MINUTES OF THE MEETING OF THE NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE HELD ON FRIDAY 16 JANUARY 2015

MEMBERS: Councillors Alev Cazimoglu and Anne-Marie Pearce (LB Enfield), Alison Cornelius and Graham Old (LB Barnet), Alison Kelly (LB Camden), Gideon Bull and Pippa Connor (LB Haringey), Jean-Roger Kaseki and Martin Klute (LB Islington)

Officers: Andy Ellis, Jane Juby (LB Enfield), Rob Mack (LB Haringey)

Also Attending: Dr Josephine Sauvage (Islington CCG), Clare Henderson (Islington CCG/LB Islington), Deborah Sanders and Andrew Panniker (Royal Free), Graham McDougall (Enfield CCG), Dr Samit Shah (Clinical Lead – NHS 111 Governance, North Central London CCGs), Alison McMilan (NHS England), Emma Whitby (Healthwatch Islington), Four Members of a Deputation – Defend Haringey Health Services Coalition and 38 Degrees.

Approximately 12 members of the public.

1. WELCOME AND APOLOGIES

Apologies for absence were received from Cllr Klute.

Condolences were expressed to the family of Cllr Brayshaw.

2. DECLARATIONS OF INTEREST

None declared.

3. URGENT BUSINESS

Cllr Cazimoglu requested an update on the current position regarding A&Es in all hospitals in the five Boroughs and what plans were in place to address the significant demand and pressure on these services.

It was proposed that a letter be written to the relevant Trusts to request an urgent update and details of any Action Plans. Cllr Bull confirmed that he would co-ordinate this with colleagues.

AGREED:

That a letter be sent to relevant hospitals in the north central London area expressing the concern of the Committee at recent A&E performance figures and asking for an update and details of any action plans to address the issue.

4. MINUTES

AGREED:

That the minutes of the meeting held on 21 November 2014 be approved.

5. INTEGRATED CARE

Dr Josephine Sauvage, Clinical Lead for Integrated Care, Islington CCG and Clare Henderson, Programme Director Integrated Care, gave a presentation, the key points of which were as follows:

- Integrated Care in Islington was the culmination of a significant body of work in this area over the last 10 years.
- Multi-Disciplinary Teams (MDTs) had been created which looked to support people at home for longer and to help create a better quality of life.
- Care Co-ordinators worked in communities supported by the MDTs. Care Co-ordinators were able to liaise directly with GPs and also refer people to voluntary organisations nearby.
- In turn Care Co-ordinators had felt that they had gained new skills, and were less professionally isolated.
- The film 'Maggie and Rose' outlined a case study which demonstrated how Integrated Care worked. The link would be emailed to colleagues
- Islington had gained 'Pioneer Status' for its person centred approach. Pioneer status was a 'support system enabler' and provided coaching and mentoring to senior staff to help create the right system of leadership to deliver integrated care into the future.
- The 'Integrated Care Journey' demonstrated how LB Islington had implemented its programme. The voice of staff and patients had been essential in its development and there had been a testing and learning approach which had taken time to work through.
- A key issue identified was that services had been too fragmented. GPs had commented that most of their time had been spent helping patients negotiate the system.
- Professionals had been brought together to see how things could be done better and to work to improve patients overall wellbeing, as well as their health.
- 'Building a House of Care' aimed to give people the skills to understand how they could manage their conditions by providing structured support according to ability and motivation.
- 'Value Based Commissioning' had looked at new ways of commissioning based more on outcomes than activity.
- 'Ambulatory Care' was a new approach that helped to 'unblock' the system by taking specialist diagnostics out of hospitals.
- 'Personal Budgets' now enabled greater independence and for providers to work more holistically on a patient's needs.

- The workforce had been developed to encourage greater universal understanding and less silo working. Development of the workforce had also ensured consistent good values and attitudes.
- Implementation of the MDTs had so far reviewed around 600 patients and this had already resulted in a reduction in admission rates, attendances at A&Es and increased patient satisfaction.
- The Better Care Fund (BCF) was a national scheme which pooled money in support of integrated working. In Islington, the BCF allocation for 2015 was £18m. Much of this allocation was not 'new' money but previous sources of funding brought together.
- Through the BCF, Islington was developing its locality offer which aimed to provide consistent care wherever a person lived in the Borough. In addition, MDT teleconferences were being built on and Islington wished to develop its prevention offer by bringing acute hospital staff out into the community.
- Professionals could come together weekly at GP practices to plan care.
- The 8 test and learn sites currently covered 30% of the population and it was hoped to increase this coverage.

The following questions were then taken:

Q: With the high level of health inequalities in Islington there are a lot of people that potentially need support. How are you engaging with hard to reach communities to ensure they get this support?

A: We have very active representation within the CCG who work with Healthwatch and smaller interest groups to inform what we do. This work is of course, always ongoing. We are trying to look at new ways of doing things all the time, for example at the New River Green Estate which is an example of a very targeted engagement programme.

Q: Can you comment on the Expert Patient Programme?

A: Whittington Health formed part of the original pilot in this respect. There are generic and specialist elements to the Programme. The Programme is not just aimed at patients but is complemented by a programme of educational change for clinicians. We also look at the commissioning that supports all of this; for example, increasing GP appointment slots so that they have extra time to talk to patients about ongoing conditions such as diabetes. We also, for example, arrange for diabetic patients to receive test results before their appointments so that they can discuss these with the GP at the time.

An attendee requested that the links to recent research on personalised care and the N19 pilot be circulated.

Q: What is possible for those local authorities who are not quite as far down the road as Islington to implement Integrated Care and face ongoing cuts?

A: It is partly about identifying those areas where you can really work together with other partners; looking at areas of high spend and working across the system to reduce these. Health and Wellbeing

Boards have an important role to play in this. You need, essentially, the 'right people in the room'.

Q: It feels that the implementation of Integrated Care is very patchy across the 5 Boroughs. How far away are we from delivering such aspirations across the board?

A: The issue is to make sure that leaders are working together. System leadership is about working together and getting the message across. This does take time. It also means having honest conversations and prioritising what you can achieve.

Q: Is implementing Integrated Care more difficult if services are being externalised?

A: There are national requirements around competitive tendering but in the interests of integration local solutions are equally valid. You need to make sure that services are developed in a particular way. Local authorities are accustomed to a more contract management approach than perhaps the NHS has been; the challenge is to bring these two approaches together.

Q: We are talking more of evolution, then revolution. What is different about Islington's Integrated Care Programme? The critical success factors seem to be spreading the vision, mentoring leaders and a bottom-up approach. What else has contributed to its success?

A: I'm not sure that there is much difference in our aspirations than any other's. However, we have put GPs and hospitals much more at the centre of what we are doing. Working closely with hospitals is key, as well as developing good primary care.

Q: Where on Islington's Integrated Care Journey is social services? Social services are responsible for a wide range of provision including meals-on-wheels and drop-in services critical to the success of Integrated Care?

A: Social services are embedded in our N19 pilot and a very much a part of the MDT process. Adult social care is embedded all along the system.

AGREED:

That links to recent research on personalised care and details of the N19 pilot be circulated to Committee Members

6. ROYAL FREE ACQUISITION OF BARNET AND CHASE FARM HOSPITALS - UPDATE

Andrew Panniker (Director of Capital and Estates, Royal Free NHS Foundation Trust) and Deborah Sanders (Director of Nursing, Royal Free) updated the Committee as follows:

- It was now 7 months since the Trust had acquired Barnet and Chase Farm Hospitals.
- Focus issues post acquisition were referral to treatment times (RTT) (18 week pathway), A&E, infection control and cultural change.
- A&E – the pressures on A&E services were the same as those being experienced nationally. Weekly systems resilience meetings were being held to respond to this. These meetings involved the London Ambulance Service, Barndoc, social services and a number of other partners. All partners were experiencing high levels of demand. Community nursing had experienced a 36% rise, and there had been an increase of 13% for attendances at Barnet Hospital. The target of 95% of patients being discharged or admitted within 4 hours was not being met this month. This had also been the case for December. Chase Farm's Urgent Care Centre had, however, met its target. The issues behind this were multifactorial, one of which was delayed discharge.
- Delayed discharge comprised two groups – delayed transfers of care (currently 38 patients) and pending patients (waiting on social or community care services). The current level of pending patients was 90. There were therefore 128 patients medically ready to leave hospital but who could not be discharged. Weekly meetings were being held at each site to address the issue.
- Cllr Bull requested that a breakdown of this number over the different sites be circulated.
- Figures were presented for A&E attendances for the week ending 4 January. Performance in the current week had fallen from these levels.

The following questions were taken:

Q: Why wasn't this situation anticipated? Why were A&E services downgraded without the agreed primary care in place? What is planned now in light of the situation?

A: I cannot answer for any plans that were in place up until the implementation of the BEH Clinical Strategy. It is a national issue and there are many other reasons for the rise in demand.

Q: What proportion of the increased levels of attendance at A&Es are due to lack of primary care/primary care being inaccessible?

A: We know that particular groups of people are choosing to come to A&E rather than access primary care, for example the younger age bracket (18-34). We do not have, however, proportions available as this is not something that we ask patients whilst they are at an A&E.

Q: You refer to the 18-34 year age group as attending A&Es rather than accessing primary care. Are there any particular days of the week or times of the day when they do this? If this age group, the majority of whom should be in employment, find it difficult to access a GP outside of working hours, then this might explain why they present to an A&E.

A: We do not have this information; we do not routinely provide this kind of breakdown.

Cllr Cazimoglu commented that the situation was particularly acute in Enfield and that the reason many young people may choose to attend an A&E is that they were unwilling to wait a number of days for a GP appointment. The situation regarding A&Es was also just part of the picture; GPs were experiencing high demand and long queues at practices.

Q: What is the Royal Free Hospital doing in terms of implementing Integrated Care?
A: We do have some integrated care programmes. We are interested in what, for example, the Whittington Hospital is doing especially with regard to its A&E services. We agree we can learn from this and we will be speaking to CCGs and other partners in this respect.

A member of the public felt that, since the A&E had closed at Chase Farm Hospital, those who had taken this decision had not been held accountable.

Q: Why aren't patients awaiting care services being moved into alternative temporary accommodation, rather than staying in hospital?
A: There is always the question of who will meet the cost of this accommodation. It is also not just a question of finding patients somewhere to stay, the right services to support them also need to be available before they can move out of hospital.

Q: A&E services are not working as they should in Enfield, particularly with an increasing population. Why can we not re-open Chase Farm Hospital A&E?
A: It is not within our gift to re-open the BEH Clinical Strategy. The Royal Free's acquisition of Chase Farm Hospital is based on that Strategy and therefore we are not planning to re-open an A&E at Chase Farm.

Cllr Bull commented that, as owners of the site, he believed there was no reason why the Trust could not re-open an A&E at Chase Farm Hospital, should they wish to.

It was requested that a breakdown of the 128 patients currently awaiting discharge be provided, including whether any of these patients were from care homes, since they could be returned to them.

Deborah Sanders confirmed that the Trust was looking at the proportion of A&E attendees coming from nursing homes. The Trust was in the process of setting up a call system for London Ambulance staff through which they could contact the patient's GP to establish if they did, in fact, need to be taken to hospital.

It was reported that, in LB Barnet, GPs has ceased to undertake evening visits to care homes and this was becoming an issue. CCGs had assured members of the Committee that this was being addressed. It was requested that this be taken back to the CCGs to ensure this was the case.

Deborah Sanders added that there was now in place a specific member of staff who acted as a liaison between the Royal Free Hospital and nursing homes. Acute admissions were checked each morning to establish which patients could be discharged back to their nursing home.

Q: I have heard of someone waiting 5 hours for an ambulance and 14 hours to receive treatment for a fractured hip at the Whittington Hospital. What is being done to prevent this happening again?
A: The Royal Free keeps a bed specifically for fractured hip patients open at all times, to enable someone to be referred directly from A&E if necessary. I cannot answer specifically for the instance at the Whittington Hospital.

Q: Is there a maximum wait time between admission to A&E and admission to/treatment on a ward?
A: The maximum wait time is 4 hours.

An attendee commented that, although ambulatory care had relieved pressure on A&E services at the Whittington Hospital, it was not the best financial model. Until CCGs paid differently for admissions, this would continue to be a problem.

Q: What is the BEH Clinical Strategy and how can it be changed?
A: The Strategy resulted in the reconfiguration of all of the main hospitals and pathways in Barnet, Haringey and Enfield. The result for Chase Farm Hospital was very prescriptive for the services to be delivered on the site. The Strategy was 10 years in the making. It has been implemented and the changes it prescribed undertaken. The document is available on the Royal Free NHS Foundation Trust's website.

<u>Chase Farm Hospital Development</u>

Andrew Panniker gave the following update:

- The planning application was submitted to Enfield Council on 21 November and was due to be heard at the Council's Planning Committee on 24 February.
- An initial Planning Committee briefing session was held last week and some learning taken from this meeting relating to the transport infrastructure for the site.
- A confidential draft Business Case would be sent to the Trust Board on 29 January and to the Department of Health thereafter. It was anticipated that the Department of Health would take 8 weeks to issue their report.
- A contractor had been appointed for 2 months to work on the designs to date and to look at costings to ensure these were still within the Trust's affordability limits.

- The media had recently taken an interest in the issue of the tenants on site, on the proposals for the roadways and the main entrance and on the viability assessment. These were being responded to.

The following questions were taken:

Q: There are still concerns around transport to and from the site, particularly in regard to the school. What is being done about this?
A: We are aware of the access issues and Enfield Council's Highways team are looking at this, with the possibility of acquiring land from the Mental Health Trust in order to facilitate better access at certain points.

Q: What is your future vision now for the Highlands wing, which has effectively been 'mothballed'.
A: The Highlands building was originally to house the outpatient facility but we realised that it did not lend itself to the space requirements of a modern ward. We then considered what could be accommodated instead in the building. It became apparent that the services currently in the building were over 20 years old and would need to be completely stripped out in order to do this. The cost of the degree of alterations needed was approaching that of a new build; so it was decided not to proceed. The Trust intends to retain and protect the building for health use but at present, we have not decided on its use. The Trust is prepared to enter into a covenant to ensure future health use.

Q: A large proportion of the medical staff currently living on the site are from abroad and are therefore potentially at high risk of homelessness if alternative accommodation is not found. What is being done about this and about ensuring there is affordable housing for keyworkers on the site?
A: All tenants on the site were notified of our intention to seek vacant possession by the end of March 2015 at the time of acquisition (July 2014). Tenants have therefore had longer than the usual notice period (2 months) to seek alternative accommodation. We have continued to liaise with tenants, with housing associations, with Enfield Council and with local agents to assist tenants in finding accommodation. It should be noted that although we might provide subsidised accommodation, it is not tied to any employment contract. Leases are renewed on a 6 monthly basis. The sale of the land is critical to part fund the redevelopment. The Trust therefore feels that it has done the best that it can in this respect. As to provision of affordable housing for keyworkers; 90 units will be built for this purpose.

Q: Has the Trust provided more disabled parking bays?
A: The Trust will be providing more disabled parking bays; but this is dependent upon relocating people currently in portakabins on the intended site. We are looking to complete this by early summer.

Q: What are the parking restrictions now for disabled visitors and how is this being communicated to people?

A: New signs have been put up conveying this information and staff are walking around car parks to provide assistance. We have also undertaken leaflet drops.

AGREED:

1. That the Royal Free be requested to provide a breakdown of the number of delayed discharges over the Trust's different, including whether any of these patients are from care homes;

2. That the Royal Free be requested to take appropriate action to ensure that relevant CCGs are addressing the issue of the ceasing of evening visits to care homes by GPs.

7. NHS 111 and GP OUT OF HOURS SERVICE COMMISSIONING

The Committee received a deputation from members of Defend Haringey Health Services Coalition and 38 degrees, as outlined in the paper provided.

Members of the deputation emphasised the lack of public engagement undertaken, which in their opinion was a legal obligation, the recommendations from Camden's Scrutiny Panel of Enquiry into its OOH services, potentially increased travel times for patients and the need to have local services with local GPs.

Members of the deputation mentioned that they had recently attended a meeting of the Haringey CCG but were not given the opportunity to put a question to them as the issue they wished to raise was not on the agenda. In addition, they commented that what the public wanted should be taken into account when planning OOH and 111 services. Residents did not want a large, 'faceless' organisation running these services. They added that the proposed model was becoming a discredited one but that GPs did not yet have the capacity to take over.

Members of the deputation expressed the view that they could not see evidence of proper integration of OOH and 111 services in the proposals and had no confidence that the proposed model would work. A clearer plan needed to be consulted upon. They also expressed concern at the procurement process and that it seemed to be moving forward too rapidly. They asked what the implications of the upcoming purdah period might be on the process.

The Committee then received a presentation from Dr Samit Shah, Clinical Lead for NHS 111 Governance, North Central London CCGs and Graham McDougall, Enfield CCG, the main points of which were as follows:

- CCGs were working with local providers to better organise OOH and 111 services around particular populations and develop a different offer of care.

- Individual elements of urgent care could no longer be commissioned separately.
- Urgent Care Centres in acute hospitals formed part of the health care offer.
- The 111 service was now in its second year. After initial difficulties at a national level, the service was now well embedded.
- The main issue for operation of OOH and 111 services was managing more effectively the handover between them, which could manifest in clinical risk. As the majority of OOH cases were referrals from the 111 service, it was important to better manage pathways.
- Most of the large contracts within the NHS were on an annual rolling basis. This made it easier to bring them together.
- The issue of local GPs delivering local services was not a new one; this would be addressed as part of the new process.
- The 111 service in North Central London area was currently delivered by LCW Unscheduled Care Collaborative which was a social enterprise in West London and was originally the GP Co-operative in that area.
- OOH services in the area were delivered by Care UK and Barndoc.
- The majority of users of the 111 service were between 18 and 64 years old.
- Regular clinical quality review meetings were held to assess the performance of the 111 service and so far, this had been very good.
- Use of the services by ethnic populations was self-reported; difficulties in access were not always linked to language. It was acknowledged that further work with local groups and local authorities could be undertaken to improve access for these populations.
- The OOH service had existed for a number of years in different forms; most people were therefore aware of it. This was not necessarily the case with the newer 111 service and greater engagement therefore needed to be undertaken to raise awareness of the service.
- The most common symptoms presented to the 111 service were tracked and monitored.
- There was no evidence to suggest that increased attendance at A&Es was a result of unnecessary referrals from the 111 service. Only 7% of activity for the London Ambulance Service had originated with the 111 service.
- There were no geographical ‘clusters’ for users of the 111 service since people did not necessarily call from home, but could access the service anywhere in the five boroughs. Any new model would therefore need to effectively overlay the whole NCL area.
- An urgent care review had recently been undertaken in Camden and Islington, which had recommended changes to the 111 and OOH services.
- The process for procuring a new service had only just started and CCGs were keen to involve users from the beginning in shaping the specification. GPs were also closely involved.
- The procurement process was governed by NHS England and therefore incorporated an assurance process.

- Pathways and workforce needed to be more flexible and integrated between the services, particularly as the OOH service could prescribe, whilst the 111 service could not. A better skill mix in the workforce was also needed.
- IT platforms would also need to be integrated.

Dr Shah concluded by responding directly to the concerns raised by the Deputation and made the following comments:

- The views expressed were welcomed; it was important to start dialogue with residents and users from the beginning.
- Remodelling the 111 and OOH services was not about simply choosing one provider but about improving the services and reducing inequity.
- Local providers could come together to deliver the services if they wished.
- There was no suggestion that the distance patients would have to travel would change under the new model. Indeed, travel times may be reduced if inequity was resolved.
- It was important to note that in London, OOH services staffed entirely by local GPs did not exist. The key issue was ensuring, instead, that GPs offering these services had the right skills and training; and operated to the right standards.
- Price was a factor but it was essential to ensure a correct balance between this and quality.

The following questions were then taken:

Q: Do GPs receive any training so that they can effectively negotiate the areas they operate in?
A: GPs have drivers with them who are familiar with the local area; however, there is no suggestion as yet that the current hubs will change.

Q: If more people are using the 111 service, why is there still a pressure on A&Es?
A: In my personal opinion, I think this is because the case complexity has changed in A&E.

Q: You refer to integrating IT platforms; will patient data be shared with external providers?
A: There are different types of arrangement with regard to data sharing but there is an overarching governance structure nationally within the NHS. Barndoc, for example, currently does not have access to GP patient notes. This may be something we would like to implement, but it will depend upon GPs consenting to this.

Q: Staffing of the 111 service is currently on a ‘customer call centre’ basis and staff are not clinically trained to go ‘off framework’. Would this in itself be a factor for more people attending A&E?

A: Any health advisor on the 111 service can pass the call to a clinician if they feel it needs to be managed off framework. A clinician can also reverse any previous decision to refer a caller to A&E.

Q: Is there a public consultation running at the moment on the proposals and how does one get involved with the CCG?
A: As this is the start of the process, CCGs would welcome your views on how to continue with engagement.

Cllr Bull invited attending members of the public to submit any questions they wished to raise in writing after the meeting, and to lobby any individual scrutiny panels if they were concerned about the procurement process.

Q: What is the timeline for the procurement process? Has this been impacted by the urgent care review which doesn't conclude until July?
A: The impact of the review has been taken into account, although the urgent care review has a slightly different remit.

Cllr Cazimoglu commented that many people were concerned about companies running the service 'just for the money' and asked if consideration had been given to using not for profit organisations?

Dr Shah responded that all options were open and a mixed economy of providers would be needed. The process did not preclude anyone, including local GPs and not for profit organisations, from bidding. It would be essential, however, to ensure that any providers did not derogate away from quality.

8. COMPLAINTS REGARDING PRIMARY CARE SERVICES

Alison McMilan, Head of Complaints, NHS England, gave a presentation which detailed the process for submitting complaints, which was as follows:

- Complaints in the first instance should be made directly to the provider (e.g. the GP practice or hospital concerned).
- If a complainant did not wish to do this, they could raise their complaint with the commissioner of that service.
- If the complainant was not satisfied with the provider's response they would be directed to the Ombudsman.
- Complaints relating to Primary Care (GP, dental pharmacy or optician) and Specialised Commissioning, including Prison services, fell under the responsibility of NHS England.
- Complaints relating to hospital, mental health, community trust and local health services fell under the responsibility of the provider and Clinical Commissioning Groups (CCGs).
- NHS England operated national and local area teams for dealing with complaints. The national team would direct complaints to the relevant local team, who would then consider if informal resolution was appropriate and acknowledge the complaint. The complaint would then be forwarded, if appropriate, to the service provider for resolution. In

these cases the consent of the complainant would always be obtained beforehand.

- A response would be drafted by the service provider, which would then be reviewed by the local complaints team and signed off by the Head of Primary Care and Delivery Director.
- Quarterly review meetings were being set up to look at complaint handling.
- Complaints would be opened within 24 hours of receipt by NHS England, if there were any immediate concerns these would be raised with the appropriate provider as soon as possible.
- An improved complaints recording system was being implemented in February which would enable more detailed breakdowns of complaints data.
- The greatest proportion of complaints were currently made in respect of GP practices, and related to clinical issues.
- Complaint volumes had not increased this year from last year, but had not fallen either.
- The National Customer Contact Centre could be contacted on telephone number 0300 311 22 33 or at england.contactus@nhs.uk.

The following questions were then taken:

Q: Are customers encouraged to contact the Practice Manager in the first instance in respect of GP related complaints?

A: Yes. We also work with GPs to encourage them to raise awareness with patients that they should do this. Many GPs have set up Patient Participation Groups to raise awareness and discuss issues of concern.

Q: Is the formation of a PPG required in legislation or is it at the discretion of individual GP practices?

A: I believe it is required in legislation.

Q: Will the improved data you mentioned be useful to organisations like Healthwatch?

A: Yes, we do already provide data to Healthwatch but this is very high level information; the new system will enable us to provide more detailed statistics.

Q: How accessible is NHS England's complaints process for people, for example, with disabilities, deaf people or blind people?

A: We do have translation services available but, as customers contact us primarily by telephone, sometimes it is difficult to ascertain what their needs are immediately. We do, however, have processes and systems to help us do this.

Deborah Fowler, Healthwatch Enfield, commented that there could be improved accessibility for BSL users and those from BME communities.

Q: Where and how is organisational learning taken?

A: I review any organisational learning with the NHS England London Team. We share any organisational learning in respect of independent contractors with the Medical Director. Meetings are held monthly to discuss complaints and learning from them. With individual GP practices, Action Plans can be put in place and we track these.

Q: Is the learning publicly available?
A: NHS England currently produces a national annual report; however at the moment there is no local equivalent that is publicly available. Sometimes it is not appropriate to share information, for example, when it relates directly to independent contractors. We do identify themes and trends however and raise them with practices accordingly. Our new IT system will track any organisational learning and produce this information in a more appropriate format for sharing.

Cllr Cazimoglu and Pearce commented that they had recently met with members of the deaf community who had raised as an issue the accessability of NHS services. They suggested a meeting with NHS England representatives would be useful.

Q: If a complainant withdraws their complaint, does NHS England still take this forward if necessary as an anonymous complaint?
A: Yes, particularly if the issues raised are of high risk; we still need to capture that learning anonymously.

Q: Can the contact details for the Ombudsman be provided?
A: Yes, I can obtain these.

Q: Do you produce leaflets with information on how to raise a complaint or display such information in GP practices?
A: Healthwatch Islington reviewed the information displayed at GP practices and this has since improved. Mystery shopping was also conducted to ensure practice staff were able to deal appropriately with anyone raising a complaint.

Q: Will you be able to capture diversity data on the new IT system?
A: Yes.

AGREED:

That contact details for the Ombudsman be circulated to Members of the Committee.

9. WORK PLAN AND DATES FOR FUTURE MEETINGS

The date of the next meeting was noted as 20 March 2015, to be held at a venue in LB Camden.

The Work Programme was noted**.**

It was proposed that a meeting of Barnet, Enfield and Haringey Members regarding mental health issues within the three boroughs as well as issues relating to Barnet, Enfield and Haringey Mental Health Trust be arranged prior to the Purdah period. It was also suggested that dates/times of the meetings going forward be reviewed.

Cllr Bull requested any proposed agenda items be sent to him.

AGREED:

1. That a meeting of Barnet, Enfield and Haringey Members regarding mental health issues within the three boroughs as well as issues relating to Barnet, Enfield and Haringey Mental Health Trust be arranged prior to the Purdah period;

2. That dates and times of future meetings be reviewed at the first meeting of the Committee after the annual meetings of participating boroughs.