Scrutiny Health & Social Care Sub-Committee

Meeting held on Tuesday, 12 March 2024 at 6.30 pm in Council Chamber, Town Hall, Katharine Street, Croydon CR0 1NX

MINUTES

Present: Councillor Eunice O'Dame (Chair); Councillor Robert Ward (Vice-Chair);

Councillors Adele Benson, Patsy Cummings and Holly Ramsey

Co-optees: Gordon Kay (Healthwatch Croydon) and Yusuf Osman (Resident Voice)

Also Present: Councillors Yvette Hopley (Cabinet Member for Health & Adult Social Care), Margaret Bird (Deputy Cabinet Member for Health and Adult Social Care, Janet Campbell (Shadow Cabinet Member for Health & Adult Social Care; virtual) and Rowenna Davis (Chair of Scrutiny and Overview Committee; virtual)

Apologies: Councillor Sherwan Chowdhury (joined online)

PART A

8/24 Minutes of the Previous Meeting

The minutes of the meeting held on 22 January 2024 were agreed as an accurate record.

9/24 Disclosure of Interests

There were no disclosures of interest made at the meeting.

10/24 Urgent Business (if any)

There were no items of urgent business for consideration of the Health & Social Care Sub-Committee at this meeting.

11/24 Update on Pharmacy First scheme

The Sub-Committee considered a report set out on pages 15 to 18 of the agenda which provided an update on the Pharmacy First Scheme that was recently rolled out nationally by the Government and NHS England which aimed to give patients quick and accessible care while easing the pressure on GP services.

- Councillor Yvette Hopley – Cabinet Member for Health and Adult Social Care
- Councillor Margaret Bird – Deputy Cabinet Member for Health and Adult Social Care
- Matthew Kershaw – Chief Executive at Croydon Health Services and Place-based Leader for Health
- Rachel Flowers – Director of Public Health
- Annette McPartland – Corporate Director of Adult Social Care & Health

Mathew Kershaw, Chief Executive at Croydon Health Services and Place-based Leader for Health, introduced the report. It was explained that the main objective of the Pharmacy First scheme was to open up the option for residents to access pharmaceutical advice as opposed to attending primary care or in some cases emergency department in hospitals. It was further added that it was a national initiative. It was stressed that Croydon had very good coverage compared to other authorities, with around 68 community pharmacies signed up for the programme. It was explained that this translated into around 96% coverage across the Borough. It was further explained that in many cases these services had been previously available in many pharmacies, however, the Pharmacy First scheme aimed to bring more structure and consistency to the offered services.

The first question asked by the Sub-Committee considered any unintended consequences of rolling out the Pharmacy First scheme, and asked whether the scheme required the participating pharmacies to have a designated private area for examination and conversations between pharmacists and patients. Mr Kershaw responded that so far, they had not observed any unintended consequences, however, it was stressed that the scheme was rolled out very recently. It was also highlighted that pharmacists were trained healthcare professionals and before the scheme was launched, they were already able to provide the same level of support. Therefore, they did not expect any unintended consequences to arise. Nonetheless, it was stressed that they would continue to monitor the scheme. In terms of pharmacy facilities, it was agreed that designated spaces allowing privacy were very important. Confirmation could not be given as to whether each pharmacy had adequate space, however, this would be expected to be available when a pharmacy signed up to participate in the scheme.

A supplementary question was asked by the Sub-Committee Member regarding the referrals and whether a patient could be refused care by a GP practice if they did not want to seek help in a pharmacy beforehand. It was explained that a patient cannot be forced to seek care elsewhere, and their needs would be assessed at the GP practice. It was stressed that this kind of appointment would often not require an engagement with a GP, but then a different healthcare practitioner would be assigned.

Subsequently, the Sub-Committee asked a question about what was being done by the Council to advertise this scheme. It was stressed that this type of

care was often provided by many pharmacists and a considerable proportion of the population already knew that they could seek help there. It was explained that to increase awareness, Croydon Health Service NHS Trust (CHS) would continue to publicise it alongside the ongoing national campaign. It was also stressed that all possible routes of promotion would be considered, including direct work with communities. It was questioned whether the awareness raising work had already started. It was explained that work on this had only recently commenced and there would be more publicity rolled out in the near future.

The next question asked by the Sub-Committee considered the effect of pharmacists working from home on the scheme. It was explained that as all different health-care providers, including pharmacies had been exploring different ways of working and providing support. However, it was stressed that the premise of Pharmacy First scheme was different, as it was expected that in the great majority it would be expected that patients received care in-person and in the timeliest manner possible.

Subsequently, the Sub-Committee Member asked a question on data regarding the number of people accessing care through the scheme and whether there were any capacity concerns. It was explained that there were some early estimates, which were in the reach of 1500 visits over the first six to eight weeks across all the participating pharmacies. Assurance was offered that at this stage there were no capacity issues arising, and they were not expected to arise in the future.

The next question considered accessibility of pharmacies' and whether there were dedicated staff to monitor the experience of patients attending pharmacies rather than GP practices. Also, the Sub-Committee raised anecdotal concerns about the tidiness and cleanliness of some pharmacies. It was explained that CHS was not aware of any work being done nationally around patient's insight and there had been no work locally as the scheme had only been rolled out very recently. However, it was stressed that there would be work to gather patient feedback in the future.

In terms of facilities, it was stressed that it was very important to ensure that people were examined in appropriate spaces. However, it was explained that pharmacies would not do more complex examinations, therefore, the spaces they used did not require the same standard as GP practices or hospitals. It was also stressed that there were no identified GDPR concerns. It was highlighted that in terms of access, it was often easier for residents to visit a pharmacy than a GP practice. However, it was stressed that people would have a choice to seek care at a GP practice, if they wished to do so.

The Sub-Committee asked a supplementary question about the risk of a large pharmacy chain closing some of its pharmacies in the Borough and how this might impact upon the scheme. It was explained that CHS were not aware of any particular risk of pharmacy closure and it was expected that the scheme would have a positive effect on their business, as it would generate more

footfall and potentially increase sales. Therefore, it was in the interest of pharmacies to provide a good experience for their customers.

The next question followed-up on the accessibility considerations, and asked whether the GP surgeries were aware that people had the freedom to choose how they accessed care, whether at a pharmacy or in their practices. It was explained that the GP practices and other relevant parties knew that it was not a mandatory scheme and people were allowed to receive care wherever they preferred to.

Subsequently, the Sub-Committee asked a question on the access to medical history records for pharmacists and how much testing in this area had been carried out before rolling out the scheme. Assurance was given that there was an information flow between GPs and pharmacies, and it that it had been robustly tested before the scheme was rolled out. It was also added that so far there had been no issues reported to CHS. It was also explained that the pharmacists would only provide treatment for less complex conditions, which were of less significance in terms of medical history. However, the NHS would like to ensure as strong and robust information flow as possible, and therefore, it would be continuously monitored and managed accordingly.

The next question asked by the Sub-Committee asked whether the tool for the GP triage was finalised. It was explained that it was about to be completed, and it agreed that it would be confirmed to the Sub-Committee once it had been completed.

The next question considered whether pharmacists had received any additional training in relation to the seven conditions they would be covering, particularly around ‘uncomplicated urinary tract infections in women’. It was explained that these conditions would not be new territory for the pharmacists, and they would have sufficient knowledge to provide treatment without additional training. It was assured that if a pharmacist thought that a condition was more complicated and beyond their area of expertise, they would signpost the patient to a GP practice.

A supplementary question was asked about how residents could access information to confirm which pharmacies had signed up for the Pharmacy First scheme. In response to the question, it was explained that this could be included as part of the communication strategy, as this information was not currently available.

The next question asked by the Sub-Committee asked what the process would look like if someone was not registered with the GP. It was explained that in order to receive help from a pharmacist an individual did not need to be registered with a GP. It was also explained that pharmacists did not prescribe medication, they only provided medical advice and dispensed medication that did not require a prescription.

Subsequently, the Sub-Committee asked a question about conditions that would require examination of more private body parts, including shingles, and

how an examination would take place in a pharmacy. It was explained that it would be up to an individual to choose whether to go to a pharmacy or a GP practice with such conditions. It was also highlighted that a pharmacist could provide some medical advice and signpost the individual to a GP practice if the examination could not happen in conditions the patient was comfortable with.

The next question considered the mechanisms implemented to continuously monitor the scheme's effectiveness and what data was going to be collated to ensure there were no disparities in terms of service provision. It was explained that CHS had already started collecting data to monitor how many people were using the scheme, what had been treated, and any issues arising. It was further explained that disparity was a challenging to monitor and manage, as it was a voluntary scheme and not universal provision. Therefore, there could potentially be parts of the Borough where access was slightly less than in other parts. However, it was assured that data would be continuously monitored and evaluated.

The next question asked by the Sub-Committee asked a question about whether there was any financial remuneration available for those pharmacies participating in the scheme. It was explained that there was no direct remuneration, although, there would be other benefits for the participating pharmacies, such as higher footfall and higher revenue.

A Sub-Committee Member asked a question about whether there was any monitoring of who was providing medical advice in a pharmacy. It was explained that only a qualified pharmacists could provide medical advice.

The next question asked by the Sub-Committee considered the possible expansion of the medical conditions that were treatable under the scheme. It was explained that they were not aware of any concrete plans at this stage. However, if the scheme was successful, it was possible that opportunities to expanded the number of conditions would be considered.

Subsequently, the Sub-Committee asked a question on how the NHS worked to increase patient confidence in the scheme. Also, it was queried whether there were any particular groups that would be more reluctant to go to a pharmacy for advice, and if so, how was this reluctance being addressed. It was explained that at this early stage, there was no indication that any particular group or areas were more or less likely to use the scheme. However, data would be reviewed both locally and nationally to identify any areas of concern and action would be taken as needed.

Actions:

Following its discussion of this item, the Sub-Committee agreed the following actions for follow-up after the meeting.

1. It was requested that more information would be provided regarding the suitability checks of participating pharmacy's facilities.

Conclusions:

From its discussions of the Update on Pharmacy First scheme, the Sub-Committee reached the following conclusions:

1. The Sub-Committee agreed that ensuring the cleanliness and tidiness of the examination spaces within participating pharmacy's facilities would be a key factor in building patients trust in the scheme.

12/24 **Croydon University Hospital - Elective Care Waiting Lists**

The Sub-Committee considered a report set out on pages 19 to 26 of the agenda which provided a follow-up from the Sub-Committee's visit to the Elective Centre at Croydon University Hospital in regard of managing its waiting lists for elective care. The report was introduced by Mathew Kershaw, Chief Executive at Croydon Health Services and Place-based Leader of Health.

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The first question asked by the Sub-Committee asked how the reduction in waiting times for patients waiting for more than 65 and 78 weeks had been achieved and what strategies were being implemented to maintain the process. It was advised that the hospital had created a facility that allowed services to be planned more efficiently, and as a result utilise existing resources more effectively. It was explained that the hospital had created an area for elective care only, which helped to reduce the risk of postponing the surgery due to emergency needs. It was further explained that CHS had also improved the efficiency and expanded capacity of their operating theatres. However, it was stressed that it continued to be an ongoing journey, and they had not yet achieved the desired results.

The next question from the Sub-Committee asked about the analysis conducted on the waiting list data, and whether it had indicated that any groups were being more affected by prolonged waiting times than the others. It was explained that the most effective way to reduce the disparities was to decrease overall waiting times. It was added that together with Public Health, CHS had been working on population health management and health inequalities to identify any potential themes. Assurance was offered that if any inequalities were identified, there would be appropriate changes implemented. It was also highlighted that waiting times in Croydon were lower than the rest of the South-West London and most of London.

The Sub-Committee questioned whether residents requiring more complex surgery tended to have a longer wait than other patients. It was explained that surgery was scheduled based on the urgency. Therefore, if a more complex surgery was relatively urgent, then the waiting time would be appropriately shorter. It was further explained that if the clinical urgency was equal to many other procedures, then the waiting time would depend on the demand for that particular service and availability of the consultants. It was assured that for areas with historically higher waiting times, for instance hip surgeries, CHS were constantly trying to improve the efficiency and availability of slots.

The Sub-Committee asked a supplementary question about whether a patient's condition was monitored while they were waiting for their elective surgery. Assurance was given that an appropriate mechanism was in place to monitor patient's conditions. If it was identified that the level of urgency had increased, the waiting time would be amended accordingly. It was also highlighted that a patient was able to request reassessment if they felt that the condition was worsening.

Then, the Sub-Committee asked about the main reason for the long wait times for the elective surgeries. It was explained that currently almost all Croydon patients were treated in the Borough, which in past had not always been the case as they had been able to rely on availability in the neighbouring boroughs. It was explained that staffing numbers was having a clear impact on waiting times, and recruitment to fill up the vacancies was challenging. However, it was assured that a lot of work had been done to reduce vacancies, which included the use temporary staff where needed. Another significant factor was the available capacity within the system, which in the last 12 months had been particularly affected by industrial action, which had an impact on maintaining elective services on a consistent basis. However, it was assured that CHS had mechanism in place to minimise the negative impact on the elective care.

The next question from the Sub-Committee asked how much capacity was lost due to patients not attending their scheduled surgeries, what was being done to address this, and how much capacity was lost due to patients not wanting surgery at certain times of the year, for instance Christmas. It was explained that the NHS monitored the number of patients not attending surgeries (DNA – did not attend). It was explained that in the last 11 months there were approximately 1,200 DNA cases for inpatients and day cases, which was equal to 4%. It was explained that DNA were caused by a variety of reasons, including some caused by the hospital – for instance, the operation date was communicated too late. It was assured that CHS had been constantly working to decrease the number of DNAs, through action such as improving communication with patients, including explaining the risk and loss of resources as a result of missed appointments. It was also explained that there were slots that were not taken up, however, it was normally easy to predict these, allowing work to be planned around it to ensure that as little resource was lost as possible.

The next question asked how communication between the patients awaiting elective care and the hospital was maintained. It was explained that there was a dedicated team within the hospital that managed this type of communication, and they constantly monitored the situation with the clinical team. It was explained that in general this team was performing well, however, they managed a considerable number of patients, which could result in delays or mistakes. In follow-up, further information was requested about how CHS communicated with DNA patients and the impact of DNA on the system. It was advised that in many cases CHS tried to communicate the impact of missed operations. However, this needed to be managed carefully as in some cases it was not patient's fault.

The Sub-Committee moved on to questions about sexual health provision in the borough. The first question asked about complex sexually transmitted infections (STIs) in the Borough and what was being done about it. The Director of Public Health explained that the Council emphasis focused upon preventative work and informing residents about sexual health. This included teaching people how to negotiate sex safety. As part of this work, the Council tried to target groups that were particularly vulnerable. It was emphasised that an important piece of work was to destigmatise sexual health and STIs. The Chief Executive of Croydon Health Service added that one of the most important factors was the changing nature of the population, for example HIV infections and the significant change in the life expectancy. There was added complexity related to the increase in life expectancy and the treatments available as previously many HIV patients would not get many other infections in their lifetime. It was highlighted that there had been a lot of work on the prevention and early detection of HIV, including every blood sample in Croydon being tested for HIV, unless a patient opted out. It was also highlighted that Public Health worked directly with residents to develop communication around HIV and other STIs.

The next question asked by the Sub-Committee related to the access to sexual health clinics and testing. The Sub-Committee Member pointed out that currently the Council's website was signposting to the wrong website. The Director of Public Health assured the Sub-Committee that the information available on the website would be improved.

The next question asked what were the most common STIs in Croydon, and whether there was any STI that was harder to detect. The Chief Executive of Croydon Health Service explained that the NHS monitored this kind of data, and more precise information could be provided to the Sub-Committee. The Director of Public Health added that they could also share information with the Members in regard to the numbers and symptoms.

Subsequently, the Sub-Committee asked a question about feedback from service users and whether this had led to any risks or issues being identified. The Chief Executive of Croydon Health Service advised that they listened to patient feedback and had amended the operation of the clinic accordingly. It was also added that the postal service was very good and allowed residents

to access tests more discretely. It was highlighted that CHS had a dedicated part of the service that focus on education.

The final question from the Sub-Committee asked how people were recruited to be part of the coproduction, how the localised message was spread, and whether there was a focus on any particular groups. The Chief Executive of Croydon Health Service explained that CHS used a bus, which allowed them to reach many local groups directly. It was also added that they worked together with existing community groups, and tried to spread the national campaigns. The Director of Public Health also provided assurance that they tried to target the most vulnerable audience to decrease the risk of spreading STIs. Then, the Sub-Committee asked a supplementary question concerning the influence of the Sexual Health strategy on their services. It was explained that the STI part of the strategy was a standard piece of communicable disease control, and it was part of health protection.

Actions:

Following its discussion of this item, the Sub-Committee agreed the following actions for follow-up after the meeting.

1. It was requested that the section regarding sexual health on the Council's website was reviewed and updated.

Conclusions:

From its discussions of the Croydon University Hospital – Elective Care Waiting Lists, the Sub-Committee reached the following conclusions:

1. The Sub-Committee recognised and commended the hard work of the Croydon Elective Centre for receiving the 'Get it Right the First Time' accreditation from the NHS England.
2. The Sub-Committee acknowledged and commended progress made in reducing elective care waiting times.
3. The Sub-Committee recognised the hard work of staff in reducing waiting times and providing sexual health services.

13/24 **Update from Healthwatch Croydon**

Gordon Kay representing Healthwatch Croydon provided a presentation covering two following areas – (i) Preventable Mental Health and Wellbeing Support Services within Black African and Caribbean Communities, and (ii) Virtual Wards.

Conclusions:

From its discussions of the Update from Healthwatch Croydon, the Sub-Committee reached the following conclusions:

1. The Sub-Committee recognised and commended the hard work done by the Healthwatch Croydon.

14/24 **Scrutiny Work Programme 2022-23**

The Sub-Committee considered a report set out in the agenda on pages 27-31 which set out its work programme for the remainder of the year.

The Sub-Committee agreed to have a separate meeting to discuss the work programme for the upcoming municipal year. In addition to that the Sub-Committee Members stressed the importance of including the mental health topics, including SLAM and their work at schools, and Croydon Health Services Quality Accounts.

Resolved: That the Health and Social Care Sub-Committee work programme is noted.

15/24 **Exclusion of the Press and Public**

The meeting ended at 9.15 pm

Signed: .....

Date: .....