MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
Tuesday 11 June 2013 at 7.00 pm

PRESENT: Councillor Daly (Chair), Councillor Hunter (Vice-Chair) and Councillors Colwill, Harrison, Hector, Hossain and Ketan Sheth

Also present: Councillor Cheese, Councillor Hirani (Lead Member for Adults and Health) and Councillor Jones.

An apology for absence were received from: Councillor Leaman

1. Declarations of personal and prejudicial interests

Councillor Ketan Sheth declared an interest as the Vice Chair of Central and North West London NHS Foundation Trust, however he did not view this as a prejudicial interest and remained present to consider all items on the agenda.

2. Minutes of the previous meeting held on 19 March 2013

RESOLVED:-

that the minutes of the previous meeting held on 19 March 2013 be approved as an accurate record of the meeting, subject to the following amendments:-

- page 2, last paragraph, second line, add 'not' after 'could'.
- page 5, last paragraph, third line, replace 'LES' with 'LAS'.
- page 6, second paragraph, sixth line, add 'hospital' before 'care'.

3. Matters arising (if any)

None.

4. Pathology Service - incident and investigation

Jo Ohlson (Brent CCG Chief Operating Officer) introduced the final report in respect of the incidents and subsequent investigation for pathology services in Brent and Harrow. Pauline Johnson (Interim Head of Quality and Safety, Brent CCG) then drew Members' attention to the six actions listed in the resulting action plan as set out in the report. Dr Patel, chair of the Root Cause Analysis (RCA), was also present to respond to members' questions.

Members then discussed the item and raised a number of issues. One member commented that the incidents may not have happened had there been more staff with the necessary expertise and the number of consultants available was queried. Further comments were sought in respect of the reference in the report to GPs not attending working group meetings and were steps being taken to ensure that they

did. It was acknowledged that there had clearly been communication issues, in particular a lack of cascading information down to staff at all levels, with CROs not sure who was responsible for ensuring this was happening and it was asked whether this had now been addressed. An update on the communications strategy was also sought. In relation to transportation of samples, it was enquired why it had not been specified in the service specification that samples be transported at room temperature, despite clinical opinion stating they should. Information was sought with regard to future arrangements for risk assessments and would this include involvement from GPs. The committee asked for an explanation of the process for when laboratories presently issued tests. A member commented that the incident and the RCA had flagged up issues that were also national ones and it was asked whether there had been a formal response to this.

A member acknowledged that one of the main reasons the pathology contract had undergone a procurement exercise was to test if the market could produce potential savings. However, although this was necessary, there was no evidence to suggest that a proper risk assessment had been undertaken and it was asked what had been learnt from this. It was enquired whether both the previous and current provider of pathology services was clinically accredited and what date had they been confirmed as being so. It was commented that in the Francis report, it had been stated that consultants had been commissioned to advise hospitals as opposed to CCGs and it was asked how expert advice had been sought during the procurement. Members asked what the total costs of the incident had been and what steps were being taken to address management and leadership issues in respect of the CCG and Central Middlesex Hospital. It was commented that the procurement of the pathology contract had been undertaken without the knowledge of GPs and she asked what steps were being taken to keep them informed.

In reply to the issues raised, Pauline Johnson advised that although consultants were being used at around the time the incident happened, some of them had not been able to devote as much as time as had been hoped. In respect of GPs being absent from meetings, initially there had been two GP representatives, however they each had a heavy workload, so the membership allocation for GPs had been extended to increase the likelihood of GP presence at future meetings. Pauline Johnson acknowledged that there had been clinical advice to ensure samples remained at room temperature during transportation and although this had not been specified in the contract, this area was to be re-visited. She stated that a risk assessment would be undertaken in respect of any future procurement exercises. Members heard that there was a communications strategy, however this was presently being reviewed, and GPs and TDL were being involved in this. The review was due to finish at the end of July 2013 and a new communications strategy would follow. Pauline Johnson informed the committee that when a laboratory wanted to issue tests, the Director of Compliance at TDL would report to herself and SROs. If the tests were urgent, the results would be sent to the GP on the same day, whilst all others would be available within either 48 hours or five working days. TDL were also formulating a response in respect of issues that had been identified nationally. Pauline Johnson advised that both the previous and present pathology services provider was clinically accredited and it was noted that TDL had recently revised the accreditation process. In terms of consultants providing advice, for hospitals this was in providing on-going support in respect of quality assurance. The CCG did not have automatic right of access to consultant advice, however they could still make such a request.

Jo Ohlson added that TDL produced a regular newsletter and this was being monitored for the quality of the information it was providing. She acknowledged that there had not been adequate consultation with GPs during the procurement and this had been identified and addressed by the RCA and action plan. The committee heard that information on key changes and developments, such as procurement exercises, would go the lead doctor and practice manager at each practice and this issue would be looked at further. Many lessons had been learnt as a result of the RCA and it was acknowledged that the pathology service had not been sufficiently clinically robust. There had been a risk assessment in terms of the service, although a separate one had not been undertaken specifically in terms of the procurement, although there would be for future ones. With regard to costs of the incident, these had not been quantified as such and would be difficult to do so. The costs would be incurred by the GP practices in using resources to contact patients, whilst there were also delays in receiving test results. However the RCA and action plan had been put together to ensure such an incident did not recur.

Dr Patel confirmed that there was now a minimum of five GP representatives for meetings with the CCG. With regard to issues raised nationally as a result of the incident, he informed members that Ealing Hospital NHS Trust had advised its GPs about this. Rob Larkman (NHS North West London) added that the way CCGs operated was fundamentally different to PCTs and that steps would be taken to ensure grassroots input from GPs. A key priority was to develop leadership and managerial skills within the CCG, whilst the procurement of the pathology service aimed to ensure high quality services at better value for money. Tina Benson (Director of Operations, North West London Hospitals Trust) informed the committee that TDL were responsible for the laboratory contracts and the CCG in managing the acute services contract. Dr Sarah Basham (Brent GP) added that there had been a long history of disseminating information to GPs in Brent and she added that lead GPs, who were responsible for cascading information to other staff, had done this well in Brent.

The Chair felt that concerns for pathology services remained, with a number of serious issues needing further consideration. It was of the utmost importance that a safe and effective pathology services was provided and there was evidence to suggest that this was not completely the case. The Chair requested that an update on this item be provided at the next meeting on 24 July 2013 to show evidence of progress and that the committee would also like to look at the CCG’s procurement processes in more detail.

5. Emergency Services at Northwick Park and Central Middlesex Hospitals

Tina Benson presented the report and stated that the North West London Hospitals (NWLH) Trust had held a number of discussions, including a risk summit, with staff and other stakeholders to explore ways of reorganising emergency services across both Central Middlesex Hospital (CMH) and Northwick Park Hospital (NPH), to make best use of staff and other resources. A project board had been created and set up three workstreams underpinned by a number of projects, which will require the support of all key health and social care partners to deliver:-

- Increasing bed capacity at NPH
- Maximising capacity at CMH

- Moving more orthopaedic work to CMH

Tina Benson explained that for CMH, the changes in particular focused on moving recovery and rehabilitation care to the hospital for patients who had received surgery for hip fractures. It was also proposed to have an enhanced recovery programme. CMH would sustain an acute medical intake to treat patients with a medical problem, whether they arrived by ambulance or through GP referral, at any time day or night. Currently ambulance arrivals were not accepted out of hours, but this was being discussed with the London Ambulance Service. With regard to NPH, additional bed space on existing wards, including a short term change of 11 private beds on Sainsbury Ward to NHS beds would be undertaken. It was also intended to expand the ambulatory care unit and surgical assessment unit on Fletcher Ward to include the STARRS assessment lounge to accommodate a further 10 to 15 patients a day and move STARRS to focus on the Emergency Department to prevent unnecessary admissions. Other measures included patients in need of a surgical assessment not necessarily having to be assessed in the Emergency Department first and being referred directly to the relevant consultant depending on their condition. Work had also started on a new Emergency Department and state-of-the-art operating theatres at NPH.

During discussion, clarification was sought in respect of acute medical intake at CMH and whether staff numbers would be increased in order that it could remain open at night and was there the budget to be able to do this. Moreover, would the hours be extended at CMH in the event of additional staff being recruited in any case and what was the recruitment policy for the hospitals. Comments were sought as to whether the patient footfall remained low at CMH and was this an attributable reason for the difficulty in recruiting staff there. Members also noted the concerns of residents to the ongoing evening closure of the Accident and Emergency (A and E) department at CMH and it was enquired what was being done to improve communication with residents in the area to keep them informed of services available at the hospital. It was also asked if A and E targets at CMH were being met and were residents in the area visiting A and E less, and if so, where were those who were in a serious condition being treated. Furthermore, was there an increase in the number of patients being taken to CMH by ambulance and was there an issue between patients arriving by ambulance and waiting times at hospitals in the borough.

A member queried whether dealing with patient numbers at NPH remained a serious challenge. Further explanation was sought in respect of the risk summit, including what they were, why they had happened and why had they not been mentioned at the previous meeting of this committee. A member asked if the council had been informed about the outcome of the risk summit. Details were also asked about the inspection that had been carried out in November 2012 and what had instigated it. Another member, in noting the need to improve out of hospital care, sought an update on progress in this area. The number of cancellations of planned surgeries in the last three months was also asked.

With the agreement of the Chair, Councillor Cheese addressed the committee. Councillor Cheese asserted that the London Ambulance Service was diverting patients to CMH because NPH was so busy, and because less services were available at CMH, this was putting patients in the south of the borough at risk and he asked what was being done to address this.

In reply to the issues raised, Tina Benson advised that discussions were underway with regard to acute services at CMH, with one of the suggestions being that patients will be admitted to the hospital at night irrespective of whether the A and E unit was open or not. She confirmed that an additional consultant had been recruited at CMH, however there remained nine vacancies. Although patient numbers remained a challenge for NPH, performance had improved and the waiting times in May 2013 had been met. However, patient demand was always greater in winter and every effort was being made to improve waiting times next winter in comparison with the last. Tina Benson advised that the risk summit looked at all the risks the health economy posed for emergency care and there had been a number of workshops focused on performance, risks to patients and the patients' experience. It was noted that the borough based Urgent Care Board now led the response to the risk summit and workshops. With regard to the inspection of A and E in November 2013, this was as a result of a complaint received about a patient's experience and featured inspections carried out both during the day and night. The inspection had resulted in a favourable report and Tina Benson agreed to provide members with information on this. An audit of 40 patients waiting at A and E had also been undertaken and this had shown that all of them had received the care and treatment required and Tina Benson added that this information could be made available to members if they so wished. She also agreed to undertake to provide information on the number of cancelled planned surgeries over the last three months.

Tina Benson advised that there was not sufficient staff numbers to extend A and E hours at CMH, however if extra staff were recruited, this could be looked at again. The committee heard that staff were recruited as employees of the Trust as opposed to a specific hospital. A budget was currently available to increase staff numbers at CMH, however it needed to be noted that patient numbers particularly in respect of A and E continued to fall. The committee was informed that CMH A and E was meeting its waiting target, although it did see a considerably lower volume of patients than NPH and St Mary's Hospital, which found it easier to recruit staff as it was a major trauma centre. Tina Benson confirmed that presently there were 18 private bed spaces at NPH, although 11 of these were to be reallocated to the Trust. Tina Benson advised that data sharing with partner agencies was taking place to look at specific needs of patients, particularly in relation to out of hospital care.

Jo Ohlson added that prevention of unnecessary visits to hospitals was a key driver in respect of improving out of hospital care and STARRS played an important role in this, with hospital patients referred to them where appropriate. The Willesden Centre for Health and Care also provided therapy weekends and there was a robust protocol in place as to when patients could be discharged from hospital. With regard to A and Es, Jo Ohlson advised that the excellent clinical service required of them was only feasible at NPH, as CMH lacked the necessary support services. The Urgent Care Centre (UCC) also operated on a 24/7 basis at CMH and around 85% of cases were admitted to it. It was noted that the UCC could also refer patients to the appropriate medical practitioners.

David Cheesman (Director of Strategy, NWLHT) added that the UCC had been very successful since opening at the CMH and had exceeded expectations. He also advised that the composition of health services was being reviewed at macro

level through the Shaping a Healthier Future Programme. He acknowledged that explaining the health services available was complex, however it was intended to increase utilisation of each hospital.

Pauline Cranmer (Performance Improvement Manager, London Ambulance Service: West London) advised that the London Ambulance Service was working with UCCs to identify the most appropriate locations to send patients to. During April 2013, around 2,800 patients had been sent by ambulance to NPH, and 670 to CMH. Pauline Cranmer advised that waiting times in A and Es was a London-wide issue, due to increases in patient demand and in acute cases. She added that for critically ill patients, these would be categorised as blue light calls and the hospital concerned would be duly informed so that staff were waiting at the entrance of the hospital to attend to the patient as soon as they arrived.

Phil Porter (Interim Director of Adult Social Services) confirmed that while he had not attended the risk summit, he was aware of the outcome and the council was represented on the Urgent Care Board that was overseeing the three work streams.

The committee noted that the council was informed of the outcome of the risk assessment on 6 March 2013.

The Chair felt that the waiting times for A and E patients were not acceptable at present, whilst she also commented that there needed to be more clarity as to where residents would be treated depending on their condition. She requested an update on A and E, the London Ambulance Service, treatment provided to patients at home and clarification with regard to services at CMH for the next meeting on 24 July 2013.

6. **111 telephone number - service implementation**

Jo Ohlson presented the report and confirmed that the 111 service went live on 26 February 2013, its launch being delayed as a result of the findings of the risk assessment. The launch in February was a ‘soft launch’, meaning the service was only available for patients contacting GPs on the out of hours telephone line. Since the launch, there had been some performance concerns, particularly in respect of performance over the Easter Bank Holiday weekend, both locally and nationally. This had led to a performance notice being issued to the contractor, Harmoni, and a remedial action plan had been put in place. Since Easter, performance had improved with performance meeting or being very close to the required standard of answering calls in 60 seconds and call abandonment. However, Jo Ohlson added that the performance indicator of call backs to patients within ten minutes of their initial call remained a challenging one, and actions such as queue prioritisation were put in place whilst underlying issues in respect of staff numbers and rotas were addressed. Any call backs talking longer than an hour were investigated. There had also been deemed to be a lack of professionals to transfer the calls to which had led to the number of call backs required increasing. Jo Ohlson advised that NHS London would decide when the full service would be launched in London, although 111 performance was better than the national average.

During discussion, Members sought clarification with regard to the differences between the 111 service and 999 service and what issues presently remained unresolved with the 111 service.

In reply, Richard Penney (111 Project Manager for North West London) advised that the 999 service was for life-threatening situations, whilst the 111 service was for all other urgent and non life-threatening situations. The 111 service helped direct callers where they were not sure who to contact and there was also direct access between 111 and 999 and vice versa. Richard Penney added that a protocol had been agreed between the 111 service and the London Ambulance Service. He advised that the problems the 111 service had experienced were not to do with how the service operated, but in meeting a whole range of standards and issues such as a lack of professional advisers had affected the ability to meet some of these. However, following the problems experienced during the Easter Bank Holiday weekend, meetings with providers had led to a recovery plan and the introduction of a number of measures to address these issues. Richard Penney explained that the call back target was a particular problem at national level and there still remained challenges to overcome, however Harmoni were addressing these and were also recruiting new staff.

The Chair requested details of the training programme for 111 service advisers, the remedial action plan and progress with regard to the key indicators performance at the next meeting on 24 July 2013.

7. **North West London Hospitals/Ealing Hospital merger**

David Cheesman advised that there were no changes to the timescale of the merger since the last update to the committee. He confirmed that the financial aspects of the business case were to be finalised.

8. **Colposcopy Services at Central Middlesex Hospital**

Tina Benson presented the report which outlined the reasons for relocating the colposcopy service at CMH to NPH on a temporary basis from 1 April 2013. This had been done as there had remained only one colposcopist at CMH following the retirement of their colleague and so the relocation was necessary in order that they had retained support and to not be left working in isolation, which would be against the national screening programme's statutory clinical guidelines. Members noted that the Trust was in the process of training one of its gynaecology specialist nurses to take over the vacant colposcopist position and they would be appointed to this post, subject to meeting the required competencies.

During discussion, a member commented that their spouse had received good service at NPH. Another member commented that the Did Not Attend rates were high and were they getting worse. She also noted that a four week wait to be seen following a smear test result was long and what steps were being taken to reduce this.

In reply, Tina Benson advised that a lot of work was being focused on explaining to patients of the importance of taking smear tests to identify conditions such as cancer and to explain the procedures involved in the test. Members heard that the waiting times for smear test results were nationally set standards and four weeks was only the target, however if the smear test had conclusively identified cancer, patients would be seen within two weeks.

9. **Public Health transfer update**

Imran Choudhury (Interim Director of Public Health) confirmed that there had been a successful transfer of staff from the NHS to the council and staff were in the process of being embedded and getting used to the new working culture.

Members commented of the need to receive regular reports on how public health services were working.

Phil Porter (Interim Director of Adult Social Services) added that the first meeting of the Health and Wellbeing Board would be responsible for overseeing the response to the broader issues involved in improving public health services.

10. **Sexual and Reproductive Health Services in Brent**

Members had before them a report on sexual and reproductive health services in Brent. A member commented that the mention of sexual health prevention in the report was perhaps inappropriate and misleading and should be re-termed. It was also enquired whether there was any risk to the contracts for the pan-London HIV prevention services.

In reply, Imran Choudhary advised that pan-London HIV prevention services were not at risk, however there had been some concerns with regard to the robustness of these services so these were being reviewed by the London Borough of Lambeth, the lead borough on this matter. He acknowledged the need to reconsider the term sexual health prevention.

11. **Health Partnerships Overview and Scrutiny work programme 2013-14**

The Chair drew members' attention to the committee's work programme. In respect of commissioning intentions for the 24 July 2013 meeting, she stated that issues concerning CCG procurement, such as how they operated, the main principles and priorities and who was consulted, be explained. In addition, the current procurement programme should also be outlined and explained in the context of the Francis report, the needs of services and the community. The Chair also advised that a report on how Health Watch was working would also be put to the committee.

12. **Any other urgent business**

Dismissal of Deputy Borough Director for Brent NHS

Rob Larkman updated members in respect of the recent dismissal of the Deputy Borough Director for Brent NHS, Craig Alexander, following the revelation that he had a previous conviction for armed robbery. Members heard that he had been recruited through an agency, who were not required to undertake Criminal Records Bureau/Disclosure and Barring Service checks. Craig Alexander had not disclosed the criminal offences during his application and he had provided satisfactory references, whilst his work performance had also been satisfactory. Rob Larkman explained that as soon as the criminal offences were known, an immediate review was undertaken and Craig Alexander was swiftly dismissed. A report had also subsequently gone to the Governing Body making various recommendations in

respect of employing agency staff. The recommendations would be reported in a public meeting.

The committee enquired whether the police had provided any advice in respect of the case and could assurances be given to the person who had bought Craig Alexander's background to the attention of Brent NHS.

In reply, Jo Ohlson advised that NHS Protect were involved in the case and were advising other bodies accordingly. She gave her assurances in respect of the member of staff who had first highlighted the case.

The Chair requested that the number of agency staff in the CCG and the total expenditure on them be provided at the next meeting of the committee on 24 July 2013.

13. **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 Wednesday, 24 July 2013 at 7.00 pm.

The meeting closed at 9.15 pm

M DALY
Chair