Agenda

INEL JHOSC

Inner North East London Joint Health and Overview Scrutiny Committee

Date **Wednesday 13th February 2019**

Time **7.00 p.m.**

Venue **Council Chamber, Old Town Hall, Stratford, E15 4BQ**

Contact: via Robert Brown, Senior Scrutiny Policy Officer, robert.brown@newham.gov.uk

MEMBERSHIP	
Councillors: Councillor Christopher Boden Councillor Kahar Chowdhury Councillor Dr Rohit Kumar Dasgupta Councillor Ben Hayhurst Councillor Michael Hudson Councillor Saima Mahmud Councillor Yvonne Maxwell Councillor Anthony McAlmont Councillor Catherine Saumarez Councillor Patrick Spence Councillor Richard Sweden Councillor Winston Vaughan **Observers:** Councillor Catherine Saumarez Councillor Saima Mahmud Councillor Michael Hudson Councillor Richard Sweden **(Quorum: 7, from 2 Boroughs)**	**Officers usually in attendance:** Robert Brown, Senior Scrutiny Policy Officer

Rokhsana Fiaz
Mayor of Newham

Katherine Kerswell
Chief Executive

Agenda

1. Welcome and Introductions

2. Apologies for Absence

3. Election of Chair (Pages 1 - 2)

The Committee Members are asked to PROPOSE and SECOND nominations for Chair of the INEL JHOSC. Members are then asked to VOTE for nominations.

4. Election of vice-Chair (Pages 3 - 4)

The Committee Members are asked to PROPOSE and SECOND nominations for vice Chair of the INEL JHOSC. Members are then asked to VOTE for nominations.

5. Declarations of Interest Register (Pages 5 - 6)

This is the time for Member to DECLARE any interest they may have in any matter being considered at this meeting. The Code of Conduct is set out in Part 5.1 of Newham Council's Constitution.

6. Minutes of Previous Meeting (Pages 7 - 16)

The Committee are asked to AGREE the accuracy of the minutes of the previous meeting.

7. INEL JHOSC Terms of Reference (Pages 17 - 24)

The Committee is asked to APPROVE the INEL JHOSC Terms of Reference.

8. INEL JHOSC Protocols (Pages 25 - 36)

The Committee is asked to APPROVE the INEL JHOSC protocols.

9. NHS Long Term Plan (Pages 37 - 38)

The Committee is asked to NOTE the verbal update and future plans of ELHCP and the NHS Long Term Plan.

10. Patient Transport (Pages 39 - 72)

The Committee are asked to:

- ENDORSE the introduction of the Department of Health's medical eligibility criteria for NEPTS (Non Emergency Patient Transport Service) across Barts Health NHS Trust and in conjunction with the WEL CCGs;
- ENDORSE the actions already taken with regards to engagement;
- Submit additional recommendations for patient transport improvements;
- Submit additional recommendations for patient transport savings.

11. INEL JHOSC Work Plan (Pages 73 - 76)

The Committee are asked to APPROVE on the draft INEL JHOSC Workplan.

INNER NORTH EAST LONDON (INEL)
JOINT HEALTH and OVERVIEW SCRUTINY COMMITTEE (JHOSC)

Report title	**Election of Chair**
Date of Meeting	Wednesday 13 February 2019
Lead Officer and contact details	**Robert Brown** Senior Scrutiny Policy Officer DDI: 020 3373 7142 I robert.brown@newham.gov.uk
Report Author	**Robert Brown** Senior Scrutiny Policy Officer DDI: 020 3373 7142 I robert.brown@newham.gov.uk
Witnesses	n/a
Boroughs affected	• City of London Corporation • Hackney • Newham • Tower Hamlets

Recommendations:

The Committee Members are asked to **PROPOSE** and **SECOND** nominations for Chair of the INEL JHOSC. Members are then asked to **VOTE** for nominations.

Background

INEL JHOSC have not met for a while and the previous meeting was held over 12 months ago as a virtual meeting. There are new Cllrs on INEL JHOSC and as such a new Chair and vice-Chair need to be proposed, seconded and voted for.

Key Improvements for Patients

- n/a

Implications

Financial Implications

n/a

Legal Implications

n/a

Equalities Implications

n/a

Background Information used in the preparation of this report

- n/a

INNER NORTH EAST LONDON (INEL)
JOINT HEALTH and OVERVIEW SCRUTINY COMMITTEE (JHOSC)

Report title	**Election of vice Chair**
Date of Meeting	Wednesday 13 February 2019
Lead Officer and contact details	**Robert Brown** Senior Scrutiny Policy Officer DDI: 020 3373 7142 I robert.brown@newham.gov.uk
Report Author	**Robert Brown** Senior Scrutiny Policy Officer DDI: 020 3373 7142 I robert.brown@newham.gov.uk
Witnesses	n/a
Boroughs affected	• City of London Corporation • Hackney • Newham • Tower Hamlets

Recommendations:

The Committee Members are asked to **PROPOSE** and **SECOND** nominations for vice Chair of the INEL JHOSC. Members are then asked to **VOTE** for nominations.

Background

INEL JHOSC have not met for a while and the previous meeting was held over 12 months ago as a virtual meeting. There are new Cllrs on INEL JHOSC and as such a new Chair and vice-Chair need to be proposed, seconded and voted for.

Key Improvements for Patients

- n/a

Implications

Financial Implications

n/a

Legal Implications

n/a

Equalities Implications

n/a

Background Information used in the preparation of this report

- n/a

INNER NORTH EAST LONDON (INEL)
JOINT HEALTH and OVERVIEW SCRUTINY COMMITTEE (JHOSC)

Report title	**Declarations of Interest**
Date of Meeting	Wednesday 13 February 2019
Lead Officer and contact details	**Robert Brown** Senior Scrutiny Policy Officer DDI: 020 3373 7142 I robert.brown@newham.gov.uk
Report Author	**Robert Brown** Senior Scrutiny Policy Officer DDI: 020 3373 7142 I robert.brown@newham.gov.uk
Witnesses	n/a
Boroughs affected	• City of London Corporation • Hackney • Newham • Tower Hamlets

Recommendations:

This is the time for Member to **DECLARE** any interest they may have in any matter being considered at this meeting. The Code of Conduct is set out in Part 5.1 of Newham Council's Constitution.

Background

The Code of Conduct is set out in Part 5.1 of Newham Council's Constitution with regards to the Declaration of Interests.

Key Improvements for Patients

- n/a

Implications

Financial Implications

n/a

Legal Implications

n/a

Equalities Implications

n/a

Background Information used in the preparation of this report

- n/a

INNER NORTH EAST LONDON (INEL)
JOINT HEALTH and OVERVIEW SCRUTINY COMMITTEE (JHOSC)

Report title	**Minutes of Previous Meeting**
Date of Meeting	Wednesday 13 February 2019
Lead Officer and contact details	**Robert Brown** Senior Scrutiny Policy Officer DDI: 020 3373 7142 I robert.brown@newham.gov.uk
Report Author	**Robert Brown** Senior Scrutiny Policy Officer DDI: 020 3373 7142 I robert.brown@newham.gov.uk
Witnesses	n/a
Boroughs affected	• City of London Corporation • Hackney • Newham • Tower Hamlets

Recommendations:

The Committee are asked to **AGREE** the accuracy of the minutes of the previous meeting.

Background

INEL JHOSC have not met for a while and the previous meeting was held over 12 months ago.

Key Improvements for Patients

- n/a

Implications

Financial Implications

n/a

Legal Implications

n/a

Equalities Implications

n/a

Background Information used in the preparation of this report

- n/a

LONDON BOROUGH OF TOWER HAMLETS

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

HELD AT 6.30 P.M. ON THURSDAY, 9 NOVEMBER 2017

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

Members Present:

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

Other Councillors Present:

Councillor Richard Sweden	Waltham Forest

In Attendance:

Dr Sam Everington	Chair, Tower Hamlets Clinical Commissioning Group
Daniel Kerr	Strategy, Policy & Performance Officer, LBTH
Denise Radley	Corporate Director, Health, Adults & Community
Rehan Khan	East London Local Maternity Service
Wendy Matthews	East London Local Maternity Service
Kate Brintworth	East London Local Maternity Service
James Cain	Health Education England
Tracey Fletcher	East London Community Health Partnership
Sanjiv Ahlumalia	Health Education England
Ian Tomkins	East London Health and Care Partnership
Steve Gilvin	Newham Clinical Commissioning Group
David Knight	Senior Democratic Services Officer
Rushena Miah	Committee Services Officer

1. APOLOGIES FOR ABSENCE

Apologies were received from Councillor Muhammad Ansar Mustaquim and Councilman Christopher Bolden.

2. DECLARATIONS OF INTEREST

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

Councillor Ben Hayhurst declared he is a Governor at Homerton University Hospital.

Councillor Sweden declared that he is manged by North East London Foundation Trust but he is not employed by them.

3. MINUTES OF THE LAST MEETING AND MATTERS ARISING

Correction on page 10 of the pack, change Terry Bay to Terry Day.

Correction on page 10 – Chairs of JHOSC are not members of the STP board. Statement to be removed.

Clarification on page 13 of the pack, paragraph 4 – Ian Tompkins, Director of Communications East London Health and Care Partnership, added that the East London Health Partnership was launched in July 2017 as an internal meeting but there were reps present. The meeting was targeted at health partners and other government transformation groups. The work on the payment programme was extended to September 2017 and there will be further engagement with interested parties in the New Year.

Councillor Anne Munn added that her interpretation of the discussion was that Councillor Maxwell was asking for an update on the east London health payment system consultation and requested to receive a report on this at the February meeting of this group.

In order to have more time to discuss the topic, the Chair decided that an update on the East London Health and Care Partnership Consultation should be included on the February agenda of this meeting.

It was agreed that a standing item for updates from the new Single Accountable Officer (Jane Milligan) should be included on future agendas.

Mr Tomkins confirmed Jane Milligan was appointed Accountable Officer from 1 December 2017. Shadow arrangements will be in place until April 2018. One of her first tasks will be to look at governance arrangements and the scheme of delegation. He advised that this topic should be revisited at the next meeting.

Councillor Hayhurst expressed concern that Hackney's population may be too small to form a Sustainability and Transformation Partnership (STP). It was confirmed that there was no minimum population figure to form an STP, the half a million figure was guidance and not a requirement.

Having noted the above amendments, the minutes were agreed as an accurate record of the meeting.

ACTIONS

1. **An update on the East London Health and Care Partnership Payment System Consultation to be added to the February agenda of this meeting.**
2. **Chair to provide a list of working groups.**

4. STATEMENTS FROM MEMBERS OF PUBLIC

Michael Vidal

'Will the commission consider referring the decisions of the CCG Boards to the Secretary of State?' My reasons for making this request are:

1. The question of how you can legally remove the existing Accountable Officers and replacing them has not been given a satisfactory answer. I would refer the Commission to paragraph 4.1 of my August submission to the last meeting of the Commission.
2. It is clear from the comments made by some of the members of the City and Hackney CCG Board in approving the proposal they only did so because of a threat from NHS England to use its intervention powers if they did not agree to the proposals.
3. The power to make these arrangements under s.14Z3 of the NHS Act 2006 (as amended) is a discretionary power as can be seen by the use of the word may and not must in the section. Accordingly, in making the threat NHS England caused the NHS City and Hackney CCG Board to unlawfully fetter its discretion.
4. NHS England in saying that matters have to be done at the NEL level are subjecting the statutory function of the CCGs which only relate to people in its area to the need to comply with a non-statutory requirement.
5. The proposal seeks to circumvent the abolishing of Strategic Health Authorities by s.33 of the Health and Social Care Act 2012 by creating bodies with a strategic role but no legal basis.

Mr Vidal's questions were noted.

Jackie Applebee

Our question is: When the NHS is on the point of collapse due to unprecedented underfunding by the current Government, do the councils agree with us that this money would be much better spent on front line patient care?
We also urge the councils to note the most recent Kings Fund report which expresses concerns about STPs and their ability to deliver within the financial constraints:
https://www.kingsfund.org.uk/sites/default/files/2017-09/STPs-London-Kings-Fund-September-2017_1.pdf
and to join with us in insisting that these plans are not deliverable without swingeing cuts to NHS services."

Ms Applebee's question was noted.

5. ITEM 4. MATERNITY

Kate Brintworth, Head of Maternity - East London Health and Care Partnership, introduced the item. As part of the Five Year Forward View the Maternity Transformation Board was set up by NHS England to ensure recommendations from the Better Births Review were delivered. Key areas of action included, reducing still birth, learning, ensuring women have a better experience of care, continuity of care and the option to give birth in a midwifery setting.

It was recognised that collective action would be required to meet the new standards so Local Maternity Systems were introduced to take leadership and action. The East London Local Maternity System (ELMS) provided a report on their activities over 2016/17.

With reference to page 55 of the reports pack, Councillor Ann Munn asked to learn more about the new models of cross boundary working. The Chair of the East London LMS used the Neighbourhood Midwives social enterprise as an example of continuity of care throughout pregnancy to six weeks after birth.

Councillor Ben Hayhurst asked how continuity of processes is maintained when they have five hospital sites across the patch and the Trust is a separate entity.

Ms Brintworth explained that communication between the sites is good because there is an existing network in place that regularly meets. There are five delivery packs used across the sites which have been standardised to save £80,000.

Councillor Susan Masters queried how the ELMS programme will be funded over the next five years. Tracey Fletcher, Chief Executive of Homerton Hospital, informed the Committee that an NHS England bid for £7.5 million had been submitted and feedback on the bid would be given in the New Year.

There was a discussion on the flow of patients across London. Ms Fletcher informed the group that a piece of research has been conducted on demand levels but it was difficult to predict birth numbers due to changing demographics. She said the birth rate is expected to go up but this is unlikely to be by a huge amount. This year there were 2000 less births than the 5000 predicted. There has been a recent trend in more women, particularly from Hackney, choosing to go to north east London hospitals such as the new University College London Hospital (UCLH).

Representatives from Homerton Hospital acknowledged Hackney's changing demographics. They said they needed to challenge the local perception that new hospitals like UCLH have better maternity care because on the whole UCLH and Homerton provide a comparable service.

The discussion moved on to maternal mortality rates. Councillor Hayhurst suggested higher mortality rates in east London may be what is driving patients away. Ms Brintworth explained that the mortality rate is relatively low considering the number of high risk cases that are presented. She said East London hospitals are seeing an increase in the number of older women, diabetic women, obese women and women diagnosed with cancer choosing to give birth. These factors can influence the maternal mortality rate.

Councillor Hayhurst asked what measures were in place to handle a maternity related death. Ms Brintworth said that there was an action plan in place and a report was written on the topic.

The Chair queried if patients were being tracked between births. Ms Brintworth confirmed that all patients had a trackable birth record and that all of the providers within the ELMS had a bereavement team who were able to monitor a patient's wellbeing up to their next birth. One provider piloted a National Care Bereavement Pathway for traumatic birth; this service included the support of a consultant midwife who was available for advice up until the next pregnancy. The pilot produced successful case studies.

It was noted that the slightly higher mortality rate figures between the years 2013-2015 were an anomaly.

It was confirmed that maternity care would be provided to all women regardless of their citizenship status. Overseas patients who have elected to have maternity care in the UK will be billed. A migrant or refugee would not be turned away if they required care but could not afford it.

The Chair thanked speakers for their report and invited them to the Tower Hamlets Health Scrutiny Committee meeting on 8 January 2018 which would be discussing a report on the Royal London Hospital Maternity Services.

RESOLVED

(a) To note the report

6. ITEM 5. WORKFORCE

James Cain, Head of Workforce Transformation, Health Education England, presented the report on Workforce. He said that when the 44 STPs were formed Health Education England was tasked with creating 44 multi-agency action boards.

Population growth has resulted in pressure on health services.
There are pockets in east London which are under doctored. In addition to this the nursing workforce is migrating away due to affordable housing issues.

Workforce retention is included in a work stream. Providing people with careers as opposed to jobs is a key theme in the work. The apprentice levy has increased to enable local people to enter the workforce as local people are more likely to stay on longer term.

The national target for increasing the number of GPs is 500. North East London has a target of employing 19 additional GPs. Given the population demand, new roles are to be introduced into primary care including Physician Associate and Care Navigator. In secondary care, a Nursing Associate role will be introduced.

Dr Sam Everington said that investment is a key factor in retention. Commissioners have invested in training science graduates to learn some GP skills over a 2 year training course. He argued that the diversification of roles is an essential benefit to a changing workforce and used the example of utilising pharmacists to support GPs with paperwork and prescriptions. He also advocated for e-contact consultations.

The Chair asked primary care colleagues what they thought about virtual consultations, also referred to as the Babylon Project. On the whole the GP's agreed that it was a major risk and encouraged 'cherry picking'. They thought the funding formula was rather crude, for example a young person with significant needs would generate the same charge as a low risk patient.

Steve Gilvin, Chief Officer, Newham Clinical Commissioning Group, acknowledged that cherry picking could be an issue but said there would be a menu of options on what could be provided, which was a good thing.

Wendy Matthews, Deputy Chief Nurse /Director of Midwifery, Barking, Havering and Redbridge University Hospital NHS Trust, asked what impact Brexit would have on European nurses.

Mr Cain replied that on average European junior nurses left after two years but experienced nurses tended to stay on. Health Education England is focussing efforts on training newly qualified nurses. There is a Capital Nurse Programme to ensure London nurses are given the best training. With regard

to Brexit, there has not been a significant shift towards nurses leaving the country but the reduction of the pound has resulted in difficulty in attracting European nurses on salary.

Councillor Hayhurst asked a question about housing options available to nurses and whether the health service and local authority worked in a joined up way to ensure key workers were provided with suitable housing.

It was noted that there had been little joined up working with the health service and local authorities on key worker housing. Members suggested offering workers a suite of benefits such as nursery places, housing, and training to encourage people into entering the profession.

Councillor Susan Masters asked about the job roles of the Physician Associates. Dr Everington said some of them will be trained on hospital work and some on GP work. It is envisaged that the roles will specialise in chronic conditions but this will depend on the individual's strengths.

A Member asked what the contingency plan would be if these roles could not be filled. Mr Gilvin responded saying that the GP Resilience Programme has allocated some funding to practices that are struggling. It is not a huge amount but the workstream is there in case intervention and advice is required.

There was a discussion on NHS estates and the sale of land.
Mr Tompkins explained that any sale of NHS assets goes into a general pot with no guarantee that the funds will be allocated to an east London Trust.

Councillor Richard Sweden asked how GPs felt about the dilution of their profession with the introduction of the new roles. Dr Everington responded that initially there was some opposition to the idea but it is now widely welcomed due to the demands on the service.

Mr Gilvin informed the committee about a piece of work on quality improvement with Newham CCG that is being piloted.

RESOLVED

(a) To note the report

The Chair thanked delegates for their contributions and brought the meeting to a close.

7. ANY OTHER BUSINESS

There was no other business.

The meeting ended at 8.47 p.m.

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

INNER NORTH EAST LONDON (INEL)
JOINT HEALTH and OVERVIEW SCRUTINY COMMITTEE (JHOSC)

Report title	**INEL JHOSC Terms of Reference**
Date of Meeting	Wednesday 13 February 2019
Lead Officer and contact details	**Robert Brown** Senior Scrutiny Policy Officer DDI: 020 3373 7142 I robert.brown@newham.gov.uk
Report Author	**Robert Brown** Senior Scrutiny Policy Officer DDI: 020 3373 7142 I robert.brown@newham.gov.uk
Witnesses	n/a
Boroughs affected	• City of London Corporation • Hackney • Newham • Tower Hamlets

Recommendations:

The Committee is asked to **APPROVE** the INEL JHOSC Terms of Reference.

Background

INEL JHOSC have not met for a while and the previous meeting was held over 12 months ago and the Terms of Reference have not been updated for some considerable time. With new Members on the Committee, the ToR have been updated.

Key Improvements for Patients

- n/a

Implications

Financial Implications

n/a

Legal Implications

n/a

Equalities Implications

n/a

Background Information used in the preparation of this report

- n/a

INNER NORTH EAST LONDON (INEL)
JOINT HEALTH and OVERVIEW SCRUTINY COMMITTEE (JHOSC)

TERMS OF REFERENCE

(draft as at 04 February 2019)

INTRODUCTION

1. Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (Reg 30) ensure that there are sufficient scrutiny procedures and policies in place to cover the cross-Borough wide NHS Sustainability and Transformation Plan (STP).

ROLE

2. Consider and respond to any health matter which:
   2.1. Impacts on two or more participating local authorities or on the sub region as a whole, and for which a response has been requested by NHS organisations under Section 244 of the NHS Act 2006; and
   2.2. All participating local authorities agree to consider as an INEL JHOSC

3. To collectively review and scrutinise any proposals within the STP that are a substantial development / variation of the NBS or the substantial development / variation of such service where more than one local authority is consulted by the relevant NHS body pursuant to Reg 30;

4. To collectively consider whether a specific proposal within the STP that's is not a substantial development or variation is only relevant for one authority and therefore should be referred to that local authority's Health Scrutiny Committee for scrutiny;

5. In the event that a participating local authority considers that it may wish to consider a discretionary matter itself rather than have it dealt with by the joint committee it shall give notice to the other participating councils and the joint committee shall then not take any decision on the discretionary matter (*other than a decision which would not affect the council giving notice*) until after the next full Council meeting of the council giving notice in order that the council giving notice may have the opportunity to withdraw delegation of powers in respect of that discretionary matter;

6. To require the relevant local NHS body to provide information about the proposals under consideration and where appropriate to require the attendance of a representative of the NHS body to answer such questions as appear to it to be necessary for the discharge of its function;

7. Make reports or recommendations to the relevant health bodies as appropriate and/or the constituent authorities' respective Overview and Scrutiny Committees (OSC) or equivalent;

8. Each Council to retain the power of referral to the Secretary of State of any proposed "substantial variation" of service, so this power is not *solely* delegated to the JHOSC.

9. To review the procedural outcome of consultations referred to in any substantial development / variation, particularly the rationale behind contested proposals;

10. To undertake in-depth thematic studies in respect of services to which the NHS Trusts contribute and where a study is done on a Trust wide and cross borough basis;

11. To take account of relevant information available and in particular any relevant information provided by Healthwatch under their power of referral;

12. To maintain effective links with Healthwatch and other patient representative groups and give consideration to their input throughout the Scrutiny process;

MEMBERSHIP

13. The INEL JHOSC will be a committee serviced by the participating local authorities on a two-yearly cycle – *the current local authority hosting the INEL JHOSC is the London Borough of Newham* in accordance with section 101(5) of the Local Government 1972;

14. The membership shall be made up of three members from each of the larger participating local authorities and one from the City of London Corporation; making a total of 10 members, with each council's membership being politically proportionate and with non-executive councillors making up the membership.

15. Substitutions will be accepted if a councillor is not able to attend a meeting of the JHOSC and that councillor has informed the Chair and Scrutiny Officer five working days in advance of the meeting.

16. Guidance suggests that co-opting people is one method of ensuring involvement of key stakeholders with an interest in, or knowledge of, the issue being scrutinised. This is already a power of overview and scrutiny committees by virtue of the Local Government Act 2000. However, the Guidance also recommends other ways of involving stakeholders by, for example, giving evidence or by acting as advisers to the committee.

17. A Chair (from the host authority) will be appointed by the JHOSC at the first meeting.

18. A vice-Chair (from non host local authorities) will be appointment by the JHOSC at the first meeting. Where agreed, a second vice-Chair may also be nominated to ensure parity across the Membership.

QUORUM

19. The quorum for meetings will be seven members from at least two local authorities. During any meeting if the Chair counts the number of councillors present and declares there is not a quorum present, then the meeting will adjourn immediately. Remaining business will be considered at a time and date fixed by the Chair. If a date is not fixed, the remaining business will be considered at the next meeting.

DECISION MAKING PROCESS

20. Decisions will be taken by consensus. Where it is not possible to reach a consensus, a decision will be reached by a simple majority of those members present at the meeting. Where there are equal votes the Chair will have the casting vote.

REPORTING ARRANGEMENTS

21. Prior to the agenda for each meeting of the JHOSC being finalised officers will convene a planning / pre-meeting with the Chairs of the individual HOSC's or their nominee, along with key individuals presenting papers from the NHS and other informal briefings as considered appropriate;

22. In terms of the JHOSC's conclusions and recommendations the Guidance says that one report has to be produced on behalf of the JHOSC. The final report shall reflect the views of all local authority committees involved in the JHOSC. it will aim to be a consensual report.

23. In the event there is a failure to agree a consensual report the report will record any minority report recommendations. At least seven members of the JHOSC must support the inclusion of any separate minority report in the committee's final report.

24. Any report produced by the JHOSC will be submitted to the local authority's council meetings for information.

25. The NHS body or bodies receiving the report must respond in writing to any requests for responses to the report or recommendations, within 28 days (*calendar, not working*) of receipt of the request.

26. In the event that any local authority exercises its right to refer a substantial variation to the Secretary of State, it shall notify the other local authorities of the action it has taken and any subsequent responses.

FREQUENCY AND ADMINISTRATION

27. INEL JHOSC to meet quarterly, with at least one meeting within a 12 month period aligned with ONEL JHOSC to consider issues that cover the STP footprint;

28. To constitute and meet as a Committee as and when participant boroughs agree to do so subject to the statutory public meeting notice period;

29. Meetings will usually be led by each authority rotating on a two-yearly basis with the Chair being a councillor from the current lead local authority;

30. The lead authority will be responsible for the servicing of the JHOSC. Suitable officer resources (Legal, Democratic) will be provided to meet the requirements of the committee. This includes (but is not restricted to):

    30.1. providing legal advice;
    30.2. liaising with health colleagues ahead of the meeting;
    30.3. updating action sheets from previous meetings;
    30.4. producing agenda papers and co-ordinating public forum;
    30.5. creating formal minutes and actions sheets;

31. If there is a specific reason, for example, if the issue to be discussed relates to a proposal specific to the locality of one Local Authority area the meeting venue can change to a more appropriate venue. The lead Local Authority would remain the same, even if the venue changes;

32. Any changes to the host authority must be agreed by the committee;

33. Agenda and supporting papers to be circulated and made publicly available at least five working days before the meeting;

34. Actions to be circulated to those with actions as soon as possible after the meeting – no later than 48hrs following the meeting;

35. Minutes of the meeting to be circulated within 10 working days of the meeting;

36. Meetings to be held in public, with specific time allocated for public questions;

PETITIONS, STATEMENTS AND QUESTIONS

37. Members of the public and members of council, provided they give notice in writing or by electronic mail to the proper officer of the host authority (and include their name and address and details of the wording of the petition, and in the case of a statement or question a copy of the submission), by no later than 12 noon ***ONE WORKING DAY BEFORE*** the meeting, may present a petition, submit a statement or ask a question at meetings of the JHOSC. The petition, statement or question must relate to the terms of reference and role and responsibility of the committee;

38. The total time allowed for dealing with petitions, statements and questions at each meeting is thirty minutes;

39. Statements and written questions, provided they are of reasonable length, will be copied and circulated to all members and will be made available to the public at the meeting;

40. There will be no debate in relation to any petitions, statements and questions raised at the meeting but the committee will resolve;

    40.1. "that the petition / statement be noted"; or
    40.2. if the content relates to a matter on the agenda for the meeting: "that the contents of the petition / statement be considered when the item is debated";

RESPONSE TO QUESTIONS

41. Questions will be directed to the appropriate Director or organisation to provide a written response directly to the questioner. Appropriately redacted copies of responses will be published on the host authority's website within 28 days.

42. Details of the questions and answers will be included on the following meeting's agenda.

PRINCIPLES OF EFFECTIVE SCRUTINY

43. Scrutiny undertaken through the JHOSC will be focused on improving the health and health services for residents in areas served by the JHOSC through the provision and commissioning of NHS services for those residents;

44. Improving health and health services through scrutiny will be open and transparent to Members of the Local Authority, health organisations and members of the public.

45. All Members, officers, members of the public and patient representatives involved in improving health and health services through scrutiny will be treated with courtesy and respect at all times.

46. Improving health and health services through scrutiny is most likely to be achieved through co-operation and collaboration between representatives of the various Local Councils, NHS Trusts, representatives of Healthwatch and the Clinical Commissioning Groups commissioning hospital services;

47. Co-operation and joint working will be developed over time through mutual trust and respect with the objective of improving health and health services for local people through effective scrutiny.

48. All agencies will be committed to working together in mutual co-operation to share knowledge and deal with requests for information and reports for the JHOSC within the time scales set down.

49. The JHOSC will give reasonable notice of requests for information, reports and attendance at meetings.

50. The JHOSC, whilst working within a framework of collaboration, mutual trust and co-operation, will always operate independently of the NHS and have the authority to hold views independent of other Members of representative Councils and their Executives;

51. The independence of the JHOSC must not be compromised by its Members, by other Members of the Council or any of the Councils' Executives, or by any other organisation it works with;

52. Those involved in improving health and health services through scrutiny will always declare any particular interest that they may have in particular pieces of work or investigation being undertaken by the JHOSC and thus may withdraw from the meeting as they consider appropriate;

53. The JHOSC will not to take up and scrutinise individual concerns or individual complaints.

54. Where a wider principle has been highlighted through such a complaint or concern, the JHOSC should consider if further scrutiny is required. In such circumstances it is the principle and not the individual concern that will be subject to scrutiny.

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INNER NORTH EAST LONDON (INEL)
JOINT HEALTH and OVERVIEW SCRUTINY COMMITTEE (JHOSC)

Report title	**INEL JHOSC Protocols**
Date of Meeting	Wednesday 13 February 2019
Lead Officer and contact details	**Robert Brown** Senior Scrutiny Policy Officer DDI: 020 3373 7142 I robert.brown@newham.gov.uk
Report Author	**Robert Brown** Senior Scrutiny Policy Officer DDI: 020 3373 7142 I robert.brown@newham.gov.uk
Witnesses	n/a
Boroughs affected	• City of London Corporation • Hackney • Newham • Tower Hamlets

Recommendations:

The Committee is asked to **APPROVE** the INEL JHOSC protocols.

Background

INEL JHOSC have not met for a while and the previous meeting was held over 12 months ago as a virtual meeting. There are new Cllrs on INEL JHOSC and as such a new Chair and vice-Chair need to be proposed, seconded and voted for.

Key Improvements for Patients

- n/a

Implications

Financial Implications

n/a

Legal Implications

n/a

Equalities Implications

n/a

Background Information used in the preparation of this report

- n/a

INNER NORTH EAST LONDON (INEL)
JOINT HEALTH and OVERVIEW SCRUTINY COMMITTEE (JHOSC)

Substantial Variation Protocol

Background

The Inner North East London (INEL) Joint Health and Overview Scrutiny Committee (the "JHOSC") is responsible for undertaking the joint health scrutiny function across local authority boundaries, as set out in:

- National Health Service Act 2006;
- Health and Social Care Act 2012;
- Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013;
- Local Authority Health Scrutiny: Guidance to support Local Authorities and their partners to deliver effective health scrutiny.

There is also statutory guidance for NHS commissioners that is relevant to health scrutiny and public consultation:

- Patient and Public Participation in commissioning health and care: Statutory guidance for Clinical Commissioning Groups (CCG) and NHS England (NHSE).

The JHOSC is responsible for reviewing and scrutinising any matter relating to the planning, provision and operation of the health services in joint areas and across boroughs.

The 2013 Regulations require that where there are proposed substantial developments / variations to health services in an area, the responsible organisations must consult with the JHOSC.

The health scrutiny guidance is clear that the commissioner is responsible for undertaking the consultation (4.3.1):

> *"In the case of substantial developments or variation to services which are the commissioning responsibility of CCGs or NHS England, consultation is to be done by NHS commissioners rather than providers i.e. by the relevant CCG(s) or NHS England. When these providers have a development or variation "under consideration" they will need to inform commissioners at a very early stage so that commissioners can comply with the requirement to consult as soon as proposals are under consideration."*

The JHOSC must invite the views of interested parties and take into account any relevant information made available to it; including Healthwatch in particular.

The JHOSC has the power to make reports and recommendations, and there is a duty on the local health services and providers to consider and respond formally.

The regulations state where a recommendation is not agreed by the commissioner, it must:

- Notify the committee of the disagreement;
- Work with the committee to take reasonable steps.

The regulations do not define what qualifies a substantial development / variation, however, the guidance suggests that a locally agreed protocol is in place between the health scrutiny function and commissioners.

Principles

This protocol and the guidance on when to submit items to the JHOSC is provided to support the following:

- Give a clear understanding of roles and responsibilities for elected officials, commissioners, providers and health scrutiny members;
- Ensure effective delivery of health scrutiny's primary aim:
    - to strengthen the voice of local people;
    - ensure needs and experiences are considered as an integral part of the commissioning and delivery of health services; and
    - that those services are effective and safe."[1]
- Strengthen and enhance the role of public involvement in respect to commissioning health services;
- Ensure compliance with statutory powers and duties related to substantial developments / variations, as well as modelling best practice in respect to the role of joint health scrutiny.

The guidance encourages early engagement with joint health scrutiny in order to establish how best to consult on any proposals.

It is important to note that any agreement with the joint health scrutiny committee does not alter the wider duty to consult service users placed on NHS organisations. In particular, any decision regarding whether a proposed change does not constitute a "substantial reconfiguration" will not impact on the wider duty to consult as set out under sections 14Z2 and 242 of the NHS Act 2006.

This is important as it will ensure there is a clear record of health scrutiny being involved in early planning discussions, and a clear audit trail in case a decision is challenged in the process. Compliance with the process reduces the risk of decisions being delayed, put on hold or subject to judicial review.

What are the other Boards?

Health Scrutiny Board
what is it?

The primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the commissioning and delivery of health services and that those services are effective and safe.

Health Scrutiny is part of the accountability of the whole system and needs the involvement of all parts of the system. Engagement of relevant NHS bodies and relevant health service providers with health scrutiny is a continuous process.

Health Scrutiny should be outcome focused, looking at cross-cutting issues, including general health improvement, wellbeing and how well health inequalities are being addressed, as well as specific treatment services.

Local Authority Health Scrutiny, June 2014

Health and Wellbeing Board
what is it?

The Health and Wellbeing Board is separate from Health Scrutiny and is responsible for producing a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy (JHWS) in each borough. It also has a role in promoting integration between Health and Social care.

Membership of the Health and Wellbeing Board is set out in the Health and Social Care Act 2012 and comprises:

- Relevant Cabinet Members and Chief Officers from the Council;
- Senior Representatives from the local NHS Bodies including the CCG;
- Representatives of Healthwatch and local Voluntary Sector representative body;
- Representatives of other key stakeholders (RBLs, police etc)

What is the JHOSC?

Joint Health and Overview Scrutiny Committee (JHOSC)

what is it?

The Inner North East London Joint Health Overview and Scrutiny Committee (INEL JHOSC) is a joint committee made up of a delegated number of scrutiny Councillors from the London Boroughs of Hackney, Newham, Tower Hamlets and the City of London Corporation to consider health scrutiny issues across the subregion.

The Committee's remit is to consider London wide and local NHS service developments and changes that impact all the authorities mentioned above. The Committee meets as required and is established in accordance with section 245 of the NHS Act 2006 and Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002.

JHOSC

arrangements and items for scrutiny:

Local Authorities may appoint a discretionary joint health scrutiny committee (reg 30) to carry out all or specified health scrutiny functions, eg: scrutiny of issues that cross borough boundaries. Establishing a joint committee of this kind does not prevent the local authorities from separately scrutinising health issues, however there are likely to be occasions on which a joint committee is the best way of considering how the needs of a local population are being met with cross borough commissioning. *(Local Authority Health Scrutiny: June 2014)*

Broadly there are two main types of agenda item:

- Request from NHS for early input to emerging proposals, this could be part of wider engagement eg: a full public consultation or engagement with PPIs or Healthwatch;
- Request from NHS for formal engagement of a specific 'case for change' proposal ie: a service charge. In these cases the JHOSC can either 'endorse' or 'not endorse' the proposal. The JHOSC can also refer the matter to the Secretary of State.

Process for deciding what constitutes a substantial variation and items for consideration:

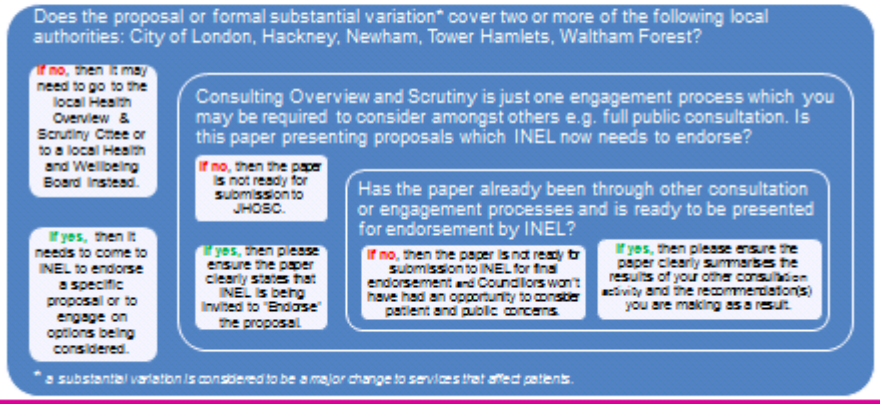
INEL JHOSC
items for consideration:

Regulation 30 also requires local authorities to appoint joint committees where a relevant NHS body or health service provider consults more than one local authority's health scrutiny function about substantial reconfiguration proposals. In such circumstances, Reg 30 sets out the following requirements:

- ONLY the JHOSC may respond to the consultation and not the individual local authorities;
- ONLY the JHOSC may exercise the power to require the provision of information by the relevant NHS body or health service provider about the proposal;
- ONLY the JHOSC may exercise the power to require members or employees of the relevant NHS body or health service provider to attend before it to answer questions in connection with the consultation.

There should be an initial discussion and agreement between the NHS and local authority Scrutiny Officer about whether or not a proposed change constitutes a substantial development / variation. The commissioner will contact the committee scrutiny officer to discuss the details of the proposed change.

INEL JHOSC
items being submitted:



The item will then be referred to the JHOSC Chair and vice-Chairs, along with any recommendations.

The Chair will make a decision on the basis of the evidence; the following factors should form the basis of their consideration:

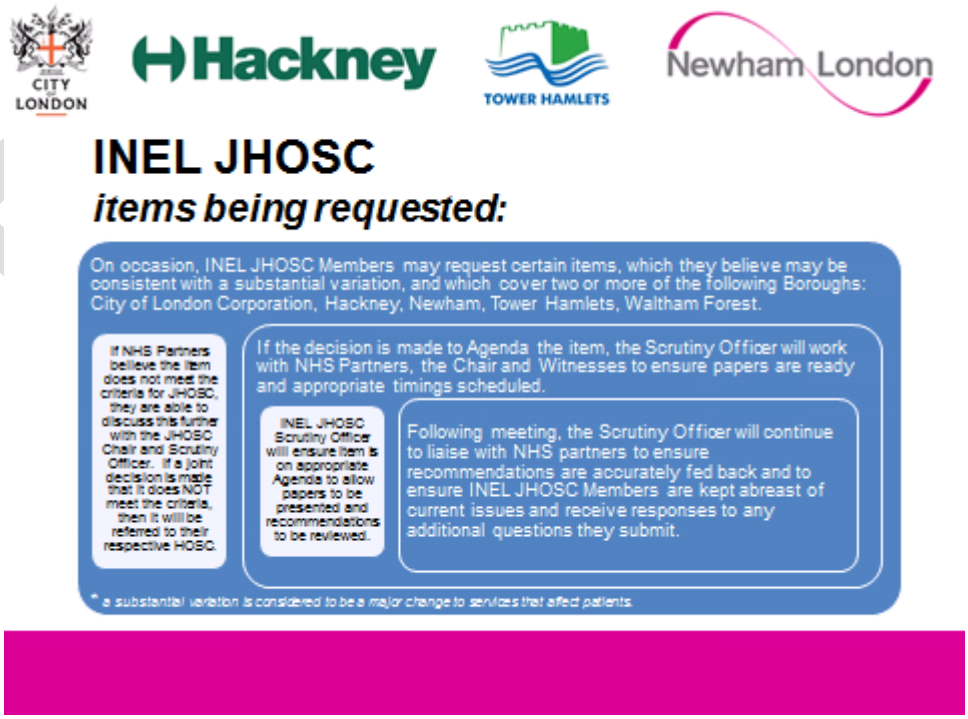
- Changes in accessibility of services;
- Impact of proposal on the wider community;
- Numbers of patients affected;
- Numbers of staff affected;
- Methods of service delivery;
- The impact on specific groups of patients, eg: older people, those with mental health conditions or those with a life-long condition.

The scrutiny officer will confirm with commissioners in writing the outcome of this discussion, and schedule an agenda item for a future meeting.

The guidance states that the JHOSC and the commissioner should try to reach a consensus about what qualifies as a substantial variation. Where disagreement arises, it is recommended that the commissioner seek the advice of the Independent Reconfiguration Panel.

The JHOSC reserves the right to make a referral to the Sectary of State if an agreement cannot be reached (sec 224 (2ZA) National Health Services Act 2006 as amended).

The JHOSC may also request items to be brought to a meeting if members feel strongly that certain areas or items need further scrutiny.



PROPOSED

Substantial Development / Variation Discussion Pro-forma form:

Substantial Variation Discussion Pro-forma	
What are the Recommendations you are asking from INEL JHOSC? *(eg: endorse, submit further recommendations).*	
What is the background for this change? *(ie: why is this change required?)*	
What is the change proposed? *(for example relocation of wards, change of service model, closure of services)*	
What is the likely impact of the change for patients?	
How many patients are likely to be affected? *(include specific groups where identified)*	
What are the financial implications if changes do not occur?	
To date, how have people been involved in the planning for the change?	
What is the timescale for the change and what consultation activity is planned?	
What consultation has occurred and is planned?	
Has this topic been considered by the committee before, and if so what was the outcome?	
What equalities impact analysis has been undertaken, and what were the key findings?	

PROPOSED
Substantial Development / Variation Discussion cover sheet:

INNER NORTH EAST LONDON (INEL)
JOINT HEALTH and OVERVIEW SCRUTINY COMMITTEE (JHOSC)

Report title	**INEL JHOSC**
Date of Meeting	
Lead Officer and contact details	**Robert Brown** Senior Scrutiny Policy Officer DDI: 020 3373 7142 I robert.brown@newham.gov.uk
Report Author	
Witnesses	
Boroughs affected	• City of London Corporation • Hackney • Newham • Tower Hamlets
Recommendations: That INEL JHOSC: • •	

Background

xxx

Key Improvements for Patients

- x

Implications

Financial Implications

x

Legal Implications

x

Equalities Implications

x

Background Information used in the preparation of this report

- x

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INNER NORTH EAST LONDON (INEL)
JOINT HEALTH and OVERVIEW SCRUTINY COMMITTEE (JHOSC)

Report title	**NHS Long Term Plan**
Date of Meeting	Wednesday 13 February 2019
Lead Officer and contact details	**Robert Brown** Senior Scrutiny Policy Officer DDI: 020 3373 7142 I robert.brown@newham.gov.uk
Report Author	**Alan Steward** Senior Responsible Officer, Transition and OD East London Health and Care Partnership alansteward@nhs.net / 07500 559031
Witnesses	**Alan Steward** Senior Responsible Officer, Transition and OD East London Health and Care Partnership alansteward@nhs.net / 07500 559031
Boroughs affected	• City of London Corporation • Hackney • Newham • Tower Hamlets

Recommendations:

The Committee is asked to **NOTE** the verbal update and future plans of ELHCP and the NHS Long Term Plan.

Background

INEL JHOSC have not met for a while and the previous meeting was held over 12 months ago as a virtual meeting. There are new Cllrs on INEL JHOSC and as such a new Chair and vice-Chair need to be proposed, seconded and voted for.

Key Improvements for Patients

- n/a

Implications

Financial Implications

n/a

Legal Implications

n/a

Equalities Implications

n/a

Background Information used in the preparation of this report

- n/a

INNER NORTH EAST LONDON (INEL)
JOINT HEALTH and OVERVIEW SCRUTINY COMMITTEE (JHOSC)

Report title	**INEL JHOSC**
Date of Meeting	Wednesday 13 February 2019
Lead Officer and contact details	**Robert Brown** Senior Scrutiny Policy Officer DDI: 020 3373 7142 I robert.brown@newham.gov.uk
Report Author	**Ellie Hobart** Acting Director, Corporate Affairs Tower Hamlets CCG
Witnesses	**Ellie Hobart** Acting Director of Corporate Affairs Tower Hamlets CCG **Daniel McLean** Project Manager Transport Eligibility Engagement & Implementation Barts Health NHS Trust **Dianne Barham** Chief Executive Officer Healthwatch Tower Hamlets
Boroughs affected	• City of London Corporation • Hackney • Newham • Tower Hamlets

Recommendations:

That INEL JHOSC:

- **ENDORSE** the introduction of the Department of Health's medical eligibility criteria for NEPTS (Non Emergency Patient Transport Service) across Barts Health NHS Trust and in conjunction with the WEL CCGs;
- **ENDORSE** the actions already taken with regards to engagement;
- Submit additional recommendations for patient transport improvements;
- Submit additional recommendations for patient transport savings.

Background

The NHS in north east London is aiming to improve non-urgent patient transport services for local people accessing services at Newham University, The Royal London, Whipps Cross, St Bartholomew's and Mile End hospitals.

This briefing outlines the background, the potential for improvements, the engagement that has been undertaken with users of the service and next steps.

Key Improvements for Patients

- Improving access for vulnerable patients;
- Making the service more effective and reliable by reducing delays;
- Bringing down the cost of aborted travel ensuring a more effective service.

Implications

Financial Implications

The current situation means the service is currently c£12m a year over budget (c£1m a month) and whilst introducing the DoH eligibility criteria won't completely close the gap, it will ensure a reduction.

The introduction of the criteria would enable greater expenditure on patient care which is currently being directed towards non-urgent patient transport for those who do not meet the medical eligibility criteria.

Legal Implications

There are no legal implications anticipated.

Equalities Implications

See equality impact assessment at Appendix 1.

Background Information used in the preparation of this report

- Department of Health's NEPTS Eligibility Criteria policy 2007;
- PTS briefing paper produced by CCGs and Barts Health Trust

Improving patient transport in north east London

Introduction

The NHS in north east London is aiming to improve non-urgent patient transport services for local people accessing services at Newham, The Royal London, Whipps Cross, St Bartholomew's and Mile End hospitals.

This briefing outlines the background, the potential for improvements, the engagement that has been undertaken with users of the service and next steps.

Background

Non-emergency patient transport is a free transport service, which is only provided to patients who have a specific medical need and are attending healthcare services.

Every day, thousands of people use services provided by the Barts Health group of hospitals. Some with long-term conditions or mobility problems need help to get to an appointment or come home after treatment. The Barts Health NHS Trust non-emergency patient transport team provides a safe and free service for those who cannot travel to or from hospital.

Every month, over 10,000 patients are transported to Newham, The Royal London, Whipps Cross, St Bartholomew's and Mile End hospitals.

All NHS trusts must provide transport for those who need it on medical grounds, under Department of Health guidelines on patient eligibility. Since taking over the service from ERS Medical in 2017 Barts Health has put in place improvements. For example more than 90% of renal patients have been dropped off and picked up on time for their vital dialysis sessions. This is an improvement of more than 35% since January 2016.

However, there are still significant improvements that the local NHS would like to make.
In recent years the Department of Health's eligibility rules have not been implemented or followed effectively. The result was that the number of users rose by 10 per cent a year - impacting on both the quality of the service received by those who need it most as well as driving up costs. The service now costs £2m per month to run and is not sustainable in the long run if demand keeps increasing.

Potential improvements

- There are still too many delays, and other hospitals in London have shown that prioritising patients that need transport most can reduce delays by 15%.
- Too many journeys are made in relation to the number of patients who need transport. This is partly due to the high number of carers transported; currently carers accompany patients in one out of every five journeys, whereas other hospitals transport less than one carer in every ten journeys.

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Barts Health NHS Trust
Newham Clinical Commissioning Group
Tower Hamlets Clinical Commissioning Group
Waltham Forest Clinical Commissioning Group

- Too many patients fail to cancel their journeys when they choose not to attend appointments. This means vehicles regularly arrive to transport patients to hospital, only to be told the patient is not travelling. This contributes to delays and unnecessary journeys. In some months more than 2,000 journeys have been aborted as patients failed to cancel their transport request.

These issues all contribute to creating a service which is not as reliable as the local NHS would like it to be, a service which is not able to prioritise those who need the service most and a service which is costing too much public money.

Part of the reason for these issues is that the national guidance on eligibility criteria has not been consistently applied. Other hospitals in London and across the country assess patients' eligibility thoroughly against a set of national criteria before deciding if they are eligible for transport.

Currently patients needing to get to and from Barts Health hospitals are not assessed against these criteria, so many people are using NHS non-emergency patient transport when there is no clinical need.

The local NHS in north east London is preparing to introduce the same assessment process that other hospitals use. It will be introducing eligibility criteria to ensure the most vulnerable patients are prioritised for transport services, and provide information on alternative options for those who do not meet the criteria. It is estimated that around 12.5% of patients who currently use the service do not meet the national eligibility criteria.

Engagement

In recognition that introducing the criteria is likely to mean a number of people who had previously used patient transport would no longer be eligible, the local NHS has sought views of the users of the service. Engagement has been developed in partnership with Healthwatch, and has been delivered over the last year.

Letters outlining the reasons for the improvements were sent to over 20,000 people who had used the service in recent months. These letters also invited patients to attend facilitated workshops to discuss the potential impact and co-design exactly how the criteria would be applied locally.

Three workshops were held - in Waltham Forest, Tower Hamlets and Newham. These workshops sought to consider the likely impact on local people and gather service users' views on the application of the criteria. These sessions covered a range of issues, including transport alternatives and the rationale behind the proposed changes to the eligibility criteria.
In parallel, local clinicians including GPs attended a workshop to help formulate the plans to apply the national criteria locally. This proved a valuable forum for debate on the issues clinicians face in ensuring everyone who currently uses the service continues to receive the best care possible.

At the workshops, which were independently facilitated, there was universal acceptance and agreement that patient transport eligibility should be more tightly assessed through clearly defined eligibility criteria.

There were also a range of suggestions made about how to improve the service in the short, medium and long term. For example, people suggested it would help if the local NHS:

- Provided more wheelchairs and assistance at drop off points
- Provided clearer information to patients about reclaiming alternative transport costs
- Provided clearer information to patients about getting to and from hospital
- Improved the customer experience for patients using our transport service

In response, we are arranging for more wheelchairs and assistance at drop off points. We have also updated our website with the information you need to know about coming to and from our hospitals, including information to reclaim travel costs. Finally, we have started a customer care training programme for drivers, call centre staff and ward clerks. We will continue to work with users of the service to make further long-term improvements.

Next steps

Following this engagement, the local NHS will be introducing three changes which will be phased in early in the new year.

1. **Prioritising patient transport services for patients that need it most because of a medical or clinical need**

To help us better understand patients' transport requirements, our booking team will ask patients a set of questions when they contact us to request transport. These questions are based on the national Department of Health and Social Care framework used in other hospitals up and down the country, and have been adapted by engaging patients, doctors and nurses in east London. There will be an independent appeals mechanism for borderline cases.

Initially, outpatients phoning to book hospital transport will be asked a series of questions by our trained call-handlers to establish eligibility. Subsequently, renal patients needing to visit hospital for kidney dialysis - who currently account for half of all journeys – will be invited to receive a personal face-to-face assessment. Cancer patients attending hospital for radiotherapy will be able to book transport direct through their cancer service.

2. **Prioritising carers that need to provide additional support to their friend or relative because of a medical or clinical need**

There will be times when patients need their carer to travel with them; however where patients can travel safely in ambulances with the support of trained staff, carers will need to access other transport options to attend hospital appointments with their friend or relative.

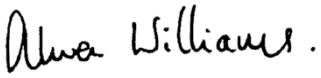
3. **Removing access to patient transport services for patients that contribute to avoidable delays to the service**

Access to the transport service for patients that regularly contribute to avoidable delays will be removed. This includes patients that fail to cancel their transport request when they choose not to attend their hospital appointment. We appreciate that circumstances can change unexpectedly, so this will only apply where patients fail to provide us with more than 24 hours' notice of cancellation on three separate occasions.

We are confident that these changes will lead to a better, more reliable service for patients who have a real medical need for non-urgent transport to and from hospitals in north east London. We will continue to engage with those who use our services in order to make further improvements.

We would be very happy to provide more detail or information, in writing or in person, on the local implementation of this national criteria if you have any questions based on this briefing.

Alwen Williams



Chief Executive
Barts Health

Selina Douglas

Managing Director
WEL CCGs

Brought to you by:
Barts Health NHS Trust
Newham Clinical Commissioning Group
Tower Hamlets Clinical Commissioning Group
Waltham Forest Clinical Commissioning Group

NHS
Newham
Clinical Commissioning Group

EQUALITY ANALYSIS
(Equality Impact Assessment)

Name of policy/function

Barts Health Patient Transport Service

Is this a new or existing policy/function?

[Please check appropriate box]

New ☐ **Existing** ☒

Please give a brief description of policy/function

Barts Health provides non-emergency patient transport (PTS) to clinical appointments at four of its sites. Patient eligibility criteria used to be enforced but has not since ERS Medical took over as the provider for the past three years. Now that patient transport service has been taken back in house, the eligibility criteria needs to be reinforced due to the c10% year on year increase in activity since it was with ERS Medical as transport has been offered to a wide range of patients and carers without adequate checks on eligibility. Discussions at the Barts Health Collaborative Commissioning Committee proposed that the eligibility criteria should be reviewed and enforced by the Trust as a means to ensure adherence to national policy for PTS and that the criteria be applied fairly across Barts Health sites.

Scope of the Equality Analysis

The impact on the current users who are receiving PTS without meeting the eligibility criteria in terms of equitability on age, race and disability, as well as other protected and not protected characteristics

Consultation, engagement and contribution/outcomes

[Please list who you have consulted with on this EA and what contribution they have made, if any. If the policy/function is customer facing then please mention which protected group from the potential beneficiary groups has been involved]

Barts Health and WEL CCGs engaged SHA Disability to assess, engage stakeholders in a series of workshops and events and to compile recommendations. Letters were sent to all current users of PTS who could be affected in May / June 2018 and invited to attend road shows and events. The Renal team and the Cancer teams have been met with on numerous occasions and Healthwatch have been involved in the project all the way through. Bi-Weekly meetings are in place with all relevant stakeholders and third parties, which also includes Healthwatch and a volunteer renal patient liaison officer.

As a result of the engagement and partnership approach taken with SHA Disability, patient and clinician feedback, a three stage approach to eligibility implementation and an external appeals process has been created.

Three Stage Approach:-

1. Outpatients – For outpatients booking transport, the Serco contact centre staff will handle the calls and the assessment of the patients
2. Cancer Patients – Staff are being trained to use the online patient transport booking tool (PTS Online) and will be responsible for administering the eligibility checks with the patients when they are on site. Due to cancer patients only accounting for 2% of the service users, the staff know their patients well and this approach was suggested to us by the cancer teams.
3. Renal Patients – Two weeks after the go-live for outpatients and cancer patients, the transport service in partnership with SHA will embark upon a three month site by site, face to face eligibility implementation roll out plan. Each patient will be met with face to face to undergo the eligibility assessment by a member of SHA Disability (who will be a qualified OT) and once all patients at a site have been met with, the eligibility criteria will be switched on for that specific site.

*We will not be implementing eligibility checks for discharges during this project so as not to have any negative impact on the patient flow pathway.

Appeals Process:-

The eligibility criteria works on a cumulative points scoring basis. Once a patient has accrued 4 points, call handlers are automatically able to book transport and the assessment ceases to continue. Patients scoring 0-2 points will no longer be eligible for patient transport but are entitled to complain. Patients scoring 3 points have both the complaints process but also an appeals process available to them. The rationale being that this cohort of patients are on the borderline of being eligible and if they are unhappy with the decision made, they firstly escalate their concern to the contact centre supervisor who will spend more time with the patient on the phone, asking more questions to try and elicit the necessary information that may assist the patient to improve their score and thus be eligible for transport.

Should this not happen and the patient decides to appeal the decision, a case is created and the patient is transferred to SHA Disability. SHA Disability will conduct a more in depth telephone interview with the patient and if needs be meet them face to face to assess them in person. The

decision has been made to outsource the appeals process for these patients to an independent third party so that any decisions made are at arm's length from the trust and CCG's. Whilst this whole process is taking place, patients will still be provided with transport without prejudice. SHA has Disability have experience of providing a very similar service with the Blue Badge Scheme on behalf of Tower Hamlets Council and their input has assisted with developing this process.

*A training programme was also co-authored between the trust and SHA and delivered to the Serco Contact Centre staff in December. All contact centre staff are therefore fully aware of the project, the department of health guidelines and how to direct patients based on their points score. Furthermore each question within the eligibility question set has been clinically signed off by Dr Charlotte Hopkins (Bart's Deputy Chief Medical Officer) and role played so that the Serco staff are aware of the likely responses and potential objections that they may have to handle.

Impact assessment and actions

Protected Group	Relevance YES/NO	Evidence of impact (describe how the policy will impact on each protected group)	Nature of potential impact (positive/negative/unknown)	Recommendations/mitigating actions (what actions the CCG should implement to tackle inequality and advance equality of opportunity)
Age	YES	'meek' and often aged and alone patients who remain at clinical risk e.g. of falls, despite having answered PTS assessment questions to indicate they are not eligible on paper.	Patients may not articulate their needs and be assessed as not meeting PTS criteria when they do, and may attempt to access alternate, inappropriate transport or miss appointments if cannot access transport	Ensure the project develops robust safety net for this group over and above the eligibility criteria assessment and that this is monitored by project leads and CCGs; plan is to inform existing service users that from an agreed date, new criteria would be implemented and users would need to undertake an eligibility assessment. This would give a lead-in period for existing service users. Ongoing formalised review of patient feedback post implementation and of any issues that arise from a service delivery perspective will be formulated into a summary report post implementation. Department of Health guidelines on eligibility also afford those making the decisions on patient transport the discretion to

Protected Group	Relevance YES/NO	Evidence of impact (describe how the policy will impact on each protected group)	Nature of potential impact (positive/negative/unknown)	Recommendations/mitigating actions (what actions the CCG should implement to tackle inequality and advance equality of opportunity)
				provide transport to patients that do not meet the criteria but in their professional opinion that feel it would be unsafe or detrimental to the patients' health if the transport was not provided.
Disability (including mental health and learning disability)	YES	Most patients with disability in terms of mobility or mental health issues will continue to receive transport, but there will be some patients who are not fully eligible for free transport but who have mobility/disability needs, who would not be provided PTS transport	Patients who are not fully eligible for free transport but who had mobility/disability needs on assessment can travel with their carer to the site they are receiving treatment at. It is the patients responsibility to pay for parking out of their income/ benefits, however if it is determined that a patient is of limited means and meets the criteria, then they would qualify for the Hospital Travel Cost Scheme (HTCS) which will reimburse the patient for the costs they have accrued.	Ensure the project provides support to identify suitable alternatives. Meetings have taken place with London Councils and a meeting is also being arranged with the Commercial Manager of TFL to explore the option of a TaxiCard scheme. The trust is also exploring the option of having a park and ride scheme once suitable land is identified and subject to approval successfully procured for this facility and this will be monitored by project leads and CCGs; plan is to inform existing service users that from an agreed date, new criteria would be implemented and users would need to undertake an eligibility assessment. This would

Protected Group	Relevance YES/NO	Evidence of impact (describe how the policy will impact on each protected group)	Nature of potential impact (positive/negative/unknown)	Recommendations/mitigating actions (what actions the CCG should implement to tackle inequality and advance equality of opportunity)
				give a lead-in period for existing service users. Ongoing formalised review of patient feedback post implementation and of any issues that arise from a service delivery perspective will be formulated into a summary report post implementation.
Race/Ethnicity	YES	Indirect impact possible due to custom, culture and language barriers – some patients may not be able to access alternatives or request re-assessment or appeal	either miss clinical appointments or be forced to use inappropriate transport	Ensure the project provides support in minority languages / advocates if necessary and that this is monitored by project leads and CCGs; plan is to inform existing service users that from an agreed date, new criteria would be implemented and users would need to undertake an eligibility assessment. This would give a lead-in period for existing service users. Ongoing formalised review of patient feedback post implementation and of any issues that arise from a service delivery

Protected Group	Relevance YES/NO	Evidence of impact (describe how the policy will impact on each protected group)	Nature of potential impact (positive/negative/unknown)	Recommendations/mitigating actions (what actions the CCG should implement to tackle inequality and advance equality of opportunity)
				perspective will be formulated into a summary report post implementation.
Sex/Gender	NO			
Gender Reassignment	NO			
Sexual Orientation	NO			
Religion/Belief	NO			
Pregnancy and Maternity	NO			
Marriage and Civil Partnership	NO			

Protected Group	Relevance YES/NO	Evidence of impact (describe how the policy will impact on each protected group)	Nature of potential impact (positive/negative/unknown)	Recommendations/mitigating actions (what actions the CCG should implement to tackle inequality and advance equality of opportunity)
Human Rights	NO			
Socio-economic Groups	YES	There is potential that some patients may not be able to pay for alternative transport	Unequal access to healthcare for the economically disadvantaged stratum	Ensure the project provides support and liaison with social care to ensure such individuals are appropriately assessed and advised, for example, the 'Healthcare Travel Costs Scheme' (HTCS)/NHSBSA run for those in receipt of certain benefits, or with a low income through the NHS Low Income Scheme. This should be monitored by project leads and CCGs
Social Inclusion	YES	There is potential that some patients may not be able to pay for alternative transport and will not attend clinical appointments	This will have the potential of isolating or further isolating those patients	Ensure the project provides support and liaison with social care to ensure such individuals are appropriately assessed and advised, for example, the 'Healthcare Travel Costs Scheme' (HTCS)/NHSBSA run for those in receipt of certain benefits, or with a low income through the NHS Low Income Scheme. This should be monitored by

Protected Group	Relevance YES/NO	Evidence of impact (describe how the policy will impact on each protected group)	Nature of potential impact (positive/negative/unknown)	Recommendations/mitigating actions (what actions the CCG should implement to tackle inequality and advance equality of opportunity)
				project leads and CCGs
Community Cohesion	NO			

Final outcomes:
[Please check appropriate box]

A. Continue with the policy/proposal as it is ☒
B. Continue with the policy with adjustment or further analysis ☐
C. Stop/remove the policy/proposal ☐
D. Carry out a further analysis of new data ☐

Signature of the SRO/Director:

Date:

11 January 2019

Date of Next Review:
[Statutory requirement at least 3 years unless there is any change in existing policy/function]

Jan 2020

Further information:
Please read the CSU guidance on 'how to complete an equality analysis' when completing an equality analysis.

Please forward a copy of this EA report to the Equality and Diversity Team at the CSU at equality@nelcsu.nhs.uk

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Application of Eligibility Assessment - High Level Impact Analysis

Total Transport JOURNEYS per annum based on current year indicative year end figures	**396,854 Journeys per annum**
Total Mileage completed by our vehicles per annum	**2,419,923 miles per annum**
Year upon Year increase in transport journey demand	**Increasing at a rate of 9 % per annum**
Approx number of PATIENTS using transport services at Barts Health NHS Trust per annum	**Approx 94,446**

	Renal Services	NEPTS activity	Cancer Services
The three approaches being taken to reduce risks associated with the Introduction of Eligibility Assessment	Phased face to face assessment starting week commencing 4th February 2019 over a 13 week period visiting each renal dialysis centre	Starting 21st January 2019 Assessment made on all NEPTS / Outpatient transport requests via Call Centre	From 21st January 2019 Local controls using the application of eligibility via on-line assessment tool
Approx split of journeys per annum by specialty	**190,000**	**180,108**	**26,746**
Approx number of PATIENTS using transport services	**774**	**93,000**	**672**
Patients expected deemed eligible with current transport mobility needs	**163**	**26,545**	**195**
Patients expected to go through the Eligibility Assessment process	**611**	**66,455**	**477**
Expected number of patients **not** meeting the criteria and directed to use alternative forms of transport. This is based on discussions with other London Trusts when Eligibility was first introduced. Around 15 - 20% demand reduction seen when eligibility first introduced	**107**	**11,630**	**83**
Trustwide Impact of the application of Eligibility Assessment in terms of numbers of patients that would potentially **not** reach the eligibility criteria and be directed to alternative forms of transport to reach the Hospital	**11,820**		

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Eligibility Criteria for Patient Transport Services (PTS)

Eligibility Criteria for Patient Transport Services (PTS)

PTS eligibility criteria document

Prepared by
DH Ambulance Policy

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Performance
Management	IM & T
Planning	Finance
Clinical	Partnership Working

Document Purpose	Best Practice Guidance		
ROCR Ref:		**Gateway Ref:**	8705
Title	Eligibility Criteria for Patient Transport Services (PTS)		
Author	Department of Health		
Publication Date	23 Aug 2007		
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , Local Authority CEs, Directors of Finance, PTS provider representative organisations and groups		
Circulation List	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , Local Authority CEs, Directors of Finance, PTS provider representative organisations and groups. It will also be available on the internet for any interested parties.		
Description	Following responses to a thirteen-week consultation this document provides revised eligibility criteria for non-emergency patient transport services		
Cross Ref	Chapter 20 of the NHS Finance Manual		
Superseded Docs	PTS Guidance 'Ambulance and other patient transport service – Operation, use and performance standards' (1991)		
Action Required	To take account of the revisions in PTS eligibility		
Timing	Immediate		
Contact Details	Ambulance Policy 11th Floor New Kings Beam House 22 Upper Ground SE1 9BW emergencycare@dh.gsi.gov.uk www.dh.gov.uk/consultations/fs/en		
For Recipient's Use			

First published date

Published to DH website, in electronic PDF format only.
http://www.dh.gov.uk/publications

Contents

Document Purpose

1. ‘Ambulance and other Patient Transport Services: Operation, Use and Performance Standards’ [HSG 1991(29)] was published in 1991. This set out guidance for the NHS on the operation, use and performance standards for emergency and urgent ambulances. It also set out criteria for establishing which patients were eligible for non-emergency patient transport services (PTS).

2. The White Paper (‘Our health, our care, our say: a new direction for community services’, January 2006) made a commitment to extend eligibility for the Hospital Travel Costs Scheme (HTCS) and PTS to procedures that were traditionally provided in hospital, but are now available in a community setting. This will mean that people referred by a health care professional for treatment in a primary care setting, and who have a medical need for transport, will also receive access to PTS and HTCS.

3. This extension to PTS, as outlined in this document, is expected to come into force in 2007/08, although Primary Care Trusts (PCTs) can of course amend local eligibility criteria for PTS in line with the White Paper before that date, should they wish to do so.

4. This document therefore updates and replaces the 1991 guidance and applies to both NHS and independent service providers contracted to the NHS.

What is PTS?

5. Non-emergency patient transport services, known as PTS, are typified by the non-urgent, planned, transportation of patients with a medical need for transport to and from a premises providing NHS healthcare and between NHS healthcare providers. This can and should encompass a wide range of vehicle types and levels of care consistent with the patients’ medical needs.

Who is eligible for PTS?

6. PTS should be seen as part of an integrated programme of care**.** A non-emergency patient is one who, whilst requiring treatment, which may or may not be of a specialist nature, does not require an immediate or urgent response.

7. Eligible patients should reach healthcare (treatment, outpatient appointment or diagnostic services i.e. procedures that were traditionally provided in hospital, but are now available in a hospital or community setting) in secondary and primary care settings in a reasonable time and in reasonable comfort, without detriment to their medical condition. Similarly, patients should be able to travel home in reasonable comfort without detriment to their medical condition. The distance to be travelled and frequency of travel should also be taken into account, as the medical need for PTS may be

affected by these factors. Similarly, what is a "reasonable" journey time will need to be defined locally, as circumstances may vary.

8. Eligible patients are those:
   - Where the medical condition of the patient is such that they require the skills or support of PTS staff on/after the journey and/or where it would be detrimental to the patient's condition or recovery if they were to travel by other means.
   - Where the patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patient's condition or recovery to travel by other means.
   - Recognised as a parent or guardian where children are being conveyed.

9. PTS could also be provided to a patient's escort or carer where their particular skills and/or support are needed e.g. this might be appropriate for those accompanying a person with a physical or mental incapacity, vulnerable adults or to act as a translator. Discretionary provision such as this would need to be agreed in advance, when transport is booked.

10. A patient's eligibility for PTS should be determined either by a healthcare professional or by non-clinically qualified staff who are both:
   - clinically supervised and/or working within locally agreed protocols or guidelines, and
   - employed by the NHS or working under contract for the NHS

Who provides PTS?

11. For simplicity, the text of this guidance will refer to PCTs when discussing the role of the commissioner. There is an expectation that over time, where it is not already the case, PCTs should take on responsibility for PTS contracts and commissioning.

12. PCTs are responsible for commissioning ambulance services (which could include patient transport services) to such extent as the PCT considers necessary to meet all reasonable requirements of the area for which they are legally charged with providing services. It is for the PCT to decide who receives patient transport services in their area. PCTs should therefore apply the principles outlined in this document either to consider each case on its merits or to develop more detailed local criteria for PTS use. PCTs may lawfully ask other bodies to assist in the exercise of their commissioning functions. Yet where they make such arrangements, it is still the responsibility of the PCT to ensure that appropriate services are being provided at an appropriate cost and standard.

13. A range of different providers may provide PTS - for example the local NHS ambulance trust, independent sector providers, or a combination of providers.

14. PTS eligibility has not been extended to include patients who do not fit the criteria outlined above e.g. those who have a social need for transport. Local transport plans should address issues of access to health services to enable integrated transport provision and PCTs have been encouraged to engage in this process through accessibility planning guidance and the NHS Modernisation Agency's 'Driving Change – Good Practice Guidelines for PCTs on Commissioning Arrangements for Emergency

Ambulance Services and Non-Emergency Patient Transport Services' best practice material.

15. The White Paper ('Our health, our care, our say: a new direction for community services') made clear that PCTs and local authorities should be working together to ensure that new services are accessible by public transport. Existing facilities should also work closely with their PCTs and with accessibility planning partnerships (in those areas that produce local transport plans) to ensure that people are able to access healthcare facilities at a reasonable cost, in reasonable time, and with reasonable ease.

Who pays for PTS?

16. Eligible patients are not charged for patient transport services provided by the NHS. PCTs are ultimately responsible for the costs of PTS.

17. The cost of providing PTS is for PCTs to negotiate for their registered population, dependent on local needs and priorities. It will vary depending on the nature of services provided, distance to be travelled and is a matter for local agreement.

18. The cost of PTS remains within the scope of Payment by Results as an integral part of the relevant tariffs and will remain within tariff during 2006/07 and 2007/08. If it is agreed locally that the acute trust should not be responsible for providing PTS then locally agreed adjustments should be made to the tariff to facilitate the PCT contracting for PTS directly with providers.

Duty of care to patient

19. The provider of the transport service owes a duty of care to the patient (and any accompanying escort or carer) being transported, from the time they collect the patient to the time they hand them over. However, during patient transfer, the NHS will still owe a duty of care to a patient, regardless of whether there is an escort in attendance. The PCT will still be responsible to the patient being transported in so far as the PCT must exercise reasonable care to ensure that the arrangements it makes for provision of PTS ensure that PTS will be provided to a safe and adequate standard. See Chapter 20 of the finance guidance for more detail on quality standards.

Out of area

20. Patients are now being offered a choice, through the extended care network, over where they receive treatment when they are referred for elective care. Therefore, it is likely that the number of out of area PTS journeys will increase. The principle that

should apply is that each patient should be able to reach hospital in a reasonable time and in reasonable comfort, without detriment to their medical condition. Distance to be travelled should actively be considered when assessing whether the patient has a medical need for transport.

21. In terms of funding arrangements, the general principle should be that a patient's home PCT would be expected to bear the cost of their PTS journeys.

22. See Chapter 20 of the finance manual for more detail on charging for out of area journeys.

Private patients

23. If a private patient is treated as such by a NHS Trust, any requirement for PTS will generally be provided under the PCT service agreement. However, the NHS Trust will recover the cost from the patient rather than the patient's home PCT by reflecting the cost of the transport provided in the private patient rates it charges and, if necessary, by supplementing those charges to allow for the cost of any additional PTS activity. It will then reimburse the PCT.

24. If a private patient is treated in a private hospital, any PTS supplied by an NHS PTS provider will be charged to the private hospital, which will make its own arrangements for recovering the cost from the patient.

25. A private patient transferred as an NHS emergency case is liable for the cost of transport only if the patient, or a person acting on the patient's behalf, opts for private treatment and signs an undertaking to pay charges.

Escorts

26. PTS could also be provided to a patient's escort or carer where their particular skills and/or support are needed e.g. this might be appropriate for those accompanying a person with physical or mental incapacity, children or to act as a translator. Only one escort should travel with a patient under such circumstances. Such discretionary provision would need to be agreed in advance, when transport is booked.

27. The eligibility criteria for PTS have not been extended to include visitors.

28. Where, exceptionally, a friend or relative accompanies a patient to hospital or for treatment, return transport provision is at the discretion of the provider.

Carriage of wheelchairs

29. There is currently no regulation covering the carriage of wheelchairs: the Department for Transport (DfT), Local Government and the Regions (DTLR) document VSE 87/1 Code of Practice: "The Safety of Passengers in Wheelchairs on Buses" remains the main guidance available.

30. Some patients have wheelchairs with special seating or controls. Such patients have the right, wherever possible, to be transported in or with their wheelchair for reasons of comfort and mobility. In deciding how best to meet requests for wheelchair transport, purchasers/providers will, however, need to adhere to the requirements produced by the DfT and guidance provided by the Medical Devices Agency, which is referenced at the end of this document.

Setting standards

31. *Our Health, Our Care, Our Say* sets out the Department's intention to provide national standards for what people can expect from patient transport services, as well as exploration of options for accrediting independent sector providers of PTS, to ensure common minimum standards.

32. In the meantime, PCTs should ensure that whatever arrangements are adopted for the provision of PTS are underpinned by an effective transport management quality assurance, and health and safety system.

Social needs for transport

33. The NHS can use income generation powers to charge patients for the provision of transport for 'social', rather than 'medical' needs.

34. PCTs do not have to provide transport for social reasons however Section 7 of the Health & Medicines Act 1988 allows a charge to be levied for the provision of transport to patients with a social need. The main provisos for income generating schemes are:

    a) The scheme must be profitable as it is unacceptable for it to be subsidised from NHS funds;
    b) The profit must be used for improving the health services; and
    c) Income Generation schemes must not in any way interfere with the provision of NHS services to patients.

35. Guidance is contained in National Health Service income generation – 'Best practice: Revised guidance on income generation in the NHS', February 2006.

Help with travelling expenses and travelling arrangements for patients on low incomes – Hospital Travel Cost Scheme (HTSC)

36. The Hospital Travel Costs Scheme provides financial assistance to those patients who do not have a medical need for ambulance transport, but who require assistance in meeting the cost of travel to and from their care. Reimbursement of travel fares are provided for services that must be:

    - Currently under the care of a consultant (such as a surgeon or rheumatologist, but not a GP)

    - for a traditional hospital diagnostic or treatment, (i.e. non-primary medical services or non-primary dental services), regardless of where the treatment is carried out

    - paid for by the NHS, regardless of whether it is carried out by an NHS care professional or an independent one

37. Benefits and allowances that entitle patients (and their dependents) to full or partial reimbursement of travel expenses under HTCS are means-tested and include Income Support, Income-based Jobseeker's Allowance, Pension Credit Guarantee Credit, Child's Tax Credit, Working tax credit with Child's Tax Credit, Working Tax Credit with a disability element, or the NHS Low Income Scheme.

38. PCTs are ultimately responsible for payment of the scheme. However, in practice and for convenience, patients claim their expenses from the NHS trust where they receive their treatment, and that trust reclaims the expenses from the responsible PCT. Guidance on the operation of the scheme is available from the Department of Health's website

39. http://www.dh.gov.uk/assetRoot/04/12/77/39/04127739.pdf

Complaints

40. From 1 September 2006, changes to the NHS complaints regulation came into force. The changes were designed to make the complaints procedure clearer and easier to access for those who need it. Purchasers of emergency ambulance services and PTS should ensure that local arrangements and procedures for investigating complaints conform to the requirements of that guidance. Guidance is available through the DH website:

www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/ComplaintsPolicy/NHSComplaintsProcedure/fs/en

41. Independent Complaints Advocacy Service (ICAS) provides support to people in England wishing to complain about the treatment or care they received under the NHS. ICAS delivers a free and professional support service to clients wishing to pursue a complaint about the NHS.

42. Patient Advice and Liaison Services (PALS) provide confidential advice, support and information on health-related issues to patients, their families and carers.

43. A more general complaints leaflet is available for the public, available on the DH website: www.dh.gov.uk/assetRoot/04/02/00/39/04020039.pdf

References

- *Ambulance and Other Patient Transport Services: Operation, Use and Performance Standards*, HSG (91)29, NHS Executive, December 1991.

- Establishing the Responsible Commissioner www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069634

- *Our health, our care, our say: a new direction for community services*, The White Paper, Department of Health, January 2006. www.dh.gov.uk/assetRoot/04/12/74/59/04127459.pdf

- *NHS Trusts - Detailed Guidance - 20. Finance arrangements for patient transport services (PTS)*, Department of Health www.info.doh.gov.uk/doh/finman.nsf/4db79df91d978b6c00256728004f9d6b/c13b0f39ccbfd3fa802568a9005a0c1f?OpenDocument

- Code of Practice: *The Safety of Passengers in Wheelchairs on Buses* Department for Transport (DfT), Local Government and the Regions (DTLR) document VSE 87/1

- *Guidance on the Safe Transportation of Wheelchairs (MDA DB2001(03) June 2001)*, the Medical Devices Agency. www.mhra.gov.uk/home/idcplg?IdcService=GET_FILE&dDocName=CON007343&RevisionSelectionMethod=LatestReleased.

- *Guidance of the Safe Use of Wheelchairs and Vehicle-mounted Passenger Lifts (MDA DB2003(03) March 2003)*, the Medical Devices Agency. www.mhra.gov.uk/home/idcplg?IdcService=GET_FILE&dDocName=CON007320&RevisionSelectionMethod=LatestReleased

- *Medical Devices Regulations 1994 (SI 1994 No 3017)* www.opsi.gov.uk/SI/si1994/Uksi_19943017_en_1.htm

- *Manual Handling Operations Regulations 1992 (SI 1992 No 2793)* www.opsi.gov.uk/SI/si1992/Uksi_19922793_en_1.htm

- *The Health & Medicines Act 1988*, Section 7, ISBN 0105449881 www.opsi.gov.uk/ACTS/acts1988/Ukpga_19880049_en_1.htm

- *National Health Service income generation - best practice : revised guidance on income generation in the NHS,* Department of Health, February 2006 www.dh.gov.uk/assetRoot/04/13/06/68/04130668.pdf

- *The Hospital Travel Costs Scheme Guidance*, Department of Health, May 2005 www.dh.gov.uk/assetRoot/04/12/77/39/04127739.pdf

INNER NORTH EAST LONDON (INEL)
JOINT HEALTH and OVERVIEW SCRUTINY COMMITTEE (JHOSC)

Report title	**INEL JHOSC Workplan**
Date of Meeting	Wednesday 13 February 2019
Lead Officer and contact details	**Robert Brown** Senior Scrutiny Policy Officer DDI: 020 3373 7142 I robert.brown@newham.gov.uk
Report Author	**Robert Brown** Senior Scrutiny Policy Officer DDI: 020 3373 7142 I robert.brown@newham.gov.uk
Witnesses	n/a
Boroughs affected	• City of London Corporation • Hackney • Newham • Tower Hamlets

Recommendations:

The Committee is asked to **APPROVE** the INEL JHOSC workplan.

Background

INEL JHOSC have not met for a while and the previous meeting was held over 12 months ago and the Terms of Reference have not been updated for some considerable time. With new Members on the Committee, the ToR have been updated.

Key Improvements for Patients

- n/a

Implications

Financial Implications

n/a

Legal Implications

n/a

Equalities Implications

n/a

Background Information used in the preparation of this report

- n/a

Inner North East London (INEL) Joint Health and Overview Scrutiny Committee (JHOSC)

Meeting: Inner North East London (INEL) Joint Health and Overview Scrutiny Committee (JHOSC)
Chair: to be confirmed **vice-Chair** to be confirmed
Support: Robert J Brown, Senior Scrutiny Policy Officer
Venue: Old Town Hall, Stratford, 29 Broadway, LONDON E15

Dates of meetings:
1900-2100hrs

13 Feb-19	18 Sep-19
20 Mar-19	27 Nov-19
19 Jun-19	

	mins	Agenda Item	13-Feb-19		20-Mar-19	19-Jun-19		18-Sep-19		27-Nov-19	26-Feb-20		24-Jun-20	30-Sep-20	25-Nov-20
APOLOGIES			Cllr Rohit DasGupta		Cllr Rohit DasGupta			as there are no meetings currently scheduled for ONEL after May 2019, I am proposing that a joint ONEL / INEL meeting takes place to look at STP-wide issues only - this is still to be confirmed			tentative date		tentative date	tentative date	tentative date
Overview and Scrutiny Committee															
	mins	**Agenda Item**	**AGENDA**		**AGENDA**	**AGENDA**		**AGENDA**		**AGENDA**	**AGENDA**		**AGENDA**	**AGENDA**	**AGENDA**
STANDING ITEMS (20mins)		01	Chair's Announcement		Chair's Announcement	Chair's Announcement		Chair's Announcement		Chair's Announcement	Chair's Announcement		Chair's Announcement	Chair's Announcement	Chair's Announcement
	10	02	Welcome, Apologies and Introductions (inc substitutes)		Welcome, Apologies and Introductions (inc substitutes)	Welcome, Apologies and Introductions (inc substitutes)		Welcome, Apologies and Introductions (inc substitutes)		Welcome, Apologies and Introductions (inc substitutes)	Welcome, Apologies and Introductions (inc substitutes)		Welcome, Apologies and Introductions (inc substitutes)	Welcome, Apologies and Introductions (inc substitutes)	Welcome, Apologies and Introductions (including substitutes)
		03	Declaration of Interest Register		Declaration of Interest Register	Declaration of Interest Register		Declaration of Interest Register		Declaration of Interest Register	Declaration of Interest Register		Declaration of Interest Register	Declaration of Interest Register	Declaration of Interest Register
		04	Minutes of Previous meeting		Minutes of Previous meeting	Minutes of Previous meeting		Minutes of Previous meeting		Minutes of Previous meeting	Minutes of Previous meeting		Minutes of Previous meeting	Minutes of Previous meeting	Minutes of Previous meeting
	5	05	Submissions and Questions from the Public		Submissions and Questions from the Public	Submissions and Questions from the Public		Submissions and Questions from the Public		Submissions and Questions from the Public	Submissions and Questions from the Public		Submissions and Questions from the Public	Submissions and Questions from the Public	Submissions and Questions from the Public
	5	11	Work Plan		Work Plan	Work Plan		Work Plan		Work Plan	Work Plan		Work Plan	Work Plan	Work Plan
AGENDA ITEMS (100mins)	each section to last for 20mins	06	Election of Chair Election of vice Chair Terms of Reference / Membership / Protocols	RJB			NELCA		NUHFT			ELHCP			
		07	NHS Long Term Plan - *Simon Hall / Alan Steward*	RJB	STP / ELHCP Estates Strategy - *Henry Black*		LAS	STP / NHS Long Term Plan - *Simon Hall / Alan Steward*							
		08		NELCA			C&HCCG		NELCA						
		09	Patient Transport - *Ellie Hobart*				ELHCP								
		10		NELCA	Last minute items	Last minute items		Last minute items	NELCA	Last minute items	Last minute items		Last minute items	Last minute items	Last minute items
INFORMATION ITEMS			National Audit Office Reports Forthcoming proposals for comments News reports and stories		National Audit Office Reports Forthcoming proposals for comments News reports and stories	National Audit Office Reports Forthcoming proposals for comments News reports and stories		National Audit Office Reports Forthcoming proposals for comments News reports and stories		National Audit Office Reports Forthcoming proposals for comments News reports and stories	National Audit Office Reports Forthcoming proposals for comments News reports and stories		National Audit Office Reports Forthcoming proposals for comments News reports and stories	National Audit Office Reports Forthcoming proposals for comments News reports and stories	National Audit Office Reports Forthcoming proposals for comments News reports and stories

INEL JHOSC informal pre-meetings

date to be confirmed	**date to be confirmed**	**date to be confirmed**	**date to be confirmed**
venue to be confirmed	**venue to be confirmed**	**venue to be confirmed**	**venue to be confirmed**
Briefing with CHAIR and vice-CHAIR	Briefing with CHAIR and vice-CHAIR	Briefing with CHAIR and vice-CHAIR	Briefing with CHAIR and vice-CHAIR
External Attendees	**External Attendees**	**External Attendees**	**External Attendees**
NHS Long Term Plan	**Moorfields Eye Hospital**		**NHS Long Term Plan**
Simon Hall	Simeon Baker, Camden CCG		Simon Hall
Alan Steward	Denise Tyrrell		Alan Steward
	Naa Akle Noi, Camden CCG		
Patient Transport			
Ellie Hobart, Tower Hamlets CCG			
Brian Gracey, Barts Health Daniel McLean, Barts Health			

LBTH	London Borough of Tower Hamlets	C&HCCG	City & Hackney CCG
ELHCP	East London Health Care Partnership	NCCG	Newham CCG
LBH	London Borough of Hackney	THCCG	Tower Hamlets CCG
NELSON	North East London Save Our NHS	WFCCG	Waltham Forest CCG
LBN	London Borough of Newham	WEL	WF and East London
CoLC	City of London Corporation		

Suggested items:

Cancer	Simon Hall	ELHCP	Mental Health	Dan Burningham	City and Hackney CCG
Early End of Life	Jayne Taylor	LBN	Health and Social Care PBR	Sunil Thakker	City and Hackney CCG
Digital	Luke Readman	ELHCP	Moorfields Eye Hospital (Sep)	Denise Tyrrell	NHSE
End of Life / Help at Home	Simon Hall	ELHCP	London HIV Strategy	Simon Hall	ELHCP
Community chiropody / foot clinics	??	ELFT / NELFT	ICS workplan	??	ELHCP
Estates Strategy (Mar)	Henry Black	ELHCP	NHS Long Term Plan	Simon Hall	ELHCP
Policies of Limited Clinicial Value (June 2019)	Alan Stewart	ELHCP	Suicide Prevention Plan	??	ELHCP
Maternity			Health Place Bases of Safety (Jun/Sep)	Simon Hall	ELHCP

Items Suggested that did not meet JHOSC criteria:

Item	Submitted by	Reason:
Joint Autism Strategy Refresh and Action Plan	Helen Murphy	Item relevant only to one borough, therefore does not meet JHOSC criteria.
Joint Learning Disabilities Strategy	Helen Murphy	Item relevant only to one borough, therefore does not meet JHOSC criteria.
Joint Mental Health Strategy	Helen Murphy	Item relevant only to one borough, therefore does not meet JHOSC criteria.
Newham Hospital CQC update		Local scrutiny and commissioning, not JHOSC
NHS111 update		Item passed, therefore too late to appear at INEL JHOSC
Out of Area Contracts		Item would not be coming for 'endorsements' or recommendations.

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