HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE (SPECIAL)

MINUTES

19 SEPTEMBER 2012

Chairman:	* Councillor Krishna James	
Councillors:	* Jerry Miles (1)	* Ben Wealthy
	* Mrs Vina Mithani	* Simon Williams
Advisers:	Julian Maw	- Harrow LINk

* Denotes Member present
(1) Denotes category of Reserve Member

116. Attendance by Reserve Members

RESOLVED: To note the attendance at this meeting of the following duly appointed Reserve Member:-

Ordinary Member	Reserve Member
Councillor Victoria Silver	Councillor Jerry Miles

117. Declarations of Interest

RESOLVED: To note that the following interests were declared:

Agenda Item: 4 - Shaping a Healthier Future for Harrow

Councillor Krishna James declared a disclosable non pecuniary interest in that she was a Registered Nurse and had relatives who were in the medical profession. She would remain in the room whilst this matter was considered.

Councillor Mrs Vina Mithani declared a disclosable non pecuniary interest that she was employed by the Health Protection Agency. She would remain in the room whilst this matter was considered.

Councillor Ben Wealthy declared a disclosable non pecuniary interest in that he was an employee of a Patients Association. He would remain in the room whilst this matter was considered.

118. Deputations

RESOLVED: To note that no deputations were received at the meeting under the provisions of Committee Procedure Rule 16.

RESOLVED ITEMS

119. Shaping a Healthier Future for Harrow

The Chairman welcomed Tina Benson, Deputy Director of Operations, Dr Amol Kelshiker, Harrow CCG, Javina Sehgal, NHS Brent and Harrow, Marcel Berenblut, NHS Brent and Harrow, David McVittie, North West London Hospital NHS Trust and Dr Mike Anderson, Medical Director, Chelsea and Westminster Hospital NHS Foundation Trust to the meeting.

Dr Kelshiker, the Chair of the Harrow Clinical Commissioning Group supported by Javina Seghal, acting Harrow Borough Director gave an overview of the proposals for out of hospital care. The following comments were made:

- there was a commitment to providing care and services as close to a patient's home as possible through primary or community care;
- patient access to GPs services would be important to ensure timely interventions and to prevent unnecessary admissions to hospital;
- the new 111 system would provide a single point for patients to receive advice and to be signposted to other services;
- the integrated care pilot had involved case management of those patients at a higher risk of being admitted to hospital. There was multi-agency support to prevent undue risk of an admission to hospital.

The Corporate Director of Community, Health and Wellbeing stated that one of the positive advantages of the new CCG for Harrow was that it included the whole of the borough and all of the GP practices. There would be six neighbourhood areas and all of these would have an integrated team.

Members raised several points which were responded to by the representatives as follows:

- an emergency admission of a patient to hospital should be foreseen and safety nets should be in place involving various agencies such as social services. Consideration should be given to what had failed to result in a patient presenting to a GP as a crisis and being admitted to hospital;

- a pilot had taken place in inner London which had shown that intervention prevented unnecessary admissions to hospital. A similar arrangement was being considered for other outer London areas including Harrow and Ealing. The focus was putting patients first and there was a need to make people aware of the arrangements;

- this would be the largest integrated care programme in the world involving two million people;

- the 35 GP practices in the borough would be included in the six neighbourhood groups, which would have the skills to support patients who previously might have gone to hospital. Services would be developed to enable other health problems such as diabetes and cardiac problems to be treated in this way;

Members expressed concern about accessibility under the proposed new arrangements and Dr Kelshiker responded by making comments, including the following:

- accessibility issues would be addressed as part of the Shaping a Healthier Future programme as the approach would be coherent and integrated. A key issue was how primary and community care complimented hospital care. There would need to be investment in primary and community care;

- it was accepted that not all services could be delivered from all surgeries and centres but in many cases care and services would be available closer to patients homes;

- over the next 3 years, between 17 and 19 million pounds would be invested in primary and community care and therefore a long term strategy was required;

- in respect of cardiology, it was usual for a patient to see a GP, then be referred to hospital, wait for tests to be carried out and to be seen as an outpatient for the results and management plan. It was anticipated that in the future, the tests would be carried out as a part of community care and the patient would only be referred to hospital if there was a need. There had been a pilot of consultants working in the community with support teams.

Members then considered the implications of patient satisfaction for the proposed new arrangements and the representatives made the following comments in response:

- the majority of issues around patient satisfaction and complaints about GPs were dealt with at the first stage. In some cases the cause of the complaint was not known, for example were accessibility complaints due to a different interpretation of the meaning of accessibility;

- if the majority of funding continued to be directed at hospitals then it would not be possible to invest more in care nearer to a patient's home;

- people would need to be convinced that the new arrangements would work and for the shift in care to be effective, the funding would need to follow the patient;

- this was the first time that health care arrangements were being considered as a whole;

- communications would need to be clear about funding and an extensive programme had been launched;

- there was a need to prove to patients that out of hospital care levels would be equivalent to hospital care;

- communications about Urgent Care Centres and the services available would be issued in the next few weeks.

In response to a Member's questions about the Alexandra Avenue Clinic the representatives made the following comments;

- the closure of the centre during the day had resulted in an increase in the number of patients at Northwick Park Hospital;

- the provision of health care needed to respond to modern life as many patients wished to access health care between 6.00 pm and 12.00 pm.

The Chairman thanked Dr Kelshiker and Javina Seghal for attending the meeting.

Dr Anderson then made a presentation to the Committee on Shaping a Healthier Future. During the presentation the following issues were addressed:

- the challenges, including the population demographic, clinical advances and financial issues, which the NHS in North West London was facing;

- the vision for care which was localised, centralised and integrated;

- the quality standards for care outside of hospitals;

- the eight settings for care, including at home, local hospitals, major hospitals and health centres;

- urgent care centres which would be open 24 hours a day, seven days a week and led by GPs and nurses;

- elective hospitals which would do planned operations. A proposed elective hospital was Central Middlesex Hospital;

- the evaluation process and the criteria for identifying the options;

- the three options which had been identified, of which option A was preferred. Under all three options Northwick Park Hospital would remain a major hospital with Accident and Emergency Services;

- the range of engagement activities, such as newsletters, social media and attending public meetings;

- there would not be any changes to the hospitals until 2016, following the implementation of the out of hospital plans.

Members of the Sub-Committee asked questions regarding the financial arrangements and Dr Anderson responded making the following comments:

- the proposed arrangements were not based on saving money as the budget was flat for the next few years, it was about spending the budget wisely;

- the challenge would be to find the resources to fund out of hospital care and there had been regular meetings of the finance group.

Members then examined the impact of the changes and raised concerns including the likely increase in volume of patients to accident and emergency at Northwick Park hospital if the accident and emergency service at Ealing Hospital was closed. Members also questioned the increase in maternity admissions. The representatives made the following comments in response:

- under all the options available, the hyper-acute stroke unit would remain at Northwick Park Hospital and under option A, which was the preferred option, the unit currently located at Charing Cross hospital would be moved to St Mary's;

- it was accepted that Northwick Park Hospital was experiencing higher numbers of patients and this was partly due to internal factors and also because of the current arrangements for community and primary care. Internal measures such as Short Term Assessment, Rehabilitation and Reablement Services were being developed;

- changes to hospitals would be possible if there were changes in community and primary care;

- it was unacceptable that patients had been discharged at night and improvements were required to the expected discharge dates. However, it should be noted that patient choice was considered when discharging took place;

- in other boroughs, such as Westminster and Kensington and Chelsea, social services were engaged in out of hospital care;

- the programmes published by Clinical Commissioning Groups across London would be similar but each would include local elements;

- the Members of the Sub-Committee could monitor developments and look for evidence that the changes were happening.

The Corporate Director then made the following comments:

- the integrated care pilot was user driven and had a bottom up focus;

- the test would be whether all health care partners could design the future together;

- the potential reasons as to why integrated care would not work should be monitored and one of the main challenges would be working across organisational boundaries. The Health and Wellbeing Board was a good start to organisations working together;

- it was welcomed that there would not be any changes to the arrangements for hospitals until 2016 as this would allow time for preparation;

- the wider financial context was correct but there were local financial issues, such as an overspend in the Harrow health economy. There were important local decisions on funding which would need to be made.

Members asked questions about the communication regarding the programme and the representatives made the following comments:

- 60% of the national budget was spent on hospitals and the remaining 40% was spent on elements such as primary care and drugs;

- changes to hospitals were inevitable and there was a trend towards specialisation;

- the focus was on patient care and not budgetary issues;

- communication was crucial and people should be given all the information required. The work carried out with stakeholders had been thorough.

The Corporate Director commented that it was important that the local message was right and that it addressed the specific concerns of the residents of Harrow.

Members raised concerns about the need to have local services in place and the implications for staff. The representatives responded to the concerns by making comments including the following;

- the date for changes to the hospitals had initially been suggested as 2015 but had been moved back to 2016;

- there would be a planned transition with investment being made in primary and community care before changes to hospital care;

- medical education would be changing and GPs would need to be able to address more care issues;

- there would not be large impact on staff as it would be a shift in employment rather than unemployment. There would be more nurses in the community and if there was a reduction in the number of beds in hospitals then there would need to be fewer nurses required in hospitals. It was possible that there would need to be more GPs;

- staff would need to be trained to have the skills necessary for their jobs and skills would need to be utilised in a better way;

- the age profile of the NHS would mean that retirement should address any employment issues and there would be a reduction in the reliance of temporary staff.

A Member of the Sub-Committee asked what the risks of the proposed programme were and it was explained that one of the major risks was political opposition to the proposed changes. This was because the changes to the service would happen and through the proposed programme the changes would be planned. The programme would mean that no hospitals shut.

Another Member asked about potential land receipts and the representatives advised that if a site was under used it was likely that some of the land would be sold. The programme would require money to invest in the major hospitals.

Members then considered the possible future access and transport requirements for Northwick Park Hospital and expressed concerns about the adequacy of access to the 3 train stations for the elderly, those with a disability and visitors. In response, the representatives made the following comments:

- it was unlikely that there would need to be an increase in car park capacity;

- a disability access audit of Northwick Park Hospital would be undertaken;

- the programme did have a transport group which was in discussions with Transport for London;

- the new Accident and Emergency department would help to ease the direction and travel of patients;

- there was a need to charge for car parking as there were costs associated such as lights and security. In addition, if a charge was not levied it was possible that people who were not using the hospital would park there. An assessment of hospital car parking fees was carried out against the fees for parking of other public facilities.

An officer advised that the discussions at the meeting would help inform the response to the consultation from Harrow and that it was hoped that the response would be endorsed by Cabinet. The response from Harrow would be shared with the North West London Joint Overview and Scrutiny Committee.

The Chairman thanked all those present at the meeting for attending.

RESOLVED: That the presentation be noted.

(Note: The meeting, having commenced at 7.35 pm, closed at 9.14 pm).

(Signed) COUNCILLOR KRISHNA JAMES
Chairman