MINUTES OF
HEALTH AND ADULT SERVICES SELECT COMMITTEE

Wednesday, 7 September 2016
(7:00 - 9:05 pm)

Present: Cllr Peter Chand (Chair), Cllr Linda Zanitchkhah (Deputy Chair), Cllr Sanchia Alasia, Cllr Edna Fergus, Cllr Jane Jones, Cllr Eileen Keller, Cllr Hardial Singh Rai and Cllr Faraaz Shaukat

Also Present: Cllr Maureen Worby

Apologies: Cllr Abdul Aziz

12. Declaration of Members' Interests

There were no declarations of interest.

13. Minutes - To confirm as correct the minutes of the meeting held on 19 July 2016

The minutes of the meeting held on 19 July 2016 were confirmed as correct.

14. Primary Care Update from Barking and Dagenham Clinical Commissioning Group

Sarah See, Director of Primary Care Transformation (DPCT) for Barking and Dagenham Clinical Commissioning Group (BDCCG), delivered a presentation to update the HASSC on Primary Care, which covered the following:

- Personal Medical Services (PMS) contracts
  - These are locally negotiated GP practice contracts which follow national regulations
  - They have the ability to introduce local flexibilities not available under the General Medical Services contract. PMS contracts aim to improve the quality of services by basing them on the needs of the local population and provide value for money
  - Practices on a PMS contract receive more funding per patient than most practices across London working to the national contract
  - The difference in funding between these two types of contracts is called the ‘PMS premium’.
- Primary Care Transformation
  - Plans for an extended, place-based (locality) team.

In response to questions, the DPCT stated that:
- The draft Key Performance Indicators (KPIs) for the new contract covered a range of areas such as cervical screening, vaccinations and immunisations and indicators from the GP Patient Survey. The contract would also include provisions around the accessibility of appointments, managing prescriptions and patient records. There is a large variation in the amount of funding PMS practices in Barking and Dagenham receive and the services they provide with this funding – although this ‘offer’ was subject to discussions being held
at a pan-London level between NHS England (NHSE) and the London-wide Local Medical Committee.

- The CCG anticipates it will be advised by NHSE within the next two weeks as to whether the pan-London discussions are to continue or whether clinical commissioning groups will be asked to lead and complete the review. The review would need to be completed by March 2017 which would be a challenging deadline to work to for CCGs.

- One of the aims of the Primary Care Transformation Strategy is to get individual practices to work more proactively together to improve their services and coordinate people’s care.

- The CCG is working with its partners on an integrated locality based model with BDCCG’s first meeting with its members on this tomorrow – there will be a focus on diabetes care and health checks.

- The Care Quality Commission (CQC) is in the process of inspecting all of the borough’s GP practices and it had emerged recently that they had put two practices into ‘special measures’ as a result of an overall inspection rating of ‘inadequate’. The CCGs across Barking and Dagenham, Havering and Redbridge (BHR) had increased monitoring of practices across these areas to identify and actively manage their performance when potential issues are identified. An action plan has been developed by the CCG based on common findings from recent CQC inspections to provide training and support to help practices improve. The CCGs will be rolling out a series of workshops to practices who had had an inspection as well as those who had not. They will be working with their north east London colleagues to develop a quality collaborative with the intention of having a base in Barking and Dagenham; information on this would be going out to partners soon. Nine of the borough’s other practices had been rated ‘good’ and a number of inspections were yet to be complete between now and January 2017.

- Of the three GPs currently in special measures one had been re-inspected and there was informal feedback that the re-inspection had gone well. The other two had action plans and additional resources to address areas of concern. They all have the opportunity of accessing the Royal College of General Practitioners programme and resilience monies.

Members asked why the borough’s GP practices’ had the second highest premium in London. The DPCT stated that that there was a pilot of PMS contracts in the 1990s which did not involve a clear methodology for agreeing the contracts. Practices were awarded a premium amount depending on various factors such as workforce or the delivery of additional services. This led to a PMS contract situation with variations amongst practices. London has the highest premium due to a big drive to get practices on PMS contracts at that time. It would be very important for those doing the review to balance the need to achieve equity amongst practices in the premium received against the need to ensure practices do not fall into an instable financial position.

Councillor Jones asked why the borough’s GPs were performing relatively poorly in the early detection of certain diseases, if they received the second highest premium in London. The DPCT stated that this was a complex question and performance was down to a number of complicated and interrelated factors, such as how practices recorded clinical data, the skill mix of staff, the number of vacancies, and the amount and type of expertise. For this reason the BHRCCGs wish to create networks of GPs based on localities, which they were currently
planning to pilot.

Councillor Jones asked, why, if the borough’s GPs were not performing relatively as well as others, the possibility of funding being taken away from them, was being considered. The DPCT stated that the need to achieve premium equity amongst practices was a separate issue from general performance. The funding received by a practice would depend on what was stipulated in its PMS contract. Currently, if the practice was not meeting its target, money was recovered. Furthermore, in London, the performance of some practices who were based in more advantaged areas was also coming down. The review of PMS contracts was a national agenda, not one that the BDCCG specifically was undertaking. To address performance issues, CCGs would need to support practices with quality improvement frameworks, practice management and training, which is what the BDCCG was looking to achieve with the new locality model pilot. The Director of Public Health (DPH) stated that the variation in performance could not be addressed by more funding; rather CCGs would need to look at how practices could work in a different way.

Councillor Shaukat asked how the BHRCCGs planned to transform primary care. The DPCT stated that the CCG wished to change primary care so that it would:

- Provide more proactive care;
- Focus on prevention;
- Support self-care;
- Actively manage patients' long-term conditions;
- Avoid unnecessary hospital admission; and
- Reduce unnecessary referrals to hospital.

The DPH added that general practice would not be able to solve all the problems in primary care alone and all aspects of the local health system would need to play their part, particularly in managing demand, including pharmacies and the Local Authority. This would include providing the right information to residents as well as supporting professionals to make appropriate referrals. Councillor Alasia stated that there was much anecdotal evidence of people not being referred to the right services by GPs in a timely fashion, which led to serious consequences for individuals. She asked how the CCGs would ensure that their approach to demand management would not have adverse impacts on individuals. The DPCT stated that the transformation strategy was not about stopping appropriate referrals; rather, it looked to create collaborative networks of GPs, which would improve communication and the sharing of good practice between GPs so that they could contact one another for expertise and opinion, for example, as well as providing more care in a community setting.

Councillor Fergus stated that as well as ensuring the correct systems were in place to make the changes happen, the CCGs would also need to ensure that primary care professionals had the right attitude and want to work together. The DPCT stated that she completely agreed, and that this principle was a core part of the ‘change management’ of the primary care transformation programme. She added that she was seeing a lot of passion and energy for change in the primary care sector and people were incentivised to work together for the benefit of their patients.

Councillor Rai stated that it was his understanding that it was very difficult for a GP
to remove a patient from their register and asked, in the light of this, what could be done about the number of people who do not show up for their appointments. The DPCT stated that the issue of patients not turning up for appointments was a big issue for the NHS, costing it millions per year. GPs did send out text message reminders to patients before the appointments and some also enabled patients to cancel their appointments online. She welcomed ideas as to what further actions GPs could take to address the issue.

The local Healthwatch representative, Richard Vann, asked whether the BDCCG was anticipating a negative impact on GPs’ ability to provide a good service, as a result of the PMS review it was likely to have to undertake. The DPCT stated that there was potential for it to have a negative impact, however; they would work hard to mitigate this. The BDCCG had already visited every GP in the borough and the stability of practices was on the CCG’s risk register. Practices on the GMS contract were more welcoming of the review due to the potential that they would possibly receive more funding eventually. The BDCCG was very clear that it did not want to demoralise those who worked in general practice and that it would need to strike a fine balance between achieving equity and stability.

Councillor Worby, the Cabinet Member for Social Care and Health Integration, stated that she accepted that every GP was an individual contractor and that there were no sanctions the BDCCG could impose on them until the CQC put a practice into ‘special measures' following an inspection. Nonetheless, it was concerning that three of the boroughs’ GPs were now in special measures, particularly Abbey Medical Practice, a relatively large practice, based in purpose built premises. The DPCT stated that part of the problem was contractual issues and part of it was a national problem. She acknowledged that it was disappointing to see three practices placed in special measures, particularly as some of the areas they were found to be inadequate in were quite basic. However, nine GPs in the borough were rated as ‘good’ by the CQC, which was positive and one of the practices that was placed in special measures had been re-inspected and found to be making good progress, although the outcome was yet to be made formal.

The Chair thanked the DPCT for her presentation.


The DPH presented the scoping report for the Committee’s chosen area for in-depth scrutiny review – Cancer Prevention, Awareness and Early Detection. He explained that since the agenda had been circulated, officers had met and wished to propose some amendments to the work plan within the report:

- The 2 November 2016 HASSC meeting was unlikely to be used for budget scrutiny and therefore the Presentation on the outcome of B&D Cancer Awareness Measure (which was currently listed for January 2017) could now be brought forward to November.
- Furthermore, there would be an event in the Mayesbrook ward focussing on the potential for a ‘lifestyle hub’ in October 2016. There was potential for this work to link in with this scrutiny review in January 2017 by considering how the potential Hub could play a part in prevention and raising awareness of cancer.

The HASSC agreed the above changes.
The DPH delivered a presentation to set the context of the Cancer Scrutiny Review, which covered the following areas:

- The national challenge
- Cancer Taskforce Strategy priorities
- The Taskforce’s ambition for 2020
- Barking and Dagenham Cancer numbers
- Prevention
  - How can 4 in 10 cancers can be prevented?
- Early diagnosis
  - Screening Uptake: Breast Screening
  - Screening Uptake: Bowel Screening
  - Screening Uptake: Cervical Screening
- Emergency Presentation
- Barking and Dagenham – what are the problems?
- How is B&D responding to the challenge?
- Survivorship – cancer as a Long Term Condition (LTC)
- HASSC Cancer Review – suggested Terms of Reference.

A member stated that a member of his family had presented himself to his GP late, complaining of symptoms which transpired to be prostate cancer. However, to make matters worse, his follow-up hospital appointment was not given to him until many weeks later and in the meantime the patient suffered a heart attack, which was probably related to stress. The DPH stated that unlike some other cancers, there was no national screening for prostate cancer due to there not being an effective screening test. If a GP suspects cancer, the referral should be made within two weeks. Furthermore, it was also recommended that direct relatives of a man diagnosed with prostate cancer, also be examined.

The Chair stated that his understanding was that only a fraction of the local health economy’s budget was spent on cancer prevention, and asked whether this aspect of prevention could be looked at closely as part of the Review. The DPH stated that officers would need to do some benchmarking work and gather the data on this as part of the research underpinning the review.

Members expressed concern that many GPs applied a ‘rule’ that patients could only raise one problem at a time when seeing their GP, and that the appointment would only last up to 10 minutes. This was problematic because if a person had cancer they may have several symptoms, not realising that they were linked. Members were concerned therefore, that this rule may impact on early detection of cancer and that this was exacerbated by the tendency of the borough’s residents to be accepting of services standards rather than challenging them. The DPH stated that it was recognised that these rules may be seen as restrictive; however, all GPs were trained to take an opportunistic approach to consultations and ask follow up questions to help determine other symptoms and their possible cause. SS added that GPs had systems that would flag up if the person being seen was due for a screening test.

In response to a question the DPH stated it now seemed apparent that an oversight was made when bowel cancer screening had moved to Homerton Hospital because the borough’s residents were not responding well to hospital requests to attend screening. The BDCCG was looking at what it would take to get
GPs more involved in screening requests as the suspicion was that the response rate would be better. The DPCT added that requests to attend cervical cancer screening was sent by GPs and had better attendance rates, therefore GPs would argue there’d be a better response rate if they managed bowel screening requests.

Mr Vann asked whether the impact of air pollution on cancer could form part of the Review. The DPH stated that air pollution was more related to respiratory diseases than cancer. Some industrial materials such as those with asbestos and some industrial dyes were linked to cancer but this was beyond the scope of this review.

Mr Vann asked what could be done to ensure a smooth transition for those with cancer who had moved areas, for example, those who were being looked after Barking, Havering and Redbridge University Trust and then by Barts Health Trust.

The DPH stated that there were two cancer networks in London and BHRUT and Barts were in the same network. Secondly, every trust had a multi-disciplinary team (MDT) who were in charge of cancer patients’ care. There should be a point of contact in the MDT that the patient can contact to make the transition easier. Having said this, it was acknowledged that there were delays in inter-network transfer and more could be done to improve transition. Furthermore, one of the Cancer Taskforce’s priorities was to ensure that patient experience is on par with clinical effectiveness and safety, which included smooth transition.

Members commented that Personal, Sexual and Health Education (PSHE) in schools may have a role to play in teaching children and young people about healthy lifestyles and the risks of factors such as smoking and obesity in relation to getting cancer.

The Chair thanked officers for the report and presentation and reminded members that a ‘Talk Cancer’ session was being held for HASSC members as part of this Scrutiny Review at 2.00pm on 12 October 2016 and urged members to make arrangements to attend as it would be a very engaging session.

16. Inspections by the Care Quality Commission of Local Adult Social Care Services

The Council’s Principal Commissioning Manager presented a report on the outcomes of the inspections carried out on a number of the borough’s social care providers. Members noted the details of the providers who were rated by the CQC as ‘requiring improvement’ during the fourth quarter of 2015/16 and first quarter of 2016/17 and the action the Council was taking in working with the providers to improve. Members noted that the Council did not rely solely on CQC inspection outcomes before intervening; rather, it took a proactive approach to supporting care providers to improve.

Members expressed concern that many of the providers judged as requiring improvement were used by people with learning disabilities. The Council’s Commissioning Director for Adults’ Care and Support (CDACS) stated that this potentially relates to the fact that providers who support people with learning disabilities tend to be smaller, and therefore may find it more difficult to sustain themselves, compared to larger providers who were providing care for elderly people, for example. He acknowledged that for this reason, it was important to monitor these providers carefully.
Members also expressed concern that it was currently relatively easy to become a registered provider and asked whether the Council could intervene prior to registration if it suspected that the prospective provider was not ready to start providing care. The Strategic Director for Service Development and Integration (SDSDI) stated that the Council was statutorily responsible for the quality of care given by the providers in the borough, but was not the decision-maker about new registrations for care businesses, which rested with the Care Quality Commission. The Council could not refuse planning permission for a care home on the basis that it was concerned about the quality of care that would be provided. Furthermore, sometimes the clients of the provider wished to continue using its services, even if the Council expressed concerns. Councillor Worby echoed these comments, adding that ideally, residents should not place their family members with a provider if the Council was not placing residents there; however, in reality, this did occur.

Councillor Fergus expressed concern regarding provision for young people with mental health problems as she had been made aware that some of these young people’s care was not being followed up. The SDSDI asked Cllr Fergus to provide further details outside of the meeting so that she could follow this up and address any issues.

In response to questions the CDACS described in detail the support provided, and the proactive action the Council took to ensure that the borough’s providers were providing good care. The Council held thorough information about each provider and was not normally surprised with the outcomes of CQC inspections due to the close work it undertook with providers. However, some matters were out of the Council’s control, for example, a change in management could lead to rapid changes in the quality of service provided.

The SDSDI stated that approximately two years ago the Committee was offered the chance to undertake a programme of visits to care homes; however, take-up of this offer was poor. She stated that members who had a particular interest in this area should inform the Chair, as officers would be happy to facilitate a programme of visits.

The Chair asked whether a person who was placed by a neighbouring borough into a care home in this borough would become a Barking and Dagenham resident. The Council’s Operational Director, Adults’ Care and Support (ODACS) stated that this area was complicated as there may be some people who live in the borough for years without legally becoming a borough resident. Councillor Worby stated that if a neighbouring borough wished to house their resident in Barking and Dagenham, and they then went on to develop care needs, then this could cause a challenge for the Council as the person would legally become a borough resident for the purposes of their care costs.

The CDACS stated that the Council undertook a lot of work with neighbouring boroughs, particularly when suspending placements to ensure those in need of care were safeguarded.

As two hours had passed since the start of the meeting, the HASSC agreed to extend the meeting in accordance with the meeting rules in the Council’s Constitution.
17. Joint Health Overview & Scrutiny Committee Update

The HASSC noted the update on the issues that were discussed at the last meeting of the Joint Health Overview and Scrutiny Committee.

18. Work Programme

The Chair stated that the HASSC had already agreed during discussions relating to agenda item five, the changes proposed by officers to the scope of the Cancer Scrutiny Review, and asked the Democratic Services Officer to make amendments to the Work Programme to reflect these changes. He also stated that Councillor Worby had recently asked the HASSC to consider placing the issue of Continuing Healthcare on the Work Programme and asked the ODACS to briefly describe to members what this issue entailed so that members could take a decision. The ODACS stated that Continuing Healthcare was a free NHS package of health care offered to individuals with a primary health need, which could be provided within the person’s home or at a provider care home. However, there was currently a funding crisis across the BHRCCGs as a result of a significant overspend in this area. In response to the overspend the CCGs now intended to carry out a review of the care packages offered to those with learning disabilities, as they believed that the overspend related mainly to these care packages. The Council was concerned about the potential negative impact this review could have on residents with learning disabilities. Councillor Worby stated that Continuing Healthcare was an example of an issue arising at Health and Wellbeing Board meetings, which could be referred to the HASSC for a more appropriate and thorough examination.

The HASSC agreed to place the issue of Continuing Healthcare on its Work Programme for the meeting on 11 January 2017.

Furthermore, in response to questions from the Chair, the HASSC agreed that should the outcome of the recently announced re-inspection of BHRUT be that the Trust is to remain in special measures, an item should be placed on the Work Programme for the meeting on 1 March 2017 focussing on the Trust’s improvement plan.