HEALTH SCRUTINY SUB-COMMITTEE

Minutes of the meeting held at 4.00 pm on 6 March 2019

Present:

Councillor Mary Cooke (Chairman)
Councillor Robert Mcilveen (Vice-Chairman)
Councillors Gareth Allatt, Ian Dunn, Judi Ellis, David Jefferys, Keith Onslow and Angela Page

Roger Chant and Mina Kakaiya

Also Present:

Councillor Diane Smith, Portfolio Holder for Adult Care and Health

31 APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTE MEMBERS

Apologies for absence were received from Councillor Evans, Justine Jones and Lynn Sellwood. Apologies for absence were also received from Councillor Cuthbert and Tim Spilsbury, and Councillor Onslow and Mina Kakaiya attended as their respective substitutes.

Apologies for lateness were received from Councillor David Jefferys.

32 DECLARATIONS OF INTEREST

There were no declarations of interest.

33 QUESTIONS FROM COUNCILLORS AND MEMBERS OF THE PUBLIC ATTENDING THE MEETING

One oral question and two written questions were received from Councillors and members of the public and these are attached at Appendix A.

There was no supplementary oral question.

34 MINUTES OF THE MEETING OF HEALTH SCRUTINY SUB-COMMITTEE HELD ON 17TH OCTOBER 2018 AND MATTERS ARISING

RESOLVED that the minutes of the meeting held on 17th October 2018 be agreed.

35 PRESENTATION ON PRIMARY CARE WORK (CCG)

Dr Agnes Marossy, Consultant in Public Health, Bromley Clinical Commissioning Group, attended to present the findings of the Bromley Primary Care Needs Assessment. Dr Marossy had been seconded to the CCG to carry out a Primary Care Needs Assessment.

The aim of the Primary Care Needs Assessment was to describe both the need for primary care, and the needs of those delivering primary care, in order to inform the development of a sustainable model of primary care in Bromley. The Primary Care Needs Assessment had been informed by a Steering Group and a Clinical Reference Group. The Steering Group had consisted of GP Clinical Directors, the Bromley GP Alliance, the CCG Primary Care Team, the CCG Nurse Lead and the Director of Organisational Development, and the Clinical Reference Group had included GP's (Partners, Salaried, Locums and Trainees), Practice Nurses and Practice Managers.

The Consultant in Public Health had undertaken a number of tasks, including workforce analysis and workforce surveys which identified trends, but the bulk of her time had been spent carrying out public engagement. This had included attending the Practice Nurse Forum, which was attended by around fifty Practice Nurses, and visiting and spending time at forty two of the forty five Practices in the Borough, to get an understanding of how they operated. The work also included engagement with patients and public, including vulnerable groups, and some of this was commissioned out to Healthwatch Bromley.

The results of the public engagement had found that patients were now more accustomed to not seeing the same person each time they visited their Practice. Patients did not feel this was an issue, acknowledging the positive impact of being 'known' at the Practice by clinical and non-clinical members of the team, and that a person's job title was not important as long as they sorted out the patient's problem. However, certain vulnerable groups, such as those with mental health issues and those with learning difficulties, benefitted from having continuity with one GP. A fundamental issue raised was the length of consultations, as neither doctors nor patients were happy about the ten-minute consultation time. Ten minutes was perceived to be too short. It was highlighted that an older patient may take longer to reach the consultation room, and then may need time to sit and compose themselves before speaking to the GP, would find most of the appointment time had already been used up. Patients also particularly objected to the 'one appointment, one problem' policy where it was being implemented.

There had been a number of questions asked when visiting Practices, and one key area of focus had been resilience and how they would continue to manage to provide care if a Partner went on long-term sick leave or retired; if a neighbouring Practice closed; or a new housing development was built close by. Other issues regarding how the Practices recruited and retained their workforce had been highlighted. There had been a number of key outputs, but the main ones to be addressed had been 'workforce' and 'workload'. With regards to workforce, it was stated that in order for Bromley to reach the same ratio as London, an additional 2.7 whole time equivalent GP's

were needed in Bromley, and to reach the same ratio as England, an additional 13.4 whole time equivalent GP's were needed. Bromley had a higher nurse to patient ratio than London, but an additional 18 whole time equivalent nurses, of all types, were needed to reach the same ratio as England. In order to keep up with population growth, an additional 1.5 GP's per year were needed in Bromley. The annual workforce survey had shown that Bromley had lost 1.85 whole time equivalent GP's the previous year, which highlighted that the gap was getting wider.

Views had been gathered on recruiting to Partnerships, and the responses received had included "as a Partner it was not possible to control your workload", and that "there was a feeling of uncertainty about the future of General Practice as a whole which discouraged commitment to Partnerships". It was also considered that it was "not clear what incentive there was in 'slaving to death' and not being adequately remunerated". Recruiting salaried GP's took on average six months, from the post being advertised to being filled, and there were too few applicants. This was due to a combination of Practices not knowing how to access the trainee cohort, there being high indemnity fees and competition from higher paid posts at access hubs and Urgent Care Centres. There were also difficulties in retaining salaried GP's once they were recruited, due to excessive workloads which caused them to resign. Views had also been gathered on the recruitment of Locums, a number of which the Consultant had found worrying. The feedback received included statements that Locums did not do any admin; did not deal with difficult issues; did not follow up results; were unwilling to do home visits; and referred excessively because they were risk adverse. This indicated that the work life balance and caring responsibilities or life choices had created a shift in thinking about how doctors wanted to work. The evidence suggested that the negotiation of contracts between Locums and Practices was not always done well; and that there was imperfect understanding between the three distinct groups of GP's (Partners, Salaried and Locums). It was also evident that young doctors were making very different career choices.

With regards to the recruitment of Nurses, the annual workforce survey had shown that in the previous year, Bromley had lost 1.13 whole time equivalent Adult Nurse Practitioners, whilst gaining 2.95 whole time equivalent Practice nurses, which related to an overall increase of 1.83 whole time equivalent Nurses. Alongside this, there was a loss of 1.37 whole time equivalent Health Care Assistants. When the Consultant in Public Health had met with around fifty Nurses and Nurse Practitioners, they had highlighted that they felt they were not valued enough, and that they were tired, so a number of longstanding experienced nurses would choose to retire on a full pension at the age of 55. Newly recruited Nurses would not gain experience instantly - it took ten to fifteen years to 'grow' a good Nurse, and it was highlighted that there were a lack of training courses available, which needed to be addressed. Key issues that this underlined for the workforce were: that there was an insufficient number of GPs and Nurses; a lack of skill mix; competition between local services for GPs and Nurses; and an undesirable workload and work life balance.

With regards to workload, it was noted that under the GP Contract, GPs must provide a service to manage a registered list of patients. This included consultation, treatment, onward referral for investigation and extended primary care services such as prevention, screening, immunisations and some diagnostic services. GPs also helped to ensure effective coordination of care for their patients with other NHS services, social care and health services outside the NHS. Analysis had been undertaken to quantify the workload of GP's in Bromley. On average, they had 103 face to face appointments with patients, issued 513 prescriptions, provided 97 sets of results to patients, dealt with 107 items of incoming correspondence and made 27 referrals, per week. There had also been an increase of 55.7% in the number of home visits made in Bromley (from 11,596 in 2015 to 18,052 in 2017), which was in contrast to the national trend which had seen a decrease. Nearly 28% of these visits were to patients living in care homes, and it was noted that for some Practices, this represented 80% of their total home visits. An analysis of administrative workload filtering, looking at how non clinical staff could help filter the administrative workload of the GPs, had found that 28 Practices diverted a proportion of the GP's administrative workload, but it was largely ineffective. The findings of the assessment were that they were at the point where the issues of insufficient capacity and overwhelming workload were creating an unsustainable future for Primary Care in Bromley, and therefore something transformational was needed.

The traditional model of a Practice had five elements - GP Partner, Salaried and Locum GPs, Practice Manager, Practice Nurse and Receptionist / other admin roles, to which new roles of Physician Associate, Clinical Pharmacist, Medical Assistant and Health Care Assistant had been added. A 'first draft' of a new model had been provided, however it was noted that this may cover more than one Practice, and that the new roles would need to be wrapped around with training and support. Following further refining, a new conceptual model for Bromley had been created, based on five to six Practices working with a population of between 30,000 to 50,000 patients. The principles of the model were that it included sustainable ways of working; utilised a wider skill mix, including new roles; ensured all staff worked to the top of their skill set; refocused the role of the GP as an expert medical generalist; improved the quality of care; maintained continuity of care; and met the needs of the population.

On 31st January 2019, the NHS Long Term Plan and GP Contract Reforms had been published, which agreed with the findings of the Bromley Primary Care Needs Assessment, and also included Network Directed Enhanced Service (DES) and the expansion of digital access for patients. NHS England and committed to the implementation of a number of additional new roles over the next two years, with a 70% reimbursement for five years, and 100% for social prescribing link workers. Digital improvements included access to online and video consultation for all patients by April 2021; online access to full medical records by April 2020; electronic ordering of repeat prescriptions and electronic repeat dispensing from April 2019; 25% of appointments to be bookable online by July 2019; and up to date and informative online presence

for Practices by April 2020, although it was hoped that this would happen sooner.

In response to a question from a Co-opted Member, the Consultant in Public Health said that as Practices adopted the new way of working they would be encouraged to strategically engage with Patient Participation Groups (PPG), to involve PPGs in the plans for new ways of working, e.g. active signposting, and consideration was being given to the PPGs also joining in networks.

The Portfolio Holder for Adult Care and Health highlighted the Borough's older people demographic, and enquired if Occupational Therapists and Physiotherapists would be included in Practices to reduce the workload of GPs as part of a preventative agenda. The Consultant in Public Health responded that patients could self-refer to the Crystal Palace Physio Group, and that this would form part of the signposting role of Practice Receptionists. It was hoped that this would deliver faster treatment of common conditions. It was noted that preventative services were likely to be around cardiac rehabilitation and other chronic conditions, not just bones and joints.

In response to a question, the Consultant in Public Health said that the enhanced Care Home Service was intended to be a virtual Practice for around 1,800 patients. It was considered that the service would be more proactive if dedicated to them. It was noted that the home visits in general were largely reactive, and that pro-active care for the housebound was a matter of concern.

The Chairman queried if the proposal of 25% of appointments being bookable online by July 2019 was feasible. The Consultant in Public Health responded that most patients in the Borough should already be able to book appointments online, and that Practices had targets for signing patients up to use this service. There were two main apps that patients could use, Patient Access and My GP, and an NHS app would also be launching shortly. Online consultations were quicker than face to face consultations, and took place via eConsult, which allowed patients to describe their symptoms and navigate through a questionnaire. A report of the results was then created and provided to the patient's GP, and a response would be received in 24 to 48 hours. The response could be for the Practice to call the patient advising them to book a face to face or a telephone consultation, or to provide them with a prescription of further information. Video consultations were aimed at improving access for certain groups or patients, such as those with a disability or mental health issue, and were not intended to save time.

A Member considered what could be done in terms of attracting entry level practitioners to the Borough and suggested that a recruitment campaign could be helpful to sell the benefits of locating to Bromley. The Consultant in Public Health agreed, and said that this was something that would be discussed at the steering group and could be fed back to Members.

The Chairman led Members in thanking Dr Agnes Marossy for her excellent presentation which was attached to the minutes at Appendix B.

RESOLVED that the presentation be noted.

36 VERBAL UPDATE ON DIABETES: FLASH GLUCOSE MONITORING (CCG)

Dr Angela Bhan, Managing Director, Bromley Clinical Commissioning Group provided a verbal update on Diabetes Flash Glucose Monitoring. These were devices for Diabetics to self-monitor their glucose levels, without the need for a pin-prick test. The devices were placed under the skin, and monitored the levels of glucose in the fluid found between cells in the body. This was intended to develop a better understanding of each patient, and was a new way of continuously recording the glucose found in their bloodstream.

Despite there being only a very limited amount of evidence as to the outcomes of their use, these devices were taking off by popular demand. However, there was a cost to the CCG associated with their use, and for the patients in Bromley that were eligible, and most severely affected by Diabetes, this would be at least an additional £250k per year. It was recognised nationally that to provide the devices, the CCG's funding would be top-sliced and that the devices would be rolled-out gradually.

The Chairman said that a constituent had spoken with her, and questioned why they had not been able to obtain a Flash Glucose Monitoring device, and asked for further information on their availability. The Managing Director, Bromley Clinical Commissioning Group said that information regarding eligibility had not been distributed effectively. This had led to the demand for the devices growing within patient groups that were not eligible to receive them, and also a number of patients obtaining devices when they were not necessarily the most appropriate solution for the individual patient. It was acknowledged that there had not been a cohesive approach, and that there was a need for a patient education programme. It was noted that there was still a need for evidence to gauge the long-term impact of the devices, such as whether they made patients more anxious, and resulted in them constantly checking their glucose levels.

A Member expressed that they felt this was a major step forward, however there were concerns as to what would be done with the data gained from the device, and the implications as to how Diabetes was managed. Some Flash Glucose Monitoring devices could be bought 'off the shelf' and the extra demand could lead to patients modifying their own treatment, which could be counter-productive.

Another Member said that she was aware of the devices through a Child Looked After (CLA), and that the definition as to who could, and could not, receive the devices was unclear. It was felt that children were a relevant group of patients to be receiving these devices, especially those that had hospital admissions as a result of their Diabetes, and it could be considered a safeguarding issue if the devices were not provided to them. It was noted that the devices could be particularly helpful for parents dealing with their children 'midnight eating', as it would allow them to monitor the child's glucose levels

on their phone. It was requested that Members be provided with a copy of the patient criteria to receive a Flash Glucose Monitoring device, and the questions asked to consider eligibility. The Managing Director, Bromley Clinical Commissioning Group agreed to provide Members with a copy of the patient criteria, and noted that alongside a patient education programme, GP's also needed to be further educated about the devices. It was noted that patients who had received the devices would have their use reviewed every three to six months by a specialist Diabetes team.

37 Work Programme 2018/19

Report CSD19029

Members considered the forward rolling work programme for the Health Scrutiny Sub-Committee.

The Chairman invited Members of the Sub-Committee to provide details of any other items they wished to discuss at future meetings to the Clerk to the Committee.

RESOLVED that the work programme be noted.

38 ANY OTHER BUSINESS

Moorfield's Eye Hospital

Dr Angela Bhan, informed Members that Moorfield's Eye Hospital planned to move to new premises at King's Cross, for which a consultation had been launched. Members agreed that this was felt to be advantageous for the residents of Bromley as they would benefit from a new and improved building, and a much easier journey by public transport to get to King's Cross than Old Street. In response to a question, the Managing Director, Bromley Clinical Commissioning Group said that between 700 and 750 patients were referred by Bromley CCG to Moorfield's Eye Hospital each year.

Treatment Access Policy

The Managing Director, Bromley Clinical Commissioning Group advised Members that there was a revised Treatment Access Policy, which had been produced jointly by the six South East London CCG's. It was proposed that there would not be a formal consultation on these changes, but instead a period of engagement. A few local changes had been made to the policy to reflect national evidence based interventions and NICE guidance, which included:

- Stating that micro-suction is suitable for earwax removal
- Not removing bunions for cosmetic purposes
- Adhering to the national 'pause' on using vaginal mesh surgery for urogenital prolapse
- Shoulder arthroscopy replaced by decompression

- Bariatric surgery was now a CCG responsibility, which was a move from being commissioned by NHS England

Meeting with King's / PRUH

Councillor Jefferys informed members that he had attended the King's College Hospital NHS Foundation Trust Council of Governors meeting that afternoon. There had been a change in personnel, with Ian Smith's role as Interim Chair of King's College Hospital NHS Foundation Trust having ended on 1st March 2019, and Sir Hugh Taylor being appointed to the post for the next two years. Simon Stevens, Chief Executive Officer (CEO) of NHS England had also taken over responsibility for NHS Improvement, resulting in the body that oversaw finances being under one person.

Sir Hugh Taylor had taken on the position of Interim Chair of King's College Hospital NHS Foundation Trust alongside his existing role as Chair of Guy's and St Thomas' NHS Foundation Trust, but he had been clear that they were two separate hats, and it was not a takeover. He was aware that there were a number of issues at the PRUH, which he was keen to progress forward, and expressed the need for the closest cooperation with Bromley. With regards to the financial situation, it would be a difficult period with challenging budgets, as there was already an in-year deficit of £145m.

The Chairman noted that the PRUH needed to look at the service being provided to residents, as it was felt that changes were needed. Councillor Jefferys responded that staff surveys had highlighted that staff were feeling down beaten and dealing with incidents of bullying and harassment, which meant that morale was not good. A Member said that when talking to people about the PRUH, perception and reality were very far apart. Some services were considered to offer fantastic levels of treatment and care, but only the negative reports were heard. The Chairman agreed that the clinical care the PRUH provided was, on the whole, very good, but many felt that the people care needed to be improved.

RESOLVED that the issues raised be noted.

39 FUTURE MEETING DATES

4.00pm, Wednesday 3rd April 2019
4.00pm, Tuesday 2nd July 2019
4.00pm, Tuesday 8th October 2019
4.00pm, Tuesday 28th January 2020
4.00pm, Thursday 23rd April 2020

The Meeting ended at 5.50 pm

Chairman