

MINUTES OF HEALTH SCRUTINY COMMITTEE

Tuesday, 3 September 2019
(7:00 - 9:10 pm)

Present: Cllr Eileen Keller (Chair), Cllr Paul Robinson (Deputy Chair) and Cllr Donna Lumsden

Also Present: Cllr Maureen Worby, Cllr Cameron Geddes, and Cllr Bill Turner

Apologies: Cllr Mohammed Khan, Cllr Chris Rice and Cllr Emily Rodwell

7. Declaration of Members' Interests

There were no declarations of interest.

8. Minutes - 25 June 2019

The minutes of the meeting held on 25 June 2019 were confirmed as correct.

9. Consultation on Proposed Continuing Healthcare Placement's Policy

Dr Amit Sharma, the Clinical Lead for Continuing Healthcare (CHC), and Sharon Morrow, the Director for Transformation and Delivery for Unplanned Care (DTDUC), delivered a presentation on the Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups' (BHR CCGs) consultation on their proposed policy for CHC placement decisions.

The Committee noted from the presentation that CHC was the name given to a package of ongoing care, arranged and funded solely by the NHS, for adults who have been assessed as having a 'primary health need', as set out in the Department of Health and Social Care's national framework for CHC. CHC packages could be provided in different settings, including an individual's own home or in a care or nursing home. The proposed Policy did not concern the eligibility criteria for CHC, rather it related to decisions by the BHR CCGs as to where the care would be provided. The proposed Policy was that BHR CCGs would generally not fund a CHC package in a person's home if the cost of doing so was more than 10 percent higher than providing the same care in a care or nursing home (referred to in these minutes as "the general rule proposed in the Policy). The Committee further noted that, for a small number of patients (approximately 20 – 25 per year) this might not be with the provider or in a location of their choice.

Members noted from the presentation that the Policy included:

- The considerations that would be taken into account when deciding the most appropriate location for a CHC package, including exceptional circumstances;
- The review process for CHC packages; and
- The appeals process for when patients and their families or carers disagreed with a decision on placement.

The Cabinet Member for Social Care and Health Integration (CMSCHI) who was

also the Chair of the Council's Health and Well Being Board (HWBB), stated that given that the proposed Policy potentially had significant commissioning implications, she would have expected the HWBB to be consulted as well as this Committee. The Cabinet Member added that she was highly uncomfortable with the proposed Policy as it would enable the BHR CCGs to take away an individual's right to decide where to receive their care. This was all the more concerning in respect of CHC residents at the end of their life, as they potentially would not be afforded the choice and dignity to die in the place of their choice. Furthermore, being split from their spouse and other members of their close networks could be devastating for some patients.

The Cabinet Member felt that the potential implications of this Policy went against the principles of patient choice and dignity. Furthermore, she expressed concern at the composition of the Appeals Panel as she felt there was not enough information as to who the lay members of the Panel would be and whether they would understand fully the circumstances and needs of the Borough's residents.

The Chair of the Committee supported these comments and put forward a recommendation that the BHR CCGs also consult the Council's HWBB and the Outer North East London's Joint Health Overview and Scrutiny Committee (JHOSC) on the proposals. With regards to the composition of the Appeals Panel, it was recommended that a statutory Adult Social Care Officer of the Local Authority be a member of the Appeals Panel to bring in their expertise as well as act as a 'check and balance' on decisions being reviewed.

The DTDUC stated that the proposed Policy did not cover those assessed as needing 'fast-track' CHC - care which was provided to people who had a rapidly deteriorating condition and may be approaching the end of life. She added that whilst BHR CCGs recognised that a situation where it was decided that a person would not receive care at the location of their choice was not ideal, they had a duty to make transparent how they would make placement decisions where costs of care were very high.

Members stated that they recognised that the proposed Policy did not cover patients assessed as needing 'fast-track' CHC; however, they believed that it would apply to those on a 'standard' CHC package who eventually come to end of life, and therefore the BHR CCGs would have the ability to decide that a resident would die in a care home (potentially one not of their choice), against their wishes. Members also felt that given this, all local councillors, whose residents could potentially be affected by the proposed Policy, should have been informed of the consultation.

Members felt that ultimately, the proposed Policy would lead to more people's care being provided in a care home setting against their wishes, which went against the principles of personalised care and patient choice. Members agreed with the recommendations put forward by the Chair, namely that the consultation should be taken to the HWBB and JHOSC and that a statutory Adult Social Care Officer of the Local Authority be a member of the Appeals Panel.

Dr Sharma welcomed the feedback and expressed his desire for the BHR CCGs to get the Policy right. He emphasised that other CCGs who had undertaken similar consultations, had decided to put a cap on the cost of care, whereas BHR CCGs

decided not to do this. He assured members that the BHR CCGs would only come to a decision on placement, having considered the patient and their family's wishes, the patient's safety and clinical needs, and the resources available, and that where there were exceptional circumstances, they would depart from the general rule proposed in the Policy. A further safeguard was the appeal process.

Members asked whether the general rule proposed in the proposed Policy would apply to a young person (over 18) as they were concerned that placing a young person in a care home against their wishes, would run the risk of institutionalising them, resulting in adverse implications on the rest of their life's outcomes. Dr Sharma confirmed that this was not the intended outcome behind the proposed Policy; a case such as this would be considered an exceptional circumstance and the general rule proposed in the Policy would not apply.

Dr John, Chair of the Barking and Dagenham CCG, stated that the underlying principle of the proposed Policy was that decision making around placement in cases where costs were very high should be open and transparent. He welcomed the comments from members and stated that he felt it was necessary that the BHR CCGs undertake some work to clarify some of the queries raised today, and update their presentation to reflect what the outcomes were for other boroughs whose CCGs had adopted a similar CHC placements policy; for example, whether there was a sudden significant increase in the number of people receiving care in a care home. This updated information could then be presented to the HWBB and JHOSC.

Members were pleased to hear from Dr Sharma, as the End of Life Care Lead, that he had made good progress in promoting advance care planning, which would help enable better planning and care of people nearing the end of life.

The Chair thanked Dr Sharma and the DTDUC for attending the meeting.

10. Update on Barking Riverside

The Director of Public Health (DPH) and Dr John presented a report updating the Committee on the Barking Riverside development. Members noted that:

- If successful, the healthcare models being considered for piloting in the area could act as a model for improving health services across the borough;
- One of the ideas being considered was the placement of a 'link worker' with good knowledge of services in the front door, as opposed to a traditional receptionist so that the resident could be referred to the correct service right away;
- Also being discussed was a new role of 'special advocates' for particular fields that the CCGs and the Local Authority could fund together; and
- In terms of the accountability of service leaders, locality boards were being formed which would act as a prototype for services in Redbridge and Havering. The Locality Board for Thames ward had a direct accountability line to the HWBB.

The CMSCHI stated that the Barking Riverside development had acted as a blank sheet for designing services that could avoid some of the existing barriers and challenges and recognise that people are residents first, and not just service users

or 'patients. However, she felt one of the main challenges around bringing the vision to life was the willingness of partners to put funding in jointly and building a trusted system in which they could safely pool funds.

In response to a question, the DPH stated that a locality board would have delegated functions and be composed of clinicians, commissioners and residents, who would together, commission services for their locality. The challenge would be to find the right people, who were not just the 'usual suspects' to sit on the Board. The CCGs would become more distant as part of governance changes in North East London, which meant that Locality Boards could have a stronger role in place-based care, which was an innovative concept. Dr John stated that the main value of this model was that residents could play an important role in finding new solutions to health needs.

Members welcomed the role of residents in the decision-making process being developed in Barking Riverside; however, questioned whether this would be in the best interests of all residents, as they would not be experts in commissioning health services. Dr John stated that members of the Locality Board would all be provided with detailed information on the needs of residents in Barking Riverside so they could make evidence-based decisions. Furthermore, their role would involve issues wider than health, and residents could bring in their experience in commissioning other services, such as support for victims of domestic violence.

Members questioned the notion of using neutral branding in the development (as opposed to using NHS branding) referenced in the report, as people generally had a lot of trust in the NHS. Members also felt that whilst the ideas around involving residents in the governance arrangements were good, outcomes were paramount and that they would like to see what outcomes were being sought for the residents of Barking Riverside. An example of an outcome that should be sought for Barking Riverside was achieving the highest rates of immunisations in the Borough, particularly as the potential for health inequalities in the area were high.

Members felt that more work was needed to recognise that Barking Riverside was in the Thames ward and there would be many interlinks to the wider community as time went by. Members also referred to the lack of reference in the report to the new Youth Zone and how that would form part of the picture.

The CMSCHI accepted the point about using NHS branding but added that the idea was to inform people that NHS services were only part of the picture and that there would be a range of services, which could be accessed differently and in different settings by different providers. She also emphasised that project leaders were acutely aware that Barking Riverside was part of the Thames community and not a separate entity.

The Chair thanked the DPH and Dr John for the update.

11. Barking & Dagenham, Havering and Redbridge Integrated Care Partnership and Provider Alliance Updates

Alison Blair, Director of Transition for Barking and Dagenham, Havering (BHR) System delivered a presentation on the work of the Integrated Care Partnership and the vision to move towards a single CCG for seven East London boroughs

(including BHR) by April 2021. She stated that she was fairly new in post and would welcome Members' thoughts on the developments taking place so she could feed this back to system leaders.

Members expressed concern that the move towards a single CCG would potentially mean local needs would not be met; for example, the Borough's readmittance rate into hospital was higher than that of neighbouring boroughs because its homes were smaller and there was often not enough room to make the adaptations necessary to enable the resident to live at home safely. Furthermore, the Council's HWBB had decision making powers in respect of health matters whereas these powers were held by Cabinet in some local authorities. Members emphasised that there must be checks in place to ensure the 'bigger system' would take such local variations into account to ensure commissioning would strongly reflect local needs, as well as predictions about population growth and changes in demography.

Dr John echoed members' sentiments and emphasised the importance of getting governance arrangements at the 'bottom' level right. The locality boards would therefore be very important and the principles of working together cohesively were paramount to success.

The Chair thanked the Director for her attendance.

12. New Primary Care Networks

The DPH delivered a presentation on the new Primary Care Networks (PCNs), the most significant reform to general practice in England in a generation.

The DPH's presentation covered the following:

- Nature of the change;
- The Model of Care;
- Relationship to Integrated Care Systems;
- What are PCNs and what will they do?;
- Map of PCNs in the Borough;
- Who are PCNs accountable to?;
- What leads to successful collaboration in general practice?;
- What difference will PCNs make for patients?;
- Challenges of PCN establishment; and
- Priorities for 2019/20 and 2020/21.

Standing Order 7.1 (Part 2, Chapter 3, of the Council Constitution) was suspended at this juncture to enable the meeting to continue beyond the 9pm threshold.

Dr John felt that the PCNs would achieve more equality in service because if one practice within a network did not deliver a particular outcome, this would affect other practices, and therefore there would be more accountability. PCNs would also provide a better infrastructure to deal with a potential a crisis such as an outbreak. They would potentially also provide better access to appointments as they would include professionals other than GPs who could provide care. There was the potential for PCNs to act as the basis of the Locality Boards discussed in the previous item, but this would require further consideration.

Members asked how patient care would be affected if a professional, working in a given PCN, wished to move to another area. Dr John stated that NHS England had a policy which stipulated the process to be followed in this situation.

The Chair thanked the DPH for his presentation.

13. Joint Health Overview and Scrutiny Committee Update

The Committee noted the update.

14. Work Programme

The Committee noted the latest version of its Work Programme.