MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
Wednesday, 16 February 2011 at 7.00 pm

PRESENT: Councillor Ogunro (Chair), Councillor Hunter (Vice-Chair) and Councillors Beck, Hector, Kabir and Sheth

Apologies were received from: Councillor Adeyeye

1. **Declarations of personal and prejudicial interests**

   None.

2. **Deputations (if any)**

   None.

3. **Minutes of the previous meeting**

   RESOLVED:-

   that the minutes of the previous meeting held on 16 December 2010 be approved as an accurate record of the meeting.

4. **Matters arising (if any)**

   ICO Board

   In response to a request for an update on the voting status of the Council observer, Andrew Davies (Performance Officer) undertook to write to Ealing Hospital Trust expressing the Committee's disappointment that the Council had not been offered a place on the ICO Board, with voting rights.

5. **Primary Care Services in Brent update**

   Jo Ohlson (Brent Borough Director, NHS Brent) introduced this report which was in response to members' request for a report from NHS Brent on GP retirements and ensuring an adequate distribution of GP services across the borough. There were two issues in particular that the committee had concerns over; the first was succession planning and preparing for GP retirements, particularly post 2013 when the NHS Commissioning Board would become responsible for primary care contracting and secondly, updates on developments with the Brent GP commissioning consortia.

The Borough Director informed the Committee that succession planning was an area that all GP clusters had considered, but one that required further work to be carried out. She assured the Committee that NHS Brent was dealing with this issue and that a number of changes to primary care in the next six months had been agreed as detailed in her report. She alluded to further potential changes but added that as they had not been agreed with contractors, information on them had not included in her report. She added that as the National Commissioning Board (NCB) would take over the responsibility for the GP consortia from April 2011, the Primary Care Trust (PCT) would no longer be responsible.

The Borough Director continued that the Health Bill contained detailed proposals regarding the establishment of the NHS Commissioning Board which would become effective in 2013 and until then, PCTs would continue to retain the statutory responsibility for primary care contracting. As from April 2012 primary care contracts would be managed under a sector team for North West London which would have the responsibility for all primary care (GP, Dental, Pharmacy and Optometric) contracts. An Outcomes Framework had been produced by NHS London in conjunction with a number of clinical and management stakeholders which was being finalised. The Outcomes Framework would be used and implemented by the Sector Team and would become a useful framework for each of the GP Commissioners to use in driving up standards of primary care within their consortia.

In the discussions that followed Councillor Beck enquired about consultation processes on the planned changes. Councillor Hunter noted that each of the 5 localities reported differently without any indication as to their performance. Councillor Ogunro asked as to whether any steps were being taken to ensure that the distribution of GPs was evenly spread in the Borough.

In responding to the above issues, Jo Ohlson stated that GP practices were expected to provide a full range of services within clusters as the ability to move practices around was somewhat limited. She added that detailed benchmark data existed with locality profiles already developed which were available on-line and which she could circulate. She confirmed, in response to Councillor Kabir's question, that there were no plans to charge for GP services at the point of delivery.

Councillor Hunter also requested an update on Stag Lane, Kingsbury premises. Jo Ohlson responded that as Kingsbury premises were one of the most challenging issues, NHS Brent and GPs had been working together to explore various options for a new locality health centre in the area. The preferred option (based on financial and non-financial benefits appraisal) was a single development at Roberts Court, to house three or more practices (including Willow Tree, Fryent Medical Centre and Stag Lane). The Outline Business Case was being finalised next week with practices within the scope of the development but there remained a significant affordability gap. The need to identify how this additional cost could be funded within existing budgets still remained.

Following discussions, the committee agreed to consider a follow up report at their next meeting, which would set out the GP performance against four of the indicators in their outcome standards. The indicators were:

18. Satisfaction with overall care received at surgery.
19. Patients changing practice without changing address.
20. Ability to see a specific GP or Practice Nurse if wanted.
21. Advanced appointments. Satisfaction with opening hours. Ease of getting through on the phone

RESOLVED:

that the update report on Primary Care Services in Brent be noted.

6. GP Commissioning Pathfinder - verbal report

Jo Ohlson (Brent Borough Director, NHS Brent) in presenting a progress report on Pathfinder stated that by July 2011 all GP Commissioning Consortia would be included in the Pathfinder Consortia. She added that there would be funding of about £2.00 per patient to support commissioning and that discussions were being held with various partners including NHS colleagues and local authorities on how to work together to manage local budgets and purchase services including mental health and community services.

Mr Mansukh Raichura (Chair of Brent Local Involvement Network) stated that whilst the support being received from the Council was helpful in developing a new vision, he had concerns about the budget of £2.00 per patient, patient engagement and the limited time within which to set up the consortia. Mr Raichura asked the Director to outline other programmes that the NHS Brent had in mind to address the concerns.

Dr Ohlson responded that there was a 2 year development programme and although additional support would be required from approved providers such as KPMG to undertake specific services only, there were no plans to bring in private contractors.

RESOLVED:

that the verbal update on GP Commissioning Pathfinder be noted.

7. Public Health White Paper

The Health Partnerships Overview and Scrutiny Committee received a briefing paper on the Public Health White Paper, *Healthy Lives, Healthy People*, which was published on the 30th November 2010. The Scrutiny Committee considered the implications of the White Paper for public health services which could then be

incorporated in the Council's final response to the Public Health White Paper by the deadline date of 31 March 2011.

Andrew Davies, Policy and Performance Officer in setting out the main points of the White Paper informed the Committee that there would be two significant changes to the public health system; the creation of Public Health England (PHE) and the transfer of some public health responsibilities to local government. Members noted that the PHE would be created within the Department of Health and be accountable to the Secretary of State for Health. It would hold the ring fenced public health budget, estimated to be around £4bn and bring together the health protection functions, the regional Directors of Public Health and the Public Health Observatories. In addition it would work with local government, the NHS and other agencies to prepare and respond to emergency threats and to build partnerships for health. It would also have a local presence in the form of Health Protection Units (HPUs).

He continued that the other significant change would be the transfer of some public health responsibilities to local government which would give local authorities the responsibility to take steps to improve the health of their population from 1 April 2013. Andrew Davies added that the Government believed that this transfer would facilitate the creation of local solutions to meet varying local health needs as well as enabling joint approaches to be taken with other local government services and with key partners to tackle health inequalities.

Andrew Davies added that the Government also intended to publish a plethora of documents linked to the White Paper within the next 12 months in respect of the following areas;

Health visitors, mental health, tobacco control, Public Health Responsibility Deal, Obesity, Physical activity, Social marketing, Sexual health and teenage pregnancy, Pandemic flu and Health protection, emergency preparedness and response.

Members noted that the Health and Social Care bill included details on the establishment of health and wellbeing boards in every upper-tier local authority. Health and wellbeing boards were intended to lead on improving the strategic coordination of commissioning across NHS, social care, children's services and public health. Their main functions would include encouraging integrated working among persons who arranged for the provision of health related services, providing appropriate advice, assistance or other support in connection with the provision of such services. GP commissioning consortia would be required to consult with health wellbeing boards when drawing up their annual plan. Health well being boards would also be statutory partners for councils in establishing Joint Strategic Needs Assessments and subsequent strategies which would emerge from the assessments when carrying out their functions.

Members were informed that if the Health and Social Care Bill was passed in its current form the boards would be established as a committee of the local authority with statutory membership consisting of the following;

at least one councillor
directors of adult services, children's services and public health
a HealthWatch representative
a representative from each of the partner GP commissioning consortia
other members as appropriate, including a representative from the NHS Commissioning Board where JSNAs and related strategies are being considered.

In response to a request by Councillor Hunter for a clarification on the scrutiny functions following the establishment of the health and wellbeing boards, Phil Newby Director of Strategy Partnerships and Improvement stated that a report outlining the options would be put to the all party Constitutional Working Group (CWG) for their consideration after which clear and robust responses would be sent to the Secretary of State. The Director noted that more work needed to be done which would require patience and understanding of each other's cultures

Whilst welcoming the Government's commitment to public health, Simon Bowen (Assistant Director of Public Health NHS Brent) added that the Government would have to give further thoughts to areas such as HIV prevention and treatment as well as a consistent approach to issues relating to children aged 0-5 and 5-16. Mr Bowen emphasised the need to build on partnership, identify visions and hold further discussions on how to progress the implications of the White Paper locally. In responding to comments by members Simon Bowen stated that the outcome framework, currently out for consultation, would be set by the Government but that prioritisation would be a local decision. He undertook to circulate copies of the document for members' information.

RESOLVED:

that the briefing paper on Public Health White Paper – Healthy Lives, Healthy People be noted.

8. **Khat in Brent**

This report was in response to members' concerns expressed at the prevalence of khat use in parts of Brent which led to their request for more information about the problems associated with this drug. The NHS Brent paper attached to the report provided useful information to members about khat.

Members noted that khat was openly sold in shops in the Church End area where the majority of people of Somalian origin resided. Khat (Catha edulis) was a flowering shrub native to northeast Africa and the Arabian Peninsula chewed by individuals for its stimulant effects, similar to but less intense than those caused by abusing cocaine or methamphetamine. Khat typically was ingested by chewing the leaves, brewed in tea or cooked and added to food. After ingesting khat, the user experienced an immediate increase in blood pressure and heart rate, the effects of the drug generally subsiding between 90 minutes and 3 hours after ingestion, however, they can last up to 24 hours. (There have been reports of Khat-induced psychosis.) The drug was also known to be able to cause damage to the nervous, respiratory, circulatory, and digestive systems.

The use of khat was accepted within the Somali, Ethiopian, and Yemeni cultures, and in the United States khat use was most prevalent among immigrants from those countries. Abuse levels were highest in cities with sizable populations of immigrants from Somalia, Ethiopia, and Yemen.

A khat support group was already offered through Addaction in Cobbold Road with outreach and engagement services to be undertaken by CRI Brent Outreach and Engagement Team (BOET). It was noted that counselling services and support would be provided for khat users and their families through two sites (Wembley Centre for Health and Care and the Cobbold Road Treatment and Recovery Service). In addition, funding would be sought in partnership with Brent Council Community Safety Unit to develop a work programme in partnership with the Help Somalia Foundation for a Peer Mentoring Project with Somalian youth in the Church End area. This would assist in raising awareness of khat misuse and improve awareness of local treatment provision and access to GP practices.

Mr Ali Awes a member from the Somali community who was in attendance gave his views on khat use. He informed the Committee that individuals who abused khat typically experienced a state of mild depression following periods of prolonged use. Taken in excess khat could cause extreme thirst, hyperactivity, insomnia, and loss of appetite (which can lead to anorexia). He continued that frequent khat use often led to decreased productivity because the drug tended to reduce the user's motivation and that repeated use could cause manic behaviour with grandiose delusions, paranoia, and hallucinations.

Mr Ali Awes added that he was working with other London Boroughs including Camden on ways to stop and to address the problems associated with khat use and would therefore be happy to be involved with the future work of the task group on khat.

RESOLVED:

that the report on Khat be noted and an overview and scrutiny task group looking into the impact of khat in Brent be established.

9. **Fuel Poverty and Health Scrutiny Task Group report**

The Committee considered a report from the Fuel Task Group which was established to look at the effect that fuel poverty had on peoples' health in Brent. The task group was set up following various research projects that fuel poverty and its consequences could have a major impact on physical and mental health and well being. In addition there were also specific factors in Brent such as the high proportion of housing in the private rented sector (where the proportion of households in fuel poverty was highest), the relative deprivation of the borough, particularly income deprivation and the general health inequalities that existed in Brent.

The cross party task group chaired by Councillor Long developed 13 recommendations which they considered could make a positive contribution to addressing fuel poverty and urged the Committee for its endorsement. The recommendations addressed the following subject areas:

(i) advice and information
(ii) improving energy efficiency of the housing stock and reducing fuel bills
(iii) working with landlords; and
(iv) working with the NHS

The task group acknowledged the work of a local charity, Energy Solutions, which had been working on fuel poverty issues in Brent and naturally brought an expertise to this issue. Ms Ros Baptiste, Energy Assessor from Energy Solutions was present at the meeting and gave an overview of the work of the charity. She informed the Committee that Energy Solutions were working in close partnership with other local organisations, local authorities and registered social landlords to deal with referral cases. Energy Solutions also made trust fund applications and negotiated with energy suppliers on behalf of clients.

In welcoming the report, members thanked the task group for their work. Councillor Kabir however expressed a view that pre-paid key meter was quite expensive for most families and that its use did not help in addressing fuel poverty and therefore required a review.

RESOLVED:

that the recommendations made by the Fuel Poverty Task Group appended to the report be endorsed to be forwarded to the Council's Executive and the local NHS trusts for approval.

10. **Health services for people with learning disabilities task group**

This report updated members of The Health Partnerships Overview and Scrutiny Committee on the implementation of the recommendations arising from the health services for people with learning disabilities task group. Following the task group's report to the Executive in September 2010, the Committee agreed to set up a task group to consider concerns by carers about the difficulties that people with learning disabilities faced when accessing health services.

Members noted that the cross party task group took evidence from a wide range of witnesses including the Chief Executive, Brent MENCAP, Assistant Director for Community Care, Brent Council, Head of Service for People with Learning Disabilities, Head teacher, Hay Lane School, Brent Council Brent Carers and Support for Living Project in Ealing. Among its findings, the group reported that Brent carers reported a number of on-going difficulties when using services such as hospitals, dentists, GP's and opticians. In particular, there was a lack of awareness about learning difficulties and a failure to implement reasonable adjustments required to make these services accessible to all patients. The group also found out about a project in Ealing called Treat Me Right! that had developed a range of

measures to improve the experience for patients with learning disabilities when they used Ealing Hospital. The measures included reader-friendly information such as the complaints policy and admission information as well as staff training on working with people with a learning disability. The task group recommended the development of a similar model for hospitals in Brent hospitals.

RESOLVED:

That the task group report on health services for people with learning disabilities be noted.

11. **Childhood Immunisation task group**

The Childhood Immunisation Task Group was established as a result of councillors' concerns about the low immunisation rates in the borough which were reported to be below target for all of the immunisations in the national immunisation programme except human papilloma virus vaccine and tetanus, diphtheria and polio booster. This report presented The Health Partnerships Overview and Scrutiny Committee with an update on the implementation of the recommendations arising from the Childhood immunisation task group.

It was noted that childhood immunisation against illnesses such as measles, mumps, polio and diphtheria were crucial to protect the long term health of young people in our borough and whilst that immunisation had the most robust evidence in terms of safety, efficacy and cost effectiveness of all healthcare activities, there had been long standing problems in achieving good levels of coverage in London. Brent was no exception to the London-wide trend of low immunisation rates.

Although the task group made a number of recommendations that it felt would help to improve immunisation services in Brent, members were encouraged by the efforts being made by NHS Brent to improve the immunisation service during the course of the review. There was a genuine commitment from the organisation to improve immunisation rates in the borough and stop the spread of diseases that were clearly preventable.

RESOLVED:

that the progress report and the recommendations of the Child Immunisation Task Group be noted.

12. **Health Partnerships Overview and Scrutiny Committee Work Programme**

RESOLVED:

that the schedule of the Committee's work programme through to the next meeting on 5 April 2011 and the list of items to be timetabled be noted.

13. **Any Other Urgent Business**

None.

14. **Date of Next Meeting**

It was noted that the next meeting of the Health Partnerships Overview and Scrutiny Committee would be held on Tuesday 5 April 2011 at 7:00pm.

The meeting ended at 9:00pm.

B OGUNRO

Chair

The meeting closed at 9.00 pm

B OGUNRO
Chair