NOTES OF AN INFORMAL MEETING OF THE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

10 March 2022 (4.30 - 6.18 pm)

Present:

COUNCILLORS

London Borough of Barking & Dagenham	Paul Robinson
London Borough of Havering	
London Borough of Redbridge	Beverley Brewer and Bert Jones

Apologies were received for the absence of Councillors Agedboyega Oluwole and Donna Lumsden (Barking and Dagenham) Nisha Patel (Havering) Neil Zammett (Redbridge) Umar Alli (Waltham Forest) and Marshall Vance (Essex).

Apologies were also received from Ian Buckmaster, Healthwatch Havering and Richard Vann, Healthwatch Barking and Dagenham.

The following Members were present via videoconferencing:

Councillor Adegboyega Oluwole, Barking & Dagenham
Councillor Marshall Vance, Essex
Councillor Richard Sweden, Waltham Forest
Richard Vann, Healthwatch Barking & Dagenham (co-opted Member)

26 **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman gave details of the arrangements in case of fire or other event that may require the evacuation of the building.
It was noted that, for legal reasons, the meeting would be classified as an informal meeting but would otherwise be run in the normal way.

27 DISCLOSURE OF INTERESTS

There were no disclosures of interest.

28 MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 14 December 2021 would be agreed at the next meeting.

29 INTEGRATED CARE SYSTEM GOVERNANCE

Officers advised that the Integrated Care Partnership (ICP) for North East London would now be established on 1 July 2022. The Board would have two Council representatives – one for Inner and one for Outer North East London. Governance would also take place at local partnership level and a lot of engagement was taking place on the process.

The accountable officer for the partnership would be Zina Etheridge who had a Local Authority background having been the Chief Executive of London Borough of Haringey. Members expressed concern about the proposed removal of the power to refer matters to the Secretary of State although officers responded that this had not been finalised as yet and it was possible this could be amended in the House of Lords.

Primary and secondary care would have their funding streams consolidated and specialist commissioning would be devolved to the ICP from NHS England in due course. A financial framework would be developed. The ICP would continue to support scrutiny and how Councils operated. Officers were happy to discuss the future shape and geographical coverage of the JHOSC.

The draft constitution of the Integrated Care Board could be shared when available and it was confirmed the Board would also include 2 Local Authority Members.

The Joint Committee noted the position.

30 CONTINUING HEALTHCARE HARMONISATION

The Chief Officer of the North East London Clinical Commissioning Group (CCG) explained that a review was being undertaken of people who may require ongoing care after hospitalisation. The CCG was keen to engage with stakeholders around what the new policies should be for this and an equalities health impact assessment would be undertaken.

A dispute resolution process would be used if different organisations involved disagreed. Families could ask for an independent review of their case, managed by NHS England. Figures could be provided on how many cases went to this appeal stage although local resolution was always preferred.

The type of respite care available depended on the individual and respite was also available for family members. Referrals for continuing healthcare could be made by GPs or social workers. It was aimed to provide support to people in their home in the first instance. The continuing healthcare service was not a one-off and assessments would be undertaken to see what additional support was needed under a multi-disciplinary approach.

The 2020 Ombudsman report on the Continuing Healthcare Service would be taken into account by the review and officers confirmed that engagement would not take place during the forthcoming pre-election period. Facilities rated as 'inadequate' by the Care Quality Commission would not be used unless the person's family wanted this and quality assurances would also be asked for. Clarity would be given on the position if more than 8 hours care per day was required.

The Joint Committee noted the position.

31 PARTNERSHIPS UPDATE

The Chair in Common of BHRUT and Barts Health advised that a clinical performance director had been seconded to BHRUT. Joint work was also taking place on areas such as the thoracoscopy service. Pay rates of temporary staff were being harmonised and closer working on backroom functions was also being put in place across the Trusts. Capacity would be shared in order to reduce waiting lists.

The new Intensive Treatment Unit at Queen's was due to open that week which it was felt would improve staff recruitment and retention. Digital support was improving and a new electronic patient records system was being developed at BHRUT. There was now improved financial stability at BHRUT and a new Chief Executive Officer would be appointed at Barts Health. The two Trusts would however remain separate organisations.

Patient flows from Essex were monitored by BHRUT and the Trust Chief Executive confirmed that he wished to improve treatment pathways with Essex. Other developments included the Trusts collaborating on respiratory work to make more use of local anaesthetic and the trauma centre at the Royal London Hospital helping to improve survival rates. Similarly, the Hyper Acute Stroke Unit at Queens was producing better outcomes for stroke patients.

Officers emphasised that it was not necessary for services to move towards Inner North East London. It was important that teams for e.g. complex heart surgery had as much experience as possible.

A Member raised the poor recent figures for waits in the Queens Emergency Department where only 25% of patients were being seen within 4 hours. The BHRUT Chief Executive responded that the Trust as a whole was achieving around 65% for the 4 hour target compared to a London average of 72%. The Queen's Emergency Department had recently been praised in a Care Quality Commission inspection. The separate Covid Emergency Department at Queens had now been closed with all patients now treated again in the one department. A pilot scheme to reopen capacity was in progress but it was accepted that waiting times were likely to increase in the next year.

The Chair in Common wished to support the new and permanent Chief Executive of BHRUT in making improvements and would remain accountable to the Joint Committee re the improvements. The intention of the collaboration across the Trusts was not to move services but to make them more accessible to local people. Any move of services would be consulted upon.

A representative of the North East London NHS Foundation Trust (NELFT) explained that collaborative working was also being developed on mental health pathways. This had included female psychiatric intensive care and it was confirmed all in-patients could be placed locally. High intensity mental health care for children was delivered at home where possible. A Joint Chair would be appointed for NELFT and the East London NHS Foundation Trust.

Age, gender and ethnicity data was collected for mental health in-patients and this could be provided for admissions data. Any safeguarding issues would also be raised. Post discharge support was available from the Home Treatment Team.

As regards primary care, the Outline Business Care for the St George's health hub had been passed in October 2021 and public consultation had finished on 14 February. There had been a good response to the consultation which had expressed support for the development. It was hoped the facility would be open in 2024. The centre would be open 8 am – 8 pm, seven days per week and would include two GP practices and diagnostic facilities. Further literature on the plans for the St George's site could be provided.

A workforce strategy was being compiled that would allow the hub to develop its own staff. Funding for the redevelopment would be mainly from the National Hospitals Programme with the remainder from internal NHS resources.

The Joint Committee noted the position.

32 FERTILITY POLICY PROPOSALS

The Joint Committee was advised that it was aimed to harmonise fertility policy across the North East London CCGs. This covered a wider area than just IVF issues and all stakeholders would be given the opportunity to contribute to the engagement process. The numbers of IVF cycles funded by the NHS would be included in the engagement process and the consultation document would be shared with the Joint Committee. The consultation outcome would also be shared.

All stakeholders would be engaged with across all age ranges, ethnicities, sexual orientation etc. Community groups and Healthwatch would also be engaged with.

The Committee agreed to receive an update on the outcome of the consultation, once this was available.

Chairman

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