# SCRUTINY REVIEW PANEL 1 – INEQUALITIES

## MINUTES

## Thursday 19th January 2017

**PRESENT**: Councillors: Ciaran McCartan (Chair), *Mohammad Aslam* (Substitute for Tejinder Dhami), Jon Ball, Theresa Byrne, Paul Conlan, Fabio Conti (Vice-Chair), Dee Martin, Mohinder Midha, Karam Mohan, Ian Proud and David Rodgers.

**Ealing Officers Present:**

| | |
|---|---|
| Dr Jackie Chin | - Director of Public Health |
| Anna-Marie Rattray | - Scrutiny Review Officer |
| Lee Teasdale | - Democratic Services Officer |

**External Attendees:**

| | |
|---|---|
| Dr Raj Chandok | - Vice-Chair, Ealing CCG |
| Rachel Donovan | - Assistant Head of Primary Care Commissioning, NHS England |
| James Guest | - Chair, Healthwatch Ealing |
| Tessa Sandall | - Managing Director, Ealing CCG |
| Neha Unadkat | - Deputy Managing Director, Ealing CCG |

**1. Apologies for Absence**
(Agenda Item 1)

Councillor Tejinder Dhami was substituted by Councillor Mohammad Aslam.

**2. Declarations of Interest**
(Agenda Item 2)

There were none.

**3. Matters to be Considered in Private**
(Agenda Item 3)

There were none.

**4. Minutes (08.09.2016)**
(Agenda Item 4)

The Panel considered the minutes of the last meeting of the Panel which had taken place on 17 November 2016.

**Resolved:** That the minutes of the previous meeting of the Panel held on 17 November 2016 be agreed as a true and correct record.

**5. Health Inequalities**
(Agenda Item 5)

The Chair invited Dr Jackie Chin (Director of Public Health) to address the Panel on Health Inequalities in the Borough.

Dr Chin explained that there were many different determinants which led to inequalities in health – with wide ranges in life and healthy life expectancy being seen geographically, by social class, by gender, ethnicity and many other varied factors.

There were differing views on how such health inequalities came about. Some viewed it was being a direct result of socio-economic circumstances, such as income, wealth or power. However, some behavioural theories saw differences in lifestyles as the overriding cause of inequalities. Some stated that there were cultural reasons for inequalities in health stemming from 'dependency cultures' which were inter-generational.

**Marmot Review – 'Fair Society, Healthy Lives'**

An important driver of current work around health inequalities was the Marmot Review 'Fair Society, Healthy Lives' published in 2010. The Review proposed new ways to reduce health inequalities in England, arguing that, traditionally, government policies had focused resources on limited segments of society and to improve health for all, action was needed across the entire social gradient.

The Review asserted that it was not sufficient just to focus upon the bottom 10 per cent of the social gradient, because poorer outcomes were seen all the way down from the very top. Universal action was needed to reduce the 'steepness' of the social gradient of health inequalities, but with a scale and intensity proportionate to the level of disadvantage.

Key to such an approach was to create the conditions for people to take control of their own lives. This placed renewed emphasis on the role of local government, along with national government departments. The voluntary and private sectors would also have a key role to play.

**Life expectancies in Ealing**

There were wide variations in life expectancy across London. In Ealing, men could now expect to reach 80.6 years old compared to 84.2 for women – a gap of 3.6 years (with the London average being a gap of 4.1 years).

It was known that for every 10 per cent increase in older people suffering deprivation, life expectancy fell by six months. A 10 per cent increase in employment deprivation, life expectancy fell to a year lower.

Across the borough life expectancy for men ranged from 77.1 years in Southall Green, to 84.0 years in Perivale, a gap of 6.9 years in life expectancy. For women, it ranged from 80.1 years in South Acton to 87.5 years in Northfield, a gap of 7.4 years in life expectancy.

With regards to 'healthy' life expectancy, males in the borough could expect 62.9 years of healthy life and females 62.6 years.

**Children & Childhood Obesity**

Health inequalities had a particularly striking effect upon children, putting them at a disadvantage which would continue into later life. By way of example, three of five

(60%) of the most deprived boys aged five to eleven were predicted to be overweight or obese by 2020, this compared to one in six (16%) of the most affluent group. Child poverty and adverse childhood events could influence the brain development of children and heightened their chances of risk of death in adulthood from a broad range of conditions. Children living in poverty were more likely to have health problems such as asthma, and mental health problems, and would also have lower educational attainment than their more affluent peers.

Figures for 2015 showed that 23% of Ealing's children lived in income-deprived families; this was an improvement over 2010, where the figure was 32.5%.

In 2014/2015, obesity prevalence in Reception year children in Ealing was 10.6%, rising to 23.9% for those aged 10-11.

**Smoking**

Of the 339,509 people registered with Ealing GP practices (and aged 15 or over) in 2014/2015, 54,958 (16.2%) were listed as current smokers. The distribution of smokers varied in different parts of Ealing, with prevalence ranging between 14.2% and 19% for all the wards, though these differences were not considered to be statistically significant. The highest rates of prevalence were seen in the five wards of Southall, whilst the lowest rates were based in wards around Central Ealing.

**Cardiovascular Disease**

The main risk factors for death from cardiovascular disease (smoking, raised blood pressure, diabetes, obesity, lack of physical activity) were associated with living in a deprived area.

Deaths in Ealing from cardiovascular disease in those aged under 75 from 2010-2014 were found to be highest in the Southall wards, whilst the lowest rates were in the Central Ealing wards.

**Sexually Transmitted Infections (STIs)**

As with wider health-related issues, there was also a strong link between areas with higher social deprivation scores and STI's. In Ealing, there were higher rates of STI's in Lower Super Output Areas associated with deprivation.

**Questions**

The Chair thanked Dr Chin for the report and invited panel members to comment and ask questions.

The Chair opened the questions by querying progress made on 'Future Ealing' health plans.

Dr Chin advised that Future Ealing was still at the 'beginning of the journey'. Principles had been agreed, but further work was needed on how to put resources into it and maximise the opportunities it presented. Closer working was taking place between the Local Strategic Partnership and the Health and Wellbeing Board who would both be heavily involved in taking it further.

Councillor Conti asked if there were examples of joined up working between departments already in place.

It was advised that joint training had been taking place between the Early Years Team and health visiting staff. This was part of a drive to encourage uptake of educational facilities from age 2.

Councillor Rodgers thanked Dr Chin for the report but reminded the Panel that health inequalities should be seen as an outcome arising from social disadvantage and not as a cause of social disadvantage. Poverty and socio-economic disadvantages were the major underlying cause of health inequality and it was paramount that these aspects were addressed. The effect of poverty on diet was clear, with evidence being seen at food banks of how the cheapest food types were often nutritionally poor.

Dr Chin stated that programmes were in place in which the teaching of cooking skills were offered, in order to allow families to make nutritionally balanced meals cheaply rather than opting for ready meals.

Councillor Midha expressed concern that life expectancy in the Borough's most deprived wards was up to 7 years earlier than the most affluent wards. Dr Chin stated that unfortunately this was the case due to increased likelihood of high blood pressure, heart disease, diabetes etc.

The Chair noted that despite men having a shorter life expectancy overall, their 'healthy' life expectancy was higher (62.9 years in men compared to 62.6 in women). Was any work done to address the fact that women, living longer, would be expected to live longer with health issues?

Dr Chin advised that there was no specific work done on this in Ealing, but if there was work being done within the wider national picture this information would be fed back to the Panel.

Councillor Martin noted that the figures on life expectancy were not entirely consistent with expectations by ward. For example, highest life expectancy in men was found in Perivale. Were ward by ward breakdowns reliable for comparisons?

Dr Chin stated that she would look into the background of the Perivale figures and feed back to the Panel.

The Chair noted that improvements in the 'good level of development' of children had been seen year on year for some years until a slight dip in 2015 against the London average. Was there a particular reason for this dip?

Dr Chin stated that she would look into the reasons for the dip and feed back to the Panel.

Councillor Proud asked if the transient nature of sections of the Borough's population had an effect upon, or skewed the reported figures in any way. It was advised that it could impact upon STI figures which were most prevalent in the age groups most likely to only live in the borough for a short period such as students.

Councillor Conti asked if work was taking place regarding sexual health trends. Dr Chin advised that most outreach work that was taking place focussed upon HIV education and intervention. Particular work was taking place on combating late diagnosis of HIV. Dr Chin advised that she would share the Sexual Health Needs Assessment with the Panel.

Councillor Rodgers asked if health officers addressed the correlation between poverty/homelessness and the extra demands such situations placed upon the NHS and healthcare services.

Dr Chin acknowledged that rises in homelessness would directly impact upon wellbeing and result in increased health pressures. Local authority public health officers had a role to play in making healthier lifestyles choices easier and more accessible, developing the right sort of local environment and encouraging walking, exercise, use of green space and being 'sugar smart'.

Councillor Proud expressed concern that Gurnell Leisure Centre had snack/drink machines where the only options were all high sugar content snacks. Could officers ask that they lead on the provision of healthy options? Dr Chin stated that she agreed with this concern and it had been raised with the leisure centre.

Councillor Rodgers raised the nitrous oxide trend which was still popular amongst teenagers and young adults. Were any statistics available on the usage of this, and were there any nationally recorded fatalities in relation to its usage?

Dr Chin advised that whilst no local figures were available she would look to feedback information on the wider picture back to the Panel. She agreed that usage was a concern regardless of the level of danger, as it relates to a willingness to take risks through recreational drug use.

The Chair asked if the recommendations arising from the Health and Adults Services Scrutiny Panel review of public health were being taken forward. Dr Chin confirmed that many of these recommendations had been acted upon and confirmed the work undertaken so far to the Panel.

The Chair then drew the item to a close, thanking officers and attendees for their contribution to the discussion.

**Resolved:** That

(i) the report on health inequalities in Ealing be received;

(ii) information on support for women living longer with health issues be fed back to the Panel if available;

(iii) further details on the Perivale life expectancy performance be fed back to the Panel;

(iv) further details be fed back to the Panel on the reasons for the dip against the London average for good levels of development in children during 2015;

(v) the Ealing Sexual Health Needs Assessment be fed back to the Panel; and

(vi) information detailing nitrous oxide usage and the dangers involved be fed back to the Panel.

## 6. Access to Primary Care in Ealing

(Agenda Item 6)

The Chair invited representatives from Ealing Clinical Commissioning Group (ECCG) to address the Panel. The representatives were Dr Raj Chandok (Vice-Chair, ECCG), Tessa Sandall (Managing Director, ECCG), Neha Unadkat (Deputy Managing Director, ECCG) and Rachel Donovan (Assistant Head of Primary Care Commissioning, NHS England).

Tessa Sandall outlined the current context of primary care in Ealing. There were 76 contracted general practices across the borough at the present time, grouped into three geographical localities (Ealing & Acton, North, Southall) and then further subdivided into seven networks (Acton, Central Ealing, South Central Ealing, North North, South North, North Southall and South Southall). These 76 general practices varied in size, from 1200 registered patients up to 15000 registered patients.

### GP Forward View

The 'GP Forward View' had been published in April 2016 and detailed the complexities of providing primary care within the context of a growing and aging population, dealing with increasingly complex health conditions.

The share of funding for primary care had not grown in line with the rest of the system, therefore the Forward View included a plan for action, highlighting clear proposals for investment in primary care in order to tackle workforce gaps, increasing workloads, improving the infrastructure and redesigning care in line with the changing needs of the expanding population.

The plans for how the GP Forward View funding would be utilised were still being developed. The ECCG was working closely with the Local Medical Committee (LMC), Ealing GP Federation, Local Primary Care Providers and other boroughs across North West London and NHS England.

### Out of Hospital Services

ECCG had been working with partners to reduce unwarranted variations in primary care across a number of care pathways. From July 2015 ECCG had commissioned primary care to deliver a range of services, namely the Out of Hospital Services contract which commissioned a range of 19 services (through 21 service lines), including services such as diabetes care, homelessness services and severe mental illness transfer of services.

These 19 services were commissioned via the local GP Federation but were delivered by individual practices.

The aim of the out of hospital services were to:

- Deliver care closer to home

- Improve care quality
- Reduce primary care variation; and
- Deliver services equitably across the Borough

**Additional Capacity in Primary Care**

In recognising the increasing demand upon primary care services in Ealing, additional capacity had been commissioned during winter months, helping to increase access to appointments at times when the systems was particularly stretched.

Weekend access clinics were also commissioned across three sites in Ealing; these could be accessed by patients via the 111 service.

The CCG would be transitioning the weekend access clinics to a new extended access service with both pre-bookable and urgent appointments, provided at three fixed hub sites across the borough that would open every evening between 6:30 and 8pm and at weekends from 8am to 8pm.

**Newly Arrived Communities in the Borough**

Ealing CCG had worked closely with the voluntary sector to identify newly arriving communities and encourage them to register with local practices.

Local partners helped with access and links to local communities, allowing for the sharing of key messages on the appropriate use of emergency services and how to register with GP Practices.

A patient facing website (www.healthyealing.com) had also recently been launched and provided information on how to access services and register with GP practices.

**Urgent Care**

Ealing Urgent Care Centre (UCC) (delivered by Greenbrook) had been commissioned to provide urgent care on the Ealing Hospital site 24 hours a day, 7 days a week.

The provider had recently recruited a ‘patient champion’, who linked with patients who had attended the UCC rather than going to a GP practice, finding out why they chose to attend the UCC and support them to register with a GP where necessary.

**Known High Level Issues in Primary Care**

Known issues being addressed included:

- Accessing appointments in general practice – Extended hours services and additional capacity were being put into place to tackle this issue.

- Services users of no-fixed-abode unable to register with general practice of their choice – An Out of Hospital Service for the homeless has been commissioned by the CCG.

- Wound care capacities at weekends – Extended hours services were required to provide wound care services.

- Patients living in a neighbouring London borough but registered to an Ealing practice facing difficulties in accessing Ealing CCG commissioned services – Work was taking place with neighbouring commissioners and trusts to enable a seamless service.

**Development Planning**

The GP Forward View was clear on local areas for focus in improving primary care going forwards, the areas of focus included extended access, online consultations, provider development, training care navigators & medical assistants, the workforce and estates.

**Improving Quality**

The CCG and NHSE had in place a Quality Sub Group which reviewed the various indicators of quality.

Work had also taken place with local partners and GP providers to highlight the potential risks to the resilience and sustainability of GP services in Ealing.

**Secondary Care and Out of Hospital Hubs**

Three local hubs were due to be based across the borough, one based within the existing Ealing Hospital site, and two new sites due to be built in Greenford and Acton.

The hubs would bring together lots of different NHS and social care services into one location. The aim was to better co-ordinate the services patients needed rather than having to arrange multiple appointments in different locations. This was considered especially important for older people, and people with one or more long-term illnesses.

**Questions**

The Chair thanked the attendees for their presentation and invited Panel Members to comment and ask questions.

Councillor Conti asked for reassurance on how residents who were ‘non-digital’ would be fully informed on how to access services available to them?

It was answered that whilst many people now preferred the option to access information online, it was fully appreciated that such options would not be suitable for everyone. Efforts were made to ensure that information was freely available through printed communications as well.

Councillor Ball expressed concern about additional out of hospital services overwhelming primary care providers.

It was stated that demand would inevitably 'ramp up' hence the introduction of additional fixed sites. GP practices were closely monitored in relation to the level of demand placed upon them. Further funding was in place to broach demand issues where needed, though a 'deluge' of extra demand was not anticipated.

Councillor Ball asked if all 76 GP sites across Ealing had the capacity to deal with diabetes issues. It was advised that GP practices could buy-in additional nursing where needed for diabetes treatment. The need to support staff with relevant training was also recognised.

Councillor Mohan asked about the formal mechanisms in place for monitoring GP practices. It was advised that NHS England managed GP contracts – ECCG were however, looking into delegation of the management of primary care contracts.

Councillor Rodgers asked if the increased demands being placed upon health services were largely down to increasing socio-economic issues arising in the wake of government imposed austerity measures.

Officers stated that whilst they were not in a position to make such causal links, it was seen that demands were increasing across all health areas. Increases had happened for a number of reasons. For example, due to people living longer, large increases in the amount of frail and elderly residents needing high levels of care had increased exponentially.

Councillor Rodgers then asked about funding. It was stated that underfunding was an issue at present, but over the next five years funding would be increased to a position closer to where the CCG needed it to be. It was imperative that this extra funding was invested wisely, hence the planning modules being put in place.

Councillor Rodgers expressed concern that the funding would not be enough, and that health inequalities would further increase as a result. Officers stated that they were not in a position to demand more funding, and therefore needed to wisely spend all funding that was made available to them to minimise health inequalities as best as possible.

Councillor Conti stated that there were many nuances involved in health care, and it could not be painted as a simple black and white case of directly resulting from socio-economic factors – many of the issues now coming to the fore had been building up over a significant period of time and had not just appeared following austerity measures. It was therefore important that any recommendations arising from the Panel were balanced.

Councillor Byrne asked whether Ealing had any particular issues around staff recruitment. It was advised that there were no specific Ealing issues, but there were obvious issues that fed into wider London and Nationwide concerns. More GP's were needed, many retirements were looming which could see shortages. One way of combating such shortages was to upskill nurses where possible. Work was taking place on attracting more nurses into general practice. Work was also taking place on the retaining of quality staff.

Councillor Conti noted that many of the practices operating in Southall were 'single-handed'. Taking this into account, could Southall in particular be at risk of access problems over the next five to ten years?

It was advised that this was a concern, though as these were private practices, no structural demands could be placed upon them. The GP Forward View looked at the most successful models going forward.

It was emphasised though that whilst smaller practices were less resilient, there was no future prescriptive plan of 'super services' in place.

Councillor Byrne asked if transport access to the 3 'hub' sites had been fully considered. It was advised that patient events were taking place to review the potential hub sites within the local context, and were considering parking locations and public transport accessibility.

Councillor Martin asked about joint working to address inequalities. How were these being picked up and resolved?

Joint working had taken place on heart failure admissions to address root problems and investment decisions were made based upon where failures in outcomes were seen at the present time. The Joint Strategic Needs Assessment flagged up a raft of areas where need was seen and would benefit from a tied up strategic approach between health providers and the local authority (such as homelessness concerns).

Councillor Conlan asked whether officers had an idea of how many residents remained unregistered with a GP. Was this growing? And were any groups particularly hard to connect with?

The difference between registered patients and resident levels was recognised and pro-active work was taking place on registration. Work was also taking place on trying to connect with hard to reach demographics, many of these groups visited UCC's and work was done in these locations to encourage registration.

A specific piece of work had taken place on working with Eastern European groups. Once the outcomes of the work had taken place, these could be fed back to Councillors.

Councillor Rodgers expressed concern regarding mental health access. It was advised that there had been a huge push over the last 18-24 months to increase funding and prominence resulting in easier access to mental health services. A new large scale call centre had been opened in April 2016, a one stop call service which helped to reduce unnecessary admissions.

Councillor Rodgers then asked about Ealing vaccination programmes, at present needed percentages for herd immunity were not being met, what was being done to improve this? Officers advised that an action plan was in place to drive up herd immunisation levels, arrangements would be made to forward the action plan to the Panel.

Councillor Ball made reference to a shortage of the BCG Vaccine; some people were now resorting to getting these vaccines through private sources, was there a timescale for increased availability?

It was advised that some vaccines had now become available, and these were going to the areas with the highest levels of need. A definitive timescale was not available at present but when the information was available it would be forward to the Panel.

The Chair then thanked all present and drew the item to a close.

**Resolved:** That

(i) the report detailing access to primary care in Ealing be received;

(ii) information on the success of the patient champion in supporting those people attending the Urgent Care Centre not registered with a GP to register be provided to Councillors when available;

(iii) the action plan for driving up herd immunisation levels be fed back to the Panel; and

(iv) information on the BCG vaccine availability timescales be fed back to the Panel.

**7. Panel Work Programme**
(Agenda Item 7)

The Chair advised the Panel that a representative from the New Policy Institute would be invited to the next meeting along with Kieran Read (Director of Communications) and Councillor Peter Mason (Portfolio Holder for Prosperity, Skills, Employment and Transformation).

**Resolved:** That the Panel Work Programme be noted.

**8. Date of Next Meeting**
(Agenda Item 8)

It was noted that the next meeting of the Panel would take place on Thursday 30 March 2017.

Councillor Ciaran McCartan, Chair.

The meeting ended at 9.10pm.