MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
Tuesday 9 October 2012 at 7.00 pm

PRESENT: Councillor Kabir (Chair), Councillor Hunter (Vice-Chair) and Councillors Al-Ebadi (alternate for Councillor Hector), Gladbaum, Harrison and Hossain and Sneddon (alternate for Councillor Leaman).

ALSO PRESENT: Councillors Brown, Butt (Leader of the Council/Lead Member for Corporate Strategy and Policy Coordination), Cheese, S Choudhary, McLennan, J Moher (Lead Member for Highways and Transportation) and R Moher (Deputy Leader of the Council/Lead Member for Finance and Corporate Resources), Dr Sarah Basham (NHS Brent), Tina Benson (North West London Hospitals Trust), Dr Titus Bradley (Care UK), Simon Bowen (NHS Brent), Mark Burgin (Brent Council), Dr Prakash Chatlani (Brent Local Medical Committees), David Cheesman (North West London Hospitals Trust), Andrew Davies (Brent Council), Sarah-Jane Graham (Care UK), Phil Newby (Brent Council), Phil Porter (Brent Council) and Ian Winstanley (NHS Brent).

An apology for absence was received from: Councillor Colwill.

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

None declared.

2. **Minutes of the previous meeting**

RESOLVED:-

that the minutes of the previous meeting held on 18 July 2012 be approved as an accurate record of the meeting, subject to the following amendment:-

Paragraph 6, page 7, replace all mentions of ‘Alison’ with ‘Amanda’.

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

Brent Tobacco Control Service – progress report

Members noted that the recommendations agreed at the previous meeting on this item would now be considered by the Brent Pension Fund Sub-Committee at the meeting taking place on 20 November 2012.

4. **Care UK Urgent Care Centre - Serious Incident Report**

Ian Winstanley (NHS Brent) introduced the report that provided further details of the findings of the investigation carried out in the wake of the serious incident at the Care UK Urgent Care Centre (UCC) at Central Middlesex Hospital (CMH) identified

in March 2012. The report included the findings of the root cause analysis, the recommendations that followed and subsequent action taken to implement these recommendations and monitoring of their success. Ian Winstanley advised that NHS Brent was satisfied that Care UK had undertaken all action required following the Governing Body meeting on 3 October.

During discussion, Councillor Hunter sought an explanation as to why sufficient action had not initially been taken despite concerns being raised on five separate occasions that radiology procedures were not being followed. An update was also requested on the nine patients who had required onward referrals regarding the outcome of their cases. Councillor Hunter enquired whether the incident had prompted Care UK to look at how they operate nationally and whether they would be subject to any financial penalties if there were any further breaches of contract. Councillor Gladbaum asked why staff turnover had been high at the UCC and could the incident be partly attributable to an over reliance on agency staff. She also enquired why there had not been a robust protocol for staff with regard to procedures previously and she emphasised the importance of ensuring high standards for the safeguarding of children. Councillor Harrison sought assurance that the necessary measures would be in place to ensure that staff had read and understood the protocol.

The Chair enquired if NHS Brent was satisfied to date with the implementation of the recommendations made as a result of the Root Cause Analysis investigation and sought clarification with regard to the issuing of a remedial notice to Care UK under Section 57.

In reply to the issues raised, Dr Titus Bradley (Care UK) acknowledged that the incident should have been noticed and escalated appropriately at an earlier stage. This had been partly attributable to rapid staff turnover, failure to communicate clearly and insufficient induction of new staff. Dr Titus Bradley advised that during the time of the incident, there was a significant number of interim staff and the high staff turnover was due to staff changing jobs, doctors taking up post overseas and a number of other reasons. Since then, there had been much effort to increase the number of permanent staff and the workforce now was considerably more stable and dedicated to CMH. A number of other measures had also been undertaken following the Root Cause Analysis investigation and all new staff undertook a robust induction that required them to sign a declaration that they understood what they had been told and all staff needed to adhere to the new protocol in place. Members heard that the previous protocol had been less robust and had not been policed and enforced sufficiently. Furthermore, managers were available on a 24/7 basis to be contacted if staff were unsure about a particular issue and experienced doctors had been given supervisory responsibilities. An audit of activities was also being undertaken at the UCC, including scrutinising of X-ray material, and this would enable any inappropriate action to be tracked.

Dr Titus Bradley added that Care UK had learnt from the serious incident at CMH and that the investigation, which he had led, had revealed that upon a review of all patients affected, most did not involve significant abnormalities. Patients who had been recalled had undergone a thorough process to ensure that the appropriate action was taken. With regard to the nine outstanding referrals, responses from the patients' relevant GPs was still awaited and there would be follow-up action to obtain this.

Ian Winstanley confirmed that the serving of a Section 57 notice was a contractual procedure that required Care UK to apply the prescribed remedial action within a certain period. He advised that at the time of the incident, the contract did not include provision for CMH to impose financial penalties, however since then discussions with the NHS had taken place to standardise all such contracts and to include the right to impose financial penalties where certain conditions had not been adhered to.

Dr Sarah Basham (Brent NHS) commented that Care UK had been very forthcoming in reporting to NHS Brent the mistakes that had been made and of the action they intended to undertake to remedy the situation. Similarly, NHS Brent had also learnt from the experience and was more aware of where things can go wrong when running a new service like an UCC and they would continue to monitor the actions being taken by Care UK.

The Chair stated that Members expected high standards of care for Brent residents and that it was fortunate that there were not more serious implications arising from the incident in view of the number of patients affected. She requested that an update on how the recommendations arising from the report were being implemented and details of any additional ones introduced be provided at a committee meeting in around six months' time.

5. **Accident and Emergency Services at Central Middlesex Hospital**

Tina Benson (North West London Hospitals NHS Trust) introduced the report and advised that recruitment of staff, in particular doctors, to Accident and Emergency (A and E) services remained difficult, whilst the number of patients attending had now reduced to around 30 a day. A number of efforts had been made with regard to recruitment and although 15 applicants were invited to interview for middle grade or junior doctor posts, none were thought suitable following the interview and clinical workstation assessments. However, since publication of the report, a further 10 applications had been received. In view of the above, Tina Benson advised that it was recommended that the interim overnight closure of the A and E remain in place for a further year with a review of arrangements taking place in six months' time.

Councillor Harrison enquired whether the recruitment plans were based on the A and E services re-opening at night in the future. Councillor Hunter sought reasons as to why none of the candidates had passed the interview stage for middle grade and junior doctor posts and Councillor Sneddon sought clarification as to whether any of these applicants had passed the clinical workstation assessment. With regard to advertising for these posts for a publication in Eastern Europe, Councillor Gladbaum enquired what consideration there had been with regard to language issues and how would such staff be supported if they were recruited. Councillor Hossain asked for further information on what steps were being taken to improving the quality of staff at middle grade level.

In reply, Tina Benson advised that it was intended to recruit posts across the whole of the hospital trust and initially to appoint sufficient numbers to operate A and E services on a 24/7 basis, however this no longer looked likely to be achievable. All staff were now rotated across the trust in order to maintain their skill levels. Tina

Benson stated that it was a surprise that none of the candidates for the middle grade and junior doctor posts passed the interview stage, however the shortage of suitable candidates could be attributed to a shortage of A and E doctors nationally. This had led to a number of junior doctors applying for more senior posts when they were not yet suitably experienced or qualified in the hope they would be able to secure these posts. It was noted that only one candidate for middle grade and junior doctor posts had passed the clinical workstation assessment. With regard to recruiting staff from Eastern Europe, Tina Benson informed Members that the advert and recruitment pack would be translated into the appropriate language and all staff were subject to a checking and sign off process before they were approved to work unsupervised and twice weekly training sessions would also be run. In efforts to improve the quality of middle grade posts, CMH now worked with only one agency and efforts were being made to address responsibility and managerial roles as well as clinical duties. CMH was also re-examining what it expected from staff and to communicate these clearly. Tina Benson advised that recruitment of nurses, however, had been successful.

David Cheesman (Director of Strategy, North West London Hospitals NHS Trust) added that there had been much work to address the recruitment issues at the hospital and recruitment on both sites of the Trust were also being undertaken as part of the Shaping a Healthier Future programme.

The Chair requested an update on this item in around six months' time, including details of progress on recruitment.

6. **North West London NHS Hospitals Trust and Ealing NHS Hospital Trust merger update**

David Cheesman introduced this item and confirmed that the Final Business Case had been submitted to NHS London on 10 September. The document had undergone minor amendments since the last meeting of this committee and the merger was presently at the 'due and careful enquiry' stage with some financial aspects being considered. The Final Business Case would be presented to the Trust Boards on 17 October followed by the NHS London Board on 25 October and it was anticipated that, subject to their approval, the merger would commence in April 2013.

During discussion, the Chair sought further information with regard to financial targets and how the transitional arrangements would be funded. Councillor Hunter asked for an explanation as to why the projected savings were not presently being met. Councillor Harrison enquired if the merger would continue if it was ascertained that the savings would not be achieved.

In reply, David Cheesman advised that the financial aspects were not progressing as quickly as hoped and the projected savings were not yet reaching the expected levels. This was partly attributable to increasing demand and the fact that the use of agencies was costly. With regard to the transitional costs, David Cheesman stressed that this was a one-off cost and the savings that would be made from the merger in the longer term were more important. The issue of whether the merger would continue if the savings could not be achieved would be a point of serious discussion, however David Cheesman advised that in essence, the clinical

argument for the merger was sound, but the financial aspects needed to be more robust.

The Chair requested that information be provided to Members through Andrew Davies (Policy and Performance Officer, Strategy, Partnerships and Improvement) regarding the outcome of the Board meetings on 17 October and 25 October respectively and that an update be provided at the next meeting on the merger and progress towards achieving the trust's savings targets.

7. **Shaping a Healthier Future - Health Partnerships Overview and Scrutiny Committee response**

Members had before them the committee's draft response to the proposals set out in the Shaping a Healthier Future consultation for further discussion and consideration.

Councillor Gladbaum expressed some concern about the proposals for more out of hospital care provision and potentially vulnerable people being placed in the community. Councillor Harrison commented on the shortage of GPs in Brent and queried what recruitment measures were being taken to address this. She sought clarification in respect of paragraph 2.3 of the report concerning underuse of health facilities and did this mean underused staff. Councillor Harrison felt that concern in relation to the future of CMH, particularly in relation to A and E services and the services to be provided by the UCC, should be emphasised in the committee's response. Councillor Sneddon also thought that more clarity should be requested with regard to the future role of the UCC and A and E services at CMH and also that the impact on the community to these changes should be investigated further and this should be reflected in paragraph 3.13 of the report. Councillor Al-Ebadi expressed concern about the transfer of managerial responsibilities to GPs who may lack the appropriate skills to undertake this.

Councillor Hunter suggested a revision to paragraph 4.6 and circulated the revised version to Members for their consideration. The revised version commented that A and E patients in the south of the borough were already frequently being directed to St. Mary's, Royal Free and University College hospitals. It was to be queried whether the ratio of patients from this area going to these Imperial Healthcare hospitals would remain the same, or was one of the consequences of the proposed changes mean that more patients would go to Northwick Park Hospital as this issue needed clarification. Councillor Hunter added that the last sentence in paragraph 4.6 of the report should be retained.

The Chair commented that it was important that out of hospital care services were properly resourced and acknowledged that the lack of GPs in Brent remained a concern and another issue was difficulties in relation to patient access to primary care services. She added that every effort should be made to address recruitment issues regarding A and E services at CMH.

Andrew Davies advised that underuse of health facilities referred to some health centres being under-occupied and mention of this term in the report will be re-worded accordingly.

Members agreed to the amendments to paragraph 4.6 as suggested by Councillor Hunter. The committee also agreed to add the word 'clinical' after 'strong' in the first line of paragraph 5.1 of the report as suggested by Councillor Hunter and to the add the words 'before the reconfiguration of acute services are made' at the end of the first sentence of paragraph 5.2 (i).

RESOLVED:-

that the response to the Shaping a Healthier Future consultation be agreed subject to the amendments as set out above.

8. **Sharing a Director of Public Health and proposed structure for the Brent Public Health Service**

Phil Newby (Director of Strategy, Partnerships and Improvement) presented the item and began by emphasising the importance of making public health services more effective and to complement the needs of the borough's population. The two main aims of the proposals were to create a fully integrated structure for commissioning public health services and to focus on illness prevention. Commissioning would take place jointly between the council and the Clinical Commissioning Groups (CCG) and public health services would be mainstreamed to enable improvements in health and make it a core council activity. Turning to the role of the Director of Public Health (DPH), the intention was to have a shared DPH with Hounslow whose role would be strategic and dynamic in helping to promote fresh ideas on public health matters and help drive policy. The council was already sharing some services with other authorities, such as trading standards. In addition, other local authorities such as the London boroughs (LBs) of Harrow and Barnet were already sharing a DPH. Phil Newby explained that initial discussions with neighbouring London boroughs had involved the possibility of appointing a West London wide DPH, however councils had since followed the route of pairing up where they had identified compatibility. In the case of LBs Brent and Hounslow, both shared a vision to place public health back into council services and this was the main reason why they were to work together and the shared intelligence of both authorities would benefit them.

Members then discussed the proposals in detail. Councillor Harrison sought clarification with regard to the budget available for public health services and whether there was potential for conflict between local authorities and CCGs as to how it would be spent and convincing health professionals to be working within the council. She enquired whether there was an element of risk in pioneering a new way of public health which had not been tried and tested elsewhere. Councillor Harrison also felt that it was important that a DPH be able to concentrate solely on the needs of Brent residents. Councillor Sneddon enquired about the main differences between the LBs Brent and Hounslow partnership as compared to LBs Harrow and Barnet. He asked whether there was a risk that that the Government would raise issues about the LBs Brent and Hounslow partnership as guidance from the Department of Health and Local Government Association suggested that councils should already have a shared management team in place or share a boundary with each other. Councillor Sneddon expressed concern that a lack of direct management responsibility and non ownership of any budget could reduce the influence of the DPH, whilst in turn the postholder's views could be unduly influenced by other budget holders.

Councillor Gladbaum enquired whether the appointment of a DPH would also entail additional staff being recruited and was the council's Public Health Intelligence Team already in place. She stated that a shared DPH would mean they would spend less of their time on each borough and suggested that during the first year of the arrangement, there could be separate DPHs for each borough. Councillor Al-Ebadi sought confirmation of the views of LB Hounslow on the proposals and comparisons of costings between appointing one DPH for both boroughs and one for each borough. He felt that as the DPH was an advisory role, it would not present any problems appointing one for both LBs Brent and Harrow.

Councillor Hunter commented that she agreed with proposals to bring public health services into the council, however she was yet to be convinced that working with LB Hounslow was necessarily the best solution, although she welcomed opportunities to share Best Practice with other local authorities. She suggested that as public health was going through a transitional period, a full time DPH should be appointed for Brent on an interim basis and this would also allow for consideration on whether sharing a DPH with LB Hounslow was desirable. Councillor Hunter added helping guide strategy was a full time role, whilst it was also important that the DPH was a member of the Corporate Management Team.

The Chair indicated her support in locating public health workers across council service areas and the integration of public health within the council but enquired whether there was sufficient expertise within the organisation to supervise such staff. She emphasised the importance of the role of the DPH and remained unconvinced that it should be shared with another borough. In addition, she queried whether the DPH's ability to influence would be compromised by not having control over a budget. The Chair also commented that the economic situation and welfare reforms would place even greater demand on public health.

The Chair then invited Simon Bowen (Acting Director of Public Health, NHS Brent) to outline his views to the committee. Simon Bowen began by supporting proposals to bring public health under local authority control and the vision to mainstream these services and he felt the changes offered good opportunities to improve public health. However, he expressed concerns about proposals with regard to the DPH and felt that the role may lack credibility with no budget to control or staff to manage and not being a member of the Corporate Management Team. In order to strengthen the role, he felt that the DPH should have these powers and responsibilities. Simon Bowen also commented that Brent had gone from one of the worst to amongst the best of public health providers in London, whilst in his view Hounslow was at the same level that Brent was five years ago and so he questioned the value of LB Brent partnering LB Hounslow.

In reply to the issues raised, Phil Newby confirmed that nationally local authorities would receive £2.2bn to provide public health services, although this was less than 50 per cent of the total public health budget. Discussions would take place between the council and CCGs to determine how the budget would be spent. Phil Newby explained that as well as a DPH, there would also be a DPH representative each for both LBs Brent and Hounslow, whilst in addition public health consultants working in each borough who would be able to provide advice to councillors and the CCG. Most staff carrying out public health functions, however, would be transferred from the NHS and a Public Health Intelligence Team was already in place. As the

DPH would be representing two boroughs, this would help carry more weight in influencing the Government and other bodies. In addition, LBs Brent and Hounslow shared similar characteristics and had similar visions for public health and wished to provide much more integration with CCGs than others. LBs Harrow and Barnet, however, were taking a more traditional approach to public health and did not intend to embed public health services within the council. The DPH would provide leadership and expertise, however officers and councillors would also gain more knowledge of public health as it become embedded within the council. Phil Newby advised that the Government was interested in seeing a number of different models for public health being set up and the innovative approach taken by LBs Brent and Hounslow would not be objected to.

Phil Newby advised that as the role of the DPH was strategic, it was felt appropriate to share the role with LB Hounslow who were fully in support of the proposals. The DPH was not being recruited in a traditional managerial sense, but would play a role in influencing and shaping public health and sharing a DPH also released more funding to deliver public health services. Phil Newby cited a number of examples of postholders in the council who were not responsible for a budget and not on the Corporate Management Team, but who nevertheless have considerable influence and helped shape policy.

Councillor R Moher (Deputy Leader of the Council/Lead Member for Finance and Corporate Resources) added that an integrated model for public health services was being pursued by LBs Brent and Hounslow who shared similar ideas. The DPH's strategic role may allow to pilot new ways of providing public health services and she advised that local authorities were statutorily obliged to appoint a DPH. Dedicated teams would be created to manage demand for public health services and the DPH would play a vital role in providing expertise and sharing information with them.

Members then agreed to the Chair's suggestion that whilst the proposed mainstreaming of public health services was supported, concerns about sharing a DPH with another borough remained and so the Executive be recommended to not agree to share this post with LB Hounslow.

RESOLVED:-

(i) that proposals to mainstream public health services, as outlined in the report for the proposed structure of the Brent Public Health Service, be supported; and

(ii) that because of the importance of public health, the committee is concerned about the proposal to share a Director of Public Health with another borough and recommends that the Executive does not agree to share the post with Hounslow Council.

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

Members noted the committee's work programme for 2012-13 and agreed to Councillor Gladbaum's suggestion that items on abortion and teenage pregnancy be added to it.

10. **Date of next meeting**

It was noted that the next meeting of the Health Partnerships Overview and Scrutiny Committee was scheduled to take place on Tuesday, 27 November 2012 at 7.00 pm.

11. **Any Other Urgent Business**

None.

The meeting closed at 9.40 pm

S KABIR
Chair