MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
Tuesday 27 November 2012 at 7.00 pm

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

An apology for absence was received from: Councillor Colwill

ALSO PRESENT: Councillors Butt (Leader of the Council/Lead Member for Corporate Strategy and Policy Coordination), Cheese, S Choudhary, Hirani (Lead Member for Adults and Health) and McLennan and Olasumbo Ajala (Brent Local Involvement Network), Tina Benson (North West London Hospitals Trust), Mark Burgin (Brent Council), Dr Prakash Chatlani (Brent Local Medical Committees), David Cheesman (North West London Hospitals Trust), I Choudhary (NHS Brent), Alison Elliott (Brent Council), Claudia Feldner (Brent MENCAP), Maurice Hoffman (Brent Local Involvement Network), Toby Howes (Brent Council), Jacinth Jeffers (Ealing Hospital NHS Trust), Dr Ethie Kong (Brent Clinical Commissioning Groups), Yvonne Leese (Ealing Hospital NHS Trust), Sarah Mansuralli (Brent Clinical Commissioning Group), Phil Newby (Brent Council), Ann O'Neil (Brent MENCAP), K Perrin (Brent Council), Hema Patel (Pharmacist), Mansukh Raichura (Brent Local Involvement Network) and Phil Sealy (Brent Local Involvement Network)

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

2. **Minutes of the previous meeting held on 9 October 2012**

RESOLVED:-

that the minutes of the previous meeting held on 9 October 2012 be approved as an accurate record of the meeting.

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

Brent Tobacco Control Service – progress report

Councillor Hunter advised that the Brent Pension Fund Sub-Committee had considered the recommendations of the Health Partnerships Overview and Scrutiny Committee and in light of these had decided that the Statement of Investment Principles be amended by incorporating into the Statement the current practice of not directly investing in tobacco companies. However, Councillor Hunter advised that the final wording of the recommendation would be agreed at the next meeting of the Brent Pension Fund Sub-Committee. She explained that Members of the Brent Pension Fund Sub-Committee had been advised that they did not have the powers to terminate current fund manager contracts, however it would have the ability to instruct fund managers accordingly for future contracts. Councillor Hunter felt, however, that the council could go further and introduce a policy to not invest in tobacco companies either directly or indirectly and to invest ethically. Members

agreed to her suggestion that the committee await the final wording of the Brent Pension Fund Sub-Committee's decision on this matter before making any further recommendations to the Sub-Committee.

4. **Update on Director of Public Health**

Phil Newby (Director of Strategy, Partnerships and Improvement) updated Members on this item and confirmed that the Executive had agreed to integrate public health services and to appoint a single Director of Public Heath for Brent. Staff were being engaged during the consultation with regard to the integration and draft proposals had been circulated to them for further discussion. The committee heard that the interim Chief Executive had appointed Paul Corrigan, a health consultant, to advise her in respect of the new arrangements and he had also worked with Brent clinical commissioning groups (CCGs).

Councillor Harrison enquired whether the transfer of staff would lead to any redundancies. Councillor Leaman enquired whether the post of Director of Public Health had been advertised and would there be an appointment by April 2013. He also sought clarification as to whether the appointment would be made by the Senior Staff Appointments Sub-Committee.

In reply, Phil Newby advised that the proposals did not include redundancies for any permanent staff, although some fixed term contracts would be terminated. He advised that the timing of the appointment of the Director of Public Health was yet to be determined and would be subject to clarification of the final integrated structure.

The Chair requested that an update on this item be provided at the next meeting and that any other information be provided to Members in the meantime should there be any significant developments.

5. **Health services for people with Learning Disabilities - A report from Brent MENCAP**

Ann O'Neil (Brent MENCAP) introduced the report updating Members on the work of Brent MENCAP to help people with learning disabilities in using health services. Ann O'Neil informed the committee that the NHS health check day had been well attended by a wide mix of professionals, carers and people with disabilities and feedback had been used to inform the Brent NHS Self Assessment Framework (SAF). It had been identified that there had been issues in providing exact figures and this needed to be addressed in order to deliver the necessary services and appropriate safeguarding measures. Ann O'Neil advised that it was hoped that funding for the Health Action Group would continue beyond March 2013. The committee noted that a learning disability nurse had been in post for around a year and there were plans to appoint an acute liaison nurse, although more hospitals would need to be covered. Funding for a focus group for carers and people with learning disabilities had recently been secured and it was anticipated that it would meet on a monthly basis, whilst a patient focus group for people with learning disabilities had met twice at Central Middlesex Hospital to look at issues in all hospitals in Brent.

Ann O'Neil advised that Brent MENCAP had provided a comprehensive response to the Joint Strategic Needs Assessment (JSNA) consultation, and whilst funding for training GPs and other health care staff in respect of people with learning disabilities had ceased, it was hoped it would re-commence once a business case had been developed. The Royal College for General Practitioners had developed an online training course and also hoped to provide training sessions. Members heard that mystery shopper exercise at GP practices and Central Middlesex Hospital had found that whilst staff were helpful, there was very little information or help with regard to signage.

During discussion, Councillor Hunter enquired what steps were being taken to improve the amount of accurate data available. With regard to signage, she felt there was much room for improvement and stated that this not only helped people with learning disabilities, but also those where English was not their first language and she enquired what action was being taken to address this. Councillor Hunter also welcomed the pilot health passports scheme and she hoped that it would provide stimulus to make the scheme more widespread. Councillor Leaman welcomed the report and suggested that in order to gain more real data, the Health and Wellbeing Board should consult with the voluntary sector and he enquired if there was any mechanism which provided voluntary sector organisations such as Brent MENCAP to provide feedback to the Health and Wellbeing Board.

The Chair enquired what the main issues raised by Brent MENCAP with regard to the JSNA consultation and she requested a copy of the document that was submitted. She stated that members had concerns about health services provided for those with learning disabilities mainly due to lack of information and knowledge given to them.

In reply to the issues raised, Ann O'Neil advised that there was an increasing number of patients who were borderline in terms of learning disabilities and this situation needed to be monitored carefully and responded to appropriately. However, the largest concern was with regard to funding and the committee noted that Brent MENCAP was staffed by professionals and not volunteers and this should be taken into due account. With regard to improving accuracy of data, Ann O'Neil explained that it was intended that the learning disability nurse would visit GP practices to compile patient information. GPs were also being trained to ask the appropriate questions to patients with learning disabilities and it was estimated that there were around 9,000 people with learning disabilities living in Brent. Ann O'Neil advised that there were also a number of other people with learning disabilities coming to the borough to access health services and this raised issues in respect of safeguarding. It was imperative that adult social care services and Brent NHS continued to work more closely with each other to address these issues. Ann O'Neil added that clear signage helped a wider audience other than just those with learning disabilities and this was being impressed upon hospitals and GP practices and she added that this issue should also be addressed in implementation of equality action plans. Ann O'Neil added that the introduction of a local Healthwatch in 2013 could improve the effectiveness of patient representation.

Claudia Feldner (Brent MENCAP) added that only a relatively small number of health passports had been issued as part of the pilot scheme due to limited funds and this remained an issue that needed further consideration.

Councillor Hirani (Lead Member for Adults and Health) advised that the Health and Wellbeing Board had mainstreamed mental health as a key priority and there would be a separate strand of work on this issue. He acknowledged issues with regard to funding and added that finding different ways of working were part of the solution to this issue.

The Chair welcomed an update at a future meeting with regard to the work of Brent MENCAP and health services for people with learning disabilities.

6. **Recruitment of Health Visitors in Brent**

Jacinth Jeffers (Ealing Hospital NHS Trust) introduced the report that updated Members on the recruitment of health visitors in the borough. She began by stating that the pan-London recruitment programme had accepted 250 new health visiting students by October 2012 specifically for health trusts across the capital. However, the planned number of 'return to practice students' had fallen short of that forecast for London, with just one interviewed in October 2012. As a result of this shortfall, a refocusing of efforts on recruiting more full time students was being undertaken. Jacinth Jeffers drew Members' attention to the table in the report dealing with recruitment of health visitors in Brent, which included two externally recruited health visitors and three internal staff that had trained in Brent and she emphasised the importance of retaining students trained in the borough. Members heard that a new role, a peripatetic specialist community practice teacher (SCPT) had been introduced, of which there were five allocated places including three for student places. Efforts to recruit health visitors internationally were also being considered and an update on this could be provided at a future meeting of the committee.

During discussion, Councillor Gladbaum enquired how long the health visitor training courses were and whether those who had declined offer of posts was due to pay differentials between different boroughs. Councillor Hunter sought an explanation as to why return to practice student numbers were low in London and was the refresher course being re-structured accordingly for their needs, such as taking into account a possible lack of familiarity with some of the IT tools used. She also asked if job sharing was available and why was there a shortage of health visitors in London and why did problems continue in respect of their recruitment. Councillor Hector felt that issues with regard to lack of IT familiarity should be applicable nationally and felt that there needed to be further exploration as to the underlying reasons why there was lack of return to practice students.

Councillor Harrison, in noting that Brent had a shortage of seven health visitors, sought confirmation that those leaving the service were asked for their reasons why and what measures were in place to try and attract more to the borough. Councillor Leaman enquired what authority would be responsible for the overall strategy for recruiting health visitors when NHS London ceases to exist in 2013.

The Chair asked if discussions had commenced regarding arrangements when the council would take over recruitment of health visitors.

In reply, Jacinth Jeffers confirmed that all health visitors were required to be registered nurses and that the health visitor course lasted a year. The main reasons given for declining health visitor posts in Brent were usually of a personal nature and it was confirmed that health visitors were paid the same rate across the country

at national pay scale at Band 6 of the NHS Agenda for Change pay scale. A London-wide evaluation was being undertaken as to the lack of return to practice students, which drawing on the comments from the two candidates interviewed for Brent was down to lack of familiarity with regard to IT. However, training could be adapted according to need and depending on how long they had been absent from the service and a year's training would be required if they had been away for more than ten years. The Director of Nursing for London was also developing a strategy to provide greater incentives for those considering being a health visitor. Jacinth Jeffers informed Members that the usual reason for those leaving the health visitors service was because they were retiring and there were also a number of part time returnees, with some sharing caseloads, although every effort was made to retain health visitors recruited for as long as possible. Support was also given to university colleges to explain the role of health visitors to those students who were studying other types of nursing. However, historically health visitors' role had always been under promoted and this partly explained the shortfall. Jacinth Jeffers advised that incremental steps were being devised with regard to the council taking over recruitment of health visitors.

Yvonne Leese (Ealing Hospital NHS Trust) added that the London regional office of the National Commissioning Board would assume the overall strategy for recruitment of health visitors when NHS London dissolves in 2013. In the meantime, NHS London was working collectively with all London NHS trusts on this issue. With regard to the problems in recruiting health visitors, she explained that some nurses were wary about the role in terms of safeguarding issues and assuming a front line role, however efforts were being made to reassure potential candidates. Information was still being put together as to why return to practice students was low, however work practices had changed significantly over the years and the appropriate training and support needed to be in place.

7. **Update on the merger of Ealing Hospital NHS Trust and North West London Hospitals NHS Trust and on progress towards the £72m savings target**

David Cheesman (North West London Hospitals NHS Trust) introduced this item and reaffirmed that there was a sound clinical argument for the merger, however the full business case had been deferred as NHS London wanted further discussion on it, however it still supported the merger in principle. The main reason for deferral of the full business case was that there was not yet sufficient financial assurance and the originally proposed merger date of 1 April 2013 would not now be achieved. A new proposed date for the merger was yet to be identified whilst the trajectory of the move was still in the process of being set out. David Cheesman emphasised that it was important that the full agreement of NHS London was achieved before it was replaced, as otherwise discussions would need to start afresh with the new organisation. In the meantime, integration planning and developing opportunities for as much joint working as possible with clinical and support services between the two Trusts continued and shared IT and joint procurement functions were being considered.

Turning in more detail to the financial aspects of the proposed merger, David Cheesman advised that the full business case had identified required savings of £73.2m over two years, with £30m identified for 2012/13 and £43.3m for 2013/14. Members were informed that as of end of September, the Trusts had achieved £9.8m savings, slightly behind the £11m target to date, however it was still forecast

that 2012/13 savings target would be achieved as most savings had been back ended for the second half of the year. Pressures on the savings included having to use more agency staff for nursing posts and increased medical products due to rising demand in the number of patients. David Cheesman added that the merger was essential in achieving recurrent savings.

Tina Benson (North West London Hospitals NHS Trust) then provided an update with regard to recruitment for the Accident and Emergency (A and E) unit at Central Middlesex Hospital (CMH). She explained that five international candidates were to be interviewed for middle grade posts and another candidate at consultant level. It was hoped that the A and E vacancies could be filled in time for winter when patient demand was always historically higher. Tina Benson advised that a single recruitment agency was now being used which would bring more stability to the A and E unit. Members noted that Northwick Park Hospital (NPH) was becoming busier as winter neared, particularly at weekends, whilst CMH continued to become less busy with an average of around 30 patients a day at its' A and E unit. Tina Benson advised that discussions were also taking place with NHS London and NHS Harrow with regard to handling patient numbers, particularly as there were physical capacity factors to consider in respect of NPH.

During discussion, Councillor Hector enquired why recruiting agency staff was problematic and were there insufficient middle grade staff available to recruit from. She also asked how the ambulance service was coping in bringing patients from the south of the borough to NPH in view of the distances involved. Councillor Gladbaum enquired whether high standards could be maintained in view of the increasing patient numbers, particularly for NPH. Councillor Hunter enquired whether the financial issues facing the two Trusts would put the merger at any risk of going into administration, considering that this had happened to the South London Healthcare NHS Trust. With regard to A and E, Councillor Hunter commented that patient visits were often found to be unnecessary and in view of the rise of patients to NPH, she enquired whether there were any initiatives to promote visits to GP practices or other health facilities for non-urgent matters. Councillor Leaman enquired what the largest threat to merger was, whether there was any possibility that it would not be undertaken in 2013 and were there any alternative plans should the merger not happen.

The Chair sought further details of how NPH would cope in view of the increasing numbers and the possibility of CMH A and E closing in the evenings.

In reply to the issues raised, David Cheesman explained that there were numerous job opportunities for agency staff in London and this made recruiting for posts more difficult. He acknowledged that rising demand in patients, particularly at NPH, represented a challenge in maintaining high standards of healthcare, however clinical outcomes at NHP remained good and stroke case outcomes were amongst the best in London. The biggest impact was on waiting times which were becoming longer. However, the Trust Board had stated that there must be no compromise in quality of services. David Cheesman informed Members that Harrow LINk had also expressed concern with regard to NPH's ability to cope with extra demand and consultation was taking place with the North West London cluster of Trusts as to how to address this, particularly in respect of improving patient access. In terms of the NPH, consideration was being given as to ensure that it was fit for capacity,

including whether space on the site currently occupied by a third party could be used for clinical purposes.

David Cheesman felt that the merger would still go ahead in 2013, subject to final financial assurance and a joint management team was being put together as part of the merger preparation. There was no alternative plan at present should the merger not happen, however in such eventuality, possible options could include offering the Trust to a third party management. David Cheesman stated that the Trust was aware of the potential risks posed by the financial situation, however the situation was far removed from any kind of regime failure that had led to the South London Healthcare NHS Trust going into administration and there were also no clinical issues. In respect of signposting patients to prevent unnecessary visits to A and E units, David Cheesman confirmed that the 111 health telephone line was due to be launched in January 2013 and there would be a big national campaign to promote this.

Tina Benson advised that there was a national shortage of A and E doctors as the 24/7 nature of it was less attractive than other roles and it also did not allow the opportunity to specialise in the way that other disciplines did. With regard to improving capacity at NPH, Members noted that this had also been raised as an issue as part of the post consultation of the Shaping a Healthier Future programme. In the event of the A and E at CMH being closed, the majority of patients were unlikely to go to NPW and were more likely to go to a hospital closer to the south of the borough. It was noted that the ambulance service would identify the most appropriate hospital to take the patient to depending on the nature of their case.

Dr Ethie Kong (Chair, Clinical Commissioning Group) advised that winter planning and early sign posting were critical and also that health professionals were aware of the appropriate health service depending on need and the role of organisations such as Brent Short Term Assessment, Reablement and Rehabilitation Service (STARRS).

8. **Establishing a Local Healthwatch for Brent**

Phil Newby presented the report that detailed the creation and role of a local Healthwatch that are required under the Health and Social Care Act 2012. Under the Act, local authorities would be statutorily required to ensure that an effective and efficient local Healthwatch was operating in their area by April 2013. Phil Newby explained that the local Healthwatch should act as a 'consumer champion' and would have a seat on the Health and Wellbeing Board, as well as ensuring the views and experiences of patients, carers and other service users are taken into account during the preparation of local needs assessments and strategies, such as the JSNA and authorisation of the CCGs. The local Healthwatch would also offer an information service that would provide people with information about their choices and what to do when things go wrong. Phil Newby advised that in contrast to Brent Local Involvement Network (LINk), the local Healthwatch will be a corporate body carrying out statutory functions and must be a social enterprise, which although not legally defined, the Department of Health's current view was that it meant a 'business with primarily social objectives whose surpluses are principally reinvested for at purpose in the business or in the community.'

Phil Newby advised that a two stage competitive procurement process was being undertaken in accordance with the council's Standing Orders to award an organisation to operate the Healthwatch. He drew Members' attention to the procurement timetable which started with the invitation to tender on 27 November 2012 with contract starting on 1 April 2013. A consultation had also been held on 23 October to obtain feedback from residents, members of community and voluntary groups and councillors on the role of the local Healthwatch and the overriding views were that it must have a local focus. Phil Newby added that the local Healthwatch would be expected to interact with this committee.

Councillor Gladbaum commented that in the past, community health councils had operated and were effective and she asked whether the local Healthwatch would operate in a similar way. Councillor Leaman asked if there was any more information on the structure of the local Healthwatch. Councillor Hunter sought further clarification with regard to the mention in the report that local authorities were to take on responsibility for commissioning an NHS complaints advocacy from April 2013.

The Chair sought confirmation as to when decision to award the contract to operate the local Healthwatch would be made.

In reply, Phil Newby commented that the structure of the local Healthwatch and how it would operate would be included in the contract specification as part of the tender criteria. In respect of the local authority's responsibility to commission an NHS complaints advocacy, he advised that would be part of a pan London scheme.

Mark Burgin (Policy and Performance Officer, Strategy, Partnerships and Improvement) advised that the decision to award the contract would take place in January 2013.

The Chair welcomed the report and asked that a further update be provided at a future meeting.

9. **Report from Brent LINk on work in 2011/12**

The committee noted the Brent LINk's report on their work in 2011/12 and the first part of the 2012/13. The Chair advised that Brent LINk's annual report had been received on 26 November 2012 and so it was agreed that this item be deferred to the next meeting. Councillor Hunter added that a number of actions had been undertaken as a result of Brent LINk's visit to the Willesden Centre for Health and Care. Members noted that further visits to health facilities were being undertaken and details of these would be provided to the committee at a future meeting.

10. **Time to Change pledge**

Councillor Hirani introduced this item and confirmed that the Time to Change pledge had been agreed unanimously at the Full Council meeting on 19 November 2012. The pledge gave public notice of the council's commitment to addressing mental health discrimination and the council's Human Resources department would be looking at a number of measures in respect of this issue. Stress awareness training for staff was already available and the staff handbook provided information of indicators of stress and relevant links to the pledge would also be provided.

Internal policies were being considered and mental health issues were already included in the equalities policy, whilst a number of other policies, such as stress management and staff absence were also being reviewed and an online staff attendance management system was being set up. Members noted that a staff Health and Wellbeing Group had been set up. Councillor Hirani advised that councillors could also individually sign the pledge and this would be the last act of the current Mayor of Brent.

During discussion, Councillor Harrison enquired what support measures were in place for staff whose workloads were increasing as a result of the efficiencies being undertaken as part of the One Council programme as this was a potential source for more stress. The Chair suggested that stress management sessions could also be provided for councillors.

In reply, Alison Elliott (Director of Adult Social Care) advised that it was understood stress could increase as a result of efficiencies and so procedures had been reviewed accordingly. A degree of stress could be beneficial in raising staff productivity, however excessive stress was counter-productive and managers were expected to manage stress within their department. The absence management system would also help identify reasons for staff being absent.

Councillor Hirani commented that stress management could be added to the Member Development Programme.

11. **Work programme 2012-13**

Councillor Hunter advised that the scope of the female genital mutilation group had been widened to include rape and honour crimes. The Chair added that it had been agreed that the task group would also include child marriages. She informed Members that a report had been presented to the House of Lords on 27 November 2012 which had estimated that there had been around 10m child marriages worldwide in 2011, and although less were expected this year, it was still a major issue. The Chair also advised that the role of community pharmacists in improving health and wellbeing would either go to the 29 January 2013 or 19 March 2013 meeting and was particularly relevant as pharmacists were playing an increasingly important role and dealing with a rising number of customers.

12. **Any other urgent business**

None.

13. **Date of next meeting**

It was noted that the next meeting of the Health Partnerships Overview and Scrutiny Committee meeting was scheduled for Tuesday, 29 January 2013 at 7.00 pm.

The meeting closed at 8.55 pm

S KABIR
Chair