CITY OF WESTMINSTER

MINUTES

Health Policy & Scrutiny Urgency Sub-Committee

MINUTES OF PROCEEDINGS

Minutes of a meeting of the **Health Policy & Scrutiny Urgency Sub-Committee** Committee held on **Thursday 7th August, 2014**, Rooms 3 & 4 - 17th Floor, City Hall.

Members Present: Councillors David Harvey, Jan Prendergast and Barrie Taylor

1 MEMBERSHIP

1.1 The membership of the sub-committee was noted.

1.2 Councillor David Harvey was appointed as Chairman.

2 DECLARATIONS OF INTEREST

2.1 The Chairman sought any personal or prejudicial interests in respect of the items to be discussed from Members and officers, in addition to the standing declarations previously tabled by the Adults, Health and Public Protection Policy and Scrutiny Committee and included in the agenda. No further declarations were raised.

3 CENTRAL AND WEST LONDON CLINICAL COMMISSIONING GROUPS PROCUREMENTS OF HEALTHCARE SERVICES

3.1 The Sub-Committee received the report which detailed the procurement plans for Planned Care Services across Central and West London and the development of the Clinical Commissioning Group's (CCGs) joint procurement approach as part of the Tri-borough strategic objectives. The Sub-Committee considered the report in order to provide a formal response on behalf of the City Council, in accordance with Section 244 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

3.2 Mona Hayat, Head of Planned Care for Central London CCG, introduced the report and informed Members that the NHS Central London and West London Clinical Commissioning Groups were commencing the service review, re-design and procurement of 9 and 6 (respectively) end-to-end Planned Care Services in 2014/15. Ms Hayat detailed that, in the planning stages of the

2014/15 NHS Central London and West London CCG's Commissioning Intentions, it was identified that a procurement programme to address the gaps in planned care (outpatient services) community provision would be required. This was to be significantly aligned to the Out of Hospital Strategy 2012-15 and the successful delivery of planned care, which includes more patient self-management, preventative care, more home based care; and an extended range of services available in primary care to prevent the need for more specialist treatment.

3.3 The Sub-Committee noted that a proposed programme of procurement for planned care had been presented and ratified by the City Council's Health and Wellbeing Board between July and September 2013. Subsequently, Central London CCG had undertaken a programme to review and redesign specific outpatient services to ensure that patients receive simple, timely, convenient and effective planned care, supported by a set of consistent protocols and guidelines for referrals and the use of diagnostics.

3.4 In response to a query from Members regarding the reportedly "robust" approach to service redesign, Ms Hayat provided an overview of the measures taken to ensure the proposals were fully supported and evidenced. This included data analysis of incident and prevalence rates in 7 key areas, extensive benchmarking; and work with external clinicians to support the plans, seeking expertise from the University of Leicester in respect of cardiology and respiratory.

3.5 Davey Thomason, Head of Planned Care for West London CCG, explained that, by reviewing and redesigning community planned care provision, NHS Central London and West London CCGs aim to undertake a process of simplifying planned care pathways. Mr Thomason noted the ambitious nature of the plans but emphasised the importance of commissioning community services which provide intermediate outpatient services in a community setting, which crucially prevents the need for patients to attend hospital clinics for diagnosis and treatment where it is unnecessary. Mr Thomason provided Members with an overview of the first phase of the programme and the planned care services which would be re-procured during 2014 – 2016.

3.6 The Sub-Committee reviewed the proposed governance framework which intends to provide accountability and quality assurance around the programme, but noted that the structure focused on 'groups' and provided no detail in respect responsible officers. Members therefore sought clarification of the mechanisms by which issues and potential risks would be raised, resolved and/or mitigated.

3.7 The Sub-Committee were informed that the Heads of Planned Care would be responsible for highlighting issues to the Governing Body and for providing regular updates on emerging risks. Mr Thomason explained that this good governance practice is already undertaken through a regular reporting requirement to the hospital committees – where risks are highlighted and the Heads of Planned Care, as the 'responsible officers', ensure mitigating actions are agreed. In this context Ms Hayat detailed a recent example where it emerged that due diligence had not been followed during the course of a

wheelchair procurement. Ms Hayat subsequently raised her concerns to the North West London Collaborative Senior Management Team and recommended that the procurement be terminated to allow the issues to be resolved and to ensure due process was followed.

3.8 The Sub-Committee discussed the stakeholder/patient engagement and consultation plans detailed in the report and raised the fundamental issue of mobility, in respect of how both patients and staff will travel between different clinical sites. Members emphasised that the issue of mobility will be crucial to informing reconfiguration and must be at the forefront of location planning.

3.9 Members highlighted the forthcoming providers survey into how often patients raise transport as a barrier in accessing health appointments and activities, and enquired as to whether other methods of engagement and information gathering had been utilised, such as the GLA or working with the local community directly? The Sub-Committee heard that transport issues had been a key focus for the CCGs and, as such, transport boards had been created at both the North West London Collaborative and Tri-Borough, which are directly aligned to the procurements. The CCGs have also received feedback from a TfL survey into how services could be effectively delivered in the community. Members requested to be provided with the results of the aforementioned TfL survey.

3.10 In response to a suggestion from the Sub-Committee that Healthwatch could provide effective 'critical friend' challenge to the procurement proposals, Ms Hayat confirmed that Healthwatch had previously been commissioned to undertake a wheelchair review which subsequently informed the procurement. The CCGs are also commissioning Healthwatch to undertake a review of dermatology.

3.11 The Sub-Committee discussed the policy of 'patient choice' and sought comments on firstly, why this should be an important consideration and secondly, whether many patients actually exercise this choice or simply utilise services on the basis of locality and ease of access? Louise Proctor, Managing Director of West London CCG, explained that there is an emerging population of patients who are internet savvy and who actively choose to select consultants and other clinical providers on the basis of a wide range of information and according to a number of factors. Some of these factors are clinical (such as reputation, quality of facilities or waiting times) and others are practical (such as car parking space or proximity). Ms Proctor agreed with Members that many patients may find this element of choice superfluous, or even confusing. However, many patients feel a greater sense of independence and ownership over their treatment when they are given the option to choose. Kiran Chauhan, Deputy Managing Director of Central London CCG, further explained that modern treatment is increasingly a two-way partnership between the doctor and patient and should be encouraged and facilitated.

3.12 The Sub-Committee noted and welcomed the wider approach to encouraging Small and Medium Enterprises (SMEs) to participate in tender processes for public sector contracts. Members noted the work undertaken by the CCGs to

ensure that tenders are open to SMEs, such as providing tender opportunities as “lots” which divide up tenders and contracts in to clinically safe, patient focused components that SMEs will be able to take on in a sustainable manner.

3.13 RESOLVED:

(1) That the West London and Central London CCGs plans to address the gaps in outpatient services and community provision be conditionally endorsed.

(2) That a formal response from the Health Urgency Sub-Committee, to both phases of consultation and the plans, be provided to the West London and Central London CCGs on the grounds that the plans are considered to constitute a ‘substantial variation’ to services in Westminster.

(3) That it be recommended that Healthwatch Central West London be directly solicited to provide input at both phases of the consultation; and

(4) That the CCGs ensure the Westminster Adults, Health and Public Protection Policy and Scrutiny Committee is regularly updated on the progress of the procurements and that Members be alerted to any proposed changes when these are fully known.

4 IMPERIAL COLLEGE HEALTHCARE NHS TRUST'S CLINICAL STRATEGY

4.1 The Sub-Committee received a presentation from Dr Bill Oldfield, Consultant in Respiratory Medicine at Imperial College Healthcare NHS Trust, which detailed and explained the proposals outlined in the Trust’s recently published Clinical Strategy. As part of his presentation Dr Oldfield addressed the following key areas:

(i) The Trust’s vision and objectives – to be a world leader in transforming health through innovation in patient care, education and research.

(ii) Drivers for change – transforming clinical services to meet changing demands and expectations, such as a growing population; evolving technologies; increased pressure on public spending and personalisation of health and social care.

(iii) The key features of the Trust currently in respect of being one of the safest in the country, with a long track record of healthcare innovation and pioneering better care (recognised by AHSC status).

(iv) The Trust’s approach to clinical service change as part of the ‘Shaping a Healthier Future’ programme (“Localise, Centralise, Integrate and Personalise”) and the clinical strategy framework.

(v) Service and site plans for Charing Cross Hospital (proposed to be a local hospital), St. Mary's Hospital (proposed as the major acute centre for the region) and Hammersmith Hospital (proposed to be a specialist centre).

(vi) The proposed scale and shape of the Trust's estate by 2020 and the steps the Trust will take to realise these ambitions in respect of enabling strategies, clinical transformation and site developments.

4.2 The Sub-Committee sought clarification about the integrated care to be provided at St. Mary's Hospital and received a detailed explanation of the proposals from Dr Oldfield. He noted that patients would enter St. Mary's through a GP surgery in order for their treatment needs to be assessed at the outset of their visit and to prevent unnecessary admissions where alternative care could be provided or appropriate referrals recommended.

4.3 Members emphasised the importance of ensuring that the special needs of elderly residents were at the forefront of the Trust's proposals for change, specifically in respect of how these residents could be treated in their homes as an alternative to hospital admissions. Members noted that travelling can be extremely difficult for elderly patients, many of whom have complex medical requirements and may therefore be required to travel between different sites for specific types of care. In this respect Members had key concerns around the issue of inter-hospital transfers and requested a written response to address these points.

4.4 Dr Oldfield updated the Sub-Committee on the recent implementation of the Cerner Patient Administration System and confirmed that the roll-out went well overall and continues to be embedded positively, despite some loss of information at the outset. Members were informed that the implementation of the new system will drive further improvements to the Trust's business processes and systems and encourage greater collaboration across the Trust.

4.5 The Sub-Committee discussed the increasing necessity to focus on methods of prevention and intervention across the arena of integrated health care and home care services, in addition to improving patient experience and achieving greater efficiency and value from health delivery systems. To achieve these aims, Members emphasised the importance of undertaking consultation on how effectively processes are working 'on the ground' - from the perspective of patients and health care users. Members voiced key concerns regarding the Trust's ability to successfully develop multi-agency working and suggested that the Council's Health and Wellbeing Board could be an appropriate body to drive forward this area of work.

4.6 Members discussed the Trust's plans for capital investment and sought reassurance that the Council would be appropriately engaged and consulted, to ensure the best deal for Westminster's residents is achieved.

4.7 The Sub-Committee noted that the Trust not only needs to manage a process of clinical transformation but must simultaneously manage a huge programme of planning and engineering change. In this context, Members queried whether the Trust had the right level of expertise to successfully deliver both

aspects of transformation? In response, Michelle Dixon, Director of Communications for Imperial Healthcare NHS Trust, assured Members that a transformation office had been established to lead the programme and expertise across all portfolios will be in place. Ms Dixon also emphasised that the programme of change will entail a transformation of behaviours and culture at the Trust, which Members welcomed.

4.8 Ms Dixon recognised that local opposition to the proposals, primarily based upon transport issues, will be a key risk to the programme. The Trust will therefore need to ensure it effectively communicates the benefits of the proposed locations of the three sites and how the changes will minimise transfers between hospitals. The Sub-Committee recommended that an effective means of involving and consulting residents would be to utilise a 'community champions' model of engagement which reaches the local community directly and urged the Trust to give careful consideration to how residents can have greater involvement in the Trust's plans going forward.

4.9 RESOLVED:

(1) That the direction of travel outlined in the Trust's Clinical Strategy be endorsed, subject to a formal review of the Outline Business Case, which will contain the financial aspects of the plans, before formally endorsing the Strategy itself;

(2) That the Adults, Health and Public Protection Policy and Scrutiny Committee conduct an annual review of the proposals and progress;

(3) That whilst the changes outlined in 'Shaping a Healthier Future' were subject to rigorous consultation with patients and the public, it be noted that the Trust's interpretation of the planned reconfiguration will contain service changes which may have been unanticipated in the Decision Making Business Case. As such the Trust should consult service-users in specialties where there will be a shift in service provision (i.e. changes to Radiotherapy). It is considered that patient feedback will inform how the Trust can safely and effectively implement the plans set out in the Clinical Strategy;

(4) That the Trust provides Westminster's Adults, Health and Public Protection Policy and Scrutiny Committee with further information and evidence on the modeling assessments undertaken to ascertain patient flow once Central Middlesex Hospital's A&E department has closed;

(5) That the Trust provides details on the financial modeling undertaken to assess post-implementation revenue streams;

(6) That the Trust works with a small task group of Members of Westminster City Council to review the outcomes of the service moves of renal / haemotology in 2010 / 2011;

(7) That the Trust provides further evidence to Westminster City Council regarding the implementation of new patient administration software; and

(8) That the Trust actively engages local residents through the implementation of a ‘Community Champions’ model of engagement.

5 ANY OTHER BUSINESS THE CHAIRMAN CONSIDERS URGENT

5.1 There was no urgent business to raise.

The Meeting ended at 8:15pm

CHAIRMAN: _____ **DATE** _____