MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
Tuesday 28 January 2014 at 7.00 pm

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

Also present: Councillor Hirani (Lead Member for Adults and Health)

NHS representatives present: Dr Sarah Basham (Co-Clinical Director, Brent Clinical Commissioning Group), David Cheesman (Director of Strategy, North West London NHS Hospitals Trust), Isha Coombes (Manager, Brent Clinical Commissioning Group), Rachel Donovan (NHS England), Sarah Mansuralli (Deputy Chief Operating Officer, Brent Clinical Commissioning Group), Jo Ohlson (Chief Operating Officer, Brent Clinical Commissioning Group), Jonathan Wise (Chief Finance Officer, Brent Clinical Commissioning Group).

Council officers present: Mark Burgin (Senior Policy Officer, Assistant Chief Executive Service), Toby Howes (Senior Democratic Services Officer, Legal and Procurement), Phil Porter (Strategic Director, Adult Social Care) and Melanie Smith (Director of Public Heath, Assistant Chief Executive Service).

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

None declared.

2. **Minutes of the previous meeting held on 4 December 2013**

RESOLVED:-

that the minutes of the previous meeting held on 4 December 2013 be approved as an accurate record of the meeting.

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

None.

4. **Diabetes Services in Brent**

Melanie Smith (Director of Public Health) presented the report that had been jointly produced by the council's Public Health Team, Brent Clinical Commissioning Group (CCG) and NHS England. Members were aware that diabetes was of particular concern in the borough and noted that 22,097 people were on GP diabetes registers in Brent. Diabetes UK had estimated a diabetes prevalence rate of 10.5% overall in Brent in October 2013, although rates varied across the borough. It is estimated that one in four people with diabetes in London are undiagnosed and are at high risk of developing long term complications. The committee heard that there

had been a 38% increase in diabetes rates for NHS Brent between 2008/09 and 2012/13. Melanie Smith informed members that those with diabetes in Brent were more likely to develop complications arising from their condition than the general population, including heart disease, stroke, foot disease that may necessitate amputation, kidney disease and loss of sight. However, early diagnosis, good diabetic care and self management could all be effective in preventing complications from arising. Melanie Smith referred to the findings from the 2011/12 National Diabetes Audit that identified that people with diabetes in Brent were less likely to suffer complications than the national average of those with diabetes, despite the borough's relatively high levels of deprivation. This served as evidence that both health services and residents were responding well once diabetes was diagnosed.

Isha Coombes (Manager, Brent CCG) then summarised the current diabetes services currently operating in the borough. A total budget of £9.493m had been set for diabetes services for 2013/14 and it included a range of services. This included health promotion and prevention of diabetes schemes run in conjunction with the CCG and the council, including physical activity programmes, healthy eating, diabetes awareness raising, risk assessment and health checks and the Moving Away from the Pre-diabetes programme. The council commissions the NHS Health Check programme offered by Brent GPs aimed to prevent diabetes as well as heart disease, stroke, kidney disease and certain types of dementia. The council was also working with Diabetes UK through a community engagement programme, using community champions to promote awareness of diabetes for the high risk groups in the borough. Isha Coombes advised that diabetic patients were currently managed in primary care under the standard General Medical Services (GMS)/Personal Medical Services (PMS) contract, including additional health checks under the Quality and Outcomes Framework (QOF), a voluntary scheme which all Brent practices participated in. Other schemes to tackle diabetes included the Brent GP insulin initiation scheme, which had been rolled out across Brent in April 2012 and the Ealing Integrated Care (ICO) Organisation service that helped patients with type II diabetes, secondary care services and the Brent diabetic eye screening service. The latter is commissioned by NHS England from Ealing ICO. Those patients with positive screening tests would subsequently be referred to ophthalmology services at Central Middlesex Hospital (CMH).

Isha Coombes then outlined the proposals for the diabetes service redesign commencing in April 2014. The committee heard that Brent CCG recognised the need to invest in diabetes services, particularly as diabetes was expected to continue to rise in the borough. A redesigned integrated pathway community based service would realise a number of benefits, including:

- Providing a consultant led service where patients were seen by a multi-disciplinary team and treated in one appointment rather than a series of appointments
- Achieving value for money, ensuring patients were treated in the most appropriate environment according their needs at the right cost
- Opportunities to upskill GPs and practice nurses in diabetes care
- Facilitate early discharge back to GP care
- Develop a clinical network of care to provide tiers 1 and 2 care within localities.

Isha Coombes advised than Brent CCG had agreed an additional £693K of funding to enhance and further develop the community based integrated diabetes pathway, including increasing clinical capacity through additional specialist staff. Members heard that the redesigned service would improve health outcomes through:

- Providing early detection and identification of diabetes
- Involving patients in the decisions around personalised care planning
- Developing patient knowledge, skills and confidence for better self-management
- Demonstrating robust and clinical outcomes
- Targeting high risk populations

During members' discussions, Councillor Colwill stated that the report lacked any reference to the task group on diabetes that he had chaired, including the recommendations it had made and he asked what progress had been made on these. A member acknowledged that overall most Brent GP practices were achieving a high number of points for the diabetes domain of QOF, however they enquired what steps were being undertaken to improve the small number that were underachieving. Surprise was expressed that the Wembley site was unable to cope with demand for diabetic eye screening and why had there not been extra clinics laid on or staff redistributed accordingly. Further information was also sought in respect of initiatives to support healthy eating in Brent. A member commented that the report needed more detail in order for the committee to fully scrutinise the matter and the report focused too much on providing an overview, whilst he felt the section on diabetes service redesign was also too brief. He suggested that there could be more details, for example, on plans for diabetes services in the Kingsbury locality as it had the highest diabetes prevalence in the borough.

The committee enquired whether the £9.493m designated for diabetes services was inclusive of the council's public health spend. In noting that the QOF was optional, clarity was sought as to whether it was included as part of NHS Brent contracts and what was the total spend on GPs participating in the scheme. Details of NHS England funding for commissioning of diabetic eye screening services for Brent and funding for the Brent GP insulin initiation scheme and the Ealing integrated care pathway programme was sought. Clarity was sought as to whether the ophthalmology services commissioned by Brent CCG at CMH were different from community based services and on community screening services in Brent. It was also enquired whether an interpretation service was available for patients whose first language was not English and what was the total number of diabetic consultants in the borough.

In reply to the issues raised, Melanie Smith stated that the report explained the current position in respect of diabetes services, so some initiatives such as healthy eating were still in the process of being developed. She acknowledged the role played by the diabetes task group and the recommendations that it had made and the task group would be referred to in future reports. Members noted that all of the task group recommendations had been referenced, however those relating to schools would be more difficult to achieve, whilst there were also resource limitations in respect of the recommendations relating to green gyms. However, a number of methods were being considered in respect of awareness raising,

including working with Diabetes UK and using community champions as an outreach. Melanie Smith advised that the high demand for diabetic screening in the borough was very welcome and exceeded that in other areas and consideration of how to reconfigure the service to cope with this demand was being undertaken. She advised the committee that there were practical difficulties in identifying the exact public health funding allocated for addressing diabetes as resources were allocated to address risk factors for a range of conditions, for example promotion of physical activity might reduce diabetic risk but would also improve mental wellbeing. The committee noted that Ealing ICO operated community diabetic eye screening in the borough at Wembley, the Jeffery Kelson Centre at CMH and Willesden Community Hospital and Melanie Smith added that in some cases, it was more useful to monitor and screen patients rather than refer them to the ophthalmology service.

Isha Coombes confirmed that the funding allocated by Brent CCG for diabetes service included both primary, community and acute care. For the Ealing ICO integrated pathway, the funding would increase from £391K in 2013-14 to nearly £1m in 2014-15. Members noted that Brent CCG commissioned an interpreters service for all services, including diabetes, and liaised with the service providers to put in place the appropriate arrangements. The committee also heard that there was presently one full time diabetes nurse consultant and five diabetes specialist nurses and the new model would include additional staff as set out in section 10.6 of the report.

Jo Ohlson (Chief Operating Officer, Brent CCG) acknowledged that diabetes prevalence was highest in the Kingsbury locality, however it was also a significant issue across the whole of the borough and early diagnosis was critical in achieving positive outcomes. In respect of Brent CCG commissioned services at CMH, Jo Ohlson clarified that although diabetic clinical services were not part of out of hospital care, some eye conditions may be unrelated to diabetes and so the service covered a range of possible conditions. She added that future reports could include more information on pathways, staff and intervention.

Dr Sarah Basham (Co-Clinical Director, Brent CCG) acknowledged that the Wembley site was underperforming, however this was partly attributable to both it being a small centre and because it operated on a walk-in basis. Steps were being taken to ensure practices were up to speed through investment in training and through staff cascading their skills, such as those qualified in the Brent GP insulin initiation scheme, and through peer pressure to raise standards, however most practices were scoring above the national average. Dr Sarah Basham advised that many GPs in the borough were already insulin initiation scheme trained, however the process of initiating a patient was a lengthy one and required regular contact with the patient. Where practices could not provide a particular service, they could facilitate access to those that could.

Rachel Donovan (NHS England) added that those practices that were underperforming would be assessed to identify the underlying reasons for this and then given the appropriate tools to be able to improve. She confirmed that GP practices were remunerated for providing diabetes services under the QOF and that the total spend on this could be provided.

The Chair stated that the committee had felt that more information in future reports was necessary in order for effective scrutiny to be able to take place, including financial details. The Chair added that a description of the type of information that members wished to be provided at future meetings would be sent to the council's Public Health Team and Brent CCG. She also requested further details in respect of the diabetes service redesign from April 2014.

5. **Brent Clinical Commissioning Group finances**

Jonathan Wise (Chief Finance Officer, Brent CCG) introduced the report and outlined Brent CCG's finances in the context of the national financial framework, explaining that NHS England would be responsible for allocating funding to CCGs for the next two years. Members heard that CCGs' statutory functions were more restrictive than they had been for primary care trusts. Hospitals received most of their income from CCGs, as well as NHS England and local authorities, through national tariffs. Jonathan Wise drew members' attention to Brent CCG's financial position, which was relatively healthy and a surplus budget of £26m had been agreed for 2013/14. Brent CCG had also agreed to be part of two pan-CCG financial arrangements, the first to support the Shaping a Healthier Future implementation and the second an agreement with Harrow and Hillingdon CCGs to be part of an in-year risk share arrangements. Jonathan Wise advised that the supplementary paper circulated prior to the meeting provided an explanation of the process of how risk share arrangement would operate. He informed members that Brent CCG had been awarded the minimum level of growth in 2014/15 and 2015/16 as it had been assessed as being overfunded in 2014/15. He advised that the uplift of 2.14% for 2014/15 and 1.7% in 2015/16 would not keep pace with the estimated 3.4% per annum increase in cost pressures that were expected due to local demand and cost growth.

During members' discussion, it was queried whether the national tariffs influenced clinical decisions in any way and was there any possibility of local tariffs being applied. In respect of Brent CCG's agreement with Harrow and Hillingdon CCGs, it was commented that their financial situation was not particularly healthy and why was there no mention of Brent CCG having an agreement with Ealing CCG whose financial position was stronger. An enquiry was made as to whether community and out of hospital services were subject to national tariffs. It was commented that there were significant costs involved that did not actually include costs of commissioning services and treating patients, such as contingency costs, and a further explanation of this was sought. Moreover, it was asked how end of life services would continue to be provided in view that funding on this had been reduced. A member commented that if more patients wished to see out their lives at home rather than hospital, this would impact on resources in social care. Members also queried why NHS England did not fund GP's IT equipment. In respect of Shaping a Healthier Future, it was asked whether Brent CCG had allocated 2% headroom funding for last year as well as 2013/14 and did other CCGs do the same. Turning to investments, the committee queried whether these would contribute towards primary care network development and achieving better GP outcomes and improving primary care hub access. It was also commented that the proportion of spending on GPs was considerable and what steps were being taken by NHS England to raise GP standards. A member also asked what the Procurement Panel would be recommending to the Governing Body on 29 January

with regard to commissioning of all services currently commissioned through a local enhanced service agreement.

In reply to members' queries, Jonathan Wise advised that nationally set tariffs were expected to be used to pay hospitals, although there could be some circumstances where local tariffs could be used where there had been a prior agreement to do so. In respect of Brent CCG's agreement with Harrow and Hillingdon CCGs, he explained that each CCG had produced their plans regarding Shaping a Healthier Future at the beginning of the year and once they had agreed the arrangement with NHS England, they were expected to adhere to it. Jonathan Wise added that it was sensible to have a wider geographical sphere and in any case each CCG's starting point in respect of Shaping a Healthier Future was independent from their overall financial situation. Members noted that Brent CCG had allocated 2% of headroom funding in the last two years and whilst some CCGs had allocated the same, others had not due to their financial situation, in which case consideration would be given as to what the appropriate allocation would be. Jonathan Wise confirmed that 1% of spend per annum was allocated for contingency costs, whilst the CCG also had a financial responsibility in respect of its estate, even where it was under utilised and so the CCG was committed to maximising use of its' estate. Members noted that an explanation of corporate running costs had been provided in the supplementary report circulated prior to the meeting.

Jo Ohlson added that discussions would take place over what services it would be possible to provide for less and she confirmed that national tariffs did not apply to community and out of hospital services. In respect of end of life services, she advised that this service would be re-configured, including saving costs in hospital admissions, especially as some patients preferred to see their last days at home and they could receive pain relief medicines too. It was noted that hospital admissions in such cases were already reducing. Jo Ohlson advised that GPs were being encouraged to work together and there was a support team to help facilitate primary care network development and there were also incentives for GPs to improve outcomes. Three primary care hubs had also been identified to offer extended opening hours. She explained that whilst funding was being reduced for hospitals, a significant amount of it was being diverted to out of hospital care as GPs were expected to offer more services and a number of procurement exercises were being undertaken during commissioning to run such services. Jo Ohlson added that some spend, such as on Shaping a Healthier Future, was non-recurrent. With regard to the local enhanced service agreement, the Procurement Panel would be recommending that these services continue to be commissioned to help continue to raise standards in out of hospital care.

David Cheesman (Director of Strategy, North West London NHS Hospitals Trust) advised that there was more flexibility in terms of agreeing tariffs for community services. He added that the Urgent Care Centre's tariffs at CMH had been closer to national tariffs, however lessons had been learnt and their were opportunities to reduce costs in this area. Rachel Donovan advised that NHS England had devolved costs to the CCGs for GP funding, including for IT equipment. With regard to improving GP standards, CCGs had been delegated powers to achieve this through commissioning and improving services locally. Phil Porter (Director of Adult Social Care) advised that in respect of end of life care, those who had chosen to remain at home would have access to prompt healthcare.

The Chair requested more information at a future meeting on end of life services, including details of how those remaining at home had been increased, the number who were looked after and the number who had been re-admitted to hospital. She also stated that Brent CCG finances would be revisited at a future meeting.

6. **Brent Clinical Commissioning Group commissioning intentions 2014/15**

Sarah Mansuralli (Deputy Chief Operating Officer, Brent Clinical Commissioning Group) presented the report that outlined the key aims and desired outcomes of Brent CCG's commissioning intentions. The main intention was to help fulfil the improvements identified as necessary and provide more community provision. The committee noted that the providers shared the CCG's intentions and the aims would be achieved through collaborative working between the CCG, service providers, patients and the public. The CCG had undertaken benchmarking exercise across four nationally defined domains, however data had not been available for the fifth domain in relation to treating and caring for people in a safe environment and protecting them from avoidable harm, so local data was being obtained. Members heard that CCG's commissioning intentions had been supported at draft stage by the EDEN Committee and the final proposals would be reported to the EDEN Committee on 29 January, following which their feedback would be available. Sarah Mansuralli emphasised the importance of producing clear commissioning intentions as these were instrumental in shaping the CCG's investment plans. The CCG's intentions were both broad and ambitious and aimed to maximise patient outcomes and experience.

During members' discussion, a member queried whether the proportion of acute contracts making up 73% of the Brent CCG contract was what the CCG had intended. In noting the intention for providers to work collaboratively towards electronic records, she noted that such initiatives had not worked in the past and she enquired what steps would be put in place to ensure that this was more successful this time. She expressed her approval of proposals with regard to the assessment tariff, mental health and elderly care and added that the conference on dementia in December 2013 that had included the attendance of Dr Ethie Kong and some Members of Parliament had been a worthwhile exercise. In view of this, she queried why dementia had not been explicitly included in the report. Another member welcomed the overall purposes of the CCG commissioning intentions, however she felt that they lacked specificity and in view of the financial constraints, she enquired what areas would be focused on and what consultation had been undertaken with patients. A member asked if podiatry services would be available, especially as some diabetic patients would benefit from this. In respect of dementia, he enquired how the quality of assessments would improve to ensure they got the appropriate level of care.

With regard to intentions for outpatients' services, it was queried how these would be delivered in view that the CCG's Quality, Innovation, Productivity and Prevention (QIPP) investment plan for 2014/15 was subject to a 3% budget reduction. In respect of community health services and pathways, information was sought in respect of plans, including the budget allocated for it and a timetable for implementation. It was commented that intentions for community paediatrics lacked detail and further information was sought, particularly in respect of services for children with acute diabetes. Further details were also sought in respect of proposals for mental health services for children and eating disorders .

In reply to the issues raised, Sarah Mansuralli advised that there was an investment programme for 2013/14 in respect of dementia and this was already showing improvements in diagnosis rates and further data would be forthcoming on this. A 'dementia café' had been jointly set up by Brent CCG and the council and this was indicative of the progress that had been made in this area. Sarah Mansuralli added that treating dementia was one of NHS England's priorities. In respect of outpatients services, the improvements would be delivered through competitive dialogue to achieve the appropriate model of delivery and it was felt that QIPP targets would be met at reduced cost. Members heard that a project initiation document was in place to deliver community health services and pathways and once a business case had been produced, budget details would be drawn up. Sarah Mansuralli drew members' attention to page 70 in the report that outlined commissioning intentions for children's services including mental health. She added that eating disorders amongst children was especially prevalent in the borough, however such a condition was addressed by the Child and Adolescent Mental Health Service (CAMHS).

Jo Ohlson added the CCG action plan provided specific details on how the commissioning intentions would be achieved, whilst podiatry services for diabetic patients would continue, although stricter criteria for access to this service would apply for non-diabetic patients. Isha Coombes added that there would be increased capacity for podiatry services. In respect of children with acute diabetes, she advised this would be addressed through both an acute provider and taking a holistic approach and would include the support of a specialist nurse.

The Chair requested that in future for all reports going to committee, any associated documents that could provide further detail that may be of interest to members should be referenced in the reports. She also requested further information on services for children with acute diabetes and the commissioning of Tier 3 services from the Royal Free Hospital.

7. **18 Weeks Referral To Treatment Incident and Urology Serious Incident**

David Cheesman presented this item and began by referring to the Northwest London Hospitals Trust (NWLHT) capacity paper. He stated that the NWLHT continued to carry out waiting lists initiatives and following the review of demand and capacity, the NWLHT had planned an increase in internal capacity with the majority of work being carried out by CMH. In addition, the CCGs within the NWLHT had agreed to fund additional capacity through outsourcing and as a result of this, the BMI Healthcare Group, the Hillingdon Hospitals Trust and the Royal National Throat, Nose and Ear Hospital had been selected as providers.

Turning to the urology serious incident, David Cheesman advised that a review of urology patients on the planned waiting list in October 2013 had identified that 196 patients had waited over ten weeks for a flexible cystoscopy appointment. This had resulted in an investigation to see if any patient's safety had been affected and results would be reported to the NWLHT Board in March. David Cheesman added that to date, the investigation had not identified any patients who may be at risk of harm, however the seriousness of the incident could not be underplayed.

During members' discussions, a member queried whether Brent was funding the whole exercise when only 20% of patients were from Brent. She referred to a

national audit report that had stated that 58 out of 100 hospitals had problems with waiting lists and asked if a fundamental flaw was responsible for the system not working properly. Further observations were sought with regard to review of mortality rates whilst on the waiting list and what were the plans to meet the needs of patients requiring routine surgery in future. It was also asked whether there was any data available on the additional time patients had waited on top of the 18 weeks that they had been on the waiting list.

In reply to the issues raised, David Cheesman advised that Brent CCG was only funding its patients' treatment and not from the whole waiting list. He emphasised the need for sound data to evaluate ways to ensure that the 18 weeks referral to treatment could be achieved and external organisations were being used to help with this. In addition, effective management of waiting lists was also necessary. He advised that investigations continued in respect of review of mortality rates for those patients on waiting lists, including assessing whether the condition of patients had worsened. In respect of routine surgery, steps were in place to increase capacity both internally and through external sites, however this would need time to be achieved. Members noted that there were sufficient staff to operate clinics and operational theatres. David Cheesman advised that data was not yet available concerning how long patients had waited in addition to the 18 weeks they had already remained on the waiting list, although efforts would be made to provide this.

The Chair requested an update on this item at a future meeting.

8. **Plans for Central Middlesex Hospital**

In noting the report provided, the Chair advised that members wished to defer this item to the meeting on 18 March to allow more time to consider this matter and also to consider it in the context of mental health and the paper on Shaping a Healthier Future.

9. **Health Partnerships Overview and Scrutiny Committee work programme 2013/2014**

The Chair requested that the mental health services paper be included as part of the plans for CMH report at the meeting on 18 March, whilst sexual health was to be deferred to a future meeting. In respect of public health, this should be placed on the agenda for meetings as more detail and important developments emerge.

10. **Any other urgent business**

In noting that this would be David Cheesman's last meeting before he joined a hospitals' trust in South London, members placed on record their thanks for his contributions at the committee meetings and wished him all the best for the future.

11. **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, 18 March 2014 at 7.00 pm.

The meeting closed at 9.15 pm.

M DALY
Chair