London Borough of Hammersmith & Fulham

Housing, Health And Adult Social Care Select Committee

Minutes

Wednesday 13 November 2013

PRESENT

Committee members: Councillors Lucy Ivimy (Chairman), Joe Carlebach, Stephen Cowan, Oliver Craig, Peter Graham, Rory Vaughan, Andrew Brown and Daryl Brown

Co-opted members: Patrick McVeigh (HAFAD) and Bryan Naylor (Age UK)

Care Quality Commission: Gale Stirling, Head of Regional Compliance
H&F Clinical Commissioning Group: Daniel Elkeles, Chief Officer and Dr Tim Spicer, Chair
Imperial College Healthcare NHS Trust: Professor Nick Cheshire, Chief Executive, Dr Chris Harrison, Medical Director Bill Shields, Chief Executive

Officers: Stella Baillie (Tri-borough Director, Provided Services, Mental Health Partnerships and Safeguarding for Adult Social Care), Liz Bruce (Tri-borough Executive Director of Adult Social Care), Craig Bowdery (Scrutiny Manager), Mike England (Director Housing Options, Skills and Economic Development), David Evans (Service Development Project Manager) and Sue Perrin (Committee Co-ordinator)

23. MINUTES AND ACTIONS

RESOLVED THAT:

The minutes of the meeting held on 10 September 2013 be approved and signed as an accurate record of the proceedings.

24. APOLOGIES FOR ABSENCE

Apologies were received from Councillor Peter Tobias.

25. DECLARATIONS OF INTEREST

Councillor Joe Carlebach declared a personal interest in respect of 'Shaping a Healthier Future Proposals' in that he is a trustee of Arthritis Research UK.

26. CARE QUALITY COMMISSION

Gale Stirling, Head of Regional Compliance, London provided a presentation on the role of the Care Quality Commission (CQC) and its revised direction.

All care homes, home care agencies and hospitals were inspected at least once a year. Inspections, which were mostly unannounced, focused on quality and safety as experienced by service users.

The presentation set out the key changes including the appointment of Chief Inspectors of Hospitals, Social Care and Primary Care and Community Care. Inspections were continuing as normal, alongside these developments.

There would be a new approach to inspecting social care services, with homes rated as: outstanding, good, requires improvement and inadequate. Larger and improved inspections teams would consider whether a service was: safe, effective, caring, responsive to people's needs and well-led.

The CQC worked closely with a number of agencies, including overview and scrutiny committees (OSCs). It was hoped that there would be regular contact between OSCs and the CQC and that they would be able to work together and share information. The CQC made available Information for councillors and scrutiny committees on its website and a two monthly bulletin was available by e-mail alert.

Councillor Lucy Ivimy stated that the committee did not have the capacity to monitor standards across the borough, and would welcome notification from the CQC of any services which were a cause of concern.

Ms Stirling responded to Councillor Stephen Cowan's queries in respect of performance management, training and skills set of inspectors and providers being able to mislead the CQC. All inspectors received two months induction training and ongoing training. In addition to performance appraisal, there was a quality monitoring system whereby line managers reviewed inspectors' judgements and evidence and feedback from providers. Initially inspectors were not allowed to undertake an inspection on their own, and only very small units were inspected by a single inspector.

Whilst most providers considered themselves ready for a CQC inspection, this was often lost because of the unannounced nature of visits. Inspectors were trained to ask probing questions, and were supported whilst on inspections. There were regular team meetings, which were followed by reflections sessions, to which they could bring issues for team discussion/learning.

Ms Stirling responded to Councillor Peter Graham that there was a variable standard of services in the borough. There had been an increase in the level

of adult social case non-compliance during the last eighteen months, resulting in a number of services being inspected several times. However, there were some excellent services, and over all the borough compared reasonably with other boroughs. There had not been significant changes in the inspection to bring about this increase, which could possibly be attributed to more experienced inspectors.

All services were inspected annually, with the exception of some dentists, who were on a two year programme. Inspection of GPs was a new responsibility and currently 20% of GPs had been inspected.

Ms Stirling responded to Councillor Rory Vaughan that a borough based report was available and a copy would be provided.

Action: Gale Stirling

In response to a query from Councillor Joe Carlebach, Ms Stirling stated that the CQC worked with Monitor by sharing information and advising of any concerns. In respect of care provided by different organisations, the patient pathway was reviewed, with patient experience as the primary focus.

Councillor Andrew Brown queried the CQC's work with patients and how it could ensure that there was not another 'Mid-Staffordshire'. Ms Stirling responded that the CQC worked with Healthwatch (and previously LINks), local focus groups and organisations with direct access to patients, for example Age UK and also talked directly to patients and their families. The feedback was integrated into the inspection regime.

In respect of Mid-Staffordshire, the CQC had reviewed its whistle-blowing policies and talked to patients' groups. Sharing of information was now a key focus of inspections.

Councillor Oliver Craig queried CQC reporting to the public. Ms Stirling responded that information was available on the website and through newsletters and e-mail alerts. Ms Stirling was not aware of whether hits on the website were monitored, and would provide a written answer.

Action: Gale Stirling

Mr Naylor referred to older people dignity champions, who provided information in respect of their visits to hospitals and care homes to the CQC, and the lack of direct feedback. Ms Stirling responded that this information was very helpful and feedback was likely to be given through Healthwatch. In addition information was taken from 'experts by experience' who made themselves known to the team and the range of people who worked with them. Mr Naylor suggested that the CQC took a more proactive approach.

Action: Gale Stirling

Councillor Ivimy thanked Ms Stirling for attending the meeting and for her presentation.

RESOLVED THAT:

The report be noted.

27. SHAPING A HEALTHIER FUTURE PROPOSALS

This item was taken after the Francis Report.

Dr Tim Spicer and Daniel Elkeles outlined: the background to the Shaping a Healthier Future (SaHF) Proposals; the acceptance of the changes to NHS services in North West London by the Secretary of State; and the Urgent and Emergency Care Review report, which had been published earlier that day. A report of the key points from the review was tabled.

The proposals would be implemented over five years. Providers would continue to develop outline business cases and there would be stakeholder workshops and public drop-in sessions to identify the most appropriate range of services at Charing Cross and Ealing hospitals.

The presentation set out where the Programme Board should: continue as planned; respond to urgent priorities; and give further consideration as to how to proceed.

Mr Elkeles stated that the review supported the North West London direction of travel. There would be a system-wide transformation over the next three to five years, with a fundamental shift in the provision of urgent care away from hospitals. Broader emergency care networks would be developed, dissolving traditional boundaries between hospital and community-based services.

Urgent and Emergency care would be provided from:

- Emergency Centres capable of assessing and initiating treatment for all patients;
- Major Emergency Centres, larger units, capable of assessing and initiating treatment for all patients and providing a range of specialist services; and
- Urgent Care Centres with walk-in facilities, including GP out-of-hours care, and services for minor injuries and illnesses.

Charing Cross would be designated an Emergency Centre; St. Mary's and Chelsea and Westminster Major Emergency Centres; and Hammersmith an Urgent Care Centre.

The Shaping a Healthier Future and Imperial College Healthcare NHS Trust representatives then responded to Members' questions.

Approximately 70% of walk-in patients would be treated in the Charing Cross Emergency Centre. It was unlikely that ambulance patients would be taken there. Suspected heart attack patients would currently and in the future be taken to Hammersmith Hospital Heart Centre. Similarly, following a major car

accident, a patient would currently and in the future be taken to the major trauma centre at St. Mary's Hospital. The hyper-acute stroke unit would be located at St Mary's Hospital, as it had been agreed that it should be sited with the major trauma centre.

Professor Nick Cheshire responded to a query in respect of reduced in-patient beds, that elective surgery was becoming more efficient, with many patients requiring only an overnight stay and then progressing to rehabilitation.

Mr Elkeles responded to a query in respect of Charing Cross as a specialist hospital that there was an ambitious proposal for a substantial site, with a range of services and an Emergency Centre. The distinction between Charing Cross and St. Mary's was the model which, Professor Sir Bruce Keogh, the National Medical Director had proposed for the whole country.

There were three key differences between an Emergency Centre and an Urgent Care Centre: a 24/7 GP presence and emergency treatment for children; an enhanced range of diagnostic services; and beds for assessment and initiating treatment. Members commented on the deficiencies in GP training in respect of children.

Councillor Graham referred to the previous rationalisation of services, whereby the number of stroke units had been reduced from 32 to eight, and queried how many lives had been saved. Professor Cheshire responded that the outcome was not just in terms of survival but also reduced impairment. The number of lives saved was not known, but might be in the region of 400 across London.

Councillor Carlebach queried the resource for GP extended hours. Dr Spicer responded that proposals had been put forward, as seven day access to GP surgeries was essential to the reforms. A number of practices had already opted to open at weekends to cope with winter pressures. Collective access to services would be facilitated by GP networks. It was agreed that an update should be added to the work programme.

Mr Elkeles stated that three practices in Westminster were open all day on Saturdays and Sundays, and it was intended to extend across the tri-borough, by the end of winter. These practices had been advertised in local newspapers and on telephone kiosks, and patients ringing 111 were informed.

Councillor Rory Vaughan queried the definition of 'immediate access to specialist consultant opinion'. and the closure of Hammersmith A&E Department as soon as practical. Mr Elkeles responded that the emergency teams would work together, with support being provided by the Accident & Emergency (A&E) consultants at the major hospitals to Charing Cross and Ealing hospitals, in person or possibly by teleconference. Proposals in respect of Hammersmith Hospital A&E Department would be brought to a future meeting. The department was a medical unit, and not for blue light ambulances. It could not provide safe care to walk-in emergency patients. Mr

Elkeles confirmed that the heart attack and renal units would continue at Hammersmith Hospital.

Councillor Vaughan queried why GPs had not been balloted in respect of the proposals. Dr Spicer responded that the Clinical Commissioning Group (CCG) had followed the appropriate constitutional measures and had sought opinion through events in GP practices. The proposals had been a standing agenda item for the Governing Body for the previous eighteen months.

Professor Cheshire responded to Councillor Andrew Brown that Charing Cross would continue to provide a range of out-patient and diagnostic services, but it might be necessary for in-patient treatment to be provided at another hospital. Professor Cheshire confirmed that it was not possible to provide comprehensive state of the art services at all three hospitals. There needed to be appropriately trained staff, support services and technology. In addition, there was a relationship between volume of patients and outcome. Professor Cheshire provided examples of improved mortality rates and of the reduced length of stay in vascular and cardio-vascular surgery.

Councillor Cowan queried the services and buildings which would remain on the Charing Cross site. Mr Elkeles responded that the land sale would fund new developments at Charing Cross and St. Mary's. The scale of the services and buildings remaining at Charing Cross would be shared with the Joint Health Overview & Scrutiny Committee, at its December meeting.

Professor Cheshire stated that there would be consultants on site at Charing Cross, but not Accident & Emergency consultants. Charing Cross would be part of a bigger hospital system, with St. Mary's providing full emergency services. Patients with suspected heart attack and fractured neck of femur were already being taken to Hammersmith and St. Mary's hospital respectively. It would be necessary to educate patients to understand the limits of the new centres. The 30% of walk-in patients who would not be treated at Charing Cross would, for example have a heart attack, early stage stroke or abdominal pains. Those who called an ambulance would be taken to a Major Emergency Centre.

Councillor Cowan considered that as there had not been a ballot of GPs, their support was only an opinion. Dr Spicer responded that the CCG had acted within its constitution and consulted with its membership.

Mr Patrick McVeigh commented that short stays in hospital would need to be supported by district nurses, and gave free parking for district nurses as an example of how other boroughs were helping to support the process. The strategy needed to set out how out of hospital (OOH) care would work now and in the future and identify the number of people to be employed and any gaps. Mr Elkeles responded that, until other services were in place in the community, the changes could not be made.

Mr Bryan Naylor queried the Imperial College Healthcare NHS Foundation Trust status application being progressed when the Charing Cross options were unavailable. Mr Bill Shields responded that the business case would set

out the direction of travel, and would take into account the SaHF proposals and Professor Keogh's review.

The Chairman then opened the meeting to questions from members of the public.

Professor Cheshire confirmed that the UCC would be able to provide emergency treatment for diabetic and asthmatic patients.

Mr Andrew Slaughter queried the differences between UCCs and Emergency Centres and set out some of their similarities: both would be able to deal with broken bones; admit for rehabilitation and assessment; and provide 24/7 GP children's services. Whilst the UCCs would be GP led, there would be immediate access to A&E consultant opinion. Mr Elkeles responded that the Emergency Centres would have some beds. UCCs would have 24/7 GP care and would have a full range of diagnostic services.

Professor Cheshire responded to a query in respect of emergencies being dealt with at Hammersmith Hospital, that it was not suitable for 'unselected' emergency admissions, as this required an enormous range of diagnostic facilities and expertise to monitor 24/7. Mr Elkeles added that there would only be beds for specialist emergency admissions. In respect of the transfer of the UCC from Hammersmith Hospital to the White City Centre, a detailed proposal would be brought to a future meeting.

Mr Slaughter queried the impact of the dedicated elective centre at Central Middlesex on elective services at Charing Cross and the percentage of the Charing Cross site remaining in five years time. Mr Elkeles responded that proposals were currently being developed to maintain a range of services on the Charing Cross site.

Dr Spicer responded to Mr Slaughter's queries in respect of the budget cut of £29million that the borough had historically received over per capita funding on the basis of the national formula. The changed formula, if implemented, could bring about a reduction of £29 million funding over a number of years. NHS England required two year budgets to be prepared, although allocations would not be known until late December. Savings of 5% had already been made, and this was expected to continue.

A member of the public commented on the requirement for concrete evidence in respect of additional community and primary care.

In accordance with paragraph 27 of the Overview and Scrutiny Procedure Rules, the Committee extended the meeting by 30 minutes.

Dr Spicer responded to the concerns raised that services would not be closed until OOH services were working efficiently to safely care for patients. The proposals would be implemented over a five year transition period, during which providers would seek to use capacity differently, for example through better use of skill mix, telephone consultations, virtual wards and joint working with social care.

Councillor Carlebach stated that he had not been provided with a response to his questions at a previous meeting in respect of flu vaccinations for vulnerable people. Dr Harrison responded that he held this information and would provide a written answer.

Action Dr Chris Harrison

In conclusion, it was confirmed that there would be an Emergency Centre at Charing Cross Hospital.

28. FRANCIS REPORT

Craig Bowdery presented the report, which reviewed the recommendations of the Francis Report regarding local authority scrutiny and their impact on health scrutiny in Hammersmith & Fulham.

The Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC, had been set up to examine the commissioning, supervisory and regulatory organisations in relation to their role monitoring the Mid Staffordshire Trust between January 2005 and March 2009, during which time, failings at the hospital are thought to have caused between 400 and 1,200 deaths.

In total, the Francis Report made 290 recommendations. Members considered the six recommendations which related directly to local authority health scrutiny committees.

Recommendation 47
Engagement with the CQC had been covered in a previous item.

Recommendation 119:
A presentation on the role of Healthwatch and a CCG annual health performance report would be added to the work programme.

Councillor Vaughan commented on the large remit of the committee and whether there were sufficient meetings, although the Joint Health Overview & Scrutiny Committee facilitated further scrutiny of the Shaping a Healthier Future proposals.

Members commented on the difficulty in pursuing complaints, with only fairly general answers being provided because of the requirements of the Data Protection Act.

RESOLVED THAT:

The report be noted.

29. HEALTH & WELLBEING STRATEGY

David Evans introduced the draft Health & Wellbeing Strategy between the Council and H&F CCG, produced by the Health & Wellbeing Board (HWB).

Councillor Andrew Brown commented that the strategy seemed to be describing the status quo, rather than the new joint working between local government and the NHS. Priority 1 of the vision was an overarching priority. Mr Evans responded that the primary aim of the HWB was to promote integration and partnership working between the NHS, social care, public health and other local services, rather than replicate work already being done by the Council. The HWB considered that it could have the greatest impact in developing integrated care, by identifying blockages to help organisations work more effectively to promote the agenda.

Councillor Ivimy considered that information sharing and security implications was a key blockage. Councillor Marcus Ginn responded that there were also legal, technical and cultural issues. New IT systems would enable the local authority and GP practices to share information securely. Lack of good information sharing was a key blockage preventing a seamless integrated network of care.

Councillor Cowan suggested that the strategy was similar to other documents and that there should be consultation with residents on how the vision could be aligned with service delivery. The strategy appeared to be an aspiration, did not have drivers to deliver and did not set out how the priorities would be achieved.

Councillor Ginn responded in respect of the drivers to deliver on these aspirations, which had been based on the key issues identified by the HWB. There were financial drivers in that SaHF would only be delivered if a large proportion of the acute budget was transferred to the community budget. The pressures on the CCG budget would be resolved by reducing waste from care pathways, joint commissioning with local authorities and improved outcomes. In addition, there were local authority budget pressure.

The strategy was a compromise between diverse organisations represented on the Board and therefore less specific in some aspects. The strategy would evolve and drill down to deliverables over the next few years.

Councillor Cowan did not consider that there had been a strong history of working together to build integrated health and social care (priority six), and suggested that it should be replaced with a priority to demonstrate openness and challenge of the status quo in order to improve outcomes.

Councillor Vaughan commented that the strategy did not focus on what was happening in practice, but did include some previous priorities such as the public health budget.

The guillotine fell at this point.

30. SAFEGUARDING ADULTS IN HAMMERSMITH & FULHAM

This item was deferred.

31. WELFARE REFORM: UPDATE

This item was deferred.

32. WORK PROGRAMME AND FORWARD PLAN 2013-2014

The work programme was received.

33. DATES OF NEXT MEETINGS

21 January 2014

Meeting started: 7.00 pm
Meeting ended: 10.30 pm

Chairman .....

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