MINUTES OF A MEETING OF THE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Havering Town Hall
14 October 2014 (2.00 - 4.05 pm)

Present:

COUNCILLORS

London Borough of Barking & Dagenham	Danielle Lawrence and Eileen Keller
London Borough of Havering	Nic Dodin (Chairman) and Gillian Ford*
London Borough of Redbridge	Stuart Bellwood and Mark Santos
London Borough of Waltham Forest	Richard Sweden

*- part of meeting

Co-opted Members present:
Alli Anthony, Healthwatch Waltham Forest
Anne-Marie Dean, Healthwatch Havering
Mike New, Healthwatch Redbridge

NHS officers present:
Zoe Anderson, North East London Commissioning Support Unit
Rylla Baker, NHS England
Alan Steward, Havering Clinical Commissioning Group (CCG)

Council officers present:
Bruce Morris, Barking & Dagenham, Adult Social Care
Masuma Ahmed, Scrutiny Officer, Barking & Dagenham
Anthony Clements, Principal Committee Officer, Havering (Clerk to the Committee)
Jilly Szymanski, Health Scrutiny Coordinator, Redbridge

One member of the press was present.

14. CHAIRMAN'S ANNOUNCEMENTS

The Chairman gave details of the arrangements in case of fire or other event that would require the evacuation of the meeting room.

15. APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (IF ANY) - RECEIVE.

Apologies were received from Councillors Sanchia Alasia (Barking & Dagenham) Dilip Patel (Havering) Tom Sharpe (Redbridge) and Chris Pond (Essex).

Apologies were also received from Richard Vann (Healthwatch barking & Dagenham) and from Ian Buckmaster (Healthwatch Havering) (Anne-Marie Dean substituting).

16. DISCLOSURE OF PECUNIARY INTERESTS

There were no disclosures of interest.

17. MINUTES OF PREVIOUS MEETING

The minutes of the meeting were agreed as a correct record and signed by the Chairman.

Under matters arising, members from Redbridge confirmed that the information they had requested on locations of mobile breast cancer screening units had now been received as had an assurance that there were no plans to change that service. The Committee noted that the proposed breast cancer service changes had also been scrutinised by the Havering Health Overview and Scrutiny Committee who had supported the proposals. The Committee therefore **AGREED** that formal consultation on the breast cancer service proposals was not required.

18. URGENT CARE PROCUREMENT

The chief operating officer of Havering CCG explained that the way in which people currently accessed urgent care services in Outer North East London was very complicated. The four local CCGs therefore wished to improve this system.

At present, there were a large number of different providers of urgent care across the four boroughs. The procurement exercise would cover services including NHS 111 and the GP put of hours service. All walk-in centres in NHS London would also be included with the exception of that at Barking Community Hospital where a new contract had recently been put in place.

Work on the procurement exercise was in progress with stakeholders including Councils, CCGs and patient engagement forums. Each CCG also had a lay member for patient and public involvement.

The priority for any new services procured was that they be of high quality and clinically safe. Services should also be responsive to patient needs and provide a seamless service. It was not possible to continue with the existing system. The CCGs therefore wished to procure an innovative service. Any

successful bidder would also have to demonstrate that it had strong public and patient involvement. This would also apply to any sub-contractors involved.

A process of competitive dialogue would be used during the procurement which would allow bidders to show how they would take services forward. It was anticipated that final bids for the urgent care service would be submitted to the CCGs by April 2015. It was hoped the successful bidder would be announced by July with the new service starting in September 2015. Should a period of formal consultation be required, it was possible that these dates would need to be amended.

The chief operating officer agreed that it was critical that patients and the public were engaged in the procurement process. Patient engagement forums had been asked what they felt were the key elements of the urgent care pathways and these forums would be involved in the decision making process. The CCGs felt that the procurement was an exciting opportunity to resolve issues in urgent care.

The CCGs were keen to bring data together to understand patient flows across the system. It was confirmed that discussions had been held with the patient engagement forum in Havering and that consultation with patient groups in all boroughs would be ongoing.

It was explained that not many places in the UK had previously undertaken reprocurement on this scale, across the whole of the pathway. The appointment of a consortium of providers was therefore a possibility. A lead provider would however be expected to be appointed to take the lead with other organisations. This would include work with GPs, the local Hospitals Trust etc. A final specification for the urgent care services would be developed by the end of March.

An estimate of the proportion of A&E attendees who would be better placed in urgent care was 25-30% (not including Waltham Forest) and figures could be provided for the proportion in the different A&E departments. It was not possible to guarantee that services would remain in precisely the same locations as currently as this depended on the proposals received from providers.

Some consultation events had only been held in the daytime thus far but the CCGs were attempting to address this by e.g. holding stakeholder events during the evening.

The CCGs were already looking at sharing patient records across the system and would look at provider proposals around this. It was not possible at this stage to determine what proposals would constitute a significant change to local services and hence require a period of formal consultation. The detailed service proposals would need to be considered before this could be decided. Four bids had been received this far from organisations in

both the NHS and private sector. Due to reasons of commercial confidentiality, it was not possible to give any further details at this stage.

Bids had been made to the Prime Minister's Challenge Fund around data sharing of care records but the chief operating officer would look into the Pioneers Project of the Better Care Fund as a potential alternative source of funding.

The Committee **NOTED** the position.

19. INTERMEDIATE CARE CONSULTATION

The consultation on changes to intermediate care services had been discussed in each of the affected boroughs – Barking & Dagenham, Havering and Redbridge. Meetings had taken place with overview and scrutiny committees, health and wellbeing boards and patient and community groups. The consultation had in fact been extended by a period of two weeks and was due to close on 15 October. There had been approximately 300 responses to the consultation to date.

Officers felt that the consultation was clear that the number of rehabilitation beds was reducing as many of these services could now be provided in people's homes. Approximately 9,000 people had been treated under the new model, compared to 1,000 if the bed base only model had been used. The new services (community treatment team and intensive rehabilitation service) had also received good feedback from patients.

Members from Redbridge welcomed there being more services available at home but were disappointed that much of the consultation had taken place over the summer period. Redbridge had also previously asked for the consultation period to be extended. There were also concerns in Redbridge over the bed modelling system used and Redbridge Members indicated that they were minded to refer the matter to the Secretary of State.

A Member from Waltham Forest reported that a constituent had recently been discharged to the Heronwood & Galleon Unit at the age of 102 and had received a very good service.

It was not certain what the average number of physiotherapy visits per week was but visits could take place up to four times per day. Officers could supply data on the number of patients received daily or four-times daily physiotherapy visits.

It was accepted that staff recruitment was an issue across the health economy but both the Community Treatments Teams and the Intensive Rehabilitation service were currently fully staffed.

The number of beds at Grays Court in Dagenham would be reduced as services were centralised at the King George site. The stroke beds at Grays Court would be retained however as they were not part of the consultation. If the rehabilitation beds were removed from Grays Court, the future use of the building would be considered.

There were performance indicators measured for discharge services and outcomes from rehabilitation services. The reasons why people were admitted to hospital were also considered.

Officers would provide figures on the proportion of step up and step down referrals to the rehabilitation service. The number of step up referrals had reduced in the last year due to the introduction of the Community Treatment Team.
Officers clarified that the Ainsley Rehabilitation Unit was based in Waltham Forest and was not part of this consultation. Only one patient from the affected boroughs had used the unit for intermediate care and this had been requested under their patient choice. The Ainsley Unit was also run by the North East London NHS Foundation Trust.

Officers were aware of the National Audit of Intermediate Care Beds 2013 but felt that the audit had been a snapshot and added that it had not been obligatory for Trusts or CCGs to participate.

The Committee **AGREED** to keep to the individual borough Health Overview and Scrutiny Responses to the consultation and decided not to submit a response on behalf of the Joint Committee.

A Member's view was noted that support for those cared for at home should have at least the intensity of support for those cared for in hospital.

20. GP LIST SIZES AND CONTRACT ARRANGEMENTS

The Deputy Head of Primary Care (London Region) at NHS England explained that strategic planning groups were being introduced consisting of the CCGs from, for example, Barking & Dagenham, Havering and Redbridge. There was increasing to bring CCGs together in order that strategic planning group could take over co-commissioning arrangements for primary care.

NHS England was also required to make a 15% management cost saving which meant 24 people would be lost from the current London team of 108.

The new GP/General Medical Services (GMS) contract from 2015/16 was expected to lead to more GO federations and practices working together

etc. There would be more extended GP hours and weekend opening. More effective use of IT would also be expected.

The current (2014) GP/GMS contract had seen money going into practices per patient but would also see the beginning of the removal of the Minimum Practice Income Guarantee over the next seven years. There would also now be a named GP for all patients over the age of 75. This would extend to a named GP for all patients under the 2015/16 contract which would also expect GPs to take over commissioning of an out of hours provider.

The Friends and Family test would start for primary from December with results being published from January 2015. From January 2015, patients would also be able to register with a GP near to where they worked as well as with a home visiting service. New emphasis would be placed on GPs identifying cases of dementia avoiding unplanned admissions to hospital.

It was also explained that patient participation and alcohol reduction services would change under the 2015/16 contract to become contractual requirements of GPs. The formula for calculating pay to GPs would also be reviewed to ensure it was more reflective of levels of deprivation etc. GP net earnings would be published from April 2015.

There were also expected to be a lot of IT changes under the 2015/16 GP contract. All IT funding came from NHS England and GP practices would be expected to introduce on-line services such appointment booking and the availability of medical records.

In Havering for example, the overall number of GP practices had reduced by four over the last year. The number of smaller practices in Havering had also reduced from 21 to 13. The number of whole time equivalent GPs was reducing across the four Outer North East London boroughs and it was accepted that the number of GPs retiring was an issue for the whole area.

The NHS England officer accepted that there was still a difference between list size and the total population for each borough. List maintenance was being undertaken, concentrating on female groups. The overall GP list size for ONEL was however continuing to rise.

GPs were required to provide appointments to meet the reasonable need of their population but it was emphasised that NHS England had no powers or information concerning GP appointments or waiting times. NHS England did wish however to work with CCGs to improve access. NHS England was that patients were able to access a full range of services. The number of sole GP practices in the ONEL boroughs could be provided.

A representative of Havering CCG added that money had been received from the Prime Minister's Challenge Fund to extend access to GPs. It was hoped that the new GP Federations could be used to provide more appointments and GP services collectively.

Some GP contracts such as those for Personal Medical Services did include key performance indicators and these were monitored by NHS England. The standard GP contract for General Medical Services did not however include these types of indicators.

Complaints about GPs should normally be received by the GP practice itself but these could also be e-mailed to NHS England direct. While NHS England could only collate complaints, this did allow practices which received large numbers of complaints to be identified.

The Committee **NOTED** the presentation.

21. AMENDMENTS TO COMMITTEE'S TERMS OF REFERENCE

The Committee considered a report by the clerk to the Committee suggesting some changes to the Committee's Terms of Reference in light if the latest Department of Health guidance on health scrutiny. The report was **AGREED** without division and it was **RESOLVED**:

That the following paragraphs be added to the Committee's Terms of Reference:

Formal Consultations and Referrals to Secretary of State

25. Under guidance on Local Authority Health Scrutiny issued by the Department of Health in June 2014, only the JHOSC may respond to a formal consultation on substantial variation proposals covering health services in more than one constituent Council area. This power also extends to the provision of information or the requirement of relevant NHS officers to attend before the JHOSC in connection with the consultation.

26. The JHOSC may only refer matters directly to the Secretary of State on behalf of Councils who have formally agreed to delegate this power to it.

It was also noted that the introductory wording in the Committee's agenda papers would need to be revised in the light of recent Regulations allowing for the filming or recording of meetings by members of the public.

22. COMMITTEE'S WORK PROGRAMME 2014/15

The Committee's work programme was noted and there were no current changes suggested.

23. NEXT MEETING

The next meeting of the Committee would take place on Tuesday 13 January 2015 at 2 pm at Redbridge Town Hall.

24. URGENT BUSINESS

There was no urgent business.

Chairman