MINUTES OF A MEETING OF THE HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE
Havering Town Hall
19 April 2017 (7.00 - 8.20 pm)

Present:

Councilllors Dilip Patel (Vice-Chair), Carol Smith, June Alexander and Linda Van den Hende. The meeting was chaired by Councillor Patel.

Also present:

Barbara Nicholls, Head of Adult Services,
Alan Steward, Chief Operating Officer, Havering Clinical Commissioning Group (CCG)
Andrew Rixom, Consultant in Public Health
Natalie Keefe, Director of Primary Care Transformation, Barking & Dagenham, Havering and Redbridge CCGs
Hannah Murdoch, Communications and Engagement Manager, BHR Clinical Commissioning Groups

36 ANNOUNCEMENTS

The Chairman gave details of the arrangements to be followed in the event of fire or other event that may require the evacuation of the meeting room.

37 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS

Apologies were received from Councillor Michael White and from Councillor Alex Donald (Councillor Linda Van den Hende substituting).

Apologies were also received from Mark Ansell – Interim Director of Public Health (Andrew Rixom substituting).

38 DISCLOSURE OF INTERESTS

There were no declarations of interest.

39 MINUTES

The minutes of the meeting held on 26 January 2017 were agreed as a correct record and signed by the Chairman.

40 PMS REVIEW AND PRIMARY CARE UPDATE

Officers explained that the review of the Primary Medical Services (PMS) contracts held by some GP practices had now resumed with only a local rather than London-wide offer to be negotiated. The review aimed to ensure that all patients could expect to receive the same level of care from their GP.

Of 44 GP practices in Havering, 12 operated under a PMS contract. This allowed a total additional investment of around £1 million although this was the third lowest premium in London. The overall contract value would increase by £7.3 million over the next five years due to a combination of population growth and other cost pressures.

The CCG was looking at the transition costs of a new contract with a lower premium. Overall primary care investment was also being looked at as were economy wide solutions where possible. The new contracts were required to be agreed by the start of October 2017.

Any Havering practices that had been rated by the Care Quality Commission (CQC) as 'requires improvement' would be offered additional support. The CCG had also now developed policy and procedure templates for GP practices. Mandatory on line training was also supplied for practice staff in areas such as complaints, health and safety and infection control.

Whilst all Havering GP practices had now been inspected by the CQC, not all the inspection reports had been published as yet. Practices would be supported to develop an action plan based on the relevant CQC findings. It was confirmed that a CQC inspection did assess the quality of the relationship between a GP and patients by speaking to patient representatives.

There were three GP networks now established covering the north, central and southern parts of the borough and network leads had now been recruited.

The Sub-Committee NOTED the position.

41 ICP AND LOCALITIES MODEL

The Integrated Care Partnership (ICP) sought to address issues such as population growth, quality of service and financial issues. The ICP also aimed to allow more decision making to take place at a local level and ensure services were delivered in a more integrated, joined up way. This would avoid instances of, for example, patients having to give their details more than once during their care pathway.

It was accepted that recruitment and retention was a challenge for all partners involved. There was also a significant financial challenge facing the health economy, meaning it was important to encourage people to self-care

where possible. The Partnership sought to join up services offered by the Council, Hospitals' Trust and community service providers but the role of the community and voluntary sector also needed to be considered.

The localities would have a population of around 80,000 each and a locality design group included a broad range of stakeholders such as the Council, Havering CCG and Healthwatch. Stakeholders were keen that people should be involved in this different way of delivering services.

The north locality would focus on children's services initially whilst the central area would investigate how delays in referral to treatment could be avoided and the southern locality would consider access to urgent and emergency care. The work on children's services would focus on emotional health and wellbeing. The difficulties sometimes experienced in accessing child and adolescent mental health services would also be considered. It was planned for example for GPs to work with families and schools to arrange access to counselling. Referral to more formal mental health services would only be made at a later stage, if necessary.

Urgent and emergency care work would be linked to the intermediate care offer. It was aimed to divert people from attending A&E and to ensure that people spent as little time in hospital as possible. In order to improve outcomes, it was preferable to support people to stay at home.

For intermediate care, an integrated rehabilitation and reablement service had recently been launched and officers hoped the benefits of this would be seen within six months. It was hoped that this service would reduce duplication and hence benefit residents.

A joint commissioning board would be established across the 3 local boroughs and CCGs. A system programme delivery board would look at the CCG deficits and how to reduce these. It was emphasised that the localities work also involved other Council functions such as housing, benefits advice and careers advice.

The number of care visits in a person's home depended on their assessment. This could be as many as 4 visits a day when a person was first discharged from hospital. Homecare was currently monitored via a swipe card system and the new service would also have a full monitoring mechanism for the quality of care.

The operational management of the integrated rehabilitation and reablement service would be undertaken by NELFT. Officers clarified that there were not currently any social workers in the service but this would be kept under review.

The Sub-Committee NOTED the report.

42 PUBLIC HEALTH SERVICE PERFORMANCE REPORT

Officers explained the dashboard showing progress against the current service plan for public health. This covered areas such as stronger partnership work (within the Council and elsewhere) and improving quality and cost effectiveness via for example the recommissioning of the Council's sexual health services. Other developments included the establishment of the Health Protection Forum and more representation of public health on safeguarding groups. The Health Champion programme would also be expanded with the aim of improving health knowledge in the workplace.

Members expressed disappointment that a specific health objective would not be included in licensing applications but officers felt that the licensing policy in Havering was influenced by public health issues.

The strategy for childhood obesity covered the need for more exercise and the role of video games etc.

The Sub-Committee NOTED the performance report.

43 Q4 PERFORMANCE INFORMATION

It was noted that the Council's performance on the proportion of service users successfully completing drug treatments had improved and was currently at 52.3% of users undertaking the treatment.

44 HEALTHWATCH REPORTS

A director of Healthwatch Havering explained that the organisation had increased the number of visits to GP practices over the last year. This had been prompted by problems encountered by the Rosewood Practice. It was noted that, following a successful merger, the situation at Rosewood had improved. This practice would be revisited by Healthwatch shortly.

Over the last year, a total of 13 Practices had been visited by Healthwatch, some as part of a review of the GP hub system. Healthwatch had found that the availability of out of hours GP services was not widely known.

Many GP premises were converted houses which could be problematic and other surgeries shared the same premises but failed to work together. A particular issue noted by Healthwatch was the situation at the Harold Hill Health Centre where 4 GP Practices each operated from the site with a separate reception desk and no evidence of any working together etc. Healthwatch felt therefore that the CCG should do more to encourage practices to work together. A site such as the Harold Hill Health Centre should have been a super-practice rather than housing 4 separate practices.

Healthwatch wished to see fewer physical barriers between GP receptionists and patients. A training package for GP receptionists had been

developed by Healthwatch but this had not seen a good take up. It was acknowledged that GP receptions were also often short staffed.

A GP in the Rainham area had recently been placed into special measures and it was confirmed that the CQC did have the power to close practices where necessary – something that had already happened in Barking & Dagenham and Newham. Around 40% of Havering GPs whose inspection reports had been published had been rated as requires improvement or inadequate which was the highest proportion in London. This was felt to also be a regional problem as similar outcomes were being seen in neighbouring boroughs.

It was unclear how many GPs with lower ratings were single-handed although it was agreed that single-handed GPs often received better patient feedback via the Quality Outcomes Framework. Healthwatch had also noted a lack of GP partners due to the added responsibility of running a practice business. There was now a move towards larger companies operating GP practices.

Healthwatch had visited Maylands Surgery in October 2016 in response to the flash flooding at that site and the long period of time it had taken to make repairs. Healthwatch had therefore recommended that the CCG and the practice should look at resilience plans and that the CCG should also ask all its practices to review their resilience plans. It was emphasised that Healthwatch felt that Maylands had done a good job in difficult circumstances.

Healthwatch had also recently inspected the Mungo Park surgery based at South Hornchurch clinic. It had been found that patients were unable to use the surgery car park as this was taken up by local parents and business parking. The building owners had confirmed they were now looking at introducing parking enforcement for the car park – an improvement that had been suggested by Healthwatch.

45 **URGENT BUSINESS**

There was no urgent business raised.

Chairman