taken seriously. It is also suggested that school nurses are 'not trained properly' and 'offer ice packs for everything'.

Communication is also noted as a problem – teachers will often send an email to the nurse about a student's health concern that is not picked up until the end of the day.

Mental health issues are addressed at assemblies, however students cite a shortage of named teacher contacts, and lack of follow up.

Schools

Selected comments:

"I would never go to a teacher as you just get sent to the nurse and given an ice pack, whatever the issue!" [Westminster]

"Our health isn't taken seriously at school - it puts some people off asking for help." [Westminster]

"Student wellbeing should be a priority and should override any suspicion that a young person may be trying to skip class." [Westminster]

"Health services not embedded/normalised in daily school life." [Westminster]

2. Primary Care Services

Young people cite good support from NHS 111 and GPs, and a 'good atmosphere' at the pharmacy. However, it is noted that 'staff are overworked' and this impacts on quality.

Some people comment on a lack of information from their GP and poor liaison between GPs and Pharmacists.

Primary Care

Selected comments, GPs:

"Provides good support and reminds you to stay healthy and make regular appointments." [Westminster]

"Staff are overworked so can't provide optimal care." [Westminster]

"Information in the surgeries, and what is given from GPs, on specific conditions is sporadic." [Westminster]

"You can be charged for medication with no guarantee that it will be effective." [Westminster]

There is not enough consistency or communication between the doctors and the patient and within and between services. The impact of this on the patient is strong because they can feel lost in everything that is happening and they need stability to help their recovery. [Hillingdon]

YP are ready to do anything to get a diagnosis including travelling for a couple of hours but they feel it it's better if services are closer to them. [Hillingdon]

Selected comments, Pharmacies:

"In general, the atmosphere is calm which helps to relieve stress form patients." [Westminster]

"Not enough staff to serve at the counter so wait times can be very long." [Westminster]

"Sometimes pharmacies run out of stock. [Westminster]

"Communication between GPs and surgeries is not good - you can be given the wrong medication or they are unsure of what dosage. [Westminster]

Selected comments, other services:

"NHS 111 is a really efficient service" - they give you good instructions and keep you calm." [Westminster]

"NHS 111 - Some questions you are asked seem irrelevant and there is some time-wasting. If you have a serious issue these unnecessary delays could be life threatening." [Westminster]

"NHS Go - Very little awareness that it exists - worrying because it was specifically designed for 16-25 year olds." [Westminster]

3. Emergency and Acute Services

An example was given of 'a clear and supportive' service from 999, however some young people feel they 'won't be taken seriously' and this can be a disincentive.

Emergency and Acute Services

Selected comments:

"999 - Emergency call staff are supportive and give you clear steps on what to do." [Westminster]

"999 - It is rarely used by young people - partly due to the fear that they won't be taken seriously." [Westminster]

"Hospitals - There is not enough balance - there should be more hospitals in the less affluent areas." [Westminster]

"Hospitals - There can problems with treatment: "I was given the wrong cast at St. Charles and had to go to St. Mary's." [Westminster]

"Hospitals "A&E waiting times are too long rooms and waiting rooms are too cramped which heightens the risk of stress and the spread of disease." [Westminster]

4. Experiences – From Prevention to Support

We talked about various aspects around assessment, diagnosis, treatment and ongoing care and support.

Key themes emerging from a Westminster workshop include how to successfully promote healthy eating, how to utilise technology to engage young people, how to highlight the adverse health outcomes of smoking and how to create an inclusive and nurturing environment for open conversations about mental health.

Prevention to Support

Responses to Key Themes:

- **Physical and psychological impact of smoking:** Regular engagement e.g. school assemblies on the dangers of smoking with real people who had lived through the damage it can do to body and mind – an accord was established that creating fear amongst young people of the impact of

smoking was the best way to prevent it.

- **Early recognition:** Training for teachers and parents to identify signs of stress in young people that could lead to harmful behaviours like smoking.
- **Taking lessons from elsewhere:** There are adverts on TV about spotting the early signs of stroke, this should be applied for mental health issues amongst young people.
- **One-stop shop:** The NHS Go app should offer a young person needs to stay healthy, for example, you should be able to scan barcodes on food packaging to see the product's fat and sugar levels and the same process should be available with medication to establish if it suitable for you. However, there is an issue with data storage here.
- **Educational games:** Unlikely to rival the popularity of the big, commercial video games, but games with health messages should be available in GP waiting rooms and time should be dedicated to them at school in subjects like PHSE. Game apps would need to be free to attract young people out of school.
- **Tackling mental health stigma:** Teachers should take more responsibility in reassuring young people that it's good to talk through health concerns. This should include regular health 'check-ins' and a daily presentation at the end of the day discussing issues like exam stress and healthy eating.
- **Support for young people from young people:** Schools should have health prefects and monitors who are trained in Mental Health First Aid to offer support to young people and take their concerns seriously.
- **A place to go:** There is a real lack of free youth clubs. More work should be done to provide free access to these facilities. A great example of a successful and free youth club is 'Four Feathers' in Westminster.
- **Exercise in school:** Participation in group activities should be encouraged more as competition and feeling like part of a team are good for mental health.
- **Food warnings:** A traffic light system should be used for school meals. Any meals high in fat and sugar should have a clear red light next to them (and all around them) and healthy and nutritious options should have green light signposting.
- **Communication hubs:** A safe place to talk face-to-face with a professional should be available in the community and at school, websites and social media isn't enough.
- **Basic training:** Teachers should be given basic medical training so they are more able to establish waning signs early and can work together with school nurses.
- **Fizzy drinks:** Carbonated drinks that are high in sugar should not be allowed in hospital waiting rooms or schools, or at least they should have warning messages on them similar to cigarettes.
- **GPs Direct**: Young people should be able to have direct contact with their GPs to establish a rapport with them and build trust.

5. How could communication and engagement be improved?

Finally, we asked people how engaged they would like to be, and whether they would like to be involved in designing new services. As part of this, we asked them which aspects of communication and engagement could be improved.

How could communication and engagement be improved?

Key Themes - it was felt that:

- There was a preference for group forums over other types of engagement.
- Volunteering should be flexible, young people have different interests and ideas so some room for manoeuvre would be helpful.
- The desire to be involved in the co-design and production of solutions for problems with NHS healthcare.

Selected comments:

In a positive way, there is a lot of promotion of different options for self-care. [Hillingdon]

Generally, the process is too slow and it's not helpful so YP lose faith in the fact that doctor will find a diagnosis for them. [Hillingdon]

Acknowledgements

We would like to thank all those participants who gave up their time to contribute to the focus groups and completed the national survey.

This project was undertaken by the following Healthwatch organisations:

healthwatch Brent

3 Rutherford Way, Wembley, London, HA9 0BP

☎ 020 3598 6414
info@healthwatchbrent.co.uk
healthwatchbrent.co.uk

healthwatch Central West London

Grand Union Studios, 332 Ladbroke Grove, North Kensington, London, W10 5AD

☎ 020 8968 7049
info@healthwatchcentralwestlondon.org
healthwatchcwl.co.uk

healthwatch Ealing

45 St. Mary's Road, Ealing, London, W5 5RG
☎ 020 3886 0830
info@healthwatchealing.org.uk
healthwatchealing.org.uk

healthwatch Harrow

3 Jardine House, Harrovian Business Village, Bessborough Road, Harrow, London, HA1 3EX
☎ 020 3432 2889
info@healthwatchharrow.co.uk
healthwatchharrow.co.uk

healthwatch Hillingdon

20 Chequers Square, The Pavilions Shopping Centre, Uxbridge, UB8 1LN
☎ 01895 272997
office@healthwatchhillingdon.org.uk
healthwatchhillingdon.org.uk

healthwatch Hounslow

45 St. Mary's Road, Ealing, London, W5 5RG
☎ 020 3603 2438
info@healthwatchhounslow.co.uk
healthwatchhounslow.co.uk

The project was supported by Healthwatch England.

healthwatch

151 Buckingham Palace Road, London, SW1W 9SZ
☎ 03000 683 000
enquiries@healthwatch.co.uk
healthwatch.co.uk

Distribution and Comment

This report is available to the general public, and is shared with our statutory and community partners. Accessible formats are available.

If you have any comments on this report or wish to share your views and experiences, please contact us.

Healthwatch Central West London, Grand Union Studios, 332 Ladbroke Grove, North Kensington, London, W10 5AD

☎ 020 8968 7049
info@healthwatchcentralwestlondon.org
healthwatchcwl.co.uk

“NHS 111 is a really efficient service – they give you good instructions and keep you calm.”

Local young person

London Borough of Hammersmith & Fulham **HEALTH, INCLUSION AND SOCIAL CARE POLICY & ACCOUNTABILITY** **11 September 2019**	
Report title: Palliative Care Review Update Report	
Open Report	
Classification: For Discussion **Key Decision:** No	
Wards Affected: All	
Accountable Director: Janet Cree, Managing Director Hammersmith and Fulham Clinical Commissioning Group	
Report Author: Mark Jarvis **Head of Governance Hammersmith and Fulham Clinical Commissioning Group**	**Contact Details:** **mark.jarvis1@nhs.net**

1. Introduction

1.1 This paper provides a summary of the work that is being undertaken to consider the recommendations of the Strategic Review of Palliative Care Services that were published in the independent report written by Penny Hansford and commissioned by the Central London, West London and Hammersmith &Fulham CCGs. A separate review was undertaken previously by Brent CCG for their local services. Central London CCG is the lead commissioner for this work and is co-ordinating the work programme outlined below on behalf of, and with full engagement of the other three CCGs.

2. Background

2.1 In November 2018 the four CCGs covering Central London, West London, Hammersmith & Fulham and Brent commissioned an independent review of palliative care services. The review was undertaken by Penny Hansford, a former Chief Nurse within the palliative care field. A call for evidence was launched on 14 December 2018 and closed on 14 February. The call for evidence elicited 101 responses and provided a significant contribution to the report that Penny presented to the CCGs. In addition focus groups were held and an online survey was made available. The report was published in June 2019.

2.2 The report provides a comprehensive assessment of the current local service provision, a review of best practice and has made a number of recommendations for commissioners to consider for the future model of service.

2.3 The review identified a number of challenges across the services in the areas of:

- inequity of specialist palliative care services in the three boroughs
- inequity of access to the services, with only 48% of people who have an expected death having any contact with community palliative care services;
- 70% of patients would prefer to die in their own home but are unable to; and
- inequity of funding arrangements for the services from the CCGs.

2.4 To read the report in full please visit the homepage of the Central London CCG website, https://www.centrallondonccg.nhs.uk/news-publications/news/2019/06/strategic-review-of-palliative-care-services.aspx

2.5 The review proposed a number of options to address the challenges highlighted above. It also stated that the current provision of in-patient beds across the area is working short of their full capacity. The CCGs are working in collaboration with providers to review how we deliver these services in the best possible way, in light of the challenges and the recommendations outlined in the review.

2.6 In relation to the service provided at the Pembridge Palliative Care Centre (Pembridge) the four CCGs, in partnership with Central London Community Healthcare NHS Trust (CLCH) who provide the services at Pembridge, suspended in-patient admissions to the Centre in October 2018. This was done as both the CCGs and CLCH did not have assurance that the in-patient service being delivered at Pembridge was safe. There were a number of reasons for this but, primarily, it was due to difficulty in recruiting a specialist palliative care consultant. Without this role in post, the Pembridge cannot operate safely. No decision has been taken to permanently close Pembridge; it will, however, remain suspended for the foreseeable future.

2.7 The NHS has a statutory obligation to ensure that the services we commission are delivered safely and appropriately to meet patient's needs, therefore in-patient admissions were temporarily suspended and patients were transferred to an alternative unit.

2.8 Whilst the in-patient unit is suspended, Pembridge continues to deliver

palliative care services to local people through its day centre and community services and within people's homes.

3. Current Status Of The Review and How The CCGs Are Responding

3.1 The Chief Executives of all three local specialist palliative care providers, the Accountable Officer and lead CCG commissioners and the Chief Executive Officer of CLCH reviewed the independent report and agreed the next steps. All have agreed to approach the next steps in two stages in order to stabilise and enhance specialist palliative care services within the boroughs and North West London.

3.2 **Stage 1** – Cross organisational working to ensure the stabilisation of palliative care services, which will involve ensuring appropriate specialist support for the clinicians working in the community.

3.3 **Stage 2** This will involve the development of a new joint service specification to be developed by the end of September 2019, which will inform the new service delivery model that is hoped to be in place by 2020.

3.4. The work will be supported by a System meeting and two sub-groups. The membership of the various groups reflect the different focus of each Group. The system Group will provide strategic leadership for the work being undertaken. The Provider Operations Group will develop provider proposals to stabilise the service and develop provider proposals for long-term delivery a future contracting model. This group is made up of senior officers of provider and commissioner organisations. The Clinical Reference Group are developing the clinical model and agreeing the service specification. Membership of this group is made up of senior clinicians within provider units and senior commissioning managers.

3.5 In parallel to the development of the service specification, senior managers from all providers and commissioner will work together to ensure that the infrastructure is in place to enable implementation of the final outcome.

3.6 As part of this process we will work together with our local stakeholders, system partners, patients, families and carers to consider the opportunities for improvement highlighted by the review.

4. What Outputs Are Expected From The Work Programme?

4.1 Stage one of the work programme will work to stabilise the service and ensure that, until any changes are agreed with commissioners about the future model of care, services are safe, of high quality and can meet the needs of those patients who currently access the services.

4.2 Stage two of the work programme will see the development of a service specification for a future service. This will set out what the CCGs will commission to ensure consistency of service for all patients accessing palliative care services. It will also identify the types of service to be provided and which cohorts of patients would be expected to be able to access palliative care services.

4.3 In respect of the Pembridge service, the CCGs continue to work with CLCH as part of the service stabilisation phase of the work, to ensure that Pembridge continues to deliver palliative care services to local people through its day centre and community services and within people's homes. The position with regard to beds will, likely, be the subject of more formal engagement with stakeholders. A case for change for the bed based service is currently being written. Once this has been considered by the commissioners, Central London CCG will lead a process of wider discussion with key stakeholders on the future of the bed based service.

5. Timelines

5.1 The service stabilisation work is happening now and will be part of a continuing process that ensures the services are safe and able to provide for the needs of local people. There is no particular timescale or definitive output from this work other than for commissioners and providers to work together to maintain services until decisions are made about the future commissioning arrangements.

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6. Engagement

6.1 Ensuring that stakeholders have the opportunity to contribute to the shape of future services has been a key element of the work programme. Starting with the strategic review a call for evidence was launched which provided interested parties to submit their thoughts and views about services and what they would like services to look like in the future. These views were taken fully into account when the independent review report was written and published.

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- Services deliver high quality, effective, best practice care
- All patients have equal access to services

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Report title: Palliative Care Review Update Report	
Open Report	
Classification: For Discussion **Key Decision:** No	
Wards Affected: All	
Accountable Director: Janet Cree, Managing Director Hammersmith and Fulham Clinical Commissioning Group	
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London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY & ACCOUNTABILITY COMMITTEE** **11 September 2019**	
WORK PROGRAMME 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

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
Work Programme Development Plan 2019/20

Item / working title	Overview / Development	Report Author / service
11 September 2019		
Primary Care Network	For information. Development and implementation of the Primary Care Network	CCG
NHS Long Term Plan Update	Future vision and plans for future provision of NHS services	CCG
Pembridge Hospice	For comment and discussion	CLCH
Healthwatch Update	For comment and discussion	Healthwatch
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
- Immunisations
- 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