MINUTES OF A MEETING OF THE HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE Havering Town Hall 19 November 2015 (7.00 - 8.45 pm)

Present:

Councilllors Nic Dodin (Chairman), Dilip Patel (Vice-Chair), Gillian Ford, Jason Frost, Linda Hawthorn and Carol Smith

28 **ANNOUNCEMENTS**

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

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

There were no apologies for absence.

30 **DISCLOSURE OF INTERESTS**

There were disclosures of pecuniary or personal interests.

31 **MINUTES**

The minutes of the meetings of the Sub-Committee held on 8 September 2015 and 8 October 2015 (joint meeting with Children & Learning Overview and Scrutiny Sub-Committee) were agreed as a correct record and signed by the Chairman.

32 **PRIMARY CARE UPDATE**

The Director of Primary Care Transformation, Havering Clinical Commissioning Group (CCG) explained that there were three types of GP contact:

General Medical Services (GMS) – a national contract that could not be changed locally. This mainly covered traditional GP services along with some additional services such as influenza treatment and maternity services.

Personal Medical Services (PMS) – Local GP contracts of higher value that could be commissioned locally. It was these contracts that were currently being reviewed by the CCG. These contracts could only be held by a GP practice.

Alternative Provider of Medical Services (APMS) – Whilst still being provided by GPs, these contracts could be held by any suitable organisation.

It was noted that, in addition to whichever contract was held, the Council also commissioned some services from GPs e.g. smoking cessation services.

The review of PMS contracts locally had to be completed by March 2016 and it was possible that this could lead to changes in some GP services but officers agreed to return to update the Sub-Committee once further details were known, probably in January/February 2016.

Contracts included a number of performance indicators that providers were expected to meet in areas such as patient satisfaction. Indicators within the London Primary Care Framework also applied for areas such as on-line patient access (including to records) and the target of Saturday opening for all practices.

It was noted that CCGs were required to meet a gap in Government funding for PMS contracts and these types of contracts were therefore a cost pressure for the CCG. The CCG was therefore currently trying to complete a financial analysis of the new contract package and what services were currently being commissioned. In addition to completion of the financial modelling, discussions on the revised PMS contracts would take place with the Local Medical Committee. Discussions would also take place with the Council and with Healthwatch and a final decision on the PMS contracts would be taken by the Primary Care Committee.

A working group on PMS contracts had also been established across the Barking & Dagenham, Havering and Redbridge area, supported by NHS England and the North East London Commissioning Support Unit. The Local Medical Committee and clinical leads for Primary Care were also represented. Briefings on the new PMS contracts would be circulated, once details had been confirmed.

It was confirmed that there were a total of 15 Havering GP practices with PMS contracts although it was uncertain if there were PMS contract practices within each GP cluster. The PMS practices within Havering tended to be those that were higher performing.

It was also clarified that patients within a practice area had to be allowed to be allowed to register with a local GP, providing that practice's list was open. The target was to have 1,800 patients to each GP but there was no maximum patient number.

The issue of GPs moving to larger premises to allow them to provide e.g. minor surgery was not part of the PMS review but was covered in the CCG's programme of transformation work. A total of £1 billion of Government funding for GP premises had been announced from 2015/16 although this had not been released as yet. The funding would be managed by NHS England although it was clarified that associated revenue costs would have to be met by the CCGs. The CCG officer felt that this was deliverable but that a clear policy was needed re premises investment.

It was accepted that there were a lot of single-handed GPs in Havering as well as many GPs approaching retirement age. It was not possible to reclaim from overseas patients the cost of primary care; this was only possible with hospital treatment.

The King's Park surgery in Harold Wood was under an APMS contract, currently held by the Hurley Group. This contract was coming to an end and a procurement exercise was therefore currently under way with patient engagement and provider events planned. Contract procurement was at an early stage and a new contract would be in place by 1 August 2016.

The walk-in service formerly based at Orchard Village had moved to South Hornchurch clinic. The CCG also planned to introduce a GP practice for the Orchard Village estate although a funding route for this would be need to be agreed with NHS England. The contract for walk-in services at South Hornchurch clinic was also currently held by the Hurley Group. The walk-in service would become part of the CCG's Vanguard work and would hence be a different contract from the Orchard Village GP surgery.

The Sub-Committee **NOTED** the updates.

33 JOINT STRATEGIC NEEDS ASSESSMENT

The Interim Director or Public Health explained that the Joint Strategic Needs Assessment (JSNA) predated the establishment of Health and Wellbeing Boards and had been established by the former Primary Care Trust. Following the disbandment of Primary Care Trusts under the Health and Social Care Act 2012, the production of the JSNA was now overseen by the Health and Wellbeing Board.

A new approach had been taken to the JSNA from January 2015 and a dynamic, active work programme had now been established. The core document of the JSNA was the Key Facts and Figures document which gave a single set of health statistics, focussed on Havering. This document was updated quarterly and published on the Council website.

A high level overview of the health and social care needs of the borough was also in production and this was currently in draft. Ward health profiles would also be produced and would be available once problems with the technical platform used had been resolved.

Two 'deep dives' on specific topics would also be carried out each year although these were highly labour intensive. These exercises would aim to answer specific questions with the first review covering issues related to obesity. A local obesity strategy would be developed following the launch of the national obesity strategy early in 2016.

The JSNA summary would be updated annually and it was planned to update the ward health profiles on a six-monthly basis. Factsheets and technical briefings related to the JSNA would also be produced. It was also planned to look at aligning the Havering JSNA more closely with those for Barking & Dagenham and Redbridge.

It was accepted that the Key Facts and Figures document needed to be publicly launched, now that it was available on-line and the overall public health pages on the Council website were in the process of being changed.

The Sub-Committee welcomed the work being undertaken on the JSNA and **NOTED** the position.

34 **JOINT HEALTH AND WELLBEING STRATEGY**

The Interim Director of Public Health explained that the JSNA was also used to inform the Joint Health and Wellbeing Strategy (JHWBS). The Council's first JHWBS covered the period until 2014 and was based very much on adult social care. The priorities of the strategy had therefore recently been reviewed. Further changes had however been put on hold for the present in order to seek to align the strategy more with those covering Barking & Dagenham and Redbridge. There was not therefore an underlying action plan to the strategy although specific actions were being taken in connection with it.

It was clarified that public health did not commission most services, this was undertaken by the Clinical Commissioning Group (CCG). The public health section dealt with Havering CCG as well as with policies covering the three local CCG areas. Any commissioning that was undertaken by public health was specific for Havering residents. The CCG acted on what the JSNA decided were the services required for local residents.

It was noted that none of the organisations involved were co-terminus and that there were multiple commissioners for e.g. services provided by the North East London NHS Foundation Trust (NELFT). There had also been moves recently by central government to potentially offer more health commissioning powers to councils and it was suggested therefore that the Sub-Committee could have a role in scrutinising the work and outcomes of the Health and Wellbeing Board. Some national work had recently been

completed on evaluating the work and function of Health and Wellbeing Boards.

It was also suggested that the Health and Wellbeing Board should look at the wider determinants of public health. Community services were commissioned via the Better Care Fund in order to e.g. improve care outside of hospital. This work was overseen by the Health and Wellbeing Board. Social care outcomes were monitored by the Council and contractual monitoring of services such as district nursing was carried out by the CCG. Oversight of these areas was also kept by the Integrated Care Coalition which was chaired by the Council chief executive and by the accountable officer for the three local CCGs.

The Sub-Committee **NOTED** the position.

35 HEALTHWATCH HAVERING UPDATE

A director of Healthwatch Havering explained that the organisation had recently commenced a new campaign to encourage people to give their opinion of local health and social care services. This comprised the distribution of postage paid cards for patients and service users to complete and return to Healthwatch. The scheme would be fully launched in early 2016 but it was planned to use feedback received (both good and bad) to inform the organisation's work programme and schedule of visits planned under its powers to enter and view premises.

It was noted that Healthwatch Redbridge had recently conducted such a visit to Queen's Hospital with local people who were deaf. The report, which was available on the Healthwatch Redbridge website, had made a number of recommendations to improve accessibility of the hospital for people who were deaf or hard of hearing.

Members of the Sub-Committee were given packs of the cards to give to constituents and it was suggested that similar packs be sent by Healthwatch to all other Havering Councillors.

It was hoped to also make the comment cards available in hospitals, GP surgeries etc although it was emphasised that these did not circumvent the formal complaints systems in the NHS or social care. Respondents would be directed or signposted (where contact details were given) to the appropriate agency should they wish to make a formal complaint about their treatment etc.

Several Healthwatch listening events had been planned for 2016. It was clarified that, although it was situated in Redbridge, Healthwatch Havering could undertake an enter and view visit to King George Hospital, as Havering patients were treated there. Healthwatch Havering had not however received any complaints about King George Hospital as yet.

The Sub-Committee also considered a recent letter from the Chairman of Healthwatch Havering concerning delays to surgical and outpatient appointments at Barking, Havering and Redbridge University Hospitals' NHS Trust (BHRUT). It was emphasised that the letter did not imply any criticism of the current BHRUT chief executive or management team but there was concern about the level of backlog that had been reported.

It was therefore proposed by Healthwatch Havering that a joint topic group-style review of the delayed procedures and appointments be undertaken. This would build upon the review of appointments cancellation at BHRUT that had recently been undertaken by a topic group of the Sub-Committee. Results of recent enter and view visits conducted by Healthwatch Havering could also be fed into the review.

Officers added that it was the responsibility of Havering CCG to monitor the performance of BHRUT on referral to treatment times and the CCG should also therefore be involved in the review. This would allow Members to understand the reason for increased waiting times.

It was **AGREED** that the Clerk to the Committee and the director of Healthwatch should draft a terms of reference and outline meeting schedule for the review. Officers would also seek to meet with the scrutiny lead officer at BHRUT in order to seek to explain the purpose of the review.

36 **URGENT BUSINESS**

There was no urgent business raised.

Chairman