Working together for better health and care

NHS Thurrock Clinical Commissioning Group

MINUTES
Commissioning Reference Group
16th July 2019 at 4:00 pm
Beehive Centre

Present:	Alan Hudson (Chair) (AHu)	PPG/TCRG
	John Guest (JG)	TOFF & Orchard Forum
	Joyce Guest (JYG)	TOFF & Orchard Forum
	Reginald Sweeting (RS)	Pear Tree Surgery
	Graham Tidman (GT)	Thurrock Stroke Project
	Tony Davis (TD)	Ex - Rigg Milner PPG
	Kevin Brice (KB)	Chair PPNG
	Maureen Cushing (MC)	Hassengate PPG
	Christine King (CK)	Ex - PPG
	Alan Harmer (AHa)	Dr Yadava's Surgery PPG
	Barbara Rice (BR)	Manager - Healthwatch
	Terence Brown (TB)	Chafford PPG
	Dr P. Ambikapathy (DrA)	Dr Deshpande's Surgery
	Trevor Hitchcock (TH)	PPI Lay Member
In Attendance:	Lynne Hilkene (LH)	TCCG – Executive Business Manager
	Susan Duffy (SD) (Minutes)	TCCG – Receptionist/Administrator
	Abi Hambleton (AH)	TCCG – Work experience Communications attachment.
	Ian Stidston (IS)	TCCG – Interim Director of Commissioning
	Louise Banks (LB)	TCCG – Head of Communications and Patient Engagement
	Wendy Smith (WS)	Consultation Lead - Oriel Moorfield's Eye Hospital NHS
	Emily Hughes (EH)	Associate Director of Commissioning - Acute Commissioning Team for Mid & South Essex CCGs
Apologies:	Moira Brainwood and Gill Booth	

1.	**Welcome & Apologies**
	The Committee Chair welcomed everyone to the meeting and thanked them for coming.

	Apologies were noted as above. AH-C introduced IS, LB, LH, SD, and WS
2.	**Declaration of Interest**
	"In accordance with Section 14O of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 (and subsequent statutory guidance) the CCG must ensure that it manages any and all conflicts of interest that may arise. All members (and those attending the meeting) have a duty to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of NHS Thurrock CCG. Can I therefore ask anyone in this meeting to declare now any conflicts (real or potential) that they may have, declared or otherwise, in relation to the planned agenda for today's meeting. This must also be recorded on the signing in sheet indicating for which agenda item you may be conflicted. ***Should any unforeseen conflicts arising during the meeting, please ensure that you stop the proceedings to declare it accordingly. All declared interests are recorded in our register of interests and any conflicts arising during any CCG meeting will be recorded within the 'Recorded Conflicts of Interest Register', which are available on the CCG website"*** The Chair requested any Declaration of Interest that was not already on the register, nothing was declared.
3.	**Minutes of the meeting held on 21st May 2019 and Action Log**
	The minutes of the previous meeting were agreed with no amendments. **There were no items from the Action Log.**
4.	**Moorfield Eye Hospital Consultation – Updated Services**
	AHu invited Wendy Smith (WS), Consultation Lead from Oriel at Moorfield's Eye Hospital to address the meeting. WS explained that she was at the meeting to discuss the proposal to move the existing Moorfield's Eye Hospital City Road services to a new site as the project has now reached the consultation stage. As there are residents of Thurrock that receive treatment through Moorfield's, WS was keen for input and comments from the group on the proposal as well as ideas and possible solutions to any drawbacks. The lead proposal on the table is to build a brand new centre. The current building that houses the City Road Main Hospital dates back to the 1890's and is overcrowded and cramped. It was originally built to accommodate mainly in-patients as was the need at the time, but modern day treatment is a lot different which means much more footfall and a move to more out-patient treatment and despite adapting every room to try and bring it up to date, it is no longer suitable for purpose. Patient surveys show that the clinical care received through Moorfield's is second to none but due to the constraints of the building itself the Patient Experience does not match up to that standard. By building a new eye care centre, the plan is to incorporate research, education and training and Moorfield's are working with the UCL and the Institute of Ophthalmology to produce a centre that will be at the forefront of eye care. UCL feel that if they are to achieve this then it is necessary for a move to a more up-to-date building. Consultation so far has shown that 70% of patients agree that a new centre is the way to go. The only downside that has emerged so far is the location of the proposed site. The site leading as the best choice at the moment is at St Pancras. Recent refurbishing and remodelling has released a plot of land that would be suitable for the new centre. However, this is approximately two miles from Kings Cross station which would be the nearest transport link for many people. Feedback has been gathered with much indicating that Kings Cross itself could cause a problem as people with sight loss could find it difficult to navigate around the station and the journey from there to the centre could also prove problematic. However the benefits outweigh heavily against the negatives in as much as it could provide the

"beating heart" for breakthroughs in eye care, research, education and training; particularly with regards to Macular Degeneration and glaucoma. Plus the site is in close vicinity of many other invaluable services to those with eye problems such as the RNIB headquarters and the Guide Dog service.

Q. TD asked if this was the only option. Were there no options suggesting anything else? If not, a shuttle bus may be a way to get patients from Kings Cross to the hospital?
A. Many options were put forward including refurbishing or rebuilding on the current site – the summary documents and all the background are on the website www.oriel-london.org.uk
Serious consideration has been given to all of the options but none proved to be better than building a new centre on a different site. By using the original site it would have meant double the upheaval having to move all services off-site for two to three years and then moving them back so it was decided that it would be an easier transition to have a brand new build. This also is a cheaper option than refurbishing the current building. The shuttle bus has been suggested by several people and will be looked into.

Q. TB suggested that Kings Cross is also a Bus station so maybe a special bus route could be looked into.
A. WS reiterated that shuttles and buses were all to be looked into. LB suggested that maybe a bus route could be re-routed to accommodate.

Q. Why St Pancras?
A. London is a given to attract the best talent and best workforce. Also this is ideal for the links with research through UCL and the transport links are good. Plus the land is good value for public money.

Q. KB said that he understood the complications that Kings Cross would bring, but what is accessibility like at the current site?
A. LB said that it is very complicated having been there herself. There are 8 exits alone at Old Street station which is the nearest station to the current site. WS confirmed that there is greater accessibility at St Pancras and that the focus needed to be on the train to new centre journey.

Q. JG asked if the current hospital has been developed as much as it can be.
A. Yes – all the wards have been converted to more useable rooms but it still is just not good enough for what is needed.

Q. The time it will take to get from station to centre could impact on appointment times.
A. This is also a drawback at City Road plus there is no facility to drop off or pick up patients by car but there would be the opportunity to build this facility into any new plans. There will not be any actual parking available but there will be a major accessibility plan incorporated into a new centre. Not only do cars have to be considered but as the new centre will have an A&E department there will need to be access for ambulances as well. There are differing opinions so far on the use of shuttle buses because of the differing needs and abilities of the patients.

Q. MC agreed that a more modern building was the way forward and suggested that on the question of access would it be possible to build a bridge or other route specifically to get people safely from the station to the building? With all the extra London traffic it could cause extra pressure for patients with sight difficulties.
A. There is a route that can be taken without going on to a busy road. The RNIB and Guide Dogs are working in collaboration with Moorfield's to ensure suitable solutions for eye care patients where safety is a priority. A bridge may not be practicable because of the distance involved but something along those lines may work.

Q. WS posed the question – How do we bring the front door of the hospital to the transport hubs? TFL, Camden Council and Kings Cross already cater for people going to the RNIB and other

	services in the vicinity. It was added that Kings Cross already has excellent services for people with disabilities. **Q.** BR asked who owns the current site. In cases where buildings are to be vacated it inevitably brings controversy over what will take its place – has the mood of the local residents etc. been assessed? What would happen to the proceeds when it is sold? **A**. The building is owned by the MEH Foundation Trust so it would be up to them what happens with the old site. All of the services would transfer out so the building would be available to be sold and any profits would go back into the services at the new centre. The same would happen with the sale of the old UCL site and funds made would be contributed to the new centre. **Q**.BR said that if the building were in Thurrock the discussion would be totally different. What are the feelings of the local groups, has there been any indication of opposition to the move? **A**. The consultation process is involving Islington Council so all these issues will be addressed. **Q**. Are there any ramifications on the sale of the existing site such as preservation orders? **A.** The building is of historic significance so the facade would have to remain. **Q**. TB asked if the access from Kings Cross could be adapted. Could a specific exit be made at the opposite end to the current exit/entrance as this would make the journey to the site shorter? **A.** That would definitely be an option to look at. KB raised the issue of discouraging drivers to come into London. One idea that had been raised was having a reception for Moorfield's, RNIB etc. in the station and providing walkers to escort patients to their destination. Like a "Meet and Greet" area. MC said that the idea of a shuttle needed to be re-visited. There could be an electric driverless shuttle from the meet and greet area to the centre. AHu suggested maybe having an actual office for the centre housed in Kings Cross and also the possibility of making a deal with London taxi drivers. It seemed that these were similar problems to those with the STP concept. It is not that there is a problem with the centre itself – just in getting there. TH added that a lot of the fear would be in not knowing where to go so there would need to be very clear signage and maybe something like large arrows painted along the route. (Although it was pointed out that this could be in danger of graffiti saboteurs adding misleading arrows) TD suggested a road train run by volunteers. WS concluded by asking if the group wanted to be kept up to date with progress and asked for feedback via email or by using the links online. Website address is www.oriel-london.org.uk and the end date for consultation is 16th September 2019. WS offered to come back to give an update in the future which was unanimously accepted.
5.	**The Better Care Fund**
	AHu introduced Ian Stidston (IS), Interim Director of Commissioning, who presented a slide show on the background and purpose of the Better Care Fund (BCF) which is a considerable sum of money invested in services for the community. The fund is pooled for Thurrock between the Local Authority and the CCG and was introduced in 2013. There are many benefits to this including providing a platform to come together to bring care closer to those remaining in their own homes. Everything in the fund should link back to Better Care

Together. The scheme joins up Health and Social care to improve the lives of the vulnerable.

The fund is currently £48.4m and IS explained the breakdown of this amount and the anticipated outcomes. One of the main aims is to reduce the number of unplanned care hospital admissions and to then to aim to make sure that patients keep healthy once they are discharged. IS also explained the "RAG" rating system on the scorecard to show how the fund is monitored. The scheme is rated as being very effective in delivering services, proving the worth of working in partnership. The criterion for the use of the funds includes using money for the identification and management of patients, more effective self-care and the transformation of services – for example the new Primary Care Networks (PCNs).

The process involves a business case being submitted to the BCF manager which is then considered by the Thurrock Integrated Commissioning Executives so that a decision can be made.

The BCF is currently supporting four schemes:

1. Communication material – An engagement plan to communicate through events, leaflets and posters etc. in order to reach more vulnerable groups.
2. Flu Vaccinations – Public Health initiative to increase uptake.
3. South Essex Rape and Incest Centre – providing support and ensuring care is maintained.
4. Enhanced Discharge to Access Pathway – an intense pathway to provide support to those who are discharged from hospital with the aim to negate the need for eventual long term care.

IS apologised that it was too late for CRG input with regards to the allocation of funds for this year but the intention is to put forward plans to gather views and suggestions of spending funds going forward.

Q. KB said that Communications already issue the posters – what about social media?
A. There is work going on to look at sponsoring social media in an effort to try to reach those that have not been reached in the past. There will also be community events to talk about the new models of care. Also looking at how best to make use of GP surgery TVs and electronic message boards and having useful information pop up on those.

TCCG are also looking for different ideas as to how to get information out to the people that need it and making sure those people understand the new services.

CK raised the point that, on a personal level, she had recently discovered the Local Area Co-ordinators so there is a need to advertise their services more widely. This role can be of great help to those who do not know where to turn in times of crisis or just when they need guiding in the right direction.

Q. MC asked if different scenarios could be put on social media and also if some money could be used to target young mothers to encourage them to have their children vaccinated.
A. This is something that is being looked into at the moment. This has started with electronic messages being sent out to parents.

Q. JG raised the point that the Health Care workers provide a good service but the receptionists are not doing their job properly and not telling people about hub appointments, just telling them to come back and wait to see the Doctor.
A. More funds are going into making more appointments available so if it is not making a difference the CCG need to know.

Q. TH suggested using GP WiFi as people inevitably go online whilst sitting in the waiting room; could it take any log-in direct to a landing page for CCG issues?

	A. LB informed the group that when GP WiFi was introduced it was set up to go straight through to the website but if this is not happening then LB needs to know. **Q**. Lots of people book appointments on line – could there be something pop up when you log into that? **A**. There are links set up on this facility and there are also details on care navigation on the Practice websites so that people can direct themselves to the right professional. GT raised the point that at the Stroke Project a lot of people rely heavily on Health Watch speakers as a lot of groups do not have internet access and so need face to face information in order to find out about things. BR added that Health Watch is looking at people with long term conditions – some people seem to get the support of every service that is on offer and others get no support at all. JYG said that unfortunately not all receptionists are the same – there are some good ones but if you get the wrong one you do not get all the information that you should. AHu replied that all receptionists should have had the Care navigation training. It was agreed that if receptionists continue to just say there are no appointments and do not offer the new service alternatives the footfall into A&E is going to increase so this does need to be addressed. **Q**.TD suggested the idea of pop-up shops as they work well for other establishments. **A**. LB replied to say that this has been tried and it is an idea to look at. **Q.** CK said that she had received a letter asking if she was receiving all the services that she needed but she didn't know what services were available. Where would that have come from? **A**. LB said that this was more than likely from the council and it was agreed that it would be better if that sort of letter also included a list of available services. **Q.** AH-C suggested an event maybe for a Health Promotion week spanning the afternoon and evening so that everyone could get there to get the message across. **A**. LB replied saying that we do have an event like this run in conjunction with the library. KB suggested converting an ambulance to provide a mobile information service. **Q**. JYC said that TOFFs did not know until recently that batches of appointments were reserved to be booked on line. **A.** There will be a presentation at the TOFFs meeting in August where this will be discussed. IS concluded by saying that it was really helpful to get all this initial feedback which has raised a lot of good initiatives. IS will feed back the ideas put forward today to the Thurrock Integration Executive and will come back to the CRG with updates in the future. KB added finally that to get information out to everybody it seems as if mobile units are the way to go – Mobile Libraries and scanning units etc. all work very well and you can target them where the need is.
6.	**Thurrock Targeted Lung Health Check – Update on Progress**
	AHu introduced LB for this update. Following Kehinde Adeniji's presentation in May this year this is now a standing agenda item for CRG. LB reported that the meetings that have been held on this project have been on a very large scale because of the number of different interests involved. A separate communication project has been

	set up to ensure proper and complete communication is achieved to bring all the relevant parties together. There will be in the region of 15,000 people invited to take part so it is vital to ensure that there is enough capacity to deal with these numbers. Scanning/Screening trucks will be set up on four sites giving the facility to talk to people as well as to undertake the actual scanning. **Q.** TB asked if a patient has to be referred to take part. **A.** It will be invite only through the GPs and will be for people fitting specific criteria only – smokers aged 55 to 74. The invite will be for an initial interview to ask some questions and from that it will be determined if that person will be progressed on to the scanning stage. The narrow criteria is because this is a pilot, but it may in future capture wider groups. **Q.** TB then raised the point that Thurrock is recognised as having extremely poor air quality. What about people who suffer because of this? **A.** BR replied that Health Watch has a study at the moment of other groups and local industries that may have contributed to lung conditions. LB added that if you have symptoms you can still go to your GP even if you don't fit the criteria to be part of the scheme and you will still be treated. The hope is that the pilot will start on 6th January 2020. There has already been some warm-up activity and in October communications will be going out which have been constructed with input from the Roy Castle Foundation. These will be awareness raising and will highlight lung functions. There will be a bespoke website and a helpline number – it is planned that details will be available on GP websites and at surgeries. There will be texts, letters and emails all designed to encourage people to attend their screening appointments. There will also be encouragement to quit smoking through Stop Smoking programmes as well. LB also said that the team are going to invite a cancer survivor to share their experiences to stress the value of early detection. Health Watch will have extra workload as their role will be to make sure there is enough capacity available to in the system to cope with the demands of the numbers to be screened. BR, along with the Clinical Director and Matt Hancock will be speaking nationally on this and will make sure they represent Thurrock residents. **Q**. What about people who are not smokers but have poor lung health? **A**. This pilot just for smokers is a totally separate exercise which will not impact on current available cancer services so all other patients will still have the usual pathways available. Health Watch will monitor the situation to ensure this is the case.
7.	**Patient Transport Survey, A new service offer.**
	AHu introduced Emily Hughes (EH) who explained that she is leading on the procurement of the non-emergency patient transport service (PTS). The current service is out of date and inconsistent. There are currently three contracts that all work differently plus pay-as-you-go extra transport. The aim is to have just one service which will be more efficient and more cohesive. The demand at present is 180,000 journeys a year which equates to approximately £8m. The project is to look at service provision only – there will be no changes to the eligibility criteria which will remain the same. EH explained what will be covered under the scope. Secure Mental Health Patient Transport where caged vehicles are used will not be included in the scope and neither will Forensic transport which is provided by a specialist provider through EPUT.

So far there have been two stakeholder meetings held in March involving various councils etc. plus there has been direct clinical engagement with the Mental Health Trust and Basildon cardio-thoracic unit through events that have included Q and A sessions. There has also been direct patient engagement through surveys and face-to-face meetings at various local hospitals. The feedback coming from patients has been very positive with regards to the care given by the various transport crews but negative with regards to collection and pick up arranged times and the waiting involved with no information.

The commissioning team has developed a draft specification to go out to providers on which to base their bids. Current staff should be able to transfer over to the new provider. The team is hoping to streamline the service and make efficiencies by having just the one provider and will have the booking line hours, as well as the actual operational hours of the transport, extended to increase availability and ease for patients. .

Currently only professionals can book transport for patients online but the hope is that this will be extended to patients as well.

The aim is also that if a patient is not eligible for the PTS they should be signposted to other methods of transport.

The team has been clear in procurement that they are looking to provide services as they are now and is looking to provide an app for patients to check on pick up times. There will probably be a suite of communication methods to choose from.

Expected timings are that Governance should be established in early August, the contract will be awarded in December and operation by the new provider will start next summer.

EH then invited views and comments.

Q. What are the requirements for a person to be eligible for PTS?
A. This is based on medical need – dependent on if you need assistance from someone whilst travelling. Renal patients are automatically eligible as are Chemo and radio-therapy patients. Children and young people are also provided for. You can also have an escort if it is a medical requirement (or a parent/guardian to accompany a child)

Q. CK has personal experience where she had been told to be ready for two hours before the pick-up time. This had meant getting up at around 6:00 am to be picked up at 9:00. The return journeys can also be hours after you actually need it so again more waiting around. Will this be looked at?
A. The new service will look to provide consistency and also with better communication so that patients at least know what is happening.

Q. Also the phone line is not available for long enough – if you have an appointment after 4:00pm on a Friday and they say they want you in again on the Monday morning the phone line isn't open to book any transport
A. The commissioners are aware of this so the new contract will include extended hours of an evening and also over the weekend plus making sure that there are enough lines so that the service is more easily available.

Q. TH asked if technology could be used to track transport so that patients could find out exactly when their pick-up would be in the same way as you can track an Uber cab. Or maybe the crew could text?
A. It is hoped to develop an app with the new provider as this would be a big improvement to the service for patients.

9.	**Items to Escalate:**
	There were no items to escalate to the Board Assurance Framework. There were no items to escalate to other committee's / the Board. There were no items escalated from other committee's / the Board.
10.	**Any Other Business**
	MC wanted to update the group on the Patient Panel at Basildon Hospital that she is involved with. As part of the panel she has taken part in ward inspections. Also partners are coming in from two other hospitals to take part in inspections. The panel are now organising their own patient experience visits so those on the panel will be trained to go on the wards with patients to get feedback on the hospital services. AHu asked BR if she could provide an update on recent Healthwatch activity. BR stated that the last quarter has been very busy. Health Watch has carried out pieces of work on: Sexual Violence against women – information has been collated and a report is going to Public Health. Brighter Futures – working with troubled families and children in need and talking to children, carers, young people, parents and professionals about children's services. Long Term Conditions – Looking at whether care packages are good enough and whether the support is there for patients to take care of themselves. Usual contact with various groups in the local area has continued. The Ten-year Plan survey report is due out next week. Health Watch are co-ordinating views on the Health Service now and the vision for the future incorporating Essex and Southend data. This should be published by the end of the month. Findings have shown that online surveys do not get the best responses so Healthwatch have carried out face-to-face and paper based work. AHu informed the group that the Orsett Hospital closure went to the Secretary of State for a decision and there may be an outcome by the 19th July so to look out for any news on this. There may possibly be parts that will be sent out for further consultation. AHu thanked everyone for attending and closed the meeting.
Date of Next Meeting	
Tuesday 17th September 2019 at 4:00 pm	