MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
Tuesday 29 January 2013 at 7.00 pm

PRESENT: Councillor Kabir (Chair), Councillor Hunter (Vice-Chair) and Councillors Colwill, Harrison, Hossain and Leaman

Also present: Councillors Butt, Hirani and Lorber

Apologies for absence were received from: Councillors Gladbaum

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

   Councillor Leaman declared a personal interest in item 5, Mental Health Services in Brent, as he worked for a mental health charity.

2. **Deputations (if any)**

   None

3. **Minutes of the previous meeting**

   RESOLVED:-

   that the minutes of the previous meeting held on 27 November 2012 be approved as an accurate record of the meeting.

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

   Brent Tobacco Control Service – Update
   Councillor Hunter noted that at the previous meeting she had advised that the Brent Pension Fund Sub-Committee had considered the recommendations of the Health Partnership Overview and Scrutiny Committee and had decided to amend the Statement of Investment Principles to incorporate the current practice of not directly investing in tobacco companies. The wording of the Brent Pension Fund Sub-Committee's recommendation was due to be agreed at the next meeting of the committee, and would be available as an update to members at the next meeting of the Health Partnerships Overview and Scrutiny Committee.

   Health Visitors
   Councillor Hunter referred to the information provided to the committee at its previous meeting regarding the salary of health visitors. She explained that the committee had been advised that health visitors received the same pay nationally and that pay differentials between boroughs was not considered an incentive or disincentive to work in particular areas. However, having made enquiries of the NHS following the previous meeting, it was evident that significant differences in pay existed as a result of eligibility for either the Inner or Outer London allowance.

For those in receipt of the Outer London allowance (£3,414 to £4351), this accounted for 15 per cent of their overall salary, whilst the Inner London Allowance (£4,036 to £6,217) accounted for 20 per cent. Councillor Hunter explained that this created a clear incentive for a health visitor to work in areas where they could receive the additional allowance. Sarah Mansuralli (NHS Brent Clinical Commissioning Group) advised that the Agenda for Change pay banding was applied nationally. Health visitors working in London could receive a London allowance which acknowledged the increased costs of living in London. It was clear that the return to work strand had not yielded the intended outcomes and it was suggested that the Ealing ICO be asked what measures had been considered to attract health visitors.

Time to Change Pledge

Councillor Hirani (Lead member for Adults and Health) provided an update to committee on the Time to Change Pledge, advising that all actions had been carried out and all councillors had been urged to sign.

5. **Mental Health Services in Brent**

Sarah Mansuralli (NHS Brent Clinical Commissioning Group) presented a report to the committee on the findings of a recent review of IAPT (improving Access for Psychological Therapies) services and pathways to psychological therapy services in Brent. The report had been provided following the committee's request for a report on the mental health provision for people with more complex mental health needs.

Sarah Mansuralli advised that IAPT was a Department for Health (DfH) programme aimed at supporting the implementation of the National Institute for Health and clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders. Roll-out of IAPT had begun in 2008 and Brent IAPT had been established following a successful application by Brent Primary Care Trust (PCT) in 2010. Investment in Brent IAPT from Brent PCT had initially been achieved via a redesign of existing mental health services, including psychological services provided by Central and North West London NHS Foundation Trust (CNWL). Part of this re-design encompassed diverting a proportion of investment from secondary care psychological services to primary care based IAPT services. This diversion of funds was based on an analysis of the annual referrals and examination of therapy provision by IAPT London Lead which indicated that the majority of referrals seen in secondary care would be appropriate for an IAPT service. Brent IAPT currently provided services at Step 2 (primary care, low level interventions) through to Step 4 (secondary care, high level interventions).

Sarah Mansuralli explained that the review of IAPT services and pathways to psychological therapy services had concluded that capacity of Step 4 interventions in secondary care, which encompassed psychological treatment for more complex mental health needs, was currently limited. This had resulted in delays for patients in accessing appropriate therapeutic interventions. Nationally the average split between individuals requiring low level interventions and high level interventions was approximately 60:40. It had been found that in Brent this trend was reversed, with 60 per cent of those individuals accessing mental health services requiring high level interventions and the remaining 40 per cent requiring low level interventions. In response to the outcome of the review, it was proposed to combine

funding within IAPT and vacant sessions in secondary care services to increase the provision of step 4 interventions within secondary care. This would effectively result in a realignment of services to meet demand by shifting service capacity from Step 2 to Step 4. Brent PCT would continue to monitor the level and type of demand on the services. It was also proposed that a review would be held in the forthcoming financial year of art therapies and psychotherapy to determine how this resource would be utilised.

During in the subsequent discussion the committee sought assurance that the proposed shift in funding to increase capacity at Step 4 would not result in a lack of capacity for services provided at Steps 1 to 3. Members also noted the importance of preventative care and queried whether there was a danger that redirecting funding away from primary care services might result in a further increased demand on secondary care services. The committee noted that at present IAPT services were meeting the needs of approximately 10 per cent of those with depression and/or anxiety and further information was sought on the progress made in meeting the target set out in the NHS Planning guidance for 12-13 and 13-14 of 15 per cent. Members also queried, in light of the proposed review, whether there was an intention to retain art therapies.

Sarah Mansuralli advised that the realignment of services sought to target the level of need. Data gathered at the time of patients' referrals indicated that at the point of accessing these services, there was a greater demand for higher level intervention than lower level intervention. Therefore, whilst it was acknowledged that Stage 2 services had an important preventative role to play in reducing escalation of lower level need cases, it remained necessary to increase capacity at Stage 4 whilst maintaining a good service at Stage 2. The committee was advised that in addition to the realignment of services already described, there was a further £200,000 IAP funding for 2012/13 and a further £200,000 for 2013/14 dedicated to staffing to help meet demand. In response to a query requesting further clarification of these funds, Sarah Mansuralli explained that these funds were drawn from the Primary Care Groups (PCG), which had prioritised mental health. With regard to the performance of IAPT services in meeting the needs of those with depression and/or anxiety disorders in Brent, this currently stood at nearly 9 per cent; it was anticipated that this would be increased to 11 per cent in the forthcoming year and it was intended that the 15 per cent target would be reached by 2014/15. Natalie Fox (Service Director CNWL) added that this was the national target. The art therapy service would be maintained and it was intended that a range of therapy services would continue to be accessible to support the differing needs of patients.

RESOLVED:

That the report be noted.

6. **Role of Community Pharmacists in improving Health and Wellbeing**

Michael Levitan (Brent and Harrow Local Pharmaceutical Committee) delivered a presentation to the committee exploring the role of community pharmacists in improving public health and wellbeing. The committee heard that community pharmacists, as fully trained healthcare professionals who provided a range of services, were a highly valued resource. Importantly, community pharmacists were

also highly accessible to the public, with opening hours of between 50 to 100 hours per week and the majority of services accessible appointment free.

Michael Levitan outlined several examples to the committee of how the role of community pharmacists could be developed to the benefit of both patients and other healthcare providers. In particular, the possibility of utilising community pharmacists to reduce pressures on other healthcare providers was highlighted. The Minor Ailments service which had been introduced by Brent PCT and had ceased at the end of 2011, had enabled people to be diagnosed by community pharmacists for minor issues and obtain the appropriate medicines without attending a General Practitioner (GP). Work had been conducted which indicated that up to 20 per cent of GP appointments could be freed-up via this service. Similarly, there was evidence to suggest that up to 30 per cent of attendances at Northwick Park Accident and Emergency could have been dealt with at community pharmacies. Services that were currently being delivered by community pharmacists in Brent included flu vaccinations and an increased support role as part of hospital discharge planning. This latter service had been introduced at the end of 2012 and encompassed the provision of advice to patients or domiciliary carers on medicines received in hospital and on other therapeutic options. This service helped to encourage and enable patient compliance in taking their medicines. Martin Levitan concluded his presentation by noting it was essential that community pharmacists were included within discussions on public health issues.

In the subsequent discussion, members sought clarification on what actions were being taken by the Brent and Harrow Local Pharmaceutical Committee to champion good practice and the implementation of innovative initiatives in Brent. Further information was also requested on the level of demand from community pharmacists for expanding their role in public health and wellbeing. It was queried why the Minor Ailments service in Brent had ceased at the end of 2011. Members noted that incidents of community pharmacists providing medicines illegally had recently been publicised, with two of these incidents occurring in Brent. In light of this, several queries were raised on the mechanisms in place for self-regulation and inspection within the professional association for community pharmacists and the sector in general.

Responding to members' queries, Michael Levitan advised that the Brent and Harrow Local Pharmaceutical Committee had previously met regularly with the PCT and there had been some cases of very successful collaborations, such as the smoking cessation service. Many community pharmacists were very interested in expanding the types of services offered but it was acknowledged that the short length of contracts coupled with the investment in equipment and staffing often required could prove significant obstacles. A benefit of involving community pharmacists in the discussions around public health would be the increased confidence of community pharmacists in pursuing such developments. Ethie Kong (Chair of Brent Clinical Commissioning Group) added that minor ailment service would be revisited but would need to be developed to work more effectively. All public health services were working very hard to empower patients to engage to a greater extent in self-care and workshops were would be held to ensure that duplications in service provision would be avoided.

Turning to the incidents involving community pharmacists supplying medicines without prescription, Michael Levitan advised that the two cases that had occurred

in Brent had involved the supplying of antibiotics and not opiate based painkillers. Unlike the other cases that had been publicised, formal investigations had not been held for the incidents which took place in Brent. The committee was advised that community pharmacists were subject to very high levels of regulation and inspection by the Pharmaceutical Council. The PCT also had the right to conduct inspections on community pharmacies. It was emphasised that there were procedures which allowed community pharmacists to issue medication without prescriptions in emergencies.

Members noted that it would be useful to have greater information in respect of the evidence base for the initiatives and suggestions outlined in the presentation. The Chair advised that a deeper working relationship with the PCG, Public Health and Brent Council would be required to support community pharmacists developing a greater role in improving public health and wellbeing. It would also be important establish a substantive strategy setting out clear outcomes, expected benefits and budgets.

RESOLVED:

(i) that the report be noted
(ii) that an update be brought to the Committee in June 2013

7. **Tackling Diabetes in Brent Task Group - Final Report**

Councillor Colwill (Chair of the Tackling Diabetes in Brent Task Group) presented the final report of the task group to the committee. Members were advised that diabetes was a significant issue in the UK, with over 2.2 million people in the UK having been diagnosed with the condition. It was estimated that a further 850,000 people in England had diabetes but were unaware and had not been diagnosed. Diabetes currently accounted for 10 per cent of the National Health Service budget. The implications for Brent were compounded by the level of deprivation in the borough and the ethnic profile of Brent's residents. Specifically, there was a higher prevalence of diabetes amongst people of South Asian descent and African and African Caribbean origin and at present, 58 per cent of the Brent population originated from Black and ethnic minority backgrounds. Furthermore, deprivation had been linked with the diabetes and Brent was currently ranked within the top 15 per cent of the most deprived areas in the country.

Councillor Colwill explained that the task group had proceeded with the understanding that supporting preventative measures based upon education and the promotion of self-management was a key priority. The task group had concluded that whilst there was a lot of good work already being done to raise awareness of the disease, it was clear that further targeting of high risk groups was necessary. Members' attention was subsequently drawn to the ten recommendations of the task group set out in the report which encompassed a range of educational measures and proposed actions to be taken by the council to promote healthier lifestyles amongst Brent residents and council staff. In concluding, Councillor Colwill expressed his thanks to the members of the task group and to colleagues from the council and the NHS for their contributions and support.

RESOLVED:

(i) that the recommendations of the Tackling Diabetes in Brent Task Group be endorsed.
(ii) that the recommendations of the Tackling Diabetes in Brent Task Group be passed to the Executive for its consideration.

8. **Update on proposed merger of Ealing Hospital NHS Trust (EHT) and the North West London Hospitals NHS Trust (NWLH) and finances**

A report updating members on the proposed merger between Ealing hospital NHS Trust (EHT) and the North West London Hospitals (NWLH) NHS Trust was presented to the committee by David Cheesman (North West London NHS Hospitals Trust). The committee was advised that progress continued to be made towards merging the two trusts and it was expected that the earliest that the full business case for the merger would be submitted to the NHS London Board would be July 2013. NHS London had requested that financial modelling of the impact of "Shaping a Healthier Future" programme be included in the business case. At present, it was intended that the merger would go live on 1 April 2014. The committee was advised that the two trusts had begun to combine some back office functions, including the creation of shared IT and Estates departments. The trusts would continue to implement service sharing in other areas. In addition, as a result of vacancies arising in posts at EHT, the Chief Executive of NWLH had become the Acting Chief Executive of EHT and the Director of Nursing at NWLH had assumed the position of the Acting Director of Nursing at EHT. Steady progress was being made towards the financial targets associated with the merger which for 2012/13 equated to circa £16m for NWLH and £14m for EHT. NWLH was forecasting that it would deliver £13.4m of the planned savings, with the balance made up through other non-recurrent measures. The trusts were also working directly with the National Trust Development Authority (NTDA) which was the new NHS governing body due to take over responsibility for the oversight and support of non-Foundation Trusts from 1 April 2013.

During members' discussion, the committee raised a number of queries. Clarification was sought regarding the non-recurrent measures that would be taken to reduce meet the savings target of NWLH. A concern was also expressed by a member over whether those officers holding dual positions across the two organisations had sufficient capacity to manage the additional responsibilities over a time of significant change.

Tina Benson (North West London NHS Hospitals Trust) provided an example of the non-recurrent measures employed by NWLH to help reach its savings target for the year, explaining that where a vacancy arises in the organisation the Trust might chose to wait for a period before recruiting to the position to release a short term saving. David Cheesman confirmed that he was confident that the officers undertaking corresponding roles within the two organisations were able to manage in the present circumstances. Having one body to work with in the merger process was extremely beneficial. Furthermore, given the financial pressures the organisations were under it was appropriate to make cut-backs on senior posts where possible.

Responding to a further query, David Cheesmen advised that the Shaping a Healthier Future (SaHF) programme created both challenges and advantages for the Trusts. It had been hoped that the merger would have been completed prior to the implementation of SaHF to allow the organisations to undertake the challenges as a joint organisation; however, this had not been possible. SaHF did put pressure on Northwick Park Hospital and work was currently underway to explore issues of capacity.

RESOLVED:

That the report be noted.

9. **Accident and Emergency performance and activity at Northwest London Hospitals NHS Trust**

Tina Benson (North West London NHS Hospitals Trust) presented a report updating the committee on Accident and Emergency (A&E) performance and activity at North West London Hospitals (NWLH) NHS trust. It was highlighted that Northwick Park Hospital A&E continued to be under considerable pressure, principally in respect of assessment space within the department and bed capacity across the hospital. Performance against the four hour A&E waiting target had worsened over the winter and bed capacity was a key underlying cause of this. To address the assessment and acute bed capacity problems the trust was undertaking a complete site review. It was recognised that the Shaping a Healthier Future (SaHF) model was very different to the existing model in operation and relied significantly on an out of hospital strategy. This drew on evidence which indicated that a third of patients in hospital beds did not need to be in an acute setting. It was also anticipated that the £20m redevelopment of the A&E at Northwick Park would address some of the issues around the lack of assessment space. Turning to activity at Central Middlesex A&E, the committee was advised that this had continued to decline, although it had been busy in recent weeks due in part to the intentional pushing of activity away from Northwick Park in the interim period. The trust would be looking at how the emergency pathway could be consolidated and improved within the context of the possible outcomes of the SaHF programme.

In the subsequent discussion the committee requested an update on the redevelopment of the A&E at Northwick Park Hospital. Members also sought an update on the introduction of the 111 telephone service.

On the redevelopment of the A&E site at Northwick Park Hospital, Tina Benson explained that construction work was already underway and artists' impressions of the finished development were available. The business case had now been signed off. The underlying principal of the building was improved flow and flexible space. There would be no treatment specific rooms and instead the rooms would be suitable for the different purposes of various healthcare providers. Jo Ohlson (Brent Borough Director, NHS Brent), advised that it was important that a shift was made towards a focus on preventative care, noting that under the current system resources were predominantly orientated towards acute crisis management. Without such a shift in position, hospitals would face growing patient admissions. The perspective of the clinical commissioning group was focussed towards supporting good preventative primary care. With regard to the 111 service, a start

date of 19 February was currently in place; however, advertising of the new number would not begin until the following month. The delay in implementing the service had been due to IT issues. The contract would be signed by the forthcoming week.

In response to a question from a member of the public on potential issues of access for the redeveloped A&E facility at Northwick Park Hospital, Tina Benson advised that the access route to the facility would no longer be one-way as originally planned and that the London Ambulance Service (LAS) had signed off the plans for the new building.

RESOLVED

That the report be noted.

10. **Public Health Transfer Update**

A report was presented to the committee by Phil Newby (Director of Strategy, Partnerships and Improvement) and Alison Eliot (Director of Adult Social Care) updating members on the progress made in preparing for the transfer of public health functions from NHS Brent to the council. The transfer would take effect as of 1 April 2013, as required by the Health and Social Care Act 2012.

The report set out the agreed arrangements for the transfer of staff from NHS Brent to the council. Brent would have 19 public health staff split between the Adult Social Care department and Environment and Neighbourhood Services department. There would be a Director of Public Health (DPH) for Brent, who would manage the public health staff and would report to the Director of Adult Social Care. There would also be two public health consultants which would work across both departments on public health activity. A review would be held of the effectiveness of the functions and structure of the staffing arrangements after a period of 12 months. It was envisaged that all staff, with the exception of the DPH, would be appointed by the middle of February 2013. As the comparable DPH position was currently vacant in NHS Brent the council was in the process of recruiting to the post. However, it was considered unlikely a DPH would be in post in time for 1 April 2013.

The report also highlighted the current work taking place to ensure the successful transfer of existing contracts for public health services. The Executive had agreed that the majority of public health contracts would be extended and continued in 2013/14. The transfer of these contracts would take place under a statutory transfer arrangement (transfer order) and would take effect from 1 April 2013. Unfortunately, due to the complexity of the existing contract arrangements, officers were currently examining each contract individually to ensure it could be extended and included within the transfer order. It was emphasised that the council was committed to reviewing and re-commissioning public health services over the coming two years to comply with the council’s procurement rules and ambitions for public health.

Phil Newby advised the committee that the public health allocation for the next two years had been better than anticipated and exceeded the baseline estimate of £16.007m. The ring fenced public health allocation would be £18.355m for 2013/14 and £18.848m for 2014/15. This would allow the council to meet contract and staffing costs and also have funding for development opportunities in public health.

A working budget was in place for 2013/14 and an indicative budget was being developed for 2014/15.

During discussion a member queried the current uptake of drug and alcohol services and the arrangements in place for sign posting service users to other appropriate services. Noting the three contracts that would not be extended in to 2013/14, the committee sought further details regarding alternative provision, particularly in relation to the Young Addaction – teenage pregnancy services and sexual health services for young people. Several queries were raised in relation to the structure and arrangements for public health staff. It was queried why the DPH was unlikely to be in post by 1 April 2013. A member also queried who would hold corporate responsibility for ensuring that teams who had not been used to supporting public health functions were doing so appropriately. Clarity was sought regarding public health staff within the Children and Families Department. A query was raised regarding the current number of public health staff compared to the number of posts transferring to the council. It was queried whether the public health consultants would be medical professionals.

Allison Elliot advised the committee that information on the take up of drug and alcohol services could be provided to the committee. These services were all delivered from the same location in Brent which eased the process of sign posting service users to other appropriate services. Brent was one of the most successful boroughs for treatment completion for these services. Information on Brent's ranking for successful treatment completion would be circulated to the committee. With regard to the sexual health advice provided under the Young Addaction service, the committee was advised that the contract would continue.

Turning to the issue of corporate responsibility for public health functions, Alison Elliot advised that this would fall to the DPH, and whilst that post was vacant, to other public health colleagues and the Director of Adult Social Care. At present, there were 26 permanent public health staff and there would be 19 public health posts transferring to the council. It was confirmed to the committee that the public health consultants would be clinical consultants. With regard to public health staff in Children and Families, the committee heard that colleagues in Children and Families had worked with the NHS to identify what public health investment was needed for children's services. This process was managed through the Adult Social Services commissioning board as it had capacity to support this. The committee was reminded that at present, the council did not have public health responsibilities for children under the age of 5 years old.

RESOLVED:

That the report be noted.

11. Brent LINk Annual Reports 2011/12 and 2012/13

The annual reports for Brent LINk (Local Involvement Network) for 2011/12 and 2012/13 were presented to the committee for its consideration by Mansukh Raichura (Chair of Brent LINk). Brent LINk was an independent network comprising individuals, community groups, voluntary sector organisations and local businesses, which worked together to improve local health and adult social care services in Brent. The annual reports detailed Brent LINk's structure, main activity and

achievements. With reference to the 2012/13 report it was noted that as this was the final year of Brent LINk's existence, it was allowed to produce the substantive part of its 2012/13 annual report earlier than would usually be required. Funding for Brent LINk would cease at the end of March 2013 and a new consumer champion organisation, Healthwatch Brent, was due to absorb into its broader functions the role currently carried out by Brent LINk. A legacy document was being developed to pass to Healthwatch Brent. Mansukh Raichura emphasised that the success of Brent LINk was due to the contribution and commitment of its members who had given a great deal their time and personal expertise to the organisation. It was intended that all existing Brent LINk members would become active members of the local Healthwatch when the service commenced.

The committee expressed its admiration for the work undertaken by Brent LINk and commended the organisation for its achievements.

RESOLVED:

That the annual reports of Brent LINk for 2011/12 and 2012/13 be noted.

12. **Work Programme**

The Chair drew the committee's attention to the work programme, noting the items scheduled for the next meeting. The committee was advised that an update following the publication of the Advisory Council on the Misuse of Drugs report on khat would be added to the work programme for the next meeting.

13. **Any Other Urgent Business**

ACMD Khat Report

Councillor Hunter advised that the Advisory Council on the Misuse of Drugs (ACMD) had published its report on Khat usage in the UK. The report was entitled 'Khat: A review of its potential harms to the individual and communities in the UK' and had concluded that there was insufficient evidence to warrant a ban on Khat. This mirrored the view of the Brent task group which had explored the health and social impact of Khat usage. The task group had contributed significantly to the ACMD review and an update on the task group's recommendations would be brought to the committee at its next meeting. Councillor Hunter highlighted that of the 24 members of the ACMD review, 15 were clinically qualified.

14. **Date of Next Meeting**

The committee noted that the next meeting of the Health Partnerships Overview and Scrutiny Committee was scheduled for 19 March 2013.

The meeting closed at 9.00 pm

S KABIR
Chair