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JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE AGENDA

3.30 pm	Tuesday 10 July 2012	Havering Town Hall, Council Chamber

COUNCILLORS:

LONDON BOROUGH OF BARKING & DAGENHAM

Councillor Sanchia Alasia
Councillor George Barratt
Councillor Abdus Salam

LONDON BOROUGH OF WALTHAM FOREST

Councillor Khevyn Limbajee
Councillor Sheree Rackham
Councillor Nicholas Russell

LONDON BOROUGH OF HAVERING

Vacancy
Vacancy
Vacancy

ESSEX COUNTY COUNCIL

Chris Pond

LONDON BOROUGH OF REDBRIDGE

Councillor Stuart Bellwood
Councillor Hugh Cleaver
Councillor Joyce Ryan

EPPING FOREST DISTRICT COUNCIL

Brian Sandler (observer status)

CO-OPTED MEMBERS:

Malcolm Wilders

Barking & Dagenham LINk: Richard Vann
Havering LINk: Med Buck
Redbridge LINk: Mike New
Waltham Forest LINk: Neil Collins

For information about the meeting please contact:
Anthony Clements, anthony.clements@havering.gov.uk tel: 01708 433065

London Borough of Redbridge

Waltham Forest

Havering LONDON BOROUGH

The London Borough of Barking & Dagenham

NOTES ABOUT THE MEETING

1. HEALTH AND SAFETY

The Joint Committee is committed to protecting the health and safety of everyone who attends its meetings.

At the beginning of the meeting, there will be an announcement about what you should do if there is an emergency during its course. **For your own safety and that of others at the meeting, please comply with any instructions given to you about evacuation of the building, or any other safety related matters.**

2. MOBILE COMMUNICATIONS DEVICES

Although mobile phones, pagers and other such devices are an essential part of many people's lives, their use during a meeting can be disruptive and a nuisance. Everyone attending is asked therefore to ensure that any device is switched to silent operation or switched off completely.

3. CONDUCT AT THE MEETING

Although members of the public are welcome to attend meetings of the Joint Committee, they have no right to speak at them. Seating for the public is, however, limited and the Joint Committee cannot guarantee that everyone who wants to be present in the meeting room can be accommodated. When it is known in advance that there is likely to be particular public interest in an item the Joint Committee will endeavour to provide an overspill room in which, by use of television links, members of the public will be able to see and hear most of the proceedings.

The Chairman of the meeting has discretion, however, to invite members of the public to ask questions or to respond to points raised by Members. Those who wish to do that may find it helpful to advise the Clerk before the meeting so that the Chairman is aware that someone wishes to ask a question.

PLEASE REMEMBER THAT THE CHAIRMAN MAY REQUIRE ANYONE WHO ACTS IN A DISRUPTIVE MANNER TO LEAVE THE MEETING AND THAT THE MEETING MAY BE ADJOURNED IF NECESSARY WHILE THAT IS ARRANGED.

If you need to leave the meeting before its end, please remember that others present have the right to listen to the proceedings without disruption. Please leave quietly and do not engage others in conversation until you have left the meeting room.

AGENDA ITEMS

1 CHAIRMAN'S ANNOUNCEMENTS

The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

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

3 DISCLOSURE OF PECUNIARY INTERESTS

Members are invited to disclose any pecuniary interest in any of the items on the agenda at this point of the meeting.

Members may still disclose any pecuniary interest in an item at any time prior to the consideration of the matter.

4 MINUTES OF PREVIOUS MEETING (Pages 1 - 8)

To approve as a correct record the minutes of the meeting held on 10 April 2012 (attached) and authorise the Chairman to sign them.

5 WHIPPS CROSS UNIVERSITY HOSPITAL NHS TRUST

To receive an update from senior officers on current issues facing the Trust.

6 BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST (BHRUT)

To receive an update from senior BHRUT officers on key issues facing the Trust.

7 NORTH EAST LONDON NHS FOUNDATION TRUST (NELFT) - ACUTE CARE SERVICES

Discussion on proposed changes to acute care services at NELFT.

8 COMMITTEE'S WORK PROGRAMME 2012/13 (Pages 9 - 12)

Report attached.

9 FUTURE MEETINGS OF THE COMMITTEE

Provisional dates as shown below, for agreement by the Committee. Start times and host Councils also to be agreed.

Tuesday 9 October
Tuesday 8 January (2013)
Tuesday 9 April

10 URGENT BUSINESS

To consider any other item in respect of which the Chairman is of the opinion, by means of special circumstances which shall be specified in the minutes, that the item shall be considered at the meeting as a matter of urgency.

Anthony Clements
Clerk to the Joint Committee

MINUTES OF A MEETING OF THE
JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Waltham Forest Town Hall
10 April 2012 (3.30 - 6.00 pm)

Present:

COUNCILLORS

Barking and Dagenham	
Havering	Wendy Brice-Thompson, Nic Dodin and Pam Light
Redbridge	Filly Maravala (substituting for Stuart Bellwood) and Joyce Ryan
Waltham Forest	Laurie Braham, Nicholas Russell and Richard Sweden (in the Chair).

Co-opted Member: Malcolm Wilders

LINk representatives present:
Barking & Dagenham: Richard Vann
Havering: Joan Smith (substituting for Med Buck)
Redbridge: Mike New
Waltham Forest: Neil Collins

NHS officers present:
Ken Aswani, Medical Director, NHS North East London and the City
Ben Smith, North East London NHS Foundation Trust
Marie Price, NHS North East London and the City
Carol White, North East London NHS Foundation Trust

Scrutiny Officers present:
Anthony Clements, Havering (Clerk to the Committee)
Jilly Mushington, Redbridge
Glen Oldfield, Barking & Dagenham
Corrina Young, Waltham Forest

All decisions were taken with no votes against.

14 **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman gave details of the arrangements in case of fire or other events requiring the evacuation of the meeting room.

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

Apologies were from Councillors Sanchia Alasia, Josephine Channer & Abdus Salam (Barking & Dagenham) Stuart Bellwood+ & Hugh Cleaver (Redbridge) and Chris Pond Essex.

+Councillor Filly Maravala was substituting for Councillor Bellwood.

Apologies were also received from Med Buck, Havering LINk (Joan Smith substituting).

Councillors Paul McGeary (Havering) and Winston Vaughan (Newham) were also present.

16 **DECLARATION OF INTERESTS**

Councillor Sweden declared a personal interest as he was managed in his employment by the North East London NHS Foundation Trust (NELFT).

Councillor Braham declared a personal interest as he worked for the NHS but not in a paid capacity.

17 **MINUTES OF PREVIOUS MEETING AND MATTERS ARISING**

The minutes of the meeting of the Committee held on 10 January 2012 were agreed as a correct record and signed by the Chairman.

It was agreed to defer the planned presentation to the Committee on hospital transport until after the Olympic and Paralympic period.

Officers would confirm if the revised slides from officers concerning Health for North East London had been circulated to the Committee.

18 **COMMISSIONING SUPPORT ORGANISATION**

NHS officers explained that, with effect from 1 April 2012, primary care services were being provided by NHS North East London and the City (NHS NELC) covering all seven North East London boroughs. The Health and Social Care Act had now received Royal Assent however and all Primary Care Trusts, including NHS NELC would therefore be abolished from April

2013. The replacement structures including Clinical Commissioning Groups (CCGs) would operate in shadow for the 2012/13 year.

There would be one CCG in each borough and all CCGs had now appointed Chairs and Clinical Directors. CCGs were planning for full authorisation from April 2013. CCG managerial support costs (a separate budget from the cost of providing medical treatment) had been set at £25 per head of population.

An organisation called Commissioning Support Services had been set up to develop support for CCGs in North East and North Central London. This would be able to provide services efficiently to local CCGs by utilising economies of scale. The Commissioning Support Services organisation was however itself under development and it was planned to submit a full business plan for the organisation to the Department of Health in August 2012. Service level agreements with CCGs and performance indicators were also being developed. Engagement with other stakeholders including Local Authorities would continue throughout the 2012/13 period.

Officers explained that there was already a great deal of collaboration or joint commissioning taking place and discussions were ongoing to ensure that the £25 per head budget was sufficient. Officers agreed to hold discussions with Councillor Braham separately from the meeting regarding issues around the introduction of community matrons into a Waltham Forest health centre.

The issue of “ghost patients” – people who had moved away from an area but remained on a local GP’s list was presently under discussion with the British Medical Association. Members noted this but were concerned that this could impact negatively on services if GP lists were not up to date.

It was accepted by officers that CCGs could collaborate on certain issues for example recent changes to psychotherapy services, but this was not a cross-subsidy.

The Committee questioned why only some GP surgeries had patient participation groups and also how the Commissioning Support Organisation would engage with the public. Officers responded that each CCG was obliged to have a named lead for patient and public involvement. Issues around non-IT access were being considered but equally many young people preferred to respond by e-mail rather than for example attend a patients’ meeting. Members felt that many GPs in, for example Waltham Forest did not take these responsibilities seriously and officers responded that these were matters that could be taken up at practice level. A further problem was difficulties seen in some areas with attempts to cleanse GP lists which had in fact been postponed in Waltham Forest.

It was clarified that the NHS NELC Chief Executive – Alwen Willams and Board now covered seven PCT areas. Inner and Outer North East London were two of the smallest clusters in London and it was felt to combine these constituted the best use of resources. For this year, NHS NELC would retain

accountability for health budgets even though the CCGs were now operating in a shadow form.

The Commissioning Support Organisation would not simply be the Primary Care Trusts in another form as it would not have a statutory role. Rather, its services would be provided as a business to the CCGs who could decide whether or not to purchase them.

Officers agreed to supply the current management support figure for PCTs but pointed out that a 40% cost saving had been made by bringing the clusters together.

The Committee **noted** the presentation and thanked the officer for her attendance and input to the meeting.

19 **CHANGES TO PSYCHOTHERAPY SERVICES**

NELFT officers explained that, during its most recent round of negotiations with commissioners, it had been agreed that NELFT could go ahead with changes to its psychodynamic psychotherapy services. These had previously been delivered from a dedicated building in Waltham Forest but the Trust now wanted to offer equal access to these services across its geographical area. Consultation on the proposals had been undertaken with CCGs, Local Involvement Networks and the Overview and Scrutiny Committee in Waltham Forest.

The Head of Psychological Services at NELFT added that broad support for the model had been received from NELFT staff and funding for the new service had been confirmed by the Trust Board. The Waltham Forest Health Overview and Scrutiny Committee had also broadly supported the proposals. It was emphasised that, although psychodynamic psychotherapy formed a very important part of NELFT's services, the Trust did offer a whole range of other services with for example cognitive behavioural therapy also playing an important role.

It was accepted that one reason for the planned changes was to make financial savings but the Trust was also committed to all areas or boroughs having equal access to its services. There was also a need to ensure the diverse population of Outer North East London received sufficient services with for example BME communities, refugees and asylum seekers all needing mental health support. Changes such as those proposed would assist NELFT to deliver more services with less money. Officers agreed that the National Institute for Clinical Excellence (NICE) did not currently give sufficient emphasis to psychodynamic psychotherapy and the UK Council of

Psychotherapists had recently said therapies of this type were not sufficiently represented in NICE guidelines.

Officers agreed that there was currently not enough access to this type of therapy in areas such as Havering and insisted that services would not be equalised down to the lowest current level. These changes would allow for the first time the introduction of a specialist service in Barking & Dagenham, Havering and Redbridge. There would be teams in each borough and more resources would be allocated to reflect e.g. the high numbers of older people in Havering.

At present, some people needing psychodynamic psychotherapy services would be referred to the Tavistock Clinic in central London. Officers emphasised that the proposed model would give people access to the service in their home borough. All treatment currently carried out in Waltham Forest would also be guaranteed.

The Chairman thanked the officers for their attendance and for the considerable changes they had made to their original proposals following their appearance at the Overview and Scrutiny Committee in Waltham Forest.

The Committee **noted** the presentation.

20 **PRIMARY CARE STRATEGY**

The Medical Director of NHS NELC thanked the Committee for the invitation to attend. The primary care strategy had been consulted on between November 2011 and February 2012. All responses from stakeholders had been collated and presented to the cluster Primary Care Trust Board. The strategy had now been further developed with local stakeholders and partners via the CCGs. Ninety per cent of health care contacts were through GPs and so the strategy aimed for as high a quality of GP care as possible. There was also a need to reduce health inequalities via the strategy.

The Primary Care Strategy was based on three key principles – ensuring the best outcomes for patients, achieving value for money in primary care provision and that services are provided from fit for purpose premises. The strategy also sought to take into account the increasing number and diversity of population in North East London and the variation of health outcomes across the different boroughs.

Key recommendations of the primary care strategy included a sustained focus on improving quality and the establishment of an integrated network of primary care providers. This was already seen with a group of GPs in Chingford who had established links with health and social care and community pharmacies in order to attain a level of critical mass for treatments. The strategy also sought to ensure a suitable workforce to provide care both now and in the future and effective IT to support the health system.

The Medical Director added that a number of very useful suggestions had been made during the consultation and individual CCGs were now working with partners to develop their own local primary care strategies. CCGs would be expected to have dialogue with overview and scrutiny committees and other stakeholders concerning the strategy over the coming months. The key personnel in each borough at this stage and the main contacts would be the CCG Chair and the NHS NELC borough director.

The Medical Director recognised there was a rising prevalence of TB in certain areas. It remained a priority under the primary care strategy to seek to prevent TB in North East London. The recognition of the relevant symptoms was important and best practice would be followed in terms of advertising of TB examinations etc.

It was the case that there were very significant undiagnosed long term conditions in the local area and the Medical Director wished to ensure that patients went to their GP at an earlier stage. GPs wished to support patient engagement and would work with CCGs on how this can happen in practice. This could potentially include allowing space for self-help groups etc. to meet in surgeries, where this was practicable.

CCGs were organised to cater for specific, differing needs in each borough and to obtain the best health outcomes for the local population. There would not be a standard size of practice set as the Medical Director felt that service quality did not correlate with the size of a practice. A hub practice could be used for services that a smaller surgery could not provide. There were also issues to be considered around ensuring disabled access to surgeries.

The Medical Director emphasised that he felt patient experience was crucial. Dialogue would be needed at a local level to establish why patient experiences differed. Patient experience could be measured and it was essential to be able to show that this had improved over time. It helped that North East London health services were more advanced in IT than other areas. The strategy would also seek to make the best use of very large premises as, if patients could receive treatment more locally, they would not need to attend hospital to receive these services.

Members from several boroughs reported problems encountered by residents in getting GP appointments. The Medical Director felt that appointment availability varied by surgery and that patient participation groups should have dialogue with their surgeries on this. Drop in clinics etc. were not suitable for all surgeries since they could lead to long waits if many patients arrived at the same time. The Medical Director's view was that all surgeries should be able to offer emergency on the day appointments for patients.

Implementation of the primary care strategy would be at borough level, led by the CCGs. Members raised the issue of premium rate phone numbers

bring used by GPs and the Medical Director confirmed this was the subject of national guidance. He felt there were now fewer cases of surgeries using these numbers but any specific cases should be taken up with the relevant CCGs.

It was accepted that some patients were not comfortable with making complaints to GPs but support could be given to patients by the surgery's patient participation group. It was clarified that patient participation groups were not mandatory for surgeries but having clear patient engagement was a requirement of GPs. Surgeries that were not engaging sufficiently should be reported to their CCG.

The expectation of health officers was that patients diagnosed with long-term conditions would receive follow up appointments from their GP. For example patients with diabetes should be monitored at least annually and have access available to a specialist diabetes nurse.

The Medical Director agreed that broader primary care should also encompass mental health. He agreed that the role of carers should be covered far more explicitly in the primary care strategy. He also accepted that there could be communication difficulties between consultants and GPs and felt that more seamless care was needed in the future to enable the sharing of for example medication details between professionals.

As regards cancer survival rates, early diagnosis was key. The most important factors in ensuring early diagnosis were patients presenting early enough and GPs making the appropriate referrals. This was linked to efforts to improve primary care outcomes and would reduce the need for patients to go into hospital. A key objective of the strategy was the achieving of high quality, consistent care. The precise strategy for achieving earlier interventions would be included in the detailed implementation plan which would be developed with CCGs.

Members felt it would be important to compare progress and improvements across the four boroughs and therefore **agreed** to take an update of progress with the primary care strategy at every other meeting of the Joint Committee. The Medical Director suggested that CCG Chairs and borough directors could give updates on progress in each borough.

The Committee **noted** the presentation and thanked the Medical Director for his attendance at the meeting.

21 FUTURE MEETINGS OF THE COMMITTEE

The Committee discussed the arrangements for future meetings including whether these should be held in the morning, afternoon or evening (or a combination of different start times). It was **agreed** to defer a decision on this until the matter had been discussed further at the next meeting.

22 **URGENT BUSINESS**

The Committee congratulated Councillor Sweden on his appointment as the Mayor of Waltham Forest and thanked him for his hard work with the Committee. Councillor Sweden thanked the current and previous members of the Committee as well as supporting officers including the Clerk to the Committee. He asked that particular thanks be recorded to Councillor Ted Eden of Havering for all his input into the Joint Committee in previous years.

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Chairman

Joint Health Overview and Scrutiny Committee

REPORT

10 July 2012

Subject Heading:	Committee's Work Programme 2012/13
Report Author and contact details:	Anthony Clements, London Borough of Havering Tel: 01708 433065 Anthony.clements@havering.gov.uk
Policy context:	To agree the Committee's work programme for the 2012/13 municipal year.
Financial summary:	The work of the Joint Overview and Scrutiny Committee will be covered by the previously agreed charging scheme between the boroughs.

SUMMARY

At this stage of the municipal year the Committee needs, so far as is practicable, to agree its work programme for the forthcoming year. This applies to both the work plan for the Committee as a whole and to the subject of any panel or topic group run under the Committee's auspices.

RECOMMENDATIONS

1. That the Committee agree its work programme for the 2012/13 municipal year.

REPORT DETAIL

Shown in appendix 1 is a draft work programme for the Committee's meetings during the municipal year. This has been drawn up by officers following initial discussions with the Committee.

Members may wish to add further work items arising from the issues discussed at the first (July) of the Joint Committee for example further updates from the local Hospital Trusts.

Members will note that a significant proportion of the workplan has been left blank at this stage. This is to reflect the fact that Members may well wish to select further issues for scrutiny in light of the briefings they are given by Health Trust officers during the year. In addition, previous experience has shown that it is beneficial to leave some excess capacity for scrutiny in order to allow the Committee to respond fully to any consultations or other urgent issues that may arise during the year.

Additionally, the Committee has the power to select an issue for more in depth scrutiny as part of a scrutiny panel or topic group review. It is recommended that, in view of limited resources, only one such topic group is run at any one time. The Committee is therefore requested to consider at this stage, again with the support of officers, if it wishes to undertake a topic group review and what its subject should be.

It should be noted that the Committee also has the power to request written information from local Health Trusts on any subjects within its remit. This power can continue to be used by the Committee at any time and is not therefore considered within this report.

IMPLICATIONS AND RISKS

Financial implications and risks:

None – it is anticipated that the work of the Committee will continue to be funded via the existing charging scheme between the Councils.

Legal implications and risks:

None.

Human Resources implications and risks:

None.

Equalities implications and risks:

None although one outcome of effective health scrutiny will be to reduce health inequalities for Outer North East London residents.

BACKGROUND PAPERS

None.

Appendix 1: Draft Work Programme for Joint Overview and Scrutiny Committee

10/07/2012 Havering	**9/10/2012 Venue TBC**	**8/01/2013 Venue TBC**	**9/04/2013 Venue TBC**
BHRUT	TFL and hospital transport	Commissioning Support Arrangements	H4NEL Update
Whipps Cross/Barts Health	Community Services (ONELCS)	NHS NELC	NHS Commissioning Board
Work programme report	Primary Care Strategy	CCGs	Primary Care Strategy
Future meetings – Venues and start times			
NELFT acute care consultation			

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