Present: Cllr Peter Chand (Deputy Chair), Cllr Abdul Aziz, Cllr Edna Fergus and Cllr Adegboyega Oluwole

Apologies: Cllr Eileen Keller, Cllr Sanchia Alasia and Cllr Hardial Singh Rai

1. Declaration of Members' Interests

There were no declarations of interest.

2. Minutes - To confirm as correct the minutes of the meeting held on 4 March 2015

The minutes of the meeting held on 4 March 2015 were confirmed as correct.

3. Timing of meetings

It was agreed that the start times for meetings of the Health and Adult Services Select Committee (HASSC) during the 2015-16 municipal year would be 6.00pm.

4. Joint Health Overview & Scrutiny Committee

The HASSC noted the local arrangements relating to joint health scrutiny, the terms of reference for the Outer North East London Joint Health Overview and Scrutiny Committee (JHOSC) and the update on the issues that were on the agenda of the last JHOSC meeting.

The report asked the HASSC to agree which three of its members would represent Barking and Dagenham on the JHOSC during the 2015-16 municipal year. Members noted that in previous years the Lead and Deputy Lead Members of the HASSC had been appointed to fill two of the three vacancies and that if the Committee wished to continue this arrangement, one further member would still need to be appointed.

Members agreed to appoint Councillors Keller, Chand and Oluwole to the JHOSC to represent the HASSC during the 2015-16 municipal year.

5. BHRUT update on the Care Quality Commission's Re-inspection

Matthew Hopkins, Chief Executive of Barking, Havering and Redbridge University Trust hospitals (BHRUT) delivered a presentation which covered the following:

- Background to the Trust being placed in ‘special measures’ following inspection by the Care Quality Commission (CQC) in December 2013
- Publication of the Trust’s improvement plan, ‘Unlocking our Potential’
- Leadership and organisational development
- Improvements in outpatient services
- Patient care and clinical governance
Members expressed concern that should BHRUT be taken out of special measures following the re-inspection by the CQC, the Accident and Emergency (A&E) Department at King George Hospital (KGH) would be closed. Mr Hopkins stated that the view that plans around the A&E Department at KGH were entirely dependent upon whether the Trust would be taken out of special measures or not, was not correct. It was important for the Trust to achieve resilience and consistency in A&E performance before making decisions about changes to services. Once consistent performance is achieved, the plan was that the A&E Department at KGH would be changed to an urgent care centre. It was estimated that approximately 60% of those who would have attended the A&E Department at KGH would use the Urgent Care Centre, with the remaining attending the A&E Department at Queen’s Hospital. The Trust would first need to be assured that Queen’s A&E would be able to accommodate and serve these extra people.

The Corporate Director, Adult and Community Services (CDACS) stated that there was anecdotal evidence to suggest that the London Ambulance Service (LAS) was diverting ambulances away from KGH A&E, and sought clarification as to the reasons for this. Mr Hopkins stated that he had not seen any direct evidence to suggest that patients were not being taken to KGH A&E and that any policy decision by the LAS to not take patients there was not based on BHRUT. He suggested that a possible reason why some people were not being taken to KGH A&E was that the LAS staff were basing their decision on which hospital to take a patient to, on which hospital had the smallest queue. Mr Hopkins stated that he was happy to raise the issue with the LAS himself and suggested that alternatively, the Committee may wish to raise the issue in its own right.

Ms Kearns, representing Barking and Dagenham HealthWatch, asked Mr Hopkins what was being done to build on the work that had occurred to improve access for people with hearing and sight difficulties. Mr Hopkins stated that clearly the Trust had not got all processes right and there was more work to do. Recently, letter templates had been revised, for example.

In response to a question Mr Hopkins stated that staff were predominantly based at a particular location with a small degree of flexibility shown when necessary.

Members asked Mr Hopkins how the Trust was planning to improve its financial situation. Mr Hopkins stated that there were current challenges around dependency on agency staff, billing commissioners, and ineffective ways of working but that he was confident that the Trust would improve its deficit by overcoming these challenges.

The Director of Public Health asked Mr Hopkins whether the Trust was prepared to deal with the cap on agency staff pay that would be effective from October 2015. Mr Hopkins stated that he felt the Secretary of States’s announcement that a cap would be introduced was helpful. The Trust was working on ensuring that appropriate agency framework arrangements were in place. He felt that there
would still be some dependency on agency staff after the implementation of the cap and that in his view, there was no risk that whole wards would close because of the lack of agency staff.

Members congratulated the Trust on the achievement of the 95% regular answer rates in Outpatients, amongst other achievements made by the Trust and thanked Mr Hopkins for his attendance and presentation. Mr Hopkins stated that he would be happy to attend a future HASSC meeting to update the Committee on the CQC re-inspection outcome and further progress made by the Trust.

6. **Together First's Primary Care Appointments Service**

Dr Arun Sharma, Chair of Together First, a local GP Federation, delivered a presentation explaining:

- the structure and business activity of Together First
- data on the usage of a 'hub' in Barking providing GP appointments for residents who were not able to get an appointment with their own GP, and
- arrangements for establishing a data sharing agreement.

During the presentation Dr Sharma stated that:

- There were GP federations and hubs in Redbridge and Havering too
- The data showed that the hubs had a positive impact on A&E
- Awareness of the Barking Hub was rising gradually
- 50% of those using the Barking Hub were children
- Friends and family test results showed that patient satisfaction with the Barking Hub was very high
- Allowing GPs to access the patients' medical records with consent was very important in the success of the hubs.

The HASSC asked why Barking and Dagenham was the last of the three boroughs to receive a second hub. Dr Sharma responded that the second hubs in the other two boroughs were in premises that used to be general practices. This made the process to open second hubs in those areas much easier as the premises were laid out appropriately and it also made it easier to obtain CQC approval to open the services. Together First was in the process of identifying suitable premises in Dagenham for the borough's second hub and had worked with HealthWatch on this. Suggestions had been made and a criteria had been identified which included accessibility, facilities and affordability. There was no set date but Together first wanted to finalise the premises as soon as possible.

Members asked what the difference was between the hubs and a walk-in centre. Dr Sharma stated that people would need to make an appointment to be seen by a GP at the hubs and could not just walk in. Furthermore, the hubs were serviced by GPs whereas walk-in centres sometimes used nurses.

Ms Kearns stated that there used to be the walk-in centre in Broad Street, there was talk of there being an urgent care centre at KGH and soon two hubs would be providing services in the borough also. Some members of the public were confused about where to go for their health problems. Dr Sharma stated that the urgent care design was complicated, due to a number of initiatives arising and being implemented. There was an opportunity to look at re-designing urgent care services; the Clinical Commissioning Group (CCG) would be looking at
rationalising urgent care this year. He would like to see the hubs and urgent care centres become part of the same entity eventually but this would take a lot of work, including getting over IT challenges.

The Divisional Director, Adult Social Care (DDASC), asked who a resident should contact if they needed to see a GP urgently. Dr Sharma stated that the resident would first try their own GP and if they could not get an appointment with them, their GP’s reception would give them their local hub’s telephone number, which they would ring to make an appointment.

Members commented that it would be easier if people could be referred to the hub directly by their GP’s reception. Sarah See, Director of Primary Care Transformation at the CCG, stated that the London Transformation Board had a vision to create a ‘one click or one call’ system for accessing health services. Across Barking, Redbridge and Havering, commissioners were trying to streamline services to move towards this.

In response to a question, Dr Sharma stated that the telephone number for the hub would be a local number, as opposed to an ‘0845’ number, for example.

The CDACS observed that usage of the Barking hub by people over the age of 65 was limited. Given that the data showed that A&E was being used more by the older age groups, there appeared to be a strong need for the hubs to ensure that their services were accessible to this age group. It would be important for the hub and partners to understand why more older people were not using the service.

Ms See stated that the Nutfield Trust would be evaluating the hub service via interviews and surveys. The hub had only opened in Barking in January 2015 and so more time may be needed for messages around the availability of the hubs to reach all parts of the community. The CDACS stated that it was, however, important for the Committee to know the answer to the question as access to primary care for older people had implications on long term care costs for the authority and other service providers.

7. **Primary Care in Barking and Dagenham**

Ms See delivered a presentation on Primary Care which covered the following:

- Key policy drivers for primary care and the work of key agencies to improve primary care including NHS England, London Health Commission, Strategic Framework for Primary Care in London, the CQC and think tanks.
- The Royal College of GPs had developed a blue print for a new deal for general practice set out five overarching actions to strengthen general practice for the future:
  - Invest 11% of the NHS budget in general practice
  - Grow the GP workforce by 8,000
  - Give GPs time to focus on patient care
  - Allow GPs time to innovate
  - Improve GP premises.
- The Clinical Commissioning Group would be working on a Primary Care Transformation Strategy to improve primary care across Barking and Dagenham, Redbridge and Havering. The areas being explored for inclusion in the strategy were:
Members asked how many GPs the borough should have and how many it in fact had. Ms See stated that projections said that there were 0.5 GPs for every 1000 people in the borough, which was short of the national rate of 1 per 1800. In response to a question she stated that it was difficult to express a view on what the standard should be because of issues relating to available data on GP numbers. The CCG would like to undertake a workforce survey to better identify the gap. It was a very important question, however, as 28 percent of GPs in the borough were over 60, much higher than the London and national percentage, which meant that there was a real need for effective succession planning. Primary care was acutely understaffed but understaffing was an issue that was common across all levels of the health service. Ms See stated that she could attend a future meeting of the Committee to give a more thorough response to this question, after she had obtained the relevant data.

The DDASC stated that two GP practices in the borough had relocated recently, as referred to in the report, and asked what the difficulties were around securing suitable premises for practices in the borough. Ms See stated that there were some challenges around available estates in the borough. NHS England had a Primary Care Infrastructure Fund, a four year £1billion investment programme to accelerate improvements in GP premises and infrastructure. The CCG would be developing an estates plan working with the Local Authority to identify and maximise on available estates in the borough.

Members asked whether there was good provision for residents who were vulnerable who needed home visits. Ms See stated that a lot of joint work had been undertaken in this regard, between organisations such as BHRUT, HealthWatch, North East London Federation Trust, The Transition Board and the CCG. More work needed to be done however, and the CCG would be looking at pathways when it undertakes its ‘frailty’ work.

In response to a question Ms See stated that the CCG was working with various organisations including other local authorities to transform primary care.
Transformation would take a long time to achieve.

Members asked what was being done to attract GPs into the area. Ms See stated that it was difficult to attract GPs to Barking and Dagenham because GPs felt there were fewer opportunities to invest and stay in the borough. Many salaried GPs did not want to be a partner. The Community Education Provider Network and the Care City Model would provide professional development opportunities for GPs which were being promoted.

The DDASC stated that Ms See talked about the potential reduction of weekend access to general practice because it was not being utilised enough during her presentation. However, this did not take into account the impact on the discharge of patients during the weekends; hospitals sometimes would not discharge the patient during the weekend because their GP was not open. Long term conditions are better managed when the patient is seen by his or her own GP and therefore any reduction in access was a concern.

Ms See stated that the seven day model would be discussed during the Urgent Care Conference to see if it could be shaped better. Also, the CCG would be looking at GP contracts to look at what they were offering that would ease access such as telephone consultation.

The CDACS stated that the two GP relocations referred to in the report were two significant changes which had occurred without the HASSC being given sufficient opportunity to comment. This was of concern as GP relocations to other boroughs, as in the case of Dr Pervez' practice, may affect the funding allocation to the Barking and Dagenham CCG as well as significantly affect residents. Ms See stated that the CCG was given late notification of these relocations too and had alerted NHSE of its concerns.

In response to comments from the HASSC Ms See provided assurance that the CCG was clearly aware of the Committee’s role and the duty of health service commissioners to consult it on proposed significant changes.

The Committee agreed to write to NHSE regarding its concerns around inadequate consultation for the two general practice relocations.

In response to questions Sharon Morrow, Chief Operating Officer for the BDCCG, stated that the Primary Transformation Strategy would be monitored via the Transformation Programme who would oversee the measures for transformation of primary care.

In response to questions the CCG clarified that the CQC had powers to inspect GP services and seek closure through the courts if a practice was failing.

Members asked how the CCG planned to join up different pieces of the picture to ensure primary care would be smoother in future. Ms See stated that the Strategy would focus on this and that one of the roles of the Transformation Board was to align primary care transformation with other transformation work, for example, urgent care and social work.

In response to questions the CCG and officers confirmed that there was no longer a compulsory retirement for workers, including GPs.
Members thanked Ms See for her presentation.

8. **Scrutiny Review of Local Eye Care Services - results of staff survey**

The Public Health Consultant (PHC) delivered a presentation outlining the observations made on the results of a staff survey on eye health, undertaken in April 2015 as part of the HASSC’s in-depth scrutiny review on eye health as follows:

- 88 responses had been received.
- There were clear limitations of the data
- Only half of the respondents knew to get their eyes tested every two years
- People felt a pressure to spend money on glasses
- People were sometimes not aware of whether they or a close relative had glaucoma or diabetes; this means they were not accessing free tests to which they were be entitled.

The HealthWatch representative asked if the employees who took part in the survey all lived in the borough. The PHC stated that this had not been checked as part of the survey. Ms Kearns stated that the results of the survey potentially did not tell the Committee anything about the borough’s residents. The CDACS accepted this and stated that members could survey residents at the One Borough Show on 25 July 2015 to mitigate the effect of this to an extent. The HASSC agreed to this.

Ms Kearns stated that StreetLife, a social media website for Barking and Dagenham residents, was also potentially a good place to try.

9. **Intermediate Care Proposals - update**

The Scrutiny Officer stated that the report updated the Committee on developments regarding the Intermediate Care proposals since its last meeting on 4 March 2015. Members noted that the Secretary of State for Health had written to Redbridge’s Health Scrutiny Committee informing them that their referral with regards to the proposals, in its current form, did not constitute a legitimate referral. Redbridge’s Health Scrutiny Committee had met since receipt of the letter to discuss its next steps and the HASSC would be updated once details of that meeting were made public.

10. **HASSC Work Programme 2015/16**

Members noted the report and the draft work programme. It was agreed that the Committee would undertake a review on ‘Falls’ between September 2015 and March 2016. Members stated that the scoping paper for the review would need to take into account this short time period and that it would therefore not be possible for the review to cover all the issues outlined in the ‘options’ paper. It was agreed that the scope for the review be agreed with the Lead and Deputy Lead members between now and August 2015 so that the review could be started promptly in September 2015.

The other items on the work programme were agreed.