THE LONDON BOROUGH OF CAMDEN

At a meeting of the **NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **FRIDAY, 11TH MARCH, 2016** at 10.00 am in the Committee Room 4, Town Hall, Judd Street, London WC1H 9JE

MEMBERS OF THE COMMITTEE PRESENT

Councillor Alison Kelly (Chair) (LB Camden)
Councillor Pippa Connor (Vice-Chair) (LB Haringey)
Councillor Martin Klute (Vice-Chair) (LB Islington)
Councillor Alison Cornelius (LB Barnet)
Councillor Graham Old (LB Barnet)
Councillor Abdul Abdullahi (LB Enfield)
Councillor Anne Marie Pearce (LB Enfield)
Councillor Charles Wright (LB Haringey)
Councillor Richard Olszewski (Substitute) (LB Camden)

MEMBERS OF THE COMMITTEE ABSENT

Councillor Danny Beales (LB Camden)
Councillor Jean Roger Kaseki (LB Islington)

The minutes should be read in conjunction with the agenda for the meeting. They are subject to approval and signature at the next meeting of the. North Central London Joint Health Overview and Scrutiny Committee.

MINUTES

1. APOLOGIES

Apologies for absence were received from Councillor Jean-Roger Kaseki (Islington) and Councillor Danny Beales (Camden).

2. DECLARATIONS OF INTEREST

Councillor Pippa Connor declared that her sister was a GP in Tottenham.

Councillor Richard Olszewski declared that he was on the governing body of the Royal Free Hospital and that he gave communications advice to the Pharmacists' Defence Association.

Councillor Alison Cornelius declared that she was a trustee of the Eleanor Palmer Trust, which ran care homes.

3. ANNOUNCEMENTS

There were no announcements.

4. NOTIFICATIONS OF ANY ITEMS OF BUSINESS THE CHAIR DECIDES TO TAKE AS URGENT

There were no notifications of any items of urgent business.

5. MINUTES

Consideration was given to the minutes of the meeting of 29th January 2016.

Members enquired whether a letter had been sent on behalf of the Chair regarding support for the Committee. Members were informed that a letter had been sent to the Camden Chief Executive and a Camden strategy officer was liaising with the Haringey officer who had previously supported the Committee on this.

Members noted that information on the spend on preparing for inspections had been provided by two trusts. They welcomed this.

It was noted that reference to Councillor Cornelius as chairing the meeting on Barnet, Enfield and Haringey Mental Health Trust Quality Accounts at the bottom of page 12 should refer to Councillor Connor instead.

RESOLVED –

THAT the minutes be approved, subject to the amendment of 'Councillor Cornelius' to read 'Councillor Connor' at the bottom of page 12.

6. GPS IN CARE HOMES

Consideration was given to a report on Primary Care-related Support for Residential and Nursing Care Residents.

Members received a presentation from representatives from Barnet, Enfield and Haringey Clinical Commissioning Groups (CCGs) (Paul Allen, Raksha Kukadia and Cassie Williams). The presentation highlighted the differences between the boroughs, as some had much larger care home sectors than others. Barnet had more than 100 care homes, whereas Haringey had only 436 beds spread between 12 homes (10 nursing and 2 residential).

Mr Allen explained that Enfield CCG had created a Care Homes Assessment Team (CHAT) as a joint service to help support residents in care homes. Virtually all GPs and care homes in the borough had signed up to this, having rolled out from an initial 7 homes, and it seemed to be working well.

Ms Williams said that Haringey did not have a service such as CHAT; however, they had a plan to institute 'ward rounds' in care homes to identify incidents of poor health

which required primary care for residents. This proposal would be submitted to the CCG's Investment Committee for approval. It was noted that funding arrangements for GPs treating care home residents needed to be carefully designed so that GPs were not being paid twice for attending to patients there.

Ms Kukadia reported that Barnet CCG had had a pilot of an enhanced service for care homes from 2014-15. The pilot had not been renewed for future years, as they did not see a decrease in A & E visits or ambulance call-outs as a result.

It was noted that there was not a full list of Camden care homes in the report. The Chair noted that some care homes which had caused members concern were not on the list. She expressed disappointment that no one from Camden CCG was in attendance.

There was a discussion about training for care home staff. It was noted that some care homes did not take advantage of opportunities to train their staff, and that turnover of staff was high – so it was a constant task to train new staff as they started.

Members welcomed the Enfield approach and queried why it had not worked in Barnet. They were informed that there were more care homes in Barnet and that the Enfield scheme was multi-disciplinary, whereas the Barnet scheme was GP-led.

Members asked what the metrics of success were, and were informed that they were statistics such as: reductions in A & E visits, reductions in the number of cases of ulcers and fewer falls. Members asked that the 5 CCGs work together on standardising KPIs and driving improvements together. Officers said that commissioning of a large proportion of care home beds was done by local authorities, so aspects of the way they operated were driven by local authority procurement policies.

Members queried how enhanced payments to GPs operated. They were informed that the details varied from CCG to CCG, but enhanced payments were paid to cover the time involved in visiting care homes and seeing the residents. Councillor Klute expressed concern that this could take GPs away from their normal work in their surgeries and so have an adverse impact on their other patients. CCG officers said the enhanced payments enabled practices to employ locums or part-time staff to visit care homes or who could cover for colleagues who were doing the visits.

Councillor Connor welcomed the more multi-disciplinary, nurse-led approach taken by CHAT. She commented that the approach taken by Haringey CCG seemed to her to be too doctor-led. Haringey CCG commented that it did not employ nurses and so was not in a position to create a nurse-led team. Additionally, there were certain tasks that only doctors were authorised to perform and so a nurse-led team would not be able to tackle these as effectively.

Councillor Cornelius informed the meeting that Barnet Health Scrutiny had received information on the number of hospital admissions and what they were for from the largest 10 care homes. This was suggested as something that other borough health scrutiny committees could obtain information on for the care homes in their boroughs.

RESOLVED –

THAT the report and the comments above be noted.

7. WHITTINGTON HOSPITAL - DEVELOPMENT OF ESTATES STRATEGY

Consideration was given to a summary report from the Whittington Hospital.

Simon Pleydell, the Chief Executive of Whittington Health, addressed the Committee and made a number of points, including:

- The need for the Trust to have a modern estate that met the needs of patients.
- There were 38 premises in the Trust's "estate" – a number of which were shared with primary care services.
- The Trust wished to consolidate its operations into fewer, fit-for-purpose, buildings.
- The implementation of the estate strategy could be a 20 year process but the Trust wanted to establish the general parameters soon.
- The Trust was aiming to use IT to change working practices and enable more efficient use of resources.

Members noted Mr Pleydell's report and presentation and asked if a copy of the full Estate Strategy document could be circulated.

ACTION: Vinothan Sangarapillai (Camden Committee Services)

Councillor Klute mentioned that the estate strategy had been discussed at Islington's most recent Health Scrutiny meeting. He noted that there had been concern by members that the Trust would be working with outside companies and that there was a danger of being entangled in unsuitable PFI contracts. He highlighted a disadvantageous LIFT (Local Improvement Finance Trust) contract which the hospital had been tied into for 25 years.

Mr Pleydell said that there was a need for the Trust to work with firms that had expertise which the Trust lacked. He also noted that NHS England had told NHS trusts that they should not expect capital funding from the Treasury. It was therefore necessary to explore other options. He said that the Trust would not necessarily be entering into PFI arrangements with the private companies it was working with.

The Chair said that Camden Council, in its Community Investment Programme (CIP), had been able to finance developments through revenue from the sale of council land and of flats in mixed developments. She urged the Whittington to look at Camden's example from the CIP and see what could be done to maximise the value of sites the Trust wanted to dispose of and to minimise borrowing.

There was a discussion about the need to consolidate the buildings health services were provided from. It was reported that health visitors worked from 14 different sites in one borough.

There was a discussion about the estimate of a £6m backlog of capital works that was required. Members queried the source of the figures. They were informed that the Whittington was required to rate its buildings as a form of stock survey and that there were figures known as 'ERIC (Estates Return Information Collection) returns' to calculate backlogs.

It was noted that there was a high staff vacancy rate. A major factor in this was that many health workers could not afford to live in London. Hence, they were moving out of the city and not wishing to work for London institutions. The Trust needed a residential accommodation strategy to house its staff in shortage occupations. Members commented that health bodies should work with local authorities on their key worker housing strategy, as this was an issue that local councils in London were very concerned about as well.

A question was asked about how the estate strategy tied into the health devolution pilot. Mr Pleydell said that the Whittington was involved in the group, but its effectiveness depended on other bodies such as foundation trusts being willing to pool their assets. It was early days for this North-Central London pilot.

Members asked that local authorities be kept informed of what the Trust were trying to do. They were of the view that poor communications had caused a number of problems before.

Members asked how local authorities were involved in the Trust's consultation process outside of JHOSC and borough's health scrutiny bodies. They were informed that the Trust had a well-being board that included local authority representatives and other stakeholders.

Mr Pleydell agreed to provide a programme of updates to the Committee as the estate strategy progressed and to answer questions members wished to email him individually.

ACTION: Simon Pleydell (Whittington Health)

RESOLVED –

THAT the report and the comments above be noted.

8. PROCUREMENT OF URGENT INTEGRATED CARE SERVICE (111/OUT OF HOURS)

Consideration was given to a report on the Procurement of an Integrated Urgent Care Service for North Central London.

Dr Sam Shah and Dr Jo Sauvage addressed the Committee. Dr Shah was accompanied by his students who were specialising in public health.

Dr Shah and Dr Sauvage thanked the Committee for its input into the process. They said that they had had positive interactions with patients and the public and this had helped them design the questions to ask bidders. They had screened bidders and issued invitations to tender. A decision would be made on which provider to select at the end of March. The provider's contract would start in October.

Members welcomed the fact the procurement exercise had taken on comments from councillors, patients and the public.

Questions were asked about a number of KPIs (key performance indicators). With regard to KPI L5, Dr Shah said this was about ensuring that the out-of-hours provider had access to those GP records which they needed. With regard to KPI N9, he clarified that this was about identifying how long it took a patient to go through the clinical journey for a particular incident. KPI L13 was about reducing the number of cases where the OOH service referred someone for an ambulance but on re-triage an ambulance visit was felt to be not necessary.

Members asked about whether pharmacists and other related medical professionals would be being included in the service. They were informed that providers would not be being mandated as to how many and what type of staff they should employ, but that bidders had submitted a detailed workforce model which did show what specialists they would be employing.

A question was asked about how often the CCGs would meet with the provider. They were informed that, initially, there would be frequent meetings – more than one per week – but that they would become less frequent as the service stabilised and bedded in.

A member asked how they could measure whether people had equal access to the service. Dr Shah said that the CCGs would receive statistics on the population of the area and on service usage and could see if there were discrepancies.

It was suggested that a report could come back in a year's time on how the service had launched, what the issues that had arisen were and how they had been resolved.

ACTION: Dr Sam Shah & Jo Sauvage

RESOLVED –

THAT the report and the comments above be noted.

9. WORK PROGRAMME

Consideration was given to the work programme report.

Members were of the view that they wanted to see reports on health estates devolution, an update on the primary care 'case for change', the five-year NCL CCGs strategic plan and the London Ambulance Service for the next meeting. They also wanted an update on the LUTS clinic when the review had concluded.

There was discussion about items members wished to consider at meetings later in the year. Some members wished to have a report on sexual health services, but the majority view was that this was something that could be considered by borough health scrutiny committees.

Members wanted to have information about dementia and stoke pathways. They noted that GPs had been given targets to improve their diagnosis of dementia this year.

Members wished to see information about the plans for 7-day NHS services. The CCGs could be asked to provide information about the framework that would be implemented, and members could question them on it.

There was a discussion on CAMHS (Child and Adolescent Mental Health Services). A view was expressed by a member that it was not person-centred enough. Councillors Connor and Kelly agreed to liaise on this outside of the meeting to identify the best way of tackling the issue.

RESOLVED –

(i) THAT it be agreed that items on health estates devolution, the primary care 'case for change', the five-year CCG strategic plan and the London Ambulance Service be put on the agenda for the next meeting;

(ii) THAT the work programme report be updated to reflect the comments made above.

10. DATES OF FUTURE MEETINGS

Members agreed to move the June meeting to 10th June 2016 and the March 2017 meeting to 24th March 2017.

RESOLVED –

THAT the meeting dates, times and locations for meetings in 2016-17 be:

- Friday, 10th June 2016 @ 10am (Islington)
- Friday, 30th September 2016 @ 10am (Haringey)
- Friday, 25th November 2016 @ 10am (Barnet)
- Friday, 27th January 2017 @ 10am (Enfield)
- Friday, 24th March 2017 @ 10am (Camden)

11. ANY OTHER BUSINESS THE CHAIR CONSIDERS URGENT

The meeting ended at 1.05pm.

CHAIR

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MINUTES END