Joint Health Overview & Scrutiny Committee

Draft Minutes

Monday 7 September 2020

PRESENT

Members Present:
Councillor Ian Bott (Westminster City Council)
Councillor Mel Collins (LB Hounslow) – Chair
Councillor Daniel Crawford (LB Ealing) – Vice-Chair
Councillor Marwan Elnaghi (LB Royal Borough of Kensington and Chelsea)
Councillor Vina Mithani (LB Harrow)
Councillors Lucy Richardson (LB Hammersmith & Fulham)
Councillor Ketan Sheth (LB Brent)

NHS Representatives Present: Rory Hegarty, Director of Communication and Engagement, NWL Collaborative of CCGs; Louise McCudden, Public Affairs and Engagement Manager, NWL Collaborative of CCGs; Jo Ohlson, Chief Accountable Officer, NWL Collaborative of CCGs; and Dr M C Patel, Chair of Brent CCG. Dr Genevieve Small

1. WELCOME AND INTRODUCTIONS

Councillor Lucy Richardson welcomed members to the virtual meeting of the Committee. Councillor Collins commended the work and commitment of Councillor Robert Freeman, Royal Borough of Kensington and Chelsea, who had stepped down from the Committee. Councillor Collins thanked Councillor Freeman for his unique insight, expert knowledge and measured advice in supporting the work of the Committee.

2. APPOINTMENT OF CHAIR AND VICE-CHAIR 2020/21

The Committee Services Officer from the London Borough of Hammersmith & Fulham conducted the elections for the JHOSC Chair. Cllr Melvin Collins from LBH was duly nominated, seconded and elected. Councillor Collins accepted the position of Chair and thanked members for the privilege of Chairing the Committee once again. Nominations for Vice-Chair of JHOSC were invited, and Councillor Daniel Crawford was duly nominated seconded and elected.

RESOLVED

1. That Councillor Melvin Collins was elected Chair of the Committee for the municipal year 2020/21; and

2. That Councillor Daniel Crawford was elected Vice-Chair of the Committee for the municipal year 2020/21.

3. APOLOGIES FOR ABSENCE

There were no apologies for absence.

4. DECLARATIONS OF INTEREST

Councillor Ketan Sheth declared an interest as Lead Governor for Central and North West London Foundation NHS Trust.

5. MINUTES OF THE PREVIOUS MEETING

RESOLVED

That the minutes of the deferred minutes 27 January 2020; and the minutes of the previous meeting held on 9 March 2020 were agreed.

Actions / matters arising:

1. Minutes - 09 March 2020

i) **Patient Transport** - Committee would like to examine this issue again in the New Year given the increasing importance to residents following changes resulting from the pandemic;

ii) **Whole Systems Integrated Care Dashboards** – The Committee received a demonstration of the dashboards by Dr M. C. Patel, it was likely that the Committee receive a further update about this. Dr Patel recommended that the item be formally included as an item for the work programme as further refinements of the Dashboard are currently being developed and he thought it would be helpful for members to consider it, both in the context of Covid-19 how they proposed to address health inequalities. It was noted that the complete set of dashboards would be available for the Committee to view; and

iii) **Communication and Engagement** – A further update was planned to be included in the Work Programme for the Committee to consider again. Rory Hegarty reported that the EPIC (Engage, Participate, Involve, Collaborate) programme had recommenced and that work was in train. They had also worked on the Community Voices programme focusing on BAME (black and Asian ethnic minorities) which could also be reported back to the Committee. The new citizens panel had been established and views were currently being canvased on their experiences of the pandemic.

2. Minutes - 27 January 2020

Healthcare inequality assessment - Councillor Collins provided clarification regarding the CCGs health inequality assessment which had formed part of the questions that the Committee submitted in advance of the informal conference call on 31 July, between health colleagues and members of the

Committee. This information had not been included in the CCG's written response. Councillor Crawford confirmed that the Committee had sought assurance that the CCGs were proactively working towards addressing health inequalities across the north west London area. Jo Ohlson informed members that Dr Patel was the health inequalities lead and that a board had been established to examine the impact of Covid-19 locally to understand what could be done to alleviate health inequalities. Addressing the needs of the most vulnerable groups and at-risk patients remained a top priority.

Dr Patel confirmed that they had undertaken extensive, local work on multiple levels across NWL to identify the patterns and variations in practices and compared this to provision in the areas that had been hardest hit by Covid-19. A pilot using two Brent wards involved analysing data from key indicators, for example, diabetes, cardiovascular disease and immunisations, which would be used to inform borough localised, focused provision. The aim was to work with providers and primary care networks (PCNs) to improve outcomes and alleviate inequalities. If successful, this would be replicated across north west London. The selected wards had experienced historic deprivation linked to poor housing and low employment. Several local, engagement meetings with community groups and leaders, and clinical health directors were planned to understand public views and patient priorities.

Understanding local perceptions as to healthcare delivery was critical in shaping what was needed most and how this could best deliver a model of care that fully reflected proactive engagement. Dr Patel explained that this was about taking care into the community and could help build more resilient communities who would be better equipped to manage their own healthcare care needs. A long-term approach was required to change the mindset as to perceptions about primary care and to change how this was provided. Dr Patel commended Brent Council and Councillor Sheth for their contribution and support in developing the pilot.

Following a question from Councillor Sheth, Dr Patel confirmed that the implementation of the delivery programme would hopefully commence by mid-October but would be adjusted and refined as needed, following consultation and any engagement. Using diabetes and cholesterol conditions to illustrate, it was no longer enough to simply monitor or set targets. Improved outcomes were more likely where patients were able to take ownership, be supported in gaining stronger control and better understanding of their conditions.

Access to primary care also needed to be addressed, understanding what the barriers were was a key component to understanding how change could be delivered. Using the low uptake of immunisation and cervical screening as examples, Dr Patel advocated a phased approach to target setting. Pragmatic, achievable targets and identified barriers to the lack of take up, access or the lack of resources were much more helpful indicators. Longer term, targets could be phased in and adjusted upwards, underpinned by robust evidence. Despite the challenges, the project had been welcomed locally. It offered primary care practitioners a new way of working but would require some adjustment. Dr Patel agreed to share information about targets

with the Committee but confirmed that it would not be appropriate for members to provide input in helping set those targets which should be done at a local level working with the CCG and the local health and wellbeing board.

ACTION: Dr Patel / NWL CCGs to provide the Committee of details of the targets set for a range of conditions

6. NWL COLLABORATIVE: THE CASE FOR CHANGE FOR A SINGLE CCG - AUGUST 2020

Councillor Collins welcomed Jo Ohlson to the meeting who provided a brief overview of the planned merger of the eight north west London CCGs into a single entity. The merger reflected an administrative change and while this did not diminish the scale of the change, this was not a change in service provision. In line with national provision this would align with national expectations that this new, single CCG would follow the footprint of the local integrated care system.

The timing of the merger had been deferred to April 2021 to suit the needs of North West London. It was important that the case for change helped expediate a reduction in health inequalities, encourage greater consistency in services and generate equitable outcomes. The prevailing view was that a single CCG would be better placed to achieve this and allow a more strategic allocation of resources. Jo Ohlson emphasised the need to nurture strong, local relationship with councils, and strengthen the link with CCG teams as the development of integrated care partnerships (ICPs) progressed. ICPs offered greater local autonomy and allowed for the reallocation of resources. A borough committee structure would have 23 members, including chief executives from local authorities and one director of public health (it was noted that H&F had challenged having a single public health director which was not considered to be fully representative). Jo Ohlson listed several commitments that the new, single CCG would hold to:

- A reallocation of resources and increased investment in hospital services. Resources would be moved to focus on areas of greatest need and would have the most impact.
- Increased investment in primary care in every borough to facilitate a levelling up of resources.
- Development of local engagement at both local and north west London levels.
- Retain health and wellbeing boards, and overview and scrutiny committees to facilitate local learning from patients, practices and local authorities about what services were needed locally.

Councillor Collins thanked Jo Ohlson for her presentation and before moving to questions added that the JHOSC had been instrumental in advocating for a deferral of implementation of the case for change to April 2021. This had allowed time for a more measured approach and placed people once more at the heart of health provision. Councillor Collins asked how local interest and patients voices would be represented at local committees, how the

governance arrangements for these would be formulated, their level of accountability and how responsible they would be for primary care and services that were currently jointly commissioned with local authorities such as the Better Care Fund and section 75 funding. Jo Ohlson explained that given the membership of GP practices there was a level of accountability by association with the borough committee. An elected member would also sit on the borough committee together with clinical members who would sit on the single CCG committee. There was an expectation that the person who sat on the governing body would also chair the local committee. This person would also be a key link working with the overview and scrutiny committee and health and wellbeing boards regarding ICPs.

Dr Genevieve Small expanded on the form and function of the local committee which would be a sub-committee of the governing body of the single CCG and directly accountability to it. This would give a critical local focus to the borough which GPs had welcomed. Dr Small felt that the CCG through their engagement had clearly listened to the 'clinical voice' and that the local committee would be the link between the health and wellbeing board and the governing body.

Councillor Richardson sought further clarification about the local committee. Jo Ohlson explained that the person reporting to the local committee would also link to the scrutiny committee to ensure effective lines of communication between the organisations.

Councillor Richardson asked about what the overall cost of the merger might be. Jo Ohlson explained that there would be an increase in the allocation of resources but recognised that this would have to be delivered alongside a significant deficit of £100 million, with a system deficit of £230 million. There would be an increase in funding for out of hospital care, but the deficit would mean less spending on acute services. There now existed an 'open book' between the trusts and commissioners, meaning that a new financial model would be put in place. Instead of paying a sum of money for a service with no assurance about the financial breakdown (using analytic tools) the aim was to achieve greater clinical and financial efficiencies without a reduction in the level of patient services.

The CCG was benchmarking and challenging orgnisations to reduce overheads such as management cost and consolidate back office functions such as payroll but the investment of £18 million in primary care was not predicated on attaining planned efficiencies. In a third question, Councillor Richardson sought further details about the mechanisms that would be put in place to ensure that local population demography was considered in service modelling. It was understood that this would be made possible by the additional investment into primary care.

Jo Ohlson reported that they were currently consulting with staff on changes to the operating model and regardless of whether the CCG merger progresses, the intention was to reduce the management budget by £18 million or 20% although it was acknowledged that this may be impacted by the current, difficult and uncertain, financial regime. Funding for the second

half of the funding year was unlikely to be as generous as the earlier payment but there was a suggestion that this would be influenced by the restoration of outpatient and planned surgery to previous levels. The current funding position was better than in previous years, but this was not expected to continue. In response to a follow up question from Councillor Richardson, it was clarified that there would be no additional costs and that there would in fact be a net saving. The running costs of eight governing bodies would be reduced following a revision of the membership structure and there were unlikely to be costs arising from the merger itself.

Jo Ohlson clarified that the Collaborative CCGs had undertaken borough level equality health impact assessments and acknowledged that there were local variations and areas of need to which they should be more responsive to. Referencing Dr Patel's earlier comments Jo Ohlson outlined how there were targets for childhood immunisation and screening across all CCGs. The function of PCNs was to help ensure parity in terms of take up for individual wards, irrespective of income and education but naturally focusing on the most deprived areas. The engagement of PCNs in identifying which subset of the population experienced inequalities was important to ensure that these could be tackled at a local level. Jo Ohlson concurred that local data was a key factor and would facilitate more focused service delivery.

ACTION: Equalities health impact assessment data to be shared with local overview and scrutiny committees

Councillor Sheth enquired about the clinical case for the merger and how this might improve health outcomes for residents across north west London. Dr Small responded by focusing on clinical leadership and setting standards for care. Acknowledging Councillor Collins earlier comment, it was pivotal that the reorganisation delivered improved health outcomes and addressed the variation in provision across the area by tackling inequalities. The experience of dealing with Covid-19 had highlighted the benefit of a single commissioning model and demonstrated the standard of care that the CCG aspired to.

Dr Small was of the view that not achieving the merger would be detrimental, would undermine strategic leadership and impact on the development of transformation. A unified, single commissioning approach for diabetes and cardiovascular disease was now possible, something that had been an aspiration for north west London residents but had previously been very difficult to achieve.

Responding to a related and second question from Councillor Sheth referencing the possible statistical and operational risks, Dr Small felt that there was a strong concern by practices that the primary care voice may be lost. One of the aims of having a local committee was to ensure that this did not happen but given the rapid development of health policy, GPs were being encouraged to get involved in commissioning to counter-balance, for example, the influence of acute trusts such as Imperial. In referring patients to acute services, it was important for GPs to understand that the care provided works holistically from a patient perspective. An additional concern was the pace of change. While there was a significant focus on reducing

inequalities, some parts of north west London, Westminster and RBKC were concerned about the potential loss of services, which would be mitigated.

Dr Small reiterated that this was to be an administrative change but the intention to form a single CCG would also lead to an expanded, mitigating role for primary care networks (involving local authorities and the third sector) working with the ICS and the ICP. These were different component parts of a system moving through change at the same time, but the CCG indicated that they were aware of the risks associated with this, with levelling up and on delivering change at a local level. Delivering on these aspirations will be closely monitored.

Councillor Collins welcomed the response and referenced his own experience. He expressed concern about the pressure on services such as hospital discharge arising from Covid-19. There should be a strengthening of hospital to home services and better awareness of a patient's care status and discharge pathways. Jo Ohlson sympathised and explained that a learning from Covid-19 was the positive experience of joint working between community services and hospitals. During this time, community services had led on discharge arrangements, but the CCGs had considered proposals for strengthening discharge hubs which could be in place from October. However, there was a financial cost, although there was a strong argument for getting people home, with better support in place so they did not need to return to hospital, and, the added benefit of improved patient flow. There had been some work on standardising the community offer in 2019, for example, rapid response and community nursing response times with the intention that this would be the same across all the boroughs regardless of the provider. Winter pressures would also be an added concern in dealing with Covid-19 and further expected outbreaks. They were working with providers and community services to ensure that patient need would be meet.

Councillor Sheth asked Dr Patel and Rory Hegarty to respond to the issue of patient risk. Dr Patel felt that GPs might experience a loss of traction with the local trusts, but this might be mitigated by having a strong integrated care partnerships at a local level. The borough committee would ensure that the functions provided by the ICP were scrutinised and this was perceived as a clinical risk. A system that did not recognise that there were varying types of patient needs from different boroughs was not helpful and flexibility was needed to accommodate this.

Rory Hegarty noted Jo Ohlson's earlier response regarding the primary care voice and highlighted the other side of this which was to ensure that the local resident's voice was not lost within the bigger north west London system. The EPIC programme addressed this potential risk. The programme had arisen out of discussions about what future engagement would look like, and this would be co-produced with patient and public involvement groups and Healthwatch. This was a significant strand of work that would undertake outreach engagement in addition to the more quantitative work with the citizens panel mentioned previously. Ultimately, the aim was to create a more enhanced approach to resident engagement.

Councillor Bott sought an assurance that there would be no reduction in services for residents in Westminster. He also sought an assurance that the health equality impact assessment on how the proposals might impact services would be undertaken. Jo Ohlson replied that in terms of Westminster a draft financial strategy had been prepared. Central CCG would not have to spend £6 million at the end of the five-year period and that there was no intention to have a correlated reduction in services (this reflected the financial formula and a "levelling up" approach, to ensure parity of provision according to population need). One of the issues the proposal had highlighted was that anyone picked up by London Ambulance Service in Westminster was a cost that was met by Central London CCG. There was a programme to collect patient NHS numbers (it was not possible with overseas visitors) to ensure greater financial efficiencies and avoid unnecessary expense.

Jo Ohlson also clarified that primary care funding for the boroughs was ring fenced and any proposed service changes would be subject to consultation. It was explained that some parts of north west London may receive increased funding. The financial model operated since 2014 meant that the full allocation of funding had not always been drawn down so the precise impact on Westminster and RBKC would need to be calculated.

Councillor Bott referred to the governance arrangements for the local committee and the process for selecting the director of public health representative as each borough's director of public health would prioritise a local agenda. Jo Ohlson explained that this would be a matter of choice for the collective boroughs following a nomination process. She added that the views of each borough would be fully represented through local authority officer representation. Illustrating this with the example of Covid-19, it was noted that directors of social care had been directly involved in influencing the local health response with for example, testing arrangements and hospital discharges. The importance of ensuring local accountability to a borough's electorate was recognised. The CCGs had met with Westminster and RBKC recently to discuss the bi-borough configuration and proposals around the management structure. However, it was noted that this structure would not indicate how services would be organised within the ICP which would be locally maintained. A shared chief operating role across the bi-borough was not regarded as a significant concern but simply a way of reducing management costs.

Councillor Elnaghi questioned the basis of the merger which he viewed as being a cost driven exercise. The quality of patient care did not appear to be a major factor driving the change. As a councillor for RBKC, he reported that the borough had experienced a difficult period beginning with the Grenfell Tower disaster in 2017 and a traumatised community that was still coming to terms with this, and now Covid-19. Councillor Elnaghi expressed his concern about the pace of operational change and how this might impact on the quality of integrated services. Councillor Elnaghi asked if a modular approach could be followed, to identify the impact on different services. Councillor Elnaghi asked the CCG to provide robust, quantifiable data to demonstrate that a change of governance would not impact on services. In addition, he asked what quality assurance mechanisms might be implemented to

safeguard the quality of services and to measure and identify any future potential impact of such changes.

Jo Ohlson clarified that any financial saving arising from the case for change proposals were a by-product of the process, which was a national policy requirement, regardless of whether the merger proceeded. It was acknowledged that savings that resulted from a reduction in management costs would be harder to achieve if the move to a single CCG did not occur. Having eight governing bodies and eight sets of accounts was problematic and it was likely that the staffing element of this would have to be revisited. Using the example of mental health services, Jo Ohlson reiterated the CCG's commitment to change was evidence based and underpinned by robust data. While she could not provide the data requested by Councillor Elnaghi, in terms of measurable outcomes the intention was to achieve better, local services. The ICS reflected an 'inverse' pyramid, with local service delivery prioritised and supported by a single CCG which would enable local autonomy.

Responding to the second part of Councillor Elnaghi's question, Jo Ohlson described how the 'whole systems integration' tool operated in north west London. This offered a way of measuring and monitoring the progress of service delivery and would allow local boroughs to hold the proposed, single CCG to account. Jo Ohlson acknowledged that no change had unforeseen consequences, which would be closely monitored but not moving forward with a merger had a greater risk. Any further delay would detract from the work of improving services for the people of north west London. As the on-call director responding to the Grenfell Tower disaster, Jo Ohlson understood the high level of trauma experienced in the aftermath and had been instrumental in securing additional resources to support affected north RBKC residents. She also recognised that the same group of people were also now affected by Covid-19, which was why it was important to consider individual borough health impact assessments.

Dr Patel empathised with Councillor Elnaghi but felt that the level of aspiration to tackle inequalities, and the focus on having a clear vision for holistic, quality health services was extraordinary. Dr Patel felt that there had been a remarkable and positive shift in attitude, both in primary care and operationally. This indicated an outcome focused, organisational change. Dr Patel recognised the critical importance of ensuring that health services were not adversely affected by operational change which he acknowledged was difficult but there had been no evidence to indicate this. Dr Patel also recognised the important role of scrutiny committees in terms of maintaining local accountability that would follow governance changes to the single CCG. Councillor Elnaghi cautioned that advocating change for the sake of change was unhelpful. Councillor Elnaghi outlined his own recent experience and how a delay in consulting his GP had led to worrying consequences for his long-term health. The role of primary care was critical to ensuring that patients had timely access to healthcare and Councillor Elnaghi hoped to see a greater integration of primary care services to facilitate this. In closing, Councillor Elnaghi felt that his previous focus on preventative healthcare had now shifted to the provision of mental health services as a result of the Covid-19 pandemic and the impact of the move to virtual meetings and working from

home. Jo Ohlson offered her sincere apologies for Councillor Elnaghi's experiences and assured him that this was why this scale of operational change was required, to address gaps in provision and failures within the system. Jo Ohlson concurred with Councillor Elnaghi's views on integrated care and emphasised that she hoped to see an organisation that would become more patient focused, with the removal of artificial barriers. It was acknowledged that during the lockdown period, it had become very difficult for people to access care and that they had tried to mitigate this. Many people had experienced anxiety and depression, and this was now the focus of mental health teams going forward.

Councillor Crawford commented on the governance arrangements planned to support the merger and expressed concern about having one local authority represented on the governing body although he recognised the rationale for this. In a second comment, he felt that it was essential to build on the resident engagement work commenced by Rory Hegarty and colleagues which included the EPIC programme, Community Voices and the Citizens Panel.

In response to two points of clarification sought by Councillor Richardson, Jo Ohlson offered to provide members with information about the way in which the new financial formula for calculating primary care service expenditure according to local population need would be reached and more detailed information about the proposed governance arrangements that would indicate the links between the new committees. Following this point, Councillor Sheth asked if information could be provided on how the single CCG planned to monitor and measure performance. Clarification was also sought on the phrase "levelling up". Jo Ohlson explained that the phrase reflected a financial framework that offered an allocation of resources which recognised the need to address poorer health outcomes in more deprived areas and vulnerable communities. The financial framework paper that would be circulated also contained information about the governance arrangements and committee structure.

ACTIONS: NWL CCGs to provide information about formula for calculating primary care service funding; and to provide more detailed information about the governance arrangements following the move to a single CCG

7. WORK PROGRAMME

Councillor Collins confirmed that business items for the next meeting included Covid-19 which would examine the impact of the pandemic on north west London, residential and nursing care homes, and the impact resulting from the withdrawal of services. The January meeting would examine the financial strategy.

8. ANY OTHER BUSINESS

None received.

9. DATE OF NEXT MEETING

The date of the next meeting of the Committee was noted as Thursday, 8 October 2020.

Meeting started 11am
Meeting ended 1.03pm

Chairman .....

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