NHS
North East London Commissioning Alliance

NELCA Joint Commissioning Committee questions from the public - Log

Reference	Meeting date	Submission date	Submitted by	Question	Answer
JCCQ - 1	9/5/2018	4/5/2018	Michael Vidal, Hackney resident	It is noted that no provision is made in the Terms of Reference for the approval of the Budget for the Joint Committee or the North East London Commissioning Alliance. As CCGs are not allowed to exceed their Running Costs Allowance can an explanation be given as to how the budget for the Joint Commissioning Committee: • is approved and the proportions payable by each CCG agreed • when is the budget and the amount payable by each CCG is notified to each CCG • what mechanism is in place to ensure that where the notification of the budget and the proportion payable by each CCG is made after a CCG has allocated its budget the payment of the proportion of the costs would not cause a CCG to exceed its running costs allowance.	The CCGs have agreed that any changes to structures that are needed to create the Commissioning Alliance should be cost neutral on a recurrent basis, so this will not affect the requirement to keep spend within the running cost allowance. These details are being worked through now and in the coming months as the structures are discussed and decisions taken through the established governance structures of each CCG. During the process of transition and mobilisation there may be some one-off start up costs and the CCGs have set aside some funding to cover this within existing budgets to ensure the running cost allowance is not breached.
JCCQ - 2	9/5/2018	9/5/2018	Andy Walker, BHR resident	Will this committee accept the recommendation of Redbridge Health Scrutiny committee to open 2 acute wards at BHRUT? and Will the committee be lobbying for funding for more critical care beds at King George or Queens?	This was a suggestion by Redbridge Scrutiny Committee following a presentation on BHRUT ED to scrutiny on 28 March. At the meeting, BHRUT explained that staffing remains a real challenge at Queen's and King George Hospitals now, so staffing any additional wards would be even more difficult. This is an operational matter for the Trust. NEL CCGs do work with providers to agree resources, including bed capacity and funding.

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JCCQ - 3	11/7/2018		Jan Savage, Save our NHS	Following the June meeting of the Estates Board, can the Committee give an update on the Estates Strategy in terms of the disposals and investments currently under consideration"	The Estates strategy draws together the individual objectives and plans for the organisations within the Partnership. Commissioners are working closely with Trusts and NHS Property Services which own the majority of the NHS estate and are therefore responsible for identifying and, if appropriate, disposing of surplus assets. Commissioners recognise that buildings not currently in use, or those that are unfit for use, and which incur costs, may release money that could be used for patient care if they were sold. In line with national policy we would also wish to see proceeds from any sales reinvested directly into patient care, modern fit-for-purpose health and care facilities and to provide affordable housing for NHS staff and local people. In all cases public consultation would be needed, and neither commissioners nor the East London Health and Care Partnership would support any proposal that did not offer clear patient and public benefit.
JCCQ - 4	11/7/2018		Terry Day	Implementation of the Urgent and Emergency Care Strategy for North-East London: In the report introducing this item the expected outcomes include 10% reduction in London Ambulance Service Emergency Department conveyances and 20% reduction in Emergency Department attendances overall, but these expected outcomes are not referred to in the presentation. When are these outcomes expected to be achieved by? How much money is expected to be saved, if these outcomes are achieved? Does the contract for provision of the new service include targets for these expected outcomes, with any financial incentives for	The NHS 111 and clinical assessment service will have a contributory impact on the overall strategic aims described in the cover paper. There are other schemes which will have the joint objective to reduce the impact of rising populations on our hospitals across NEL. These include for example the ability for our ambulance crews and care homes to call a clinician in 111 through a special direct line, streaming at the front door of our urgent treatment centres, same day care at our emergency departments for certain conditions For NHS 111 and Clinical Assessment Service in particular we expect there to be an incremental achievement to reduce the level of unnecessary attendances at our emergency departments with full achievement by 20/21 The plan to introduce NHS 111 and Clinical Assessment Service was not a financial one within North East London we are expecting to see a high percentage of population growth and need to make sure the current urgent and emergency care system can meet this growing demand through right time/first time principles We estimated that by 20/21 £24m could potentially be saved from

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				achieving them? Will call handlers be aware of the service having any targets for reducing London Ambulance Service conveyances and Emergency Department attendances?	reduced Emergency Department attendances and ensuring people are safely directed to the right place, first time. However these savings are offset by further investment needed within the care close to home space There are quality financial targets which include • 33% closure to self-care • 80% reassessments of low level ambulance call outs which may not need and ambulance but another right service instead • 51% of people assessed and treated by a clinician Yes however they will be aware thorough training around the main objectives of the Integrated Urgent Care 111 and Clinical Assessment Service which is to take pressure off downstream services.
JCCQ - 5	11/7/2018		Terry Day	Is there a target for the % of calls closed as self-care? Will there be any way of monitoring what proportion of the people making those calls end up coming back into the Emergency Department as emergencies?	We have a target of 33% close to self-care we are looking to map NHS Numbers and currently reviewing General Data Protection Regulations (GDPR) around this. London Ambulance Service have not normally recorded NHS Numbers we have asked this within the reporting elements of the contract and understand the rationale of needing to map the whole system re patient flow
JCCQ - 6	11/7/2018		Terry Day	Will part of the 111 triage include identifying patients deemed ineligible for free NHS care? If so, how will this work?	If a patient phones 111 and is unregistered they are given 3 nearest GP practices for them to potentially register with. Fuller information re the eligibility of NHS Free care would need to be done at the point of face to face contact and not with 111.
JCCQ - 7	11/7/2018		Paul Rosenbloom, and Brian Steedman, from Waltham Forest Save Our NHS, submitted on behalf of Mary Logan.	Has the Sustainability and Transformation Plan been audited, and if so, is the outcome publicly available?	The STP is not a statutory body and as such is not subject to NHS external audit processes. CCG external auditors in considering the standards of governance in the CCG will have regard to the arrangements in place in relation to STPs and no significant risks were identified during the 17/18 audit process.

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JCCQ - 8	11/7/2018		Paul Rosenbloom, and Brian Steedman, from Waltham Forest Save Our NHS, submitted on behalf of Mary Logan.	Are there plans for a Public Health Doctor to sit on the Committee?	We do have a public health representative on the committee: Mark Ansell is the public health lead for Havering and is the nominated representative for the borough. Additionally, as part of the Joint Commissioning Committee we will also be reviewing the membership before Christmas and will consider public health as part of this. We are also in the process of recruiting a Secondary Care Consultant and a Nurse for the committee too.
JCCQ - 9	11/7/2018		Andy Walker, BHR resident	Refer to page 22 of your minutes: 'Will the committee be lobbying for funding for more critical care beds at King George or Queens?' This was not a recommendation of the Redbridge Health Scrutiny Committee, although they did call for more 2 general and acute wards to be opened at Barking, Havering and Redbridge University Trust (BHRUT). King George Critical Care beds were full up 12 times in February 2018 and on three occasions, both King George and Queens Critical Care beds were full up on the same days. There is irrefutable evidence linking not only improved mortality rates with critical care bed usage, but also better recoveries from serious illness as well. Keith Prince AM and other elected representatives will be going to 10 Downing Street tomorrow to seek more funding for these lifesaving beds.	Barking & Dagenham Councillor Maureen Worby had also raised a question regarding critical care beds at a recent health and wellbeing board and it was noted that the local health and social care economy continue to request assurance on critical care beds for its population. Mr Walker also requested clarification around surgical step down beds and it was suggested that he direct this question to local Trusts.

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				Will anyone in this committee support their call for more funding for critical care beds or at least support a review of existing provision? This committee may not have direct control of BHRUT, but it does have the power of advocacy.	
JCCQ - 10	11/7/2018	11/7/2018	Carol Ackroyd, Hackney Keep our NHS Public	I'm extremely concerned that the estates strategy is being termed as prop co disposing of "inefficient underused sites" The strategy needs to be about what estates/facilities the STP needs in order to deliver appropriate services to the population. 1. Please can we see an estates plan that sets out all the sites that will be required to provide services over the next period (10+ years) and what services will be located in each. 2. What are the implications for proposed changes of use/disposals?	1. The ELHCP estates strategy is in draft form and has not yet been published, although it is our intention to publish it as soon as possible. The strategy is based on the consolidation of a number of strategic documents from all 20 partners in ELHCP so it is important that all of the organisations are given time to check the final version for factual accuracy or if there is anything which needs to be updated. This process takes time but we expect to be able to publish in the next month or so. 2. It is not possible to comment on the specific implications of a particular building but as a general strategic aim ELHCP wants to see assets used to their maximum benefit. In some cases where buildings are not well used or are in poor condition this may mean they need to be disposed or replaced. In all cases any such plan would be consulted on widely in line with statutory requirements. The overall strategy is about improving and modernising the estate and is necessary for us to access much needed national capital funding.
JCCQ - 11	11/7/2018		Dr Coral Jones, GP, Hackney	1. Given Barts Trusts is the responsible employer, how will the Trust ensure that SERCO staff who were forced to go on strike last year for the London Living Wage, will be granted the uplifts in pay as part of the new agenda for change negotiations. 2. Re pathology: What is IHI? Is this private? What effect will IHI – ELFT partnership have on the Homerton? Are any of the Directors of IHI	Letter from Barts Health to Unison on 10 September 2018 states: As you would expect, the nature of the services provided by such workers differ and so do the commercial terms between the Trust and the workers' employing organisations. We do not have, and are not always entitled to, full visibility of the terms and conditions of workers who we do not employ and it is not always possible therefore to know, at any given time, the relativities between their terms of employment as compared to the national bargaining infrastructure for NHS employees. Contractual arrangements with supplier organisations will often allow for annual adjustments for

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				involved in decision-making about pathology services via NHSE or DoH?	inflation and the Trust will meet such contractual obligations. However, the unusual method of funding the NHS pay review means that no increased funding has been made available for any workers not on the NHS payroll. Our soft facilities management contract, with Serco, ensures all workers enjoy at least the London Living Wage as well as comparable non-pay terms and conditions. As we migrated to this contract, many workers received a significant increase in pay as a result and many others secured permanent contracts of employment as we also sought to prevent zero hour contracts being abused. You will appreciate that in recent years, the LLW has grown much ahead of pay for AFC staff. We are aware that with the abolition of Band 1 AFC, the new pay deal for NHS staff provides a pay minimum higher than LLW. We have, therefore, flagged this to NHSI and NHS Employers as we are concerned that many of our lowest paid workers are potentially disadvantaged by virtue of the funding flow excluding non-NHS employers. At the same time, both Unison and Unite are in discussions with Serco and a three-year pay offer is in place. It is my understanding that negotiations are on hold, pending the conclusion of national level dialogue, including unions and the British Services Authority. Barts Health has met with all parties and continues to discuss this challenge with Serco, as we await further news.
JCCQ - 12	11/7/2018		Neelma Saleem, Newham resident and Access & Inclusion (Advocacy) Officer-London at the British	I have concern regarding the new 111 service – how is it accessible to deaf people? Many deaf people go to A&E because they can't use NHS 111 etc. The new service doesn't seem to have taken in to account the access issues for deaf people. Can you outline what is in place to address this? There is a big issue with access to interpreters. Often we are asked to bring our children or friends along to interpret for	For people with a hearing impairment New Generation text will be used. This is the national 'text to voice' relay service utilised by individuals with hearing or speech impairments. The use of this service enables users to access services such as NHS111 and the emergency services. Relay assistants provide a text-to-voice and voice-to-text service to enable effective communication. In order to access the New Generation Text service users must dial 18001 followed by the number they wish to contact. For example; in order for a patient/caller to call the NHS111 service they will dial 18001 111.

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			Deaf Association	us at GP appointments, this is unacceptable. How does a deaf person access out of hours services for example? This needs to be addressed in order to relieve pressure on A&E which is the only option for many.	For people who don't speak English as a first language these callers will be offered language line which is a telephone interpreting service that can access all the key languages. The service is available 24/7.
JCCQ - 13	12/9/2018	6/9/2018	Michael Vidal, Hackney resident	Please could this be asked in absentia? What steps does the Committee propose to take to improve its financial openness and transparency. I note that six months after the Committee came live it does not as far as I am aware have an approved budget	Essentially the NELCA structure and operating model are still being developed and iterated, but the funding to cover the cost of shared posts has been set aside by each CCG separately at the beginning of the year. One of the benefits of collaboration across NEL is being able to do some things once where it makes sense. Having a single top tier of management to oversee the collaborative work should generate efficiencies and economies of scale. We expect this to result in some savings and this will be included at a high level with the next JCC pack of papers.
JCCQ - 13	12/9/2018	6/9/2018	Michael Vidal, Hackney resident	Please could this be asked in absentia? While technically a question relating to the ELHCP as there is no mechanism for a question to be posed to it may I ask for clarification on a point. It has come to my notice that there is a document in existence called ELHCP Hospital Only List. This list was not approved by the Area Prescribing Committee for City and Hackney which had in fact decided against having a single list opting to keep its own. In those circumstances can an explanation be provided how this document came to be approved and what its status is.	The CCGs and Hospital Trusts are working together as a collaborative Medicines Optimisation group to support consistent, safe and evidence based prescribing across all organisations within ELHCP. The 2017 Hospital Only List was a document to support this work. While all organisations are supportive of this principle there may be local variation due to existing arrangements. The ELHCP HOL 2018 is being updated and will reflect the C&H CCG and Homerton Hospital position and direct viewers to the appropriate resource for their specific recommendations.

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JCCQ - 14	12/9/2018	5/9/2018	Jan Savage, on behalf of NELSON	This question about the disposal of NHS estates is on behalf of the North East London Save Our NHS coalition. Background: According to the minutes of the JCC's meeting in May, the most recent estates and capital plans for the Partnership had to be submitted to the London Estates Board by July 6th, and to the national team by July 16th. The capital plan had to outline all 'disposable opportunities'. The minutes also noted that the JCC have developed a common estates strategy for the ELHC Partnership, and agreed a single plan for investment and disposals (among other things). We understand from Hackney Healthwatch that these plans will be made public after they have been seen by NHSE. The question has four parts: 1. How soon after plans for disposals and investments have been submitted to NHSE will the plans be made public? 2. How will they be made available? 3. When does the ELHC Partnership or JCC plan to consult the public on these plans? and 4. What status do the plans have, without public consultation?	1. We are anticipating publishing the strategy in early October. We cannot yet give a definitive date as regional partners (including NHSE and the GLA) at the London Estates Board have requested that all 5 London STPs make their plans public at the same time to avoid any confusion and to paint a coherent picture across London. If this causes undue delay we will consider publishing separately. 2. They will be published on the ELHCP website and then each partner organisation in NEL will decide whether to also place on their own websites. 3. The strategy is not a definitive plan to pursue a specific course of action. It attempts to describe the estates challenges across NEL and then set out an approach to tackling those challenges through better collaborative working. In some cases a range of options to these challenges may be described but it deliberately tries to avoid defining any specific solutions as these will need to come out of local engagement on a case by case basis. As such it would not be appropriate to consult on the strategy itself, although public engagement will be sought and welcomed. Once a business case is required for a particular site or project then the appropriate level of public consultation will be carried out. 4. The strategy has no formal status – it is an attempt to bring together and summarise the local estates plans and strategies already in existence to reflect the fact that many large estates issues cannot be solved by any one organisation working in isolation, so the strategy provides a context for the collaborative work needed but doesn't commit any organisation to any specific action.
JCCQ - 15	14/11/2018		Question from Jan Savage, on	This question about the disposal of NHS estates is submitted on behalf of the North East London Save Our NHS coalition. In response to previous questions that we	**1.** The above mentioned sites are part of our Investment Plan priorities and funding for future health and social care capacity requirements. Land at the sites has not been declared surplus to requirements and is part of a medium to long term strategic plan for

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			behalf of NELSON	have put to the JCC about the ELHCP's plans for the disposal of NHS property, we have been told that the estates strategy "is not a definitive plan to pursue a specific course of action". However, a response to an FOI request dated 28 September revealed that a number of disposals have already been identified from local estates strategies and Provider Estates Plan reports. These disposals include sites at: o Whipps Cross, o Newham General, o King George's and o St Leonards hospitals, as well as five unidentified, 'commercially sensitive' sites belonging to Barts Health and the London Ambulance Service NHS Trusts. Our questions to the JCC are: 1. When will plans to sell these sites, including 'commercially sensitive' sites, be made fully public (and how)? 2. When will the business cases for selling these sites be made available (and how), 3. Why were sites previously part of the RLH estate sold to the DHSC without public consultation? and 4. What assurances will the JJC provide that there will be public consultation on the proposed sale of NHS land or buildings in future?	NEL. We make a strong request in our Strategic Estates Plan (SEP) for The Department of Health and Social Care and the Treasury to provide robust assurance that any sale receipts will not be recovered centrally, so they can be reinvested locally. Until we have reassurance on this, no plans will be accelerated for any land release. In line with national policy we would also wish to see proceeds from any sales reinvested directly into patient care, modern fit-for-purpose health and care facilities and to provide affordable housing for NHS staff and local people. The process for disposing of any NHS land would follow Estate code guidance, and prior to any site being declared surplus, the owner organisation should produce a business case setting out the case for disposal and considering the level of consultation or engagement required. For specific developments such as the Whipps Cross site, there will be consultation on any reconfiguration or major service change required. **2.** These sites present an opportunity to generate proceeds for reinvestment into new modern facilities. In all cases, public engagement would be required and ELHCP would not support any proposal that didn't offer clear patient and public benefit. Land at the above mentioned sites has not yet been declared surplus to requirements but presents an opportunity to generate capital required for local reinvestment and re-provision. This is aligned to the Sir Naylor report. We estimate that these site opportunities will not come forward before 2021. Consequently, we have not started business case development for these opportunities. We also note the need to take account of the demand for affordable housing especially among lower paid staff, and the recommendation that surplus NHS land should be prioritised for the development of residential homes for NHS staff. **3.** The sale of the Whitechapel site was within the overall DHSC group, supported by two independent valuations. Barts Health,

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<tr><th>Reference</th><th>Meeting date</th><th>Submission date</th><th>Submitted by</th><th>Question</th><th>Answer</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>Queen Mary University of London and DHSC remain committed to the development of a life sciences hub on the site, creating health improvement, jobs and economic growth for local people. There will be public consultation as plans for the new campus are developed over the next two years.
In the case of the Whitechapel sale, the land was declared surplus by the Trust and all estates code requirements were followed. This does not required public consultation as there is no change to service provision. The land remains in the public sector as it was purchased by DHSC.
4. The ELHCP through its partners, CCGs and providers, is committed to undertaking a full programme of engagement with patients, residents and healthcare professionals into the future of the above sites. Proposals for the sites will be developed with input and engagement from patient and resident representatives.
Redevelopment decisions will be subject to a review of the sites which will need to be sent to approve by NHS England. Any redevelopment of the sites will centre on the health and care needs of local residents and patients and will be approved internally via agreed governance.
The Partnership expects to have an ongoing conversation with the public about the work that is happening across north east London to deliver sustainable health and care services for local people, including the ambition to have the right infrastructure in place. This engagement will happen through the Citizens Panel for the Partnership, and a range of other appropriate channels including health & wellbeing boards, Trust/CCG and local authority meetings as more detailed strategies and plans develop.</td></tr>
<tr><td>JCCQ - 16</td><td>9/1/2019</td><td>9/1/2019</td><td>Andy Walker, BHR resident</td><td>The HSJ reported in December 2018 that the NEL STP missed out on capital funding. Can you tell me the size of the bid, the location/s and the document sent to the DoH seeking funding?</td><td>CAPITAL SCHEMES BELOW £100M:
<table>
<tr><th>SCHEME</th><th>BIDDER - Trust/CCG</th><th>Central funding required £</th><th>Status</th></tr>
<tr><td>St Georges Health Centre</td><td>BHR CCGs/NELFT</td><td>17,000,000</td><td>Bid Unsuccessful</td></tr>
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<tr><td>St James Health Centre</td><td>Waltham Forest CCG</td><td>7,253000</td><td>Bid Unsuccessful</td></tr>
<tr><td>City & Hackney Improving Primary Care access and quality</td><td>City & Hackney CCG</td><td>10,957,000</td><td>Bid Unsuccessful</td></tr>
<tr><td>Barts Health Orthopaedic Centre</td><td>Barts Health</td><td>4,956,000</td><td>Bid Unsuccessful</td></tr>
<tr><td>Acute Reconfiguration Queens and King George Hospitals</td><td>BHRUT</td><td>49,091,000</td><td>Bid Unsuccessful</td></tr>
<tr><td>Maternity Expansion at Queens Hospital</td><td>BHRUT</td><td>14,189,000</td><td>Bid Unsuccessful</td></tr>
<tr><td>Children’s and Young Person’s Assessment Unit (CYPAU) at Queen’s Hospital</td><td>BHRUT</td><td>8,420,000</td><td>Bid Unsuccessful</td></tr>
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CAPITAL SCHEMES OVER £100M:
<table>
<tr><th>SCHEME</th><th>BIDDER - Trust/CCG</th><th>Central funding required £</th><th>Status</th></tr>
<tr><td>Whipps Cross Hospital</td><td>Barts Health</td><td>343,700,000</td><td>Awaiting announcement</td></tr>
<tr><td>Whipps Cross Hospital Programme Cost</td><td>Barts Health</td><td>9,000,000</td><td>Awaiting announcement</td></tr>
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<tr><td>JCCQ - 17</td><td>8/5/2019</td><td>21/3/2019</td><td>Shujah Hamid, Integrated Heathcare Manager, North London Region, Internis Pharmaceuticals Ltd</td><td>1. Post the recent 10 Year Long Term NHS plan announcement, what will NEL JCC be doing differently moving forward?</td><td>A NEL system operating plan has been submitted to NHS England and can be viewed on our the ELHCP website http://www.eastlondonhcp.nhs.uk/ourplans. This will be discussed further under the STP refresh item on the agenda.</td></tr>
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JCCQ - 18	8/5/2019	21/3/2019	Shujah Hamid, Integrated Heathcare Manager, North London Region, Internis Pharmaceuticals Ltd	2. What primary and/or secondary care formulary will the 7 NEL CCG's be following?	

Organisation	Formulary	Link
Barts Health NHS Trust	Local Formulary - Currently under development	Link not currently available - Formulary expected to go live in two weeks
BHRUT	Local Formulary	https://www.bhrhospitals.nhs.uk/search?term=formulary&search=Search&searchType=all
ELFT	Local Formulary	https://www.elft.nhs.uk/Services/Medicines-Formulary
C&H CCG & HUHFT	Joint Local Formulary	http://www.cityandhackneyccg.nhs.uk/News-and-publications/the-joint-formulary.htm
NELFT	Local Formulary	https://www.nelft.nhs.uk/medicines-information
Redbridge CCG	Local Formulary	http://www.redbridgeccg.nhs.uk/About-us/Medicines-management/Local-Formularies.htm
Barking & Daganham CCG		http://www.barkingdagenhamccg.nhs.uk/About-us/Medicines-management/Local-Formularies.htm

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					Havering CCG		http://www.haveringccg.nhs.uk/About-us/medicines-management/Local-Formularies.htm
					Tower Hamlets CCG	Formulary Complete	https://www.formularycomplete.com/report/public/THCCG-eBNF
					Newham CCG	Local Formulary	http://www.newhamccg.nhs.uk/AdminV9/Tracker/ClickTracker.aspx?type=search&id=906464|0|-1|860980|23246532&indexid=306&terms=formulary&x=/Downloads/Health-Services/medicinesMgmt/BNF%20%20Newham%20formulary%20v%2020%20-%20March%202016.xlsx
					Waltham Forest CCG	Local Formulary	http://bnf.walthamforestccg.nhs.uk:8080/bnf
JCCQ - 19	8/5/2019	23/3/2019	Michael Vidal, Hackney resident	1. It is my understanding that all Orthopaedic Procedures have been centralised at the Olympic Park in Newham. If that is correct, can you please confirm: (i) The date the decision to do this was made.	The Barts Health Orthopaedic Centre at Newham Hospital has recently opened additional capacity to support reductions in waiting times for elective surgery. It is not the case that all orthopaedic surgery within Barts is now performed at NGH – services continue at both Whipps Cross and the Royal London Hospitals and the Trust's		

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				(ii) As this was a commissioning decision, can you please confirm how the duties under s.14Z2 of the National Health Service Act 2006 (as amended) were complied with, in particular the duty to involve patients and the public in the developing of the proposals.	clinicians work with patients at time of referral to agree the best location given the treatment required and the patient's preference.
JCCQ - 20	8/5/2019	23/3/2019	Michael Vidal, Hackney resident	2. In relation to: a) Pathway redesign b) Service redesign c) As far as not covered by a or b proposals from a Clinical Reference Group. Can you state the process that is used to develop proposals in particular how patients and the public are involved as required by s.14Z2 of the National Health Service Act 2006 (as amended)?	The NEL CCGs follow appropriate policies where public engagement and consultation are required. Any proposals for service redesign will be considered depending on their scale and impact and discussed with providers and other stakeholders.
JCCQ - 21	8/5/2019	3/5/2019	Mary Logan, Waltham Forest Save Our NHS	The executive summary for the STP Performance report states that the NEL STP is non-compliant with standards for diagnostics, with further deterioration from previous months. If diagnostics are not available in the medically required timescale, and easily accessible, cancers will continue to be diagnosed late, and there will continue to be poor survival rates. I note there is an Early Diagnostic Centre for N. E London based at Mile End Hospital, as well as the previously existing local diagnostics in the NEL area.	The latest position on diagnostics performance has improved from the time of writing the report with performance at BHRUT improving on account of additional capacity for the provision of MRIs in particular. The North East London STP has been compliant with delivery of all cancer performance standards consistently during 2018/19. NEL STP remains focussed on driving delivery of the diagnostic standard and also on the early diagnosis of cancer by staging cancers earlier, amongst other initiatives, which has also seen significant improvement across North East London since quarter 1 of 2017. When approving practices to relocate to a new site, as a general rule it wouldn't be expected to be more than 1 – 1.5 miles from their previous site. However, this is fairly flexible and would depend on analysis of a number of factors such as distribution of the patient list by reviewing a scatter map, the proximity of other local practices and

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				Research on patients presenting late with cancer shows a strong correlation with distance to travel. The moving of GPs into larger hubs and away from being dotted around residential areas means some people will already be putting off going to the GP. I realise some GP hubs are to have some diagnostics, which should benefit the patients attending there. However, others will be deterred from making the longer journey to the GP until later in the disease process. How is the impact of these changes to be monitored, and where can the public find this and other evidence re the impact of the STP changes?	accessibility and transport links. The impact on travel time is normally limited. Co-locating GPs together in hubs will increase access to a range of services and expertise as there are many that cannot be provided in multiple sites or in smaller practices (because of space constraints). Co-locating GPs means some services may be provided alongside more easily. There is no evidence that we are aware of to support the concern that GPs moving to hubs reduces the likelihood of patients attending their GP.
JCCQ - 22	8/5/2019	3/5/2019	Meenakshi Sharma, BHR resident	Where are the Equalities Impact Assessments for the Commissioning Strategy 2018/19 - 2021/22 in light of the unwarranted variation across NEL both in terms of resource allocation and health outcomes?	EIAs were not carried out at the level of the Commissioning Strategy. An EIA is carried out for each individual service change through the business case approval process. Meenakshi Sharma then raised her concerns that, in the move to commissioning at the NEL level, inequalities at borough level were not being monitored. Jane Milligan assured Meenakshi, and the Committee, that, in the joint approach to commissioning with the Local Authorities, this is regularly looked at a local level.
JCCQ - 23	8/5/2019	3/5/2019	Andy Walker, BHR resident	On midday on 3rd May Save KGH/Don't overload campaigners went to 10 Downing Street to seek a public consultation on the new plan to close KGH A&E, can this Committee support this call?	This question has been asked, and answered, in various other forums and received a consistent answer. The document is superseded by the statement by Jane Milligan at the BHR CCGs Joint Committee in January 2019 and by the open letter from the Local Authority, BHR CCGs and the Trust in April 2019. Both of statements were clear that the KGH A&E will remain open. We are not prepared to entertain further questions on a matter that has been fully answered.
JCCQ – 24	10/7/2019	5/7/2019	Meenakshi Sharma, BHR	Could you please explain how pooling resources for the Better Care Fund leads to	Allocations for the BCF are made at borough level and there is no mechanism for sharing across NEL. Each borough is able to decide to

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				reduction in inequalities across NEL, in light of what appears to be substantially lower funding for BHR as compared to the other boroughs?	what degree health and social care budgets are placed into the BCF as long as minimum contributions are met - this should not be confused with overall funding for local services (eg Newham have opted to pool a larger amount than other boroughs)
JCCQ - 25	10/7/2019	5/7/2019	Meenakshi Sharma, BHR resident	You have made clear that there are no plans to close the King George A&E site, as there is a clear need for A&E provision at the site both now and into the future but could you also please confirm that it is possible the A&E will be limited to access for the frail elderly, as indicated in the bid submitted by the ELHCP, which is now seeking alternative funding?	The proposal for a more specialist A&E dedicated to frail and elderly patients is no longer the preferred option. Recognising the broad and growing demographic pressures, the local health system is in the process of considering all options for the service model for urgent and emergency care which will best serve the whole population needs. These plans are in early stage of development and full engagement with all stakeholders will take place in due course to help shape them, including public consultation if this is appropriate. On 29 March, the local NHS and Council Leaders shared a joint statement which said: "We want to be very clear – the threat of closure of the Accident and Emergency unit arising from decisions in 2011 has been removed. The local population has changed significantly since 2011 and is forecast to change further, there is a clear need for Accident and Emergency provision at King George Hospital both now and into the future. "The review of the clinical strategy of BHRUT is an important development. This will create an opportunity to consult with all stakeholders - particularly the public - on the Trust's future clinical strategy. It will provide an opportunity for us all to contribute to shaping a long term vision and plan for services at King George Hospital including the Accident and Emergency unit." The joint statement made on 29 March still stands – nothing has changed. The proposal in the previous ELHCP bid that you refer to is not being pursued.
JCCQ - 26	10/7/2019	5/7/2019	Mary Logan	Could the JCC provide some clarity as to how accountability and transparency is to be established within the new arrangements	WEL CCG Board will be holding its first meeting on 24 July 2019 at 2pm in Unex Tower. All meetings will be open to the public unless there are confidential matters and they will be considered in Part 2.

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				for WEL and CCG's, given that WFCCG has made provision to take questions from the public in only one meeting during the first six months of this year?	From September meetings will be monthly and we are currently arranging dates for those meetings. Agendas and the meeting dates will be made available on all WEL CCG websites. There will also be an item on each agenda for Healthwatch collectively to raise issues and report on particular issues. In relation to WF Board, two of the meetings were extraordinary meetings essentially for one item agendas and hence why there was no item on the agenda for public questions. At one of the meetings the public questions item was omitted and should not have been and we will make sure that does not happen again. Also we understand that all outstanding questions have been responded to.
JCCQ - 27	10/7/2019	5/7/2019	Mary Logan, Waltham Forest Save Our NHS	Can we have more detail about the various causes mentioned for the increase in Delayed Transfer of Care (DTOC) in WF between May and Sept 2018, so we can understand the situation better? What were the "process challenges" within the Integrated Discharge team, and what were they on the wards? What were the causes of reduced capacity out of hospital? What exactly what change of practice was required following a CQC inspection of the Reablement Service? What were the mitigating actions taken which lead to lower DTOC since September 2018, and are they remaining at a lower rate?	The main reasons for delay from May to September for DTOC were: • Waiting for Care Packages in own home • Awaiting Nursing Home placements • Housing. **What were the "process challenges" within the Integrated Discharge team, and what were they on the wards?** In 2018 a strategic review was undertaken of The Integrated Discharge Team, this highlighted a number of areas for improvement, including: • Trailing a new way of working, with improved integration between health and social care staff • Clearer roles and responsibilities within the team • Review of the capacity within the Team • Streamlining of process, such as funding approval and multiple assessments undertaken. **What were the causes of reduced capacity out of hospital?** A local private nursing home closed at short notice, resulting in a reduction of 43 nursing home beds in the borough. This had an impact on the availability of beds for people to be placed in nursing

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					homes in the borough both short or long term, and both the Local Authority and CCG needing to source beds in other boroughs. In late 2019 the CCG and Local Authority are planning to open a new nursing home in the borough to increase the bed base. **What exactly what change of practice was required following a CQC inspection of the Reablement Service?** Following the CQC inspection the Reablement Service were required to put in place a number of immediate actions. These included increasing the time taken to undertake assessments and development of care plans, which impacted on the time taken to discharge patients from hospital. **What were the mitigating actions taken which lead to lower DTOC since September 2018, and are they remaining at a lower rate?** The following actions were taken by the Waltham Forest Health and Social Care Partnership: • Implementation of the Bridging Service. The Bridging Service was implemented as planned in December 2018 and has been fully evaluated. This service has had a positive impact on patients who were delayed by 1 or 2 days waiting for assessments and Reablement services. • A housing discharge specialist is in place within the IDT to manage homelessness and housing cases. This has seen a reduction in delays for patients waiting for housing issues. • Nine George Mason Lodge (GML) beds have remained open and have been available all year round. This has allowed patients to be discharged to GML as further social care needs are addressed such as deep cleans of patient properties, de-cluttering for falls safety and general housing repairs etc. The strict admission criteria to these GML beds has ensured that patients have not been stranded within the GML system and

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					this has enabled the GML resource to be used efficiently and effectively. • A social work presence within ED was implemented in September 2018 and is working well and effectively • DTOC/MO system calls twice a week at 1300hrs. • Escalation protocols for DTOCs ensuring system actions and accountability. • Improvements to DTOC data, accuracy and sign off following national guidance. • Use of real time data for daily snapshots of delays and long length of stays. The level of bed days lost due to patients delayed in a hospital bed remained at a low level until March 2019, there has been an increase in April and May due to a small number of challenging patients who were homeless and a deep dive is currently being undertaken to ensure appropriate actions are in place to reduce.
JCCQ - 28	11/9/2019	6/9/2019	Paul Rosenbloom and Brian Steedman, Waltham Forest Save our NHS	What are the key performance indicators of the success of the STP, and will these indicators be carried forward to measure success of the Long Term Plan?	There are currently 30 metrics being worked up as part of the long term plan (LTP) across the following eight areas, with improvement trajectories being set over a 5 year period via an STP data collection tool. Trajectories for the below areas will be set during the current LTP planning process: 1. Cancer 2. Mental Health 3. PHB/Personalisation 4. Diabetes 5. Stroke 6. Maternity 7. Primary Care 8. Learning Disabilities and Transforming Care Partnerships Referral to treatment targets, and Cancer and A&E waiting time measures have not been included in the data collection tool at present. There is an ongoing clinical review into these metrics due to

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					report in April 2020. These measures are, however, listed as part of the LTP's headline metrics and we anticipate that further detail may need to be provided on these metrics post the end of September LTP submission. Organisations across ELHCP will continue to be rated by the Care Quality Commission. ELHCP has seen significant improvements in ratings across all Trusts. ELFT – outstanding, Homerton and NELFT – Good, BHRUT & Barts have exited special measures. There have also been improvements in primary care, with the proportion of good or Outstanding GP practices improving in all CCGs – with 1 CCG now having only Good or Outstanding practices.
JCCQ - 29	11/9/2019	6/9/2019	Paul Rosenbloom and Brian Steedman, Waltham Forest Save our NHS	What surgical specialisms would be included if Whipps Cross is developed as a Centre of Excellence for older people, and conversely, of the surgical specialisms currently provided at Whipps Cross, what surgical specialisms would not be provided?	We have just published an outline narrative regarding surgical specialties at each of our hospitals at https://www.bartshealth.nhs.uk/news/find-out-about-our-future-plans-for-surgery-6446 We will be working with stakeholders, staff, patients and the public to develop these principles.
JCCQ - 30	11/9/2019	6/9/2019	Meenakshi Sharma, BHR resident	Is a type A&E by definition an A&E for the whole demographic or can it be for a sub-group of the whole demographic?	Type 1 A&E does not restrict by age or conditions, there is no type 1 A&E which restricts access by age in the UK.
JCCQ - 31	11/9/2019	6/9/2019	Meenakshi Sharma, BHR resident	What are the options for the future of King George Hospital that are on the table at the current time?	This question is substantially the same as the question asked at the last meeting (JCC - Q 25). The development plans are in early stages, and reassurance was given that there would be thorough engagement with the community as the plans develop.
JCCQ - 31	11/9/2019	11/9/2019	Andy Walker, BHR resident	The type 1 performance for King George and Queens was alarming last winter. Queens was especially alarming with 9071 attendances and a 4 hour performance of 48% So will or has this committee taken steps to seek extra funding for more beds and staff	A winter plan is developed each year in conjunction with our providers, and incorporates our demand and capacity work. Capacity and demand is discussed regularly at the A&E Delivery Board and there are currently no plans to increase the bed base at BHRUT – this is not currently the major driver of A&E performance, staffing is and we are working with the Trust to try to help them address the staffing issues but recruitment is a significant challenge.

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				for this coming winter to improve the service?	
JCCQ - 32	13/11/2019	7/11/2019	Shujah Hamid, Integrated Heathcare Manager, North London Region, Internis Pharmaceuticals Ltd	In the fast changing NHS and the NHS Long Term Plan being towards the creation of a North East London ICS - Integrated Care System, will the existing/future clinical treatment guidelines be shared across a single ICS structure? Currently there is variation in clinical guidance from one CCG area to another…	As part of developing an integrated care system for north east London we are considering at what a streamlined commissioning function would look like. If we move towards a single commissioning structure across north east London then we will need to ensure that we align our policies across this footprint to ensure consistency for our residents.
JCCQ - 33	13/11/2019	8/11/2019	Meenakshi Sharma, BHR resident	Despite having four pages of acronyms at the beginning of the NELCA November report, the meaning of acronyms FRF, PSF, MRET, and AfC,are not given, making understanding of appendices 1 and 2 on pages 102-108 even more impossible for the layperson. Is this a deliberate attempt to avoid scrutiny and, if not, can the essential meaning of the tables be clarified?	The list of acronyms is a by no means exhaustive list of commonly used acronyms in the NHS and by our organisations, and is continually reviewed. It is additionally common practice to spell out any acronyms in papers the first time they are used. On this occasion, Financial Recovery Fund (FRF) and Provider Sustainability Fund (PSF) were both spelled out in the accompanying letter. Apologies that Marginal Rate Emergency Tariff (MRET) and Agenda for Change (AfC) were not. These will all be added to the next iteration of the Acronyms list, many thanks for your feedback.
JCCQ - 34	13/11/2019	13/11/2019	Andy Walker, BHR resident	Does this committee agree that the principle of transparency outlined in the Francis report means that BHRUT should disclose: 1) What the purpose of £9m for additional capital funding be disclosed? & 2) Produce type 1 A&E stats for King George and Queens?	1) the £9m for BHRUT is not additional capital funding, it is a loan from the Department of Health. Michael Gilham, Deputy Director of Finance, BHRUT has said: “We’re delighted to have received this loan funding, which will be spent on modernising and improving our hospitals for our patients and staff. “It will allow us to replace and upgrade medical equipment, instruments for our theatres, as well as provide more up-to-date birthing pools and beds for our Maternity department. We will also

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					be undertaking essential maintenance work particularly at King George Hospital" "The money will also support the first phase of our IT strategy. This will see us modernising and upgrading our IT system, putting in place a platform for future opportunities using digital technology to improve our patients' care and experience." 2) A&E reporting for BHRUT is in line with national reporting requirements. At this point in time, BHRUT will not be publishing data broken down into type 1 and 2, by site, although overall four hour emergency standard data is on the Trust's website (https://www.bhrhospitals.nhs.uk/our-performance), and is broken down by site, and NHS England data is broken down by type. Data that has not yet been published by NHS England cannot be provided.