London Borough of Hammersmith
& Fulham

Health, Inclusion and Social Care Policy and Accountability Committee
Agenda

Monday 27 January 2020 at 7.00 pm
Meeting Room 2 (2nd Floor) - 3 Shortlands, Hammersmith, W6 8DA

MEMBERSHIP

Administration	Opposition
Councillor Lucy Richardson (Chair) Councillor Jonathan Caleb-Landy Councillor Bora Kwon Councillor Mercy Umeh	Councillor Amanda Lloyd-Harris
Co-optees	
Victoria Brignell, Action On Disability Jim Grealy, Save Our Hospitals Keith Mallinson, Healthwatch Jen Nightingale	

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Shortlands

3 Shortlands,
Hammersmith,
London W6 8DA

Closest Underground Station
Hammersmith

Closest Bus Stop
Latymer Court (Stop G)

Date Issued: 17 January 2020

London Borough of Hammersmith & Fulham

Health, Inclusion and Social Care Policy and Accountability Committee
Agenda

27 January 2020

Item		**Pages**
1.	**MINUTES OF THE PREVIOUS MEETING**	4 - 15

(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 11 September 2019.

(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 Standards Committee.

4. APPOINTMENT OF CO-OPTEE

The Committee to agree the appointment of a new co-optee.

5. CQC RATINGS / CCG OVERVIEW

To follow

This report will consider how Care Quality Commission evaluates GP practices and the requirements it sets out within its ratings system.

6. PARSONS GREEN WALK IN CLINIC - UPDATE

To follow

The Committee will consider the proposed closure of Parsons Green Walk In Centre, expected to close on 31st March 2020.

7. REVIEW OF LOCAL PALLIATIVE CARE SERVICES - UPDATE

16 - 115

The Committee will scrutinise the suspension of residential palliative care services at The Pembridge Hospice and in addition consider the engagement work undertaken by the CCGs to date on the provision of local palliative care services.

8. PRIMARY CARE NETWORKS, INTERIM CCG CLUSTERS AND INTEGRATED CARE SYSTEM STRUCTURES

To follow

This report will consider the recent introduction of primary care networks, Interim CCG Clusters and the introduction of Integrated Care Systems.

9. HEALTHWATCH UPDATE

116 - 166

This report provides an update to the Committee of the recent activities undertaken locally by Healthwatch. Additionally, this also includes the summary findings and consultation report on young people, “Healthcare in a Digital Era”.

10. 2020/2021 MEDIUM TERM FINANCIAL STRATEGY (MTFS) - ADULT SOCIAL CARE AND PUBLIC HEALTH

167 - 198

This report sets out the budget medium term financial strategy for Adult Social Care and Public Health departments. An update is also provided on any proposed changes in social care fees and charges.

11. WORK PROGRAMME

199 - 201

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

12. DATES OF FUTURE MEETING

24 March 2020

London Borough of Hammersmith & Fulham

Health, Inclusion and Social Care Policy and Accountability Committee

Minutes

Wednesday 11 September 2019

PRESENT

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

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

Other Councillors: Ben Coleman

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

22. MINUTES OF THE PREVIOUS MEETING

RESOLVED

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

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

Janet Cree reported that the Governing Body of H&F CCG had considered a report which set out details about the potential merger and case for change. Unfortunately, H&F Save Our NHS had been omitted from the list of organisations which had provided feedback and that this would be amended.

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

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

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

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

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

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

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

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

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

23. APOLOGIES FOR ABSENCE

Apologies for absence were noted from Councillor Bora Kwon.

24. DECLARATION OF INTEREST

None.

25. PRIMARY CARE NETWORK

Janet Cree explained that this report informed members about the development and structure of Primary Care Networks (PCNs) and the aspiration to deliver direct enhanced services. PCNs were evolving and development plans for this closely aligned to deliver the goals set out in the NHS Long Term Plan. Details about the impact of this would be provided at a future meeting.

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

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

RESOLVED

That the report was noted.

26. NHS LONG TERM PLAN UPDATE

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

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

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

The Council’s Better Care Fund had been drafted in the absence of any information about the LTP response.

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

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

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

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

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

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

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

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

Greater complexity within the NHS meant that it became harder to hear the “local voice” and it would be helpful to understand how the PCN and CCG linked together. In considering local, place-based care, Lesley Watts commented that London had benefitted greatly with the boroughs benefitting from, for example, the reforms in stroke care.

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

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

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

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

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

RESOLVED

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

27. HEALTHWATCH

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

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

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

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

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

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

RESOLVED

That the report was noted.

28. PEMBRIDGE HOSPICE

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

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

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

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

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

1. There will be a need for more palliative care beds in future. There will be an increased number of isolated elderly people and fewer cancer patients and part of the integrated care system approach is to keep people out of hospital. The role of the Pembridge unit was not just to offer beds, but it could have the potential to be a centre for learning.

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

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

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

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

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

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

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

Jim Grealy agreed that it was important that people had a support network, particularly given that many who lived in the area did not have family members who lived locally. Pembridge was in one of the poorer areas between Brent, RBKC and H&F. There were many on low incomes who would find it difficult to travel to other boroughs to visit family and friends who needed end of life care. He encouraged the CCG to consider a more creative solution for Pembridge rather than the permanent loss of palliative care beds and that the consultation should be wide ranging.

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

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

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

RESOLVED

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

Janet Cree responded that the direction of travel was based on the events that had occurred and following the independent review. An assessment of

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

As a registered practitioner Dr Medhurst assured the Committee that the recruitment issue meant that there was not the right staffing structure in place and that there was not a doctor in post with palliative care experience. There was a specialist palliative care lead consultant, but this individual lacked sufficient experience and did not have capacity to supervise Pembridge staff. In response to Councillor Colemans suggestion that the Council offer to assist in recruiting a suitable clinician, Janet Cree explained that the purpose of the review was to identify what the future service would look like and that is was not possible to accept or decline the offer of assistance while the review process was on-going.

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

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

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

RESOLVED

That the report was noted.

29. WORK PROGRAMME

Janet Cree and Vanessa Andreae jointly informed the Committee that the CCG had taken a decision to close the Parsons Green walk in centre. It was reported that the CCG had sought special dispensation from NHS England to keep the walk-in centre open until the end of March 2020 and were awaiting the outcome of that request. Formal notice of the closure would be made by the end of September. Janet Cree explained that core standards for an urgent treatment centre included being open throughout the day, access to a doctor, access to urine testing facilities and routine appointments and these could not be met at Parsons Green. Janet Cree added that the CCG had initially thought that with slight changes the Centre could continue. The CCG had carried out a review in December 2018 which concluded that the Centre offered high quality services and value for money. NHS England determined that it was not acceptable to continue to offer services from the walk-in centre and that there would be no other walk-in centres nationally. It was noted that this was also the case in other parts of London such as Barnet.

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

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

RESOLVED

That the Work Programme was noted.

30. DATES OF FUTURE MEETINGS

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

Meeting started: 6pm
Meeting ended: 9.30pm

Chair ....

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Agenda Item 7

London Borough of Hammersmith & Fulham

Report to: Health, Inclusion and Social Care Policy & Accountability Committee

Date: 27/01/20

Subject: Review of Local Palliative Care Services

Summary

This report invites the Committee to consider and explore the current configuration and provision of local palliative care services, in light of the recent suspension of residential services at The Pembridge Hospice.

Recommendations

To consider and comment on the information attached at Appendices 1-4.

Wards Affected: All

H&F Priorities

Contact Officer(s):

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Background Papers Used in Preparing This Report

None.

List of Appendices:

Appendix 1 - Palliative care services, Executive Summary Review of provision in Kensington & Chelsea, Hammersmith & Fulham and Westminster**,** Penny Hansford - June 2019
Appendix 2 - Palliative care services Independent review - full report
Review of provision in Kensington & Chelsea, Hammersmith & Fulham and Westminster
Appendix 3 – Palliative Care, letter to stakeholders, 3 January 2020
Appendix 4 – Palliative Care Review Workshop Findings

PJH FOUR
CONSULTING

Palliative care services

Executive Summary

Review of provision in Kensington & Chelsea, Hammersmith & Fulham and Westminster

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Penny Hansford - June 2019

Background

Central London Clinical Commissioning Group (CCG), on behalf of West London CCG and Hammersmith & Fulham CCG, commissioned Penny Hansford of PJH4 Consulting and former Hospice Director at St Christopher's Hospice to independently review palliative care services in the area, commencing November 2018. The aim being to deliver a report which provides a set of recommendations for a sustainable, clinically effective and cost efficient commissioning model for delivering Specialist Palliative Care Services (SPCS – both bed based and community provision), in order to achieve national strategic outcomes and best value.

Context

The review came as a result of the recognition that there were multiple providers of 'specialist' palliative care in three small boroughs with differing services and service specifications. It was also prompted by the temporary closure of the Pembridge Hospice In patient unit which occurred in October 2018, where adequate medical cover was unable to be recruited.

The current landscape

The tri-borough CCGs commission three specialist palliative care providers: Central London Community Healthcare Trust (CLCH) The Pembridge Hospice (PH), Royal Trinity Hospice (RTH) and St Johns Hospice (SJH). Central North West London (CNWL) deliver a community service to North East Westminster commissioned by Camden CCG. Marie Curie Hampstead deliver care for a very small number of patients (non-contracted). St Luke's Hospice is a peripheral part of the review as patients from Brent CCG also access the Pembridge Hospice.

Methodology.

The review included an analysis of national strategy and policy alongside local policy and context, a review of current service provision alongside what will be needed in the future. Investigating views of stakeholders via interviews with key professionals and groups and a public call for evidence via local groups and the media was central to the review.

Key findings

The review highlighted the following:

The most consistent feedback from professionals and the public was inequity of service provision across the boroughs and in the services, poor co-ordination and communication between services, lack of ease of access to services at the appropriate time and the lack of urgency of response of most services. Also consistent was the high levels of satisfaction of patients and families once they were being cared for by a specialist palliative care service.

Patients, families and carers report high satisfaction rates once they start receiving a specialist palliative care service.

There are variations in services, contracts and performance across all providers.

There is no one commissioner with oversight of all specialist palliative care provision across the tri-borough.

The NHS contribution towards the care costs varies across providers.

(range 18%-100%)

There is a variation across providers in the ratio of specialist palliative care nurses in the community per head of population.

The involvement of the community based palliative care teams significantly improves the likelihood of dying outside the hospital setting which is what patients say they want.

The palliative care services in the tri-borough reach approximately 48% of patients who have an expected death.

Getting a rapid face to face assessment from the specialist palliative care provider in the community is problematic.

Access to a senior a specialist palliative care clinician to aid decision making for a GP or community nurse can be problematic and inconsistent.

The Community Independence Service (Rapid Response team) are regularly called to patients who on initial assessment are in need of end of life care.

The model of daycare varies: Traditional model by St Johns and Pembridge saw a 47 new patients in 17/18. Trinity has a modernised day care and rehabilitative approach.

District Nursing services feel aggrieved that the Specialist Palliative Care services see themselves as advisory and not interventionist.

Specialist Palliative Care nurses perceive District Nursing to be task orientated, not holistic and personalised.

74% of the public who responded to the online survey reported poor co-ordination and communication between services for people at the end of life.

The percentage of deaths at home is higher in all 3 boroughs(28.2%) than London (23.8% or England

(23.5%)

Deaths in hospital for the boroughs(48.9%) are higher than England(46.9%)but lower than London(52.8%)

Referrers who interface with more than one provider for inpatient care have a perception that hospice A is better able to cope with complexity than hospice B and refer accordingly.

The specialist palliative care services different IT systems that have no interoperability with primary care or the hospitals (exception Pembridge)

Based on the number of inpatient bed days available across the tri-borough, there is capacity in the system to admit more patients or close some beds.

Length of stay is above the London average of 14.6 days:

- *St Johns Hospice: 17.8 days*
- *Pembridge inpatient unit: 17.8 days*
- *Royal Trinity: 16 days*

There is a lower ratio of nursing care home beds in the tri-borough compared to the London region which may impact on the length of stay.

The palliative care services still predominantly deliver care to people with a cancer diagnosis but this is steadily changing. (Average 70/30)

The balance of palliative care medical time is heavily weighted to inpatient beds and not the community

The occupancy of two of the three units is low:

63% St Johns Hospice - 67% CLCH Pembridge Inpatient Unit (2017-8 figures)

The recommended model

The recommended model and options are derived from the views of key stakeholders, including – patients and carers, and clinical and managerial professionals and the professional experience of the reviewer.

The delivery of the model needs to be integrated with the multi-speciality provider models (MCP) being developed in other parts of the CCGs. The reconfiguration of services ae progressing at different rates within the CCGs and it has not been possible within this review to describe the methodology for integration.

Implementation of the recommendations will deliver a clinically and cost- effective commissioning model for palliative and end of life care, ensuring equity and service resilience for the future. For individual services it carries a level of risk.

A model fit for the future

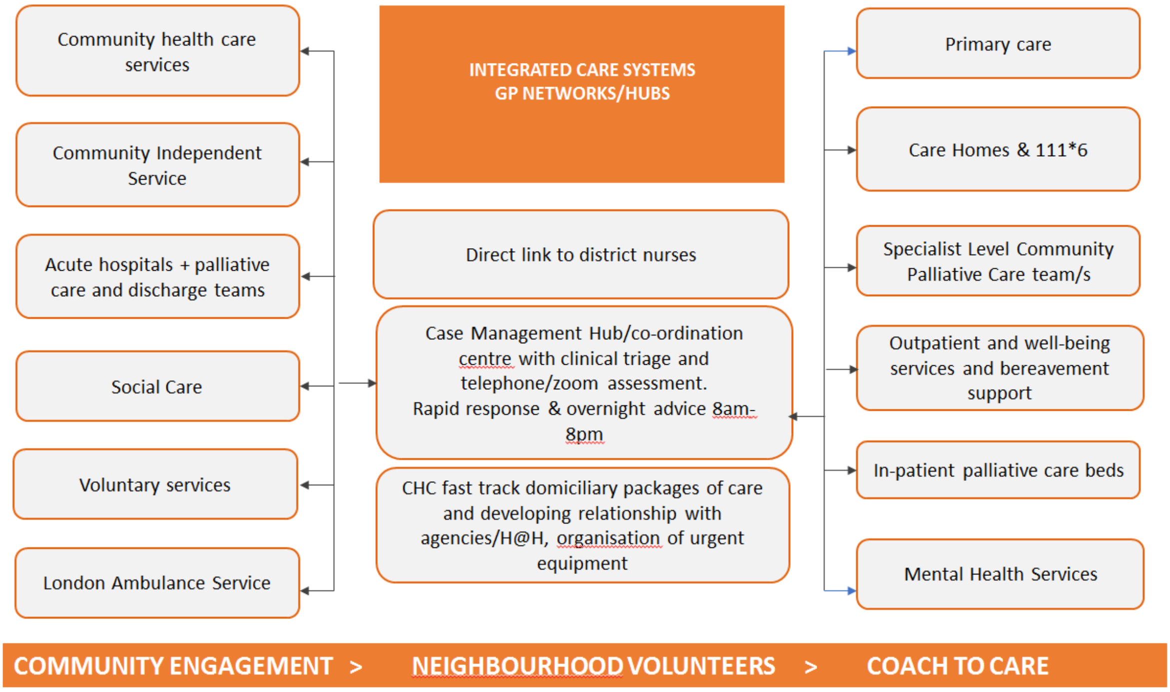

Figure 1: New model of community palliative and end of life care

Overarching Recommendation by Penny Hansford Independent Strategic Reviewer

In conducting this review it has become clear that the three major challenges for the CCG's commissioning services are:-

- inequity of specialist palliative care service provision 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
- inequity of funding arrangements for the services from the CCG's which ranges from 18-100%

Once in contact with a specialist palliative care service patients and families report high levels of satisfaction. In order to significantly improve the specialist community service I have suggested a 8am-8pm palliative care hub with skilled clinicians that can ensure patients get the right repose by the right person at the right time. The hub will also have a rapid response service. I have also recommended that the community services are retendered with a lead provider model to enable better co-ordination and accountability.

I am also recommending a reduction in specialist palliative care beds. These are not currently fully utilised. Bed modelling in appendix L has demonstrated that there is some capacity in the system and that more could be created by extra provision of continuing healthcare beds.
Since the Pembridge Hospice inpatient unit has been closed the majority of patients have been successfully admitted to surrounding hospices. This, combined with the block contracting arrangement that the CCG's have with CLCH who manage the Pembridge Hospice leads me to recommend that the Pembridge inpatient unit is decommissioned and the monies used to purchase provision in other local hospices and in the re tendering of enhanced community services.

Recommendations based on seven key areas identified in the review:

Area	**Recommendations**
1. Case Management	• To co-ordinate care from a central hub that operates from 8am-8pm, seven days a week, with access to advice outside of these hours. • Clinical triage and assessment and reassessment with competent senior staff to manage routine and urgent referrals. • Joint decision making and coordination of care between District Nursing and the Specialist Palliative Care teams. • Rapid response service, a key element of case management. • Response times from specialist level services should be in line with the degree of urgency and of patients need; this should be measured. • Bridging care packages to be offered until a continuing heath care package can be mobilised. • Rapid accessibility to equipment. • The integration and coordination of fast track care and placements (including night care). • An agreed End of Life Care plan should be implemented across the tri-borough with all health and social care providers including the acute sector. This should include the patient’s wishes and preferences for care and guidance for deterioration (escalation plan) • The service provision is the patients GP and not where the patient resides. • Joint visits with the GP in complex cases (home/care home). • For specialist community providers to be equipped to respond to the nursing needs of patients if they have a planned or unplanned visit. • Link service with the 111*6 care home initiative.

2. Planning	• To have a single End of Life Care commissioner for the tri-borough CCGs. • To commission specialist palliative care services to include the case management/care co-ordination model. • To better understand bed provision in hospices across the tri-borough including; reasons for the long length of stay, issues with transfer to a care home settings and patient complexity and intractable problems. • To reduce the numbers of specialist beds that are not being utilised and reinvest the money into the community provision which will further reduce the need for as many beds over time. Bed modelling in appendix L of the main report suggests that it may be possible to close between 4 and 10 beds. This modelling is however based on a series of assumptions and is linked to further work that needs doing regarding the adequacy of CHC fast track care home bed provision. • To better understand the need for CHC fast track beds for the future as it seems likely that increased bed provision in this area would allow for better patient acuity. • Specialist palliative care provision is targeted at complex patients and hard to reach groups (mental health, homeless and learning disability). Their work should be episodic where possible, but they should be case managed even when they are not directly involved, in order to recognise when their involvement is needed and to support GP's and community nurses. • The provision should include coaching and training for the wider community teams and this should be a major focus. • To commission new community palliative rehabilitation health and well-being services to replace traditional day care. • To integrate the community specialist palliative care provision with integrated care systems (including co-location). • To better utilise IT programmes like e-shift which enable a senior clinician to supervise a group of nurses/care workers via video link. • Hospices to review the balance of community and hospice work; moving to support the wider system including some bed management to be led by senior nurses. • When recruiting, consideration should be given to the balance of medical staff with some consultants, doctors in training to be palliative care consultants, speciality doctors as well as GP's with a special interest in palliative care. • Staff work across the communities and cross cover for one another. • CCGs to review the provision of nursing care home beds across the tri-borough. • CCG's within the NW London 'Sustainability & Transformation Partnership' (STP) footprint should ensure similar models of service provision are standardised and implemented throughout. • There should be an agreed mechanism for medical staff to cross cover 24/7 to ensure service resilience in the tri-boroughs.

IT systems	• To ensure IT systems that have interoperability across the central co-ordination hub, Community specialist palliative care provision, primary and nursing homes. • CCG's to ensure the prognostic indicator tool (SPICT) is embedded in SystmOne to aid patient identification at end of life.
Funding	• To ensure that core aspects of community provision are fully funded to address inequitable funding between providers. • To review the operation and expenditure of the Continuing Health Care team and the care home contracts. • To have a common understanding of the cost of a bed day and an inpatient bed tariff between the providers and the CCG.
Outcome measures	• To ensure Community specialist palliative service specifications are standardised across providers. • To ensure Community specialist palliative services reach 75% of expected deaths either by direct provision or case management or advice. • To ensure there is a reduction in hospital admissions for those in their last 90 days of life. • To ensure more patients die at home or in their care home. • To ensure all patients at the end of life have an accessible care plan e.g. CMC as it can be shared across providers. • To ensure specialist palliative care services include a rapid response that is measured. • To increase attendance at primary care multi professional meetings and assist GP's in the identification of patients in the last phase of their life. • To implement the Outcomes Assessment and Complexity Collaborative (OACC) in all palliative care settings. • To ensure that the patient feedback is collected using a validated tool as part of the outcome measures. • To develop measures for the delivery of education and training.

Training and Review	• To ensure that education and training is a core part of the provision with adequate time and resource. This should particularly include the social care workforce in domiciliary care and care homes. This should also include the development of a 'coach to care team' that will be part of the rapid response and work with domiciliary care agencies. • To maintain and develop multi professional forums (including social care and eventually the voluntary sector) in primary care to review patients in their last year of life and on the palliative care registers. • To develop joint operational guidance to ensure that there is understanding of roles and responsibilities between community specialist palliative services, GP's and district nursing. • The tri-borough CCGs and NW London STP to agree the palliative care nurse responsibilities and skill sets to work as advanced nurse practitioners.
Other	• To include joint working with the voluntary sector in service specifications. • To collaborate with the local authority to commission a lead provider to integrate and standardise the many small bereavement services that exist in the tri-borough and a new model developed. • To ensure re-commissioned community nursing services include rapid response. • To standardise models of service provision across the tri-borough and the NWL footprint. • CCG's to work towards a lead commissioner for palliative and end of life care across the NWL STP footprint. • To review nursing care home provision to ensure it is fit for purpose now and in the future. • To invest in an advance care planning programme in the memory clinics to capture the wishes and preferences for care and death at an early stage • Primary Care contracts to include monthly multi professional reviews for people at the end of life. • Referrals for the hospice inpatient care should also be directed to the care co-ordination/case management centre and forwarded to the appropriate unit. (or a joint in box for hospices to access) • Changes in operational policies of the specialist palliative care providers to enable anyone to refer to their services. • Subcutaneous fluids should be available in the community and not require a hospital admission.

Commissioning options

Option One

- Tender a new community service with one lead provider.
- This would not preclude subcontracting arrangements.
- To provide an 8am-8pm co-ordination/case management centre.
- Out-patient, rehabilitation and well -being services should be easily accessible to patients and be located within the boroughs.
- Renegotiate bed-based care with separate providers.

Option Two

- Tender a new service and reduce the number of providers to two.
- All providers to have the same service specification and contract.
- The service specification should stipulate a partnership to provide a 24/7 co-ordination/case management centre.
- Out-patient, rehabilitation and well -being services should be easily accessible to patients and be located within the boroughs.

Option Three

- Tender the service based on one community service per borough with the same service specification (including a co-ordination centre/case management centre per borough).

Summary

The recommended option from the options above is number one. The rationale for recommending option one, to have one lead provider in the community, is due to the significant transformational change needed in the specialist palliative care services to enable them to use their resources in a focussed way, acting in a consultative and training capacity to the wider care system whilst managing a small number of highly complex patients themselves, alongside case management for all expected deaths. Achieving the recommended outcomes for the new model of care will be challenging and most likely achieved with a systems leader 'driving' change.

There is also an imperative to become part of the emerging integrated care systems in the tri-borough CCGs and to provide an equitable service throughout. The reviewer believes this is best achieved by an overall lead provider, accountable for the change needed. The integrated care systems are progressing to different timescales and slightly different models in each CCG and so it has not been possible for the reviewer to make a recommendation on how the palliative care co-ordination centre will integrate, only that it will need to.

The idea of a co-ordination centre, single point of access with extended hours and rapid response was consistent feedback from many of the patients. 76% of public respondents (n46) rated co-ordination and communication between the services as very poor to fair and 64% of the same group (n42) rated access to services as fair to very poor. Rapid access to care both in and out of hours were also marked with similar scores by the public.

Contracting the beds separately to the community contract is a pragmatic approach as the provision of care in this setting requires less change management. Since the closure of the Pembridge inpatient unit it appears that patients have been successfully admitted to other units who have had capacity. There does appear to be a lack of continuing health care (CHC) fast track provision across the boroughs. Although further work needs to be done it is likely that there could be a reduction in commissioned hospice beds and consolidation on less sites with a greater provision of CHC fast track beds for dying people to improve patient flow and the correct level of acuity.

Contracting the specialist palliative care beds separately is likely to reduce the instability, both financial and operational to the provider services.

All of the recommendations in this review are in line with the vast majority of feedback from both the public and professionals.

Policies guidance and reports underpinning the recommendations

NICE Quality Standard for End of Life Care for Adults[1]
One Chance to Get it Right: Improving people's experience of care in last few days and hours of life, One year on Report[2]
Ambitions for Palliative and End of Life Care: A national framework for local action 2015- 2020[3]
Cost Effective commissioning of End of Life Care[4]
Shifting the Balance of Care [5]
Specialist Level Palliative Care, Information for Commissioners[6]
Enhanced End of Life Care in the Community[7]
Business Care for Specialist Palliative Care Provision Across London[8]
Joint Strategic Needs Assessment (JSNA) for the Royal Borough of Kensington and Chelsea, Westminster and Hammersmith and Fulham End of Life Care: Key Themes and Recommendations[9]

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[1] Nice Quality Standard for End of Life Care for Adults (QS13) November 2011 https://www.nice.org.uk/guidance/qs13

[2] Department of Health (July 2015): One Year on Report to the 'Once Chance to get it Right : Improving People Experience in the Last Days and Hours of Life.' https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/450391/One_chance_-_one_year_on_acc.pdf.

[3] Ambitions for Palliative and End of Life Care: A National Framework for Local Action 2015-20 http://endoflifecareambitions.org.uk

[4] Public Health England, Cost Effective Commissioning of End of Life Care (2017) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/612377/health-economics-palliative-end-of-life-care.pdf

[5] Nuffield Trust, Shifting the Balance of Care (2017) https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf

[6] NHS England, Specialist Level Palliative Care, Information for Commissioners. April 2016 https://www.england.nhs.uk/wp-content/uploads/2016/04/speclst-palliatv-care-comms-guid.pdf

[7] RM Partners, Enhanced End of Life Care in the community. August 2018 http://rmpartners.nhs.uk/wp-content/uploads/2017/03/Enhanced-EOLC-community-project.pdf

[8] RM partners, Business Case for Seven day Specialist Palliative Care Provision Across London , June 2018 http://rmpartners.cancervanguard.nhs.uk/wp-content/uploads/2018/09/7daySPCReport_Final_060918.pdf

[9] Joint Strategic Needs Assessment (JSNA) for the Royal Boroughs of Kensington & Chelsea, Westminster & Hammersmith and Fulham. End of Life Care , Key Themes and Recommendations , October 2016 https://www.jsna.info/endoflifecare

PJH FOUR
CONSULTING

Palliative care services
Independent review - full report
Review of provision in Kensington & Chelsea, Hammersmith & Fulham and Westminster

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Penny Hansford - June 2019

Preface

This was a complex review to carry out. Dying is not something most of us think about until it touches us personally. When it does, it often evokes strong and sometimes unfamiliar feelings. The health and social care professionals that I have met in the course of this review also had strong feelings and a desire to deliver the very best of care to dying people and their families. The clinical reference group that worked with me on this review also demonstrated a desire to get the system of support for dying people more equitable and more co-ordinated than it is at present. I am grateful to their support, challenge and robust discussion. Thank you to the many who submitted evidence, particularly bereaved carers who took the trouble to 'tell their stories' which for some will have been hard. These are the voices to which we must listen.

I am also grateful the group within the CCG's that have supported this review. Benjamin Smith, Project Manager, Central London CCG, Lena Coupland ,Delivery Manager for Integrated Care, NHS West London CCG , Ray Boateng, Head of Integrated Commissioning and Continuing Care , Joint Commissioning Team and Sarah Flynn, Communications officer, NW London CCGs.

With thanks to the Clinical Steering Group

Steve Barnes -St Johns Hospice, Ray Boateng- Joint commissioning, Jackie Bennett- Marie Curie Hospice, James Benson- CLCH, Olivia Clymer- Healthwatch, Lena Coupland- West London CCG, Sarah Cox -Chelsea and Westminster Foundation Trust and Royal Trinity Hospice, Jo Dedes -St Luke's Hospice, Jennifer Karno -Imperial College Health care, Molly Larkin NW London CCG's, Sam Lund -Royal Trinity Hospice, Farukh Malik GP, Jo Medhurst CLCH, Clare Montagu-Royal Trinity Hospice, Neil Nijhawan -Charing Cross Hospital, Alex Rogers -St Johns Hospice, Michelle Scaife NW London collaboration of CCG's, Benjamin Smith -Central London CCG, Paul Trevett Central North West London.

Penny Hansford

Independent Reviewer
PJH4 Consulting

Contents

Background & rationale

Central London Clinical Commissioning Group (CCG), West London CCG and Hammersmith & Fulham CCG (the tri-borough) commission their palliative care services together for the boroughs of City of Westminster (WCC), the Royal Borough of Kensington & Chelsea (RBKC) and the London Borough of Hammersmith & Fulham (LBHF).

Current provision is commissioned via three contracts. Two are with independent charitable hospices, St Johns Hospice (SJH) and Royal Trinity Hospice (RTH) and one is with an NHS provider, the Central London Healthcare Trust (CLCH) who delivers services at The Pembridge Hospice (PH). There is also a community service provided by Central and North West London NHS Foundation Trust (CNWL), for patients in North East Westminster. This is a small part of a larger service which provides care to South Camden, Islington, UCLH and HCA and commissioned by Camden CCG.

Context of the review

On October 1st 2018, the inpatients beds at the PH were suspended, as there was inadequate medical cover for the inpatient unit. A consultant registered on the specialist register for palliative care is required to cover inpatient care. This event, combined with commissioners desire to ensure palliative care services are fit for the future, meant the tri-borough CCGs decided to review the current provision of specialist palliative care.

Central London CCG, on behalf of West London CCG and Hammersmith & Fulham CCG, commissioned Penny Hansford, former Director of Nursing at St Christopher's Hospice, South East London; as the independent reviewer in November 2018. A 'Call for Evidence' was launched on 14 December 2018 and a clinical steering group was created, with representatives from GPs, acute trusts, community trusts and hospice providers, all with an interest in specialist palliative care.

Timeline

The process for the review followed this timeline:

Event	Date
Suspension of inpatient admissions to the PH	1st October 2018
Penny Hansford commissioned to review palliative care services within the tri-borough CCGs	26th November 2018
First clinical steering group held	29th November 2018
Call for evidence launched	14th December 2018
Engagement with providers, stakeholders and patient groups	1st December-14 February 2019
Call for evidence closed	14 February 2019
Publishing of review	14 June 2019

Figure 1: Timeline of palliative care review

The review was launched on the 26th November 2018 and concluded on February 28th 2019. The review included extensive consultation with health and social care professionals, and a public and patient consultation via available communication channels, the media and patient/public engagement groups (see appendix A). A literature review was undertaken of key national policies and recent research evidence was included, to ensure that any recommendations were evidence based.

The review also looked at a number of new models of palliative and end of life care being developed in the UK aimed at improving inequalities in access and to modernise services. All of the recommendations are included in this report and summarised in the Executive Summary.

Defining specialist palliative care

This strategic review of 'specialist' palliative care services has caused some confusion in terminology.

Palliative care is the active holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Traditionally, services called 'specialist' as opposed to 'palliative care' services, which has included hospices, would define themselves as caring for people with the most complex physical and psychological symptoms. However, given there is no standard definition of 'complexity' it is not possible to distinguish in any standardised way those people who need specialist input. Furthermore, the needs of a patient and family are not linear and most people will have episodes or situations where review and advice will need to be sought from the experts who specialise in palliative care.

This review concentrates on the 'specialist' palliative care services delivered by SJH, RTH, PH and the CNWL service. However, as palliative care is 'cross cutting' the review has needed to consider how the wider system works together with community nursing, primary and social care. All of whom are also delivering palliative care as part of, rather than the entirety of their role. The term ‘specialist palliative care’ and ‘palliative care’ are used interchangeably in this report.

Statistics - End of life in the boroughs

The boroughs

- The total population of the tri-borough CCGs is 583,525. (Hammersmith & Fulham 182,998, Westminster 244,786 and Kensington & Chelsea 155,741) (2017)[1]
- The average number of deaths per year in the tri-borough is 2,815 between 2014-2017. In 2017-18 there were 2,777 deaths.[2]
- Of these 2,222 are said to be 'expected' deaths.
- On average there are 844 (30%) deaths per year due to cancer, 768 (27%) due to circulatory disease, 341 (12%) deaths due to respiratory disease and 863 (31%) deaths due to other causes.[3]
- In England there was a 1.6% rise in deaths since last year and this is expected to rise by 10% by 2030. However, in the tri-borough the number of deaths is not expected to significantly rise, therefore no recommendations have been made specifically about forecasted capacity for the next three years.
- The population of over 65's is projected to grow by 20.4% in England over the next 10 years. However, the tri-borough has a lower than average population of over 65- year olds compared to 16.3% for England. (RBKC 13.6%, WCC 10.6% and LBHF 10.3%) The predicted rise of this age group is negligible with only LBHF predicting a 6.7% rise in the ten-year period.[4]
- Almost two thirds of deaths occur in the over 75 age group in the tri -boroughs, which mirrors the national picture.
- Care home provision across the three boroughs is among the lowest in England 3.1 beds per 100 of the population over 65, compared to 4.3 for London and 4.9 for England. (appendix B)

Place of Death (Appendix C)[5]

- Deaths by percentage in care homes is also correspondingly low 11.9% compared to 14.3% for London and 21.8% for England.
- The percentage of deaths at home is significantly higher in all three boroughs (28.2%) than the England average (23.5%) and the London average (23.8%) in LBHF (28%), WCC (29%) and RBKC (27.6%).
- The percentage of deaths in a hospice is slightly higher (7.7%) than the average for England 5.7% and the region 6.6%. 213 people from the tri boroughs died in a hospice in 2017-8.
- Deaths in hospital (48.9) are slightly higher than England (46.9) but below the London average (52.8%).
- A person in their last year of life with cancer can expect 3.49 admissions and use 18.25 bed days. With non-cancer conditions this is 3.01 admissions and use 18.45 bed days. The percentage of people who have 3 or more admissions in their last 90 days of life is 7.8% for the tri-boroughs, 9% for the NW London area and 6.9% for England (Appendix D).
- The number of completed 'Co-ordinate my Care' (CMC) care plans for the calendar year 2018 was 788 representing a 35% CMC completion rate (see appendix E). Use of CMC is

important as it guides professionals to a patient's wishes and preferences, especially in urgent situations.

The Impact on Place of Death when one of the 4 specialist palliative care services are involved

- Home deaths increase by 4.1%
- Hospital deaths are reduced by 23.5%.
- Care home deaths increase by 7.7%.

The literature on place of death

It is often quoted that more than 70% of people would prefer to die at home. In a systematic review looking at peoples preferred place of death, home preference estimates ranged from 31%-87%for patients, 25%-64% for caregivers and 49%-74% for the public. 20% of 1395 patients changed their preferences.[6] Dying at home is however associated with a greater sense of peace and less intense grief for the bereaved.[7]

Cost of Care

- For every 1000 living people, nine will die within the year and seven of these will have end of life care needs prior to their death and be disproportionately high users of hospital care; consuming an estimated 27% of hospital spend.[8]
- The cost of hospital care for the over 65 age group in their last year of life is £2 in every £10.[9]
- There is also a growing body of evidence that the provision of specialist palliative care services results in improved experience and reduced costs at the end of life. Benefits include doubling a person's chances of dying at home, reducing patient symptom burden and reducing costs by between 18 and 35 per cent, when compared with usual care. [10]

Recommendations for Commissioning Outcomes:

- Decrease the numbers of admissions in the last 90 days of life.
- That more people are supported to die at home or in their care home.
- Increasing the 'reach' of the specialist palliative care services to reach 75% of expected deaths either by direct provision or by case management/advising.

Local & national policy on palliative and end of Life Care

There are nine key documents that have been published between 2015 and 2017 that have been used throughout the development of the recommendations found within the review, (appendix F):

- 'Specialist Palliative Care, Information for Commissioners' 2016 [11]
- 'Ambitions for Palliative and end of life care' 2015 [12]
- Review of Choice in End of Life Care' 2016[13]
- Commissioning Person Centred End of Life Care: A toolkit for health and social care. 2016[14]
- 'Actions for End of Life care 2014-16 [15]
- 'What is important to me-a review of choice in end of life care 2015[16]
- Shifting the Balance of Care-March Nuffield Trust 2017[17]
- Independent Review of the Liverpool Care Pathway 2013 [18]
- Introducing the Outcomes Assessment and Complexity and Collaborative Suite of Measures. Kings College London University 2015[19]

North West London STP Priorities[20 21]

The boroughs of RBKC, Hammersmith & Fulham and Westminster sit within the footprint of the North West London Sustainability Transformation Plan (STP). In June 2016 the STP was published; one of the key objectives was to improve the overall quality of end of life care.

In 2015/6 a steering group was formed as part of the NW London STP plan - to improve care in the last phase of life. The recommendations of the group include:

- Implement a 24/7 telemedicine co-ordination, advice and support line for care home staff and their residents.
- Build on St Luke's Hospice experience of a single point of access co-ordination centre for people at the end of life
- Align GP's more closely with individual care homes and develop enhanced care services.
- Develop robust and consistent identification of patients in the last phase of life and avoid unplanned admissions work in primary care
- Support specific extensions and adjustments to existing Hospice@Home /rapid response /community pharmacy services.
- Build on schemes such as homeward, STARS, CIUS to avoid acute admissions and support greater co-ordination of health, social and voluntary sector services.
- Develop training and education for GP's, Care Home and LAS staff.

Some of the above is yet to be implemented. Each CCG within the NW London STP footprint has to mandatory commission a new dedicated care home advisory service, called 111*6. This provides urgent clinical advice for care home staff. A NW London pilot provides an enhanced version of this service, with a dedicated team of advance nurse practitioners who give clinical advice.

A care home manager leadership programme has been commissioned by NW London CCG's with funding from Health Education England NWL. A NW London care home dash board, initially focusing on unscheduled hospital service utilisation was created to enable the sharing of intelligence between health and social care, support learning and promote best practice.

Other priorities for palliative and end of life care is to work with commissioners and services to reduce the gap in variation in service delivery and to develop comprehensive standardised data sets and metrics for multiple stakeholders. The STP is clear that palliative and end of life initiatives need to be linked to advanced frailty initiatives and the development of integrated care systems.

Recommendation:

- For the CCG's within the STP footprint, ensure similar models of service provision are standardised and implemented throughout.
- For the CCG's to work towards a lead commissioner for palliative and end of life care in the STP footprint.

JSNA for the Tri-Borough CCGs[22]

In 2016, a Joint Strategic Needs Assessment (JSNA) was published but there has been a lack of leadership and structure to implement the recommendations. It has five key recommendations:

- Maximise choice, comfort and control through high quality effective care planning and co-ordination.
- Promote end of life care as everybody's business and develop communities which can help and support people.
- Identify clear strategic leadership for end of life care across both social care, health care and the independent sector.
- Develop a co-ordinated education and training programme for practitioners, the person dying, carers and for family members.

Tri Borough CCG Priorities

The individual CCG's are in the process of setting up integrated care partnerships (ICPs). These are alliances of NHS and other providers that work together to deliver care by agreeing to collaborate rather than compete. These providers include acute hospitals, community services, mental health services and GPs. Social care and independent and third sector providers may also be involved. In the tri-borough CCGs, these are at different stages of development.

Hammersmith & Fulham Integrated Care Partnership have been working together since February 2018. This partnership has three clinical workstream areas of initial focus.

- Proactive prevention and management of frailty.
- Improving the diagnosis of dementia and early advance care planning.
- Improving end of life care, including care homes.

The members of the partnership have signed an alliance agreement to work together which includes the local NHS acute trusts, the community trust, the mental health trust and the GP Federation. The local authorities attend but haven't yet signed the partnership agreement. Hammersmith & Fulham have access to a range of specialist palliative care providers, including the RTH and CLCH who operate their services from PH. CLCH are represented but RTH are not part of the partnership agreement. This leaves part of the hospice sector outside of the developing integration.

West London CCG (which includes the Royal Borough Kensington and Chelsea and the wards of Queens Park and Paddington) has developed its own integrated care strategy 2018 - 2020. The current strategy is an enhancement of the 2015 'My Care My Way' (MCMW) programme. MCMW is targeted at over 65's and provides case management and health and social care navigation. It also funds a programme of support for people with long term mental health problems. 'Community Living Well.' The current strategy aims to deliver a fully integrated community health team serving the whole populations health and social care needs by April 2019. The outcomes are based around the proactive maintenance of good health and disease management. End of Life Care is one component of the programme. A co-design group was established in 2018 to understand the challenges and develop a model for patients. This work has been paused to focus on this review.

The proposed Integrated Care delivery model will be through clusters of GPs working together in five 'Primary Care Networks'. Each Primary Care Network will have an integrated care team built around it. A reorganisation of estates is desired to enable the teams to be co-located. The longer -term vision is to develop a multi-speciality community provider (MCP), a form of accountable care system, meaning that all providers will eventually share a single capitated budget with a co-ordinated model of care.

Westminster

Central to the transformation plans for Central London CCG is their Primary Care Strategy 2017-20. GP's will be promoted as the systems leader and practices will work together in the concept of "village" working within small groups of GP practices, adult social care staff, care co-ordinators and others working together as a multi professional team referred to as a 'primary care home'. Larger more sustainable delivery models in the community between the primary care homes have already been developed. From April 2019 Central London CCG will be creating a new structure, the multi-speciality community provider (MCP) based on the system of accountable care aimed at promoting integration of care services with joint responsibility and accountability – one system, one budget and better outcomes.

Going forward and as these new structures emerge in all three boroughs the specialist palliative care service must integrate into the new models and not sit outside of them. The responsibility and thinking about how this can be implemented sits with both the commissioners and the palliative care providers. The hope of this happening will be helped if, as a result of this palliative care review the numbers of providers are rationalised to two or one lead provider for the community palliative care services.

Recommendations:

- In the planning of the integrated care services and development of primary care, the tri-borough CCGs must ensure that the community level, specialist palliative care service is fully integrated into developing systems, including the concept of co-location.
- Work with the integrated care systems to deliver care to groups that are 'hard to reach' particularly the homeless and those with a learning disability and those with mental health problems.
- To ensure primary care have regular multi professional meetings to review their palliative care patients.
- To standardise models of service provision across the Tri-Borough and NWL footprint.

National Models of End of Life Care[23] (appendix G)

In response to the changing demography and needs of dying people, nationally enhanced models of end of life care are being developed and evaluated. This enhanced care can demonstrate quality improvements and cost savings with reduced emergency admissions, reduced length of hospital stay and increased achievement of choice around place of death. Evidence suggests there are a number of overarching components that are necessary to ensure success. A published report reviewed 66 palliative and end of life care co-ordination systems with the aim of identifying best practice, improving people's experience and choice at the end of life. The components of service models from the report combined with other components from research include the following:

1. Clinical triage 24/7 with a single phone number and the availability for face to face home assessment with a short response times for clinical situations that are urgent. This is paramount as there are often multiple professionals and organisations involved as someone whose death is expected deteriorates, leading to fragmented disorientating experience for patients and families (Ombudsman report 2105).
2. Rapid response mobilisation of health and social care that is able to stay with patients for prolonged periods including overnight.
3. Availability of medication and equipment.
4. Skilled and competent practitioners.
5. Integration with all other service providers in the area, evidence of joined up services with acute care and discharge care.
6. Evidence of electronic record sharing. EPaCCS- for the tri-borough CCGs this means at the very least the formation of a CMC record.
7. The building of strong links with local community groups/ the voluntary sector.
8. Consideration of the needs of hard to reach groups and building links with local communities.

There are three excellent examples of palliative and end of life care co-ordination centres in the London region. All have been developed and run by a hospice service working as the lead organisation but in partnership with others and can be seen in Appendix H.

The provision of Specialist Palliative Care in the tri-borough

The four providers of specialist palliative care in the tri-borough CCGs, are located close together, a unique feature of the geography of London. A small number of non-contracted patient activity, goes to Marie Curie Hospice Hampstead (6 inpatients and 28 outpatients for 2017-8).

According to the 2017 CQC report hospices deliver an extremely high standard of care. 70% are rated as good and 25% are rated as outstanding. This is considerably higher than any other CQC regulated sector where only 6% of NHS acute hospitals' core services and 4% of GP practices were rated as outstanding and, within adult social care, 2% of domiciliary care agencies, nursing homes and residential care homes were rated as outstanding. [24]

SJH, PH and RTH all received an overall 'good' rating in their most recent CQC reports. The PH were inspected as part of an overall CLCH inspection as a large community provider, SJH as part of the private hospital. Only RTH received a stand-alone inspection.

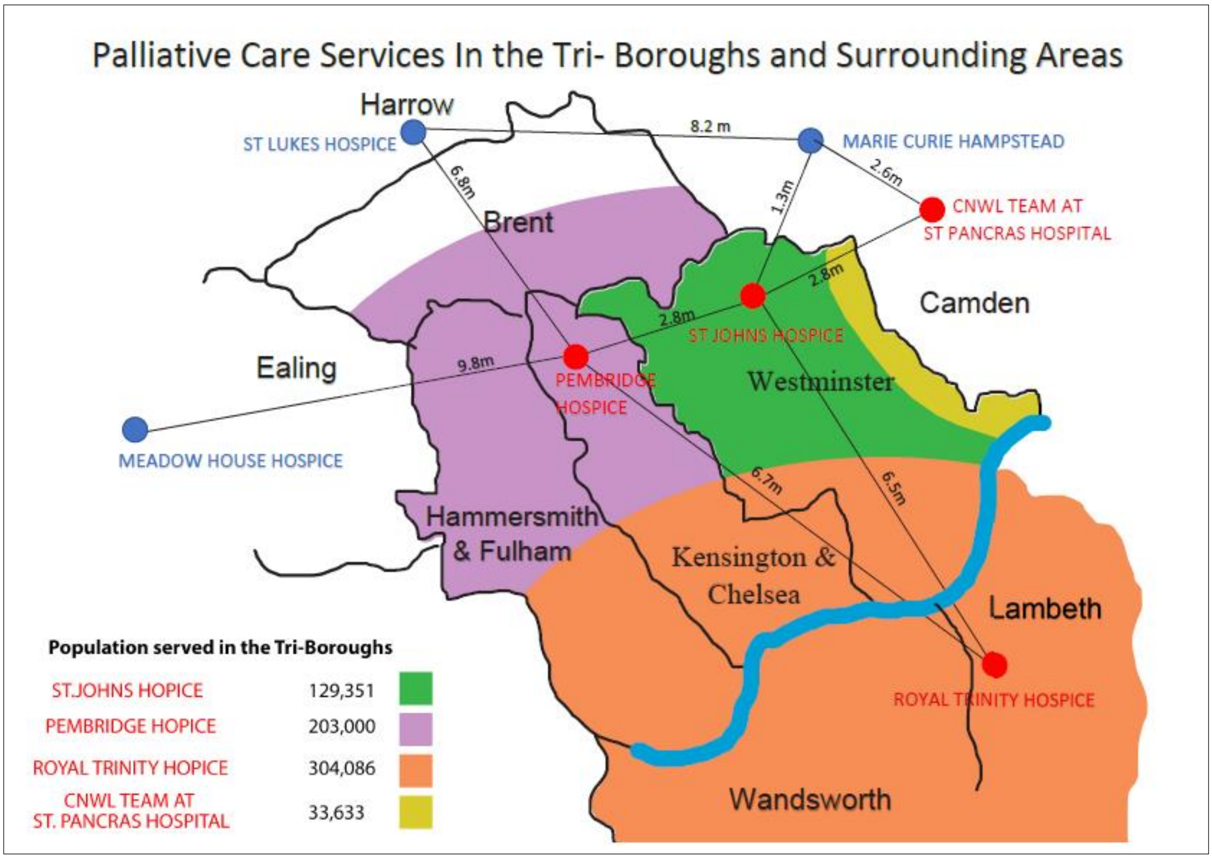
The hospices have significant variations in their service provision particularly in their community services. For example, the SJH finishes at 5pm with advice available from a ward nurse overnight. PH community specialist palliative care nurses also finish at 5pm, but the clinical nurse specialists are available to give telephone advice overnight. At RTH, the CNS's finish at 8pm and are on call until the next morning for telephone advice. At CNWL, they operate a Monday-Friday 9am-5pm visiting service with on call support outside of these hours. At these times advice can be obtained over the telephone and clinical visits provided at weekends or at night if necessary. Contact is made via the hospital switchboard. The ratio of specialist palliative care nurses per head of population also differs.

RTH have a 1:47,000 ratio, PH 1:48,000 and SJH 1:23,000. RTH has one independent nurse prescriber and PH has two and SJH have none.

Although NHS Central London CCG is the lead commissioner for CLCH and the PH, palliative and end of life services are commissioned by the Joint Adults Commissioning team, held by Hammersmith & Fulham CCG. No single CCG is responsible for all palliative and end of life services in Westminster, Kensington & Chelsea and Hammersmith & Fulham.

Both RTH and SJH deliver an in-depth quality analysis of their services to the CCG's. The PH does not. Commissioners stipulate what is required of the providers but some hospices produce quality reports as part of their governance which they share with their commissioner. A community palliative care service, continues to operate in North East Westminster and is provided by CNWL, based at St Pancras Hospital Monday-Friday 9am-5pm. This service is commissioned by Camden CCG.

Figure 2: Location of palliative care services



The Pembridge Hospice

Overview
Pembridge Hospice (PH) is part of Central London Healthcare NHS Trust (CLCH). The Hospice is one of a small number of NHS Hospices in England. CLCH is a large provider of community healthcare managing 78 different services across 11 London boroughs and in Hertfordshire. It employs 3,500 staff. Pembridge Hospice is the only specialist palliative care service in its portfolio.

Workforce
Pembridge Hospice has 69 staff representing 60 full time employees (FTEs) and 45 volunteers. At any one time it supports approximately 400 patients. As part of the CLCH CQC inspection that took place in 2017, the trust which included the PH was rated as ‘good’ in all domains.

Finance, contract and monitoring
PH is commissioned as part of a block contract. The commissioner has not specified any palliative care key performance indicators in the contract for the service. However, the trust reports to commissioners on the number of admissions, number of community and day care contacts/attendances. Quality of care is reported on a monthly basis to the CCG Quality Group in terms of patient experience and clinical care. As well as the tri-boroughs it also delivers services to Brent CCG.

CLCH operates a registered charity with a number of named funds within the overall CLCH charity. The largest fund is ‘The Pembridge Hospice Charity’. The accounts for 2017-8 show a balance in the Pembridge Hospice Charity Fund of £2.069m, which aims to support the entire trust. The Pembridge Hospice Charity funds 4.97 FTE posts. These posts support the wellbeing of patients, families and carers and are not clinical posts. This equates to £187k funding. Additionally the charity provides £50k per year to support patient activities such as a reading service. The total annual charitable contribution of £238k represents 7% of the overall running costs.

Strategic plan and progress
The Trust End of Life Care strategy is a broad strategy and incorporates all end of life services e.g. Community Nursing and the specialist palliative care services provided by the Pembridge. The overarching aims of the End of life Care strategy 2017 to August 2019 are:

- To enable integrated, co-ordinated end of life care.
- To promote the early identification of people at the end of life and delivery of compassionate end of life care by the CLCH workforce and other partners.
- To improve end of life care and experience for patients and their families receiving care from CLCH with advanced, progressive and incurable illness.
- To reduce inequalities, eliminate discrimination and advance equality when developing, arranging and delivering end of life care.
- To improve access to end of life care services, improve the coordination and choice of type and place of care and reduce inequalities of service provision across CLCH.
- To increase the proportion of patients who are cared for and die in their preferred place of care.
- To be aware of the role of the wider community in the dying person and other important networks.

Key achievements to date include:

- The implementation of a patient user group at Pembridge and the Swan Song project ensuring the patients voice is heard and listened to when making changes to the services.
- A revised paper and electronic Individual plan of care.
- The implementation of further training on advanced communication, key documentation and the care and use of syringe drivers.
- Competencies related to end of life care for staff which are now embedded as part of existing development programmes.
- The implementation of an Always Event focused on bereavement.
- Trust wide Schwartz round programme.

The strategy is reviewed on a regular basis by the Trust End of Life care committee. This is chaired by the Director of Patient Experience and reports into the Trust Quality Committee, a sub-committee of the Trust Board.

The strategy is currently being updated using patient feedback, latest end of life care guidance, the new Trust Clinical Strategy and the new NHS 10 -year plan with the aim of being launched in August 2019.

The Pembridge business plan

The Pembridge has its own business plan which includes a number of aspirations for the service over the next 3 years. This has led to the development of a communications plan leading to improved communication with relatives and carers. Current work is looking to redesign the Pembridge Day Hospice to include a wider range of clinical treatments.

Recent service developments

The Pembridge Hospice has recently implemented the SystmOne IT system which gives them intra-operability with primary care and the service has begun to implement the Outcomes Assessment and Complexity Collaborative (OACC) suit of clinical outcome measures across ward, community and day hospice. This enables more patient-focussed clinical interventions and provides a real time measure of clinical effectiveness.

St John’s Hospice

Overview
St John’s Hospice is part of the Hospital of St John & St Elizabeth. The hospital has a charitable status. The Hospice Director sits on the hospital board.

The hospital board oversees the operation of the Hospital of St John and St Elizabeth and St John’s Hospice. By volume, the main business of the board is the operation of the hospital where they are about to embark on a huge project to rebuild the operating theatres at an expected cost of approximately £40m.

St John’s Hospice employs 72 staff which represents 64.33 FTE’s. It also has 150 volunteers which help with patient care on the inpatient unit and in the retail shops. At any-one time it is supporting approximately 850 patients.

They are the only hospice in the tri-borough area that run a Hospice@Home service. This is a service which delivers practical care and support in the last days of life to people at home. They also are the only hospice to run a lymphoedema service in all three boroughs.

The largest element of the Hospice@Home workload is terminal care, with the service also providing respite care, admission avoidance and facilitated discharge. The nurse co-ordinators work closely with the Continuing Health Care (CHC) team and are occasionally asked to assess a patient, to establish the level of need.

The Hospice@Home service provides care for up to two weeks, usually as day care, night care or both. Packages average six days in duration, and average 105 hours in total. Hours of care delivered in 2018 were 21,896, a 19% increase on 2017 (18,394).

Finances, Contracts and Monitoring.
For 2018, the Hospice had annual running costs of £6.9m. The revenue to cover this came from NHS contracts (£2.8m), fundraising (£2.3m) and the surplus made from the Hospital of St John and St Elizabeth (£1.8m).

Accounts submitted to the Charity Commission for the year to 31st December 2017 showed an increase of income to the hospital of 1.2% to £58.2m; and an increase in operating costs of 2.6% to £55.7m. Free reserves are £6.8m and their operating surplus for the year was £2.5m.

St John’s are commissioned on a standard NHS contract and performance is measured against bed days, new patients to the community service and day care attendances. The bulk of their specialist palliative care activity is for Central London CCG, followed by West London CCG. They deliver services for patients in Brent, Camden and Islington CCGs with NHS contracts valued at £700k annually.

In total, St John’s receives £2.8m from their NHS contracts which represents 46% of their care costs and 40% of their total costs. There has been no uplift in the NHS contribution over the past few years, despite rising costs. They meet their contractual expectations but have capacity to substantially increase their inpatient care as the unit is commissioned for and operated at 63% capacity for 2017-18.

Strategic Plan and Progress
The hospital has published a strategic business plan for 2018-2020. Within the document it has 8 actions required to be completed by the hospice in 2018-2019

- Augment Hospice@Home services.
- Develop outpatient clinics for community/day care patients.
- Achieve growth year on year in numbers of patients.
- Increase uptake of feedback methods for patients and families.
- Demonstrate full compliance with relevant quality standards.
- Perform within annual budgets for revenue and expenditure.
- Develop educational programmes for local health professionals raising awareness of the hospice.

Recent Service Developments
St John's have developed joint working with Imperial College Healthcare NHS Trust for patients with COPD and heart failure, attending a regular multi-disciplinary team meeting with the respiratory and heart failure teams.

The hospice clinical staff have regular contact with the Butterworth Centre, a care home located on the Hospital site.

Forrester Court care home is supported by a Clinical Nurse Specialist in the Specialist Community Palliative Care Team, who attends a monthly multi-disciplinary team meeting with care home staff and representatives from primary care.

The Royal Trinity Hospice

Overview
Royal Trinity Hospice (RTH) is an independent charitable hospice founded over 125 years ago with accounts submitted to the Charity Commission. There is a board of trustees governing the hospice whose sole purpose is the improvement in palliative and end of life care. RTH supports over 700 people at any-one time across central and south west London. They service four other boroughs as well as the tri-boroughs. RTH employs 256 staff and has a well -developed 'army' of volunteers who assist in almost every area of the hospice.

Finances, Contracts and Monitoring
RTH have a standard NHS contract in a multi CCG alliance as they service not only the tri-borough CCG's but Wandsworth, Lambeth, Merton and Richmond CCG's. Lambeth is the lead commissioner and achievement on the contract activity is based on bed days, numbers of patients seen by the community palliative care nursing team and outpatient attendances.

In 2017-8 they received £718,816 in funding from the tri-borough CCG's plus a further £227,607, which is a historical sum of money given over ten years ago by central government, originally via the cancer networks to hospices to help them make improvements in line with the End of Life Strategy of 2008.

There has been no uplift to the NHS contribution for many years, despite rising costs, and the NHS core contract contributes only 18% of the hospices running costs. The RTH has to raise £9.5 million each year to close the gap between NHS funding and the cost of providing services.

Forty five percent of independent hospices are reporting that expenditure is now exceeding income, with Royal Trinity Hospice included.

In 2017-18 revenues declined from £12.4m to £11.9 m, due to a decline in fundraised income, although this was partially offset by increased retail income. Expenditure increased slightly by 1.3% to £12.5m mainly due to a 1% salary increase and an increase in retail property costs. The deficit for the year was £0.635m before depreciation. Year-end net assets were £20.9m and year on investment assets were £5.9m, which would cover five months of operating costs at 2017-8.

Strategic Plan and Progress

A strategic plan for 2018-21, has been developed, which aims to:

- Develop impact reporting to identify strengths and weakness in the service;
- Ensure sustainability of their services; and
- Develop their community services to enable the hospice to see 30% more people in three years.

Royal Trinity Hospice has already made considerable progress with their strategy. They have developed an impact report, visit their website www.royaltrinityhospice.london

The published data informs us that 2351 patients were supported by Royal Trinity last year:

- 58% had cancer, 42% did not.
- 93% had an advance care plan, 69% died in the place of their choice and only 1 in 4 people died in hospital.
- 94% of patients seen reported an improvement in their pain.

Ensuring sustainability means increasing fundraising and retail income year on year to support the growth in patient services. The growth strategy has seen four new shops open during 2018/9 with more to come in future years, and an increase in fundraising targets over the next few years.

In developing their community services, they have re organised their model of care in West London CCG, with a 'team around the patient' model of shared competencies. The model is allowing for more proactive and efficient care.

Recent Service Developments

Royal Trinity Hospice have modernised their traditional day care services. The primary service intervention is therapeutic with a range of drop in activities alongside rehabilitative palliative care, enabling them to spread their resource in a cost-effective focussed way. A dementia community nursing service is provided across the whole catchment area. A converted inpatient bay has become dementia friendly, allowing the hospice to offer respite care and all staff have been trained in dementia awareness enabling them to be 'dementia friends.' They have one independent nurse prescriber and plan to develop more. Since 2015, a successful co-ordination service is provided in Wandsworth CCG (see appendix H). The hospice is also pioneering the use of 'Virtual Reality' for patients, through a research study examining its potential therapeutic effectiveness.

Central North West London NHS Foundation trust (CNWL) Palliative Care service in North East Westminster

There is also a small area of North East Westminster whose community palliative care services are provided by CNWL and commissioned by Camden CCG. The approach to the commissioning of palliative care across North Westminster boroughs is a product of legacy commissioning. The service covers 5 GP practices.

The CNWL team is part of a large established community focussed service and is working proactively as part of the North Central STP to deliver on the last phase of life plan (Appendix I). They have a quality improvement plan across a range of markers and offer a high volume of education. An end of life strategic plan is about to be ratified by CNWL which amongst other things will see an increase in the educational offering to health care professionals working in the tri-boroughs.

Many aspects of the last phase of life plan parallel the recommendations within this review. This is the only service which currently delivers a 24- hour advice and visiting service to patients in their own residence.

Services Provided by the Palliative Care Services

	St Johns Hospice	Royal Trinity Hospice	The Pembridge Palliative Care Service	CNWL palliative care team
In-Patient beds	18 beds 24/7 Admissions	28 beds 24/7 admissions	13 beds 24/7 admissions	No Hospice inpatient beds
Day hospice	10-4, 4 days a week	Traditional day care has developed into flexible outpatient, therapeutic and social activities available 9-5pm , 5 days a week	10-4 ,4 days a week	No day care facilities
Community palliative care	Mon-Friday 9-5pm with one CNS working at the weekend 9-5pm	Multi professional team around the patient with a 7 days a week visiting service led by the CNS's.	Mon-Friday 9-5pm with one CNS working at the weekend 9-5pm.	Community services provided Mon-Fri 9-5pm with clinical community visits available if needed outside of these hours
Out of hours advice	Managed through the ward nurses after 5pm. Back up doctor is the RMO on for the hospital. Second on is a palliative care consultant second on call	24/7 specialist clinical /medical advice. A CNS is on the late shift at the hospice until 8pm and then available for telephone advice 8pm-9am. This is supported by two on call doctors: a first on call specialist registrar, and a second on call medical consultant, all available to speak to health care professionals and patients/carers as required.	Usually managed by the ward nurses after 5pm with back up advice from the shared rota with St Johns. Currently a Cis on call to give advice and the medical rota is shared with 3 other consultants from different providers.	Full telephone advice accessible through an 'on call' service' via the hospital switchboard from 5pm until 9am, 7 days a week.
Hospice @ Home	Small service that sometimes bridges CHC packages of care. Not available in H&F	No	No	No

Bereavement support	yes	yes	yes	Bereavement support is delivered via the team social workers
Lymphoedema service	Yes	No	No	No

Figure 3: Provision of services

Recommendations:

- There is one commissioner for end of life care in the tri-borough CCGs.
- That the CCG's address the inequity of current funding arrangements for hospices.
- That service specifications and contracts are standardised.
- That the NHS meets the cost of all core community palliative care services.
- Response times from specialist level services should be in line with the degree of urgency of patient need and measured.
- Measured activity should not solely be based on direct face to face contact with the specialist level provider but their sphere of influence with others. For example, a specialist level practitioner may advise on the management of patients whose service is being delivered by others.
- The service provision should be based on the patients GP and not where the patient resides.
- User feedback using a validated tool should become a routine part of outcome measures e.g. Voices for Hospices (which includes non-bedded service) The CCG's may want to develop a mechanism for feedback for the whole of their integrated care programmes in which case the specialist level palliative care should be incorporated into this.

Specialist Palliative Care Activity

Available data
The review found that data collection for the specialist palliative care services was inconsistent and therefore benchmarking the activity and performance was difficult. Royal Trinity were not able to breakdown their activity into working hours and 'out of hours.' Data on bereavement services and therapy services has been omitted in this report due to the lack of accurate data. Data on the out of hours advice line activity is also missing as none of the providers collect any data in this area. The review was also unable to see data on the different aspects of the non-bedded services at the Royal Trinity, as the data was all recorded under 'home care activity.'

At the time of this report, no data was available for the CNWL service based at St Pancras Hospital. However, the data available shows:

- The reach of the current services impacts on 48% of expected deaths. It is suggested that 60-75% of dying people could benefit from palliative care[25].
- The numbers of patients seen with a non-cancer diagnosis is increasing each year, currently about 30%.
- 23% more people die outside of the acute sector if a palliative care service is involved.
- 458 people were admitted to a hospice bed out of 2,222 expected deaths. Admissions are possible out of hours but only 21 people were admitted to an inpatient bed at this time. (This excludes the RTH which is unable to provide data on out of hours admissions).
- Utilization of available inpatient beds was low in two settings; PH only had a 67% occupancy and SJH 63%. However, SJH met its contractual obligations. The PH have a block contract and the percentage occupancy and target for admissions is not stipulated.
- Insufficient doctor or nurse activity in outpatient clinics, which are a cost- effective setting to assess a patient.
- In SJH and PH, few new patients' access the service (47 for the 2017-8) and both are still running traditional day services rather than a drop in, goal focussed and rehabilitative approach service enabling many more people to benefit from palliative care.
- The length of stay in the hospice beds is amongst the highest in London. 16-17.8 days with a London Hospice average of 14.6 days (Appendix K). This may reflect the paucity of care home beds.
- Hospice@Home receives outstanding feedback for the quality of their care but are only involved in a 3% of expected deaths in the boroughs. Developing this across the boroughs is likely to be prohibitively expensive and similar to the cost of a bed in a hospice or hospital.

Inpatient Hospice Bed Usage
It is generally accepted that hospice beds should be used for patients who have complex and intractable problems that are unable to be managed at home. This should include patients with severe psychological distress but not overt mental health problems as most hospices are not structured to have formal links with mental health services. RTH do have arrangements for psychiatric assessment and management of patients with mental health problems.

All hospices should have the facility to manage complex pain with more acute interventions such as intrathecal blocks and epidural catheters. All the tri-borough hospices are able to seek opinions from chronic pain specialists and manage intrathecal blocks and epidural catheters. The Government's ambition to deliver preferred place of death Commissioning for Quality and Innovation national goals, 'CQUIN's', has influenced hospice admissions, to admit patients whose preference is to die in a hospice, but who do not necessarily require specialist palliative care.

Bed costs

The price for a bed-day within the tri-borough CCGs are:

- Hospice - £750
- Hospital - £411 (based on 800 NW London admissions, April 2017-December 2018, average Length of Stay 13 days)
- Residential nursing home – £111-£301 (CHC contracts)
- National data for final admissions shows that 32% die after a stay of 0-3 days, 18% after a stay of 4-7 days and 50% after a stay of 8 days or longer. [26] [27] [28]

The length of stay in a hospice bed commissioned by the tri-borough CCGs is higher than the London average and slightly more people die in a hospice bed than in other London boroughs. In 2017-8, there were 458 hospice admissions from the tri-borough CCGs and 213 deaths (West London CCG - 84, H&F CCG - 50, Central London CCG - 79).

Hospice beds are an expensive place to die compared to other settings. Although the cost to the NHS is heavily subsidised in the independent charitable hospices, hospice beds should be thought of as "critical care beds" for the highly complex rather than a place to choose to die.

It is unlikely that there will be an increased need for 'critical care' inpatient beds for people who have highly complex symptoms. Given the low occupancy of PH and SJH there is probably enough capacity in the system for the tri-boroughs to operate with less specialist palliative care beds (Appendix L). Indeed, the system has been managing without the 13 beds at PH since October and as far as we can tell the majority of patients requiring admission have been redirected to other units where there has been spare capacity. As far as we are aware, there has only been one patient who refused an inpatient admission to St Luke's in Harrow because of distance.

Only RTH has kept data on admissions requested from the tri-boroughs that were not fulfilled which was 15 patients for the 2017-18 year but even with this data we do not know the reason for non - admission. The hospitals report instances of patients who died waiting for a hospice bed but unfortunately there is no data to demonstrate this.

Every hospice has reported difficulties in discharging people who need a Continuing Healthcare care home bed. Given the low ratio of care home beds to the over 75 age group in the tri boroughs, this is not surprising. This in turn increases the average length of stay in a hospice bed. To ensure robustness of this assessment it will be important to understand the impact of the long stay patients and the reasons why they cannot be transferred out of an inpatient bed. It appears that there is a problem with patient flow at the correct level of acuity. It seems likely that more CHC fast track beds are needed rather than specialist palliative care beds.

The reviewers assessment is that it is there could be a reduction in specialist palliative care beds if :

- There were more CHC beds in the system.
- The hospices ensured that the admissions truly required a ‘critical care’ hospice bed.
- The numbers of patients who require an inpatient ‘critical’ hospice care bed is approximately the same as the numbers of 2017-8 (485)
- Hospices ensured that their discharge procedures worked to NHS guidelines
- The model of specialist palliative care in the community improved in line with the recommendations.
- The number of beds that could be decommissioned is outlined in Appendix L, and is based on the assumptions as outlined.

Recommendations:

- Reduce the number of commissioned beds/bed day activity (see appendix L for modelling and assumptions.
- Reinvest cost savings to improve community palliative care service as outlined.
- Care is co-ordinated from a central hub that operates from 8am to 8pm 7 days a week involving quick and efficient access to care, advice and signposting. This will increase the reach and influence of the specialist services, particularly to those with multiple-co-morbidities in their last phase of life. Included in the co-ordination/casement management centre are:
- A clinical triage and assessment with competent staff of sufficient seniority and authority to get the right care to the right person at the right time with the right service. The district nursing services should be firmly linked into the care co-ordination centre/case management centre.
- Referrals for hospice in-patient care should also be directed to the care co-ordination/case management centre and forwarded to the appropriate unit, or have a shared referral 'box.' This will make it easier for referrers both in the acute sector and primary care.
- The care co-ordination centre/case management centre will need to provide a rapid response service.
- Consultant doctors and nurses should be part of the case management/care co-ordination centre both in an advisory capacity and for urgent assessments for people at home/care home. Joint visits with the GP are to be encouraged.
- Community specialist palliative care provision should be mostly targeted at short term episodic interventions. The majority of their work should be aimed at coaching, training and empowering others. They should take responsibility for case management to recognize when their involvement is needed. This will ensure that the reach and influence of the specialist palliative care provider is greater.
- There should be a joint audit between the CCG and the hospices to better understand the reasons for the long inpatient length of stay and the issues the hospices are raising re transfer to a care home setting.
- The CCGs should review their provision of CHC funded beds.
- Hospices should review their bed provision to ensure admissions are for those with complex and intractable problems. They may wish to develop a mixed provision with appropriate resourcing and pricing.
- Reduce the number of beds that are not being utilised, reinvest the money into the community provision, which will in turn further reduce the need for as many beds over time.
- The hospices work with the CCG's to ensure there is a common understanding of the cost of a bed day and agree a common model for funding inpatient care.
- For Commissioners and Hospice Providers to develop a service specification and pricing mechanism via a tariff to ensure effective use of inpatient beds
- Work should be undertaken with the local authority to commission a lead provider to integrate and standardize the many small bereavement services that exist in the boroughs and a new model developed.

Specialist Palliative Care Medical Provision

Royal Trinity Hospice

Establishment	**IPU**	**Community/OP/day care**
Medical Consultants	1.3	1.05
StR's/speciality Drs	2.0	0.7
Drs in training	3.2	0
Total	6.5	1.75

St Johns Hospice

Establishment	**IPU**	**Community/OP/day care**
Medical Consultants (employed by CLCH)	1.2	1.0
StR's /speciality Drs	2.6	0
Drs in training	0.45	0
Total	4.25	1.0

Pembridge Palliative Care Services

Establishment	**IPU**	**Community/OP/day care**
Medical Consultants	1.0	0.8
StR's /speciality Drs	3.0	0
Drs in training	0.5	0.5
Total	4.5	1.3

Figure 4.

The table above describes the breakdown of where the palliative care doctors are primarily based. For an inpatient bed, the doctor has primary responsibility for the clinical management; in the community this sits with the GP. Doctors in training are always likely to need their primary working practice to be in an inpatient setting as it is the place that they are able to get to see more patients in a shorter space of time. However, there are up to twenty times more patients under the community palliative care team than in an inpatient bed at any one time.

Recommendations:

- The hospices review the balance of their medical work plans and move resource to work with the care system in the community. They could consider some of the bed management to be led by senior nurses.
- When recruiting, consideration should be given to the balance of medical staff with some consultants, doctors in training to be palliative care consultants, speciality doctors as well as GP's with a special interest in palliative care.
- Medical staff in palliative care that deliver to the tri-borough CCGs, have an agreed mechanism for cross cover 24/7 to ensure service resilience.

Stakeholder data & themes

Data collection
The stakeholder feedback was collected in the following ways.

- Face to face or telephone interviews were held with more than 50 key professionals working in the provision of specialist palliative care services.
- A number of focus groups were held with patients, carers and patient representatives. A public 'Call for Evidence' which received 101 responses via an online survey (51 public-mostly informal carers and families, and 50 professionals/staff from the care system). Qualitative and quantitative data was captured
- 11 further submissions were received from individuals or larger national or local organisations.

Focus group data is in Appendix M. It is evident that the current hospice patients and their carer's are very satisfied with the services they are receiving which was largely day care. The BME user group who were not currently accessing palliative care services described feeling 'lost' in the health care arena and the terms 'hospice' and 'palliative care' were confusing. This is important feedback and better data needs to be obtained on the uptake of palliative care services from marginalised or 'hard to reach' groups.

Stakeholder themes

The key themes across all groups

Patients, families and carers report high satisfaction rates once they start receiving a specialist palliative care service.

There are variations in services, contracts and performance across all providers.

There is no one commissioner with oversight of all specialist palliative care provision across the tri-borough.

The NHS contribution towards the care costs varies across providers.

(range 18%-100%)

There is a variation across providers in the ratio of specialist palliative care nurses in the community per head of population.

The involvement of the community based palliative care teams significantly improves the likelihood of dying outside the hospital setting which is what patients say they want.

The palliative care services in the tri-borough reach approximately 48% of patients who have an expected death.

Getting a rapid face to face assessment from the specialist palliative care provider in the community is problematic.

Access to a senior a specialist palliative care clinician to aid decision making for a GP or community nurse can be problematic and inconsistent.

The Community Independence Service (Rapid Response team) are regularly called to patients who on initial assessment are in need of end of life care.

The model of daycare varies: Traditional model by St Johns and Pembridge saw a 47 new patients in 17/18. Trinity has a modernised day care and rehabilitative approach.

District Nursing services feel aggrieved that the Specialist Palliative Care services see themselves as advisory and not interventionist.

Specialist Palliative Care nurses perceive District Nursing to be task orientated, not holistic and personalised.

74% of the public who responded to the online survey reported poor co-ordination and communication between services for people at the end of life.

The percentage of deaths at home is higher in all 3 boroughs(28.2%) than London (23.8% or England

(23.5%)

Deaths in hospital for the boroughs(48.9%) are higher than England(46.9%)but lower than London(52.8%)

Referrers who interface with more than one provider for inpatient care have a perception that hospice A is better able to cope with complexity than hospice B and refer accordingly.

The specialist palliative care services different IT systems that have no interoperability with primary care or the hospitals (exception Pembridge)

Based on the number of inpatient bed days available across the tri-borough, there is capacity in the system to admit more patients or close some beds.

Length of stay is above the London average of 14.6 days:

- *St Johns Hospice: 17.8 days*
- *Pembridge inpatient unit: 17.8 days*
- *Royal Trinity: 16 days*

There is a lower ratio of nursing care home beds in the tri-borough compared to the London region which may impact on the length of stay.

The palliative care services still predominantly deliver care to people with a cancer diagnosis but this is steadily changing. (Average 70/30)

The balance of palliative care medical time is heavily weighted to inpatient beds and not the community

The occupancy of two of the three units is low:

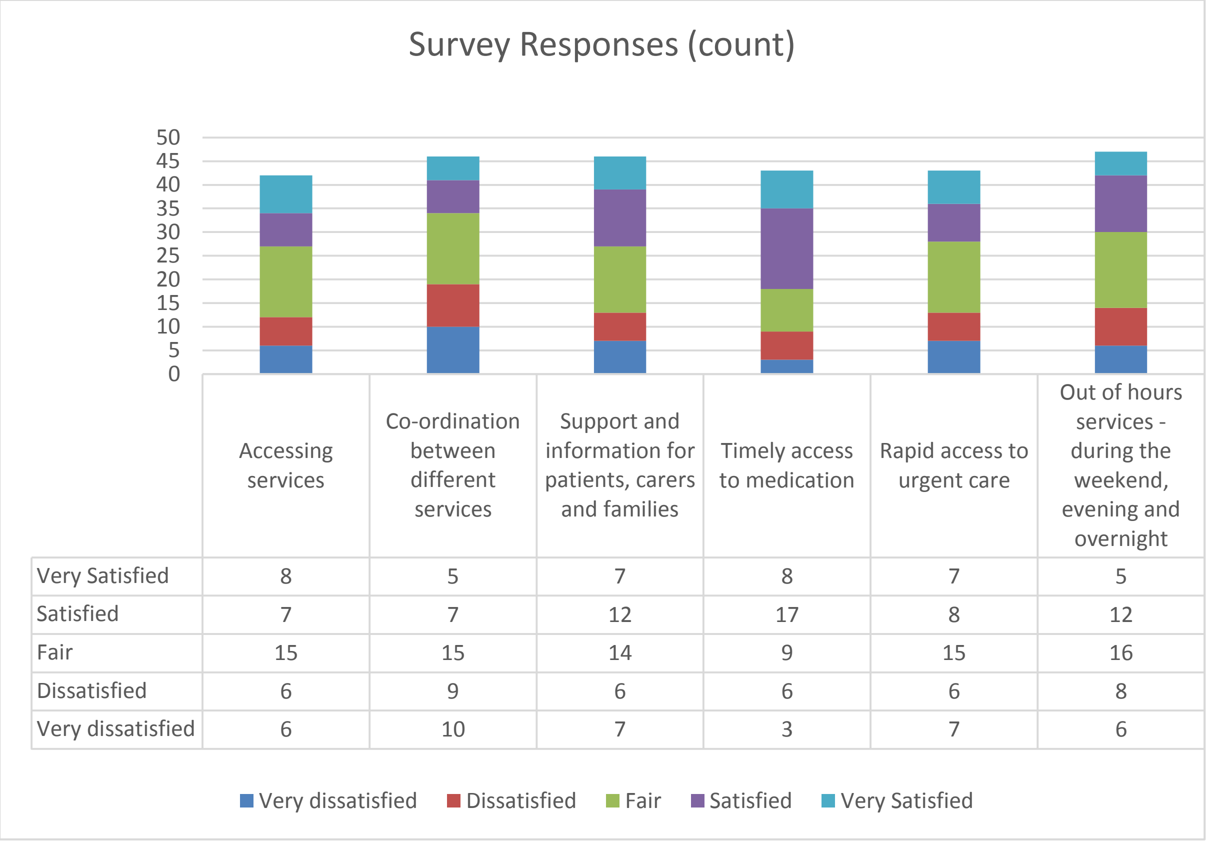
63% St Johns Hospice - 67% CLCH Pembridge Inpatient Unit (2017-8 figures)

The analysis of the survey monkey data is below. The data is split between the professionals which is largely health and social care staff and the public which is largely patients, families and informal carers.

	Numbers of respondents	**% who were very satisfied or satisfied**
Accessing Services	42	36%
Co-ordination & communication between services	46	26%
Support and information	46	41%
Timely access to medication	43	58%
Rapid access to urgent care	43	34%
Access to services out of hours	47	36%

The vast majority of the feedback from both groups is strongly corelated. The least satisfied are the public where only 26% rate the co-ordination of care and communication between professionals as satisfied or highly satisfied. On every measure there is much room for improvement.

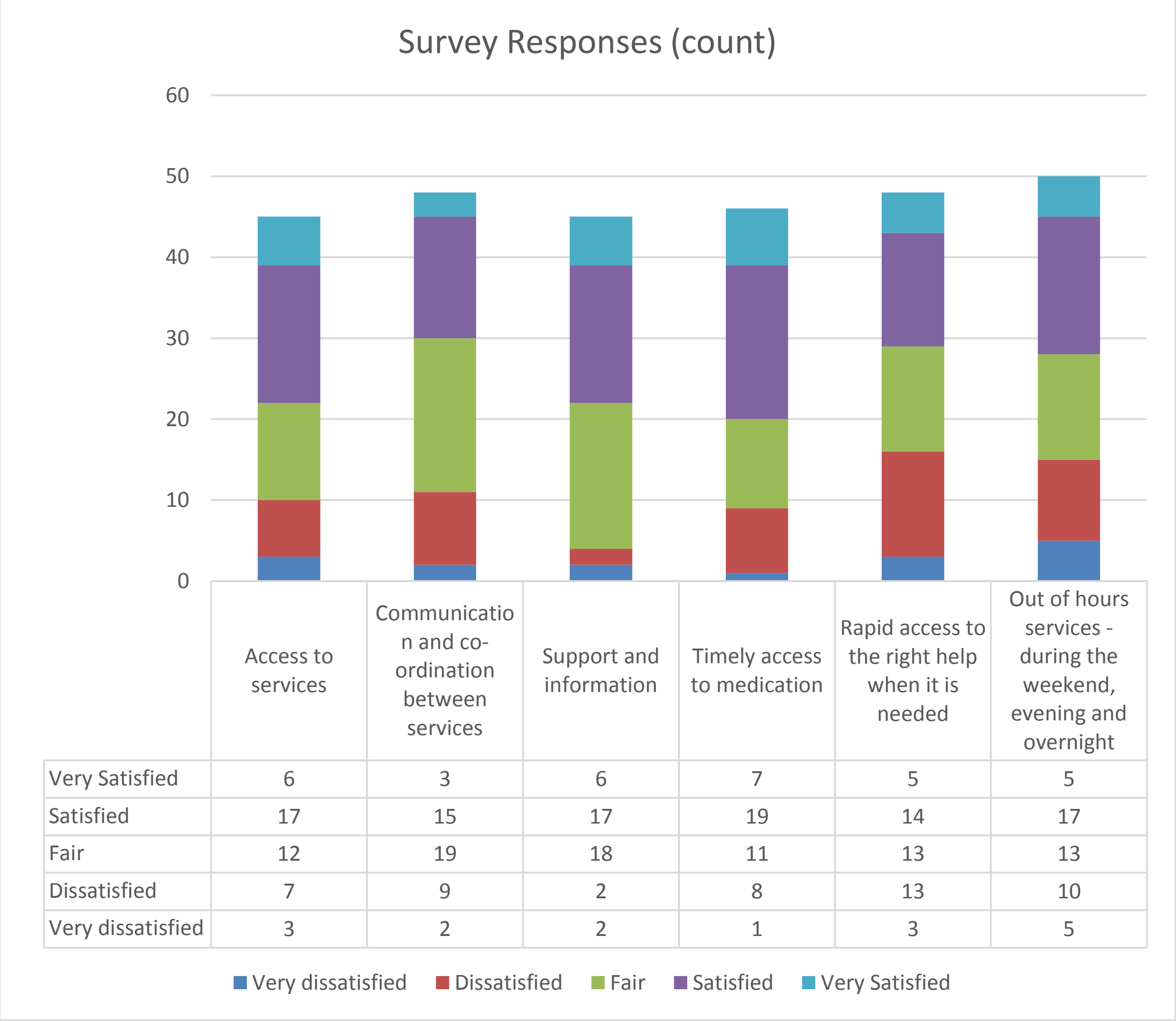
Survey Monkey Responses from the public



	Accessing services	Co-ordination between different services	Support and information for patients, carers and families	Timely access to medication	Rapid access to urgent care	Out of hours services - during the weekend, evening and overnight
Very Satisfied	8	5	7	8	7	5
Satisfied	7	7	12	17	8	12
Fair	15	15	14	9	15	16
Dissatisfied	6	9	6	6	6	8
Very dissatisfied	6	10	7	3	7	6

Responses from Professionals & staff

	Numbers of respondents	% who were very satisfied or satisfied
Accessing Services	45	51%
Co-ordination &communication between services	48	37%
Support and information	45	51%
Timely access to medication	48	39%
Access to services out of hours	50	44%


Survey Responses (count)

	Access to services	Communication and co-ordination between services	Support and information	Timely access to medication	Rapid access to the right help when it is needed	Out of hours services - during the weekend, evening and overnight
Very Satisfied	6	3	6	7	5	5
Satisfied	17	15	17	19	14	17
Fair	12	19	18	11	13	13
Dissatisfied	7	9	2	8	13	10
Very dissatisfied	3	2	2	1	3	5

Online survey comments received relating to the review from the public:

" I didn't know how to access the services we needed."	" I didn't know how to get continuing health care funding."I	" I could have done with a fact sheet on palliative care."	" We were really helped by the care at night."
"Palliative care is hugely underresourced in the tri boroughs"	"The lack of co-ordination between medical and social services is a disgrace."	"Communication between serices needs improving."	"Information is not passed from one service to another."
" I have only good things to say about services I received."	" Everyone was caring and supportive."	"Dealing with different departments was fragmented and frayed."	" closer collaboration would help-the hospital presribed a medicine we cojuldn't get at home
"Our hospice is closed, we need good doctors and more nurses- it is an exemplorary service."	" We need easier access to pain relief at home."	"palliative care made no difference."	" We needed more care at an earlier satge when the diagnosis was terminal."

A sad, articulate and detailed submission also came in from a recently bereaved carer. The carer described the difficulties that she had accessing the right care at the right time for her husband and experienced services working in silos. The patient needed urgent equipment, a care package, symptom control and a care plan. The carer and patient felt let down by most of the services and no services responded in a timely manner considering the urgency of the situation. Eventually the patient was admitted to a hospice where he received good care and died a few days later. This is a far too familiar story and serves as a ‘vignette’ of why this review is important.

Feedback from the two Hospice groups:

" I feel safe coming here every week."	" It's a wrap around service and home visits are provided , if needed."	" support for families is excellent."	" Need better cover at the weekends."
" End of life care should be as important as maternity care."	" The hospice helps me navigate the rest of the system."	" They know me well at the hospice."	"It provides me with a support network."
"It's given me a new lease of life."	"They always listen and take my concerns seriously."	" I can get rapid access at the hospice to the right help."	I didn't want to be referred but now I wish it had been earlier."
"The staff are so supportive and reliable."	"Here at the hospice I can easily get sorted."	'It's a strong word but I mean it, I love it here."	" I wish I could come more often."

The future challenges of palliative care

Defining complexity & who requires specialist care
Services have traditionally delivered care to a population of people that were considered to have complex needs. However, there is no standard definition of 'complexity' and in reality, it has been defined by a case mix classification such as disease group, age and physical symptoms.[29] This was in practice limited to those with a cancer diagnosis, younger people, alongside a limited number of those presenting with neurological diagnosis e.g. Motor Neurone Disease. There is an urgent need to define what constitutes complexity.

The specialist palliative care model, delivering a one size fits all, gold standard service to a few is no longer fit for purpose. Published research over the last few years has demonstrated similar symptom burden and distress in other disease groups and the multi morbid frail population.[30]

The trajectories of dying are different in the different groups of people as illustrated in figure 5 and new models of care must take account of this.[31] Specialist Palliative Care providers need to plan these trajectories in parallel with social care.

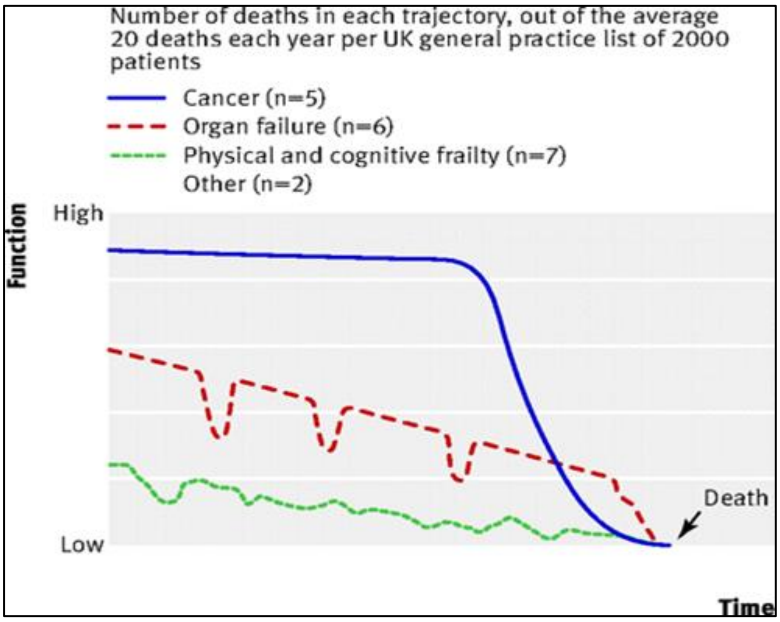


Figure 5

Rapid response
Currently in the tri-borough CCGs the specialist palliative care providers do not see themselves as needing to respond rapidly to urgent situations, the contract for community nursing states that they have up to 24 hours' to respond and so the default position often becomes a referral to the Community Independent Service (CIS). A rapid response service who have a remit to respond within 2 hours or the London Ambulance Service. Neither of whom can currently make a direct referral to all of the specialist palliative care services and most of whom require a referral to come from the GP.

The role of the palliative care nurse specialist

How specialist palliative care services integrate in a meaningful way with mainstream health and social care services is another challenge. Traditionally the clinical nurse specialist (CNS's) has had an expert advisory role within primary and community health care teams. This has led at times to challenges between district nurses and CNS's regarding role and function. District nurses have felt that nurse specialists can be overly precious about their role and are reluctant to be involved in direct hands on patient care should the situation require.

Specialist nurses have also been reluctant to become directly involved in the administration of medication via a syringe driver or for a patient who needs a one off injection. CNS's must take a more interventionalist approach and undertake nursing tasks particularly when with a patient. Palliative care nurses become frustrated when district nurses take a 'task orientated 'approach to care and fail to see and address the needs of the whole person.[32] Specialist nurses sometimes find district nurses reluctant to take instruction from other nurses and depending on the communication skills and experience of the CNS, this may or may not affect the working relationship and also the care that the patient receives.

How specialist and community nurses work together is fundamental to the delivery of high quality specialist palliative care. Where relations fracture, care is compromised and it is important for both sets of nurses to meet together regularly and discuss patients, to acknowledge both difference in practice and also role overlap and to be honest and open about how to best work together.

CNS's need to be highly competent and train to the level of an advanced practitioner These roles are experts in clinical practice, facilitate learning, provider leadership and ensure services are based on best practice. The Nursing and Midwifery Council has not yet regulated these roles but it is generally acknowledged in specialist palliative care that the advanced practitioner would need to be qualified in advanced assessment, independent prescribing and have successfully completed masters modules in symptom control and psychological care.

Recommendations:

- Introducing and using the Outcomes complexity and assessment collaborative tool (OACC) in all settings 33.
- The development of a rapid response component to the specialist palliative care services to better respond to the different trajectories of dying.
- To introduce a tri borough wide care plan that includes wishes and preferences of the patient and an escalation treatment plan.
- For specialist community providers to be equipped to respond to the nursing needs of patients if they have a planned or unplanned visit.
- For guidance to be developed to describe how primary care, community nursing and specialist palliative care clinicians work together.
- For specialist palliative care nurses to work with district nurses to improve the skillset and confidence of community nurses.
- For a borough wide agreement to be developed on the responsibilities and skillset of clinical nurses specialists to be developed into advanced nurse practitioners.
- Ensure that when the community nursing services are recommissioned the specification includes a rapid response element.
- Change in operational policies of the specialist palliative care providers to enable anyone to refer to their services.
- Primary care contracts to include monthly multi professional reviews for people at EoL.

Working with social care

Delivering personal care to patients is now considered to be the remit of the social care workforce, which is most commonly commissioned from private domiciliary care agencies. The Cavendish review (2013)[34] exposed the major difficulties and challenges for this workforce, poor training and supervision, poor terms and conditions and no established links into health services. The separation of activities of daily living from the work of health care and community nursing is particularly problematic for people coming towards the end of their life and deteriorating. It is during this period that there is a serious need for health and social care to be integrated. If they are not, social care workers don't develop the skills and confidence to manage the deteriorating patient with all the anxieties that this incurs for families.

The range of professionals that may be involved in a person's care are extensive and for the patient and family it is of the essential to their experience for professionals to work effectively together. Silo working of services in this phase of life can have far reaching consequences. Dame Cicely Saunders, the founder of the modern hospice movement said, "How a person dies lives on in the memory of those who are left[35]. The professionals involved in care can include the following; GP, community nurse, social care staff, palliative care clinicians, the acute sector, the ambulance service and sometimes mental health clinicians and the ambulance service.

Identification of dying people

This is a challenge and encompasses more complex disease groups other than cancer. Many patients are not identified as reaching the last phase of life, particularly frail older people with multiple co-morbidities and therefore do not have the benefit of assessment and care planning to meet their current and anticipated needs. However, there are now some useful tools to help clinicians identify those at risk of deteriorating and dying. The two most commonly used in the UK are the Supportive and Palliative Care Indicator Tool (SPICT) [36]and the Gold Standards Framework prognostic indicator guidance (PIG)[37].

Recommendations:

- SPICT is integrated into SystmOne for GP's.
- Integration with Health and Social Care

Mitigate silo working by:

- To set up a tri borough palliative care case management/co-ordination centre with one email address and one phone number
- To invest in IT systems that have interoperability.
- To increase the use of the CMC care plan
- For district nurses to have daily video linkage to the CNS's in the care co-ordination centre to plan the daily work for the patients on their caseload with palliative care needs.

24/7 support

Maintaining people in their own home requires appropriate support to be available 24/7. Out-of-hours palliative care is often provided by 'generalists' with no easy access to professionals with specialist level knowledge. The result is that individuals who contact an out-of-hours doctor are at a greater risk of being transferred to hospital at the end of life. An important study synthesized the components of a palliative and end of life service in the community that engendered security and confidence in patients and families at home[38].

Recommendations:

- The care co-ordination centre operates from 8am-8pm.
- From 8pm-8am advice for patients and families is obtained from the hospice advice lines and for out of hours GP's and community nursing, the on-call doctor is available.
- Rapid accessibility to equipment from the care co-ordination/case management centre.

Care Homes

Nationally 20% of the population and 30% of those aged over 75 die in care homes. 71% of permanent care home residents died in a care home and the number of deaths aged 75 years or older in care homes increased by 28% from 2011-2015[39]. Care homes are a major provider of end of life care[40], 80% of care home residents have dementia many also have multiple co morbidities. Goodman (2018) [41] notes that people usually opt to enter or are admitted to a care home when their needs can no longer be managed in their own home and they are unlikely to benefit from curative treatments.

The NHS has recognized the importance of improving end of life care in care homes[42] and there are many different models of specialist palliative care services working with care home staff both in education and training, and in assessing the resident's clinical needs.

There are no specific recommendations regarding the training of care home staff in this report as the NW London STP has a programme that it is implementing and a clinical triage service that it has introduced with telephone support from a clinician. Video consultation is also being introduced.

Recommendations:

- The care co-ordination /case management centre makes direct links to work closely with the 111*6 care home initiative
- The CCG's review their provision of nursing care home beds to ensure it is adequate for the population both now and into the future
- Ideally, each nursing care home should have an identified link to a specialist practitioner.

Workforce Challenges

The other major challenge for both medicine and nursing in palliative care is the number of people available to do the job. The ageing workforce in nursing, combined with the lack of nurses is becoming a national crisis with vacancy rates reaching higher than 25% in some areas and the national vacancy rate at 11%.[43] The numbers of senior district nurses has fallen by 30% with a reduction of 50% in the last eleven years.[44] Together with cuts in the social care budget this has reduced the number of available support staff to provide personal care to people in their last days of life.[45] Macmillan Cancer Support have identified a gap of 3400 CNS's across the UK which they estimate will rise to 7000 by 2030. Alongside of all of this is the lack of standardisation and regulation of the competencies required to function at an advanced practitioner level.

In palliative medicine the headcount of consultants in for the UK was 459 FTE's. In 2015 there were reported to be 53.8 vacancies and 30 new posts in development. Only 40 doctors gained places on the annual specialist training scheme which is inadequate to meet the current and anticipated needs. There are also 58 self-reported retirements due in the next five years.[46]

The 'Call for Evidence' and stakeholder feedback revealed a need for training of community nursing and a need to increase the confidence of some GP's in their management of people in the last phase of life.

Recommendations:

- The development of delegated responsibility in the care system through the use of IT programmes such as the 'e-shift palliative care module', where a senior palliative care clinician supervises a group of care workers via video link.
- Built into service provision and commissioning should be time and resource for the specialist level palliative care providers to train and educate the wider workforce. This should particularly include the social care workforce in domiciliary care and care homes.
- Measures are developed for the delivery of education and training.

Dying of or with Dementia or Advanced frailty

Dementia/advanced frailty has emerged as a key issue for hospices as they consider their strategic direction for the future. Dementia is one of the biggest public health challenges and people dying of dementia often receive the poorest care of our population.[47] For people with advanced dementia acute hospital admissions are distressing, inappropriate and expensive. The length of stay is longer, and a person is four times more likely to die during an admission than anyone else. Most admissions are for infections, which could be treated in a care home.[48]

Palliative care services are now beginning to embrace the needs of people with advanced dementia and taking the opportunity to work closely with both statutory and other voluntary sector organisations such as the Alzheimer's society and Admiral Nursing. Guidelines for services have been produced.[49]

Recommendations:

- To invest in an advance care planning programme in memory clinics as it is important to capture the patient's wishes and preferences at an early stage.
- The rapid response part of the care co-ordination/case management centre will be able to respond to the sudden deterioration of this group and prevent inappropriate hospital admissions.
- Subcutaneous fluids should be available in the community and not require a hospital admission.

Continuing Healthcare (CHC) in the context of the fast track process

CHC is the name given to a package of care which is arranged and funded solely by the NHS for individuals outside of hospital who have ongoing health needs. Packages of care usually involve care worker support in the patient's home or the payment of care in a care home. NHS CHC is free unlike care provided by local authorities for whom a financial charge may be made depending on your income and savings.

The tri-borough CCGs work together to administrate this contract with 12-16 care agencies to deliver this care. These care workers are an enormously important part of the patients experience of care at the end of life. The possibility of specialist providers interfacing, coaching and training these care workers is likely to have a big impact on the patient experience and the confidence of the family to manage the care. The CHC team also organise night ‘drop in’ services from their contracted agencies to patients if this is needed as part of the care package. Most of the London boroughs have contracts with Marie Curie whose traditional night service is care from 10pm-7pm, usually in the patients last few days of life. The tri-boroughs purchase this occasionally on a spot purchase basis.

In an audit from 1st April-August 31st 2018, 101 packages of care from the tri-borough CCGs were accepted for CHC funding under the fast track process. This process is to meet the needs of those who are rapidly deteriorating and entering the terminal stage of life. Of those accepted, 64% were still alive 3 months later. This implies that either the information on the application was not correct or there was not enough scrutiny of the application.

Recommendations:

- To move the fast track brokerage part of the CHC service into the care co-ordination centre to enable palliative care clinicians to help with difficult decision making and to build a relationship between palliative care services and the care agencies to impact positively on practice.
- To develop a small team of senior care workers as part of the care co-ordination rapid response service who will help to coach and empower the domiciliary care staff and bridge care packages that the agency is having difficulty mobilising quickly.
- To review the operation and expenditure of the continuing health care team and the contracts for care home provision.

Modernising Palliative Day Care

The most notable changes in the care of the dying, apart from the development of clinical co-ordination centres with advisory hubs and rapid response services, has been in the reshaping of day care services with a rehabilitation approach. Traditionally patients attended for whole days and had access to a huge range of both social and therapeutic activities. Patients often attended for months oryears. Whilst there was no doubt that the day care services were of a very high standard, only a small number of patients could access them, leading to gross inequalities. Access was usually based on patient choice rather than a specific need that required an intervention.

A model of rehabilitative palliative care has been developed, defined as:

> *"Rehabilitative palliative care is a paradigm which integrates rehabilitation, enablement, self-management and self-care into the holistic model of palliative care. It is an interdisciplinary approach in which all members of the team, including nurses, doctors, psychosocial practitioners and allied health professionals, work collaboratively with the patient, their relatives and carers to support them to achieve their personal goals and priorities.*
>
> *Rehabilitative palliative care aims to optimise people's function and wellbeing and to enable them to live as independently and fully as possible, with choice and autonomy, within the limitations of advancing illness.*
>
> *It is an approach that empowers people to adapt to their new state of being with dignity and provides an active support system to help them anticipate and cope constructively with losses resulting from deteriorating health.*
>
> *Rehabilitative palliative care supports people to live fully until they die."* [50]

Hospices are reforming their day care services taking this approach. Many more patients attend for a specific intervention rather than the whole day. Interventions such a circuit training or management of fatigue and breathlessness are proving popular with proven positive impact of increased mobility, confidence and hope under the guidance of physiotherapists. Many of these activities take place in groups, which both makes them more cost effective and enables patients to get the benefit of meeting other people in similar situations. Many more patients, particularly those with non- malignant conditions are accessing rehabilitative palliative care and hospices are becoming more efficient in spreading their resources.[51]

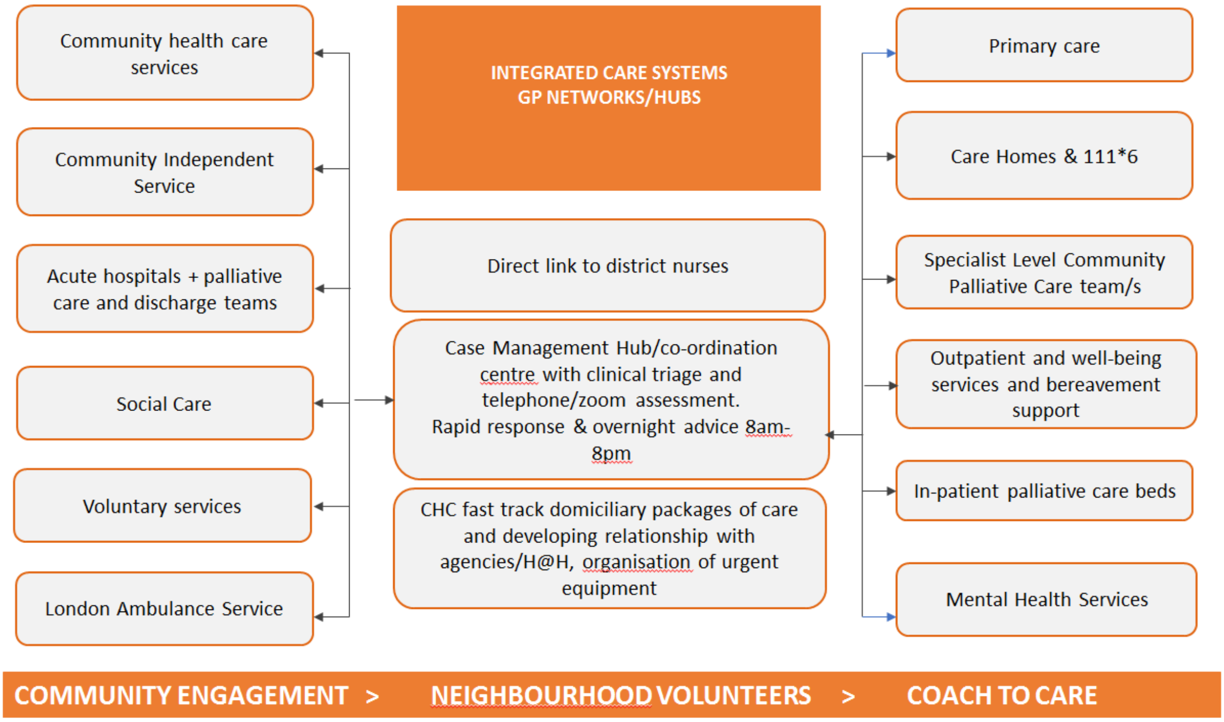
The End of Life Intelligence Network published a Palliative Care Set Clinical Data Set Evaluation Report[52]. It concludes that the use of a suite of outcome measures will drive up quality and consistency of services and help with an understanding of complexity.

Recommendations:

Commission new community-based palliative rehabilitation and health and well-being services to replace traditional day care .Working collaboratively with the voluntary sector, this should also be built into the service specifications.

Recommended model of care

Recommended Model and commissioning options to deliver the recommendations identified:



Overarching Recommendation by Penny Hansford Independent Strategic Reviewer

In conducting this review it has become clear that the three major challenges for the CCG's commissioning services are:-

- inequity of specialist palliative care service provision 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
- inequity of funding arrangements for the services from the CCG's which ranges from 18-100%

Once in contact with a specialist palliative care service patients and families report high levels of satisfaction.

In order to significantly improve the specialist community service I have suggested a 8am-8pm palliative care hub with skilled clinicians that can ensure patients get the right repose by the right person at the right time. The hub will also have a rapid response service. I have also recommended that the community services are retendered with a lead provider model to enable better co-ordination and accountability.

I am also recommending a reduction in specialist palliative care beds. These are not currently fully utilised. Bed modelling in appendix L has demonstrated that there is some capacity in the system and that more could be created by extra provision of continuing healthcare beds.
Since the Pembridge Hospice inpatient unit has been closed the majority of patients have been successfully admitted to surrounding hospices. This, combined with the block contracting arrangement that the CCG's have with CLCH who manage the Pembridge Hospice leads me to recommend that the Pembridge inpatient unit is decommissioned and the monies used to purchase provision in other local hospices and in the re tendering of enhanced community services.

Commissioning options
Option One (Recommended option)

Tender a new community service with one lead provider for the specialist palliative care services, to provide an 8am-8pm co-ordination/case management centre as in the above diagram. Out-patient, rehabilitation and well-being services should be easily accessible to patients and be located within the boroughs. The Community Model would not preclude subcontracting arrangements.
Renegotiate bed- based care with separate providers.

Strengths: This has the greatest potential of all the options of delivering a standardised newly shaped service to meet the recommendations listed above, particularly fair access and equality. As one lead provider 'palliative care' also has the potential to operate as a key player in the integrated care systems. Palliative care services are by nature 'small' with often isolated professionals such as medical consultants. This model would also ensure less vulnerability in the key professions.	**Opportunities**: To radically change the way the services currently operate, address weaknesses in the current system and move to outcomes-based commissioning. If any bed-based services are re-negotiated it will give an opportunity to use the remaining beds more effectively which is likely to be a cost- effective option whilst still accommodating the current numbers of patients who require a palliative care bed. Create a systems leader to effectively implement change.
Weaknesses: The provider of the in-patient bed services may not be the lead provider of the newly tendered contract for the community meaning the lead provider would have less leverage over the use of the beds.	**Threats:** This is the highest risk in terms of disruption to current providers and therefore potential loss of charitable funds in the health economy and instability of services.

Option Two

Tender a new service and rationalise and reduce the number of specialist providers to two, with the same service specification and contracts. Written within the specification should be the need for the successful bidders to work in partnership to provide a 24/7 co-ordination/case management centre as in the above diagram. Out-patient, rehabilitation and well-being services should be easily accessible to patients and be located within the boroughs.

Strengths: Having two organisations operating to the same specification will help to standardize services. This model will ensure central co-ordination of services and address weaknesses in the current system of co-ordination, accessibility and rapid response.	**Opportunities**: To radically change the way the services currently operate, address weaknesses in the current system and move to outcomes-based commissioning. If bed-based services are re-negotiated it will give an opportunity to use the remaining beds more effectively which is likely to be a cost-effective option whilst still accommodating the current numbers of patients who require a palliative care bed.
Weaknesses: Having two providers will be harder to ensure standardization and integration with the new integrated care systems.	**Threats**: if current bed-based providers are not successful in the tender there may be a lack of palliative care beds. There are currently 4 services in the area and with this model two would cease to exist. The boroughs may lose charitable income if the independent providers were not successful.

Option Three
Tender the services based on one community service per borough with the same service specification with one co-ordination centre/case management centre per borough

Strengths: A potential advantage in Hammersmith & Fulham where social care has formally separated from the other two boroughs. Depending on the emerging integrated care systems if the boroughs re model their services based on one single point of access and case management per borough, this model may facilitate integration rather than hinder it.	**Opportunities:** Development of relationships and collaboration with health, social care and voluntary providers at a very local level.
Weaknesses: Unlikely to deliver the new model with co-ordination and case management and rapid response as each provider service would be small with no economy of scale. Therefore, the model would be more expensive as a greater number of staff will be needed to be replicated three times. Less likely to deliver equity of both service provision with 3 providers essentially working separately.	**Threats:** Services would remain fragmented and small unless one provider was successful in all three tenders but the care co-ordination/case management model is unlikely to be realised if there is a need to replicate three times. The potential loss of beds/alignment of bed provision may be problematic.

The preferred option
The reviewer's rationale for recommending option one, a lead provider in the community is due to the significant transformational change needed in the specialist palliative care services to enable them to use their resources in a different way. Acting in a consultative and training capacity to the wider care system whilst managing a small number of highly complex patients themselves, alongside case management for all expected deaths. Achieving the recommended outcomes for the new model of care will be challenging but most likely achieved with a systems leader 'driving' change.

There is also an imperative to become part of the emerging integrated care systems in the boroughs and to provide an equitable service throughout. The reviewer believes this is best achieved by an overall lead provider, accountable for the change needed. The integrated care systems are progressing to different timescales and slightly different models in each CCG and so it has not been possible for the reviewer to make a recommendation on how the palliative care co-ordination centre will integrate, only that it will need to.

The idea of a co-ordination centre, single point of access with extended hours and rapid response was consistent feedback from many of the professionals interviewed and now backed up by the patient, family and friends feedback, 74% of whom rated co-ordination and communication between services fair to very poor and only 26% were satisfied or very satisfied.

Contracting the beds separately to the community contract is a pragmatic approach as the provision of care in this setting requires less change management. The system has been managing with considerably reduced bed days for the last year which has not been problematic as two of the three units have been running at under 70% occupancy. Beds are costly and service only a few people. The reviewer would recommend closing a small number of specialist palliative care beds and investing the money in getting the community model right. The modelling in Appendix L looks at 3 different scenarios with a potential closure of between 4 and 10 beds. This will improve the quality and experience of care for most people and will further reduce the need for as many beds. The actual number of beds that can be closed will be dependent on a further review of delays in the system for patients who need to be transferred out of a specialist palliative care bed into a CHC fast track bed in a nursing care home.

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NHS
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Sent By Email

87 - 91 Newman Street
London
W1T 3EY
Tel: 020 3350 4000
Email:
http://www.centrallondonccg.nhs.uk/

Friday, 03 January 2020:

Dear Stakeholder,

As you may be aware, Central London in collaboration with West London, Hammersmith & Fulham and Brent are undergoing a review of palliative care services across the four boroughs with the aim of improving access and quality of care. An independent review led by Penny Hansford was initiated by the temporary suspension of the inpatient unit at Pembridge palliative care centre due to insufficient medical cover; this review highlighted a number of challenges currently facing the local services. If you would like to find out more information on the work undertaken so far you can find out more at https://www.centrallondonccg.nhs.uk

We would now like to inform you of the outcome of a series of public workshops that were held in Autumn 2019 to hear the views of patients, the public, health and care professionals and local politicians. These workshops were well attended with an average of 30 attendees per workshop and we are very grateful to all those who gave up their time to help us to improve palliative care services in these boroughs.

The workshops focussed on three themes; ‘Access to services’, ‘Care’ & ‘Aftercare & transfer of care’. It was really useful to talk to workshop attendees and hear their experience and feedback of palliative care services across the boroughs. We have produced a workshop summary report which can be accessed here.

In summary, across the three workshops we found:

1. Care works well once a service or pathway has been accessed with inpatient hospice services offering peace of mind for family, friends and carers.
2. Care is not standardised across different areas in the four boroughs
3. There is inequitable access to information and support to access and navigate available services
4. Care planning should be transparent with family, friends and carers and start at an earlier stage.

5. More could be done to ensure that minority groups are aware of palliative care services and ensuring that these services are personalised for a diverse range of communities
6. Travel times to hospice services has a significant impact on carers and families and should be a focus for any future model of care.
7. More could be done to improve integration and coordination between services.
8. Bereavement services need to be planned earlier in the patient journey and be promoted better for friends, family and carers.

The information we have gathered will be used to inform our future design of palliative care services across Westminster, Hammersmith and Fulham, Chelsea and Kensington and Brent. We will be sharing our initial solutions for how we could improve palliative care services with the public so we can hear your feedback on these plans so far.

If the new model includes a significant change there will then be a public consultation so we can hear your feedback on the service. We will of course keep you posted on any updates arising from the programme.

If you have any further questions or comments, please contact us at
nwlccgs.triborough.palliativecare@nhs.net

Yours Sincerely,

Jules Martin

Managing Director, NHS Central London CCG.

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Clinical Commissioning Groups

Palliative Care Public Workshop findings:

Planning services together

Palliative care: how we will use your feedback

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- Thank you to everyone who attended our palliative care services re-design workshops.
- We’re positive about the chance to integrate services better, improve co-ordination and ensure local people get the information & service they need, faster.
- The information we have gathered will be used to inform our future design of palliative care services across Westminster, Hammersmith & Fulham, Chelsea and Kensington and Brent.
- For more information on our next steps, visit the CCG websites.

Talking about your experience of palliative care

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Thank you to everyone who has been involved in this process.

We understand that talking about your experience of palliative care may be emotional and distressing. The organisations listed here are available to provide support and are here if you need them.

Cruse Bereavement Care
0808 808 1677

Grief Encounter
0808 802 0111
https://www.griefencounter.org.uk – online chat available

Winston's Wish
08088 020 021
ask@winstonswish.org.

Child Bereavement UK
0800 0288840
support@childbereavementuk.org

Samaritans
116 123
jo@samaritans.org

Grenfell Health and Wellbeing Centre:
020 8637 6279
grenfell.wellbeingservice@nhs.net

Background to the palliative care review

Brent, Central London, West London and Hammersmith & Fulham Clinical Commissioning Groups (CCGs) are developing plans to improve palliative care services, together with local people.

- Compared to the national average in England, patients in Hammersmith & Fulham, Kensington & Chelsea and Westminster are more likely to die in hospital than their preferred place of death.
- Less than half of local people across these boroughs are accessing palliative care services when they most need them.
- The services offered are inconsistent across the four boroughs, Hospice@Home for example is not available in all boroughs.

Earlier this year we commissioned a review of services, the outcome of this review can be accessed here. As part of this process we invited local patients, carers and their families, staff and other local stakeholders to share their experience and the recommendations were published in June.

These workshops were the next stage of the review where we have involved local residents in feeding in to developing a new model of care.

Patient & Public involvement: workshops

People across the four boroughs were invited to three workshops which focused on Access to Care, Care and Bereavement.

The purpose of these workshops were to listen to public and patient views about what is currently working and how we can improve.

- Understand patient and families experience of care from palliative care services.
- Use these experiences to co-develop an improved way for patient's palliative care needs to be met from diagnosis to end of life and beyond.
- Feed in to a new model of palliative care across the four boroughs.

Palliative care services
Help to shape our plans

We are recruiting local people to help develop community palliative care services. Join our public working group or attend one of our workshops.

Workshop 1 - Access', 30 September 6-8pm,
Wembley Centre for Health & Care
Workshop 2 - 'Care' 7 October 9-12pm,
St Paul's Church, Hammersmith
Workshop 3 - 'Aftercare & bereavement support'
24 October 3-6pm, Museum of Brands Ladbroke Grove

More information & sign up at:
brentccg.nhs.uk or call 0203 350 4366

Workshop 1: Access to Care

During the first workshop in Brent on the 30th September attendees discussed the following questions in two breakout sessions.

Breakout Session 1: What is your experience of getting the right help when you need it?

- What is working well and what isn't?
- Who did you speak to, what help did you get, what was your experience in and out of hours and in an emergency?

Breakout Session 2: How can we improve this experience in the future?

- How would this process start in the future?
- Who would you want to identify the help, support and care you need?
- What would you want them to do?
- What would the information and co-ordination be like?

Responses to breakout session 1
What is working well?

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- What is working well and what isn't?
- Who did you speak to, what help did you get, what was your experience in and out of hours and in an emergency?

"Specialist palliative care was really good and offered more 'hand holding' for the patient and families"

"Acute sector felt like they were better trained"

"Community palliative care we experienced was great"

"If you have past experiences of care it makes it easier to navigate through the system which once you're in is good"

"Hospice inpatient experience – more responsive and available to support needs unlike hospitals"

"In Brent, there is a good relationship between GPs and nurses with regular communication between the two"

"Joint visits with GPs and nurses are liked by patients as they feel like they have a solid team around them and this makes them feel more in control"

Responses to breakout session 2: what needs improvement?

Themes from the workshop for areas that need improvements centred around **patients access care, communication** and **coordination of care**

Access to care

"There is a lack of information from clinicians about how to access services"

"You often need to ask for palliative care support – but if you don't know it is available how do you ask? This situation could cause inequalities"

"Different languages and cultural complexity may cause issues in accessing palliative care – important consideration in culturally diverse boroughs"

"Lack of awareness of palliative care services"

"Confusion around the system about how to access palliative care leads to unequal access and patient anxiety"

"Traveling for friends and families can sometimes be difficult"

"In certain situations telephone advice is not enough – there needs to be a crisis intervention team"

"Issues with accessing palliative care causes care to be delayed"

"Patients need to feel like they are more in control of the process"

"Travel costs, if family and friends need to travel far, it may deter them from visiting or discourage patients from access care if they don't have their friend and family attending with them"

"If you have been in the system before you know how to navigate it but this is difficult for patients and families who have not been"

"To improve access needs to be greater awareness around what is on offer"

Responses continued..

Communication

"We need to do more to talk about palliative care – sometimes it feels like people are afraid of talking about death"

"We need to raise awareness of what palliative care means to patients and families"

"It is important to have an honest relationship of trust between patients and clinicians around the reality of dying – sometimes can feel like the clinician isn't comfortable"

"More could be done to raise awareness of palliative care among minority communities"

Coordination

"There is a lack of early planning around palliative services"

"Staff recruitment – how do we recruit adequate staff and attract them in to the system"

"Lack of care coordination could reduce access to care"

Experience now

Feedback from the workshop was captured in the below illustration by Anna Greyer

Improving experiences

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Workshop 2: Care

During the second workshop in Hammersmith and Fulham on the 7th October attendees discussed the following questions in two breakout sessions.

Breakout Session 1: What is your experience of palliative care?

- What is working well and what isn't?
- What is your experience of the quality of care you or a loved one have received?
- What was the impact for you?
- Is care available at the times when you need it?

Breakout Session 2: What's important to you and your loved ones about care?

- What makes care excellent?
- What does care mean for you and what makes you feel supported?
- Where do you want your care and how can it be more personalised and inclusive of specific needs?
- What are your priorities?
- What kind of things make a difference to you and your loved ones about the care you receive?

Responses to breakout session 1: What is your experience of palliative care, <u>what is working well ?</u>

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"When patients go in to a hospice it takes the stress away from the carer"

"Hospice environments are much better for families and young children, especially compared to hospitals"

"Hospice@home is brilliant and needs to be available in more areas"

"The quality of hospice care once in a hospice is very good"

"Communication and planning is the key to positive palliative care"

"Care works very well once in the right service or pathway"

"Availability of care in all settings to support patient wishes"

"Palliative care works well when district nurses, carers, GPS are involved in providing care and are part of the patient journey"

Responses to breakout session 1: what could be improved?

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Care

“The system is clearly fragile – providers are often competing for resources (clinicians, nurses and volunteers)”

“We need a better understanding of what complex pain is, this may lead to different referrals and variations of care”

“Patients are often diagnosed as terminal too late and have no palliative care plan”

“Too many hospital deaths – this is not the right place to be dying”

“No standardisation of care between services – hospices are providing very different levels of care”

“More needs to be done to support people to die at home, this needs to include emotional support for families”

“Too many hospital admissions for older people, this can be detrimental to mental health and state-of-mind for the person”

“Sometimes families feel like they need to fight for palliative care support”

Responses continued…

Communication

"Lots of people are worried about what will happen around end of life care"

"Families are too frequently finding out about palliative care services through word of mouth"

"More conversations about dying are needed to raise awareness of services"

"Communication between providers should improve to reduce competition between services and help them work together More conversations about dying are needed"

Coordination

"Out of hours care coordination needs to improve – for example when you realise a CMC plan is not detailed enough and there is confusion over job roles and responsibilities"

"System needs to be more linked up and work better together – it is not easy to share information at the moment"

"We need a central hub of information"

"More information could be provided on how people can help hospices with volunteering"

Responses to breakout session 2: What is important to you and your loved ones about care?

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Breakout Session 2:

- What makes care excellent? What does care mean for you and what makes you feel supported?
- Where do you want your care and how can it be more personalised and inclusive of specific needs?
- What are your priorities? What kind of things make a difference to you and your loved ones about the care you receive?

Care

"Dying in dignity - offering patients informed choices about dying"

"Hospices need good estates and support facilities"

"Excellent care = human, flexible, 'can-do' attitude and personal"

"If care is in the home you need to think about the whole picture – who keeps the house clean, who does the laundry, who pays?"

"Respecting the patient, family and loved ones and ensuring that the family and carers are involved stops the care feeling too clinical"

"Better supported for people who are dying and information for people who are supporting palliative patients"

"Holistic care – spiritual, emotional, medical friendly – thinking about what to do that makes the patient calm"

"Involving families from beginning to end of palliative care – particularly when administering medication, it is important to keep families involved"

"A future model should provide for people who want to die at home"

"Making hospices feel like a home away from home"

"Going the extra mile to listen to patients and families"

"Giving patients choice – this is particularly important for aging in a multicultural society where religious and spiritual needs are important"

Responses continued…

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Communication

"Creating a death/ dying in dignity champion to encourage talking about death – encouraging the voluntary sector to do more around this"

"Improved communication and education around palliative care – potentially working with AgeUK and other organisations"

"Compassion in dying materials need to be available – this need to be socially and culturally aware of diverse communities"

"People's end of life plans should be an ongoing discussion with GPs from the start"

"Early conversations make harder conversations in the future easier"

"Need more information available locally to inform people about dying"

"Provision of help and support earlier in the process"

"Improved communication for carers on how they access resources and support"

Responses continued…

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Coordination

“Promote co-ordinate my care”

“We need a centralised hub that co-ordinates end of life care at hospices – a centralised system that acts as a core support for patients and facilities “

“A hub that includes: information about specialist advice, service information, telephone advice”

“Improved CMC usages and accessibility for patients, staff and families”

“A hub that helps district nurses, GPs, Hospices, Social Care, Mental Health services coordinate care”

“Simplicity and integration – no referrals”

“Future provision needs to take in to account demographic changes”

“Empower social care teams so they can make better decisions that improve co-ordination”

“Timely access to care”

“Improved coordination and accessibility for all e.g. homeless populations, learning disabilities, teenagers”

“Mixed economy of services that can meet the various demographic needs”

“Improved hand overs between teams”

Experience now

Improved experience

Workshop 3: Moving between care settings, bereavement and aftercare

During the third workshop in Kensington and Chelsea on the 24th October attendees discussed the following questions in two breakout sessions.

Breakout Session 1: Your experience of moving between care settings

- If you or a family member/ carer have experience of receiving care in more than one place e.g hospice to home, or hospital to hospice
- What worked well and what didn’t
- Was it the right support at the right time?
- What support would you have liked to have received and where?

Breakout Session 2: What is your experience of bereavement and aftercare support?

- What type of support have you received / are receiving?
- What worked well?
- What could be improved? What would make you feel more supported?

Responses to breakout session 1: Your experience of moving between care settings, what is working well ?

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- If you or a family member/ carer have experience of receiving care in more than one place e.g hospice to home, or hospital to hospice
- What worked well and what didn't
- Was it the right support at the right time? What support would you have liked to have received and where?

"When transitioning between care settings it is vital the patient and the family are kept informed and felt listened to"

"Changing between care settings works well when there is clear communication between healthcare providers and professionals"

"When 24 hours a day care is offered by hospices it helps carers"

"Hospice@home works well as the staff are well trained and know how to deal with complex pain and pain relief"

"The night nurse services works well – having an inhouse services makes it easier to be responsive but important that they are part of a 24 hr core service"

"Coordinate My Care (CMC) gives staff in various settings information about a person's wishes and treatment options, but only if the quality of the information is good"

Responses continued…

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Communication

"Need to have more conversations about transitioning between care settings before the change takes place"

"There are poor links and communication between specialists and acute communities"

"We need to have a means of getting answers for quick advice and support needs"

"Services are too fragmented with little communication between them"

Responses continued…

Coordination

“Moving between care settings needs improved coordination. Experiences included long waits, horrible journeys between care settings and confusion between staff”

“Lack of coordination leads to confusion and trauma for the patient and families”

“We need to improve the discharge experience for patients”

“Need to make sure that when patients are moved to a new care setting that the location works for the patient and their families”

“Coordination needs to be improved when patients move between care settings as it is during this time when patients may fall in-between cracks”

“Poor use of Coordinate My Care (CMC)”

“Need to improve urgent care at home”

“When moving between care settings need to make sure that the distance carers have to travel to visit patients is considered”

Responses to breakout session 2: What is your experience of bereavement and aftercare support, what worked well?

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"Hospices are the ultimate hub for bereavement services where you can talk to people who have experienced similar issues"

"I felt listened to"

"Safe space to talk and find out information"

"Presence of someone with empathy"

"Having informal support through being part of a network which is really important if family live abroad"

"Being able to talk to people who have been through similar experiences"

Responses continued…

Care

“Need to have bereavement support from specialists who are culturally sensitive”

“Taking the time to ask ‘what do you want?’”

“Can we provide training to bereavement staff on responding to grief”

“Personalised care – we need to listen to what people say they want and take in to account different opinions and cultural needs”

“Additional support around anniversaries and death - People going through bereavement and grief need specialist support or it can impact people long term”

“We need to de-medicalise support so it can be more holistic”

“Additional support around anniversaries and death”

“Care needs to take in to account family situations – for example considering the impact of death on family members”

Responses continued…

Communication

“Patients and families feel like they don’t have a voice”

“Spending time to understand the diagnosis and timeframe for patients”

“Need to support more people talking about death”

“We need more services that offer people opportunities to talk about their bereavement”

“Recognise that bereavement and aftercare services need to be promoted more – this could involve more signposting to bereavement services where people can receive support”

“Hospice services need to ask for feedback”

“We need a public campaign to normalise death and normalise conversations about care planning”

“Awareness campaign for hospital staff about what services are on offer in the community”

Responses continued…

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Coordination

"We need to make sure that support is accessible to different communities and that we don't have gaps"

"Services need to be accountable, so patients aren't passed around different services"

"Bereavement starts before death, services need to be prepared to offer families support pre-death"

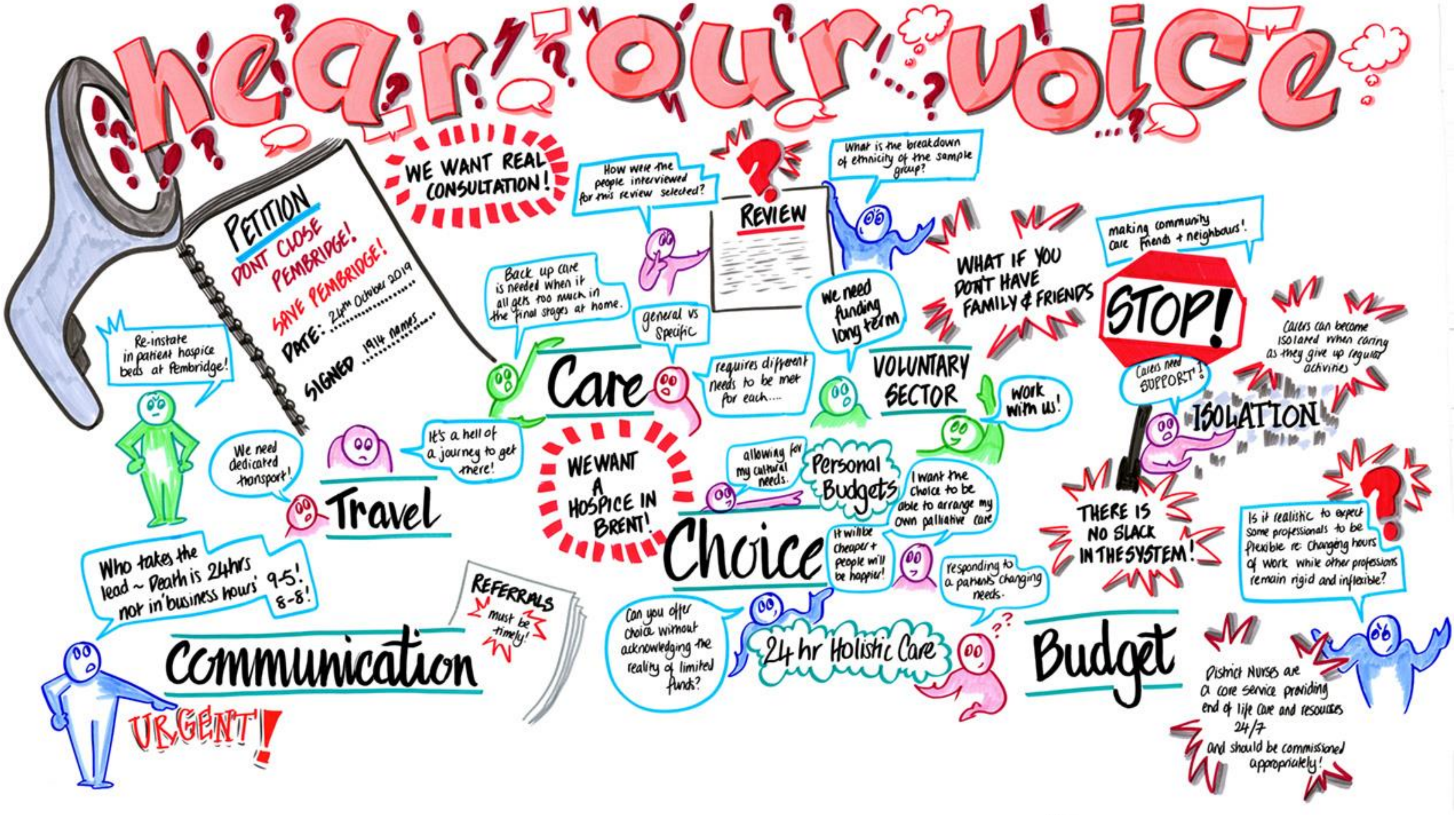
"Flexible timeframe for counselling"

"We need to think about bereavement services in the context of integrated care"

"To get good outcomes bereavement support needs to begin pre-death"

Improved experience

Hear our voice



www.newpossibilities.co.uk @AnnaGeyer_NP

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Summary of key themes

Access to care

- **Currently there is inequitable access** to information and support to access and navigate available services
- **Travel** times and the importance of services within a reasonable proximity of home as well as families, friends & carers
- Consider **barriers to accessing services** from certain population groups.

Care

- **Care planning** should be transparent with family, friends and carers and start at an earlier stage
- **Care** works very well once a service or pathway has been accessed
- **Place of death -** the acute sector isn’t the most appropriate setting for end of life care
- Care is **not standardised** across these areas.

Coordination

- **Out of hours** care isn't consistent
- Services including **health and social care need to be better linked** particularly regarding transfer of care
- **Minimise distress** when transferring a patient between settings.
- **A single point of access** would improve service integration and improve patient experience
- Improvements needed for **integration & promotion of bereavement services**

Communication

- Equip clinicians in all settings to have type **appropriate vocabulary** around palliative and end of life care.
- **Greater transparency of services** available with all clinicians informed as to what these are.
- **Conversations** around dying need to happen earlier
- **Stronger links & working** between specialist and general clinicians and teams.
- **Access to information in an emergency**

Personalised care – it is important that services are personalised to reflect the different needs of people and the diversity of our communities.

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Thank you to everyone who attended our palliative care workshops and shared their views and experiences.

What happens next?

Visit your CCG website for more information.

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North West London
Collaboration of
Clinical Commissioning Groups

North West London Clinical Commissioning Groups
15 Marylebone Road
London
NW1 5JD

17 January 2020

Dear colleague,

Following our communication earlier in January, we are writing to update you on the progress and next steps of the review of palliative care services taking place across Brent, Kensington and Chelsea, Hammersmith and Fulham and Westminster.

Public engagement - what we have done so far
Since December 2018 we have engaged; local patients, families, carers, residents, the voluntary and community sector, and patient representative groups across the four boroughs.

Initially we launched a 'Call for evidence' to hear from local people and professionals their views on services and how they are working. This information formed the basis of an Independent review which was led by Penny Hansford, who previously worked as Director of Nursing at St Christopher's Hospice in South London.

The review findings were published and a series of recommendations were outlined. Three very well attended public workshops were then held to look at people's experience of palliative care services from end to end; focussing on access, care and the transfer of care and bereavement.

In summary, across the three workshops we found:

- Care works well once a service or pathway has been accessed, with inpatient hospice services offering peace of mind for family, friends and carers. However, many people aren't in contact with any services at all.
- Care is not standardised across different areas in the four boroughs.
- There is inequitable access to information and support to access and navigate available services.
- Care planning should be transparent with family, friends and carers and start at an earlier stage.
- More could be done to ensure that minority groups are aware of palliative care services and ensuring that these services are personalised for a diverse range of communities.
- Travel times to hospice services have a significant impact on carers and families and should be a focus for any future model of care.
- More could be done to improve integration and coordination between services.
- Bereavement services need to be planned earlier in the patient journey and be promoted better for friends, family and carers.

Plans for a future model of care for palliative care services

Listening to patients so far and working with our providers, we are now thinking about how we meet the challenges identified in the independent review and the feedback we have gathered from the public, palliative care clinicians and staff to date, which identified:

- inequity of access to the services, with only 48% of people who have an expected death having any contact with community palliative care services; and
- inequity of funding arrangements for the services from the CCGs
- inequity of specialist palliative care services in the three boroughs.

We know that contact with specialist palliative care services results in an improved patient and family experience for people with an incurable condition or in their last phase of life.

We are in agreement that reaching only 48% of patients who may have a palliative care need is not good enough. It is paramount that we increase the reach of specialist palliative care services to all patients who need it, regardless of their disease type.

The four CCGs involved in this review along with our providers, are committed to increasing the ‘reach’ of these services, with the aim of 75% of patients with an expected death, their families and their carers, supported either by services, case management and/or advice, when they most need it.

What next?

At the beginning of February 2020 we will be publishing some potential solutions which seek to address the current challenges services face in terms of access, service provision and workforce shortages in this specialism, for further discussion and engagement.

We will engage with the public and key stakeholders on these proposed scenarios to gather people’s views, as we continue to develop the future model of care. The results will be presented to CCG governing bodies for consideration of the next steps and also to overview and scrutiny committees in due course.

Should we take the view that a significant change from the current service provided is required, then we would move to a public consultation which would ensure further engagement opportunities for local people to be involved in developing the future model of care.

The Pembridge palliative care centre

We know people will want to know what this means for the in-patient unit at the Pembridge palliative care centre. Commissioners and providers share the view that it is not advisable to recruit to the vacant palliative care consultant position during this period of review and transformation.

The in-patient unit will therefore remain suspended at this time, with the community and day care services continuing to operate as normal. Alternative provision will remain in place during this period. We are keen to progress this to a successful resolution as soon as possible and look forward to engaging with you in support of this.

Yours sincerely,

Sheik Auladin
Managing Director
Brent CCG

Jules Martin
Managing Director
Central London CCG

Louise Proctor
Managing Director
West London CCG

Janet Cree

Janet Cree
Managing Director
West London CCG

Steve Barnes
Hospice Director
St John's Hospice

DPounds

Dallas Pounds
Chief Executive Officer
Royal Trinity Hospice

Alpana A Malde

Alpana Malde
Chief Executive Officer
St Luke's Hospice

Dr Joanne Medhurst
Medical Director
Central London Community Healthcare NHS Trust

Agenda Item 9

London Borough of Hammersmith & Fulham

Report to: Health, Inclusion and Social Care Policy & Accountability Committee

Date: 27/01/20

Subject: Healthwatch Hammersmith and Fulham - Update

Report of: Olivia Clymer, Chief Executive Officer,
Healthwatch, Hammersmith and Fulham

Responsible Director: External report, Keith Mallinson Chair Healthwatch Hammersmith & Fulham

1. 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.

1.2 Healthwatch H&F Local Committee Partnership Work with H&F CCG: Signposting leaflet.

1.3 H&F Local Committee has worked with H&F CCG to provide advice and guidance in producing a comprehensive leaflet of how to access health services in H&F. H&F CCG said: “We are extremely grateful for the Local Committee’s support in providing us with public friendly language for this work, and advice around design”. There is potential appetite to replicate these booklets across North West London.

1.4 The leaflet can be found here:

https://www.hammersmithfulhamccg.nhs.uk/media/164170/j21616_nhs_hf_utc_gp_access_campaign_leaflet_6pp_v7-3-.pdf

Recommendations

That the Committee considers, comments and notes the report.

Wards Affected: All.

Contact Officer(s):

Name: Olivia Clymer, Healthwatch, Hammersmith and Fulham
Position: Chief Executive Officer
Telephone: 0208 968 7049
Email: olivia.clymer@healthwatchcentralwestlondon.org

Background Papers Used in Preparing This Report

None.

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2. Resident Information on Primary Care Networks

2.1 We have produced a leaflet to explain to H&F residents what Primary Care Networks are. We have shared this with H&F CCG and the GP Federation, and at the follow up Patient Participation Leadership Training for North West London residents that we co-designed and delivered with H&F CCG in October 2019. We will also be using it as part of our ongoing engagement.

2.2 The leaflet can be found on our website here:

https://healthwatchcwl.co.uk/wp-content/uploads/2019/10/PCN-infosheetmap-HFCCG.pdf

2.3 HWCWL has secured funding to support capacity development for local resident involvement in their GP practice Patient Participation Group. Healthwatch will be working with the GP Federation to link with practice managers and residents. This project will also support local resident understanding of the changes in local health provision around Primary Care Networks. The funding has been allocated by H&F CCG as their engagement lead has taken a new role. This funding is focused on the Patient Participation Group development.

3. Young People and Digital Health Healthwatch Report:

3.1 Healthwatch CWL has published its report: **“**Healthcare in the Digital Era: An exploration of young people’s health needs and aspirations in Hammersmith & Fulham”. A briefing and the full report is available on our website.

3.2 The aim of the report is to provide independent, local insight into the healthcare needs and aspirations of young people in Hammersmith & Fulham. It explores how young people would like these needs and aspirations to be met using digital technology.

3.3 The recommendations are as follows:

1. Digital Healthcare: Information and communications

Recommendation 1: North West London Collaboration of Clinical Commissioning Groups (NWL CCGs) should develop a communications plan focused on digital healthcare, which should be implemented in advance of the new Primary Care Contracts of April 2020 to support the development of the Primary Care Networks.

This should be co-produced with Hammersmith and Fulham Clinical Commissioning Group (H&F CCG), and future and perspective patients to ensure that digital interventions are based on needs of the local population.

The following should be included and addressed in the engagement plan:

- Provide information about possibilities of using digital healthcare to help people envision a health system where digital can take place.
- Increase awareness about existing online applications such as NHS 111 online, NHS Go, HealthHelpNow app, the NHS App, and advertise a list of approved NHS applications.
- Clarify the different functions of the applications above and when it would be useful for a patient to use them.
- Work with GP Practices to produce videos with self-care tips for common problems to be advertised on GP websites.

How can Healthwatch CWL help?: Healthwatch CWL will support this by advertising information material and opportunities for engagement to its members through its offline and online communications channels.

2. Prevention: Focus on Mental Health

Recommendation 2: H&F Health and Wellbeing Board and the Integrated Care Partnership should commit to develop a patient pathway that addresses mental health concerns before reaching the point of crisis. They should set out how they will develop this by April 2020.

How can Healthwatch CWL help?: Healthwatch CWL can support implementation of this pathway bringing together LBHF Public Health, West London Health Trust, H&F CCG, the voluntary sector, current and potential mental health service users and other interested parties into a stakeholder group.

3. Checklist: Digital interventions provision

Recommendation 3: H&F GP Federation, H&F CCG and the Primary Care Networks Clinical Leads should co-produce a checklist to ensure that they are delivering digital healthcare that reflects local needs with current and perspective users. The process for this should begin by April 2020.

How can Healthwatch CWL help?: Healthwatch CWL offers to work with H&F GP Federation, H&F CCG and the Primary Care Networks Clinical Leads towards the development of a checklist that could act as a guidance to streamline the digital healthcare offer locally on an ongoing basis.

The following points should be included:

- Ensure that websites and online applications are updated on a regular basis with the latest information.
- Use language that is accessible and easy to understand in line with the NHS Accessible Information Standard (**DCB1605)** in all existing digital interventions.

- Embrace innovation and be open to explore new technologies and initiatives.
- Ensure that new products/interventions are addressing people’s needs and involve people in every stage.
- Ensure that each digital intervention is linked to the NHS logo that people know and trust.
- Ensure that the promotion of digital interventions is accompanied by a reassurance that non-digital methods of healthcare and face-to-face appointments will continue.

Areas for Further Work
As part of our project, the young people we spoke to identified two areas for further work relating to the development of specific apps that interested parties could explore further to see if there is appetite for these interventions.

- **Nutrition App**
  A mobile health application with scientific information based on national guidelines as a way of creating healthy meal plans, designed specifically for each individual body. This should include guidance on nutritional content of foods, what to purchase for their individual needs, and as a reference point for a balanced diet. The app should be scientifically based, but it should be easy for the user to interact with in simple language.

- **Medication App**
  An app that could provide information on each medicine to enable the patient to double check side effects. This could be used to address concerns that a medicine might affect you by causing side-affects such as headaches and skin care etc. It could also support patients make informed decisions about their healthcare when they need to combine different types of medication to address one specific health matter, especially if they are on a long-term treatment.

3.4 Healthwatch CWL will be working with relevant stakeholders towards the implementation of the above recommendations.

Healthwatch would welcome PACs views on the report and how it might be shared for maximum impact.

4. Pembridge Hospice Provision

4.1 CL CCG supported by NW London have convened a working group (Palliative Care Review working group) of locally recruited members of the public with an interest in the future of palliative care. People attending the earlier workshops were able to apply and the opportunity was promoted on our website.

4.2 There is some concern that the pace of the working group is too quick with members not being able to comment and shape the outcome. Healthwatch has raised this with those organising the meetings as this should be used as a genuine opportunity to work with the group and address concerns, with an appropriate forward plan for meetings, minutes and the extent of influence for the group clarified.

5. North West London Collaborative CCG

5.1 Healthwatch received a response to the questions posed by local residents and our Local Committee members on the NW London Case for Change. Our Chair Christine Vigars has been championing the voice of the patient at the various NW London CCG meetings, the Collaboration Board, NW London Quality Assurance meeting and the Integrated Lay Partners Group.

5.2 A NW London wide patient engagement event was held on the 17th December to share the draft engagement strategy and get feedback for future ways of working and ensuring that the patient voice is at the heart of decision making. The event was well attended and well received with participants across NW London.

List of Appendices:

Appendix 1 - Briefing Note - Summary of Young People and Digital Health Report
Appendix 2 - Young People and Digital Health Report 2020 16.01.20

Briefing Note:

Young People and Digital Healthcare Report 2019/20

Introduction

This briefing note provides a summary of the key findings and recommendations from research completed by Healthwatch in 2018 and 2019. It accompanies the full **Young People and Digital Health** report, which identifies the health needs and aspirations of young people in Hammersmith and Fulham, before exploring how these can be addressed by using digital technology. The full report will also be available to view on our website, www.healthwatchcwl.co.uk/reports

Why did we focus on young people and digital healthcare?

- To meet the current need for information on how young people access healthcare
- To test the common assumption that young people want to access healthcare online
- To grow engagement between Healthwatch CWL and young people
- Because the digitalisation of the NHS is increasing, both in terms of online engagement and through use of digital technology for service delivery
- Because the introduction, and subsequent popularity, of the Babylon GP at Hand service*[1] in Hammersmith & Fulham suggests that there is increased demand for online consultations

What is the aim of this project?

The project was focused on giving some initial findings to answer the following questions:

- How, and if young people they want to access healthcare digitally
- Which of their healthcare needs (if any) could be covered by digital technology
- What a digital healthcare system for young people would look like

Key Findings

- The use of digital technology is not necessarily linked with health
- Self-care and patient empowerment through knowledge and information provide opportunities for digital interventions
- A combination of traditional and digital approaches is required to address wider healthcare needs
- There are concerns about receiving wrong information when searching online

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[1] A practice in Hammersmith & Fulham that offers 1) general medical services to patients registered with them and 2) a digital first service using a mobile app which is provided by Babylon Health. www.gpathand.nhs.uk

Engagement

- We completed a survey with 16-21-year olds, mainly through outreach at West London College, and received 72 responses.
- We held four focus groups, with a total of 32 participants aged 11-21 years, at Hammersmith and Fulham Youth Council, Youth Action on Disability, Sobus and St Andrews Church
- We held four youth leaders' sessions with young people in their 20s

We used a creative visual approach for the focus groups that was mainly focused on two exercises:

1) Discussing pictures of health issues
2) Drawing health journeys

We have developed an engagement tool for digital healthcare based on our methods.

Key Themes

1. Mental Health

Mental health has been identified as a key issue for the young people we spoke to. They highlighted the need for prevention, raising awareness and the need to act timely to identify if there is a need for professional intervention before reaching the point of crisis.

2. Nutrition

Young people stated their lack of knowledge regarding healthy eating and nutrition and were critical of unhealthy body image and stated the obsession with image and the need to attain a 'perfect' body to keep up with trends.

Interaction with the health system

i) Preferences

The young people we surveyed, most of them aged 16 to 21, would prefer to see a GP face to face, while they placed more importance into seeing the same health professional rather than accessing health services quickly.

At the focus groups, these preferences seemed to be particularly strong among the younger ones aged 11-16 and young people with learning disabilities that would turn to their parents and carers for advice stressed that everyone needs to "trust the doctor".

ii) Information

The young people we spoke to seemed to be aware of the danger of false diagnosis online and said that they wouldn't use the internet to check their symptoms. Most of them would choose contacting their GP as their first point of contact.

There was limited knowledge of NHS 111, NHS Go and the newly launched NHS digital app. HealthHelpNow was about to be introduced to the public at the time we conducted this project.

iii) Treatment and self-care

Participants at focus groups also expressed the need to be able to address health issues themselves without visiting the doctor at all if they could find suitable and reliable information. Another potential digital intervention that has been identified was the use of video consultations and text messages in follow up treatment to check progress.

Medication app: Project participants suggested the development of an app that would provide information n each medication and enable them to double check side effects.

Key Recommendations

- **Digital Healthcare: Information and communications**

Recommendation 1: North West London Collaboration of Clinical Commissioning Groups (NWL CCGs) should develop a communications plan focused on digital healthcare, which should be implemented in advance of the new Primary Care Contracts of April 2020 to support the development of the Primary Care Networks.

- **Prevention: Focus on Mental Health**

Recommendation 2: Hammersmith & Fulham Health and Wellbeing Board and the Integrated Care Partnership should commit to develop a patient pathway that addresses mental health concerns before reaching the point of crisis. They should set out how they will develop this by April 2020.

- **Checklist: Digital interventions provision**

Recommendation 3: H&F GP Federation, H&F CCG and the Primary Care Networks Clinical Leads should co-produce a checklist to ensure that they are delivering digital healthcare that reflects local needs with current and perspective users. The process for this should begin by April 2020.

Healthwatch Central West London works across Hammersmith and Fulham, Kensington and Chelsea and Westminster. It is an independent charity with the duty to ensure that people's voices count when it comes to shaping and improving local health and social care services.

Contact us to help improve health and social care!

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

Twitter: @healthwatchcwl Facebook: HWCWL Instagram: @healthwatchcwl

healthwatch
Central West London

Healthcare in the Digital Era

An exploration of young people's health needs and aspirations in Hammersmith & Fulham

Healthwatch Central West London
January 2020

Contents

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2. Health needs and the online world

i. Mental Health
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i. Access
- First point of contact
- Symptoms
- Lack of suitable information

ii. Treatment
- Preferences
- Follow ups
- Self-Care
- Medication

4. Opportunities and concerns

5. Conclusion, key findings and recommendations

6. Methodology

7. Appendix

i. Survey
ii. Focus Groups: Participant Information Sheet, Consent form, Privacy Notice
iii. Engagement tool

Acknowledgements

We would like to thank the organisations that worked with us to organise focus groups with young people: Hammersmith and Fulham Youth Council, Youth Action on Disability, Sobus and St Andrews Church.

Special thanks to Sharon Tomlin, Community Organiser at Sobus, and Sakina Dharas, Instructional Designer and Clinical Pharmacist at University College London Hospitals NHS Foundation, for their ongoing support and contributions throughout the delivery of this project.

Most importantly, we would like to thank all of the young people that trusted us with their views.

1. Introduction

i. Healthwatch Central West London

Healthwatch Central West London (HWCWL) is an independent organisation for people who use health and social care services. We deliver the statutory Healthwatch projects in Hammersmith & Fulham, Kensington & Chelsea and Westminster. Through our research and local engagement, we make sure that local people's views are always at the centre of decision making about health and social care.

We make this happen by:

- Listening to what people like about services and what could be improved
- Monitoring how changes in the healthcare system affect local people
- Helping to improve the quality of services by letting those commissioning, running, and making decisions about services know what people want from care

ii. The Young People and Digital Health project

Healthwatch Hammersmith & Fulham made working with young people (16-24 years old) a priority for 2018-20. Local engagement with this group had been limited in the past, and we set out to better understand their health and wellbeing needs with this project.

The last few years have seen an increased digitalisation of the NHS: more patients are being given the option to access health services and information online, and the number of these services is expected to increase.[1]

Discussions of how and where more online services could be used often follow the assumption that young people prefer to access health information and local services online.[2] We spoke directly to young people, to find out whether or not this assumption is the reality for 16-24 year olds.

The aim of this report is to provide independent, local insight into the healthcare needs and aspirations of young people in Hammersmith & Fulham. It explores how young people would like these needs and aspirations to be met using digital technology.

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1 NHS England (2019) Chapter 5: Digitally-enabled care will go mainstream across the NHS (Long Term Plan, Chapter 5) https://www.longtermplan.nhs.uk/online-version/chapter-5-digitally-enabled-care-will-go-mainstream-across-the-nhs/
2 NHS England (2016) Healthy Children: Transforming Child Health Information (National Information Board) https://www.england.nhs.uk/wp-content/uploads/2016/11/healthy-children-transforming-child-health-info.pdf

We chose to focus on this area in response to the following issues:

- The current lack of information about how young people access healthcare
- Common assumptions that young people want to access healthcare online
- Limited engagement between HWCWL and young people
- Increased digitalisation of the NHS (digital transformation), both in terms of online engagement and the use of digital technology for healthcare service delivery
- The introduction of the Babylon GP at Hand service* in Hammersmith & Fulham, and its popularity suggesting increased demand for online consultations

Overview of the project's methods

To explore the new territory of digital health, and how this links to the needs of young people, we used three different research methods.

1. A survey with 16-21 year olds, mainly from outreach at West London College
2. Four focus groups at Hammersmith & Fulham Youth Council, Youth Action on Disability, Sobus and St Andrews Church (32 participants aged 11-21 years)
3. Four youth leaders sessions with people in their 20s[3]

The quotes and comments attributed to young people in this report are taken from the focus groups we held for this project. A more detailed breakdown of the methods we used, and how we applied them to reach this report's findings, is available in the Methodology section (page 26).

*Babylon GP at Hand

A practice in Hammersmith & Fulham that offers:

1) general medical services to patients registered with them

2) a digital first service using a mobile app which is provided by Babylon Health.

https://www.gpathand.nhs.uk/

Overview of the project's goals

This report sets out what young people told us about:

- How they access their healthcare
- What they think about digital healthcare
- Which of their healthcare needs (if any) could be covered by digital technology
- How they would like a digital healthcare system for young people to look

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[3] The project group would be led by older "Project Leads", with a view to having students in their 20s co-produce some of the project's areas of focus and conduct some of the research.

iii. Summary of the key findings

Young people told us:

1. The use of digital technology is not necessarily linked with health
2. Self-care and patient empowerment through knowledge and information can provide opportunities for digital interventions
3. A combination of face to face and digital approaches is needed to address wider healthcare needs
4. They have concerns about receiving incorrect or unreliable information when searching online

Their ideas for how specific needs can be supported using digital technology through applications have been identified and are worth exploring further.

Applying these findings to future research

Engaging with young people has helped us to identify the types of questions about digital technology and healthcare that can be addressed to residents of all ages. Speaking to young people about digital technology and healthcare has shown us that there are some interesting possibilities for healthcare development. However, it will be important for other age groups to be included in the conversations about this. To help with this, we developed an engagement toolkit, which has been included in the appendix.

We hope that this piece of work can contribute to discussions about the digitalisation of health and social care at both the local and national level, particularly following the publication of the NHS Long Term Plan*, which laid out plans for increased investment in digital services over the next decade.

We hope these findings will put the patient's voice at the centre of discussions about current digital interventions, and possible future strategies.

We presented our key findings at the Digital Health and Care Congress at Kings' Fund's "Listening to patients and citizens" panel session in May 2019.

*NHS Long Term Plan

The NHS Long Term Plan, published in January 2019, is a report that explains the priorities for healthcare over the next ten years. It shows how NHS funding will be used.

https://www.england.nhs.uk/long-term-plan/

2. Health needs and the online world

Overview

We explored two main areas:

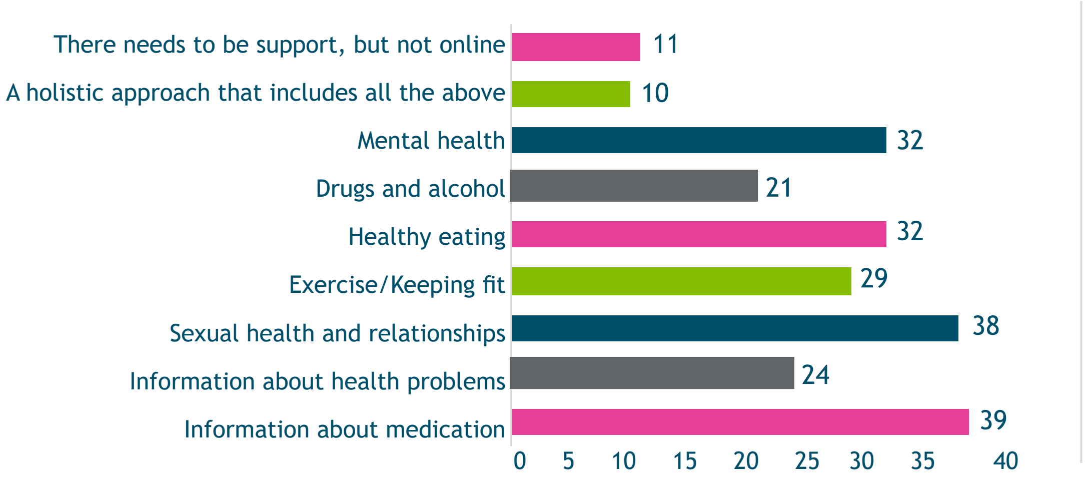
1. **How we could identify what the health needs of young people are**
2. **Which of these needs could be addressed using digital technology**

The participants provided their responses to these two areas by completing surveys, the findings of which are displayed as graphs throughout this part of the report. Some young people also participated in our focus groups, in which they selected priority health issues during an interactive exercise, choosing pictures that represented different aspects of health and discussing them.

All of the quotes and comments in the following sections are taken from the focus groups we held with young people for this project. The issues that this report focuses on were those identified as key areas of interest for young people.

We asked young people (11-21) to talk to us about their health needs, and how these needs could be addressed by digital interventions, such as online tools and apps.

For which of the following do you think there should be online/ digital health support for young people?



The figures in this graph represent the number of responses for each question. Survey respondents could select multiple options within the survey.

Some of our findings from this part of the study included:

- Young people told us that there are opportunities for online interventions to be developed to address most of the key public health issues (see table above).[1]
- More than half of the young people we surveyed believed that it is important for information about medication to be available online.
- Although **38 (52%)** survey respondents identified “sexual health and relationships” as a key issue, it was not widely discussed in the focus groups. This perhaps indicates that engagement about sexual health and relationships should be carried out in a more confidential way.
- Almost **45%** of the survey sample cited the need for digital health interventions regarding mental health (**32 people**) and nutrition (**32**).
- Drugs and alcohol received the lowest number of survey responses as a key issue. Young people demonstrated a general understanding of the negative effects of drinking and smoking during the focus group discussions.

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[1] 72 young people completed the survey. Therefore, these findings do not indicate which health need is the most important. However, what is evident is that there are opportunities for all issues to be addressed through online interventions.

The following section provides more detail on how young people responded to questions about the health issues that affect them, and how online tools could support their access to the relevant information and services.

The section focuses on:

1) Mental health
2) Nutrition and wellbeing
3) Drugs and smoking

Mental Health

Raising awareness

> "Just because you can't see it doesn't mean it's not there."

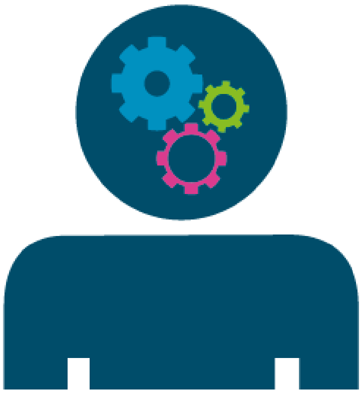
The young people we spoke to in the focus groups, and during the sessions we had with the Project Leads, identified mental health as a key issue.

They said people needed to be more aware of what mental health means, and what can be done to support it, in order to ensure people are given support to speak out and to access services. One young person expressed concern that mental health still carries a stigma that is difficult to change.

Participants suggested that apps and websites could be used to show that mental health issues are normal, and to share resources and spaces that can help. They commented that although mental health is not a "positive" issue, there is the potential to turn discussions of the issue into something positive.

One participant voiced the need for a distinction between mental health illness and "not feeling well":

> "When someone says "mental health" it becomes something – [there is] no need to label it mental health."



> "Feeling low doesn't necessarily mean a mental health issue. If you say mental health, you feel so crazy; it doesn't unravel what people are going through."

Prevention and Self Care

> "Somewhere you are free to speak in a non-judgemental way"

The young people we listened to said that there should be a combination of both conventional and online spaces. They expressed the need to be able to freely discuss health concerns in a non-judgmental way, either within a support network or with a trusted friend.

They identified a series of digital interventions that could support these needs:

Mindfulness apps

"I use an app for mindfulness, called Aura; it's very good. I would suggest someone stick to [meditation]. If it's not working for you, look for other solutions and alternatives."

Practical tips and stories blogs

"There are not many blogs out there that are practical."

"People who have gone through the same thing [could share], how they got through it, positive stories in a blog style."

Online self-care information

"Simple information on what to do; go for a walk, have a bath."

Chatrooms

"There could be chatrooms with people who have the same mental health issues."

Schools online

"Schools should focus on positive messages – [it] would help if there was advice you could receive online to help with exam stress."

A key theme in the mental health focused discussion was identifying the need for professional intervention, and responding in a timely way, before reaching the point of crisis or engaging with health services. Young people said that digital interventions, along with support networks and individual confidential conversations, could provide young people with the space to understand whether they could address their issue themselves, or if it required them to contact the health services.

Interacting with the health system

> "I was speaking with a friend [who] wanted to speak to someone - she didn't know which number to call."

Participants identified a lack of knowledge around how to identify the most appropriate first contact within the health system. Many of them did not necessarily consider the need to speak with someone to mean they were at a "crisis" point.

They suggested that GPs should provide better access to mental health professionals and that there should be more easily accessible options than medicines and antidepressants. They added that pharmacists should have mental health training, estimating that they are often the first point of contact.

Healthy eating

In focus groups and in the online questionnaire, young people indicated that they lacked knowledge of what is meant by healthy eating and nutrition.

Body Image

During discussions about healthy body image, young people in the focus groups mentioned social media as a cause of unhealthy body image, citing the obsession with appearance and the need to attain a 'perfect' body to keep up with those presented to them online. They described seeing models and bloggers advertise meal replacements and weight loss products. Young people reported drastically changing their diet by eating significantly less in response to these trends, explaining that this had a negative impact on their health.

What is healthy?

In addition to social media, the group participants also identified a general lack of awareness of which food is and is not healthy. They were uncertain as to how they could discern between food that is marketed as healthy versus what really is healthy, despite there being extensive available healthy eating advice.[4] In the focus groups, young people suggested that schools should provide healthy meals, and that GP practices should provide nutrition information to help change this.

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[4] The following online resources provide accessible information about healthy eating:

- NHS England website: https://www.nhs.uk/live-well/eat-well/
- Hammersmith & Fulham CCG website: https://www.hammersmithfulhamccg.nhs.uk/your-services/healthy-living.aspx
- London Borough of Hammersmith & Fulham Council website: https://www.lbhf.gov.uk/health-and-care/public-health

A nutrition app

The young participants in the study identified a need for a digital health intervention. They suggested a mobile health app with scientific information, based on national guidelines, as a way of creating healthy meal plans, designed or adapted to each individual body. Some also expressed a need to know what the nutritional contents in food mean, to know which types of food to purchase for their individual needs and as a reference point for a balanced diet. Language used in any digital intervention should be simple, with any extra scientific knowledge added as a reference.

As one young person put it: "I can eat so many vegetables, I can eat vegetables with no limitation, but they can still have deficiencies. You can eat spinach, but it might not help. The important thing is understanding the combination of what to eat and what is good for your individual body."

Drugs, alcohol and smoking

In the focus groups, young people expressed concerns about peer pressure through digital platforms and social media that promotes a "cool culture." This might include drugs, alcohol and smoking. They suggested that it would be good to have more information presented in different ways, including apps to persuade people not to smoke.

However, young people also felt that there is already enough information about the negative health effects of smoking and alcohol, but that people will still do it because it is addictive. Most of the young people who raised the issue of drugs, alcohol and smoking agreed that there should not be imposed controls and that everyone should be free to make their own informed choices.

"Saying don't smoke, [or] do drugs, makes people do it. You should focus more on treatment because people will still do it."

"Cigarette packets warn that is bad for you, but if they want to do it and know [the] risks; it's their choice."

"Anti-smoking [is] not effective, not changing views. The government is not doing enough because selling cigs is good for the economy."

3. Health journeys and digital interventions

To complement the survey responses to questions about digital interventions, HWCWL invited the young participants to describe a "health journey," using pictures to show the different steps they would take to access care if they were unwell.

i. Access

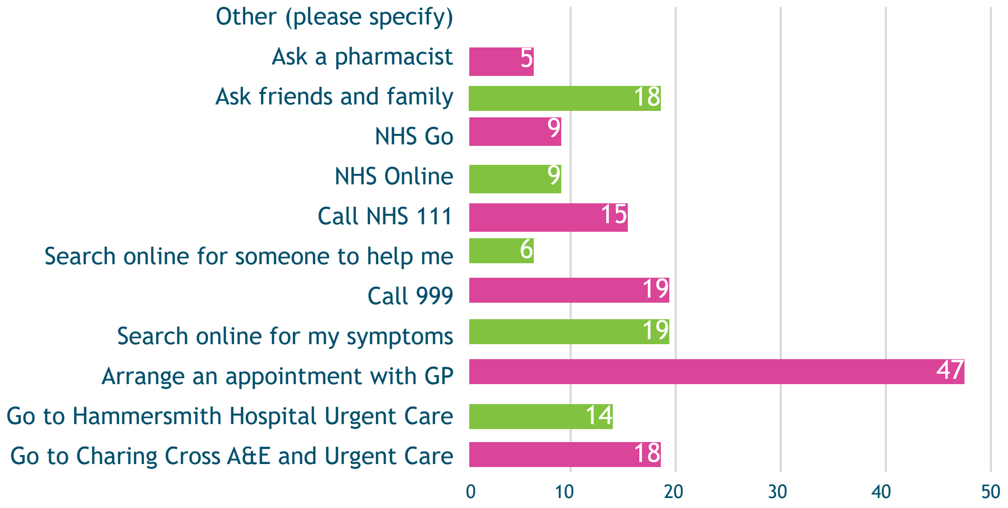
First point of contact

As we explored in the previous chapter, there are opportunities for digital interventions to be applied alongside the current health system, with an emphasis on prevention and self-care. We asked young people which type of digital interventions they thought would be suitable for those using the healthcare system.

To answer this, we asked young people to select the places they would visit first if they had a health concern. In the survey, participants could choose as many different options as applicable.

- The most popular answer, with 47 responses (25%), was to arrange a GP appointment.
- The number of those using NHS Go or accessing 111 online was low compared to the other options.
- 32 responses (18%) selected going to an urgent care centre (Hammersmith Hospital and Charing Cross).

In general, what are you most likely to do when you have a health problem or concern?



The figures in this graph represent the number of responses for each question. Survey respondents could select multiple options within the survey.

Respondents could select multiple options, as this more accurately reflects the different routes that many people make take. From this, we can see that the most popular response was to arrange a GP appointment. Combining the responses for the two urgent care centres shows that they were the second most likely route to take to access health support. It is therefore useful to not only consider the options selected on an individual basis, but to also group responses according to theme, where applicable.

We realised through our conversations with young people that the number of options available could make it difficult for them to know where to go for help. It is particularly important to examine the beginning of the health journey, as the young people we spoke to considered this stage to have most potential for a digital intervention, with digital tools being used to signpost users to the right service.

It is worth mentioning that for a lot of young people – especially the younger ones – their parents or carers were their first point of contact.

Symptoms

The young people we spoke with seemed to be aware of the danger of false diagnosis online. They told us they do not tend to use the internet to check their symptoms because they believe that they might not receive the right information.

> “Feel sick - google symptoms and something worse than what it is, can’t always trust the internet.”

> “I used to do it all the time but stopped. I thought I had cancer!”

They told us that one way to address this would be to provide appropriate information through the NHS website. However, they said the website is not currently very user friendly and is difficult to navigate.

Having an initial understanding of the symptoms that young people are experiencing is important. This helps the person to decide which is the most effective way to address the issue. A common opinion was that a minor issue could probably be addressed through an online intervention, but that more worrying issues require face to face GP appointments.

> “When it’s urgent the internet doesn’t help”

This view demonstrates the need for people to be able to make informed choices about their health.

Lack of suitable information

Use of the NHS 111 number was limited. Some of the youngest focus group participants were not aware of it, and some thought it was the equivalent of 999.

> “More info (online) that we can understand, not long words [that leave you wondering] what does that mean? Everything gets a long word when [it] actually is quite simple.”

It is important to make sure that existing services are well advertised, before creating more digital services that people cannot keep up with. As the table on the next page shows, young people we surveyed knew more about Babylon GP at Hand, which was widely advertised through a successful campaign, than NHS 111 Online. There seems to be good knowledge of the NHS Go app*, but this could be improved.

> “What is NHS Go? Never heard of it. Is it useful? I don’t know about it, it could be a good service. Could be helpful. We need to have more information.”

*NHS Go

A confidential health advice and information service for 16-25 year olds.

It provides free, confidential advice, local services, guides to key health issues, and information about young people’s rights.

https://nhsgo.uk/

We asked young people whether the NHS website could be the most appropriate first point of contact. Although they didn’t find it attractive enough, the group participants were aware of it, and felt it could be used because it is trustworthy.

*NHS HealthHelpNow

An app, which aims to help people find the right service for their health needs, lists common symptoms and offers suggestions for treatment.

https://www.nhs.uk/apps-library/health-help-now/

*NHS App

The NHS App enables people to check their symptoms, use NHS 111 online, register as an organ donor, and other services.

If their GP practice is connected to the app, they can register and use the app to book appointments, order repeat prescriptions, and securely view their medical records.

https://digital.nhs.uk/services/nhs-app

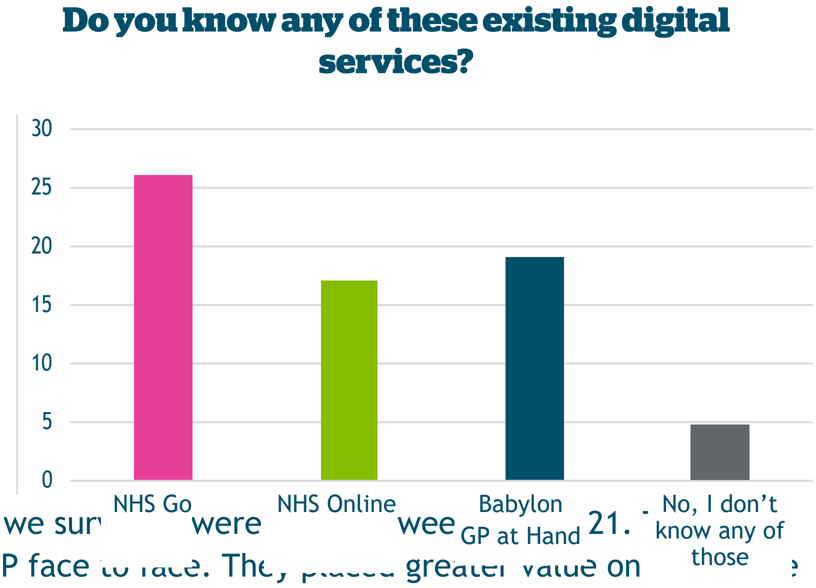
They suggested that the NHS website should signpost to other health resources and information. They said that they could not find what they need when they used the website, and that it is not very user friendly, or easy to access.

They suggested that it could work better as an app. There was no mention of the NHS digital app* that had been recently launched or North West London HealthHelpNow*, which was about to be introduced to the public.

> “NHS website doesn’t feel aimed at the individual, [it] feels generic, impersonal.”

Other suggestions included for the Council and the local NHS to provide accessible information and maps of where all the health services are located.

Young people said that this information is useful for someone new in the area or for whom English is not their first language.


Do you know any of these existing digital services?

ii. Treatment

Preferences

The majority of young people we sur were wee 21. that they would prefer to see a GP face to face. They placed greater value on e same health professional for follow up appointments than on being able to access health services quickly.

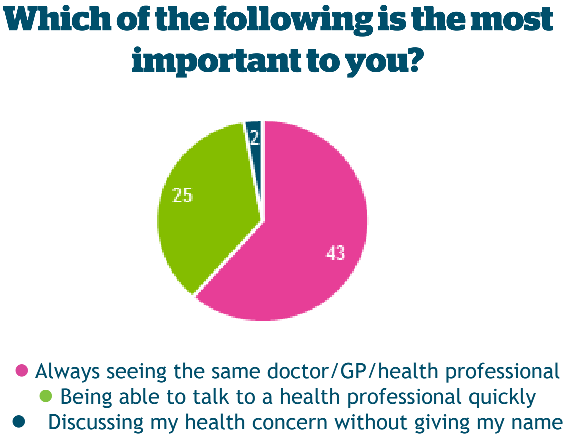
In the focus groups, these preferences seemed to be particularly strong among the younger participants, aged 11-16, and with young people who have learning disabilities.

They said that they would turn to their parents and carers for advice and stressed that everyone needs to "trust the doctor."

"Go to the doctors straight away. Family might go online to have a look."

"Family and friends who know [how to] help or healthcare professional. They might go online."

"Always go to the doctor and take what they give you. Trust the doctors. More important to see a doctor. Especially when it's urgent."


Which of the following is the most important to you?

This suggests that relationships with health professionals are important to young people. This has been reflected in the NHS Long Term Plan. A further study looking at how these priorities change as people get older would be interesting: feedback on the Babylon GP at Hand Independent Evaluation[5] has demonstrated that young professionals are more likely to want to access care services digitally.

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[5] Evaluation of Babylon GP at hand (2019) Ipsos MORI, York Health Economics Consortium, Prof. Chris Salisbury for NHS Hammersmith and Fulham CCG and NHS England https://www.hammersmithfulhamccg.nhs.uk/media/156123/Evaluation-of-Babylon-GP-at-Hand-Final-Report.pdf

This suggests that for some groups, access is prioritised over continuity of care. We are also seeing distinctions made between what is and is not considered urgent, which would be interesting to compare between different age groups.

Another concern that was shared in this part of the focus groups was that people had witnessed the health professional searching their symptoms online to provide advice.

Follow ups

One potential intervention identified during this project is the use of digital technology as an alternative to follow up visits to the GP. This could be carried out via video consultations, text messages and phone calls to ensure that the patient is getting better following treatment without having to arrange a revisit, unless necessary.

In most of the experiences that young people shared with us, there was always a follow up visit to the GP because the health issue persisted. They felt that a visit could have been avoided if there were a way to check the progress of the treatment using digital technology. This is another area in which further research may be useful.

Self-care

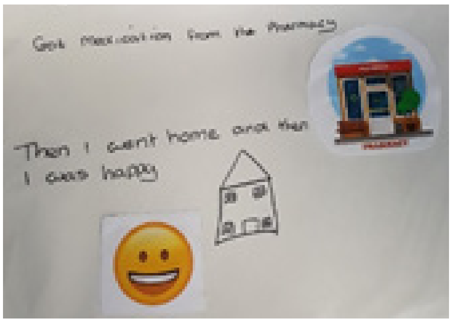
Participants in the focus groups also said they would like to be able to address health issues themselves, without visiting the doctor at all, if they could find suitable and reliable information.

For example, one young person described an experience where they had gone to the GP for ankle pain. The GP gave them a list of exercises that the person thought that they could have found on their own if there was a website showing them what to do when experiencing ankle pain.

Exercises to address health issues seemed to be a popular choice amongst the young people we spoke to, as they also suggested an exercise app could provide positive reinforcement and reminders to those undergoing physiotherapy.

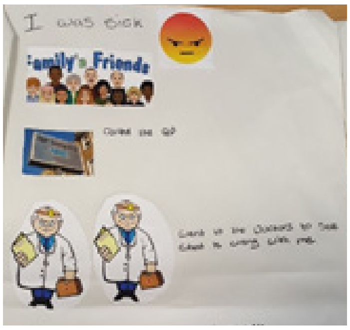
Medication

As young people told us, trust in the healthcare system is not limited to where to check the symptoms online or what happens to the patient data; it is also important for finding information regarding medication.



An interesting idea discussed during one of the focus groups, which was popular with the young people in the survey, was the development of a "medication" app that could provide information on each medicine to enable the patient to double check side effects.

They said that this could be used to address concerns that a medicine might cause headaches, skin reactions, or other side effects, especially since most people do not keep the paper version of the information from their medication box. This would help people to "take healthcare into your hands" as one participant said.



"Information about medication" was the most popular choice amongst the survey responses (see table on page 20), which indicates that there might also be some potential for the development of a medication app that innovators could explore further.

"By the time that the medication has a side effect I would have to go to back to GP and find a new one. Then I will have another medication. And I am thinking, what are they not telling me?"

"Doctors just want to give you medicine to get rid of you."

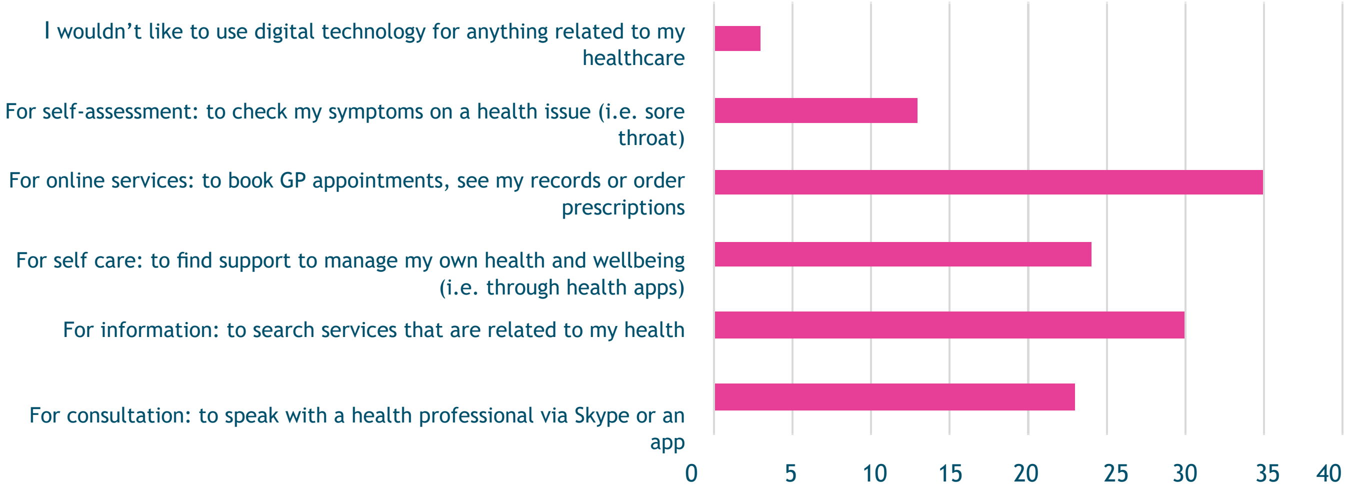
There were also concerns about medication in general, with suggestions for the NHS to explore and accept alternative methods of treatment such as holistic treatment and herbal medicines, as there isn't always a need for drugs.

4. Opportunities and Concerns

We asked young people why they preferred to use digital technology for their healthcare and finding health information. We identified key aspects of intervention to ask them about, which included:

- Self-assessment
- Online health services
- Self-care
- Information and video consultation

Why would you prefer to use digital technology to access your care?



Most of the young people selected some healthcare services for which they would use digital technology, with many of them receiving a high number of responses (with the exception of symptoms checking, which we discussed in the previous chapter). These responses suggest that there is scope for digital innovation in healthcare.

However, the young people found it challenging to navigate potential digital interventions in the healthcare system. Although young people use smart phones in their everyday life, they have not necessarily associated digital technology with their health, and find it difficult to imagine a digital healthcare system. This observation applies to the young people we reached through each different research method (focus groups, Project Leads and survey).

Many stated that although digital health would make access to healthcare much easier and seeking advice more efficient, there was still a need for a holistic approach involving healthcare professionals and face to face appointments.

The young people said that websites or applications can be impersonal and they made suggestions to incorporate healthcare professionals within a digital setting or seeking professional advice alongside digital health interventions.

"Real life interactions make things personal. Digital technology can't offer personal connections."

At the same time, it was recognised that digital technology can help empower people to be responsible for their own health.

"We all have a phone; it is like a tool to have more information and understanding. You are more autonomous."

"(Phone) gives you independence and you can take healthcare in your hands."

There were also concerns about patient data and sharing data online, with some young people saying that they would use fake names and access websites through different devices so that they can't get tracked.

Concern about patient data is part of a wider issue that has been raised with us by adults as well. This needs to be part of further thinking when digital resources are being designed.

Exploring possibilities for digital technology to help people become more responsible for their healthcare, combined with the reassurance that the existing ways of receiving care will not be lost, is crucial to ensuring that a future digital health system is patient centred and effective.

5. Conclusion and Recommendations

Conclusion

Throughout the delivery of this project, we wanted to explore with young people what a digital healthcare system for young people would look like to them.

We explored this by:

1. **Identifying how they could access health digitally**
2. **Which of their needs could be covered by digital interventions.**

Our initial findings show that there are opportunities for digital innovation in healthcare that could be explored more.

This report's findings suggest that digital technology could be used to avoid follow up visits to health professionals and to empower patients with the necessary knowledge and tools to address their healthcare needs. Examples of this, which we have discussed in this report, include interventions for websites that have self-care suggestions and exercises to address issues, as well as phone and tablet apps for nutrition and medication.

Although there is scope for developing digital interventions, there is also a need to maintain the existing face to face approaches that feel more personal and can offer that level of reassurance when needed. A holistic approach was identified as key for mental health and wellbeing in particular, with different choices and options for young people being a priority.

Young people found the idea of being able to take charge of your own health using your phone attractive. Still, with limited knowledge of what digital technology can mean for healthcare, young people found it challenging to explore what this could look like in any depth.

The stage at which service users access healthcare and information online seems to be the best point at which to incorporate digital interventions. However, there are concerns about receiving incorrect or unreliable information when searching online (i.e. symptoms checking) and providing personal information. Young people also have a lack of knowledge regarding existing NHS digital interventions that focus on access and symptoms checking; those who were aware of them did not consider them user friendly.

Below are our recommendations based on this study. We feel that more work needs to be done in the digital healthcare landscape, for all age groups.

Recommendations

We expect the following recommendations to be implemented in advance of the new GP Contracts in April 2020, which are expected to have a digital priority.

1. Digital Healthcare: Information and communications

> Recommendation 1: North West London Collaboration of Clinical Commissioning Groups (NWL CCGs) should develop a communications plan focused on digital healthcare, which should be implemented in advance of the new Primary Care Contracts of April 2020 to support the development of the Primary Care Networks.

This should be co-produced with Hammersmith and Fulham Clinical Commissioning Group (H&F CCG), and future and prospective patients to ensure that digital interventions are based on needs of the local population.

The following should be included and addressed in the engagement plan:

- Provide information about possibilities of using digital healthcare to help people envision a health system where digital can take place.
- Increase awareness about existing online applications such as NHS 111 online, NHS Go, HealthHelpNow app, the NHS App, and advertise a list of approved NHS applications.
- Clarify the different functions of the applications above and when it would be useful for a patient to use them.
- Work with GP Practices to produce videos with self-care tips for common problems to be advertised on GP websites.

How can HWCWL help?

HWCWL will support this by sharing information and promoting opportunities for engagement to its members through its offline and online communications channels.

2. Prevention: Focus on Mental Health

Recommendation 2: Hammersmith & Fulham Health and Wellbeing Board and the Integrated Care Partnership should commit to develop a patient pathway that addresses mental health concerns before reaching the point of crisis. They should set out how they develop this by April 2020.

How can HWCWL help?

HWCWL can support implementation of this pathway bringing together LBHF Public Health, West London Health Trust, H&F CCG, the voluntary sector, current and potential mental health service users and other interested parties into a stakeholder group. o its members through its offline and online communications channels.

3. Checklist: Digital interventions provision

Recommendation 3: H&F GP Federation, H&F CCG and the Primary Care Networks Clinical Leads should co-produce a checklist to ensure that they are delivering digital healthcare that reflects local needs with current and prospective users. The process for this should begin by April 2020.

How can HWCWL help?

HWCWL can work with H&F GP Federation, H&F CCG and the Primary Care Networks Clinical Leads to develop a checklist that could act as a guidance to streamline the digital healthcare offer locally on an ongoing basis.

The following points should be included:

- Ensure that websites and online applications are updated on a regular basis with the latest information.
- Use language that is accessible and easy to understand in line with the NHS Accessible Information Standard (DCB1605) in all existing digital interventions.
- Embrace innovation and be open to explore new technologies and initiatives.
- Ensure that new products/interventions are addressing people’s needs and involve people in every stage.
- Ensure that each digital intervention is linked to the NHS logo that people know and trust.
- Ensure that the promotion of digital interventions is accompanied by a reassurance that non-digital methods of healthcare and face-to-face appointments will continue.

Areas for further work

As part of our project, the young people we spoke to identified two areas for further work relating to the development of specific apps that interested parties could explore further to see if there is appetite for these interventions:

Nutrition App

A mobile health application with scientific information based on national guidelines as a way of creating healthy meal plans, designed specifically for each individual body. This should include guidance on nutritional content of foods, what to purchase for their individual needs, and as a reference point for a balanced diet. The app should be scientifically based, but it should be easy for the user to interact with in simple language.

Medication App

An app that could provide information on each medicine to enable the patient to double check side effects. This could be used to address concerns that a medicine might affect you by causing side effects such as headaches and skin care etc. It could also support patients make informed decisions about their healthcare when they need to combine different types of medication to address one specific health matter, especially if they are on a long-term treatment.

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Methodology and Appendix

The strategy and supporting documents used for our reporting in Hammersmith & Fulham

Research conducted

6. Methodology

Initial desktop research, which we completed in Summer 2018, showed that despite the growing influence of digital technology, there were limited resources exploring what patients want from the digital world more widely.

Initial documents that helped us gain a better understanding of young people and digital healthcare were:

- The Joint Strategic Needs Assessment Report: “The Wellbeing Needs of Young Adults” age 18-25.
- The minutes from the presentation of the above report at the Hammersmith & Fulham Health and Wellbeing Board Meeting (8 February 2017), which acknowledged the difficulty of reaching out to young adults and that there is a need for the digital aspect to be further explored.
- Documents related to the new Babylon GP at Hand service, based in Hammersmith & Fulham, which showed that young adults across London were eager to use the service for online consultation.

Having more information on young adults, we initially decided to focus our research on the 16-24-year-old age group. However, during the delivery of the project, we learnt that we needed to be more flexible, and incorporated the views of younger people as well.

We produced a participation information sheet for those wishing to be involved in the project. To maintain confidentiality, we used consent forms for both comments and pictures. To deal with risk, we engaged with local organisations that work specifically with young people and we followed their procedures.

Since we wanted to make it as easy as possible for young people to participate, while getting a broad understanding of young people’s healthcare needs, we decided not to collect demographic information at this point.

7. Appendix

Appendix i.

What do young people want from healthcare in a digital environment?

Aged 16-24? Do you live in H&F? Answer our questions to enter a prize draw!

Following recent local and national developments in digital healthcare, Healthwatch Central West London is focusing on identifying the healthcare needs and aspirations of young people aged 16-24 living in Hammersmith and Fulham.

1. How would you prefer to contact a doctor or other health professional to talk about your health?

Online (via Skype/video chat)	☐	Face to face	☐
By Phone	☐	Messaging	☐
Other: please specify	☐		

2. Which of the following is the most important to you?

- Always seeing the same doctor/GP/health professional ☐
- Being able to talk to a health professional quickly ☐
- Discuss my health concerns without giving my name ☐

3. In general, what are you most likely to do first when you have a health problem or concern?

- Go to Charing Cross A&E and Urgent Care Centre ☐
- Go to Hammersmith Hospital Urgent Care Centre ☐
- Arrange an appointment with my (doctor) GP ☐
- Search online for my symptoms ☐
- Call 999 ☐
- Search online for someone (professional/service) to help me ☐
- 111 Online ☐
- NHS Go ☐
- Call 111 ☐
- Ask friends and family ☐
- Ask a pharmacist ☐
- Other: please specify ☐

4. For which of the following do you think that there should be online/digital health support for young people? Select all that apply.

- Information about medication ☐
- Sexual health/relationships ☐
- Healthy eating ☐
- Mental Health ☐
- Health problems information ☐
- Exercise/keeping fit ☐
- Drugs and alcohol ☐
- There needs to be support, but not online
- Other (please specify): ☐
- A holistic digital approach that includes all the above ☐

5. For which of the following reasons would you like to use digital technology?

- For consultation: to speak with a health professional via Skype or an app ☐
- For information: to search services that are available related to my health ☐
- For online services: to book GP appointments, see my records or order prescriptions ☐
- For self care: to find support to manage my own health and wellbeing (i.e. through health apps) ☐
- For self assessment: to check my systems on a health issue (i.e. sore throat) ☐
- I wouldn’t like to use digital technology for anything related to my health. ☐

6. Do you know any of these existing digital services?

NHS Go	☐	111 Online	☐	GP at Hand	☐	No	☐

7. What is your connection to Hammersmith and Fulham?

Working	☐	Living	☐
My family lives in H&F	☐	Studying	☐
Other: please specify	☐		

8. What is your age?

15 or less	☐	16-17	☐	18-21	☐
22-25	☐	26-30	☐	31 or over	☐

9. Do you consider yourself to have a disability?

Yes	☐	No	☐	Prefer not to say	☐
Other: please specify	☐				

10. To which gender do you identify most?

Male	☐	Female	☐	Transgender	☐
Prefer not to say	☐	Other: please specify	☐		

11. Any other comments?

☐

Thank you! Please return the completed form to Healthwatch Central West London, 5.22 Grand Union Studios, 332 Ladbroke Grove, W10 5AD, or contact eva.psychrani@healthwatchcentralwestlondon.org and 020 8968 7049.

You can also fill it in online at www.healthwatchcwl.co.uk

Hammersmith & Fulham

In you wish to enter a prize draw, receives updates from Healthwatch or participate in a focus group, please leave us your contact details.

Your contact details will be kept separate from your answers.

I give my consent to be added to the HWCWL mailing list

I would to enter the prize draw to win a gift card

I would like to participate in a focus group to say more about health and digital care

Name

Email

Phone

Your Data

By filling out this sign-up sheet, you give your consent to have your data processed by Healthwatch Central West London. If you have only consented to be entered in our prize draw, we will not contact you unless you have won a voucher. After the draw we will destroy your personal details.

If you have given your consent to be contacted by us about our project in Hammersmith & Fulham, we will not use your data to contact you about anything else, unless you have also agreed to be added to our mailing list.

To find our more about how we store your data, you can read our privacy policy on our website, or ask a member of Healthwatch staff to send it to you.

www.healthwatchcwl.co.uk
info@healthwatchcentralwestlondon.org
Charity number: 1154777

Appendix ii.

Focus Group Participation Information Sheet

Project title: Young People and Digital Health
What is this project about?

Following recent local and national developments in digital healthcare, Healthwatch Central West London is focusing on identifying the healthcare needs and aspirations of young
people in Hammersmith & Fulham.

The project aims to create opportunities for young people in H&F to have a say on:

a) how and if they want to access healthcare digitally,
b) which of their healthcare needs (if any) could be covered by digital healthcare, and
c) what a digital healthcare system for young people would look like.

Do I have to take part?
It is entirely up to you to decide. If you choose to participate in this focus group, we will ask you to complete a consent form to confirm that you have agreed to take part. You will only be able to take part if you have completed this consent form.

What will happen to me if I take part?
If you are happy to take part after reading this information sheet, please fill in the consent form.

Your contact details will be held for the purposes of communication before and during the focus group, but this will not be passed on to any third parties and will be held securely on our database.

The focus group should last for around x minutes and will be audio recorded with additional notes being taken by paper.

What are the possible disadvantages, side effects, risks, and/or discomforts of taking part in this focus group?
There are no anticipated disadvantages, side effects, risks, and/or discomforts of taking part in this focus group as we will only as you about your own experiences and assessments.

We will ask you and others in the group not to talk to people outside the group about what was said during the discussion. However, we need you to be aware that we cannot stop or prevent participants who were in the group from sharing information that should be confidential.

What are the possible benefits of taking part in this focus group?
This is a chance to make your voice heard and to influence future commissioning of digital offers in healthcare in Hammersmith & Fulham and across North West

London. Your views and aspirations will be added to the information gathered through other engagement activities to conduct a report that will be shared with key decision makers, including Hammersmith & Fulham Council and the Hammersmith & Fulham Clinical Commissioning Group.

Expenses and payments
Healthwatch Central West London will be covering any expenses related to the focus groups such as room booking, travel expenses of participants and refreshments.

Will my taking part be kept confidential?
We will not report your name or anything that would make you personally identifiable in any outputs from this project and we will ensure that data in this report is anonymised.

Contact details will be stored securely in our database and will not be stored in the same place as your data from the focus group. Healthwatch Central West London and its data storage procedures are fully compliant with GDPR. Please see the
privacy notice below for more details about the personal data we will collect from you and how it will be used.

What will happen when the project ends?
The collected anonymised data will be available in a published report. You anonymised data will be stored securely and then destroyed. You will not be contacted again about this or other projects, unless you sign up to be a Healthwatch Central West London member.

What will happen to the results of the project?
A report will be published on Healthwatch Central West London's website. The anonymous data will be stored securely at Healthwatch Central West London for up to two years after the project finishes. After two years this data will be reviewed and may be kept for a further three years. Your contract details will be destroyed securely after the end of the project. You will not be contacted again about this or other projects, unless you sign up to be Healthwatch Central West London member.

What will happen if I don't want to carry on being part of the focus group?

Participation in this focus group is entirely voluntary. Refusal to participate will not affect you in any way. If you agree to participate, you may nevertheless withdraw from the focus group at any time without affected you in any way. You have the right to withdraw from the study completely and decline any further contact by study staff after you withdraw. However, if the focus group has already commended, we may be unable to remove your anonymised responses.

Who is organising this focus group?
Healthwatch Central West London is organising this focus group, with help from Sobus. For the purposes of data protection legislation, HWCWL is the data controller for this project.

Who should I contact if I wish to make a complaint?
Any complaint about the way you have been dealt with during the study or any possible harm you might have suffered will be addressed.

Please address your complaint to:
Healthwatch Central West London
5.22 Grand Union Studios
332 Ladbroke Grove
London, W10 5AD

Email: info@healthwatchcentralwestlondon.org
Phone: 020 8968 7049

What if I want more information on this study?
If you have any questions about any aspect of the study, or your participation in it, not answered by this participation information sheet, please contact: Eva Psychrani at eva.psychrani@healthwatchcentralwestlondon.org

Focus Group Participation Consent Form

Focus Group Consent Form
Focus Group Participation Consent Form

You have been asked to participate in a focus group set up by Healthwatch Central West London.

1. I confirm that I have read and understood the participant information sheet dated October 2018 for the above study and the privacy notice at the end of the participant information sheet. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary, and I am free to withdraw at any time without giving any reason. However, it the focus group has started, I understand that it may not be possible to remove my data from the transcript.

3. I understand that all the answers in this focus group are captured and stored by audio recording equipment and any notes taken during this session.

4. The procedures regarding confidentiality and GDPR compliance (e.g. the anonymisation of data, etc.) have been clearly explained to me in the privacy

notice.

5. I agree to anonymised responses to be used in the final report by Healthwatch Central West London.

6. I agree to anonymised responses to be used in any other reports or communications arising from this focus group.

7. The archiving of data has been explained to me, e.g. I understand that my data will be securely stored for 5 years, in line with Healthwatch Central West London's Data Protection Policy.

8. I am aware that I need to be considerate of others and not repeat what other focus group members have said outside of this focus group. I am also aware that Healthwatch Central West London cannot stop or prevent participants who were in the group from sharing information that should be confidential.

9. I agree to take part in the above focus group. If you are under 18 years old this should be completed on your behalf by a parent or guardian.

Name:

Signed:

Date:

10. During the focus group, Healthwatch Central West London will be taking photographs to be used for promotional purposes and not to identify you. For full details please refer to the "consent form for the use of your image" available from HWCWL. Please tick the following boxes to indicate that you give consent for your photograph to be taken and used. If you are under 18 years old this should be completed on your behalf by a parent or guardian.

I consent for my image to be used to represent a fictional person.

I consent for my image to be used for the following purpose(s): In Healthwatch Central West London and Healthwatch England publications, on our website, in advertising and within the media

I consent for my image to be used by Healthwatch Central West London
I consent for my image to be kept by Healthwatch Central West London for five years.

Name:

Signed:

Date:

Focus Group Privacy Notice

Focus Group Privacy Notice
Focus Group Participation Privacy Notice

Who we are
Healthwatch Central West London is looking at young people and digital healthcare. For the purpose of data protection legislation, Healthwatch Central West London is the data controller for any personal data processed as part of this project.

How we will use your personal data
If you agree to participate, we will ask you to sign up to the focus group after reading the information sheet and signing the consent form. We will use your data to understand the health and care issues affecting you and monitor who we are hearing from in the local community.

The nature of your personal data that we will be using covers:

- Name
- Contact details
- Gender
- Age
- Ethnicity
- Religion
- Health information
- Sexual orientation

Why our use of your personal data is lawful
Under the GDPR, we are required to have a lawful basis for processing your personal data. For the purpose of this project, the lawful basis is ‘consent’ and ‘public task’.

Who will have access to your personal data
Access to your personal data will be restricted to the
Healthwatch Central West London staff and volunteers who are working on this project. We will not report your name or anything that would make you personally identifiable in any outputs from this project and will ensure that data in the report anonymised.

We will ask you and others in the group not to talk to people outside the group about what was said during the discussion. However, we need you to be aware that we cannot stop or prevent participants who were in the group from sharing things that should be confidential.

The collated researching findings will be published in a research report but none of your personal data will be included in the report.

Your right to withdraw
Participation is in this project is entirely voluntary. Refusal to participate will not affect you in any way. If you do agree to participate, you may withdraw from the study at any time: there will not be any consequences of this. You have the right to withdraw from the study completely and decline any further contact by study staff after you withdraw. However, if the focus group has already commenced, we may be unable to remove your anonymised responses.

How long we will keep your personal data
We will retain your anonymised data for two years after the project has ended, in accordance with Healthwatch Central West London's retention requirements for project data. This data will then be reviewed and potentially kept for a further three years. Your contact data will be destroyed after the end of the project.

Your data protection rights

Under certain circumstances, you have the right:

- To ask for access to information about you that we told
- To have your personal rectified, if it is inaccurate or incomplete
- To request the deletion or removal of personal data where there is no compelling reason for its
  continued processing
- To restrict our processing of your personal data (i.e. permitting its storage but no further processing)
- To object to direct marketing (including profiling) and processing for the purposes of scientific/historical research and statistics
- Not to be subject to decisions based purely on automated decision-making

If you need to contact us regarding any of the above, please email Healthwatch Central West London's Data Protection Officer at info@healthwatchcentralwestlondon.org.

For further information please see: https://healthwatchcwl.co.uk/privacy-statement/

Your right to complain
If you are unhappy with our use of your personal data, please let us know by contacting us at

Healthwatch Central West London
5.22 Grand Union Studios
332 Ladbroke Grove
London, W10 5AD
Email: info@healthwatchcentralwestlondon.org
Alternatively, you have the right to raise any concerns with the Information Commissioner's Officer (ICO) via their website at http://ico.org.uk/concerns/

Engagement Tool for Digital Healthcare

Introduction

During 2018/2019 Healthwatch Central West London did a project to identify health needs and aspirations of young people in Hammersmith and Fulham and to explore how these can be addressed by using digital technology.

For the purposes of the project we produced a baseline survey that aimed to understand the following:

- Which healthcare needs are important for young people and can be addressed by using digital technology
- Where can there be digital interventions
- Where do people go if they have a health problem
- What is their knowledge of existing digital services linked to health

We explored more the issues highlighted in the survey through a series of four focus groups that we conducted at Hammersmith and Fulham Youth Council, Youth Action on Disability, Sobus and St Andrews Church with a total of 32 participants aged 11-21 years during January – March 2019.

What is this toolkit?

This engagement toolkit gives details of the two exercises we created to run the focus group discussions. It acts as a guidance only, and facilitators should tailor it according to the issues they wish to explore and the needs of the group they are engaging with. The questions provided here can be applied to either exercise, in order to adapt to each discussion.

What is this toolkit not?

It is not the aim of this toolkit to provide information about engagement principles on how to run a focus group.

Who should use it?

We hope that this toolkit could be useful to anyone who is interested in actively engaging with people of any age around digital healthcare.

Exercise 1 - Discussing Health Issues

Aim: To inspire conversations about potential uses of digital healthcare based on wider health needs.

Materials: 30-40 pictures depicting key public health issues such as nutrition, mental health, sexual health, smoking etc. This needs to be tailored according to the specific audience.

Note: During Autumn 2018 we provided work experiences for one week to two students, aged 15-16 years old from Kensington Academy and we asked them to select pictures depicting health issues important for young people that we then use for the first exercise.

Estimated running time: 40 min (5 min picture selection, 5 min. discussion in pairs and 30 min open discussion).

Method: There are three main steps: Select picture; discuss in pairs; and then discuss in an open group.

- Lay all pictures on a big table
- Participants to spend a few minutes looking at all pictures and select one that inspires them
- Participants to discuss their selected pictures in pairs.
- Pairs could be formulated according to two different ways: Sitting arrangements (i.e. two people sitting next to each other) or - Theme selected (i.e. two people who hold a picture relating to the same issue; for example, mental health).

Questions for pairs to discuss:

1. Why did you choose that picture: what is interesting about it? What does it tell you?
2. What is the main issue/theme that is linked with that picture?
3. How can this issue/theme be addressed by using digital technology?

- Participants to come back into a group setting and have an open group discussion based on the conversations they had.

  Open discussion: The facilitator should encourage a discussion with open questions based on the pictures selected. They could also ask some specific questions:

- Do you look for information online for these issues? Where would you look for it?
- What websites are you looking for?
- What type of information would be useful to find (prevention, self-care, what to do, where to go)?
- What format you would like it to be?
- Do you think it’s important to have information only online or in other ways as well?

- Other ways that you can think of linking digital to your health?
- What are the elements that you wouldn't want to lose from "traditional" healthcare?

Learnings:

The young people we engaged with found using pictures to discuss health issues a fun and engaging way to collect their views.

- Having involved young people in the process of selecting pictures themselves helped better engage with the focus group participants that were of the same age group.
- Participants might not select pictures depicting issues that they are reluctant to discuss in a group setting. This does not mean that the depicted health issue is not important to them.

Exercise 2 - Health Journeys

Aim: To explore potential pathways for digital interventions by inspiring a visual representation of personal health journeys.

Materials: Pictures depicting key health places (i.e. hospitals), logos of digital applications (i.e. NHS 111 online) and professionals (i.e. GPs), as well as stickers of different faces (sad, happy, upset etc). Post it notes and coloured pens.

Estimated running time: 40 min. (10min to draw health journeys and 30 min for discussion).

Method: Ask participants to draw their own health journey and then discuss in an open group setting.

- Give clear instructions to participants of what you are asking them to do, inform them that the materials are there to be used should they wish to and they are not obliged to do so and most importantly state that they can choose if they want to share their drawing during the open discussion or not.
- Questions for the individual to explore to help them with their drawing:

Think about a time that you had a health concern or a problem and draw your own journey to address it.

a) What was the issue?
b) What were the steps you took?
c) Who did you contact first? Where did you go next?
d) What were your feeling in each place?

e) What would make things better?

- Participants to come back into a group setting and have an open discussion narrating their journey to the group.

Open discussion: The facilitator should encourage participants to share their experiences. Following narration, they should concentrate on a discussion with open questions based on what was shared. They could also ask the following questions:

- How did you find this exercise? What was easy/difficult about it?
- Is it important to you to see the same professional all the time? For which health issues?
- Is it important to be able to see someone quickly?
- Let's go around and see who everyone put as their first choice to contact. Why? Tell us more about it.
- What type of information you would like to see online to use that option first?
- Where in the journey could you have a digital intervention? Where you shouldn't have one?
- Are you checking your symptoms online?

Learnings:

- Asking to draw health journeys was very good for engaging with young people with learning disabilities and people of a younger age group (11-14 years old).
- We adapted this exercise by focusing on discussions instead of drawings around the different health places based on personal experiences. This has worked better for this age group.

Overall Learnings:

- Exploring health needs and how these can be addressed by digital technology allows space for innovation and meaningful suggestions. Starting with digital healthcare and asking people to fit it to their health needs, leaves no space for imagination and risks a superficial take on needs.
- The facilitator needs to be aware of the current digital healthcare climate to both inform participants and most importantly to direct discussions in a meaningful way.
- There is a need to reassure people that any engagement taken place around digital healthcare does not mean that face to face healthcare will be lost.
- People might not be familiar linking digital technology with their healthcare

despite having a smart phone or using digital in other aspects of their life. An overview of potential uses, and examples can help participants to envision a system of digital healthcare.

Healthwatch Central West London (HWCWL) is an independent organisation for people who use health and social care services. We deliver the statutory Healthwatch projects in Hammersmith & Fulham, Kensington & Chelsea and Westminster. Through our research and local engagement, we make sure that local people's views are always at the centre of decision making about health and social care.

Contact us to help improve health and social care!

Tel: 020 8968 7049

Email: info@healthwatchcentralwestlondon.org

www.healthwatchcwl.co.uk

Twitter: @healthwatchcwl

Facebook: HWCWL

Instagram: @healthwatchcwl

London Borough of Hammersmith & Fulham

Report to: Health, Inclusion and Social Care Policy and Accountability Committee

Date: 27/01/2020

Subject: 2020/2021 Medium Term Financial Strategy (MTFS)

Report of: Cabinet Member for Health and Adult Social Care – Councillor Ben Coleman
Cabinet Member for Finance and Commercial Services – Councillor Max Schmid

Responsible Director: Strategic Director of Social Care & Public Sector Reform
Strategic Director of Finance and Governance

Summary

Cabinet will present their revenue budget and council tax proposals to Budget Council on 26 February 2020. A balanced budget will be set in accordance with the Local Government Finance Act 1992***.***

This report sets out the budget proposals for the services covered by this Policy and Accountability Committee (PAC). An update is also provided on any proposed changes in fees and charges.

Recommendations

1. That the PAC considers the budget proposals and makes recommendations to Cabinet as appropriate.

2. That the PAC considers the proposed changes to fees and charges and makes recommendations as appropriate.

Wards Affected: All

H&F Priorities

Our Priorities	**Summary of how this report aligns to the H&F Priorities**
• Being ruthlessly financially efficient	We need to always confirm that spend fits our Council's priorities; challenge how much needs to be spent; and achieve results within agreed budgets. Finance is everyone's business and every penny counts.

Contact Officer(s):

Name: Emily Hill
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Name: Prakash Daryanani
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Background Papers Used in Preparing This Report

Not Applicable

Proposals and Detailed Analysis

The Budget Gap

1.1. The 2020/21 gross General Fund budget[1] is £525m of which the **net budget requirement of £154.3m** is funded from council resources (such as council tax and business rates) and general government grant.

Table 1 – 2020/21 budget requirement

Budgeted expenditure	**£m**
Housing benefit payments	110
Departmental budgets	415
Gross budgeted expenditure	**525**
Less:	
Specific government grants (including housing benefits and dedicated schools grant)	(234.5)
Fees and charges	(65)
Contributions (e.g. health, other boroughs)	(49)
Other income (e.g. investment interest, rentals	(22.2)

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[1] Figures exclude capital charges and internal service level agreements. These have a net nil impact on the budget.

and recharges)	
Budget requirement rolled forward to 2020/21	**154.3**

1.2. The budget proposals for 2020/21, and forecast to 2023/24, are summarised in Table 2. A balanced budget is proposed for 2020/21 with a contribution to reserves arising from one-off/ non-recurrent benefits, to enhance financial resilience, of £7.2m.

Table 2 - Budget Summary

	2020/21	**2021/22**	**2022/23**	**2023/24**
	£m	**£m**	**£m**	**£m**
Base budget	**154.3**	**154.3**	**154.3**	**154.3**
Add:				
Cumulative inflation (including pay awards)	4.2	8.4	12.6	16.8
Provision for future demand & demographic pressures	0	4.0	8.0	12.0
Investment	8.3	8.3	8.3	8.3
Increase in the unallocated contingency	0.9	0.9	0.9	0.9
Savings and additional income	-12.8	-13.5	-14.2	-14.2
Adjustment for one off items	0.1	0.1	0.1	0.1
Contribution to reserves	7.2	0	0	0
Budgeted expenditure	**162.2**	**162.5**	**170.0**	**178.2**
Less:				
Government resources	(34.2)	(34.2)	(34.2)	(34.2)
Business rates	(57.2)	(57.2)	(57.2)	(57.2)
Fair funding impact (estimate)	0	4.0	8.0	12.0
Council tax	(63.8)	(64.4)	(65.0)	(65.6)
One-off use of resources	(5.3)	0	0	0
Use of developer contributions for enhanced community safety	(1.7)	(1.7)	(1.7)	(1.7)
Budgeted resources	**(162.2)**	**(153.5)**	**(150.1)**	**(146.7)**
Cumulative budget gap	**0**	**9.0**	**19.9**	**31.5**

Budget Assumptions

1.3. **Government grant funding** will increase by £3.6m from 2019/20 to 2020/21 as a result of the Government's pre-election spending round in September 2019. This increase follows a decade of grant cuts with overall funding reducing by £68m from 2010/11 to 2020/21. This was a real terms funding cut of 54%.

1.4. However, the government have indicated they will undertake what they are terming a 'fair funding review' in 2020/21. This has the remit of reconsidering how grant is distributed between authorities. It is likely to be bad news Hammersmith and Fulham and other London authorities as it is anticipated that resources will be redistributed away from inner city areas, which have traditionally received funding to address higher levels of deprivation, to other parts of the country with lower levels of deprivation. The Council will campaign vigorously against any such distribution away from areas of higher need.

1.5. **The government has modelled an adult social care precept** since 2016/17. In the first years of the levy, the Council determined not to apply the levy in Hammersmith and Fulham, despite the fact the Council's funding from government was modelled on the assumption that we would. Due to the continued high levels of inflation in the social care market and the government's continued failure to propose a long-term funding solution to social care funding, the Council proposes to allow 2% of the government's adult social care levy for 2020/21. The total levy increase for Hammersmith and Fulham over the 5 years to 2020/21 will be 4% compared to the 10% increase assumed by the government. The Council is committed to using such funding to support adult social care.

1.6. **An increase in the Hammersmith & Fulham element of council tax** of 1.99% is modelled for 2020/21. This will generate extra income of £1.2m in 2020/21 and £4.9m over a four-year period. This will support investment in key services for residents and future financial resilience. The Hammersmith and Fulham Band D Council Tax charge is the third lowest in the country and 35% below the London average. This is significantly below the July 2019 Retail Price Index inflation used for the Council's financial planning.

1.7. **The business rates system,** as set out in Table 3, is changing for a fourth successive year. For 2020/21 the government have ended the pilot London Business Rates pool with the share of business rates retained by LBHF reverting to 30%.

Table 3 – Business Rates Retention Scheme

	2017/18	2018/19	2019/20	2020/21
Hammersmith & Fulham	30%	64%	48%	30%
Greater London Authority	37%	36%	27%	37%
Government	33%	0	25%	33%
Pool arrangements	None	100% pilot pool	75% pilot pool	Potential London pool
Business rates revaluation	Yes	No	No	No
H & F income (net of tariffs and adjusted on a like for like basis)				
H & F share of business rates	£59.5m	£56.5m	£57.0m	£57.2m
Pool benefit (1-year lag i.e. 2018/19 benefit recognised in 2019/20)	0	0	£4.3m (£2.3m to reserves)	£1.9m (to reserves)
Assumed in budget/contribution to reserves	**£59.5m**	**£56.5m**	**£61.3m**	**£59.1m**

1.8. London Local Government took forward a 100% business rates retention pilot in April 2018. This pooled business rates income across the 33 London Boroughs and GLA with all growth shared. The government reduced this to a 75% pilot in 2019/20 and have announced it will cease for 2020/21.

1.9. Current modelling forecasts that Hammersmith and Fulham will benefit by £1.9m from the 2019/20 pilot and this is assumed within the 2020/21 budget. As the pilot has ceased, the expected benefit is a one-off sum and therefore will be taken to reserves. The actual benefit will not be confirmed until September 2020.

1.10. London Local Government is developing a new pooling arrangement, without government support, for 2020/21. The financial benefit will be significantly less (as the government will take a higher proportion of the income raised and growth). No benefit is assumed from a possible new 2020/21 pool within the current budget forecast. Any benefit will be considered within the 2021/22 budget process.

1.11. Table 4 sets out the business rates budget for 2019/20 and 2020/21. The business rates system sets a safety net threshold which guarantees a minimum income to the Council. The 2017 business rates revaluation resulted in a high-level of rates appeals by businesses in LBHF. This has required the Council's share of business rates income to be budgeted at the safety net threshold of £57.2m. The safety net threshold is set at 92.5% of the funding baseline (compared to 95% in the pool) resulting in a lower guaranteed income from business rates.

1.12. The instability in the government's approach to business rates makes medium-term financial planning difficult.

Table 4: Comparison between 2019/20 and 2020/21 business rates income

	2019/20	2020/21
	£m	£m
Business rates baseline	123.0	78.0
Tariff payable to the government	(45.0)	(16.1)
Funding baseline	**78.0**	**61.9**
Safety net threshold (included in LBHF budget)	**74.1**	**57.2**
Less Revenue Support Grant collected within business rates in 2019/20	(17.1)	0
Budgeted business rates	**57.0**	**57.2**

1.11 An updated forecast for business rates will be undertaken by all boroughs in January 2020. This will confirm the Hammersmith and Fulham 2020/21 estimate and provide more clarity on the potential benefits from the 2019/20 pilot pool arrangements.

1.12 **Developer Contributions.** Planning obligations under s.106 of the Town and Country Planning Act 1990 (as amended), known as s.106 agreements, are a mechanism which make a development proposal acceptable in planning terms, that would not otherwise be acceptable. They are focused on site specific mitigation of the impact of development. Property developments have placed increased pressure on council services in recent years.

1.13 Local planning authorities are required to use the funding in accordance with the terms of the individual planning obligation legal agreement. This will ensure new developments are acceptable; benefit local communities and support the provision of local infrastructure. In LBHF there are three broad categories of s.106 contributions received:

- for a specific purpose defined and described in the s.106 agreement (such as specific highway works)
- for a general functional purpose defined and described in the s.106 agreement but with geographical constraints (such as provision of community infrastructure in the White City area)

- for a general purpose defined and described in the s.106 agreement but with no borough geographical constraints (such as economic development, education purposes, community safety initiatives etc).

1.15 Provided the Council respects the obligation to maintain a reasonable relationship with the developments and complies with the specific terms of each of the s.106 agreements giving rise to the funds, the Council has a degree of discretion as to how it allocates and spends some of the general purpose funds. The Council has determined that a key priority area for the investment of available s.106 funds with general purposes is the provision of enhanced community safety arrangements. The 2020/21 budget assumes that contributions of £1.7m are invested to fund enhanced arrangements in this area and this can be met from receipts currently in hand.

1.16 A number of s.106 agreements have been negotiated which will result in the receipt of additional funds in the future. There is a level of uncertainty around the receipt of future s.106 funds as this relies on developments commencing and achieving specified trigger points. The Council will continue to monitor the receipt of s.106 funds expected in the short and medium term, where the level of uncertainty around trigger points increases, and is developing a strategic approach for investment of future s.106 funds.

1.17 **Inflation**. A national pay award has yet to be agreed for 2020/21. Provision is made within the budget for an increase of up to 2% (£1.7m) and this will be held corporately until a national agreement is reached on the annual pay award. Inflation of £2.6m has also been provided, on a case by case basis, to meet contractual requirements.

INVESTMENT, SAVINGS AND RISKS

1.18 Investment in services and savings proposals for the services covered by this PAC are set out in Appendix 1 with budget risks set out in Appendix 2.

Investment

1.19 Investment in services is summarised by department in Table 5 and by category in Table 6.

Table 5: 2020/21 Investment Proposals

Department	£m
Children's Services	5.5
The Environment	0.5
Public Services Reform	0.1
Social Care	0.7
Council-wide	1.5
Total	**8.3**

Table 6: Categorisation of investment proposals

	£m
Increase in demand/demographic growth	6.4
Resident priority	1.9
Total	**8.3**

Savings

1.20 The Council faces a continuing financial challenge due to overall Central Government funding cuts, unfunded burdens, inflation, and demand and growth pressures. The budget gap will increase in each of the next three years if no action is taken to reduce expenditure, generate more income through commercial revenue and continue to grow the number of dwellings and businesses in the borough.

1.21 To proposed savings (including additional income) for 2020/21 are set out by department in Table 7.

Table 7: 2020/21 savings and additional income

Department	**£m**
Children's Services	(0.8)
Finance & Governance	(4.5)
The Economy Department	(0.8)
Public Services Reform	(0.3)
The Environment Department	(1.0)
Social Care	(2.5)
Council Wide	(2.9)
Savings	**(12.8)**

1.22 The saving proposals are categorised by savings area in Table 8.

Table 8: Categorisation of 2020/21 savings

	£'m
Service rationalisation/budget reduced in line with spend	(3.0)
Commercialisation/Income	(2.0)
Debt reduction and restructuring	(0.3)
Pension - triennial Valuation	(2.1)
Prevention	(1.5)
Procurement / Commissioning	(0.8)
Service reconfiguration	(0.9)
Staffing / Productivity	(2.2)
Total All Savings	**(12.8)**

Risk, revenue balances and earmarked reserves

1.23 The Council's General Fund gross budget is £525m. Within a budget of this magnitude there are inevitably areas of risk and uncertainty particularly within the current challenging financial environment. The key financial risks that face the Council have been identified and quantified. They total £18.5m. Financial risks of £24m were identified when the 2019/20 budget was set.

1.24 Reserves play a crucial role in good public financial management. They exist so that a council can make one off investment in service transformation for the future or to respond to one off unexpected events or emerging needs. They are the foundation for good financial management and resilience. As one-off resources they can only be spent once.

1.25 As part of the Audit Findings Report for the year ended 31 March 2019 the Council's external auditors (Grant Thornton) commented on the level of the Council's reserves:

> *'The Council's reserves level is of concern as there doesn't appear to be sufficient cushion to weather the ongoing financial challenges that the Council will face over the medium term due to reductions in central government funding and forecast pressures of the DSG funding. The Council only has finite reserves available and it is important that you continue to maintain appropriate budgetary control. It cannot be stressed enough how important it is to have a fall back position to address the challenges of the future. We have seen a number of Councils reach the financial precipice and members have a fiduciary duty to ensure the Council retains financial sustainability. We would strongly recommend that use of reserves remains limited in future years other than for specifically earmarked schemes.'*

1.26 The Council has put in place a reserves strategy to ensure effective oversight regarding the level and use of reserves and established an action plan to maintain reserves at an appropriate level. In accordance with the action plan, the 2020/21 budget proposals include new **one-off contributions to reserves of £7.2m.**

General fund balances

1.27 The Council's general balance stood at £19m as at 1 April 2019 and it is currently projected that this will not reduce in the current financial year. This will leave general balances at 3.6% (equivalent to 13 days spend) of the Council's gross budget of £525m.

1.28 Given the on-going scale of change in local government funding, and risks facing the Council, the Strategic Director, Finance and Governance considers that general balances need to be maintained within the range of £14m to £20m. The optimal level is projected to be broadly met over the next four years and is, in the Strategic Director's, Finance and Governance, view sufficient to allow for the risks identified and to support effective medium-term financial planning.

Earmarked reserves

1.29 The Council holds a number of one-off earmarked reserves. The latest forecast to 2023/24 is set out in Table 9. In the Strategic Director's, Finance and Governance, view such reserves are adequate to deal with anticipated risks and liabilities.

Table 9: Reserves forecast to 2022/23

	Opening balance 2019/20	Budgeted contributions to 2023/24	Commitments to 2023/24	Total 2023/24
	£m	**£m**	**£m**	**£m**
Earmarked reserves	44.8	36.1	(37.4)	**43.5**
New contributions in the 2020/21 budget				7.2
Forecast earmarked reserves				**50.7**
General balances	19.0			19.0
Earmarked restricted reserves	17.5		(7.7)	9.8
Current year forecast overspend				(9.5)
Other potential uses of reserves				(28.6)
Total reserves				**41.4**

1.30 The existing commitments include the planned investment of earmarked reserves on council priorities (for example implementing the Information Technology strategy and incentive payments to landlords).

1.31 Net General Fund reserves of £6m are set aside for the civic campus scheme. This is based, in line with the current programme, on funding of lease costs for a 3.5 year relocation. The call on general fund reserves would increase by £5.9m if relocation was deferred to 5 years. The scheme benefits include efficiencies in delivering modern, inclusively designed and fit-for-purpose office and civic accommodation for its staff and visitors, as well as for small and start-up businesses. It also avoids the need for significant capital investment in the existing Town Hall and Town Hall Extension, which in 2017 was estimated at between £29.2m and £53.5m for both buildings, depending on the extent of refurbishment works undertaken and excluded professional fees (estimated to be at least £2m) and the cost of decanting staff to allow works to take place.

1.32 The other potential uses for reserves includes allowance for a future shortfall in funding for **pupils with high needs.** For Hammersmith and Fulham, there was a cumulative shortfall in the Dedicated Schools Grant (from government) provided to fund expenditure on pupils with high needs of £13.8m at the close of 2018/19. The Council is developing options for a deficit recovery plan and estimates that it will receive extra grant of £2.9m from 2020/21 onwards. Despite this funding increase, demographic and other pressures, require that a further **£15m** be set aside regarding the shortfall for the current year and next 4 years. The Council is also discussing with auditors how this should be treated on the Council's Balance sheet following a consultation by the Education Funding and Skills Agency. Pending further clarification, the Council has prudently set aside a reserve to cover the potential deficit.

1.33 The Strategic Director, Finance and Governance considers that current reserves are adequate to deal with anticipated risks and liabilities. Reserves can only be spent once and the forecast to 2023/24 identifies a tightening in the Council's finances that will need careful management and review. Continued focus will be required on keeping spend within budget, avoiding the use of reserves to balance future budgets and on rebuilding reserves to support future investments and priorities.

FEES AND CHARGES

1.34 The budget assumes these are:

- Frozen for Adult Social Care, Children's Services and Housing.
- A standard uplift of 2.8% based on the July 2019 Retail Price Index applied for other non-Commercial and non-parking fees.
- Commercial services that are charged on a for-profit basis, will be reviewed on an ongoing basis in response to market conditions and varied up and down as appropriate, with appropriate authorisations according to the Council constitution.
- Parking charges and fines are set in line with transport policy objectives and are not considered as part of the budget process.

The list of the currently proposed exceptions to the standard increase for this Department, is set out in Appendix 4.

2020/21 COUNCIL TAX LEVELS

1.35 The administration proposes to increase the Hammersmith & Fulham element of council tax by 1.99% for 2020/21. The Band D charge will be £792.42. This is significantly below the July 2019 Retail Price Index inflation used for the Council's financial planning.

1.36 This will result in a net cash terms increase of 3.7% since 2014/15 and compares to real terms inflation[2] of 15% over the same period. Unlike before

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[2] As measured by movement in the Retail Price Index

2014, no grant has been offered by government to councils who freeze or cut council tax. Instead, since 2014/15 the government, within the grant process, have assumed a Council tax increase of 12.6%. The 1.99% increase will generate extra income of £1.2m in 2020/21 and £4.9m over a four-year period. This will support investment in, and protect, key services for residents and strengthen future financial resilience.

1.37 As set out below, 53% of dwellings are liable for 100% council tax with exemptions/discounts for council tax support claimants, students, care leavers and single person households.

Table 9: Liability for council tax

Total dwellings in the borough	90,500
Reductions:	
Exemptions (mainly students, includes care leavers)	(4,000)
Council tax support claimants (elderly & working age on low income)	(11,400)
Single person discount (25% discount)	(27,500)
Dwellings liable for 100% of council tax	**47,600** **53%**

1.37 **The government's modelled adult social care precept** levy of 2% will generate additional income of £4.9m over 4 years and £1.22m in 2020/21. This will increase the Band D Council Tax charge by £15.24 per annum (4.2p per day).

1.38 The overall increase in the LBHF element of the Band D charge, including the government's modelled 2% adult social care precept, is £30.40 (8.3p per day).

Table 10: LBHF Band D Council Tax Charge

2019/20 LBHF Band D charge	**£762.02**
Proposed H&F Element Increase of 1.99%	£15.16
Proposed Adult Social Care precept of 2%	£15.24
2020/21 Total LBHF Band D charge	**£792.42**

Comments of the Strategic Director of Social Care on the Budget Proposals

Budget context – Achievements, challenges and risks

Service background – Social Care

1.39 Social care funds the social care of 3,100 people. 2,600 live in the community and 500 people live in residential & nursing care. Social care has a total workforce of 280 people.

1.40 Since 2011/12 the social care net budget has decreased by £25m, which represents an overall 31% decrease in the net budget after allowing for savings delivered and growth funding. Despite these cuts, high demand and an increase of acuity of need and expectations, social care has balanced its budget and delivered £19.8m of savings over the last 5 years.

1.41 Over the same period the total number of people in care placements, home care and direct payments has increased by 295 people. This represents an overall 14% increase of people using social care.

Service background - Public Health

1.42 The Public Health service is fully funded by the Department of Health's Grant and will remain a nil cost budget to the Council. It is not guaranteed beyond 2021. For the first time since Public Health transferred into the local authority from the NHS, there will be an increase in the grant. In previous years, the funding to the Council has been reduced by £2.224m between 2015/16 and 2019/20. The Council's current base budget includes Public Health investment in Council services delivering Public Health outcomes of £6m.

1.43 Key achievements - Social Care

- We have a policy not to charge for home care and haven't charged for home care since 2015.
- We offer a meals on wheels service that costs our residents £2.00 per meal, one of the lowest in London, if not nationally.
- We offer the London Living Wage to all our contractors and their sub-contractors.
- We achieved a **Very Good** result from our ADASS Safeguarding Peer Review in June 2019 and achieved **Outstanding** for the Leadership team.
- Two services rated as **Outstanding** by CQC - Community Independence Service & Rivercourt.
- We are improving service satisfaction and one way we have measured this is evidenced by lots more recorded service compliments.
- Very good performance on reducing delayed transfers of care, H&F is now the 3rd lowest in London which significantly saves costs for the NHS.

Building excellence and compassion – our next steps

1.44 Since July 2017, the department has been working hard to build its foundations for the next phase of strategic changes. This phase looks very different to traditional social care departments elsewhere in the country as it challenges the culture and the concept that social care is care for older people and something that is done to people instead of with them.

- We are using a strength-based approach to work with our people. Simply put, our conversation focuses on ‘What are your strengths?’ rather than simply ‘What are your weaknesses?’.
- We will provide better information and advice, so people understand what choices are available to them.
- We will increase our offer of reablement, so people can regain independence and achieve things that matter to them.
- We will look for quick, practical solutions which empower both people and staff to deal with problems as they arise.

1.45 **We will continue to have another ground-breaking year of firsts.**

- ✓ Co-produced Independent Living Vision, this will be the first in the country.
- ✓ No occupational therapy waiting list, the first borough to achieve this in London, probably in the UK.
- ✓ Real time reporting of activity and costs.
- ✓ Predictive modelling of resident behaviour. For example, risk of hospital admission & dementia.
- ✓ Co-produced commissioning roles.
- ✓ New market position statement inclusive of the world of commerce, leisure & technology.
- ✓ Proactive leadership of the Disabled People’s Organisation for the direct payments service.
- ✓ Prevention strategy with resident feedback through resolution focus.
- ✓ Introduced new AI and robotics into our care offer and we have great ambition to grow and modernise the service in this area.

Care market

1.46 We have produced a market assessment analysing the social care market and advising the recommended inflation to be applied to social care contracts in 2020/21. Under the Care Act, there is an obligation for the Council to maintain and facilitate a market for social care. The key recommendations are:

- Home Care – increase of 3.60% as this equates to the average increase in the London Living Wage over the last 4 years.

- Placements – increase of 3.62% for residential beds and 3.56% for nursing beds as this is the 12-month rolling average increase covering existing and new placements.

1.47 The budget has made provision for 2.1% in home care and placements.

Social care investment

1.48 There are two proposals for investment in 2020/21. 1) Demographic Pressures and 2) Learning Disability Transitions. The growth requested represents 0.1% of the revised gross expenditure of the department and favours considerably with other departmental requests. Please refer to Appendix 1 for further detail of each growth proposal.

Investment	2020/21 (£000’s)	2021/22 (£000’s)	2022/23 (£000’s)	2023/2024 (£000’s)
Demographic Pressures	590	1,528	2,492	3,484
Learning Disability Transitions	177	671	735	810
Total	**767**	**2,199**	**3,227**	**4,294**

Savings strategy

1.49 There are savings of £2.465m in 2020-21 rising to £4.015m in 2023-24 for Social Care. In Public Health, there are savings of £0.430m in 2021/21 rising to £0.710m in 2023-24 which will be reinvested in the service.

Firm Change and Savings Proposals	2020-21 Budget Change Cumulative (£000's)	2021-22 Budget Change Cumulative (£000's)	2022-23 Budget Change Cumulative (£000's)	2023-24 Budget Change Cumulative (£000's)
Social Care	2,465	3,915	4,015	4,015
Public Health	430	710	710	710

1.51 The RAG ratings for the savings business cases have been reviewed to reflect the potential impact on residents. Of these savings, 80% represent a medium delivery risk for Social care. So far, Social care has identified £4.0m medium-term savings which represents 7.3% of the net budget.

Social care

1.52 Our future savings plan aims to deliver change at a time of increasing demand, uncertainty and risk. Many of the proposed savings require partnership working with local people, their families and friends, Health, housing and other community stakeholders.

1.53 Delivery will be supported by various programmes of work that focus on the following:

- Prevention – savings of £1.5m
- Procurement/ Commissioning – savings of £0.25m
- Service reconfiguration – savings of £0.715m

Total savings of £2.465m

Public Health

1.54 The impact of 2020-21 efficiencies proposals is detailed in this report. All expenditure and savings will be contained within the ring-fenced Public Health grant budget and earmarked reserves.

- Procurement/ Commissioning – savings of £0.370m
- Staffing/ Productivity - £0.060m

Total savings of £0.430m

1.55 Please refer to Appendix 1 for further detail of each savings proposal.

Risks

1.56 Social care have identified two main and interrelated risks for financial management.

1.57 Firstly, increasing demand for statutory services and market price that we must provide that is over and above what we have catered for. There is an inherent level of risk around the modelling that we undertake and continuing risk to further reductions in market supply and increases in workforce costs with Brexit. We are managing this risk through continued close tracking and market management and have requested additional funding as detailed in Sections 1.40 & 1.41 above.

1.58 Secondly, identifying and delivering all opportunities to better manage demand particularly through the joint work with NHS partners, other council departments particularly housing, the third sector and other providers. We have a good track record of delivering efficiency savings and tactically managing resources to achieve a balanced budget. However, there are a range of more complex opportunities that have risks and dependencies to manage and have a longer lead in time.

1.59 These include work to refocus our mental health services on recovery in the community, reducing use of placements for people with learning disabilities particularly young people and establishing a fully joined up system for managing older people with the highest risk of losing independent living capacity. We are managing these risks through the development of a local programme of transformation work in partnership and led by our commitment to coproduction.

1.60 In Public Health the following risks are identified on the delivery of the proposed savings. The allocated GUM activity budget may not be sufficient to deal with the demand on services. This is due to unexpected increase in screening costs associated with the Department of Health release of new places for the Prep pilot. Also, whilst channel shift to online testing is successful, clinic slots are being backfilled as sexually transmitted infections (STIs) are increasing. We are managing this risk through close local monitoring of the budget and monitoring of demand with London commissioners.

1.61 Appendix 2 provides further details and mitigating actions.

Fees and Charges

1.62 Despite central government funding cuts, the administration proposes to continue its commitment to making life more affordable for Older and Disabled residents by providing home care free of charge, low cost meals on wheels and not increasing Careline charges.

1.63 The cost of meals on wheels to residents is currently only £2, reduced from £4.50 in 2014/15. This would maintain the £2 charge for a fifth consecutive year and freezing Careline charges for a fourth consecutive year.

1.64 See Appendix 4 for further details.

Equality Implications

1.65 A draft Equality Impact Analysis (EIA), which assesses the impacts on equality of the main items in the budget proposals relevant to this PAC, is attached as Appendix 3. A final EIA will be reported to Budget Council.

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

No.	Description of Background Papers	Name/Ext. of holder of file/copy	Department/ Location
1.	None		

List of Appendices:

Appendix 1 – Savings and investment proposals

Appendix 2 – Risks

Appendix 3 – Draft Equality Impact Assessment

Appendix 4 – Fees & Charges not Increasing at the Standard Rate

Social Care

Firm Change and Savings Proposals					Budget Change			
Ref Nos	**Service**	**Title & Theme**	**Summary**	**Delivery Risk (H-M-L)**	**2020-21 Budget Change Cumulative (£000's)**	**2021-22 Budget Change Cumulative (£000's)**	**2022-23 Budget Change Cumulative (£000's)**	**2023-24 Budget Change Cumulative (£000's)**
SC1	Operations, Learning Disabilities & In-House	Better demand management and choice from acute hospitals	Reviewing much earlier and more effectively the arrangements on discharge from acute hospitals and making the right choices in relation to the next steps for older people. Review care needs to determine if they meet NHS Continuing Health Care funding.	M	(1,500)	(1,500)	(1,500)	(1,500)
SC2	Operations	Home Care – Improve contract management.	Prioritising reviews with people and taking very prompt action after "No replies" and cancellations of provision with the home care providers.	L	(250)	(250)	(250)	(250)
SC3	Operations, Learning Disabilities, Mental Health & In-House	Ongoing review of staffing	Continued monitoring and review of social care staffing structures and budgets through monthly staffing board & budget management meetings chaired by the Director.	H	0	(200)	(200)	(200)
SC4	In-House	Transport	Review transport model at options day services - working with our people and their carers to co-produce transport options which respect their individual circumstances and that promote independent living.	M	(100)	(100)	(100)	(100)
SC5	Mental Health	Better Mental Health Care and Support Services for new and existing demand	Supporting the transfer of our people from expensive out of Borough residential placements back into local supported accommodation, to further develop our supported housing offer and to deliver better outcomes for our residents	M	(165)	(165)	(165)	(165)
SC6	Learning Disabilities	Continued improvement of Transitions work	Further work with young people and their families to co-produce and communicate what happens at every stage of their transitions journey. Focused multi-agency work from Year 9 in schools; further development of information what's available locally in terms of education; supported employment and independent living. Work with commissioning to expand local services for young adults which enable them to achieve good outcomes in Hammersmith and Fulham.	M	(200)	(200)	(200)	(200)
SC7	Operations, Learning Disabilities, Mental Health & In-House	Change the way we approach carrying out assessments using a co-production approach	Work with the co-production team to review our procedures, involve people in sign posting and initial conversations to understand what people are able to do and how we support independent living.	H	0	(800)	(900)	(900)
SC8	Adults Commissioning	Supply and contract management	There are a number of re-commissioning opportunities for floating support services which will develop the offer, improve value for money and be subject to tighter contract monitoring.	H	(250)	(500)	(500)	(500)
SC9	All divisions	Introduce technology in how we work with people	Use of technology, to improve communications with people, access to information and advice and promote independence.	M	0	(200)	(200)	(200)
Social Care - Total Firm Change and Savings Proposals					**(2,465)**	**(3,915)**	**(4,015)**	**(4,015)**

Appendix 1

Demographic & Growth Requests					Budget Change			
Ref Nos	**Service**	**Title & Theme**	**Summary**		**2020-21 Budget Change Cumulative (£000's)**	**2021-22 Budget Change Cumulative (£000's)**	**2022-23 Budget Change Cumulative (£000's)**	**2023-24 Budget Change Cumulative (£000's)**
SCG1			Mental Health & Learning Disabilities - demographic pressures & more complex needs.		590	1,528	2,492	3,484
SCG2			Learning Disability Transitions - increasing number of disabled children transitioning into adult services.		177	671	735	810
Total					**767**	**2,199**	**3,227**	**4,294**

Appendix 2: Social Care Budget Risks 2020/24

		Risk				
Department & Division	**Short Description of Risk**	**2020/21 Value (£000's)**	**2021/22 Value (£000's)**	**2022/23 Value (£000's)**	**2023/24 Value (£000's)**	**Mitigation**
Social Care						
All divisions	There is the potential for contract market inflation and wage pressures to be greater then budget provided for.	942	846	846	846	Social Care will set up a task and finish group of staff from within Commissioning and Brokerage to negotiate with providers on the inflationary increases to be awarded. A recommendation will be presented to the Social Care Leadership team to make a final decision.
Operations	Year on year savings programmes are increasingly difficult to deliver.	600	600	600	600	The Director has a monthly budget monitoring board meeting which will monitor savings programme and identify compensating actions for potential non-delivery.
All divisions	Existing budget pressures and the full year effect / costs in 2020/21 of residents entering the care system in 2019/20	1,100	1,100	1,100	1,100	Regular reviews of residents care needs to ensure that care plans accurately reflect current assessed care needs.
All divisions	Liberty Protection Safeguarding new burdens (system implementation in 2020/21 and training costs starting in 2021/22)	100	200	200	200	The code of practice is expected to come before Parliament in spring 2020.
All divisions	Non-recurrent grant funding of Winter pressures ending in March 2021.	0	918	918	918	The Council is waiting for the announcement of the Government's 'fair funding' review to see how the impact of non-recurrent grant funding may be distributed.
All divisions	Ending of Improved Better Care Fund in March 2021.	0	8,814	8,814	8,814	
Social Care Total		**2,742**	**12,478**	**12,478**	**12,478**	

Appendix 3

DRAFT

Equalities Impact Assessment 2020/21

Social Care and Public Health

SC1 - Better demand management and choice from acute hospitals - £1,500,000

1. This business case is about reviewing residents sooner after discharge to avoid them continuing with a larger support package than is needed and thus becoming dependent on it. The first proposal is around the role of social care to support residents upon leaving hospital to regain as much mobility and confidence (and therefore independence) as possible.

2. For every day someone is in a hospital bed, they lose mobility. When someone who previously had low level support needs is discharged home after a significant stay in hospital, they may require more support (in the short term) than when they entered. Similarly, residents who before a period in hospital needed no support may now require it. This support is put in place before a resident leaves the hospital, but once home and in a familiar environment, residents generally improve rapidly over the next few weeks.

3. The second part of the business case relates to making better use of NHS and other funding streams where appropriate, including Continuing Health Care (CHC) and Funded Nursing Care (FNC). This work has already begun and seen some recent successes. The proposal is about ensuring the right amount of support is in place for the right amount of time – preventing overprovision and ensuring that the optimum funding streams are being utilised.

4. This proposal has a neutral equalities impact.

SC2 – Home Care – Improve contract management and payment of no replies and cancellations of home care packages - £250,000

5. There are two parts to this proposal – working with residents and working with home care providers.

6. H&F is the only local authority in the country which provides a home care service which is free at the point of need rather than means-tested. If a carer visits a resident and they are not there or a resident cancels a visit with less than 24 hours' notice, H&F are still liable to pay the home care provider for this visit. This business case is about reducing the number of no replies and cancellations which have a significant

cost, both financially and in staff time (as where there is no reply, staff will work until they are able to locate the resident to ensure their safety).

7. Frequent failed visits may indicate that something is not working – a resident may no longer want the support and so is turning a carer away or the support may be being provided at a time which does not fit with their lifestyle. By reviewing such residents, social care has started to make significant progress in this area. Staff have also been encouraging residents to cancel or rearrange not-needed visits (for example due to a GP appointment) as soon as possible.

8. As with SC1, it is about ensuring the right sized package for a resident and a service which works for them. It may be that a resident's support package is reduced as a result of this work, this will only be done with their agreement.

9. The second part of the proposal relates to home care providers. When a carer visits a resident, they are required to clock in and clock out using electronic monitoring. Increased staffing has led to greater scrutiny of provider behaviour, challenging coding and withholding payments where warranted.

10. This proposal has a neutral equalities impact.

SC3 – Ongoing review of staffing - £200,000 in 2021/22

11. Over the last two years, recruitment of qualified social workers and occupational therapists has been difficult, resulting in more expensive agency staff and an increasing workforce budget. Part one of the work has been to review the Council's job descriptions, pay and terms & conditions compared to other local authorities. By improving the offer, the Council should be able to attract more workers to these roles. The department is also reviewing our functions to reduce the number of qualified workers needed as many tasks can be undertaken by other roles e.g. independent living assessors.

12. This proposal relates to better resourcing and deployment of staff. The department will continue to be measured by the same resident-focused performance measures e.g. percentage residents receiving a steady home care package being reviewed every 12 months. Residents will not experience a decline in service.

13. This proposal has a neutral equalities impact.

SC4 – Transport - £100,000

14. This proposal seeks to review the transport model for the Options Day Service – working with residents and their families to co-produce transport options which respect their individual circumstances and promote independent living.

15. The Options Day Service is for residents with moderate to complex Learning Disability support needs. It has repeatedly received an ‘Outstanding’ inspection rating by CQC for its goal-orientated work to make meaningful progress and improve resident independence. The service has gone from strength to strength in the past few years, creating partnerships with local schools, visiting Africa and setting up a social-enterprise to name but three developments. The transport options however remain fairly traditional, with residents being collected from their home/place of residence via mini-bus and taken to the centre. Depending on where they live on the route, some residents may spend a long time on the bus while others are collected.

16. This proposal involves staff working with people who use the Day Service, using the same goal-orientated approach as elsewhere in the service to travel as independently as possible. For some, this may be completely independently, for others this may involve support or travel in a small group with friends.

17. Changes will be made working with residents and their families to design the options, appreciating individual circumstances and choices throughout. No resident will be prevented from accessing the centre through these transport changes.

18. As the Options Day Service is for residents with Learning Disabilities, this proposal will have a disproportionate impact on a protected characteristic. However, as previously stated, the proposed changes will not prevent anyone from accessing the Options Day Service and thus there is a neutral impact. Transport reviews have featured in previous years budgets for different parts of the service and have been successfully delivered.

19. This proposal has a neutral equalities impact.

SC5 – Better mental health care and support services for new and existing demand - £165,000

20. An extensive programme of reviewing the mental health pathways involving colleagues from commissioning, operations, clinical teams, housing and IMPOWER has taken place over the last year.

21. The programme has identified that although there is a good current mental health supported housing system in place, there are systemic issues which need to be addressed. Such accommodation should never be a permanent solution, but there is a lack of move on from services with an estimated 20-30 residents, who could with the right support, move from expensive out-of-borough residential placements back into local supported accommodation. Gradually stepping down their support would improve their independence and returning in-borough would return them to familiar networks, families and community mental health services. Out-of-borough placements are also generally more expensive and more difficult for H&F to monitor the quality.

22. Moves would be managed using a strengths-based, co-production approach to mitigate against any impact. As part of co-production we will work with residents and their family members to prepare an appropriate care setting. Some residents have lived in provision for many years and will require close working with them and their families to manage the transition in a phased manner, which will ensure there is no adverse impact upon them. Modest savings are being planned due to spending on extra support during transition.

23. This proposal will have a neutral equalities impact.

SC6 – Continued improvement of transitions work - £200,000

24. A new purpose-built property for residents with learning disabilities is due to complete in September 2020. This property, W12 Emlyn Gardens, will contain eight individual specialist flats keeping residents local to the community they grew up in, their networks, families and carers. This is the preferred service model of local residents.

25. The new development is purpose-built for a mixture of young people transitioning into adult services and adult residents currently placed out-of-borough. By creating new in-borough provision, H&F can improve its offer to residents, enable them to stay close to home and avoid expensive out-of-borough placements. 18 residents have been identified as being suitable to move into the new properties as part of this project. The final list will be created nearer the time by working closely with residents.

26. This proposal has a neutral equalities impact.

SC7 – Changing the way we approach carrying out assessments using a co-production approach – £800,000 in 2021/22

27. A strengths-based review system has recently been set up, refocussing conversations from a deficit model (what can't you do), to a strengths-based one (what can you do) and building on those skills. This includes looking at personal abilities, skills and knowledge; social networks and community resources/social capital (including benefits maximisation and applying for NHS funding where appropriate).

28. A co-production approach means working more collaboratively with residents, promoting opportunities for residents to be co-producers of services and support rather than solely consumers of services. This work is still in the early stages and changes in culture and practice take time, though there have been some initial successes resulting in savings of £200,000 in 2019/20. A staff conference and follow-up training sessions are being held to embed the principles. This proposal is

about realigning care packages based on needs. There will therefore be no reduction in service.

29. This proposal has a neutral equalities impact.

SC8 – Supply and contract management - £250,000

30. Social Care currently commissions three separate floating support contracts which are resulting in overlap and duplication. Floating support is about supporting individuals in a crisis; typically relating to tenancy issues. Floating support also provides drop-in sessions for residents; typically, this will involve help with correspondence.

31. Historically, parts of these services have been underutilised, particularly the services for residents over 55. This proposal sees the three contracts merged into one to make efficiency savings. Commissioning will also work to create a more developed offer which is better targeted and supports individuals to build resilience, reducing the frequency and severity of crises and resulting in associated savings.

32. A full EIA will be produced in line with the procurement timescale during the next financial year. These are expected to be neutral in all but potentially one area – over 55s as it will represent a decrease in their bespoke service. However, the general offer will continue to be available for them and there are other alternative services which serve very similar functions that existing clients can be signposted to .

33. This proposal has a neutral equalities impact.

SC9 – Introduce technology in how we work with residents - £200,000 in 2021/22

34. The department is seeking to utilise new technologies and robotics in social care. This is not about replacing care workers with robots but putting aids into a resident’s home to help them to better support themselves – for example, using technology to remind a resident to take their medication or that they haven’t drunk anything that afternoon - which helps them to stay well and reducing non-elective admissions. Testing of equipment is beginning, working closely with residents.

35. This proposal seeks to improve quality of life. Savings will come from increasing a resident’s independence so they need less formal support.

36. This proposal has a neutral equalities impact.

Public Health Savings Proposals

PH1 – Savings and procurement of new model for health visiting and school nursing – £220,000

37. ‘0-19’ is currently delivered by Central London Community Healthcare (CLCH) on a two-year contract 1 April 2019 – 31 March 2021. A reduction in funding for year two has been negotiated and agreed with the provider. The saving is being achieved through a collaborative service streamlining and redesign of some areas. The savings are primarily contractual – residents will not notice a change in service and therefore the equalities impact is neutral.

38. There is one area which may be decommissioned – a specific Family Nurse Partnership (FNP) which provides support for pregnant teenagers. The teenage pregnancy rate halved in H&F between 2009 and 2015, at which point there were 41 conceptions to women under the age of 18. This service is therefore being underutilised and because of its peer support nature, without sufficient numbers this service is less effective.

39. A general service for mothers is already provided which is of good quality and sufficient capacity to expand to provide a service for young mothers. Therefore, a better service can be provided for less by providing focused, specialist support for young parents through existing contracts.

40. This part of the proposal will disproportionately impact on three protected characteristics because the service is for women (sex), who are under 18 (age) and pregnant (pregnancy/maternity), however a high-quality support service for this group will still exist and therefore the overall equalities implication is neutral.

41. This proposal has a neutral equalities impact.

PH2 – Core drug and alcohol services – £280,000 in 2021/22

42. Public health currently commissions three separate drug and alcohol services for adults and young people. The current contracts come to an end on 31 March 2021. Although this proposal is for savings in 2021/22, and thus in its infancy, it is proposed that these three contracts be combined into one, with efficiency savings made through re-procurement and a reduction in associated management costs. This saving will be worked up in more detail as part of next year’s budget.

43. Savings are being made through efficiencies rather than reductions in front line services.

44. This proposal has a neutral equalities impact.

PH3 – Enhanced access to contraceptive and screening services - £150,000

45. Hammersmith & Fulham provides a high number of sexual health, screening and contraception services, including SASH (Support and Advice on Sexual Health) GUM (Genito Urinary Medicine), SHL (Sexual Health London), LARC (Long-Acting Reversible Contraception), GP services and more.

46. On 30 March 2020, a contract for screening and contraception with CNWL (Central North West London NHS Trust) will end. This service provides a comprehensive economy range of contraceptive methods, STI testing, screening and treatment for uncomplicated infections. It is proposed that this contract is not extended or recommissioned. Residents have been choosing to go elsewhere, using other services in the borough which has resulted in this service being under utilised and thus not cost effective. Furthermore, if this service is continued, the contract cost would significantly increase as other boroughs have left the partnership for similar reasons.

47. Removing this service will have a neutral equalities impact, as there are sufficient services elsewhere. Wait times for other services will continue to be closely monitored to ensure sufficient coverage.

48. This proposal has a neutral equalities impact.

PH 4 – Review of Social Care & Public Health Commissioning - £60,000

49. The proposal is to bring Social Care and Public Health Commissioning under one line management structure which would mean an improved and strengthened shared programme of work. The intention is to provide a co-produced and greater focussed strategy on delivering commission-led savings.

50. The proposal has a natural equalities impact for both residents and staff.

Social Care
Fees & Charges

2020/21

Fee Description	2019/20 Charge (£)	2020/21 Charge (£)	Proposed Variation (%)	Reason For Variation Not At Standard Rate
Meals service charges	**£2.00**	**£2.00**	⇨ 0.0%	There is no change proposed in the flat rate contribution residents will pay towards the meal service for 2020/21. This will be the fifth year the meals charge will remain unchanged. However, the meals numbers are continuing to increase year on year reflecting the greater estimated income stream figure for 2020/21. The meals service is expecting 40,000 meals to be delivered at arate of £2.00 per meal which with a projected income of £80,000.
1. Careline Alarm Gold Service (Pendant)				
Private Clients (Home owners & Private Sector Tenants)	**£23.14**	**£23.14**	⇨ 0.0%	There is no change proposed in the Careline charge in 2020/21, which will be no change for four years. The Council is planning to co-produce the development of a different model which will encourage a partnership approach and a marketable service to residents.
Council Non-Sheltered or Housing Association (RSL) Tenants	**£17.21**	**£17.21**	⇨ 0.0%	
2. Careline Alarm Silver Service (Pendant) - Monitoring Service only				
Private Clients (Home owners & Private Sector Tenants)	**£16.12**	**£16.12**	⇨ 0.0%	
Council Non-Sheltered or Housing Association (RSL) Tenants	**£10.30**	**£10.30**	⇨ 0.0%	
3. Careline Alarm Gold Service (Pull cord) - Emergency Response & Monitoring Service				
(A) Provided to Registered Social Landlord Sheltered Accommodations (RSL Financed)	**£6.76**	**£6.76**	⇨ 0.0%	

London Borough of Hammersmith & Fulham

Report to: Health, Inclusion and Social Care Policy & Accountability Committee

Date: Monday, 27 January 2020

Subject: Work Programme

Report of: Bathsheba Mall

Summary

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

Recommendations

The Committee is asked to consider the proposed draft work programme (attached as Appendix 1) and suggest further items for consideration

Wards Affected: All

H&F Priorities

Our Priorities	Summary of how this report aligns to the H&F Priorities
- Building shared prosperity	*In accordance with its constitutional terms of reference the work of the Committee will support the Council's priorities by helping to develop, shape and deliver health and social care services for the benefit of all borough residents.* *The Work Programme comprises of health and social care topics, ensuring an inclusive agenda of emerging and strategic policy areas.*
- Creating a compassionate council	
- Doing things with local residents, not to them	
- Being ruthlessly financially efficient	
- Taking pride in H&F	

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Background Papers Used in Preparing This Report

None.

List of Appendices:

Committee 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 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.	**MEETING CANCELLED**
27 January 2020		
Budget	MTFS ASC and Public Health	SAEB
NHS Updates	CQC Ratings for GP Practices Palliative Care Provision Parsons Green Walk In Clinic CCG Clusters	H&F CCG
Healthwatch update	Healthwatch to report back on their recent activities.	Healthwatch
24 March 2020		
SAEB	Presentation of LBHF, Safeguarding Adults Executive Board by the Chair, Mike Howard.	
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.	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