MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
Wednesday 4 December 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 Hirani (Lead Member for Adults and Health)

Apologies for absence were received from: Councillors Leaman

NHS representatives present: Tina Benson (Director of Operations, North West London NHS Hospitals Trust), David Cheesman (Director of Strategy, North West London NHS Hospitals Trust), Daniel Elkeles (North West London Clinical Commissioning Groups), Tracey Jepson (London Ambulance Service), Rob Larkman (Chief Officer, Brent, Ealing, Harrow and Hillingdon Clinical Commissioning Group), Ethie Kong (Chair, Brent Clinical Commissioning Group), Sarah Mansuralli (Assistant Chief Operating Officer, Brent Clinical Commissioning Group) Jo Ohlson (Chief Operating Officer, Brent Clinical Commissioning Group) and Dr Mark Spencer (Shaping a Healthier Future).

Brent Council officers present: Mark Burgin (Policy and Performance Officer, Strategy, Partnerships and Improvement), Bryony Gibbs (Democratic Services Officer, Legal and Procurement), Phil Porter (Interim Director, Adult Social Services) and Melanie Smith (Director of Public Health, Adult Social Services)

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

None.

2. **Minutes of the previous meeting**

RESOLVED:-

that the minutes of the previous meeting held on 8 October 2013 be approved as an accurate record of the meeting.

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

Rob Larkman (Chief Officer Brent, Ealing Harrow and Hillingdon Clinical Commissioning Groups (CCGs)) provided a brief update on the procurement of cardiology services. He advised that the procurement process which had identified the preferred bidder had been referred to the system regulator for review and formal enquiries were in process. A decision would be issued by February or March 2014 an the contract would not now be able to be awarded in line with the expected timetable.

4. **Health Services: Winter Provisions**

The committee considered reports from the Brent Clinical Commissioning Group (CCG) and the North West London Hospitals Trust (NWLHT) on their plans to cope with the anticipated pressure on services over the winter period. The reports were presented by Jo Ohlson (Chief Operating Officer, Brent CCG) and Tina Benson (Director of Operations, NWLHT) respectively.

In summarising her report, Jo Ohlson clarified that Brent CCG was responsible for ensuring that there were sufficient services to meet demand over the winter but did not commission General Practitioner (GP) services; this latter task lay with the National Health Service England (NHSE). A briefing had been provided by NHSE on the relevant activity undertaken by the organisation and this would be circulated to the committee.

Outlining the work of Brent CCG, Jo Ohlson explained that £6.4m funding had been secured via winter bid plans to support a range of schemes across the local Brent-Harrow health economy, with a further £6.6m provided by Brent CCG. Schemes included the Short Term Assessment, Reablement and Rehabilitation Services (STARRS), an Integrated Care Pilot aimed at those most at risk of hospital admission, and increasing access to GPs via extended opening hours, including Saturday appointments. With reference to this latter project, it was noted that there was a need to promote these expanded opening times and work was being undertaken to explore possibilities of direct appointment bookings via the 111 service. Members' attention was drawn to the table setting out the creation of additional bed capacity across several sites and an update was provided. In addition to those reported, a further 6 mental health beds would be provided on the Northwick Park Hospital (NPH) site. Members were advised that NWLHT was using capacity at both NPH and Central Middlesex Hospital (CMH) to ensure all available beds were used for suitable patients. It was anticipated that from December onwards there would be sufficient beds in the system. However, risks of a surge in demand on services remained.

Jo Ohlson set out the planned work to reduce Delayed Transfers of Care (DTOCs) from hospital to community settings. Principal causes of DTOC included patients awaiting either health or social care assessments or appropriate residential or nursing home placements, and a lack of appropriate / accurate information on potential discharges. A series of actions had been agreed to address these issues including increasing capacity within the NWLHT discharge team and creating a further 6 reablement beds. An escalation process had also been established to ensure appropriate overview of the process.

Tina Benson outlined the actions being taken by the NWLHT to address anticipated difficulties, such as excessive patient waiting times in Accident and Emergency (A&E) departments, during the winter period. These actions sought to increase bed capacity, improve flow through the emergency pathways and embed seven-day working. The report also set out performance against the four-hour emergency target, which required that those attending A&E must be seen, treated, admitted or discharged in under four hours. It was emphasised that the pressures on Northwick Park Hospital (NPH) were largely related to admissions rather than attendances, which in fact were fairly stable, lending greater importance to the Brent CCG work focussing on admission avoidance. Tina Benson explained that a capacity gap of up to 89 beds had been identified but there was insufficient space to accommodate the required number of beds at NPH. 40 additional beds had been installed at NPH

and Brent CCG had funded in excess of 50 beds within the community. There was also potential for further external capacity of 22 beds. It was emphasised that patients were being informed that their care could be provided across a network of sites. Members were advised that the additional beds were not reflected in the table setting out performance trajectory in relation to the four-hour emergency target. This trajectory gave a year end performance of 94.4 per cent against the national target of 95 per cent. Performance against this target would continue to be reviewed, with a focus on understanding the impact of the additional beds provided. Breaches of the target also related to access to specialist teams, termed 'speciality breaches'. Staffing had been expanded across these teams to address this problem. Tina Benson concluded her presentation by noting that a self-management target had been set to keep breaches of the four hour target to under 5 per day.

During members' subsequent discussion several queries and issues were raised by the committee. A member noted the impressive achievements of STARRS and further information was sought about its operation. The Committee queried the contribution of GPs to meeting the pressure on services over the winter period and asked how this was monitored. Details were requested of the number of home visits undertaken and whether, per practice, there was a correlation between levels of home visits and A&E attendances. Members queried the number of calls received by 111 via the out of hours GP services by provider, how these were dealt with and the resulting number of home visits undertaken.

The Committee also sought clarification regarding the action implemented by NWLHT to provide additional consultant emergency surgeons for critical care outreach. An update was requested on whether seven-day working had been successfully implemented. Members asked the Health representatives to outline services provided to nursing homes. Confirmation was sought that there were no 'mothballed' or unused wards at NPH and queries were raised on the co-ordination of bed capacity between NPH and CMH. A member asked how many bed days had been lost due to patients awaiting assessment. The committee queried the plans in place to work co-operatively with neighbouring hospital trusts in the event of excessive service demand.

Responding to the queries raised, Jo Ohlson explained that the STARRS scheme in Northwick Park Hospital (NPH) was funded by Brent CCG and Harrow CCG. STARRS provided a range of services with teams comprising different health professionals including specialist nurses, consultants and occupational therapists. It aimed to support patients in hospital and after discharge by providing concentrated rehabilitation support and continuing their care at home or at 'step down' facilities such as those provided at Willesden Hospital. David Cheeseman advised that a presentation on STARRS could be provided at a future meeting of the committee.

Addressing members' queries regarding GP services, Jo Ohlson explained that all GPs were required to offer home visits subject to clinical need but that this would not be monitored by NHSE. Similarly, data on use and outcomes of out-of-hours services could only be gathered by Brent CCG for the 14 out of 67 GP practices in Brent for which it retained this responsibility. The majority of GP practices had contracted their out of hours services with Harmoni and the remainder with London Central and West Unscheduled Care Collaborative (LCW UCC). To access these services, people could call either their GP's telephone number or 111. Calls would

be triaged and based on an assessment of clinical need could result in a home visit or the option to see a GP. Brent Residents accessing out of hours services provided by Harmoni would be able to attend either NPH or Hillingdon Hospital; those with LCW UCC would attend St Charles Hospital. It was emphasised that many patients would not be aware that there were three different services offered in Brent. At present, residents in nursing homes would simply be registered with a GP. There was some exploration of how this service might be commissioned with a provider to ensure greater visibility and more effective support and community care.

Tina Benson explained that the critical care outreach referred to in relation to the provision of additional consultant surgeons, encompassed specialist support to teams within the hospital site. Members were further advised that 7 day working had been successfully embedded and an increasing number of the London equality standards, many of which applied measures over 7 days, were being met as a result. This allowed greater opportunity for benchmarking performance.

Tina Benson confirmed that there were no mothballed wards at NPH and advised that patients attending NPH would be transferred to CMH where appropriate as all medical beds were treated the same across both sites. It was anticipated that there were sufficient beds to meet demand over winter but it was considered that further work was required to minimise length of stay. Improvements were expected in this area however, as a number of community strategies were implemented. Jo Ohlson advised that there had been 172 bed days lost over a period of 3 weeks as a result of patients awaiting assessment. Rob Larkman (Chief Officer, Brent, Ealing Harrow and Hillingdon CCGs) informed members that discussions were underway with colleagues across North West London to ensure that appropriate contingency plans were in place to ensure that neighbouring services supported each other in responding to surges in demand.

The Chair invited Tracey Jepson (London Ambulance Service) to comment on the winter pressures. Tracey Jepson advised that the action plan was due to 'go live' on Monday 5 January and would work alongside other relevant plans. It would be a live document and would be subject to regular review. A breakdown for the last three months of the number of ambulance conveyances to NPH and CMH for A&E, Urgent Care Centres and transfers was requested by the committee. Tracey Jepson advised that she did not have the information to hand but would provide the data for circulation to the committee.

Members thanked the representatives for their reports and advised that written summaries of the information presented to the meeting would be of assistance to the committee. The Committee also requested that any figures provided be broken down to show both the overall figure and a Brent only figure. Further to this, members' emphasised the importance of respect for patients and asked that this be reflected in any reports.

RESOLVED:

That the reports presented to the committee from the Brent Clinical Commissioning Group (CCG) and the North West London Hospitals Trust (NWLHT) on their plans to cope with the anticipated pressure on services over the winter period be noted.

5. **Brent CCG "Wave 2" Commissioning: Impact Assessment and Consultation Plans**

Sarah Mansuralli (Assistant Chief Operating Officer, Brent Clinical Commissioning Group) introduced a report to the committee regarding Wave 2 of the procurement plans of Brent Clinical Commissioning Group (CCG). Wave 2 procurement covered the re-procurement of musculoskeletal services, trauma and orthopaedics, rheumatology and gynaecology. Members were advised that Brent CCG had awarded a contract in December to consultants Mott MacDonald to undertake an impact assessment and a formal consultation in relation to the procurement. Action plans for these two components had been drawn up by Mott MacDonald and were attached for the committee's information. The impact assessment would cover four key areas: a health impact assessment, an quality impact assessment, a travel and access impact assessment and an organisational impact assessment. The consultation would primarily comprise several consultation events, an online survey and focus groups with key patient and hard to reach groups. A consultation booklet would also be produced. It was emphasised that a further consultation on the proposed service specifications would be held subsequently. Sarah Mansuralli introduced representatives of Mott Macdonald and advised that they were in attendance to address any queries the committee might have.

Members' sought clarity on the purpose of the formal consultation and discussed the importance of there being a good understanding by those conducting the consultation of Brent's diverse communities and how to best engage those communities. Rob Larkman (Chief Officer for Brent, Ealing, Harrow and Hillingdon CCGs) explained that the formal consultation was aimed at involving local people in the re-design of the services and was not a statutory consultation. The representatives from Mott MacDonald advised that they had been involved in a number of London service reconfigurations. They were currently undertaking activities to better understand the providers and had been engaging with the Council for Voluntary Services (CVS) Brent. They would be talking to those who would be affected by the service plan and would make use of the equality and engagement database of Brent CCG. For those for whom English was a second language, community groups and translators would be made use of. David Cheeseman (Director of Strategy, North West London NHS Hospitals Trust commented that he had welcomed the opportunity to talk to someone independent of Brent CCG regarding the impact on the services concerned.

RESOLVED:

That the report on Wave 2 of the procurement plans of Brent Clinical Commissioning Group (CCG) be noted.

6. **NW London Hospitals: 18 Week Referral to Treatment Targets Incident**

Tina Benson (Director of Operations NWLHT) presented the report to the committee on an incident resulting in lack of compliance with the 18 week referral to treatment target (RTT). This target related to patients' right to receive consultant led treatment within 18 weeks of referral. Members were advised that in February 2013 it was identified that 60 per cent of patients on the waiting lists did not have an open care pathway which meant that waiting times had been wrongly recorded. As a result, approximately 2700 patients had been waiting longer than 18 weeks of which

approximately 560 were Brent residents. In response to this, action had been taken which ensured that all those waiting over 18 weeks received offers of treatment, with agreed dates.

Tina Benson explained that following an internal review, NHS Interim Management and Support (IMAS) had been invited to review processes and pathways underlying the RTT. The review found that systems and processes had not been sufficiently robust, there had been a gap between increased service demand and capacity, and staff-culture had resulted in some staff members feeling under pressure to undertake actions which resulted in incorrect records of patients waiting times. Since the findings of the review were made available, considerable progress had been made and a comprehensive action plan had been produced, with input from CCGs. The action plan included updating policies, staff training, enhanced monitoring and auditing of data recording and reporting and establishing additional outpatient clinics. Additional capacity would also be outsourced to alternative NHS providers and private providers of patients' choice.

During member discussion, the committee sought assurance that patients would be appropriately tracked. Further details were sought on plans to monitor and audit patients' care pathway 'clocks'. An update was requested on post-op care and clarity was sought on the demand and capacity issue identified by the IMAS review. A member raised a query regarding communication with patients.

Tina Benson replied to the queries raised and explained that outsourced projects were frequently managed; patients were kept on a separate spreadsheet which was updated twice-weekly following information exchange between NWLHT and the provider in question. Efforts were made to ensure that a shared record was maintained which meant for instance that on the day of surgery records from both organisations were available for reference. There was also a good set of performance indicators which had been established by Brent CCG. Members were advised that additional capacity was being resourced at NWLHT in order to support routine auditing of data. It was now possible to monitor on a weekly basis the numbers of patients who had had their care pathway 'clocks' stopped and/or who had been added to the elective waiting list.

Addressing questions of capacity, Tina Benson explained that additional therapists had been employed for post-op care and additional STARRS support had also been agreed. It was acknowledged that the commissioning plan did not reflect the current level of activity and discussions were now being held to ensue a robust plan was in place for the contract for the forthcoming year. In order to address immediate issues, 87 additional theatre sessions were required, which the CCG had agreed to deliver. Use would have to be made of other centres as it was not possible to recruit sufficient numbers of staff within the required timeframe. Rob Larkman (Chief Officer – Brent, Ealing, Harrow and Hillingdon CCGs) briefly outlined the commissioning process, explaining that assumptions of service demand relating to elective activity would be agreed with the provider. If the activity exceeded the assumed level, an existing mechanism was in place through which additional activity could be funded. A capacity assessment exercise would be conducted in advance of agreeing the commissioning process for the forthcoming year to ensure that base assumptions were as accurate as possible.

Responding to a query, Jo Ohlson advised that all relevant patient information regarding the incident leading to non compliance with the 18-week target had been shared with patients' GPs and all letters sent to patients had been copied to GPs. GPs were encouraged to refer appropriately but there was no disincentive to refer. Tina Benson emphasised that it was made clear that there was patient choice but that as not all sites were able to offer all types of procedures, patients were offered a primary site initially which took account of locality.

The Chair thanked the presenting officers for their contributions and asked that the committee be provided with further details of the capacity assessment exercise at its next meeting.

RESOLVED:

That the report be noted.

7. Update on Plans for Central Middlesex Hospital

Rob Larkman (Chief Officer – Brent, Ealing, Harrow and Hillingdon Clinical Commissioning Groups (CCGs)) provided an update to the committee on the plans for Central Middlesex Hospital (CMH) under the Shaping a Healthier Future (SaHF) programme. He advised that colleagues from SaHF, Daniel Elkeles (North West London CCGs) and Dr Mark Spencer, were also present to address any queries from the committee.

Rob Larkman reminded the committee that Ealing Council had referred the SaHF plans to the Secretary of State for Health and had made an application for Judicial Review (JR). The JR had been declined and in October 2013, the Secretary of State for Health had given his broad approval to the SaHF proposals including that CMH become a Local Hospital and Elective Centre. The Secretary of State for Health had also recommended that the changes to A&E at CMH take place as soon as practicable after winter. It was emphasised that the current restricted opening hours of the A&E service at CMH were not a result of the SaHF proposals but instead were related to clinical safety issues.

Members were advised by Rob Larkman that the plans for CMH created potential for significant investment in the site. Work was currently being undertaken to build a long term sustainable model for the site. Working groups had been established which would complete evaluations of clinical and financial factors as well as exploring the impact on patients of moving existing services to CMH. An Equalities Impact Assessment would also be completed to explore how protected patient groups would be affected by any proposals. Weekly meetings were being held to oversea the progress of the work streams. Members attention was drawn to the list of options under consideration, set out in the report. In response to a query it was clarified that this list represented the core elements of the portfolio of services being considered for CMH. It was emphasised that there would be full and meaningful engagement with local residents and other stakeholders. In line with this, an engagement plan was being developed. Rob Larkman concluded by noting that a final report setting out proposals for CMH would be presented to the Partnership Board and Implementation Programme Board on 6 February 2014. Approval would then be required to be sought through several decision making bodies including the

Clinical Commissioning Groups, National Health Service England (NHSE), Trusts and the NHS Trust Development Body (NTDA).

In the subsequent discussion, the committee raised a number of issues. A member queried the percentage of the CMH site currently in use and sought an explanation for the figure provided. In response, David Cheesman (Director of Strategy NWLHT) advised that approximately 65 per cent of CMH was currently being used and at present the A&E service was closed overnight for reasons of clinical safety. Additional elective work had been transferred to CMH from Northwick Park Hospital (NPH) but without a 24 hour A&E service this would only be temporary. Daniel Elkeles explained that the aim for CMH was to make it into a large hub for elective services; this was considered best use of the site based on its size and location. It would not be possible to install additional surgical beds for instance to meet a capacity gap as whilst there was the physical space at CMH there were not the teams that were required to support those beds.

The committee expressed concern regarding the potential transfer of mental health services from the adjacent Park Royal Hospital (PRH) site and queried the reasoning for this. Dr Mark Spencer informed the meeting that there were currently four wards at the PRH, encompassing an admissions assessment unit, two acute mental health units and a mother and baby unit for those with post natal depression. The current facilities at the PRH were not sufficient and it would be possible at CMH to provide a higher quality accommodation at ground level with access to courtyards. Daniel Elkeles advised that the mental health units were low security, unlocked wards and would have a separate entrance to the rest of CMH.

In thanking the representatives for their contributions, the committee requested that an update on the plans for CMH be provided at the next meeting in January 2014, alongside a report on the proposals for Willesden Hosptial.

RESOLVED:

i. That the report be noted

ii. That an update on the plans for Central Middlesex Hospital be provided to the committee at its next meeting in January 2014.

iii. That a report on the proposals for Willesden Hospital be provided to the committee at its next meeting in January 2014.

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

The committee reviewed the work programme, noting the items that were scheduled for the forthcoming meeting in January 2014.

RESOLVED:

That the work programme be noted.

9. **Date of Next Meeting**

The committee noted that the next meeting was scheduled for 28 January 2014.

10. **Any Other Urgent Business**

None.

The meeting closed at 9.15 pm

M Daly
Chair