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Joint Health Overview & Scrutiny Committee

Draft Minutes

Wednesday 30 October 2019

PRESENT

Members Present:

Councillor Mel Collins (Chair)	London Borough of Hounslow
Councillor Daniel Crawford	London Borough of Ealing
Councillor Lorraine Dean	City of Westminster
Councillor Robert Freeman	Royal Borough of Kensington & Chelsea
Councillor Lucy Richardson	London Borough of Hammersmith & Fulham
Councillor Monica Saunders	London Borough of Richmond
Councillor Rekah Shah	London Borough of Harrow
Councillor Ketan Sheth	London Borough of Brent

NHS Representatives Present:

Richard Ellis, Joint Associate Director, Primary Care Transformation Joint, North West London Collaborative of CCGs; Associate Director, Primary Care Transformation, Rory Hegarty, Director of Communications and Engagement, North West London Collaborative of CCGs; Mark Easton, Accountable Officer, North West London of Collaborative CCGs; and Dr Mohini Parmar, Long-Term Plan Clinical Director and Chair of Ealing CCG.

1. WELCOME AND INTRODUCTIONS

Councillor Lucy Richardson, as the representative member of the host borough, Hammersmith & Fulham, welcomed members and officers to the meeting.

2. APOLOGIES FOR ABSENCE

2.1 None.

3. DECLARATIONS OF INTEREST

3.1 Councillor Ketan Sheth (LB Brent) declared that he was the Lead Governor at Central & North West London NHS Foundation Trust (CNWL). Councillor Robert Freeman (RB Kensington & Chelsea) declared he was a member of the Council of Governors of the Royal Marsden Hospital; and Councillor Lorraine

Dean (Westminster City Council) declared that she was also a Governor at CNWL.

4. MINUTES OF THE PREVIOUS MEETING

4.1 The minutes of the 22 July were deferred and will be agreed at the next meeting.

4.2 The outstanding actions arising from the previous meeting were briefly outlined by officers. These, together with those arising from the meeting would be circulated. Mark Easton provided the following response to outstanding actions which were to have been reported to the meeting on 10 December (it was noted that this meeting would be rescheduled):

1. That the Committee receive copies of the correspondence between the CCG and NHS England on the submission of applications after the September deadline.

   It was agreed that this information was no longer relevant given that the date for the merger had been postponed to April 2021.

2. That a demonstration of the Whole Systems Integrated Care (WSIC) dashboard be arranged for the Committee.

   Mark Easton confirmed that a suitable date for the demonstration would be agreed with members of the Committee.

3. That the number of local authority representatives on the new single CCG Governing Body would be increase to two.

   Mark Easton referred to his previous comment on the postponement of the merger and reiterated that a view about this would be formulated early in 2020, as part of the further work on the development of the CCG.

4. That the results of health inequality assessments carried out by the CCG would be circulated to Members of the JHOSC as soon as they were available.

4.3 Mark Easton confirmed results of the health inequality assessment had been delayed and would not be available until early in the New Year, following the development work. It was explained that the views of stakeholders had been noted and so the NWL CCGs would take a more measured approach in developing arrangements for a merged CCG.

5. NORTH WEST LONDON FINANCIAL RECOVERY

5.1 Mark Easton referred to the paper that had been circulated and briefly highlighted key points which set out a whole system approach the financial position of the NHS in North West London. Small overspends still generated large sums given the overall NHS budget of £3.5 billion. In context, the cost of treatment and unit costs had increased significantly ahead of funding levels and

acute activity had increased by 18%. The challenge of the QIPP (quality, innovation, productivity and prevention) was to ensure that savings targets were met. The intention was not to achieve a balanced budget but to address a deficit of £50.9 million. Following a deficit in 2018 an agreement had been reached with regulators that the financial year would end deficit as it would not be possible to clear the accumulated amount within a year. Mark Easton referenced the four strands of the financial recovery plan and in particular Strand three, which might impact on patient experience.

5.2 Councillor Mel Collins (LB Hounslow) enquired about the 3.4% increase in the budget and how this would be targeted to achieve stability in patient satisfaction levels. If savings of 20% were sought, he also asked how this would impact on patient satisfaction. In a related third query, Councillor Collins sought further details about Strand three. Mark Easton referred to an example annotated in the report regarding consultant to consultant referrals which was to enforce clinical policy agreed in 2014. Enforcing the policy would streamline referrals from clinician to clinician and avoid confusion in non-urgent elective cases. It was confirmed that there would be no reduction in patient safety and improve the efficient use of NHS resources.

5.3 Councillor Daniel Crawford (LB Ealing) referred to recent media coverage which suggested that the consultant to consultant referral policy would cease. Greater clarity was necessary to ensure that NHS messaging was clear and to avoid confusion. There had to date been variations in reinforcing the policy, but it was important to explain that it did not mean that patients would not be referred. Rory Hegarty added that the NWL Collaborative were in discussions with Healthwatch, local authorities and the voluntary sector organisations to ensure greater clarity in NHS communications where there was a distinction between urgent (cancer) and elective care referrals. In the discussion which followed Mark Easton responded to Councillor Robert Freeman's concerns. He clarified that constitutional standard patient waiting times would not be exceeded. Rory Hegarty commented on NHS communications with reference to the recent changes to prescriptions as an example. It was acknowledged that there had been inconsistencies in the communications campaign around this.

5.4 Replying to Councillor Collins first two questions, Mark Easton explained that the 3.4% increase reflected an uplift but much of this had already been earmarked and the financial position improved. Essentially this would alleviate the budget deficit through a five-stage process which included contract variations, demographic and non-demographic growth (technology implementation) and pay awards. The QIPP programme also offered some leeway and contributed to a reduction in the overall deficit. Councillor Crawford observed that despite factoring in contingency plans this would be a prolonged financial recovery process over an extended period. He was keen to understand the level of success expected in achieving hoped for outcomes. It was acknowledged that there were risks and that the spend would be monitored monthly to ensure that the plans were delivering as expected. With a payment by results system the NHS spend was expected to be equal to the providers cost but there were inherent risks within this that could be overstated.

In response to a query from Councillor Freeman, Mark Easton explained that if no further action was taken the deficit would continue to accrue. Continuing with the current operating plan would reduce the deficit and deliver modest improvements. However, he acknowledged that it took time to adjustment and implement measures and that a more challenging control target could be warranted.

5.5 Councillor Ketan Shah invited Mark Easton to elaborate further on each of the four strands and how any risks might be mitigated. Referring to Appendix 1, Mark Easton sited the use of £2 million in CCG reserves, with no identifiable risk. There were inherently higher risks in localising services, with the intention that local treatment could be more financially efficient. Guidance would need to be provided to GPs regarding the referral process. This was a complex and untested process and would be rag rated amber as the nature of the risk was unknown. With regards to strand three and patient choice, Mark Easton offered an assurance that patient choice would not be diluted. Most would continue to benefit from patient choice and a conversation between a clinician and patient which would facilitate shared decision making. He acknowledged that all appointments needed to be digitised and that referrals needed to be made properly so that no residents missed out on treatment. In terms of how widespread this issue was, Mark Easton clarified that it varied from borough to borough across North West London and according to GP practice. He concurred that all appointments needed to be electronic and that there was a need to ensure that referrals were made properly.

5.6 In response to a comment from Councillor Crawford, Mark Easton acknowledged that the extent of the impact might vary in different boroughs. He did not have a figure on the percentage of patients were affected by referrals (this was a relatively low number and the information could be provided) but the overall aim was to achieve a more streamlined pathway.

5.7 Councillor Collins asked that if in future meetings this particular issue remained on the agenda to be monitored. It was important that the members of the committee were able to properly with their scrutiny remit and act as critical friends. It was suggested that the committee formally drafts a letter to the Secretary of State expressing its deep concern about the NWL Collaborative of CCGs collective financial position.

ACTIONS:

- That the GP at Hand overspend of £10.2 million represented a significant portion of the overall all deficit and that this would be brought back to a future meeting for closer examination;
- Mark Easton to consider whether it would be possible to provide borough level analysis (across all eight boroughs). This would need to be discussed locally and a response prepared accordingly;
- Members to be provide with the figures for the number of patient referrals; and

- JHOSC to draft a letter to send to the Secretary of State expressing concern about the funding of the NWL Collaborative of CCGs.

6. NHS LONG-TERM PLAN SUBMISSION

6.1 Councillor Collins requested that the treatment needs of the 18-25 years of age regarding the Children and Adolescent Mental Health Service and support for this, be included within the presentation.

6.2 Dr Parmar briefly explained that the NHS Long Term Plan (LTP) response set out a clear sense of direction as to the delivery of services, covering areas of delivery, robust provision of care, primary care, mental health, prevention and personalisation of care. Three specific areas were urgent and emergency care which had increased, early cancer diagnosis and digitised services. The LTP submission sets out the NWL Collaborative's draft response. The LTP implementation framework had recently been published and they were now in the process of analysing services and would track the trajectory of the projected service. Focusing on long term care, the key areas were described as included same day emergency response where a patient presents at A&E, allowing people to spend time in receiving care in the best way possible, strong maternity services. In Ealing, the CCG were also looking at services for children and young people in the context of early years provision and long- term conditions, acknowledging that there were clear outcomes being sought in terms of responding to children in mental health crises.

6.3 Service delivery through 49 Primary Care Networks in London would be facilitated by 2021 meeting the needs of 30-70 thousand people. It was important that the delivery and support of community health services worked in tandem with PCNs. It had recently been announced that the UK had lost its measles elimination status and that this was a recognised problem in West London. In terms of improving wait times for cancer treatment, Dr Parmar confirmed that the standard wait time was 62 days but that no patient should be required to wait this length of time to start treatment.

6.4 With reference to the financial recovery plan, commissioners and providers had worked together. The formation of integrated care partnerships (ICPs) would align with each borough and combine to offer a place-based approach and reflected the Mayor of London's primary focus on obesity and homelessness which were key issues for Londoners.

6.5 Councillor Collins observed that it was unclear how the CCGs would engage with voluntary sector, an essential component of ensuring the delivery of community, placed-based services. He asked how they planned to address rental issues faced by many voluntary organisations who needed to vacate premises which they could no longer afford to rent. Councillor Collins was also keen to understand how the CCG intended to work with local authorities and the voluntary sector and how they would develop pathways. Councillor Collins viewed the proposed scheme as positive but felt that it lacked sufficient detail to ensure successful execution. Dr Parmar responded that the implementation framework had only recently been published but concurred with Councillor Collins. Referring to the work being undertaken in Ealing, Dr Parmar explained

that local government and local voluntary organisations had set up an ICP board (chaired by her) to facilitate and deliver place-based care. Richard Ellis added that in terms of engagement with the voluntary sector the LTP embodied new and innovative ideas. These would embed and sustain areas of working that had been in train for several years and represented a combined and collective approach to working with provider stakeholders.

6.6 Dr Parmar explained that they hoped to progress improvement under each of the four headings of achieving integrated care (combining health, social care and community provision), prevention, patient safety and digitisation. Mark Easton responded to Councillor Collins query regarding rental rents for voluntary bodies and explained that the trusts did not own the estate, this was owned by the NHS and therefore commercial rates were charged.

6.7 Councillor Lucy Richardson enquired if the LTP was a draft and if there would be further iterations. Mark Easton responded that they had hoped to repeat some of the mistakes made during the 2016 STP (Sustainable Transformation Plan) process. This had been criticised for its lack of transparency and so a different approach had been taken to foster greater engagement. The LTP had been published in draft form as comments were still being sought but it had been recognised that there were inherent difficulties in consulting large populations. Healthwatch events had been poorly attended and so they hoped to review local consultation methods. Rory Hegarty confirmed that the level of public attendance at these events had been poor despite being well-advertised with local roadshows and information. The LTP had tight response deadlines and the CCG recognised the importance of sustaining continuous conversations with people. Rory Hegarty commented that the LTP was a huge plan and required ongoing outreach and engagement and the need to improve the public involvement model was accepted.

6.8 Councillor Richardson concurred that having conversations with Healthwatch and patient participation groups was a key starting point requested that a timetable for reviewing the LTP be provided so that members could contribute to the process. It was observed that an ICP had been established in Ealing and noted that LBHF had not progressed as far. Councillor Richardson asked that a more detailed presentation about ICPs be provided. Rory Hegarty responded that engagement on the formation of ICPs was welcome.

6.9 Councillor Freeman highlighted the importance of consulting with providers in addition to patient groups given the extent of the aspirational aims presented in the LTP. He enquired about the cost of the changes being proposed and whether this would be cost neutral. Mark Easton confirmed that the LTP was not intended to be primarily for commissioners and that it was a whole systems approach. The question of money and cost was still being explored but the Secretary of State for Health promise of extra funding was predicated on the LTP. It was anticipated that it would not be cost neutral but that the NWL budget might increase by approximately £250 million, some of which was already earmarked.

6.10 Returning to Councillor Richardson's earlier point, Mark Easton confirmed that further details about ICPs could be provided and explained that the exact

composition of arrangements for the formation of ICPs varied from borough to borough. Hounslow had progressed the developments of ICPs furthest which indicated different strengths and challenges. It was further explained that there might be a single CCG with delegated budged, effectively managed by local teams, or, larger, more formal partnerships with corresponding delegated budgets. Mark Easton stated that it was not possible to predict a timeline or the extent of the possible variations but confirmed that the ICP would not hold its meetings in public. He acknowledged that the estates were a concern and that many estates in West London were not fit for purpose, unable to suitably meet the needs of the local population.

6.11 Councillor Crawford responded to Richard Ellis's comment regarding increased capital investment in developing and delivering more digitised services which linked to the issue of estates management. There would be many patients that would find it difficult or be unable to access the digital offer and he expressed concern regarding the lack of progress made on estate management.

6.12 Councillor Freeman highlighted concerns regarding childhood obesity and low take up of inoculations and asked how these would be addressed by the CCG. Dr Parmar responded that there was currently a immunisations crises and that they were working with Public Health to tackle this through primary care or pharmacy services. Councillor Freeman explained that RBKC, through Public Health, had invested funds in addressing these issues and welcomed any further insight that would ensure that this would be supported by the CCG. Dr Parmar confirmed that funding for these areas would feed through the primary care networks.

ACTONS:

- To provide the Committee with a review timetable for the LTP process;
- That the Committee be provided with a more detailed presentation about the formation and implementation of ICPs;
- That more information about placed based boards include financial details and when this will take place;
- Dr Parmar to provide a response on preventing eating disorders raised (by Councillor Collins) with an answer to provide outside the meeting.

7. JHOSC WORK PROGRAMME

7.1 Following discussion members agreed the agenda items for the next meetings would include estates and GP at Hand. An item on the Citizens Panel would be taken at the February meeting.

RESOLVED

That the Work Programme be amended to reflect the amended Agenda planned for the next meeting.

8. ANY OTHER BUSINESS

8.1 It was noted that the meeting date for the next had been moved from December to 14th January 2020. [later moved to 27th January 2020].

Meeting started: 2pm
Meeting ended: 4pm

Chairman .....

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