

**MINUTES OF A MEETING OF THE
HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE
Havering Town Hall
7 September 2017 (7.00 - 9.10 pm)**

Present:

Councillors Michael White (Chairman), Dilip Patel (Vice-Chair), Denis O'Flynn, Alex Donald, Carol Smith and Nic Dodin

Also present:

Ian Buckmaster, Carol Dennis, Jenny Gregory and Di Old (Healthwatch Havering)
Mark Ansell, Director of Public Health, Barbara Nicholls, Director of Adult Services,
Ian Tompkins, East London Health and Care Partnership.

11 ANNOUNCEMENTS

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

12 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS

There were no apologies for absence.

13 DISCLOSURE OF INTERESTS

There were no declarations of interest.

14 MINUTES

The minutes of the meeting of the Sub-Committee held on 28 June 2017 were agreed as a correct record and signed by the Chairman.

15 RESPONSES TO DELAYED REFERRALS TO TREATMENT REPORT

A director of Healthwatch Havering welcomed the general acceptance by the NHS of the findings of the topic group. It was accepted that recent cyber-security attacks on the NHS did not relate directly to Referral to Treatment but this did show the need for robust governance of IT systems.

The Deputy Chief Operating of BHRUT also welcomed the report and agreed with its findings overall. The national waiting time target of 92% of patients waiting less than 18 weeks had been achieved by the Trust in June

and July 2017 but the Trust also wished to ensure that this recovery was sustainable overall.

The Trust officer added that the issue had been discovered during a change of IT suppliers but this had not been the main cause. It was also felt that demand management in primary care should be more actively managed. The Trust welcomed the outcomes of the report and the opportunity to respond to it.

Whilst progress had been made in reducing waiting times, the Trust officer added that BHRUT was also under pressure from commissioners not to overspend which could lead to an increase in waiting times for treatment. It was confirmed that only a handful of patients were now waiting more than a year for treatment and that these may have complex pathways or had in fact chosen to delay their treatment.

Healthwatch could bring an update on referral to treatment data reporting to the March 2018 meeting of the Sub-Committee. It was confirmed that the Trust was penalised if targets were not delivered by each of the CCGs, NHS England and the Trust's overseeing authority. A report on performance indicators that was going to the Health and Wellbeing Board could also be circulated to the Sub-Committee for information.

The Sub-Committee NOTED the responses to the joint topic group report.

16 **EAST LONDON HEALTH AND CARE PARTNERSHIP**

The East London Health and Care Partnership (ELHCP) had previously been known as the Sustainability and Transformation Plan (STP). It had been felt however that the STPs had been developed in isolation and had not developed sufficient levels of engagement. The plan had been developed in the context of changes in East London including a fast growing, diverse population and reduced funding to Councils.

Figures from October 2016 predicted that the North East London health economy would face a £580 million gap in funding by 2021. Whilst people were living longer, they were also suffering with more complex illnesses etc. Officers were looking to relieve this position by measures such as relocating GPs and reprocurring the NHS 111 service. Work was also in progress on prevention by for example encouraging self-care and reducing delayed discharges from hospital. It was accepted that there were difficulties in recruiting doctors and nurses as well as with the provision of key worker accommodation.

The above issues meant it was necessary to collaborate and bring services together although there were different cultures in Councils compared to the NHS as well as different financing mechanisms. The STP and now ELHCP therefore sought to bring together different parties such as Local Authorities, the NHS, carers and the voluntary sector. A document had recently been produced explaining in clear language what the ELHCP meant to local

people and a revised version of this would be circulated to the Sub-Committee.

A community group had been formed to support the Partnership which comprised many different voluntary sector groups. It was also wished to involve charities, schools, colleges and hospices in this work. The Council Chief Executive was the lead Council officer for the London-wide steering group.

A wider partnership was needed to consider cross-sector issues such as performance monitoring, assurance and GP recruitment. The provision of key worker accommodation was an issue and it was hoped that proceeds from the sale of NHS estates could be retained within East London. Work was also in progress to establish career paths within midwifery.

Concerns were raised by Members over the rising population locally and that health facilities were not sufficient to cope with this. Officers agreed that the NHS workforce was the biggest single issue and that a large amount of resources was having to be spent on agency staff. Work was under way to develop the clinical training programme as well as other initiatives such as the introduction of physician associates in Waltham Forest and trying to have community pharmacies taking on some work of GPs. Some funding was also available to recruit more GPs from overseas.

It was felt that NHS language needed to be simplified in order that people attended the right facility rather than just A & E. Other changes to the system were needed including reducing amounts spent on prescribing drugs that could be cheaply obtained in any supermarket.

It was agreed that, for the aims of the ELHCP to be achieved, different ways of working had to be found such as e.g. use of phone apps to monitor heart conditions. It was aimed to give people greater control over their own health although this would take time to achieve. Updates on progress with meeting objectives could be given to the Sub-Committee.

It was also noted that there were linkages from much of this work to the BHR Integrated Care Partnership and also to work in Havering to establish a locality model.

It was AGREED that an update on the work of the ELHCP should be taken at the meeting of the Sub-Committee in March 2018.

17 HEALTHWATCH HAVERING - ANNUAL REPORT

The director of Healthwatch Havering explained that, in the year under review, the organisation had undertaken a total of 42 enter and view visits. Seventeen of these had been to GP practices in light of serious concerns about local GP practices that had been raised to Healthwatch. It was noted

that there were a lot of smaller GP practices in Havering and the locality working group was looking at alternative ways of providing GP services.

In the coming year, Healthwatch was planning to do work on vision services and this would include visits to the Queen's Hospital Ophthalmology Department as well as to local opticians. Healthwatch was also looking at ways to improve access to A & E and reducing use of confusing terminology such as walk-in clinics etc.

Work was also continuing with parents of children with learning disabilities as well as on developing relationships with other local Healthwatch organisations.

Healthwatch Havering's report on the street triage service had been taken recently to the Crime & Disorder Sub-Committee, following a referral by this Sub-Committee. The Chief Superintendent for Havering had indicated that there would now be stronger Police buy-in to the street triage service.

Members raised concerns over two local Practices giving phone diagnoses although it was noted that patients were now given a choice of doing this and that the system was now working better.

It was accepted that there had not originally been a great demand for GP hub appointments at weekends but it was felt that demand for this service may now be increasing.

The Sub-Committee NOTED the annual report of Healthwatch Havering.

18 **PUBLIC HEALTH BUDGET**

The Director of Public Health reminded the Sub-Committee that the public health service had transferred to the Council in April 2013. The service worked with the CCG and with the rest of the Council to improve the health of local residents. Some mandated public health services were provided such as health checks and health visiting while other non-statutory services such as those for drug and alcohol addiction were also provided by Public Health.

For the first two years after the transfer of public health, funding had grown and this was initially invested in children's services. Additional funding was also received in October 2015 when the service took over the health visiting function. In 2016 however an in-year cut of £600k had been made by central Government to Havering's public health allocation. Further cuts of around 4% per year would also be made for the next four years. Reserves had been used initially to cover these cuts but savings of a further £750k would be needed by 2019/20.

Some savings had already been achieved such as £450k from the reprocurement of the Drug and Alcohol Action Team. Reductions in the public health team itself had also resulted in savings of £350k. Reserves

could however only cover current overspending against the public health allocation for the next two years.

Smoking cessation support was now only offered to pregnant women and people with serious mental illness. The demand for this service had reduced due to the rise in popularity of e-cigarettes and it was no longer cost effective to provide this.

The issue of air pollution was not likely to be made a mandated service. It would be for central Government to drive technology and changes to car design etc. It was possible however to consider what could be done locally re air pollution and an update could be given at a future meeting. Air pollution in Havering was at a relatively low level.

The Sub-Committee NOTED the position.

19 **PERFORMANCE INFORMATION**

It was clarified by officers that the Health and Wellbeing Board received a dashboard of 10 indicators covering the health of the local population etc. It was suggested that the Sub-Committee could also look at indicators covering delayed transfers of care and non-elective admissions to hospital.

Obesity levels were also suggested as an indicator that could be monitored. There was not any weight management service currently offered but Public Health did work with schools on projects such as the Healthy Schools award. Curriculum support was also provided to schools in areas such as nutrition and physical activity.

The cuts to public health budgets were a national issue and had been in the same proportions for all areas. Pooled budgets were also being used with for example a joint procurement of sexual health services with neighbouring boroughs.

Following discussion, it was agreed that the following indicators would be monitored by the Sub-Committee:

Children's obesity – Public health objective 2.6

Patient experience of primary care – NHS QF 4 (a) (ii) re the GP out of hours service.

Delayed transfers of care – ASCOF indicator 2C

It was further agreed that a report on air quality in Havering should be taken at the next meeting of the Sub-Committee.

20 **URGENT BUSINESS**

There was no urgent business raised.

Chairman