MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
Tuesday 7 February 2012 at 7.00 pm

PRESENT: Councillor Kabir (Chair), Councillor Hunter (Vice-Chair) and Councillors Colwill, Daly and Ogunro

Also Present: Councillors Gladbaum, Hashmi, Kansagra and McLennan

An apology for absence was received from: Councillor Beck

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

None declared.

2. **Minutes of the previous meeting held on 29 November 2011**

RESOLVED:-

that the minutes of the previous meeting held on 29 November 2011 be approved as an accurate record of the meeting.

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

None.

4. **North West London NHS Hospitals Trust/Ealing Hospital Trust merger**

Andrew Davies (Performance and Policy Officer, Strategy, Partnerships and Improvement) introduced the item and confirmed that following on the meeting in November 2011, the chairs and vice chairs of Brent, Ealing and Harrow health scrutiny committees had met with representatives from Ealing Hospital Trust and North West London Hospitals NHS Trust on 24 January 2012 to discuss concerns raised in a letter sent to both trusts at the previous meeting. Andrew Davies referred to the main issues to emerge from the second meeting as outlined in the report and advised that the Chair of this committee was seeking to send a further letter to the trusts outlining the committee's views on the merger.

The Chair then invited Simon Crawford (SRO, Organisational Futures Project) to make some opening remarks. Simon Crawford advised that following the presentation of the outline business case to Members in November 2011, the final business case was due to be put to both trust boards in March 2012.

Members then discussed the item. Councillor Daly sought clarification regarding the amount that the 15% back office savings would represent and she also

commented that there was real concern amongst GPs about the proposed merger. She suggested that the relationship between the NHS and the public was deteriorating and that management should pay more heed to the concerns of both residents and front line NHS staff. Councillor Hunter enquired how the increase in community services would be resourced and commented that the viability of service changes needed to be considered. Councillor Colwill commented that residents wanted both hospitals in Brent to remain open after the merger and he sought assurances that this would be the case. He also asked what views the GPs had on the proposed merger.

The Chair sought assurances that there were sufficient funds to provide the transition of service provision to the community and stressed the importance of not compromising on providing a service to those who most needed it.

Mansukh Raichura (Chair, Brent LINk) was invited to address the committee. He confirmed that Brent LINk had already submitted a response to the proposals and stated that there was significant opposition to health reforms in general and concern about the impact on patients. He emphasised the need for a joined-up approach in undertaking these changes.

In reply to the issues raised, Simon Crawford advised that the outline business case submitted included plans by the commissioners to reduce acute services, with a third of its budget being re-invested in an integrated community and acute services. Members heard that the final business case needed to demonstrate the viability of the merger and that no major service changes were planned on any of the sites. The commissioners were to put together a plan to specify what services each site would provide and an earlier report had included four possible case scenarios which were to be consulted upon. Simon Crawford acknowledged that the changes presented a challenge, however a collaborative approach would be taken to provide more healthcare in the community in order to reduce demand on the already strained resources in hospitals. The strategy would include support provisions for implementing changes which would also be subject to negotiations between relevant partners. Simon Crawford acknowledged that there was some opposition within NHS generally to commissioning groups and changes, however the merger between the two trusts had been proposed prior to the health reforms as there was clinical and empirical evidence in support of this move.

David Cheesman (North West London NHS Hospitals Trust) added that Northwick Park Hospital was a particularly busy one, whilst Central Middlesex Hospital was a private finance initiative and liable for rent payments for the next 30 years and so would remain open for at least this period. He felt that the merger would make both trusts stronger in light of the commissioning changes to come.

Rob Larkman (Chief Executive, NHS Brent and Harrow) confirmed that any service changes would be subject to consultation. He explained that the overall direction included developing out of hospital services and stated that the scale of the changes both locally and nationally was a challenge for all.

Dr Mark Spencer (Medical Director) stated that the merger would ensure that funds were not lost in respect of the changes from acute to community provision and the trusts would be in a stronger shape together. He also felt that GPs overall were in favour of the merger, although some understandably had individual concerns

regarding their jobs, although it was acknowledged that it would lead to service improvements.

Ethie Kong (GP) added that every effort would be made to ensure that the changes made were in the interest of Brent residents.

The Chair requested that monthly updates to Members on the merger continue and she confirmed that this would remain a standing item on the committee's agenda.

5. **North West London - shaping a healthier future**

Rob Larkman introduced the report and explained that the North West London NHS budget of £3.5bn was under pressure and changes to service provision were required. Although schemes such as the Short Term Assessment, Rehabilitation and Reablement Service (STARRS) had improved the transition of patients between acute hospital services and community service, more changes were still needed, whilst hospitals in North West London also needed to perform better in a number of areas. Members noted that health services needed to be localised where possible, centralised where necessary and integrated across health, social care and local authorities where it improved patient care. Members then noted the timetable for the consultation and that a Joint Health Overview and Scrutiny Committee would be set up to provide external scrutiny.

Dr Mark Spencer added that a pre-cursor to these changes had started two years ago and it was intended to provide a series of quality changes to health provision.

Councillor Daly sought further details with regard to the legislative implications of the changes and commented that when the original Government legislation was approved, it was not envisaged that there would be such wholesale changes to health provision. She asked that if external consultation was undertaken, to what extent did it take place and she felt that it was important that the individual health overview and scrutiny committees of each borough concerned retained their scrutiny role to oversee the changes. Concern was expressed that hospital care needed by older persons and diabetics was to be reduced and details were sought as to how the 24% reduction in cost of care for these groups as outlined in the integrated care pilot could be achieved. Councillor Daly requested that the peer review paper for the pilot scheme, the community strategy and costings of the project be supplied and she asked how many hospitals and beds were due to close.

Councillor Hunter also expressed concern that the Joint Health Overview and Scrutiny Committee would be the sole delegated scrutiny body and that there would not be a role for the individual health and overview scrutiny committees. She stated that it was important to scrutinise on both a local and North West London wide level and she asked whether this arrangement was certain or remained a proposal. Councillor Colwill sought assurance that proper safeguarding measures were in place.

The Chair referred to paragraph 4.5 in the supplementary report and sought further information with regard to the role of the individual health overview and scrutiny committees. She commented that most individual health and overview scrutiny committees would wish to provide input regarding proposals within their own borough and asked what the next steps were with regard to the creation of the Joint

Health and Overview Scrutiny Committee. The Chair queried why the Health and Wellbeing Board was not formally involved in the scrutiny process even though the council was to have more public health responsibilities. Information on the membership of the hospital working groups was also sought.

Dr Mark Spencer advised that NHS North West London comprised of eight primary care trusts working together. The actual budget reduction for older persons and diabetics acute hospital services was around £1bn over five years, representing approximately 13%. Where people did not require hospital care, this would help reduce costs, however there would not be a reduction in care services. With regard to the integrated care pilot, Dr Mark Spencer explained that this was an example of a scheme operating in inner London. An interim report would be made available in the next six months, however the number of bed/hospital closures were yet to be outlined as modelling of the scheme continued. It was likely that all sites would remain open, however some services may change at some sites. The committee noted that the hospitals working group was chaired by a GP and the intention of the group was to consider what standards needed to be set for provision outside hospitals. Although savings needed to be made, it was intended to improve the quality of care across the whole of health services whilst ensuring the appropriate safeguarding measures were in place. Detailed information was being requested from the clinical groups to help put together the proposals for changes. There would also be further discussion on the roles of both the Joint and individual health overview and scrutiny committees at the meeting on 29 February.

Rob Larkman advised that it had been proposed that a Joint Health Overview and Scrutiny Committee undertake an external scrutiny role, however scrutiny activity undertaken by individual health overview and scrutiny committees could be discussed. Similarly, it was expected that health and wellbeing boards would also provide input and undertake informal scrutiny, however their role could also be discussed further.

Andrew Davies advised that legislation was quite clear in setting out the scrutiny role of a joint health overview and scrutiny committee. If a joint committee was not created, Members needed to be aware that the individual health and overview scrutiny committees may not retain any formal scrutiny role on this issue and this should be taken into consideration when discussing the role of committees.

Ethie Kong added that a recent example of upskilling GPs included them being trained to administer and monitor insulin use.

6. **Joint Strategic Needs Assessment consultation**

Andrew Davies presented this item and explained that some emerging themes had been raised during the presentation at the last committee meeting. The Joint Strategic Needs Assessment (JSNA) was being consulted upon until 23 March and feedback could be provided through the council's website. The JSNA was looking at what health arrangements were working well, what ones could improve and what measures could be undertaken in tackling inequalities. Focus was also being given on the major causes of mortality. Andrew Davies welcomed any suggestions to add topics which it felt were missing from JSNA. A meeting with Brent LINk would also take place during the consultation period.

Mansukh Raichura commented that it was important that Brent LINk had sufficient time to advise people that a meeting was taking place and discussions would take place with Andrew Davies in respect of this.

The Chair felt that it may be beneficial to consult pharmacists who played an important role in the community. The committee agreed to a suggestion from the Chair that it would be useful for Members to undertake a separate session on the JSNA to help inform them and to suggest any particular areas of interest to them.

7. **Khat task group - final report**

Councillor Hunter, the Chair of the khat task group, introduced the item and explained that the group had heard a wide cross-section of views concerning khat and also had read a number of Government reports on the matter. The task group had made nine recommendations as set out in the report that it had considered both practical and useful to pursue and these would also be put to the Executive for formal approval. Councillor Hunter commented that khat use was often associated with Somalians who were unemployed, particularly with those who arrived in the UK earlier and who may have English language difficulties that limited their employability. The task group was not advising on a khat ban and it was noted that this was not within the scope of the committee and this would be a matter for the Government to consider. Furthermore, a Government report published in 2005 had concluded that there was not sufficient evidence to ban khat. Councillor Hunter acknowledged that there were some within the Somalian community in Brent who had hoped that khat could be banned, whilst others had felt that criminalising khat use would worsen matters. The committee heard that the London Borough of Hillingdon had undertaken a similar study on khat last year and had concluded that banning khat was not a solution to concerns raised.

The Chair then invited Abukar Awale, who had participated in task group activities, to address the committee. Abukar Awale introduced himself as a community engagement officer and as an ex khat addict. Abukar Awale asserted that khat was responsible for damaging communities and that the majority of those attending meetings organised by the task group supported the banning of khat. Whilst it was acknowledged that there were some moderate khat users, Members heard that there were around 520 young males in West London who suffered from mental health issues as a result of khat use. Abukar Awale also cited The Netherlands as an example of a country that had outlawed khat, even though it was well-known for its tolerance to drugs. He asked that the voices of those wanting khat to be banned be heard and that felt that it was within the councillors' scope to support this.

The Chair invited Dr Muna Ismail, who had carried out a scientific study on khat, to address the committee. Dr Muna Ismail explained that she had carried out a PhD in khat use and was continuing research on this at post-doctorate level. She drew Members' attention to a document she had produced that was circulated at the meeting and advised that at present there was no conclusive evidence with regard to the question of khat being damaging to human health and there was a clear need for further scientific research to be undertaken. Members noted that there was not much evidence at present that there a high percentage of chronic habitual khat users. Dr Muna Ismail explained that she had undertaken a comparison of khat with cannabis where a lot more research documents were available and it was noted that The Netherlands had recently tightened legislation over cannabis use.

She requested the committee's support in asking for further research to be undertaken about khat.

Phil Sealy, a former Brent councillor, was also invited to address the committee. Phil Sealy advised that the Brent Community Health Council had previously requested that the issue of khat use be looked into and commented that there had been a similar acceptance amongst some from the West Indian community concerning cannabis use. He felt that there needed to be serious commitment into tackling khat use in the same way there had been towards cannabis which had proved particularly damaging to the West Indian community.

Councillor Gladbaum, another member of the task group, also spoke to the committee. Councillor Gladbaum stated that the task group had spoken extensively with the Somalian community and had undertaken considerable research before producing its findings. She stated that initially she had been in support of banning khat, however since being involved in the task group, she now felt that criminalising it would not be beneficial and would disadvantage some in the Somalian community.

Hussein Hersi, representing the Red Sea Foundation, also addressed the committee and stated that khat was used by diverse members of the Somalian Community. He felt the task group had produced a well-balanced report and thanked them for their work with the Somalian community.

During discussion by Members, Councillor Daly commented that the damage to health by tobacco could clearly be seen, however because it had been in existence for so long, outlawing it was virtually impossible. She felt that consideration needed to given as to what effects khat use had on the Somalian community and that appropriate steps needed to be taken if was seen to be damaging. Councillor Colwill concurred with Phil Sealy in relation to the harmful effects of cannabis and action had been taken against tobacco use after the council had passed a motion to ban smoking in council buildings. He felt that as the Somalian community had voiced serious concerns about kat use, along with the recent banning of it in The Netherlands, that it would be appropriate to put pressure on the Government to take action against khat use. He also felt that the task group should continue with its work to look further into khat use.

In reply to some of the issues raised, Councillor Hunter advised that there was no evidence from mental health centres to suggest that khat was a contributor to mental health illnesses. During discussions with the task group, those who did not wish for a khat ban had stated that they did not think there were any links to it leading to harder drugs use or crime. Councillor Hunter stated that one of the limiting factors at present was the lack of resources to carry out the necessary statistical research on khat use. A World Health Organisation report published in 2007 had concluded that khat was not physically addictive. Councillor Hunter acknowledged that there had been mixed views expressed by the Somalian community in respect of khat use, however khat also played a role within this community and was used in a wide variety of occasions, including weddings. She reiterated that it was not within the scope of the task group or the committee to ban khat use in Brent.

Councillor Hunter advised that in addition to the nine recommendations in the report, a further two recommendations were to be added in relation to requesting that more research be undertaken by relevant agencies about khat use and that a conference be organised in Brent about khat for all stakeholders. Andrew Davies (Policy and Performance Officer, Strategy, Partnerships and Improvement) added that he would devise the wording of the two additional recommendations and circulate to Members.

RESOLVED:-

(i) that the recommendations of the khat task group in the report, and in addition the two additional recommendations as outlined below and subject to finalised wording, be endorsed:-

- more research be undertaken by relevant agencies about khat use
- that a conference be organised in Brent about khat for all stakeholders

(ii) that these recommendations be passed to the Executive for approval.

8. **Diabetes task group scoping document**

Andrew Davies advised Members that a diabetes task group had been suggested as a result of emerging findings from the JSNA. Agreement of the scope of the task group was sought and Members should indicate if they also wanted to be involved in the task group. The committee agreed the scope of the task group and both the Chair and Councillor Colwill confirmed that they would be members of the task group. Andrew Davies advised that he would be contacting the main opposition political group regarding what member they would like to put forward to be on the task group.

RESOLVED:-

(i) that a tackling diabetes in Brent task group be created;

(ii) that Councillors Kabir and Colwill be members of the task group, and a third member from the main opposition political group is to be confirmed.

9. **Clinical Commissioning Group update**

Ethie Kong introduced this item and advised that the Clinical Commissioning Group (CCG) comprised of five localities (consortiums) and was working on developing primary care in Brent. Out of hospital services and prevention and promotion initiatives, such as immunisations and breast screening, was also being considered.

The Chair asked whether patients' representative group, such as the Kingsbury one which she recently attended, were not presently resourced and she enquired if the CCG could assist on this matter. She also suggested that the CCG could report back to each patients' representatives group. Councillor Hunter concurred with this suggestion and felt that meetings on this level could be piloted.

In reply, Ethie Kong advised that each consortium has its own patients forum and resources came from the locality concerned. There was a small budget to support

this and she advised that patients had the right to insist that this was provided. Ethie Kong also suggested that a Brent wide residents group could be created to discuss common issues. The CCG had also identified care for diabetic patients as a priority in Brent and Ethie Kong suggested they would be happy to contribute to the work of the diabetes in Brent task group.

10. **Health and Wellbeing Board update**

Andrew Davies advised that the Shadow Health and Wellbeing Board was taking a leading role with regard to the JSNA which would help inform the Health and Wellbeing strategy. A number of major health sector issues were being considered, including the out of hospital care strategy and some of the Board's work overlapped with this committee.

Councillor Hunter sought clarification on whether there was any decision in respect of opposition political group representation on the board. In reply, Phil Newby (Director of Partnerships, Strategy and Improvement) advised that consideration of the Board's composition was still being discussed and was subject to what shape the health service would take. There remained uncertainty on a number of major issues and the composition of the Board would not be confirmed until these had been resolved. Andrew Davies advised that the Health and Social Care Bill seemed to suggest that proportional representation could be provided, however it also referred to there being no requirement to provide this as was presently the case.

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

Andrew Davies advised that discussions with the Chair and Vice Chair of the committee would take place as to what items would appear on the agenda of the next meeting as there were a large number of topics that had been suggested. Councillor Daly suggested that information on waiting lists, including initial referrals and planned surgery, should be a standing item on future agendas. Councillor Hunter felt that a task group on female genital mutilation was needed and she requested that this should be added to the work programme.

12. **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, 27 March at 7.00pm. The Chair confirmed that a pre-meeting would start at 6.30 pm.

13. **Any Other Urgent Business**

None.

The meeting closed at 9.30 pm

S KABIR

Chair