MINUTES OF
HEALTH SCRUTINY COMMITTEE

Wednesday, 21 September 2022
(7:00 - 9:10 pm)

Present: Cllr Paul Robinson (Chair), Cllr Donna Lumsden (Deputy Chair), Cllr Muhib Chowdhury, Cllr Olawale Martins, Cllr Michel Pongo and Cllr Chris Rice

Also Present: Cllr Maureen Worby

45. Death of Her Majesty Queen Elizabeth II

Before moving to the formal business of the meeting the Chair with great sadness asked the Committee to note the death of her Majesty Queen Elizabeth II. Throughout her reign of more than 70 years, the Queen had been an inspiration to people not only from this Country but across the world, through her tireless commitment to her public duties and to her people. She would be sorely missed. May she rest in peace.

The Chair then asked everybody to stand in quiet reflection for a minute's silence.

46. Declaration of Members' Interests

There were no declarations of interest.

47. Minutes - To confirm as correct the minutes of the meeting held on 23 March 2022

The minutes of the meeting held on 23 March 2022 were confirmed as correct.

48. Proposed Diagnostic Centre at Barking Community Hospital

The Director of Strategy and Partnerships (DSP) and the Diagnostics Programme Director (DPD) at Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) delivered a presentation on the proposed diagnostic centre at Barking Community Hospital (BCH), which was part of a national NHS England-funded programme of diagnostic centre building, that would help to improve access to diagnostics to support the early diagnosis of disease. The presentation detailed that:

- The Community Diagnostic Centre (CDC) preparations were already underway, with a Computed Tomography (CT) scanner and Magnetic Resonance Imaging (MRI) scanner currently being built there.
- The construction of the larger building containing the majority of the diagnostic capacity had been subject to two recent public consultations, which had both reported very positive findings. The CDC was proposed to cost £15 million to build and would contain the full suite of diagnostic services (such as CTs, MRIs, X-rays, ultrasounds, physiological measurements and blood tests);
- The aim of the CDC was to enable residents to go to a 'one stop shop' for diagnostics before they were fully referred into secondary care, so that any

issues could be determined.
- Over the next couple of years, it was planned to build one CDC in Barking, one in Mile End and a third in another location.
- The Barking CDC was proposed to open between October-December 2023.

The Cabinet Member (CM) for Adult Social Care and Health Integration stated that, whilst herself and other Council colleagues had lobbied hard for this very positive development, she wished to put on record her thanks that the system had listened to all concerns and taken action to address these.

In response to questions from Members, the DSP and DPD stated that:

- BHRUT had submitted a provisional business case to NHS England (NHSE). Whilst this did not specify every exact detail, it would provide BHRUT with the
  £14.9 million for the construction of the building. NHSE had confirmed that it was satisfied with the provisional business case and had given BHRUT a formal letter of agreement to confirm that BHRUT could access this funding.
- NHSE had also committed to three years of revenue funding to pay for the staff to run the scans within the centre. Whilst this was the maximum length of funding that NHSE would currently provide, this was not to say that there would not be funding after this three-year period.
- The funding was entirely new money that was being given to the system from the NHSE pot of programme funding, that would not need to be repaid.
- Whilst BHRUT could not guarantee exact waiting times as part of this new CDC as it did not know how much demand would change and grow, the CDC would help to reduce the current backlog. The majority of access to the CDC would be through direct GP referrals, rather than through lengthier referral processes through GPs and then hospital consultants as previously.
- As the CDC would not be based in a hospital, the diagnostic services would be more sustainable and could be used for more elective appointments. Current hospital diagnostic services always had to prioritise emergencies, whereas the CDC would operate outside of the emergency hospital pathway.
- Workforce, and information and digital were the two challenges that BHRUT had with any of its investments into buildings across its services. Most recently, it had recruited a number of radiographers; however, it was also investing in a training academy for radiography and other diagnostic services. It was also working closely with other North East London (NEL) acute trusts such as Barts and the Homerton, to start to build workforce plans, so that it could have a more resilient workforce. This could include joint appointments and rotational posts across NEL, ensuring a sustainable and growing workforce, and that Barking and Dagenham and other areas of NEL could be as attractive to these professionals as inner London teaching hospitals.
- BHRUT had also secured an additional £250,000 from Health Education England in 2022, to support and improve its training academies.
- This was the start of further investment at BCH and other locations in the Borough. Discussions were being had around maximising BCH to better serve the local population, as well as how to best meet the needs of the population as it grew and changed, using data and local insights.
- The CDC was additional capacity and would not replace current capacity

and services. In the long-term, the system would need to work collectively to consider where to best place its services, understanding the need to ensure that these were conveniently located for residents.

- Whilst mental health diagnostics were not part of the first stage of the CDC, BHRUT understood the importance of mental and physical health parity and wanted to work with partners within the place-based partnership to consider how to best treat patients holistically. One further benefit of the CDC was that it could be designed in such a way that was more pleasant for people with mental health problems, or conditions such as ASD (autism spectrum disorder), in a greater way than was possible in acute settings with blue light pathways, which could prove more traumatic for patients.
- Being representative of the local community was very important to BHRUT. It had a strong apprenticeship model, and strong outreach models into colleges and schools to build relationships with young people from an early age and demonstrate the range of NHS roles that were available. A new Chief of People officer would also be starting in November 2022, to ensure that BHRUT was creating an inclusive environment to attract a diverse workforce.
- The BCH would create around 100 extra permanent jobs across different grades and responsibilities. BHRUT was keen that people could build their career within the CDC, from an apprenticeship stage to senior-level careers.

The Integrated Care Director at NELFT also stated that there was no intention to move any of the mental health services out of BCH. As part of current transformation activity, NELFT was working more closely with its primary care networks (PCNs) and investing in equipment such as portable electrocardiogram (ECG) machines that enabled some diagnostic activity to take place in the community, such as in people's homes and in GP practices, as NELFT was aware that issues, such as cardiac problems and obesity, were higher in patients with mental health issues.

In response to a question, the CM stated that there had been considerable patient and resident engagement to ascertain how residents wanted to experience services and how they wanted these to improve, with suggestions arising around garden areas and patients with multiple conditions being able to have one appointment to address all of their conditions. The DSP stated that there had also been visits to shopping centres and focus groups. Discussions were also being had with residents with additional needs, to ensure that all patients could be comfortable to visit the CDC, as well as have conveniently located and well-timed appointments.

49. Enhanced Access Update

The Director of Primary Care Transformation (DPCT) and the Clinical and Care Director (CCD) Barking and Dagenham at NHS North East London (NEL) delivered an update on enhanced access. The presentation detailed that:

- All Primary Care Networks (PCNs) in England would be required to offer patients a new 'enhanced access' model of care from 1 October 2022, which would see GP practices open between 6.30pm-8pm from Mondays to Fridays, and between 9am and 5pm on Saturdays. This would replace the current Extended Hours and Extended Access services, marking a shift in

the way out-of-hours non-urgent services were provided across North East London.

- The PCNs had subcontracted and were working alongside the GP Federation to provide these services. As part of the NHS England (NHSE) specification, the PCNs were also working alongside new roles funded by the NHSE, such as clinical pharmacists, physiotherapists and occupational therapists.
- To support PCNs with engaging their patients, NHS NEL had run a North East London-wide survey on provided services, of which there were just under 5,000 responses from Barking and Dagenham residents.
- The model would evolve as ongoing resident feedback was received, as well as to cater to the needs of patients.
- A mixture of GP, nurse and therapist services would be offered, as well as face-to-face, telephone and remote appointments.
- The new model would run from three sites locally.
- Additional funding had also been secured to keep the current GP Access Hub service running until 31 March 2023.

In response to questions from Members, the DPCT and the CCD stated that:

- The model would be flexed to accommodate the various preference types for appointments and the PCNs would continue to work with patient groups, to suit their needs. NHSE had also specified that PCNs needed to provide a range of appointment types.
- When patients booked an appointment, they would be asked which type of appointment they wanted; if a patient wished to have a face-to-face appointment, it would be offered to them.
- They would return to the Committee early in 2023 once the service had been running for a few months, to bring back data and feedback from residents as to the new services offered.
- Whilst there was already an existing weekend and evening service for urgent appointments, the ‘enhanced access’ model would be for routine appointments and would increase GP opening hours for these.
- It was estimated that around 72,000 additional appointments could be undertaken each year through the six PCNs in Barking and Dagenham working together, as part of the “enhanced access” model. NHS NEL would ensure that the current in-hours offer would not reduce due to this, and could bring back data on the number of appointments provided in the first quarter, upon their return to the Committee in January 2023.
- It was hoped that the model would increase the uptake of screening programmes, for those who were only able to book after-work appointments.
- NHS NEL was in discussion with Council colleagues about the Borough’s Family and Children’s Hubs, and services that could be provided in these. It was looking to be cost-effective by using existing sites to provide services; however, it was looking to expand these. The DPCT would feed back comments around Marks Gate and potential access issues for these residents, if services were only provided from BCH and Parsloes Avenue.
- The current in-hours offer with each GP practice would remain, with the extended hours being provided by GPs working alongside the wider primary care family. 12 new roles had been funded by NHSE, so that a blended team could work within the new service and best meet the needs of

patients. As patients often still wanted to see their GP, the support of the Committee was requested in promoting the new service and additional staff, as it was important that patients saw the right clinician for their needs, and that GP time could be best utilised for those patients with the most complex issues.

- In terms of measuring the performance of the six PCNs, NHS NEL could look at various measures, such as how many residents had received annual diabetes checks. The quality of services could also be held to account via Quality and Safety meetings, with data able to be pinpointed to PCN and practice-level and plans able to be created to improve services and increase uptake. NHS NEL was also working with the GP Federation from an equality perspective, to look into how many appointments would be available for each GP practice, to ensure that these were not all being taken by patients from a single practice.
- Patients with LD could be catered for through longer appointments and at certain times of the day, when practices were less busy. A lot of learning from the vaccine campaign, whereby clinics for those with LD were run, with amended and quieter room settings, was also being fed back to those developing the 'enhanced access' service.
- In most GP practices, reception staff would triage patients, to ensure that they were seeing the correct clinician for their ailment, and they were well trained to do this. However, clinicians would triage patients with more urgent needs.
- GP practices were working towards holding 70 percent of appointments face-to-face. The remaining 30 percent of appointments were held via E-Consult, as part of a national directive, as well as directly bookable slots via the 111 telephone number.
- The 'enhanced access' service would hopefully reduce the number of patients going to accident and emergency services (A&E), as they would instead have access to extended hours GP services.

The Cabinet Member (CM) for Adult Social Care and Health Integration stated that she was co-chair of the new partnership board, which included members from Health, the Local Authority and the Voluntary and Community Sector, and that she would be looking to see new metrics around issues such as health checks and the quality of services. The Director of Public Health noted that the new 'enhanced access' model would be very positive in improving the outcomes for residents who were unable to access current GP services due to issues such as their work schedules.

It was requested that the Committee be provided with a thematic analysis of the complaints that were being received about the PCNs and the new 'enhanced access' service. The DPCT stated that complaints data about the 'enhanced access' service could be brought as part of the January 2023 Committee update, but that she would circulate some information regarding practices and PCNs, following the meeting.

50. Tulasi Medical Centre Update

The Director of Primary Care Transformation (DPCT) and the Clinical and Care Director (CCD) Barking and Dagenham at NHS North East London (NEL) delivered an update on the Tulasi Medical Centre and the Faircross Health Centre,

following their inadequate Care Quality Commission (CQC) ratings, to assure the Committee of the action that was being taken to improve these. The presentation detailed that:

- Tulasi Medical Centre had been rated inadequate against all key questions asked by the CQC (about whether services were safe, effective, caring, responsive to people's needs, and well-led). It had also had its registration with the CQC suspended; it could still hold its GP contracts under the regulations, but whilst it was rated inadequate and addressing CQC issues, it had had to subcontract its services to the GP Federation.
- There would be a six-month period in which Tulasi Medical Centre would have an action plan in place, approved by the CQC and NHS NEL, to address the issues found by the CQC. An NHS NEL team would monitor progress with the Centre on a weekly basis, as well as to support around aspects such as medicine management, safeguarding and infection and disease control.
- As a commissioner, NHS NEL had also issued a breach notice to Tulasi Medical Centre, which the Centre had six months to address. The Centre would be monitored by the regulator, CQC, and NHS NEL as it provided its services under the GP contract. NHS NEL would also work with NHSE to look at the competencies of the clinicians working at the site.
- Faircross Medical Centre had been rated inadequate by the CQC, but could still hold their registration with the CQC. Whilst NHS NEL was working with Faircross on its action plan, it had been inspected earlier in the year, and so was further ahead in addressing its remedial actions.

In response to questions from Members, the DPCT and the CCD stated that:

- At the end of the six-month remedial period, a CQC reinspection would take place. These often took between four-five days, with the CQC bringing in a new team to thoroughly check actions across all key domains, to ensure that auditing was being undertaken correctly and that policies were in place.
- GP practices did change over time. The Tulasi Medical Centre lead held a lot of responsibility on their own; one of their actions was to look into recruiting partners to share the workload. The lead had held various roles in the system and had since stepped back from these, to concentrate on their GP practice.
- The CQC worked independently from NHS NEL, but other practices were undergoing inspections as part of the CQC's inspection cycle. Through the Borough Partnership, NHS NEL was looking at holding a quality roundtable to look into general practice, focusing on workforce, funding and workload issues, as well as what the system could do to best support practices and help them to prepare for CQC inspections. It was also holding educational training events looking at inspections, data and correct auditing practices.

The CM noted that one positive to the new NEL ICS arrangements was that extended knowledge sharing could take place, as well as the increased capacity for different parts of the NEL system to support each other. It was also important to acknowledge that the role of GPs had changed, with their responsibilities now much more widespread than previously, as well as the pressures associated with this. This also meant that more frank discussions around quality needed to be had,

as well as which other professionals needed to support GPs in their practices. The Director of Public Health noted that whilst hospital clinicians were very restricted in terms of what work they could undertake, this was not the case with GPs. As such, there needed to be more discussions about the long lengths of time that GPs were now working for, as well as around all of the responsibilities that they had.

In response to further questions, the DPCT and CCD stated that:

- It was a very tough time for GPs, with multiple demands arising from the pandemic. The system had to support GPs, as well as give them space. It was also important to have conversations about the number of roles that GPs could hold, to prevent burnout, as well as how other professionals could be developed to take on some of these roles.
- The Tulasi Medical Centre was also a Covid-19 vaccination site, with multiple asks of it. GP practices were like standalone hospitals, with many areas of practice, and were expected to meet the demands of each of these. Whilst improvements would continue, the support of patients and Councillors was needed; if for example, a person had not had their annual diabetes review, a phone call to the practice would ensure that this was picked up.
- There was a monthly GP education and training event in Barking and Dagenham, as well as for nurses and management. NHS NEL could look through common themes and issues, and look to address these.
- Whilst the Tulasi Medical Centre action plan was not in the public domain, the CQC report was, with a decision tree of the findings available. As well as with NHS NEL, the Centre was in regular contact with CQC, submitting regular updates to them as well as to NHSE.
- Patient safety was paramount and the CQC could urgently shut down a GP practice if it felt that this was needed; however, this had not happened with either Tulasi or Faircross Medical Centre.
- Tulasi Medical Centre had brought in additional resources to assist with remedial work. The GP Federation had also brought in resources and NHS NEL had provided the Centre with resilience money to support them.

The CM stated that she would consider which briefings she could deliver for Councillors, as to how they could better engage with the work of GP practices.

51. Appointments to the Outer North East London Joint Health Overview and Scrutiny Committee

The Chair presented a report asking the Committee to appoint three Members to the Outer North East London Joint Health Overview and Scrutiny Committee (ONEL JHOSC) for the 2022/23 municipal year. The Committee agreed to appoint Councillors Robinson, Lumsden and Chowdhury to the ONEL JHOSC.

52. Minutes of the Joint Health Overview and Scrutiny Committee meeting on 28 July 2022

It was noted that the minutes of the last meeting of the Joint Health Overview and Scrutiny Committee were included as part of pages 47-51 of the agenda.

53. Health Scrutiny Committee Work Programme 2022/23

The Chair presented the draft work programme for 2022/23, following previous discussions with the Director of Public Health, the Operational Director for Adults Social Care and the Cabinet Member for Social Care and Health Integration, as to what the priorities should be for the year.

Members agreed the draft Work Programme, as well as to undertake a scrutiny review relating to the Voluntary and Community Sector (VCS) during this municipal year; of which the terms of reference would be scoped and brought back for agreement at the Committee's next meeting on 14 November 2022.