Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year 2017/18
Date of Meeting Tuesday, 12th March, 2019

Minutes of the proceedings of the Health in Hackney Scrutiny Commission held at Hackney Town Hall, Mare Street, London E8 1EA

Chair	**Councillor Ben Hayhurst**
Councillors in Attendance	**Cllr Peter Snell, Cllr Yvonne Maxwell (Vice-Chair), Cllr Deniz Oguzkanli, Cllr Emma Plouviez and Cllr Patrick Spence**
Apologies:	
Officers In Attendance	**Anne Canning (Group Director, Children, Adults and Community Health), Tessa Cole (Head of Strategic Programmes and Governance), Dr Sue Milner (Director of Public Health) and Gareth Wall (Head of Commissioning for Adult Services)**
Other People in Attendance	**Councillor Feryal Demirci (Deputy Mayor and Cabinet Member for Health, Social Care, Transport and Parks), David Maher (NHS City & Hackney Clinical Commissioning Group), Shirley Murgraff, Mark Rickets (City and Hackney CCG), Kirit Shah (City & Hackney Local Pharmaceutical Committee), Jon Williams (Director, Healthwatch Hackney), Ian Barratt (GP Access) and Irfhan Mururajani (Egton)**
Members of the Public	
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Councillor Ben Hayhurst in the Chair

1 Apologies for Absence

1.1 Apologies for absence were received from Simon Galczynski, Ilona Sarulakis.

1.2 An apology for lateness was received from Dr Mark Rickets.

1.3 The Chair welcomed Dr Sue Milner the new City and Hackney Director of Public Health.

2 Urgent Items / Order of Business

2.1 The order of business was as on the agenda.

2.2 The Chair stated that he would be asking, under Any Other Business, the CCG to comment on the closure of Sorsby GP Practice.

3 Declarations of Interest

3.1 Cllr Maxwell stated that she was a member of the Council of Governors of Homerton University Hospital NHS Foundation Trust.

3.2 Cllr Snell stated he was chair of the Board of DABD UK, a disability charity.

4 Minutes of the Previous Meeting

4.1 The Minutes of the meeting held on 4 February were agreed as a correct record.

4.2 Members noted the Matters Arising as set out. Cllr Snell commended the letter which the Chair sent to the Secretary of State regarding the local impact of overseas visitor charging regulations for NHS services on vulnerable migrants.

RESOLVED:	**That the minutes of the meeting held on 4 February 2019 be agreed and the matters arising be noted.**

5 Review on 'Digital first primary care..' Evidence from system providers

5.1 The Chair stated that the Commission would proceed with the next evidence gathering session for its review on 'Digital first primary care and the implications for GP Practices'. He welcomed to the meeting

Ian Barratt (IB), Training Partner at GP Access (provider of Ask My GP platform)
Irfhan Mururajani (IM), Egton Services Development Manager.

5.2 Members gave detailed consideration to a paper from GP Access and to a tabled presentation from Egton

5.3 Introducing his presentation IB stated that he welcomed with the added impetus the government had given its plans for digital primary care and there was a need for patient demand to be understood and patient need to be managed more quickly. Ask My GP maintains the GP at the heart of the process and was a complete workflow solution. The sifting was done by GPs and nobody else. The previous week their GPs had deal with 15000 requests with an average completion time of 83 mins. Their approach leads to a reduction in stress levels for working GPs and a reduction in the use of locums by Practices as the system is run more efficiently. He cautioned that online access on its own won't effect change, instead there need to be full segmentation of the process and they can help with this.

5.4 IM introduced his presentation by stating that Egton was an online triage system and the company was part of the EMIS group which had a long history of working in NHS practices. Theirs was a web based platform it operated from a cloud and there was no downloading of software and crucially no patient data was held by them. The two entry points were online or via an EMIS web app and the patient were signposted appropriately. The practices they worked with in Newham had reduced their number of Do Not Attends (DNAs) by 50% and only 25% of those who completed forms i.e. used the system, needed to see a GP in the end. Waiting times went down from 4 weeks to 1 or 2 days. In the past their GPs would see 18 patients in 3 hours face to face. Now they could process 30 online queries with the result that satisfaction and morale goes up.

5.5 A Member asked how GP Access and Egton were being evaluated. The Chair explained that the GP Confederation were overseeing the new pilots involving key providers such as GP Access and Egton and he would ask them for further input on the result of their analysis. He added that he and Cllr Maxwell had gone on a site visit to Lower Clapton Practice to see Ask My GP in operation and to discuss it with one of the GP partners who was one of the leading early adopter GPs championing a move to digital within the Confederation.

5.6 Members asked what barriers were found in GP training and about those on the wrong side of the digital divide e.g.the elderly, those for whom English is not a first language and those who are not very technically confident.

5.7 IB replied that in Ask My GP their oldest patient was 82. There was total transparency about the system within Practices, it was GP led and they would be aware of and cater for the minority of patients who would struggle in adapting to the new system for appointments, for example. He added that each practice who uses their platform uses it in their own way. Typically the morning is used for dealing with online (and GPs dairies are blocked out for this in the system) and in the afternoon they see face to face those who have to be called in. Generally 90% get seen on the same day, which is a vast improvement and people can book in the next day. The number of DNA s plummets with this system and he added that with the old system the further out you allowed patients to book the higher the incidence of DNA. On training he added that the approach was intuitive. There was a User Group in each Practice and they gave constant suggestions for improvements and they had not experienced any major difficulties with training.

5.8 IM replied that their eldest user was 96 years old. Their system allows optimisation time management and they had not encountered any issues around training. In their system people could not just go on and book, instead they had to submit a request or ‘form’ online and this empowers the GPs to deal with the issues. For many just going on the system meant they found an answer to their query and so did not submit a form asking for an appointment. It gave the GPs the right information that was useful to them and the red flag system allowed GPs to keep control of the process.

5.9 Members asked what monitoring of equalities groups was being done and whether there a danger that Practices would lose or discourage people from engaging because of literacy, language, disability etc.

5.10 IM replied that the Stratford Village Surgery which they work with is one of the most densely populated and diverse practice areas in the country and they worked

hard with the Practice on accessibility issues re language and literacy. He added that 'frequent flyers' or the 'worried well' could be easily identified and managed in this approach. They additionally had receptionists who spoke the local community languages and patients were encouraged to bring family members. Members cautioned that there were serious equalities objections to allowing family members to do the interpreting and that these 'forms' created a barrier for those with literacy problems. IM replied that they were very conscious of this issue and they used accepted NICE pathways and their system was as robust as it could be. There would always be a small percentage who would have challenges in this system and the task then was to ensure these were identified quickly and given alternatives to assist them. The Practices would still allow walk-ins and help patients to get appointments and use the system so they would be treated the same as those who successfully used it online. He gave the example of a practice in Plaistow, in a particularly diverse and challenged area, where they already had 80% now using online.

5.11 Members commented that the 'form' filling in the Egton system still constituted a barrier unlike in Ask My GP.

5.12 IM replied that it was up to each Practice to design their own form. The general approach was that you can't just phone and if you are able you first go online for the initial triage. Those who are most vulnerable will be prioritised for call back. The value of this approach was that if frees up time so more GP appointments can actually then be offered and the majority who will get a same day appointment.

5.13 Members asked about data retention of patient data by Egton and Ask My GP.

5.14 IB replied that they don't have access, it was only the Practice that had access to patient data. He detailed various scenarios including one where a patient made 15 requests in a month. This is managed by the GP and there is no loss of data integrity. If a parent submits a request on a child or if a child themselves submits a request this is then linked to the parent/guardian. So there is retention within the system but GP Access cannot access the personal information. Also no patient can see the records of any other. GP Access was governed by the same NHS Governance requirements which were on all companies working in the NHS and they had to meet stringent NHS security requirements for their systems. Members asked if GP Access could provide more detail on how Ask My GP ensures patient confidentiality and how data retention is managed.

ACTION:	**Ian Barratt to provide further documentation on how GP Access manages retention of data.**

5.15 IM replied that the same regulations applied to Egton. Patients' using EMIS systems can be confident that their data is controlled by their GP Practice.

5.16 The Chair thanked GP Access and Egton for their attendance and for their cooperation with the review and stated that a copy of the report would be sent to them once completed.

RESOLVED:	**That the reports and discussion be noted.**

6 Review on 'Digital first primary care..' evidence from Hackney KONP

6.1 The Chair asked if the representatives from GP Access and Egton could remain for this item and they agreed.

6.2 Members gave consideration to a submission from Hackney Keep Our NHS Public (KONP) and the Chair welcomed Shirley Murgraff (SM) who took Members through their briefing.

6.3 SM stated that firstly KONP would like to included as stakeholders on all future reviews which have relevance to their remit. They also took issue with the reference in the Terms of Reference methodology section which implied Members would only be hearing from Hackney Matters. In her view that group would be predominantly younger and more digitally enabled residents and so would not would not be very representative on an issue such as digital primary care. She added that KONP was a well informed group of resident s concerned about the privatisation and financialisation of the NHS.

6.4 She stated that KONPs objections to GP at Hand were because there had been no independent scrutiny of its parent company Babylon. They made no reference to patient monitoring or to having any Patient and Public Involvement Groups. In their view Babylon was about destabilising General Practice with the result that there would be less money available for primary care. Also, Hammersmith and Fulham CCG had run up a huge deficit as a consequence of GP at Hand being based in their area and the other London CCGS had been asked to bail them out. She concluded that the contribution of GPs in the local community was immense and it was vital that the Commission and others supported them.

6.5 The Chair asked whether KONP drew a distinction between Babylon and companies such as Egton and GP Access who are working within local GP Practices.

6.6 SM replied that once the private sector got involved the public loses transparency and accountability and the primary duty of private companies was to maximise value to shareholders. This was why these players need independent scrutiny.

6.7 A Member commented that Dr Jacky Applebee of Tower Hamlets LMC had tabled some flyers at the last meeting which Tower Hamlets KONP had produced warning the public about the dangers of being de registered and these were included in the agenda for this meeting under matters arising at p.21-22. He suggested that the Commission should consider making a recommendation as part of this review that similar flyers and publicity material be produced in Hackney with the same message. Members agreed.

6.8 A Member commented that over a relatively short period of time a number of large entities had come to dominate the market and this begged a lot of questions especially for central government. Another countered that private providers had always been an important part of the NHS and the issue was if these digital systems can be provided in a way which provides equitable access for all.

6.9 Irfhan Mururajani (IM) stated that Egton was not looking to decimate patient lists because that was not their function, instead they worked with CCGs to help them to deliver better patient outcomes. They were subject to all the Information Governance regulations of NHSE and NHS Digital. The Chair intervened that the

issue surely was how the NHS's own national Apps etc will sit alongside the plethora of local systems now in place and he agreed.

6.10 Ian Barratt (IB) added that GP Access (Ask My GP) was also not in the business of siphoning off patients from GP lists. They do not provide an alternative to GP services. He added that CCGs were increasingly using procurement mechanisms which were making their work more challenging but they were not going to water down their offer although in some cases they might be pricing themselves out of certain markets.

6.11 SM returned to the issue of the lack of service user input by these companies. IF replied that they work with closely with the PPI groups in each practice they are in and they explore a number of mechanisms for providing feedback and learning from customer experience.

6.12 Dr Mark Rickets (MR), Chair of the C&H CCG, stated that in terms of local adoption of any national Apps or systems, work was ongoing here. He also added that no GP Practice had any intention to move totally digital as this would never be possible. All GP Practices were doing joint or parallel services and there great challenge will be to align this with incoming national approaches.

6.13 The Chair added the developer of the NHS App from NHS Digital would give evidence to the next meeting and he thanked participants for their papers and contributions.

RESOLVED:	**That the report and discussion be noted.**

7 Action Plan responding to CQC report on Housing with Care service

7.1 The Chair stated that they would now return to the issue of the CQC inspection report on the Council's Housing with Care services which had been rated 'Inadequate' and which had been discussed briefly at the last meeting and at which officers were asked to return with a detailed report. The Chair welcomed for this item:

Anne Canning (AC), Group Director, CACH
Gareth Wall (GW), Head of Commissioning – Adult Services
Jon Williams (JW), Director, Healthwatch Hackney
Amanda Elliot (AE), Commuinications and Intelligence Manger, Healthwatch Hackney

7.2 Members gave consideration to three papers:

(a) Action Plan from Adult Services in response to the CQC report
(b) The CQC Inspection report
and a tabled paper which from Healthwatch Hackney who had been commissioned to run feedback meetings with residents and relatives of those affected after the publication of the CQC report:
(c) *Hackney Housing with Care – Feedback from residents' and relatives' meetings 6-14 Feb 2019*

7.3 Introducing the action plan AC stated that it was important to keep in mind that this service dealt with some very vulnerable residents. The Council had been able to give reassurance to the CQC on 8 March (deadline for submitting its action plan) that

the direction of travel was now towards having a much more stable service. All the most urgent issues (as listed in 2.7 of the report) had been immediately addressed including the risk assessments on medicine management. Healthwatch had joined managers in the meetings with the residents and their relatives and their report on that would be considered fully. It was also the intention to work more closely with the housing providers here to improve the housing aspects of the issue. The publication of the CQC report had had a major impact on the whole department and major resources were deployed to address the problems. There was a need to do more in relation to service users with dementia and this was being addressed. Work was also going on to improve governance and management. Because the directorate was a major commissioner it already had in place a Provider Concern Protocol which was used when problems occurred with commissioned services and those same criteria were now also being employed in assessing and evaluating the shortcomings found in this in house service. Regular updates were being given to the Lead Member. She concluded that input from service users and evidence of co-production would be a key part of implementing the action plan and she would report back to the Commission following the CQC's re-inspection.

7.4 AE introduced the Healthwatch report. She stated that they had found that communication had been patchy and where there had been continuity of care that had been good but there had been too much dependence on agency staff who had been generally less effective. A general conclusion was that the eye had been taken off the ball as regards this service as so much focus within the directorate was on the commissioned services. The CQC rightly had concerns about the lack of or poor quality of Personal Care Plans where a one size fits all approach has unfortunately been used by managers. While there were of course many challenges in providing care in a number of different supported housing settings some service users had not had their care plans changed in three years. There had been a degree of responsibility shunting and many service users did not seem to be aware of how much care they were supposed to be receiving and some had been left physically stranded in housing at times.

7.5 Members asked why Person Centred Care, which came in in 2001, was still not being properly applied in 2018, commenting that it needed to be much more than a template and instead was about the attitude and how you worked with service users. Concerns were also expressed about the degree of reliance on agency staff and the amount of training they needed to receive. Members asked why the quality of agency staff had not been as high as expected and if service users were not getting the standard of care which was required was this then the correct provision for them.

7.6 AC replied that the issue was not the quality of the agency staff but quality of the record keeping which had taking place. Lots of work was now going into ensuring the care workers have the support they need and that managers are asking the right questions of them. Agency staff come highly trained already but the issue was about getting them up to speed on local processes and proper record keeping. Person Centred Care was vital and ensuring move-on where relevant and the voice of the service user had to be key to the process. She confirmed that there was regular training on personalisation of care.

7.7 A Member asked why the proportion of agency staff had crept up.

7.8 AC replied that there were a number of factors but there would always be a need for agency staff to complement the permanent workforce but the balance had

shifted and work was going on to stabilise the service. He asked further whether these findings had exposed that the staffing in the service was too thin with the result that it failed and now more staff had to be temporarily drafted in to urgently address the issues required in the improvement plan. He asked why this was not referred to in the report. AC replied that the CQC did not go into staffing numbers. It's for the service to get the support and the staffing right so that the service delivers. The CQC had exposed that this particular service had not kept up to date with standards of best practice and that it had not been monitored sufficiently and this was now being carefully addressed.

7.9 A Member asked if there had been any signs that the service was in trouble.

7.10 AC replied that the in-house Home Care service had been rated 'good' in 2016. On this service, a judgement had been made on areas of focus and there was later a view that it was not performing as good as it should be. It was ironic that within the directorate the Provider Concern Protocol had been highly praised as a useful tool for reviewing the performance of commissioned services but enough attention had not been given to this one in-house service. JW added that Healthwatch was now also working closely with the Council on Home Care and would be part of a stakeholders meeting with both Adult Services and Public Health the following day. AC added that two of their services Shared Lives and Housing with Care were externally moderated.

7.11 Members asked what the benchmark was for training agency staff.

7.12 AC explained the detail including that regular supervision was focused on internal staff and there was not high level supervision of agency staff. The aim was to hit 80:20 balance of staff to agency. It was also important to note that these staff required sensitive handling as they themselves were front line and under a lot pressure.

7.13 Members asked whether enough resource was being put in and asked whether there needed to be more careful monitoring of agency staff numbers.

7.14 AC repeated that the CQC did not make comments on finance or staffing. Obviously if resources were directed to an area that was underperforming that was at the expense of something else. Going forward there would be a need to look at how the care elements and the housing elements fitted together better as there were financial consequences. Cllr Demirci interjected that this was not a service which had been deprived of funding. Generally social care was underfunded on a national basis. She also added that there was a corporate commitment in the Council to reduce the number of agency staff as the percentage is still higher than they would want it.

7.15 The Chair thanked officers and Healthwatch for their reports stating they were both balanced and insightful and stated the Commission would like officers to return in 6 months, irrespective of whether the CQC re-inspection had been completed by then.

ACTION:	**a) Group Director CACH to provide an update to the Commission at its September meeting on the implementation of the action plan and of the Healthwatch Hackney recommendations.** **b) Healthwatch Hackney to provide its own update to the September meeting focusing on the views of service users and relatives.**

RESOLVED:	**That the reports and discussion be noted.**

8 Review on 'Supporting adult carers' tracking implementation of recommendations

8.1 The Chair stated that it was customary for Scrutiny Commissions to revisit their reviews one year after the Executive Response to check on implementation of their Recommendations and Members gave consideration to the Recommendations Tracker document for their review on 'Supporting Adult Carers'. He welcomed for this item:

Anne Canning (AC), Group Director, CACH
Gareth Wall (GW), Head of Commissioning – Adult Services, CACH
Tessa Cole (TC), Head of Strategic Programme and Governance, CACH
Amanda Elliot (AE), Communications and Intelligence Manager, Healthwatch Hackney

He added that the Recommendations Tracker contained responses from Adult Services, City and Hackney Carers Centre and from the local Alzheimer's Society.

8.2 GW took Members through the report noting that the Carers Service had since been through a re-commissioning exercise and as part of that they had used co-production approach with a Carers Coproduction Group. He explained that the new model broadly had 2 elements:

a) tendering for a '*Prevention, Early Intervention and Outreach'* service AND
b) Insourcing the '*Longer Term and Targeted Support'* element which would be provided jointly by the Council in conjunction with ELFT

He referred to the response from Carers Centre to Rec 11 and took issue with their scepticism about whether the new model would be effective, adding that by using social workers at this stage of the process they would speed up the assessments.

8.3 The Chair thanked officers for the report and added that he was pleased that the Commission's own review had played a role in shaping the design of the new service which was then re-commissioned.

8.4 Members asked whether additional resource was going into the system as social workers would now have more of a role in completing the assessments and whether they would have the time.

8.5 GW replied that the new system was about releasing resource in the system by re-designing the pathways of provision. He described the '3 Conversations' model that was being applied and explained how resources were being deployed to support staff to better understand assessments. There would also be an increased focus on outreach.

8.6 Members asked how the Carers Co-production Group had inputted to the re-design.

8.7 GW replied that this approach had proved very positive and how working out how to do this had led to real change in the service. The stakeholders and service users helped the team improve pathways and it helped articulate a lot of issues which had not previously been properly aired. Participants helped with the design of flow charts and the process revealed problems such as the amount of times carers are required to repeat their story.

8.8 AE stated that the Local Account had revealed that there had been a drop in the number of carers in receipt of Direct Payments and this fall off in numbers was worrying. There were issues here around a significant cohort who were effectively hovering round the edges of statutory provision and who are not receiving the support they badly needed. Too many were losing support as they were deemed not Care Act compliant and this added to the burden on their carers.

8.9 GW replied that this was a challenge that the service was fully aware of. The focus was on making the right provision for the individual to address their needs rather than taking a generic approach to a type of service user. The service was looking closely at what was already being provided and why and examining past assessments to ensure that the right decisions had been made and what learning could be taken from it.

8.10 The Chair thanked the three services for completing the Recommendations Tracker and the officers for their attendance.

RESOLVED:	**That the report and discussion be noted**

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9 Hackney Local Account of Adult Care Services 2017/18

9.1 The Chair stated that each year the Commission received the Local Account of Adult Social Care Services and he welcomed for this item:

Tessa Cole, Head of Strategic Programmes and Governance, CACH
Anne Canning, Group Director CACH

9.2 Members gave consideration to a cover report summarising they key issues and to the full *Hackney Local Account of Adult Care Services 2017/18.*

9.3 TC took Members through the reports adding that this Local Account was non statutory but was still done by the Directorate as it provided a useful survey and overview of activity over a year. They had taken on board all the suggestions from improvement to the style and format of the document which they had received last year, including from the Commission. She added that they also welcomed the valuable input of Healthwatch.

9.4 Members commended the report as accessible and very well presented. The Chair commented that it covered the year to the end of April 2018 but was being published in February 2019 and questioned whether this time lag made it less useful.

9.5 TC replied that yes it did look backwards but a shorter lead in would have resource implications. The delay was because, to be useful, it has to include

Hackney's statutory national returns and these then do not get validated for some time before they can be used. During April to June a lot of time in the team is focused on other statutory reporting and this has to take precedence. It would be challenging to produce it earlier in the year in any useful level of detail, she added.

9.6 Members asked why it didn't pick up on the issues with Housing with Care.

9.7 AC replied that it would have been difficult for it pick up on larger systemic issues although it did pick up on some live issues. There is a question for next year in how it might be re focused. There was a need to examine where the critical inputs were and for example one ongoing challenge of whether Healthwatch could also be able to access social care clients receiving services in their homes as they do with NHS patients or care home patients as part of Enter and View inspections.

9.8 The Chair thanked the officers for the reports and for their attendance.

RESOLVED:	**That the reports and discussion be noted.**

10 Verbal update on work of INEL JHOSC

10.1 The Chair stated that further to the cover note he now also had details of the agenda items for the next meeting which would be held on 3 April at the Old Town Hall in Stratford. These would be:

a) North East London Estates Strategy
b) NHS Long Term Plan and update from the Single Accountable Officer for the ELHCP (Jane Milligan)
c) NHS Staffing
d) INEL JHOSC terms of reference and protocols

For the Estates Strategy item there would be a response to the paper from the North East London Save Our NHS (NELSON) group which comprises the Keep Our NHS Public groups from the 8 boroughs.

RESOLVED:	**That the information be noted.**

11 Health in Hackney Scrutiny Commission- 2018/19 Work Programme

11.1 Members noted the updated work programme.

RESOLVED:	**That the updated work programme be noted.**

12 Any Other Business

12.1 The Chair stated that he had two items of AOB:

Minor Ailments Scheme being continued to 1 Oct 2019

12.2 The Chair reminded Members that the Commission had lobbied on the end of the Minor Ailments Scheme in City and Hackney pharmacies and he was pleased to

report that NHSE had sent a letter to the CCG confirming that they would continue to commission existing minor ailments schemes in London whilst they have further discussions with the Pharmacy Providers about the recommissioning of revised schemes. The letter stated that

"The current Minor Ailment Schemes will continue to be commissioned and paid for beyond 31st March 2019, until the process for an alternative scheme has been exhausted with the CCGs, after which, either a revised scheme, that does not conflict with the OTC guidance, will be commissioned or formal notice will be served on the existing services"

Call from Healthwatch for public reps to join Integrated Commissioning Workstreams

12.3 The Chair stated that Healthwatch, on behalf of the Integrated Commissioning workstreams, was inviting potential public representatives to an information session on 13 March at Graeae Theatre, 138 Kinglsand Rd at 7.00pm and he encouraged Members to spread the word. The representatives need to be "*Hackney or City residents, interested in improving the health and wellbeing of their community and keen to develop new ways to help people to live longer and happier lives*" he added.

Closure of Sorsby GP Practice and dispersal of list

12.4 The Chair invited the Chair of the CCG to provide an update on the just announced closure of the Sorsby GP Practice.

12.5 Dr Mark Rickets (Chair, City and Hackney CCG) stated that Sorsby had an APMS type GP contract which was time limited and when the CCG decided to re procure there had been no takers for the contract. Because of this Lower Clapton Medical Practice had taken on the management of it on an interim basis and had operated it as a satellite but that arrangement had now also come to an end. The Practice was in a poor state of repair and for some time had been kept going with locums. It lost staff and nursing staff and patients had also decided to move to Lower Clapton, where most of the staff were coming from. The process of securing a new provider was being overseen by the local NHS Commissioning Support Unit. The list size at Sorsby had been dropping and it would only operate at a loss and despite the work to turn it around, it was proving impossible to secure a GP contract holder. Because of this a decision was taken by the CCG's Primary Care Contracts Committee (GPs Practices are now commissioned locally) to have the list dispersed among the local practices. Sorsby had 4000 patients but this had dropped to 3000 and the benchmark in the NHS was that any practice below 6000 was a candidate for dispersal if a procurement exercise failed. At least 6 neighbouring Practices would take on the patients. Lower Clapton would continue to run the practice until the end of June and the practices receiving the additional patients would receive further funding.

12.6 Members stated that this was very disappointing and asked whether the CCG was aware of any other practices in the borough which might be in similar straits. MR replied that there weren't any which were similar. There was one other APMS contract due for re-procurement in 2 years' time.

12.7 Cllr Demirci provided reassurance to Members that all the patients at the Practice had been written to and dedicated support had been provided for patients by the NHS. Local ward councillors had also been fully informed.

12.8 The Chair asked if Dr Rickets would come back with a further update on the situation.

ACTION:	**CCG Chair to provide a further update on the dispersal of the patient list at Sorsby Medical Practice.**

Orthopaedic Surgery waiting times at HUHFT

12.9 Shirley Murgraff (Hackney KONP) drew Members' attention that the Homerton University Hospital Trust had been missing its targets for orthopaedic surgery. The wait was 4 to 6 months and the 18 week target was from the date of referral not the date of appointment. There was a 6 week wait for referrals and then some were waiting 6 months for surgery meaning that the Trust was 8 or 9 weeks over target. The Chair thanked her for bringing this to the Commission's attention.

Provision of Intermediate Care beds

12.10 Shirley Murgraff (Hackney KONP) suggested that the Commission should keep a watching brief on the issue of intermediate care beds in the borough. 12-16 beds had once been recommended as the target and the borough was now down to only 3 or 4 and current trends seemed to completely alter what our understanding of 'intermediate care' should be. The Chair thanked her for bringing it to the Commission's attention and suggested that Cllr Maxwell might be able to raise this issue and the orthopaedic surgery issue at the HUHFT Council of Governors of which she is a member. The Chair stated that he would discuss with the Group Director CACH having a stand alone item at the future meeting on the issue of intermediate care.

ACTION:	**That a briefing from the Group Director CACH on intermediate care provision be scheduled for a future meeting.**

Duration of the meeting: 7.00 - 9.15 pm