MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
Tuesday, 26 July 2011 at 7.00 pm

PRESENT: Councillor Kabir (Chair), Councillor Hunter (Vice-Chair) and Councillors Cheese (alternate for Councillor Beck), Colwill, Daly and RS Patel.

Apologies were received from: Councillors Beck and Ogunro.

Also present: Sarah Basham (Clinical Director, Willesden Clinical Commissioning Group), David Cheesman (North West London NHS Hospitals Trust), Andrew Davies (Policy Officer, Strategy, Partnerships and Improvement), Rob Larkman (Chief Executive, NHS Brent and Harrow), Jo Ohlson (Brent Borough Director, NHS Brent and Harrow), Mansukh Raichura (Chair, Brent Local Involvement Network), Fiona Wise (North West London NHS Hospitals Trust) and Toby Howes (Senior Democratic Services Officer, Legal and Procurement).

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

None declared.

2. **Minutes of the previous meeting**

RESOLVED:-

that the minutes of the previous meeting held on 9 June 2011 be approved as an accurate record of the meeting.

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

Minutes

Members agreed to Councillor Hunter's suggestion that the names of NHS representatives and council officers attending the meeting be recorded in future minutes.

Burnley Practice

In reply to a request from Councillor Hunter for an update on Burnley Practice, Jo Ohlson (Brent Borough Director, NHS Brent and Harrow) advised that a number of bidders had been interviewed and a recommendation of the preferred bidder would be submitted to the Board and subject to their approval, the provider would be appointed. Councillor Hunter mentioned that the Local Medical Committee had expressed concern over proceedings and had withdrawn their observer. The

committee heard that the Board would take such a matter into account during their consideration.

4. **NHS Brent GP access update - quarter 4 results**

Jo Ohlson introduced the report which provided information requested by the committee at the previous meeting to see what improvements had been made in GP satisfaction measures for quarter four of 2010/11. She reported that overall there had been improvements with regard to the access indicator, whilst although overall satisfaction indicators had dropped in respect of patient experience, the reduction was less than that reported nationally. Jo Ohlson added that "the clean, comfortable, friendly place to be in" indicator had improved slightly overall. It was felt that the improvements recorded could be partly attributed to the Access, Choice and Experience (ACE) programme. Jo Ohlson acknowledged that more work could be undertaken to provide a summary of performance by practice, however she informed Members that the ACE team's resources to undertake performance analysis had been diminished.

Prior to the committee discussing this item, Councillor R Moher (Lead Member for Adults and Health) was invited to comment. Councillor R Moher asked for an explanation as to why Kingsbury Consortia had performed worse in all indicators with regard to experience and what action was being taken to remedy this.

In reply, Jo Ohlson commented that the better performing consortia tended to show greater enthusiasm to ACE's initiatives and this had not been the experience at Kingsbury. However, all consortia were expected to consider ways to improve patient satisfaction and experience. Sarah Basham (Clinical Director, Willesden Clinical Commissioning Group) added that ACE had focused on embedding systems last year and this year would focus on standardisation, whilst a process of peer reviews whereby local practices made comparisons with neighbouring ones to see how they can improve would continue.

During Members' discussion, Councillor Hunter enquired when the results per practice would be available and in a user friendly format. In respect of large performance differences between practices, she queried whether some consortia performances was being compromised because of one particular practice performing well below the others. Councillor Hunter also expressed concern that the more detailed information previously requested and the performance improvement anticipated had not materialised to date and sought assurances in respect of these. Councillor Daly commented that almost half the patients were not satisfied in respect of the clean, comfortable, friendly place to be indicator and asked what was being done to address this. She suggested that a more helpful way of presenting the data would be to list the ten best and ten worst performing practices, as this would be particularly useful for patients. Councillor Daly felt that the customer satisfaction levels recorded overall indicated that the level of service currently being provided was not acceptable and that a more robust approach focusing on ensuring customer satisfaction needed to be taken.

Councillor Colwill commented that he personally had been content over access and experience in a recent visit to a health facility. However, he sought reasons as to why the Kingsbury and Willesden consortiums were performing below others. Councillor Cheese enquired what measures were in place to ensure that staff

behaved in an acceptable way. In respect of peer reviews, he suggested that not all neighbouring practices enjoyed good relationships and he felt that a different approach to improving practices needed to be taken.

The Chair emphasised that providing best quality of service was the highest priority and she sought details of what measures were being taken to ensure this. In respect of GPs taking responsibility to improve access to services, she enquired what support they were given to achieve this.

In reply to the issues raised by Members, Jo Ohlson confirmed that the performance results were publically accessible through the NHS Choices website. The results were compiled by consortia, however Jo Ohlson agreed to look into how to make the information more user friendly. Members were advised that practices were obliged to register and comply with the Care Quality Commission's (CQC) premises standards by April 2012. The ACE programme also encouraged staff to provide more customer support and have a friendlier approach. In the meantime, staff had contractual obligations that they were required to meet and consortia were required to provide a declaration in respect of this. From April 2012, the CQC would be checking to see if the declaration was sufficient as well as reviewing patient feedback. Each consortia was required to provide information on how it was addressing areas that were in need of improvement. Jo Ohlson advised that there was not always a direct correlation between high quality care and high patient satisfaction levels. Consideration of how to provide appropriate weight to each indicator also needed to be given, however Members heard that a traffic light system of highlighting performance results would continue to be provided. However, it was not anticipated that the measures put in place by the ACE programme would show significant improvements until quarters three and four. Jo Ohlson explained that GPs now had more support to help them improve in areas of service since the ACE programme had been launched as well as receiving advice and support from peers and neighbouring practices.

Rob Larkman (Chief Executive, NHS Brent and Harrow) added that practices across the borough would have their performances scrutinised and those performing below satisfactory levels would be challenged to raise their standards.

The Chair requested that a report providing performance information of both individual practices and the consortia be provided at a future meeting of the committee.

5. **GP list validation exercise**

Jo Ohlson introduced this item and began by stating that steps were being taken in respect of patients erroneously being removed from practice lists. Measures were being taken to ensure the smooth re-registration of patients on to the lists and prevent loss of income to practices. A complete list of patients who had been re-registered would be available within the next week and monthly updates would be available subsequently.

During Members' discussion, Councillor Cheese suggested that some GPs may already be overburdened with other tasks and that alternative staff rather than GPs and receptionists be approached to undertake such tasks. Councillor Hunter expressed interest in receiving the re-registration figures. She suggested that the

validation exercise be undertaken as a rolling programme undertaken by practices every two years. Councillor Colwill suggested that working with the council's Births and Deaths Registry may be beneficial and he enquired whether the savings targets were on schedule. Councillor Daly asked whether the number of patients removed from the lists and without a GP were known and had the appropriate risk assessments been undertaken.

The Chair enquired whether the validation exercise would become the responsibility of the North West London Primary Care Trust Cluster. She also concurred with the suggestion that validation should be carried out every two years on a rolling basis.

In reply to the comments made, Jo Ohlson stated that concerns had been raised with regard to the large number of patients involved and the six month time frame given to complete the exercise and many practices had not carried out these activities until towards the end of this period. Some practices had carried out the validation exercise in phases, such as by age group. Jo Ohlson advised that it was anticipated that a London wide validation policy would be in place by April 2012 and suggestions could be made as to what this could include. She added that it was important that such a policy was robust and the consortia would be responsible for undertaking the validation exercise. Members were informed that it was expected that the savings targets would be reached and this would be confirmed by the re-registration figures. Brent NHS would be aware of any patients who had re-registered at another practice within the borough, however in some instances they may have moved away, registered with a practice outside Brent or did not wish to be registered at any practice. Jo Ohlson confirmed that risk assessments had been undertaken and that steps had been taken in respect of ensuring vulnerable patients were not removed from lists unnecessarily.

The Chair requested that the re-registration figures be provided at the next meeting.

6. **Update on GP commissioning in Brent**

Jo Ohlson advised that the Brent Federation had been successful in its application for a delegated budget and she welcomed any questions and comments from the committee.

Councillor Hunter drew Members' attention to paragraph 2.3 of the main report which seemed to contradict paragraph 2.5 in respect of whether the proposed Clinical Commissioning Groups would actually be expected to work with local authorities and other bodies. Councillor Daly enquired about arrangements for those Clinical Commissioning Groups where patients came from more than one borough. She also requested a presentation on the relationship between the National Commission Board and GP consortia at a future meeting.

The Chair enquired when the budget would be delegated to the Brent Federation. In respect of governance, she enquired whether the Clinical Commissioning Group would be taking on lay people to serve on the governing board.

The Chair invited Councillor R Moher to comment. Councillor R Moher enquired on arrangements where an individual GP had indicated that they do not wish to be involved in the work of a commissioning group.

In reply to the issues raised, Jo Ohlson advised that the budget was due to be delegated to the Brent Federation around August/September, whilst delegation of accountability and responsibility were already in place. With regard to Clinical Commissioning Groups working with other organisations, Jo Ohlson acknowledged that the wording provided by the Department of Health on the matter needed clarifying, however currently practices were expected to work with other like-minded practices that were not necessarily their neighbours. The issue of what Clinical Commissioning Group a practice would come under depended on what part of the borough most of its patients came from. In respect of GPs not wishing to be involved in commissioning group work, the Clinical Commissioning Group concerned would deal with the situation as if felt appropriate or the GP could be allocated to a different Clinical Commissioning Group.

7. **Health and Wellbeing Board update**

Andrew Davies (Policy Officer, Strategy, Partnerships and Improvement) provided Members with a verbal update with regard to developments concerning the Health and Wellbeing Board (HWB). He reminded Members that the setting up of a HWB was required under the Health and Social Care Bill. As a precursor to the HWB that was anticipated to function from next year, a Shadow Health and Wellbeing Board had been set up and this had already met three times since February 2011. At the last meeting, the Shadow Board had reflected on changes to the Health and Social Care Bill. Andrew Davies explained that the HWB would play a formal role in developing commissioning plans and referring them back to the clinical commissioning groups or the NHS Commissioning Board, both of which would have a duty to cooperate with the HWB. The HWB could undertake Executive functions on health and social care matters on behalf of the council, whilst membership of the board was envisaged to be equally proportioned between members and officers, although there could be more elected members if this was preferred. The committee noted that the HWB was still at the developmental stage and there may be further changes as relationships between organisations developed. The matter was complicated by uncertainties with regard to the Health and Social Care Bill, however issues for further consideration included decision making, roles and responsibility, terms of reference and HWB's relationship with other committees.

Councillor R Moher added that further clarification from the Government was awaited before seeing how the relationship with the NHS Commission Board would function.

During discussion, Councillor Cheese sought clarification with regard to clinical networks of experts. Councillor Daly asked what the composition was of the Shadow Health and Wellbeing Board, did the composition of the Boards vary nationally and if it was decided that the majority of Board members should be elected representatives, should this be on a cross-party basis. The Chair commented that the membership of the Board should reflect the terms of reference.

Mansukh Raichura (Chair, Brent Local Involvement Network) was invited to comment. Mansukh Raichura expressed a wish that the views of patients was not diluted and stressed the importance of allowing them to make contributions to the Board.

In reply to the issues raised, Andrew Davies confirmed that the current Shadow Health and Wellbeing Board's membership consisted of, from the council's side, the Leader of the Council, the Lead Member for Adults and Health, the Lead Member for Children and Families, the Director of Strategy, Partnerships and Improvement, the Director of Children and Families and the Director of Adult Social Care. Jo Ohlson, Rob Larkman and Simon Bowen represented NHS Brent on the Board, whilst the directors of the five consortia were also invited to the meetings and Mansukh Raichura attended as a patients' representative. Andrew Davies advised that the original guidance had stated that the HWB required at least one member of the Board to be an elected councillor, however the guidance had since been revised to state that HWBs may also be compose a majority of elected members and this issue could be reconsidered. Members heard that the composition of HWBs did vary nationally and for example the London Borough of Enfield had three sub-groups. Members could receive a report on how HWBs operated elsewhere if they wished.

The Chair asked for updates on the HWB at future meetings.

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

Fiona Wise (North West London NHS Hospitals Trust) introduced this item and advised that a review by the Clinical Team at Central Middlesex Hospital had identified that there had been a significant reduction in patient numbers at the Paediatric Assessment Unit (PAU) since Care UK's Urgent Care Unit (UCC) had opened in March 2011. This had the effect of reducing staff morale in the PAU and there was a danger of de-skilling because of the reduced activity. As a result, it was proposed to absorb the paediatric assessment function within the UCC and to de-commission the PAU, whilst the paediatric outpatient service and Brent Sickle Cell service would remain at the hospital.

David Cheesman (North West London NHS Hospitals Trust) added that PAU had experienced a number of staff resignations and it was difficult to maintain minimum staff levels and was also costing the hospital £6.5K per week because of the lack of patients. By contrast, the UCC had proven to be a big success since its opening and on average was absorbing 87% of paediatric demand. David Cheesman advised that patients requiring specialist opinion or overnight care were being transferred to Northwick Park Hospital and this arrangement had been in place since October 2010. The committee heard that the proposals did not include major service changes and under Section 2.2, an informal consultation with relevant community groups would be required. Members noted that it was intended to implement the proposals in October 2011.

During Members' discussion, Councillor Cheese expressed concern about the time delay in transferring patients who had arrived at Central Middlesex Hospital to Northwick Park Hospital. He also queried whether St Mary's agreement to accept rare, critically unwell children was sufficient and stressed that standards could not be compromised in such situations. Councillor Daly sought clarification as to whether the UCC was staffed by Care UK and was there a protocol in place. Views were sought as to whether the Care UK contract could be extended to other services. Councillor Daly also requested that a patient satisfaction survey for Care UK be undertaken.

Councillor Hunter agreed that the relevant community groups should be consulted regarding the proposals which she felt offered the benefit of reducing unnecessary overnight stays. She also sought clarification with regard to how the proposals fitted in with the overall strategy.

In reply, Fiona Wise advised that patients were already being transferred to Northwick Park Hospital for emergencies, specialist care and overnight stays. Children who arrived at Central Middlesex Hospital would initially be treated by UCC who would determine whether a transfer was necessary. Presently PAU was only treating around 30 patients a week on average.

David Cheesman advised that there was a robust system with regard to patient arrangements which ensured that patients were receiving the most appropriate treatment at a suitable hospital. Central Middlesex Hospital would continue to provide a 24 hour accident and emergency service.

Jo Ohlson advised that a number of other services, such as sickle cell treatment and safeguarding were also being looked at and it was possible that Care UK may have further involvement in future. The committee noted that the UCC was also staffed by a paediatric trained nurse or GP on a 24 hour basis. With regard to PAU, Jo Ohlson explained that it had been anticipated that it would treat much more children when it was originally established, however the creation of UCC had proven to be more successful than had been imagined. Jo Ohlson advised that a patient satisfaction survey regarding Care UK could be undertaken as part of the customer engagement process.

Sarah Basham confirmed that the UCC was staffed by Care UK and stressed that there was a robust system in place with regard to referring patients to other hospitals. She advised that St Mary's Hospital had been treating critically unwell children from across West London for a number of years and that this arrangement was robust and effective and that this offered the best treatment in the area for such situations.

The Chair thanked the presenters and requested that there be an update on this item at the next committee meeting on 20 September.

9. **North West London NHS Hospitals in patient survey results**

Fiona Wise introduced the report and explained that the 2010 patient survey results were based on a very small sample number, with 333 respondents representing 41% of survey forms distributed. Members noted that the survey was not weighted in terms of ethnicity. In terms of comparisons with other Health Trusts, Fiona Wise stated that although general observations could be made, the individual results of each Trust were private to that Trust. The committee heard that although results were better than in previous years, there was room for further improvement and the Trust was committed to improving the patient experience.

During discussion by committee, Councillor Hunter commented on the need to make a concerted effort to improve in the three areas identified in the survey, these being nurses, care and treatment and operations and procedures. She suggested it would be beneficial to look at how the best performing Trusts operated and use this to identify best practice methods. Councillor Daly sought further reasons as to

the relatively poor results for nurses and what action was being taken to address this, in particular on how to overcome barriers between nurses and patients. She also enquired whether nurses were still routinely doing 12 hour shifts.

Councillor Colwill asked for more information with regard to hospital cleanliness and whether positive comments could be included in the survey results. Councillor Cheese asked what arrangements were available in terms of patients' relatives, particularly when they received bad news and he suggested that staff should be available to direct them to an appropriate facility.

The Chair enquired whether an improvement in patient survey results was anticipated for 2011. She commented that standards may not be as high in certain respects for agency staff and she felt more work was needed in terms of staff loyalty to the Trust. She noted that there would be a follow-up report in 12 months.

In reply to the issues raised, Fiona Wise began by explaining that specialist hospitals tended to perform better nationally in patient surveys and their results were helped by not having an Accident and Emergency unit. She advised that the Trust sought to learn how to improve by considering how similar organisations that had made significant improvements operated. Fiona Wise felt there was a reasonable chance that the 2011 patient survey results would indicate an improvement as the areas identified for improvement were being worked upon, however she warned that the format of the survey would remain the same. The committee heard that agency nurses were more likely to be the subject of complaints with regard to customer care issues and they were being given customer care training. Patients were also being encouraged to complete their surveys during their hospital experience so that better feedback could be received for staff to reflect on. A patient charter had also been developed and a strategy had been agreed by the Board to improve staff interaction with patients. It noted that all staff had the required professional training and qualifications, however agency staff faced additional challenges such as working in a new environment and needed time to get use to a particular hospital's procedures. It was noted that it was normal practice for nurses to work 12 hour shifts, however this was also the case with all other Trusts. However, Fiona Wise agreed to provide information in respect of this through Andrew Davies.

Fiona Wise advised that the survey only briefly touched on hospital cleanliness as this was covered by other inspection processes, whilst Brent Local Involvement Network and the Care Quality Commission also undertook checks. Whilst positive comments could not be inserted into the survey results, such observations could be reported to the committee. Fiona Wise acknowledged that most hospitals did not have a private area for patients' relatives, however there was a Bereavement Officer available to help in such matters.

10. **North West London Hospitals NHS Trust Budget and Annual Plan**

Fiona Wise began by advising that the budget and plan was yet to be formally agreed by the Department for Health. An underlying deficit remained and the report explained why the budget gap had widened in 2010/11 compared to 2009/10, with the deficit now at £11.6m. This was partly attributable to the loss of non-recurring funding, including Urgent Care Centre funding. Fiona Wise drew Members' attention to the savings proposed to reduce the deficit as set out in the report.

During discussion, Councillor Hunter asked if service delivery could be maintained in the face of the savings that were proposed. Councillor Daly sought further details of what kind of efficiency savings would be made and commented that reducing in-patient time may increase the risk of patient admissions. Councillor Cheese also felt that this was a risk and that such a measure may be rendered a false economy. Councillor RS Patel enquired whether consideration had been given to merging the Trust with Ealing NHS in order to help achieve savings. Councillor Colwill suggested that Government funding for frontline health services had been offered and he enquired why it was not being used for this purpose.

The Chair enquired how certain was the Trust that it could achieve £9.7m savings through the Annual Plan and she asked for an update on this item at the 29 November meeting.

In response, Fiona Wise stated that it was not intended to make all the savings required in one year as a balance needed to be maintained between maintaining service delivery and achieving savings. Efficiency savings measures included shortening the length of hospital stay for patients, re-organising staff rotas and reducing management overheads. Every effort was being made to minimise redundancies. Fiona Wise acknowledged that reducing patients' length of stay could increase the risk of re-submissions, however consideration needed to be given as to what the optimum length of stay is for each patient and many patients in any case wanted to return home at the earliest opportunity. She cited developments in best medical practice with regard to this issue, such as patients who had knee operations whose recommended length of stay in hospital had been reduced from ten to four days. The STARS scheme also addressed the issue of reducing the number of beds to increase efficiency and effectiveness whilst also reducing costs. Strict rules were in place with regard to administrating medication, ensuring patients were appropriately supervised and carrying out patient checks. In addition, comfort rounds were conducted every two hours to ensure patients' needs were being met. Fiona Wise was confident that the £9.7m Annual Plan savings could be achieved providing the conditions set down were adhered to.

Rob Larkman added that consideration of more radical ways of working was needed to both increase efficiency and achieve the required savings. In addition, the ever changing population of the area needed to be taken into account.

Alison Elliott (Director of Adult Social Care) advised that in relation to the Government funding referred to by Councillor Colwill, the pot of money was not ring fenced and that £3.24m had been allocated to Adult Social Care from Health to help address the council's priorities. The council was working with NHS Brent and Harrow to introduce preventative measures to reduce the number of patients requiring hospital treatment. Adult Social Care and NHS Brent faced huge challenges and Alison Elliott stated that the committee would be informed of how the discussions between the two organisations were progressing.

Members noted that informal discussions were taking place with regard to the possibility of considering a merger with Ealing NHS and update on this would be presented at a future meeting.

11. **Health Partnerships Overview and Scrutiny work programme**

Andrew Davies drew Members' attention to the work programme and welcomed any requests for future topics. Councillor Daly suggested that information be provided on property and land owned by NHS Brent and Harrow in the context of preparing for GP commissioning. Rob Larkman replied that work in respect of this was taking place across the entire North West London and information would be provided to Councillor Daly through Andrew Davies.

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 was scheduled for Tuesday, 20 September 2011 at 7.00 pm.

The meeting closed at 9.40 pm

S KABIR
Chair