HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE

MINUTES

1 MARCH 2016

Chair:	* Councillor Mrs Rekha Shah	
Councillors:	* Michael Borio	* Jean Lammiman (2)
	* Margaret Davine	* Lynda Seymour (1)
Advisers:	† Julian Maw	- Harrow Healthwatch
	* Dr N Merali	- Harrow Local Medical Committee

* Denotes Member present
(1) and (2) Denote category of Reserve Members
† Denotes apologies received

62. Attendance by Reserve Members

RESOLVED: To note the attendance at this meeting of the following duly appointed Reserve Members:-

Ordinary Member	Reserve Member
Councillor Chris Mote	Councillor Jean Lammiman
Councillor Mrs Vina Mithani	Councillor Lynda Seymour

63. Declarations of Interest

RESOLVED: To note that the following interests were declared:

Agenda Item 7 – Shaping a Healthier Future For NW London – Outcomes From The Independent Healthcare Commission

Councillor Mrs Rekha Shah declared a non-pecuniary interest in that her daughter attended the Pinn Medical Centre. She would remain in the room whilst the matter was considered and voted upon.

Councillor Jean Lammiman declared a non-pecuniary interest in that she attended the Pinn Medical Centre. She would remain in the room whilst the matter was considered and voted upon.

Councillor Lynda Seymour declared a non-pecuniary interest in that she attended the Pinn Medical Centre and her son was an outpatient at Northwick Park Hospital. She would remain in the room whilst the matter was considered and voted upon.

Agenda Item 9 – The Care Act: Review of Implementation

Councillor Michael Borio declared a non-pecuniary interest in that he was a trustee for Age UK Harrow. He would remain in the room whilst the matter was considered and voted upon.

64. Minutes

RESOLVED: That the minutes of the meeting held on 12 November 2015 be taken as read and signed as a correct record.

65. Public Questions, Petitions & References

RESOLVED: To note that none were received.

RESOLVED ITEMS

66. Shaping a Healthier Future for NW London - Outcomes from the Independent Healthcare Commission

The Sub-Committee received a report of the Divisional Director, Strategic Commissioning which set out the findings from the Independent Healthcare Commission for NW London.

Following a brief overview of the report, Members asked the following questions and made the following comments:

- Was there currently a shortage in the number of midwives and paediatricians working at Northwick Park Hospital?

  The Clinical Lead at NHS Harrow stated that the vacancy rate at Northwick Park Hospital had reduced following a recruitment drive and the recent merger of Ealing and North West London Hospitals (NWLHT). She undertook to send figures regarding this to Members after the meeting.

- Increasingly, Watford General Hospital was the first choice of hospital for expectant mothers in Harrow – what could be done regarding this situation?

- What was being done regarding post-natal after care at Northwick Park Hospital?

- The number of peri-natal deaths at Northwick Park continued to be an issue and this should be added to the scrutiny watchlist.

  The Clinical Lead advised that the recent CQC review of the maternity services at Northwick Park had highlighted a number of issues, which had been reviewed and actioned leading to improvements in the service. The introduction of specialist midwifery-led units would lead to further improvements and there were plans to introduce a post-natal unit at Northwick Park.

  The Chair of Harrow CCG added that there were pressures on maternity services at both Watford General and Northwick Park Hospitals. The recent merger of North West London Hospitals, the single point of access and contact at NWLHT, and the re-design of A&E at Northwick Park had all contributed to improvements in services at the hospital.

  The Clinical Lead stated that the Clinical Board at Northwick Park Hospital regularly reviewed statistical data for Maternity services, which would alert them to any pressure points requiring action.

  The Chief Operating Officer at Harrow CCG advised that there was evidence to show that the recent merger meant that there was increased resilience at LNWHT, for example, the A&E services in North West London had outperformed other A&E services in London.

RESOLVED: That the report be noted.

67. London Sexual Health Transformation Project

The Sub-Committee received a report of the Director of Public Health which provided an update on the collaboration between London boroughs on Genitourinary Medicine (GUM) services and the main findings of the market engagement developed by the pan London Sexual Health Transformation Project. The report also set out the next steps of the project consisting of a collaborative procurement plan for GUM and Contraception and Sexual Health Services (CaSH) Services.

Following a brief overview of the report, Members asked the following questions and made the following comments:

- How would high risk groups be identified? How would the CCG ensure that the new service was flexible and responsive to changes in demography and local need?

  The Head of Public Health Commissioning stated that the demographics were likely to change and the tendering pack would indicate current demographic information and the potential provider would be obliged to demonstrate that the new services would be flexible and responsive to demographic changes.

- The term 'family planning' had fallen out of use in recent years. However, this continued to be an area of concern. Was there another term that could be used to cover family planning issues for those who required this service?

  The Head of Public Health Commissioning advised that the aim was to normalise the service as far as possible. The new integrated sexual health service would include family planning and providers would be expected to response to a range of local needs, including domestic violence and child sexual exploitation.

- What were the common Key Performance Indicators (KPIs) for the GUM and CaSH services and how had they been identified?

  The Head of Public Health Commissioning stated that the KPIs has been agreed in line with national specifications in conjunction with local indicators and these related to reducing the incidence of STIs, increasing access to service and improving sexual health outcomes.

- The report indicated that a significant amount of sexual health provision was through GP practices and local clinics. However, was this provision as extensive as that provided at specialist clinics? Was this local provision financially viable or make financial sense given that there were a large number specialist providers?

  The Head of Public Health Commissioning stated that NHS England contracted GPs to provide contraceptive services and that a recent local survey shown that many women preferred to access these services locally through their GP rather than at a specialist clinic.

- The review of London GUM clinics and local authority participation in the Sexual Health Services review of 2015 showed that there were a very large number of providers. Were service users prepared to travel long distances to access these services?

  The Head of Public Health Commissioning advised that the data showed that there were 34 acute clinics in London and that the number of patients who were tested resulting in a positive diagnosis, was low. Local residents will be encouraged, in the first instance, to access GP services and the service and communications regarding this would clarify pathways to patients.

- There was a concerted initiative in Harrow to educate the community about issues such as diabetes, safeguarding etc. Had consideration been given to implementing a similar initiative with regard to sexual health?

  The Head of Public Health Commissioning advised that there were plans to develop a GP federation where groups of GPs could bid to provide specialist services to a wider range of patients in addition to those registered at their practices.

RESOLVED: That the report be noted.

68. Care Act - review of implementation

The Sub-Committee received a report of the Director of Adult Social Care which set out an overview of the implementation of the Care Act 2014.

Following a brief overview of the report, the Head of Safeguarding Assurance & Quality Services responded to questions and comments as follows:

- What was the standard rate of payment for care in Harrow for those individuals who received state funding? What were the number of third party top-up payments and what level were they paid at? What access did service users have to relevant information and advice prior to making a decision and how was this signposted?

- What constituted 'ordinarily resident' in terms of the Care Act regarding portability? Did this only apply when a service user transferred to Harrow from another local authority and did not require a new assessment?

  The Head of Safeguarding Assurance & Quality Services advised that he had interpreted ordinary residents to mean those who did not require a new assessment.

  He added, that, Harrow adhered to the rates set down in the West London Alliance Accreditation, Purchasing and Contract Management Scheme (WLAAPC), which were based on market forces and were as follows: £540 for Residential care and £620 for Nursing care. However, some local authorities sometimes paid more than this. He did not have to hand figures for third party top-ups and average amounts and undertook to send this information to Members after the meeting.

- ? was a private arrangement by individuals in care homes.

  Signposting of services had been contracted out to a consortium led by MIND in Harrow. This had been done following a mapping exercise carried out by the Support & Wellbeing Information Service Harrow (SWiSH). He did not have figures regarding the rates of referral for

service users seeking information and financial advice and undertook to send this information to Members after the meeting.

- With regard to the equipment supplied by the District Nursing Team to service users by some local authorities, did the Council have an inventory of this equipment and how was this collected back once the service user no longer required it?

  The Head of Safeguarding Assurance & Quality Services advised that the Council managed the contract for the NHS and had full visibility. The equipment contract had been outsourced to Medequip, which had detailed inventory lists. The items were not collected back as the cost of de-commissioning these was prohibitive.

- What were the priorities of the Market shaping strategy with regard to provider failure?

  The Head of Safeguarding Assurance & Quality Services advised that the Council had a strategy in cases of provider failure, and had experienced this with the Cross Roads Care Home in Pinner, which had become insolvent and the Council had been obliged to mobilise additional care to ensure continuity of care and transfer for those at the home. This had impacted on workloads and budgets. He added that there were a number of other issues on the horizon such as the minimum living wage, automatic pension enrolment that were likely to impact the care market and could have safeguarding and quality assurance implications.

- The Act required LAs to sufficiently plan for young disabled people moving to adulthood who were receiving services. How was this defined and how would it be promoted?

  He could not say how this was defined, however, the Council had moved to a lifelong disabilities model which would ensure end-to-end lifelong disability services.

- How was the information available on the Council's website with regard to the Care Act going to be consolidated?

  This work was ongoing.

- Why had there been an increase in the number of safeguarding referrals?

  The incidences of self-harm and self-neglect and some cases of modern slavery had contributed to 75 new cases.

- How carefully would the safeguarding of young vulnerable adults post-18 be monitored? The record in Harrow of the transition of 18-25 year olds SEN used to be poor. How would this be improved?

Both the Local Children's Safeguarding and the Local Adults' Safeguarding Boards would continue to work together to ensure consistency in the transition approach and a single merged service had been introduced in February 2016 to this end. The Council adhered to the pan-London approach guidelines and provided training to help identify vulnerable children and adults. The cut off date for children was 18 years of age, however, if those young adults were in education, then they would be monitored by Children's Services until they completed their education. Both Adults and Children's services had undertaken to identify all transitioners and would expect these cases to transfer to Adults' Services.

RESOLVED: That the report be noted.

69. GP Access Walk in Centres

The Sub-Committee received a report of the Chief Operating Officer, NHS Harrow CCG which set out the rationale and process being undertaken by Harrow CCG for the procurement and commissioning of GP Access Walk in Centres.

Following a brief overview of the report, the Integrated Unscheduled Urgent Care Lead at Harrow CCG, the Chair of Harrow CCG and the Chief Operating Officer at Harrow CCG responded to Members questions as follows:

- Why had the CCG not carried out a wider consultation regarding the procurement and commissioning of GP Access Walk-in Centres and why had Councillors not been notified of this process?

  A large engagement programme had been undertaken in East Harrow 18 months ago, a public engagement event had been held in December 2015 and there were plans to carry out a consultation in mid-April regarding the Harrow East Clinic. An event focussing on commissioning intentions, where discussion regarding equity of access and provision in East Harrow, had been well attended. Feedback from these events would be taken on board. Patient engagement was central to everything the CCG did.

- What were the criteria for awarding the contract? Would the services at the Walk-in centres remain 7 days a week, 8.00 am to 8.00 pm?

  The specification for both services would remain the same as before, with an intent to develop a whole systems integrated emergency programme for which the CCG would be required to re-procure all services.

  The CCG was bound by Central Government, EU and NHS procurement legislation and guidelines. However, it would involve residents to help evaluate the bids against key criteria, the main thrust of which would be the quality of services. Interested providers had been invited to meet with the CCG.

- Had a location for the proposed new Walk-in Centre been identified yet?

  There were two potential sites – the Belmont Local Health Centre and the Honeypot Lane Centre. The Service Specification would give potential providers the opportunity to comment on the suitability of any potential sites.

  A Member suggested that the Edgware Walk-in Centre should also be considered as a possible alternative site.

  A Member voiced concern regarding the lack of adequate public transport access to the Alexandra Avenue clinic, and that any new centre should be easily accessible by public transport.

  The Chair of Harrow CCG requested that the Council lobby Transport for London and the Mayor of London regarding the poor public transport provision to the Alexandra Avenue Clinic. This coupled with the lack of parking at the clinic and its surrounding area meant that it continued to be under used. He added that some patients were needlessly attending A&E at Northwick Park Hospital (because it was more easily accessible) when it would be more appropriate for them to attend the clinic at Alexandra Road.

  A Member suggested that the CCG consult the Chairs of the Harrow Public Transport Users' Association and the London Borough of Harrow Bus & Highways Liaison Meeting.

  It was agreed that a Reference be sent to the Traffic and Road Safety Advisory Panel (TARSAP) regarding the lack of adequate public transport provision to the Alexandra Avenue Clinic and the lack of adequate free parking in the vicinity of the Clinic, with a request to TARSAP to lobby TfL regarding this and for TARSAP to investigate the possibility of the Council providing free parking in the vicinity of the Clinic for its users.

The Chair asked about the recent complaints reported in the media regarding problems with the NHS 111 telephone service.

The Integrated Unscheduled Urgent Care Lead at Harrow CCG advised that there were plans to re-design the NHS 111 service in North West London and work was being undertaken jointly with Brent and Hillingdon CCGs to review the service with the intention of significantly revising the service specification. The crucial change would be for telephone assessments to be carried out by clinicians. The new Service would be launched in April 2017 and would be designed to be more local and more user-friendly.

RESOLVED: That

(1) a Reference be sent to the Traffic and Road Safety Advisory Panel (TARSAP) regarding the lack of adequate public transport provision to the Alexandra Avenue Clinic and the lack of adequate free parking in

the vicinity of the Clinic, with a request to TARSAP to lobby TfL regarding this and for TARSAP to investigate the possibility of the Council providing free parking in the vicinity of the Clinic for its users;

(2) the report be noted.

(Note: The meeting, having commenced at 7.30 pm, closed at 9.05 pm).

(Signed) COUNCILLOR MRS REKHA SHAH
Chair