Harrow COUNCIL LONDON

NORTH WEST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES

2 AUGUST 2012

Chairman:

Councillor Lucy Ivimy (LB Hammersmith & Fulham)

Councillors:

Ms Maureen Chatterley (LB Richmond, Co-opted Scrutiny Committee Member)
Councillor Mel Collins (LB Hounslow)
Councillor Sheila D'Souza (City of Westminster)
Councillor Pam Fisher (LB Hounslow)
Councillor Abdullah Gulaid (LB Ealing)
Councillor Pat Harrison (LB Brent)
Councillor Krishna James (LB Harrow)
Councillor Sandra Kabir (LB Brent)
Councillor Sarah McDermott (LB Wandsworth)
Councillor Rory Vaughan (LB Hammersmith & Fulham)
Councillor Charles Williams (RB Kensington & Chelsea)

Also Present: Dr Mark Spencer (Medical Director, NHS NW London), Daniel Elkeles (Director of Strategy, NHS NW London), Luke Blair (Comms Lead, SAHF) Peter Molyneux (JHOSC Support)

Officers: Andrew Davies (LB Brent), Kevin Unwin (LB Ealing), Sue Perrin (LB Hammersmith & Fulham) , Nahreen Matlib (LB Harrow), Deepa Patel (LB Hounslow), Gareth Ebenezer (RB Kensington & Chelsea), Ofordi Nabokei (LB Richmond), Mark Ewbank (City of Westminster)

Apologies:

Councillor Sue Jones (LB Richmond) Councillor Anita Kapoor (LB Ealing) Councillor Mrs Vina Mithani (LB Harrow) and Councillor Mary Weale (RB Kensington & Chelsea)

1. Welcome and Introductions

The Chairman welcomed those present to the meeting. She proposed that item 6 be taken first, followed by items 5, 7, 8 and 9 if there was sufficient time. This was agreed.

2. Declarations of Interest

RESOLVED: To note that the following interest was declared:

Agenda Item 6, 7 and 8 – Main Themes for the Meeting, Progress for Public Consultation, Evidence Required for Future Meetings

Councillor Krishna James declared a disclosable non-pecuniary interest in that she was a former nurse and had worked for the NHS. She would remain in the room whilst these matters were considered and voted upon.

3. Minutes of the Last Meeting

RESOLVED: That the minutes of the meeting held on 12 July 2012, be taken as read and signed as a correct record and the minutes of the informal briefing held on 6 July 2012 be taken as read and signed as a correct record, subject to the following amendments:

the final sentence in paragraph 3.1 on page 3 to read:

'It was reported that doctors understood the proposals of moving to a reduced number of sites. It was reported that few consultants would not argue for fewer sites.'

the final sentence in paragraph 3.18 on page 6 to read:

'The Member from H&F reported that financial assessments could be wrong and restated a second request for NHS NWL to consider the split site suggestion and asked NHS NWL to provide a response.'

It was noted that David Clegg's name throughout the minutes should read David Slegg.

4. Matters Arising

RESOLVED: To note there were no matters arising.

5. Structure of the Joint Health Overview and Scrutiny Committee

The Chairman stated that when the Chairman and Vice-Chairman of JHOSC had been nominated, there had been no Liberal Democrat Member on the Committee. She asked if Members felt strongly that a second Vice-Chairman should be appointed. Following brief discussion, the Committee agreed to retain its current membership and chairing arrangements.

RESOLVED: That the Committee retain its current membership.

6. Main Themes for the Meeting (Oral)

(a) Analysing the risks associated with the Implementation of 'Shaping a Healthier Future' Proposals:

(b) Underlying Assumptions behind 'Shaping a Healthier Future' Proposals:

(c) Demographics Drivers for the 'Shaping a Healthier Future' case for change:

The Committee were given a presentation by Professor David Welbourn, Visiting Professor in Health Systems Management, Centre for Health Enterprise at Cass Business School relating to the proposals in the Shaping a Healthier Future report, focussing on associated risks and a second presentation by Dr Alasdair Honeyman, Associate at the Kings Fund, about the demographic drivers for the 'Shaping a Healthier Future' case for change.

Professor Welbourn made the following points about current healthcare provision in the UK:

- transforming healthcare provision in the UK was not merely about money and resources. Although the USA spent double what the UK did on healthcare, at least 90,000 people died each year in the US as a result of inadequate healthcare provision;
- the Organisation for Economic Cooperation Development (OECD) figures showed that the UK had the fastest growing mortality rate in the West;
- the needs of NHS patients had changed dramatically over the last 20 years. In the past the NHS had focussed on treating infectious diseases. However, medical advances in recent years had meant that the NHS was now focussing on delivering interventions that enabled patients to survive their illnesses and live longer. 30% of the UK population were living with the consequences of long-term conditions such as diabetes, dementia and heart diseases. The role of the NHS had changed to helping these sufferers manage their conditions and live with them;

- 70% of the total UK health budget was spent on the above interventions. The NHS system was designed to intervene in cases of acute exacerbation of patients symptoms and was not designed to enable patients manage their conditions more proactively. Politicians and healthcare professionals were unwilling to face this reality and emotional attachment to the NHS made rational debate difficult. Currently, the NHS was not fit for purpose and any proposed changes to the NHS should be based on logical arguments, and not on sentiment;

- £300bn was spent annually on the care eco system. £100bn was spent by the NHS with a further £25m spent on social care and other expenditure related to social welfare. There were several million voluntary carers in the UK, which meant that the healthcare system was heavily dependant on the goodwill of these volunteers to function.

Professor Welbourn added that if a healthcare system were to be designed from scratch that took into consideration the current needs of the population, it would need to focus on the following:

- to enable the 30% with chronic conditions to live well and manage their conditions;

- a coherent approach to urgent care;

- engaging the population to look after themselves better and understand the consequences of lifestyle on health;

- delivery of healthcare by centres that had extensive experience in providing routine care, and highly specialist care centres for others.

The best method to achieve the above would be through engagement with the public, building trust and a non-emotional approach to the issue of healthcare provision. He said that the NW London proposals are very logical but he expressed concern that it had not engaged people sufficiently to prepare them for no longer receiving the services they had come to expect. He added that this challenge was currently facing most of the developed world. He likened the healthcare system to an engineering system, where there was a need to eliminate unnecessary boundaries, reduce the risk of failure at boundaries and eliminate the impact of the failure. The best way to achieve this was to establish clear goals.

The Chairman stated that the Shaping a Healthier Future report and consultation documents focussed exclusively on the NHS. It envisaged a shrinking of the hospital out-patient activity and an enhancement of the GP and out-of-hospital functions, which would be difficult to achieve.

Professor Welbourn stated that the social care aspect of healthcare required fuller investigation and engagement. The pilots had shown that this was the most significant aspect of healthcare. Healthcare professionals should engage with each other to gain better insight into each others' work, which would lead to an improvement in the quality of provision. There were institutional boundaries to overcome, for instance, the different budget systems used by different institutions.

The Chair asked Professor Welbourn whether, in his view, the outcomes in the proposal were deliverable. A Member from Kensington and Chelsea asked whether a reduction of out patient activity would actually lead to reduced pressure on beds. A Member from Brent asked whether the services envisioned in the community would be ready in the next two to three years. A Member from Harrow asked whether Scotland and Wales would be following England's example.

Professor Welbourn responded that:

- the success of any new model of healthcare provision would require unanimity and commitment from politicians, health professionals and community groups;

- currently, hospital bed occupancy was higher than it needed to be as the UK did not enable patients to manage conditions such as diabetes, and therefore patients who suffered acute flare-ups of their condition frequently required hospitalisation. The provision of remote diagnostics, tele-care and effective care in the community would help reduce the incidence of hospitalisation in these cases;

- the pilot had demonstrated that the services envisaged in the community could be in place within the next two to three years. However, this would require greater engagement between hospitals and community based healthcare providers. Financing this initiative could be problematic;

- all developed nations were seeking to make similar changes to their health services. Although the health infrastructures in place in Wales, Scotland and Northern Ireland were different to that in England, all were looking to make similar changes;

- the World Health Organisation had published healthcare performance data for 20 major nations which had shown that some had lower levels of prescribing, whilst others had lower bed occupancy, but no single nation performed well in all areas. Developing nations such as India and countries in Latin America, where no previous infrastructure was in place, performed well overall;

- maintaining the status quo was not an option. There needed to be a more cohesive approach. Acute care in the UK was excellent, however, 70% of the care provided was mundane as opposed to specialist. This needed acknowledgement. There was no evidence that the current system of healthcare worked, except in pockets;

- a recent debate at the Nuffield Trust regarding universal benefits had shown that, in the UK, the maximum taxation could be raised to would be 37%. However, 45% of UK's GDP was spent on the health and social care system in its entirety, and this figure was increasing. This meant that the total cost of healthcare in the UK could not be met through taxation alone. He added that the structures in place for health and social care currently allowed significant wastage.

A Councillor from Wandsworth asked whether the Health and Wellbeing Boards should be included in the consultation. Professor Welbourn responded that the Health and Wellbeing boards had substantial power and potential and represented genuine local ownership. They would be the coming together of the local authority and the NHS, sharing resources between all the constituent parts of community funding.

A Councillor from Hammersmith & Fulham asked for greater elaboration of the financial boundaries and challenges, how he envisaged the new improved system and the 'expert patient' programme.

Professor Welbourn stated that:

- the current system of payment by results was a goal-enabled system, where hospitals were funded to deliver increased activity. Under any changed system, budget allocation should be made across the entire population, encompassing healthcare, social care and welfare and that this responsibility should belong to the Health and Wellbeing Boards;

- it would require a capitalisation based approach, use of a risk management process, because some illnesses cost less to treat than others;

- partnership working with all providers (public, private, third sector) and taking examples of best practice from each and adapting these to new technology and new ways of working, would need to be under primed with a willingness to share and take risks.

A Member from Hounslow asked whether the new census data would be factored into any decision making. Professor Welbourn responded that the fundamental challenge was to identify what type and level of

care should be provided. Commissioning services should be the responsibility of the public sector and needed to ensure that those commissioning services understood how to manage contracts and hold providers to account for the outcomes the community demands. The Chairman added that ideal models depended on substantially stable and well organised populations. However, large sectors of the population in central London, particularly in boroughs such as Hammersmith and Fulham, were transient, often not registered with GP practices and she questioned whether the proposed model was appropriate for inner city challenges.

Professor Welbourn responded that any model would need to meet needs as they were. The population of London was different from other parts of the country and for this reason, the Health and Wellbeing Boards, which were aimed at responding to local needs, would be best placed to do this.

The Committee thanked Professor Welbourn for his time and invited Dr Honeyman to give his presentation.

Dr Honeyman stated that his area of interest was relationship centred healthcare, which required frank and open discussion amongst clinicians and budget holders about the following areas:

- building alignments, identifying priorities and discussing how a common pool of resources would be shared;
- being honest with patients, and admitting to not always having all the answers to their questions.

Dr Honeyman added that, in his view, clinicians often found it difficult to share resources, to work across boundaries and could sometimes be territorial.

The Chairman asked Dr Honeyman to identify what risks arose out of the Shaping a Healthier Future proposals. Dr Honeyman responded that neither he nor others could predict the risks associated with this as this was completely new ground and would require the frank and open discussions he had outlined earlier.

A Member from Ealing asked whether the proposals were being driven by a top down model. Dr Honeyman stated that research had been carried out comparing hyper-acute stroke work in London and Manchester. The Manchester model was a bottom-up approach and clinicians had worked very hard to engage the population early on. He added that a bottom up model was not necessarily superior to a top down model, however, the leadership would need to make decisions on the basis of open discussions, engender trust and mutual agreement.

A Councillor from Harrow stated that she had concerns for the area of mental health and that both patients and clinicians often felt

disempowered and not heard. Dr Honeyman responded that clinicians had a great deal of power but could not always deliver the level of care they wished to and consequently often worked beyond their remit.

A Member from Hounslow stated that for a consultation to be meaningful, it required genuine engagement with relevant stakeholders, who needed first to be identified and asked if the preferred option was a bottom up approach.

Dr Honeyman responded that any preferred option would need wide engagement and to build trust.

A Member from Brent stated that public health and, specifically, preventive measures may not receive the prominence they required and asked if sufficient resources had been allocated to this area. Dr Honeyman responded that any consideration of public health would need to take a holistic approach and take into consideration areas such as housing, education, social care, policing, leisure. He gave the example of Hertfordshire as a good example of joint working where leaders had taken a co-ordinated multi-agency approach.

A Member from Hammersmith and Fulham asked how public understanding of how they should access NHS services in the future would be achieved. Dr Honeyman stressed the importance of engagement with the public that focused on their hopes and fears. He added that this would be difficult to demonstrate in a political debate.

The Chairman asked whether given the difficulties of communicating with large sections of the population, who were not expert patients, whether the demographics of an area had been factored into the proposals. Dr Honeyman stated that this issue had caused him concern, and stressed the importance of engaging with hard to reach groups, who often did not have a voice.

A Member from Harrow pointed out that Harrow and most other North West London boroughs had ethnically diverse populations and the languages listed at the back of the booklet, which were not in alphabetical order, did not include Gujerati. Mr Blair (Communications and Engagement Workstream Lead) stated that he had received a request for the booklet to be translated into the 9 languages listed, however, he undertook to add Gujerati to this list and to ensure that the languages were listed in alphabetical order.

A Member from Ealing asked whether the consultation period needed to be extended to allow engagement with hard to reach groups. He added that the report failed to provide detailed financial data such as anticipated salaries for GPs or what resources would be allocated per patient and requested that the Committee be provided with a detailed budget. Dr Honeyman stated that the UK as a whole was living beyond its means. It needed to decide what proportion of public funds should be spent on public health, how to optimise on resources. He pointed

out that the business case for the South West London Hospitals had meant the loss of experienced staff and this was an important risk.

A Member from the City of Westminster asked whether the financial collapse of hospitals in North West London was imminent. Dr Honeyman stated that he expected the decline to be incremental, with a gradual decrease in service provision and increasing waiting times. However, he expected the main problems to arise in Urgent Care.

Daniel Elkeles, Director of Strategy, NHS NW London stated that the consultation in South West London had been due to begin at the same time as the one in North West London. However, South West London had not done enough work on its out of hospital strategy. He added that North West London was the first area in the UK to have completed this.

Dr Mark Spencer stated that the preferred model was not a top down model. The consultation had taken into consideration the demographics of North West London and had tried to build consensus. A Member from Ealing stated that this was aspirational and that in his view the community did not feel they had been adequately consulted. In order to be meaningful, a consultation needed to be an ongoing process and not be presented as a fait accompli.

RESOLVED: That the presentations be noted.

7. Progress for Public Consultation

A Member from Hounslow stated that attendance at the first consultation session in Hounslow had been poor and few people in the borough seemed to be aware of the proposals. She had not received any information through her post and asked when the summary booklet would be distributed, how consultation events would be advertised and how public engagement would be ensured.

Dr Spencer responded that:

- there had been 300 attendees at 8 roadshow events in the 8 core boroughs in North West London. These events had been widely publicised, with the first wave taking place in July, and the second wave being planned in the form of door to door leafleting. His team had been looking at value for money. The summary booklet would be sent out to the 8 core and 3 neighbouring boroughs shortly;

- reports from the 8 focus group meetings had been circulated, with an additional 11 focus group sessions planned;

- with regard to hard to reach groups, an estimated 30 groups and 800 people had been contacted.

Mr Blair added that:

- Q&A sessions were planned to take place at 14 hospital sites;

- consultation via the website had received more responses than hard copy consultation documents;

- 50 thousand leaflets had been distributed to date across the 8 core and 3 additional boroughs.

A Member from Brent asked who would be dealing with care within the community. Dr Spencer responded that there was a single commissioning strategy across North West London and GPs were being consulted. Mr Elkeles added that the out of hospital strategy was being actively implemented in each borough.

A Member from Ealing stated that money was being spent in the community without a coherent funding strategy. He asked how the proposals were being costed. He added that the budget aspect of the proposals had not been consulted on. He understood that the proposals affected approximately 2 million people and the 300 attendees at the focus groups and 800 people contacted were disappointingly low figures. Mr Elkeles stated that the budget figure was in the region of £138m, which had been based on a series of business cases. Mr Blair stated that, historically, attendance at consultation road shows were low. He added that half a million leaflets would be distributed across the 11 boroughs, but it had been difficult to persuade the public to attend consultation events.

A Member from Ealing asked what the feedback from the community at consultation had been. He added that, in his experience, people at the road shows had generally been against the proposals. Mr Blair stated that his team had tried to gather evidence from potential high users of NHS services at the road shows, and in his experience, once the drivers behind the proposals were explained to the attendees, they had been in favour of the proposals. The Chairman stated that focus groups sometimes got it wrong, and it depended on how they were led. The Chairman requested further data from the other consultation exercises be provided to the Committee. A Member from Hammersmith & Fulham asked who had been invited to the focus groups, how they had been led and how the proposals had been explained to participants. Mr Blair responded that it had been an independent and open process. The focus groups had been conducted by a third party, the materials used had been based on reports that Committee Members had seen and discussion at the sessions had been free flowing. On-street recruitment of participants had been weighted based on local demographics and had been carried out by another specialist group.

A Member from Hounslow stated that if the focus groups were being led and consulted on a preferred option, then the process could not be described as transparent. He asked whether the 9 A&E and outpatients departments were being visited.

Dr Spencer stated that the Medical Directors and A&E staff from 9 hospitals, and the Royal College of Surgeons had all been contacted. The Member from Hounslow responded that the consultation should focus on those who would be most affected by the proposals, ie the patients and frontline staff.

Mr Elkeles stated that the consultation documents and focus groups had made it clear that a preferred option was being consulted on. NHS leaders in North West London had indicated that option A, would be their preferred option, however, options B and C were also viable options. The Chairman stated that at a previous meeting, JHOSC had stressed that the consultation should look at the viability of several options, although, it had been too early in the process for the Committee to make a valid assessment of those options. The Chairman stated that the report did not contain any information on risk analysis and asked if a formal risk register was in place.

Mr Elkeles stated that all data compiled had been included in the business case. The chapter on sensitivity analysis was the equivalent of a risk assessment. Currently there was no obligation to carry out an in depth risk analysis, but, if the proposals were agreed, then a risk analysis would be carried out on the option to be implemented. The Chairman asked whether the proposals were included in the Department for Health's risk register. Mr Elkeles stated that the Department of Health had indicated that it would not be releasing these documents. He added that it had been necessary to overcome a certain criteria of risks prior to undertaking the consultation exercise. However, this was a risk log of the process rather than a risk log of implementing the proposals.

The Chairman asked whether any equalities impact assessment had been carried out. Mr Blair responded that this information had been circulated previously and undertook to re-circulate this information to JHOSC Members.

A Member from Hounslow stated that he was not satisfied with either the responses given at the meeting or the low level of public engagement. He stated that he wished to re-visit matters agreed at the JHOSC meeting on 4 April and wished to see equalities impact information relating to the initial proposed 8 options, and not merely the 3 options being consulted on. Mr Elkeles stated that the chapter on Sensitivities and the North West London clusters website did provide information on this.

RESOLVED: That the progress of the public consultation be noted.

8. Evidence Required for Future Meetings & Dates of Future Meetings

The Committee was advised that two further evidence-gathering meetings of the Committee were planned to take place during September 2012 (on 4 and 6 September). The Committee requested that future reports focus on answering the following questions:

- how the proposed changes would impact local populations and the equalities impact of these changes;

- what it means for a local population to shift from having an A&E to having an Urgent Care Centre;

- the case for concentrating care to fewer hospital sites;

- whether the level of clinical and community engagement was sufficient;

- whether local hospitals and community services would be able to cope with proposed increases in demand;

- The Committee also requested that witnesses from both in and outside of the NW London region from the following fields be invited to give evidence at a including those from adult social care, transport, and clinicians. This would be a combination of written and verbal evidence.

The Committee also requested that the minutes of previous Scrutiny meetings within each borough where Shaping a Healthier Future had been discussed be circulated to Committee Members and the following information be provided at a future meeting:

- benchmarked data from hospitals looking at excellence in provision (A&E, maternity and paediatric services), as well as viability and sustainability;

- risk-assessment of implementing the proposals;

- a summary of which hospital sites would be sold off and which would be retained and any figures relating to these.

The Committee also requested that a site visit to the Chelsea and Westminster Hospital Trust be arranged.

RESOLVED: That the above requests be noted and incorporated into the Committee's work programme as appropriate.

(Note: The meeting, having commenced at 10.00 am, closed at 1.12 pm).

(Signed) COUNCILLOR LUCY IVIMY
Chairman