LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

HELD AT 6.35 P.M. ON WEDNESDAY, 6 SEPTEMBER 2017

C1, 1ST FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG

Members Present:

Councillor Clare Harrisson (Chair)	INEL JHOSC Representative for Tower Hamlets Council
Councillor Susan Masters	INEL JHOSC Representative for Newham Council
Councillor Ann Munn	INEL JHOSC Representative for Hackney Council
Councillor Ben Hayhurst	INEL JHOSC Representative for Hackney Council
Councillor Yvonne Maxwell	INEL JHOSC Representative for London Borough of Hackney
Councillor James Beckles	INEL JHOSC Representative for Newham Council
Councillor Muhammad Ansar Mustaquim	INEL JHOSC Representative for Tower Hamlets Council

Other Councillors Present:

Councillor Richard Sweden	Waltham Forest

Others Present:

Henry Black	Chief Finance Officer, TH Clinical Commissioning Group
Dr Sam Everington	Chair, Tower Hamlets Clinical Commissioning Group
Dr Prakash Chandra	Chair, NHS Newham CCG
Dr Clare Highton	Chair, NHS City and Hackney CCG

Officers Present:

Daniel Kerr	Strategy, Policy & Performance Officer
Neal Hounsell	Assistant Director Commissioning and Partnerships, City of London Corporation
Antonella Burgio	Democratic Services Officer

WELCOME AND INTRODUCTION

The Chair welcomed all Members and guests to the meeting. She introduced herself and explained her role in the meeting and then invited all parties to introduce themselves and state their role at the meeting.

Following this the Chair advised that Councillor Richard Sweden of Waltham Forrest Council had been invited to the meeting as an active observer; additionally he would be permitted to ask questions.

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Anthony McAlmont of Newham Council.

2. DECLARATIONS OF INTEREST

The following declarations were made:

The Chair declared a non-specific interest in that she was employed by UNISON union.

Councillor Ben Hayhurst declared an interest in respect of agenda items four and five in that he was a Governor at the Hommerton Hospital

Councillor Sweden declared an interest in respect of agenda item five in that his employer was managed by East London CCG

The CCG Chairs Drs Everington, Highton and Chandra declared an interest in respect of agenda item five in that they were practising GPs

3. MINUTES

The minutes of the previous meeting were agreed as an accurate record of proceedings.

PUBLIC SUBMISSIONS

The following public submissions were received:

Terry Bay of North East London Save Our NHS made a submission regarding item five outlining the following concerns:

- The proposal will reduce democratic accountability.
- A single officer will be unable to cover all elements of the role.
- The public can no longer access the Sustainability and Transformation Plans (STP) websites - all links have been broken.

- Web access of decision-making and scrutiny of STP foot print level is unavailable to the public. This suggests that public transparency has been removed.
- The proposals suggest centralisation of power
- The proposals support the views that ever larger portions of NHS services are being transferred to the private sector.

Michel Vidal presented two submissions dated August 2017 and September 2017 concerning the single accountable officer proposals (agenda item five). He highlighted the following matters:

- Statutory functions prescribed in recent Health legislation were not compatible with the operation of a single accountable officer framework.
- The proposals could not fetter discretions already granted.
- The powers conferred do not include powers to create a single body across the CCG's in East London.

Coral Jones of NE London Save Our NHS presented a submission opposing the creation of a single accountable officer framework (agenda item five) highlighting that:

- The proposal will reduce accountability
- A single officer structure could not replicate or represent the levels of engagement provided by the current structures.
- The proposal would be a top-down structure - this would undermine statutory provisions
- Legal advice has been taken regarding the duty to consult and the proposal fulfils the conditions for consultation. However no consultation has yet been announced regarding the proposal, a matter which should be addressed.
- The Accountable Care Systems Board is unelected, none the less it will be able to make binding decisions without consultation.

A written submission from Mary Burnett was received by the Committee which related to agenda item 5 and highlighted concerns that the proposal would threaten the role and scrutiny of local authorities in health service planning, and undermine the voice and influence of local people.

The Committee noted the matters of concern raised through the written and verbal submissions from members of the public that were present at the meeting.

4. EAST LONDON HEALTH AND CARE PARTNERSHIP: CONSULTATION ON PAYMENT DEVELOPMENT

Henry Black of Tower Hamlets CCG presented the report advising that the East London Health Care Partnership (the Sustainability & Transformation Partnership for East London) had intentions to consult on payment processes across the 20 partners across which all care is paid. The report illustrated the present payment system, (comprised of two parts which do not integrate well) and indicated the direction of travel.

He informed the Committee that:

- The current funding arrangements are deemed not fit for purpose in the context of the development of Accountable Care Systems (ACS) as it has multiple facets and is complex. ACS aim to improve patient outcomes and will be able to do so more effectively if payments are better targeted to help deliver improvements for patients.

- The ultimate goal of the work is to develop an integrated payment system and to deliver better outcomes; the present system is unable to achieve this due to its complexity. It is aimed that a revised payment system will ease financial pressures on more acute parts of the system, which are presently activity based, and regularise the basis of payments.

- The consultation has been initiated to seek views on the current system. The consultation aims to capture feedback which will be analysed to determine what Partners feel does and doesn't work well and this will inform proposals for an alternative payment system.

- The consultation was due to end on 30 September 2017 and views/information would be gathered and analysed.

The Committee identified matters of concern which are detailed in the following paragraphs and Mr Black offered responses outlined below:

Payments Systems Issues:
Concerning why an alternative payments system was being explored before the environment in which it would operate was known. The Committee was informed that the consultation did not propose an alternative system but sought to obtain views on how current system worked, how to remove impediments of the current system, and to explore what it could look like in future.

There was no intention to change the payment system before designing new structures unless an appetite for this was indicated by the consultees.

A prior consultation on the care system was not necessary as the consultation on the payments system was not a technical but a broad one.

The outcome of the consultation will be reported to INEL JHOSC which is being delivered via a private provider.

No potential models have been included in the consultation or report as the CCG did not wish to influence respondents towards any particular payment model.

Breadth of Consultation:
Councillor Masters noted that there had been only 50 consultees to date and felt that this was a small sample. She was advised that there had also been outreach to NHS Healthwatch organisations. Representatives of Save Our NHS challenged this information asserting that they had sought to attend consultation meetings but had not been invited. Councillor Masters reported that she had heard hear say reports to this effect. Mr Black highlighted that CCG wanted to hear from all who wished to participate in the consultation and would ensure that they were able to participate. The Chair noted the comments and asked Mr Black to liaise with the Save Our NHS group with a view to ensuring their participation.

Councillor Maxwell requested that the Committee should evidence engagement with hitherto excluded parties and that this be reported back to the Committee. Mr Black agreed to provide updates and the Chair requested that an item be added to the next agenda in this regard.

Dr Everington noting the concerns expressed around access to the STP webpages gave an undertaking that all information will be accessible by the end of October 2017.

The Chair noted the fragmentary nature of consultations brought to Committee and that they did not appear to inform a coherent strategy or approach.

Councillor Sweden commented that there was a perception that block contracts do not pay for activities and he had observed changes in spot payments to the extent that it became difficult to provide activities due to rising prices. He asked if there would be any pre-conceptions around spot purchases versus block payments and was informed that the CCG's aim was to develop a payment system which works better than that presently in use. To this end the CCG was pleased to receive relevant submissions from Councillor Sweden.

Dr Highton advised that a move away from spot purchases can be a benefit.

Councillor Hayhurst was dissatisfied with the timescales in which information was made available to consultees (he cited the late circulation of the report relating to the Single Accountable Officer (SAO) as an example) stating that the disparity in circulation of some reports was unacceptable. He was informed that reports were circulated as soon as they were available.

Councillor Hayhurst's stance was supported by the Chair and Councillor Masters noting that the Committee encountered challenges in getting reports; although matters such as SAO had been widely known long in advance, information was made available at short notice. This contributed to a sense of things feeling rushed and information made available at very short notice. Concerning how the CCG would address Members concerns around the lack of transparency, the Committee were informed that the CCG was seeking to consult as widely as possible, and any interested party was welcome to submit a response.

Scope Outcomes and Decision Making:
Councillor Hayhurst expressed concern about the nature of consultation which he felt focussed on the negatives of the matter and fostered mistrust. He enquired if this would be a single consultation or if further engagement would follow and was advised that there would be further engagements arising from the outcomes of the present consultation. It was intended that later consultations would seek views on alternatives options and these will have been informed by the feedback from the current consultation.

Concerning who will make the final decision, the Committee was informed that a Strategic Committee would consider the outcomes of consultations and then consider the direction for progress.

Concerning how the CCGs decide what commissioning model suits them and retain autonomous control, in the context of the outcome being devised by the financial strategy committee, the Committee was informed that payment by results is default but not mandatory; therefore any CCG can choose. However payment by results is the default and NHS feels there are high risks to move away from this. Notwithstanding, if the systems agree, they may choose to move away from this method.

Concerning what feedback has been given by hospitals which may have benefited from payment by results, the Committee was informed that there was much evidence that payment by results was not working for providers or commissioners. Dr Everington used the recent Junior Doctor industrial action as an example and informed the Committee that changes could free consultants to better do their job on hospital wards.

Concerning themes and issues so far identified through the consultation, the Committee was informed that general models, included; competition across a bigger footprint and prioritisation of outcomes, three-part payment and other models. The CCG was seeking to achieve a consensus of what models will access better outcomes across the elements.

The Chair thanked Mr Black for his report and asked that a further report be brought to the meeting in November 2017 outlining the findings of the consultation so far and indicating what trends and developing themes had been identified.

RESOLVED

1. That the report be noted

2. That the Committee's concerns and views be noted

3. That a report be presented at the Committee's meeting in November 2017 outlining the findings of the consultation to date and indicating what developing trends and themes had been identified.

5. SINGLE ACCOUNTABLE OFFICER FOR EAST LONDON HEALTH AND CARE PARTNERSHIP - NEW COMMISSIONING ARRANGEMENTS FOR NORTH EAST LONDON

Drs Highton, Everington and Chandra presented the report advising the committee that the context of the proposal was austerity and efficiencies. Since health was experiencing significant financial challenges it was necessary to consider how to use the resources more effectively. Local stakeholders and interested parties have been kept up to date on developments relating to the new arrangements.

The report outlined a scheme to create a Single Accountable Officer (SAO) role to act over 7 CCGs as part of a delegated governance process which will provide leadership to ensure that big changes required to support effective local commissioning are delivered.

- SAO will take the STP lead role.
- There will be new governance arrangements

The Committee heard that:

- Presently there were no models to demonstrate what Accountable Care Systems (ACS) would look like but these would be outcome focused and the introduction of the SAO was the consequence of this change.
- There would be a strict scheme of delegation and a compulsory joint committee would be established.
- NHS England wish to act through an SAO and on this basis will release money to develop an ACS. Dr Highton acknowledged that accountability at local level had been very problematic and STP had not been allowed to share information. However accountability had to remain at local level.
- The roles of STPs and CCGs would be better differentiated and a Scheme of Delegation would address a small number of matters that cannot be undertaken at local level. The local CCG would remain the accountable body and scheme would offer more opportunities to collaborate locally. Integration of the CCGs was acknowledged as difficult to deliver, however this would change the patient experience.

- The five-year plan sets out that services should be brought as close to the patient as possible. This is demonstrated by proactively managing patients' care.
- The direction of travel has three elements; more accountability; joint commissioning and pooling of resources at STP level for value for money.
- Local accountability will be retained as the position of CCG Chairs will be retained and will not change.

Members considered the report and felt that the late circulation of the document upon which the discussion was to be had and the timeframe for the feedback placed unreasonable pressure on INEL JHOSC members.

The Committee also identified many matters of concern which are detailed in the following paragraphs and Drs Highton, Everington and Chandra offered responses outlined below:

The SAO
Concerning whether there would be an internal appointment to the SAO post, the Committee was informed that the post will be properly advertised.

Concerning whether the SAO could override CCG Chairs by means of his/her direct line to NHS England, the Committee were informed that this situation would not occur as the appointment will be made by all CCG Chairs.

Concerning the air of mistrust created amongst stakeholders and interested parties arising from the timing of the initiation of the SAO role and the issues this creates around relinquishing of control upwards to NHS England, the control that will be exercised through the ACS and the sense created that control is being centralised early, the Committee was informed that:

- The SAO would relieve the burden on CCG Chairs to manage upwards (a task that currently fell to them). However it was acknowledged that the proposal reverses CCG responsiveness and powers ahead of the implementation of the new structure.
- The three East London CCGs have worked collaboratively for three years and therefore the proposed change will not create a completely new environment

Impacts of the SAO
In regard to the following observations that:

- while noting reports of Barking, Havering and Redbridge University Hospitals NHS Trust arrangements working well, the notion of one officer across diverse boroughs was not logical and was opposed to subsidiarity of East London Healthcare Partnership and

- grading of STP plans best areas are based around one local authority therefore the footprint of the proposal was illogical (since ratings of STP plans imply that the best outcomes occur where there is focus).

The Committee was informed that perfect boundaries were impossible; however totals have been applied and will enable CCGs to avoid duplication. The challenge to be met was how most (CCGs) might do all in the best way possible. It seemed therefore that relationships would be critical in determining success. Also CCGs could not operate in isolation but if they managed differentially seeking optimum levels in each area, this might produce the best outcomes for patients.

Responding to a Member observation that the creation of large Trusts would involve levels of responsibility, the Committee was informed that there were legal posts which must be appointed to.

Concerning:

- Whether a person would be able to discharge the SAO role, the Committee was informed that the role would come into being; however there was some discussion whether realistically the role will be difficult for one person to perform.
- Whether experienced roles/officers would be lost, the Committee was informed this depended on how the system develops and who is appointed. The CCG Chairs agreed that the loss of chief operating officers would be a significant loss but this was a consequence of Accountable Care which is narrow.

Responding to the Committee's continued concerns around the impact on experienced staff; the CCG Chairs highlighted the following positive aspects of the proposal:

- one voice to approach the commissioner
- less duplication in commissioning terms
- potentially better quality outcomes
- regarding loss of talented staff, there must be action to reduce uncertainty and staff loss.

Concerning whether the changes would result in patients having to travel to other hospitals for treatment, the Committee was informed that CCGs will seek to avoid the necessity for travel to other hospitals; however patient choice was a factor that needed to be taken into account as they may ask for referral for treatment to a hospital of their choice.

Lines of Responsibility
Noting the advantages that the proposed arrangements would bring, a Member observed that the SAO appears to be a form of leadership. This officer would impact the CCG system and indirectly the experience/suffering

of patients therefore an assurance was sought that the patient experience would not be negatively affected. The Committee was informed that patient suffering is determined by resources. It was acknowledged there would be a move away from accountable CCGs; however the process of transition had elements of uncertainty. Responding to this information a Member asserted that while the transition was accepted it was not clear why accountability was being passed to an SAO and the role initiated before the scope/powers of the role had still to be defined. Additionally there were concerns around what powers the post would hold and changing structure before proposals are known.

The Chair noted that local authorities wished to know and understand the reporting lines and lines responsibility below the SAO for each borough. Members were concerned that:

- borough links will be will be diluted
- the vision was based around personalities and there needed to be a basis that would ensure longevity
- there had been frequent changes in the NHS over recent years which fostered an environment of instability.

In the context of these matters there was concern that the local voice and experience will be lost. The CCG Chairs noted the issues raised and advised that the proposed joint committee would involve local councillors. Additionally the Chairs of JHOSC and of the CCG were part of the STP Board therefore local involvement could continue. They acknowledged that the function of bringing services close to its committee was not well delivered by the STP. The Chair noting the response given asserted that none the less it was necessary that accountable care should to be integrated and the system-wide voice is heard by the local authority voice – this is lost progressively as it travels up each organisational level. Dr Everington acknowledged that there were gaps and suggested that there should be a governance arrangement that covered all seven CCG areas.

Concerning how the joint commissioning would direct scheme of delegation to increase, the Committee was informed that this matter would need to be taken through CCG and have to be directed by NHS England.

Concerning what the stages and characteristics of the consultation elements would be, the Committee was informed that all further consultation will have to go through CCG Board. It was acknowledged that the changes had caused significant uncertainty however in the view of NHS England the exercise was an engagement not a consultation. Notwithstanding it was important there was good engagement at local level as this was the most effective area. To this end City and Hackney CCG had organised a number of local meetings. There had also been consultation with Health and Wellbeing Boards and Health Scrutiny. Although it was not possible differentiate engagement/consultation at local STP level, it was perceived that STP would welcome some sort of a forum with the seven local authorities affected by the

proposal. The local authorities were asked to consider what structures would be appropriate.

Councillor Masters felt that there was confusion around the governance model for the East London Health and Care Partnership and that it was complex. She asked for a structure chart to illustrate the relationships and was directed to the tabled paper/report. The Chair asked that this be brought to the next meeting.

Action by: Dr Clare Highton, Chair, City and Hackney CCG

The Committee felt that in the context of the present political instability, it was not beneficial to undertake the reorganisation at this time especially where austerity was used as a driver. This caused concern that there were cuts for cuts sake. Responding to these views, the Committee was informed that the proposals should provide some savings. CCG Chairs were not party political but were supportive of solutions which provided more resources.
Councillor Hayhurst asserted that the proposal to discontinue accountable care officers had been known and asked that proposal to support the creation of an SAO should be put to a vote.

The Chair and members supported this motion and the following vote regarding the endorsement of the paper/report was recorded.

Votes to endorse the paper/report = 0
Votes against the endorsement of the paper/report = 6
Abstentions = 1

It was noted that Councillor Sweden participated in the discussion but not in the vote.

The Chair noting the outcome then asked that a letter be drafted for the CCG meeting on 13 September 2017 stating the Committee's refusal to endorse the proposal. She agreed to sign the letter on behalf of the Committee.

RESOLVED

1. That the Committee's opposition to the proposal and the areas of concern identified (as minuted) be noted.
2. That a letter to the CCG conveying these concerns be sent to the CCG meeting of 13 September 2017.

The meeting ended at 8.35pm

Chair, Councillor Clare Harrisson
Inner North East London Joint Health Overview & Scrutiny Committee