MINUTES OF A MEETING OF THE
HEALTH OVERVIEW & SCRUTINY COMMITTEE
Havering Town Hall
24 June 2014 (8.15 - 10.20 pm)

Present:

Councillors Nic Dodin* (Chairman), Dilip Patel (Vice-Chair - the Chair at the start of the meeting), Joshua Chapman, Gillian Ford*, Jason Frost* and Patricia Rumble.

*- part of meeting.

Councillor Wendy Brice-Thompson was also present.

There were no apologies for absence.

Also present: Mark Ansell, Acting Director of Public Health, Ian Buckmaster, Healthwatch Havering, Ilse Mogensen, North East London Commissioning Support Unit, Dr Gurdev Saini, Havering Clinical Commissioning Group (CCG) Alan Steward, Havering CCG.

The Vice-Chairman as details of the arrangements in case of fire or other event requiring the evacuation of the building.

1 **DECLARATIONS OF INTEREST**

There were no declarations of interest.

2 **MINUTES**

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

3 **INTRODUCTION TO SCRUTINY**

The clerk to the Committee gave a presentation covering the role of Overview and Scrutiny and how it was applied in Havering. The presentation also discussed the powers of health scrutiny and the Health Trusts and similar bodies operating in the local area. It was explained that a number of issues would need to be scrutinised on a cross-border basis, in conjunction with neighbouring boroughs.

The Committee **NOTED** the presentation.

4 LOCAL HEALTH ECONOMY AND INTERMEDIATE CARE

The Chief Operating Officer of Havering Clinical Commissioning Group (CCG) explained that the CCG, which had been in operation since April 2013 commissioned a large number of services covering areas such as community health, mental health and secondary or hospital care. Services were commissioned across London, not just from the local Hospitals' Trust. The CCG was principally made up of GPs and GPs themselves were mainly accountable to NHS England.

The CCG's overall commissioning budget was £304.7 million per year while annual running costs totalled £6.3 million. The CCG's work was supported by a Commissioning Support Unit that worked across the whole of North East London. The CCG was a statutory body with a governing body elected annually. The governing body included seven GPs, a senior nurse, a secondary care consultant and lay members covering audit and patient involvement. The CCG leadership was accountable to the Members' Committee which included all 49 GP practices in Havering. There was also a Joint Executive Committee working jointly with the CCGs in Barking & Dagenham and Redbridge.

The CCG was also part of the Integrated Care Coalition and was involved, with the Council, in drawing up the Joint Strategic Needs Assessment. The population of Havering was continuing to get older and there was an associated low satisfaction with e.g. access to primary care.

The CCG was focussing on a number of key areas including improved access to urgent and primary care and developing a new model for complex care. This would aim to help the most regular visitors to hospital. A system of integrated case management was also being developed for people with long-term conditions such as asthma and diabetes.

It was also hoped to integrate urgent and emergency care services by combining the contracts for these. It was acknowledged that the BHRUT Hospitals' Trust had been put into special measures and the Trust's improvement plan had been published in the last week.

As part of its focus on elderly people and long-term conditions, the CCG had commissioned a Community Treatment Team. This was a rapid response team that visited people at home who suffered from long-term conditions such as deep vein thrombosis. This could be accessed via the NHS 111 service or through a referral from another health professional. Patients with long-term conditions were also given details of the service. From April 2014, Integrated Health Teams had been introduced for the six GP clusters in Havering. These would co-locate nursing and community therapy teams and would also involve secondary care clinicians in managing long-term conditions. The Government Better Care Fund could also be used to promote integrated care services that were run jointly between the Council and the CCG.

The CCG was committed to having care provided closer to people's homes and services such as dermatology and ophthalmology were being provided in local settings rather than in hospital. This would be applied to more services in 2014/15 including cardiology and diabetes services.

The CCG had received a total of £5.6 million from the Prime Minister's Challenge Fund which was the highest amount nationally. This funding was to be used to transform primary care. It was planned that one GP in each Havering cluster would provide care 8 am to 10 pm, seven days per week. The development of a GP Federation in Havering would assist with this. It was also hoped to develop electronic sharing of care records across GP practices. A map of local health services and GP clusters would shortly be put on the GP website.

As regards intermediate care, the CCG wished to improve the productivity of community-based beds and the trial of Community Treatment Teams would continue across the three local CCGs. Intermediate care helped recovery from illness and prevented admission to hospital or long-term residential care where this was not necessary. Both the Community Treatment Teams and the new Intensive Rehabilitation at Home service had received high satisfaction rates in patient surveys. While these services were on a trial basis at present, the CCG wished to introduce them permanently in Havering. A business case for this change would be considered by the CCG executive that week and this would lead to a consultation exercise on the proposed changes.

The CCG was responsible for commissioning services for children with disabilities although the Council would have a role in this from September 2014. Public Health was also involved in work to discourage parents from taking their children to A&E unnecessarily.

Work was ongoing with social care colleagues on how care funding could be better invested in the community and more details could be provided to the Committee on this. Plans on the impact of personal budgets had recently been shared with the Health and Wellbeing Board.

It was clarified that extended GP opening times would only be for patients needing urgent or emergency treatment. The Chief Operating Officer added that the new GP contract that would commence from 2016 would require GP practices to open 8 am to 8 pm, seven days per week. Feedback from Queen's Hospital had indicated that relatively few attendances at A&E had been due to people being unable to obtain GP appointments.

It was confirmed that there was an out of hours GP service covering Havering although Members reported that telephone guidance given had stated specifically that this was not the case. It was hoped to appoint in the future one contractor for the whole pathway as this would allow a greater consistency of message to be given.

There were a total of 104 rehabilitation beds for Havering residents available at King George Hospital and other sites. The CCG felt it that only 40-60 beds would be needed, provided these were all based at one site. It was planned to start a 12 week consultation on these issues from 7 July.

The Committee **NOTED** the presentation.

5 COUNCIL CONTINUOUS IMPROVEMENT MODEL - UPDATE ON PUBLIC HEALTH TRANSITION

The Acting Director of Public Health explained that responsibility for public health had moved from the former Havering Primary Care Trust to the Council in April 2012. Certain functions such as immunisation and health visiting were the responsibility of Public Health England although health visiting was due to transfer to the Council in September 2015.

Public Health was already responsible for a large number of functions such as weight & measurement checks for children, healthcheck provision, some sexual health services and school nursing.

A public health outcomes framework was used which gave Havering data for around 100 indicators covering health improvement, premature mortality and the wider determinants of public health.

The Council received a public health allocation of funding to cover work in this area. While this funding had risen in the last two years, it remained below the target figure. The largest proportion of the public health budget was spent on sexual health and drug & alcohol services.

Public health priorities for Havering had included leading on drug & alcohol and teenage pregnancy work. Work was also undertaken with other Council teams on areas such as fuel poverty and sports development. Public health analysis was also submitted for the Joint Strategic Needs Assessment.

The health protection role of Public Health was developing and a health protection forum had been established with Public Health England. As regards health improvement, smoking cessation and weight management services were available but it was hoped to recruit more volunteers to assist with health improvement work. Other services commissioned by public health included an alcohol liaison service at Queen's Hospital and the reinstatement of vision checks for children in the reception year. Emergency contraception was also provided by Public Health to community pharmacies. Public Health did already have contact with local food banks as it was important to target those in need but this area would be investigated further.

The Committee **NOTED** progress with the issue since the Executive Decision had been taken.

6 HEALTHWATCH HAVERING - DEMENTIA AND LEARNING DISABILITIES REPORT

The Director of Healthwatch Havering explained that a series of five meetings had been held during February and March 2014 concerning dementia and learning disabilities. The meetings were attended by a mix of NHS and Social Care officers as well as service users and carers.

It had been found that the rising population in Havering (which was increasing quicker than that of London as a whole) was putting more pressure on the local health and social care economy. The increasing number of elderly people in Havering was also linked to higher numbers of cases of dementia being diagnosed.

Healthwatch had concluded that services for dementia were adequate overall although there was still a lot to do. Learning disability services were however somewhat less advanced. A more contemporary model was needed for both dementia and learning disabilities.

Concerns had been raised that service users and carers did not know where to go for support and were unaware of what services were on offer. Personalised budgets were considered to help in the longer term but it was felt people may find these difficult at first.

The Healthwatch events had led to a number of recommendations including for the review of arrangements for Annual Healthchecks and that steps should be taken to ensure all Havering GPs have training in dementia and learning disability. Areas where under-diagnosis of dementia was occurring should be identified and addressed and Healthwatch also felt there should be prompt referral of dementia patients for services such as optometry, dentistry and hearing checks.

Other recommendations included ending any delay between a diagnosis of dementia and the commencement of treatment and the development of a clear information path for learning disability and dementia. There was also a need for further clarity from the North East London NHS Foundation Trust (NELFT) on the future of Admiral Nurses in Havering.

Healthwatch had also recommended that a 'One Stop Shop' should be provided for the benefit of service users and carers and that 'reachability' should be introduced as a criterion for measuring services in these areas.

A number of actions had already been taken in response to the Healthwatch report including discussions with NELFT and Age Concern over the position if a person with dementia refuses to attend the memory service or their GP. The CCG was also discussing with NELFT the lack of Admiral Nurses in the borough.

Members welcomed the Healthwatch report and it was confirmed that the current dementia diagnosis rate for Havering was 49%. The national target

was to increase this to 67% in the next two years. Details of the work of the dementia partnership board and of the dementia alliance which was to be launched shortly could also be provided. The Committee felt it was important that the Butterfly Scheme which indicated on a patient's notes if they suffered from dementia continued to be used as widely as possible.

The Committee **NOTED** the Healthwatch report.

7 COMMITTEE'S WORK PROGRAMME

It was **AGREED** that a joint meeting should be arranged with the Children & Learning Overview and Scrutiny Committee in order to scrutinise issues relating to children's health. Committee Officers would discuss with both Committee Chairmen a date and agenda for the meeting which would be circulated in due course.

It was **AGREED** that some future meetings of the Committee should focus on specific themes within health services. The next meeting would focus on acute and hospital care. The clerk to the Committee would circulate a revised outline work programme to Members for information.

8 NOMINATIONS TO JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEES

It was **AGREED** that Councillors Dodin, Ford and Patel would be the Committee's representatives on the Outer North East London Joint Health Overview and Scrutiny Committee.

It was also **AGREED** that Councillor Dodin would be the lead representative for the Committee on any pan-London scrutiny of issues that may be required during the municipal year.

9 COUNCIL CONTINUOUS IMPROVEMENT MODEL

The Committee noted that the Executive Decision on Healthwatch Implementation was now due for review under the Council Continuous Improvement Model. It was **AGREED** that an update on this area should be given at the next meeting.

10 URGENT BUSINESS

The Committee **AGREED** that future meetings would commence at 7 pm.

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Chairman

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