Our Healthier South East London Joint Health Overview & Scrutiny Committee

MINUTES of the informal meeting of the Our Healthier South East London Joint Health Overview & Scrutiny Committee held online on 30 June 2021 at 6.30 pm.

PRESENT:

Councillor Judi Ellis (Chair)
Councillor Mark James (Vice-Chair)
Councillor Gareth Allatt
Councillor Rezina Chowdhury
Councillor Richard Diment
Councillor Liz Johnston-Franklin
Councillor John Muldoon
Councillor David Noakes
Councillor Nick O'Hare
Councillor Victoria Olisa

NHS PARTNERS: Dr Angela Bhan
Andrew Bland
Sarah Cottingham
Ben Collins

1 APOLOGIES

Apologies were received from Councillor Chris Lloyd from RB Greenwich and Councillor Marianna Masters from LB Lambeth.

2 DISCLOSURE OF INTERESTS AND DISPENSATIONS

There were no additional declarations of interest.

3 CCG PRESENTATIONS

The Committee received three the following presentations from colleagues in South East London CCG and asked questions arising from the presentation:

(a) Integrated Care Services (ICS)

It was recognised that integrating care had been the "holy grail" for health and social care services for decades. This reflected the changing demographics and needs of the population and the misalignment that had built up over decades between the needs of the population and how health and care services were organised. As the population lived longer and had increasingly complex mental

and physical health needs it had become increasingly inadequate to rely on a health system built on hospitals and small-scale primary care. Historically, the response had been to bolt on services such as community nurses, social workers, domiciliary care and this had resulted in a vast amount of fragmentation, inefficiency and poor co-ordination within the system. If we were to get integrated care services right enormous benefits could be delivered and this could translate into a genuinely good experience of care.

In terms of subsidiarity, all of the decision making regarding how to structure out of hospital care services were likely to be within the control of the Boroughs and the provider collaboratives would have greater autonomy over how resources were managed to better deliver specialist services. It was clear that the system would be built from the Borough base and the vision was that the ICS would give primacy to boroughs to take decisions if that is the most effective place for decisions to be taken.

The Joint Committee were pleased to note that there was nothing to suggest that overview and scrutiny powers would be removed through this process. Consideration would need to be given to how decisions impacted different areas to ensure consistency of decision making. Going forward the different parts of the system would need to understand how scrutiny arrangements would work. It would be helpful for joint scrutiny arrangements to continue in order facilitate an efficient decision-making process.

The Joint Committee noted that in the event of a change in the law through the Bill being passed, CCG responsibilities would transfer to an ICS statutory body. At that point responsibility for commissioning would sit with the ICS commissioning body and there were no plans to change the structure of localised commissioning. The hope was that local care partnerships – made up of commissioners and providers - would be the partnerships to whom the ICS would delegate.

The Joint Committee recognised that the proposals represented a cultural and organisational challenge to enable staff to develop the skills that would be required to work in multidisciplinary teams. The organisations were only just embarking on the project and there would be a need for continuous professional development in order to support staff in developing the skills they would require. However, it had to be recognised that if staff were provided with the right opportunities and an appropriate environment change would happen.

In relation to returning to 'in person' stakeholder and Trust Board meetings, the Joint Committee noted that, whilst there was an acceptance of a digital deficit within some areas of the community, virtual governing body meetings had in fact attracted a wider audience and going forward it was important to put some thought into any plans to ensure that the new audiences were not side-lined. Scenario planning for arrangements for meetings had begun and would be led by the data rather than dates.

(b) Vaccination

The Joint Committee received an update on the vaccination programme across London.

Members noted that there was no single reason for a lower uptake of the vaccination inn some boroughs. Whilst there was some vaccine hesitancy, there was also a strong correlation with deprivation. The focus of colleagues delivering the vaccine programme was to ensure that the reason for any differential was not any physical or other controllable barriers to accessing the vaccine.

Data on the number of individuals who were not turning up of their second vaccination was available and a programme was in place to telephone individuals and answer any questions that may exist. In terms of incentivising take up of the vaccine, there had recently been a number of queries in relation to being fully vaccinated in order to travel abroad and go on holiday. Other incentives were also being trialled such as tickets to big screen England Quarter Final football events for those who take up the vaccine. However, it had to be recognised that incentives had no impact on people who were hesitant and had genuine concerns.

In addition to the vaccine programme, the Joint Committee recognised the importance of ongoing and consistent messaging around "Hands, Space, Face". Evidence now existed that those who had been double vaccinated still contracting Covid-19 and some of these cases had been severe. Key message would continue to be promoted and national campaigns would continue.

Members noted that individuals did not need their NHS Number in order to access the vaccine and boosters would be offered to those who exceeded the 12-week gap between vaccinations. There were a number of pop up clinics aimed at targeting over 40s with the Oxford AstraZeneca vaccine which was easier to move around. Services were also being tailored with some targeted pop up clinics for the under 40s and these clinics offered the Pfizer vaccine.

(c) Recovery of Elective Surgery

The Joint Committee received an update concerning recovery of elective surgery. Members noted that the aim was to see patients who needed to be seen within a month. Other patients would be seen based on the current length of wait. It was agreed that following the meeting information concerning the order of priority and the make-up of the waiting list by speciality would be shared with Members.

The Joint Committee were pleased to note that elective and cancer referrals being made by GPs were now back to pre-pandemic levels. Where there were concerns around the ability of patients to access GP services it would be helpful to have specific examples to enable these to be investigated. In terms of the current

waiting lists, the view was that delays were due to the sheer level of demand rather than issues of access to GP Services. The system was undoubtedly under pressure however it was too early to say whether it was a sustained pressure. Planning was already underway for the winter.

Members noted that there had been a concerted effort across South East London to deliver good discharge processes and readmission rates were monitored.

4 WORKPLAN

The Joint Committee agreed that a pre-agenda meeting would be held at the beginning of September 2021 and at this meeting Health colleagues would be able to advise on the most appropriate topics for discussion at the next meeting which could be held in October.

It was agreed that consideration would be given to holding an 'in person' meeting in October.