MINUTES OF A MEETING OF THE
HEALTH OVERVIEW & SCRUTINY COMMITTEE
Havering Town Hall
18 April 2013 (7.00 - 9.35 pm)

Present:

Councilllors Pam Light (Chairman), Wendy Brice-Thompson, Frederick Osborne, Linda Trew, Ray Morgon and Barbara Matthews (substituting for Councillor Nic Dodin).

Also present:
Mary Black, Director of Public Health
John Atherton, Head of Assurance, NHS England
Alan Steward, Havering Clinical Commissioning Group (CCG)
Sarah Haider, Havering CCG
Anne-Marie Dean, Healthwatch Havering
Ian Buckmaster, Healthwatch Havering
Fiona Weir, North East London NHS Foundation Trust

62 **ANNOUNCEMENTS**

The Chairman gave details of the action to be taken in the event of fire or other event requiring the evacuation of the meeting room.

63 **APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS**

Apologies were received from Councillor Nic Dodin (Councillor Barbara Matthews substituting).

64 **DISCLOSURE OF PECUNIARY INTERESTS**

There were no disclosures of interest.

65 **MINUTES**

It was noted that Councillor Sandra Binion was in fact substituting for Councillor Wendy Brice-Thompson at the previous meeting rather than as stated. The minutes were otherwise agreed as a correct record and signed by the Chairman.

66 **CHAIRMAN'S UPDATE**

The NHS 111 telephone service had recently gone live in Havering and the Committee Officer would circulate a performance update on the service that had recently been received.

It had recently been announced that the 498 bus route from Brentwood to Romford Station would now call at Queen's Hospital. Similarly, the 499 route from Harold Hill would now stop at the rear entrance to the hospital in Oldchurch Road.

The Joint Committee had recently looked at the proposals for changes to services for urological cancer and had raised concern at the travel difficulties this may present to patients and their families. Possible solutions had included the offer of overnight stays, subsidised taxis and allocated parking spaces at the regional centres. The Joint Committee had felt it was essential that a transport plan was put in place before the changes to services were made.

A visit was being planned by the Committee to the South Hornchurch Health Clinic in order to ascertain how the building was now being utilised. It was also hoped to visit the new birthing centre at Queen's Hospital.

67 NHS COMMISSIONING BOARD

It was explained that the Board was now known as NHS England and that its main roles were to directly commission primary care and specialised services and to allocate the budget to local Clinical Commissioning Groups. NHS England also had a number of other roles however including health service strategy, civil emergencies, national standards setting, leadership development and helping commissioners to be more effective.

The London region of NHS England was split into North, Central and East areas and the establishment of NHS England had reduced complexity in the NHS. A policy of 'assumed autonomy' had been implemented with CCGs which meant there would be a more supportive, assurance driven process of supervision. Each region had a director of delivery – Paul Bennett for the region covering Havering and regional teams were made up of nursing, medical and finance colleagues.

NHS England managed the delivery of care across the whole of the sector and focussed on both standards and financial issues. Current challenges included the winter and spring pressures on A&E and the introduction of the 111 telephone service. NHS England wished to ensure that CCGs were being suitably ambitious and there were still some conditions placed on many CCG authorisations. The NHS England representative was also attending meetings of Havering's Health and Wellbeing Board.

NHS England was also involved with the regional quality safeguarding group which brought together all the agencies involved in safety and quality. The Healthwatch representative present considered this to be a very positive development.

A Member felt that the role of NHS England was too bureaucratic and that more focus was needed on local services. It was explained that the new NHS structure was leaner than previously and that NHS England was a smarter organisation than the previous Regional Health Authorities. The Director of Public Health agreed that the UK had lower health care administration costs than the USA but felt that this should continue to be monitored.

There was a financial limit in the administration costs of the CCG of £25 per head of population. Although the Havering population was rising, it did not necessarily mean that the CCG would get more funding; this would depend on the allocation formula.

The Director of Public Health wished NHS England to support efforts to increase Havering's public health allocation which was the third lowest in London. The NHS England representative accepted that Health Service structures were complicated but reiterated that the priority was to ensure good services on the ground. NHS England was itself held to account by the NHS mandate and local and regional teams ensured scrutiny of NHS England's work at a local or sector level. Local problems could also be raised by NHS England via their role with the Health and Wellbeing Board on which they were represented.

While NHS England had the responsibility of allocating funding to CCGs, it was emphasised that this would be done with a relatively light touch. Expectations around the required delivery of services would be set by the NHS Mandate and by the NHS Outcomes Framework. Struggling CCGs would be supported more directly by NHS England. Standards of performance for CCGs were expected to be published later this month.

As regards the acute sector, it was explained that BHRUT would be held to account for the performance of Queen's Hospital by the CCG which would itself be held accountable by NHS England. The NHS Trust Development Agency also addressed standards in Hospital Trusts.

Performance information for the CCG was now available and it was suggested that this could be scrutinised by the Committee in the future. This could for example include data on how BHRUT were performing against their contract with the CCG. Although NHS England saw the same CCG performance data, this was from a different perspective and officers felt that the CCG should be held to account by both the Overview and Scrutiny Committee and NHS England.

NHS England also commissioned some local primary care services which also had an impact on the numbers going to A&E etc. It was confirmed the four hour rule for A&E performance was not being dispensed with.

The Healthwatch Havering Chairman suggested it would be useful if all partners could get together in the coming weeks and seek to work through local relationships in the health sector. It was suggested that Healthwatch Havering should take this forward outside of the meeting. The Director of Public Health felt the outcome of this work could also potentially be presented at the Public Health England conference.

The Committee **noted** the update.

68 HAVERING CLINICAL COMMISSIONING GROUP

It was confirmed that the Havering Clinical Commissioning Group (CCG) was now fully authorised although, in common with many CCGs, there were some conditions on the authorisation in areas such as financial planning. The overall aim of the CCG was to improve services and outcomes for local people and communities. Specifically, the CCG was responsible for holding secondary care or hospital providers to account as well as providers of community and mental health services. While GP contracts were now with NHS England, the CCG also had responsibility for improving primary care. The CCG was also a member of the Health and Wellbeing Board which brought all partners together to check that their work fitted with overall strategies.

The CCG was made up of all Havering GP practices and had a formal governance structure. This included lay members representing audit and patient & public involvement. A secondary care consultant and a nurse were also members of the CCG Board, as well as GPs themselves. The CCG clinical directors were elected by the Havering GP practices.

The CCG could be scrutinised by each of the Health Overview and Scrutiny Committee, NHS England and Healthwatch Havering. All meetings of the CCG Board were minuted and held in public. For meetings from 1 April 2013, minutes would be available on the CCG website.

The CCG worked closely with its equivalent organisations covering Redbridge and Barking & Dagenham. Havering CCG took the lead on monitoring the contract with BHRUT. Havering CCG had developed its commissioning strategic plan following a process of engagement with patient representative groups. The CCG also had a number of different priorities including the improvement of General Practice, addressing emergency and integrated care and building effective partnerships. The work of the CCG was also closely aligned with the Health and Wellbeing Strategy.

Members were concerned that the CCG plans as presented were too generic, feeling in particular that GP surgeries should be open longer hours and that the current under use of some medical facilities should be addressed. The CCG chief operating officer confirmed that there were plans being developed to make more use of existing facilities. In the longer term, the CCG wished to see more services provided in the community or in people's homes which was also often a cheaper option. Evening GP sessions would be introduced and the CCG was also in discussion with its members about opening some GP surgeries at weekends.

The chief operating officer agreed that the use of facilities in Havering needed to be addressed and a primary care investment strategy was being developed. The CCG wished to engage with patients and the public on these plans. As regards GP access, the CCG was looking at disseminating good practice and accepted that GP access was a major issue. Members agreed, feeling that the GP should be people's first point of contact and that out of hours availability was therefore vital.

Other issues raised by Members including the need for more chiropody services in the community, particularly in the light of patients from Cranham now having to travel to South Hornchurch for chiropody services. The CCG officers agreed that services such as the removal of stitches should be offered by GPs.

GP outcomes were measured by a series of GP Outcomes Standards that were available on-line. A comparison of local GPs was also available via the My Health London website and CCG officers would supply further details.

The decision to consult on developing a centre of excellence at the St. George's Hospital site was driven by the elderly nature of the local population. There would however also be other sources of treatment for local elderly people. The consultation was only on the overall principles of the development at this stage although a Member felt that it was unclear where the St. George's proposals fitted into the wider CCG plans.

The CCG chief operating officer also wished to see an enhanced GP service at St. George's and would look at comments made about this during the consultation. Some Members felt that the consultation had been inconsistent with little meaning although the Chairman and other Members disagreed with this. The chief operating officer agreed to come back to the Committee after the conclusion of the consultation with further details of the proposals.

Members also felt that the rising elderly population of the borough should be taken into account as should local transport issues.

The Committee **noted** the update.

69 HEALTHWATCH HAVERING

The Chairman noted that the Committee had enjoyed a good relationship with Havering LINk and was keen for this to continue with Healthwatch Havering. The Healthwatch Havering Chairman agreed and felt that Healthwatch had been given a strong voice to influence how health and social care services are provided locally.

Healthwatch Havering was a company limited by guarantee with, at this stage, three directors including the Chairman. The LINk coordinator had been transferred under the TUPE regulations to a similar role with Healthwatch.

Healthwatch Havering had a voluntary membership consisting of lay members working outside the health or social care sectors and volunteers who did work in these areas. Steps would be taken to avoid any conflicts of interest that volunteers may incur during their Healthwatch work.

It was planned to recruit six lay members and seven volunteers. The lay members would work with each CCG cluster while the volunteers would each be responsible for a certain area including mental health, Queen's Hospital, young people and over 50s services. Volunteers would also cover optical and pharmacy services which were new responsibilities that had been given to Healthwatch.

Governance arrangements for Healthwatch included a policy advisory board and a separate board to consider strategic, governance and quality issues. Healthwatch Havering was a member of the Health and Wellbeing Board and was also represented on the local and regional Quality Surveillance Groups. The Care Quality Commission was also legally required to take account of information gathered by Healthwatch Havering.

A lease was currently being progressed for Healthwatch Havering to be based in office premises at Harold wood polyclinic. Two surgery sessions per week would also be held at Care Point in Romford.

Recruitment of Healthwatch volunteers had commenced and volunteers would receive an induction, CRB checks and level one safeguarding training. Training in conducting enter and view visits would also be given to all 13 volunteers and lay members.

The Healthwatch chairman had met with Havering LINk and agreed a formal handover. The Healthwatch chairman thanked the LINk for their work and also recorded thanks to John Tench on Adult Social Care for his assistance in setting up Healthwatch and the Council, Overview and Scrutiny Committee and the CCG for their welcome and support.

A CCG representative felt it was important that Healthwatch was looking to involve young people. It was suggested that Healthwatch should look in

particular at the transition between paediatric and adult mental health services. The Committee recorded their disappointment that they had not been informed of a youth service event that had been held in Romford earlier that day.

It was noted that a Healthwatch director would attend future meetings of the Committee as well as of the Joint Committee. Members felt it was important that Healthwatch should avoid duplicating the work of the Health and Wellbeing Board and the Chairman added that she planned to ask Healthwatch to undertake enter and view visits to local health premises if a suitable issue arose. The Healthwatch Havering website had also recently gone live.

The Committee **noted** the presentation.

70 **URGENT BUSINESS**

Several Members reported renewed problems with the complaints system at BHRUT where it had been stated that complaints were not being acknowledged for a long time, if at all. It was therefore **agreed** that a topic group meeting should be arranged where these issues could be scrutinised with BHRUT officers in more detail. This would include an explanation of the BHRUT standard operating procedures and worked examples of how complaints about hospital services were dealt with at the Trust.

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Chairman

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