MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
Wednesday 30 May 2012 at 7.00 pm

PRESENT: Councillor Kabir (Chair), Councillor Hunter (Vice-Chair) and Councillors Al-Ebadi (alternate for Councillor Hector) Daly, Harrison, Hector, Hossain and Leaman

Also present: Councillors Cheese, Hashmi, Mistry (Lead Member for Adults and Health) and McLennan

Apologies for absence were received from: Councillors Colwill and Hector

Others present: Colin Babb (Brent LINk), David Cheesman (North West London Hospitals Trust), Andrew Davies (Brent Council), Rachel Donovan (NHS North West London), Maurice Hoffman (Brent LINk), Toby Howes (Brent Council), Paul Jankcowiak (North West London Hospitals NHS Trust), Jacinth Jeffers (Community Services Brent , Ealing NHS Trust), Rob Larkman (NHS Brent and Harrow), Yvonne Leese (Ealing Hospitals NHS Trust), Jo Ohlson (NHS Brent), Sunil Patel (LPG Brent), Mansukh Raichura (Chair, Brent LINk), Phil Sealy (Brent LINk), (Brent Jeff Zitron (NHS North West London)

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

None declared.

2. **Minutes of the previous meeting held on 27 March 2012**

RESOLVED:-

that the minutes of the previous meeting held on 27 March 2012 be approved as an accurate record of the meeting.

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

Recruitment of health visitors in Brent

Councillor Hunter commented that a written answer was awaited in respect of her query concerning domestic violence. Phil Newby (Director of Strategy, Partnerships and Improvement) replied that he would request that Genny Renard (Head of Community Safety - Integrated Community Safety, Strategy, Partnerships and Improvement) to provide some information.

4. **Recruitment of health visitors in Brent**

Yvonne Leese (Ealing Hospital NHS Trust) introduced this item and advised that there was a shortage of health visitors both locally and nationally. The Trust was developing a recruitment and retention strategy and some progress was already being made in recruiting health visitors.

Jacinth Jeffers (Community Services Brent, Ealing NHS Trust) then presented the report and advised that a task and finish group had been created in June 2011 to progress the Department of Health paper, 'health visitor implementation plan – a call to action.' She referred to the table in the report outlining the vacant health visitor posts over the last two years, which had averaged twelve vacancies consistently despite a recruitment drive. Jacinth Jeffers advised that the most recent external recruitment exercise had shortlisted six applicants and resulted in five of these accepting job offers. Community Services Brent had also offered health visitor posts to internal students subject to them qualifying in September 2012. However, the committee heard that it was not compulsory for students to remain with the Trust once they had qualified, so it was important that students were well supported and encouraged to take up posts in Brent. In total, ten health visitor posts were due to be filled in September 2012. However, it was forecast that a further 43 additional health visitors would be required by 2015.

During discussion, Councillor Harrison enquired whether the Trust was limited to the number of students it could recruit each year. Councillor Hunter asked whether the Trust was confident that it could recruit the number of health visitors required in 2015 and what incentives were in place to encourage recruitment and retention of staff. Councillor Leaman commented that recruitment of health visitors had been a long standing problem and he asked whether exit interviews were conducted for those leaving and what were the specific problems in Brent. He also enquired what impact under capacity was having on staff and was it affecting morale. Councillor Daly asked how many health visitors were currently in post and what was the intended total number to recruit for this year and whether the ethnic mix of the staff reflected Brent's population. She also asked if there was a gap in service in view that vacancies remained. Councillor Al-Ebadi sought clarification as to whether back staff had the appropriate qualifications.

The Chair asked whether there were sufficient financial resources to cover the forecast recruitment required in the next few years and was there any kind of guarantee that the students would remain with the Trust once they had qualified. She also asked if there were an adequate number of practice teachers to train students.

In reply to the issues raised, Jacinth Jeffers advised that funds had been committed this year for the recruitment required, however funding was agreed on an annual basis with the NHS and the Trust had been funded to take on five students this year. The Trust was currently considering what incentives it could introduce to encourage recruitment and retention of staff, including analysing what motivated them, such as offering new streams that they could specialise in. Jacinth Jeffers advised that exit interviews of departing staff was undertaken and the reasons why they were leaving varied, including retirement, however sometimes staff simply wished to reduce the hours they were doing. Members heard that there were currently 29 health visitors in post and some vacancies were covered by back staff who were appropriately qualified. There was funding to recruit an additional 16 staff in total this year. The staff ethnic mix was fairly diverse and the Trust was working with NHS London to target first generations of particular ethnic groups, such as Somalians. Jacinth Jeffers acknowledged that under staffing was an issue and that its effects on staff was being closely monitored, including engaging staff through effective communication, including through staff forums and it was important that

staff were aware of the Trust's future plans. Although there was a sufficient number of practice teachers, it was always desirable to have more and the addition of two more in September would mean that there would be five teachers in total.

Yvonne Leese added that there were separate funding channels to recruit the additional qualified health visitors and to take on students in September. As there was no present requirement for students to remain with their respective Trust after qualifying, it was important that they were given a good work experience and support to encourage them to remain. There had been vacancies at the Trust for the last four years despite funding being available to recruit for these posts. Yvonne Leese advised that there was a London-wide shortage of qualified and experienced health visitors. The long term solution involved supporting new students and attracting as many maternity placement nurses as possible, including those presently out of service. However, the Trust did benefit from a low turnover with a committed group of health visitors and the main problem was in recruiting new staff as opposed to retention. The committee heard that six vacancies were currently covered by back staff, with a further six remaining unfilled. The Trust also had to prioritise particular areas, such as new births, those that involved vulnerable children or in need and those on the protection register, which meant that not as much resources could be focused on health promotion than would otherwise be desirable.

The Chair asked that the committee be provided with an update on recruitment and retention figures and training in around six months.

5. **Accident and Emergency waiting times**

Paul Jankowiak (North West London Hospitals NHS Trust) introduced the report which set out Accident and Emergency (A and E) waiting times over the last six months. He began by advising that the Department of Health's NHS Performance Management Framework set out a performance indicator that required 95% patients to be seen within four hours. He referred the table in the report outlining the performance of Central Middlesex Hospital, Northwick Park Hospital and the Trust overall. Paul Jankowiak advised that the targets were being met consistently since March 2012.

Councillor Daly sought confirmation that Northwick Park hospital received the largest number of A and E visitors and in noting that some patients had been waiting too long in February and March, she asked how they were dealt with. She also asked for further data with regard to what happened to A and E patients when they arrived, including how many had arrived by ambulance and those who were seriously ill. Councillor Daly asked if there were specific plans in place in respect of the Olympics. Councillor Leaman asked for further details about waiting times for those patients who had to wait longer than four hours to be seen.

The Chair enquired why ambulance transfer times had not been provided as this had been the committee's wish.

With the approval of the Chair, Councillor Cheese also addressed the committee and commented that the ambulance service would be under additional pressure during the Olympics, especially those ambulances needing to do patient transfers via Wembley and he enquired what steps were in place to address this. Maurice

Hoffman (Brent LINk) also addressed the committee and he enquired whether the average A and E waiting times were in effect being lowered by the Urgent Care Centres (UCC) and did waiting times vary depending on the time of day.

In reply, Paul Jankowiak explained that he thought it was the number of transfers being on target that were of particular interest to the committee and he stated that information could be provided on ambulance transfer times. Those who were deemed seriously ill received treatment within four hours. Paul Jankowiak confirmed that waiting times did include those patients treated by the UCCs and waiting times increased in the early hours of the morning and late evening.

David Cheesman (North West London Hospitals Trust) added that the UCC was effectively part of the same department as A and E and waiting times were also affected depending on the time of year, particularly during winter and capacity was scheduled accordingly. He advised that Northwick Park hospital had struggled with rising demand initially, however recent improvements in how it handled A and E cases were reflected in a boost to performance. Nurses would decide whether patients needed to go to A and E or treated at the UCC and patients categorised as 'type one' would go to A and E. David Cheesman explained that the waiting times were calculated from the moment the patient entered the hospital and he confirmed that a breakdown of figures with regard to waiting times including ambulance transfer times and those arriving by ambulance could be provided. Members noted that a large number of patients, for example, were submitted to the Stroke Clinic. David Cheesman advised that a number of measures were in place in respect of the Olympics and annual leave requests were being monitored during this period, whilst staff accommodation was also available on all sites. He acknowledged that the ambulance service could potentially be under more strain during the Olympics and the service was involved in planning for this period to ensure a resilient service could be provided. Members heard that figures were not immediately available regarding how long patients had waited where they had not been seen within four hours, however there were no examples of it exceeding 12 hours, which nationally was deemed as unacceptable.

The Chair requested that information be sent to Andrew Davies (Policy Officer, Strategy, Partnerships and Improvement) with regard to the number of ambulance transfers and their transfer times for Central Middlesex and Northwick Park hospitals.

6. **Shaping a healthier future - Brent out of hospital care strategy and an update on the North West London Joint Overview and Scrutiny Committee**

Rob Larkman (Chief Executive, NHS Brent and Harrow) introduced the report and explained that there were two main elements to shaping a healthier future, these being the future hospital-based acute services and developing a strategy for out of hospital services. Consultation on proposals would continue until October 2012.

Dr Tim Spicer (Shaping a Healthier Future) then presented further detail in the report. Following on from the two main elements of the programme, he referred to the particular challenges for North West London, which included a projected increase in population of 113,000 in the next ten years, whilst the population also continued to age with 31% having long term chronic conditions. Dr Tim Spice drew Members' attention to the variations within hospital care and the differing outcomes

of patients as set out in the report. With regard to developing an out of hospital care strategy, this would apply to each of the North West London boroughs and key themes were emerging from these. There would also be the establishment of four standards to maintain quality of care, these being:-

- Individual patient empowerment and self care
- Service access convenience and responsiveness
- Care planning and multi-disciplinary care delivery through a joined-up approach
- Standards of information and communication sharing

Dr Tim Spicer advised that the strategy would go public and UK standards would be used to model finances. Every effort would be made to demonstrate how the drive for changes would be made and it was intended to create coherence and confidence in the service whilst relieving stress on acute services.

Ethie Kong (Clinical Commissioning Group Chair, Brent) added that a borough level view was also being considered with regard to how the strategy would be delivered locally and how the local vision would change in the next three years.

Jo Ohlson (Brent Borough Director, NHS Brent and Harrow) advised that plans for outside of hospital care had been developed in the last two years and she cited the Short Term Assessment, Reablement and Rehabilitation Service (STARRS) as an example and which had achieved high satisfactory rates in providing services in the community.

During discussion by Members, Councillor Harrison commented that access to services was an issue and the reforms proposed placed a lot of focus on the role of GPs. In some cases, GP practices were not sufficiently organised and she asked what steps would be taken to ensure GPs took the appropriate action so that their practices performed to the levels necessary. Councillor Daly sought clarification of the term 'frequent flyers' as she felt it somewhat inappropriate. Councillor Leaman commented that the report did not make mention of the need to change the behaviour of the public to help ensure that the new arrangements would be effective and there needed to be measures in place to promote public awareness. He also asked what information was provided to those who may be first time visitors in accessing health services. Councillor Hunter welcomed the report overall and enquired when the programme was due to go live, however she enquired how confident were the NHS that funding from acute providers would be released to community services. She also sought more information with regard to what consultation would be undertaken and when. Councillor Al-Ebadi noted the present different outcomes for patients as set out in the report and he enquired what steps were being taken to improve these, particularly for groups who currently have poorer outcomes than others.

The Chair commented that Members were putting together a separate list of questions to forward to NHS colleagues with a view to arranging a meeting with them to discuss the issues raised.

With the approval of the Chair, some non-member councillors addressed the committee. Councillor Hashmi commented that in view of the financial pressures,

how would savings be achieved. Councillor Cheese stated that disorganised services could result in patients losing confidence.

In reply to the issues raised, Dr Tim Spicer advised that GPs were required to undertake what they were contracted to do, however more attention was needed as to how they should work with other services. It was intended to provide access to coordinated care services and linking up with social care. Dr Tim Spicer advised that GPs could produce core plans to help achieve better outcomes, whilst the health economy was moving in the direction to reduce hospitalisation and provide more appropriate care where applicable. This also involved a more planned and coordinated approach in providing services in the community. Members heard that patients that had made unnecessary visits to the UCCs were contacted to identify the reasons why they had done so and sign posted as to what would be the most appropriate services to access.

Jo Ohlson advised that 'frequent flyer' was an NHS term for patients who were frequent visitors to A and E and such patients would be identified and steps taken to see if they could be treated more effectively in a different way. It was proposed to improve access to GPs in Brent and with the other North West London boroughs and provide patients with more choice and the focus was in providing the most appropriate care. Investment in staff for community services would improve such services and help reduce hospital admissions and therefore costs in this area.

Ethie Kong commented that changes in how GP services could be accessed were being pursued, including providing appropriate sign posting and a joined up approach with the appropriate organisations was required. She stated that self care was also an important factor in improving outcomes. With regard to unnecessary visits to UCCs, Ethie Kong explained that there was a process of re-direction then education of the patient concerned. She acknowledged that the scheduling of the consultation was of particular importance in order to provide user groups sufficient time to provide feedback, including Brent LINk, and a timetable of consultation would be publicised.

Rob Larkman added that the programme was intended to improve care and provide a sustainable basis whilst also making financial efficiencies.

The Chair requested that information with regard to how the consultation be undertaken, including the timetable, be provided and that any questions Members wished to be forwarded to NHS colleagues to answer at the separate meeting be sent to Andrew Davies.

7. **Primary care update - Willesden Medical Centre, Kenton Medical Centre and Kilburn Medical Centre**

Jo Ohlson introduced the report and confirmed that the lease at Willesden Green Medical Centre expired on 31 August 2012. The two options being looked at involved either the possibility of relocating the centre and also possibly including Dr Fletcher's practice to the Willesden Health and Well Being Centre, or Willesden Green Medical Centre and possibly Dr Fletcher's practice remain at the same premises if the current landlord was able to improve their existing accommodation and provide space for Dr Fletchers' practice. Discussions and meetings were

taking place in respect of these and the committee would be updated about developments.

In respect of Kilburn Medical Centre that had been operating under a temporary contract, it had been decided to terminate this contract on 30 June 2012. NHS Brent had undertaken a review as to whether to develop a specification and tender on the open market or to list dispersal of the registered population. However, as there was no guarantee that a contract would be awarded to a new provider or that the service could remain at the existing site, it was decided to disperse the patient list. Members noted the results of the health inequalities assessment that had been undertaken as part of coming to this decision.

Rachel Donovan (NHS North West London) confirmed that the two doctors at Kenton Medical Centre were retiring and had tendered their resignation for 30 June 2012 and this would also mean the termination of the Personal Medical Service (PMS) contract. Two options had been considered, the first enabling patients to register with a GP from existing list of practices in the area and the second inviting applications from providers to take up a PMS contract at Kenton Medical Centre. Consultation had involved all patients over 16 years of age, local councillors and MPs and this committee. Following this, it had been recommended to the NHS North West London Board that patients be asked to register with an alternative practice in the area as the list of patients to existing GP practices had capacity to register additional patients and gave patients more choice as to where they would like to register. The alternative option was not being pursued as the length of time to procure a new practice on the existing site could take up to twelve months. In addition, the 2,500 patients affected was well below the average practice size. Should the recommendation be approved, the list of practices would be reviewed to ensure that they were ones closest to where patients lived, as opposed to closeness to Kenton Medical Centre. Kenton Medical Centre would also be asked to assist in identifying vulnerable patients and helping them re-register and provide assurance that they have re-registered prior to the practice closing.

During discussion, Councillor Leaman enquired whether the letter sent to patients on 5 April 2012 informing them of the retirement of the GPs at Kenton Medical Centre had also been provided in different languages, particularly as the wording used was not especially clear. Councillor Daly enquired whether patients would still have access to community facilities in Harrow that were available in Brent and felt that this was an issue that needed particular attention.

The Chair enquired what monitoring steps were in place to ensure all Kenton Medical Centre patients were re-registered and whether those transferring to practices in Harrow would have matching social services that they may require. She added that the patients' group were not informed about the situation at Kenton Medical Centre at the last meeting in April.

Councillor McLennan was also invited to address the committee and she commented that services in Harrow were not so enhanced as those provided in Brent and she queried why patients were not being offered more practices in Brent.

Maurice Hoffman also addressed the committee and enquired if demand would be monitored in respect of Kenton Medical Centre's proposed closure as it could affect services and could GP practices also consult Brent LINk.

In reply, Rachel Donovan advised that NHS North West London held the patients registry database and would be able to see what patients had not re-registered. A large number of Kenton Medical Centre patients had already re-registered and those who had not would be monitored and contacted again if they had not re-registered within two weeks. The committee heard that those who had not yet re-registered tended to be patients who visited infrequently. In respect of social services and enhanced services, Rachel Donovan commented that similar GP practices were being looked at in Harrow and Brent and demand would be monitored, whilst Brent LINk could also be kept informed.

Rachel Donovan explained that following the first letter to patients on 5 April with regard to GP practices list which was based on those closest to Kenton Medical Centre, a second letter had subsequently been sent with an extended list that included more that were in Brent and it was noted that a number of patients were located near the border with Harrow. Every effort would be made to ensure any future letters were easier to understand and although neither letter was available in different languages, the second letter had information on what patients could do if they did not understand the letter. Community Services were to be approached with regard to patients who may need such services.

Jo Ohlson added that there had been a reciprocal agreement between Brent and Harrow that patients could register with a GP practice in a different borough providing they were within half a mile of the border with the other borough. However, she acknowledged that this was an issue and it may be more prudent for patients to register with a practice in their own borough.

The Chair requested an update at the next meeting concerning where Kenton Medical Centre patients had re-registered.

8. **Serious incident at Brent Urgent Care Centre**

Jo Ohlson provided an update in respect of a recent serious incident at Central Middlesex Hospital UCC involving patients who had apparently not been discharged from the IT system and therefore it could not be confirmed that those with radiology reports had been reviewed for missed pathology. She advised that most of the patients affected had been contacted promptly once the problem was discovered, and of the 97 patients that had remained outstanding, 76 had subsequently been contacted, with 48 of these requiring no further action. Of the others, fifteen had been offered appointments, six had been re-called at the correct time following the initial x-ray, three referred by GPs to another health facility, three advised to contact their GP and one had sought follow up from a different provider. Of the remaining 21 who had not been contacted, twelve had left no contact details, six had failed to respond. However, three had subsequently been contacted following information provided by their GP. Jo Ohlson advised that of those with no contact details, GPs were being asked if they held any records. A report was due to be published on 6 June to identify how the error had happened.

Councillor Leaman asked how many of the 97 patients involved were children. He asked when the earliest failure to record a case had happened and why had the lack of discharging from the IT system not been picked up earlier. He asked whether NHS Brent had any view at this stage with regard to Care UK's role about

the situation. Councillor Hunter commented that if the build-up of patients who had not been discharged on the IT system had been happening over an extended period of time, then it appeared that there must be a fundamental system failure. She also enquired what specific action had not been done that had resulted in the incident. Councillor Daly expressed concern about the incident and felt the number of patients involved was not acceptable. She felt that NHS Brent had failed to monitor the contract with Care UK properly and she asked what steps were being taken to address this as well as seeking clarification as to who was leading the investigation into the incident. Further explanation was also sought in respect of lack of patient contact details for those affected by the incident.

Mansukh Raichura (Brent LINk) was also invited to comment and he stated that it was important that all departments of the hospital worked closely together to ensure such incidents did not happen in future.

In reply to the issues raised, Jo Ohlson advised that of the 97 patients, four of these were children and it was understood that these had been contacted. The earliest failure to record a case had occurred sometime after the UCC had opened in 2011, although the red cases which were of more concern were much more recent. At this stage, it was no possible to pinpoint the specific reasons for the failure whilst the investigative report was awaited. However Care UK had accepted overall responsibility and their contract was quality monitored by three clinical leads from the Clinical Commissioning Group (CCG) and regular meetings took place with them. The investigation was being led by Care UK and one of the clinical directors. Upon the conclusions of the investigative report, if Care UK were found to be seriously at fault, amongst the options available included financial penalties or even termination of contract. Members noted that the risk of harm to patients affected was very low and that incidents of this sort did happen from time to time in healthcare, although in this particular case once the problem was identified NHS Brent had been informed promptly. With regard to problems contacting patients, this was mainly due to the lack of information that some patients had provided.

The Chair requested that the investigation report due for publication on 6 June be sent to Andrew Davies with a view to including this item for discussion at the next meeting.

9. **Update on the procurement of new community cardiology and ophthalmology services**

Jo Ohlson gave a brief introduction to the report that was before Members updating them on the public consultation of the procurement of the new community cardiology and ophthalmology services.

Councillor Daly enquired what action would be taken following the consultation. Councillor Hunter stated that she had not seen any consultation letters to date and she enquired why consultation on cardiology and ophthalmology services were being undertaken together as they were two significantly different kinds of services.

The Chair suggested that there should be separate consultation questionnaires for cardiology services and ophthalmology services and she enquired what patient groups were being consulted. She also sought confirmation as to what body would make the final decision.

Maurice Hoffman was invited to address the committee and he commented that Brent LINk were still awaiting responses to two letters they had sent NHS Brent with regard to this issue. He queried why the consultation was being undertaken simultaneously for both cardiology and ophthalmology services as there were no obvious connection between the two. He felt that patients and stakeholders had not been adequately consulted, whilst a request to postpone consultation in order to increase public involvement had not been responded to.

In response, Jo Ohlson advised that the consultation was with regard to service specification which had been under consideration for some time and no service was to be de-commissioned. Jo Ohlson indicated that she would take on board comments made with regard to how the consultation should be undertaken and respond accordingly. Members noted that following consideration of the consultation and a response to it, recommendations would be made to the Clinical Commissioning Group's Executive and then on to the NHS Brent Board before a final decision was made.

10. **Clinical Commissioning Group update**

Ethie Kong confirmed that Rob Larkman had been appointed the Chief Executive of the North West London CCG, whilst Ethie Kong was to chair the Shadow CCG Board which also included two lay members including a lay vice chair. A timetable of public meetings would be advertised in local newspapers and the CCG would consist of five localities. Work was under way to develop the CCG constitution and the first draft had gone to GP practices for consultation. There would also be consultation with patient user groups and the CCG was working with Brent LINk to ensure that they had the relevant contact details. Ethie Kong confirmed that the CCG had been delegated its budget as of April 2012.

Councillor Leaman enquired whether details of a who's who could be provided of the CCG and how many public meetings were scheduled to take place. Councillor Daly stressed the need for the committee to see the relevant reports so that it could undertake proper scrutiny.

The Chair confirmed that the committee would like to receive progress reports in future and also a report on the CCG meeting that had happened on 30 May. In response to comments from Brent LINk representatives, she also requested that information be made more transparent in future.

Ethie Kong confirmed that two public meetings of the CCG were presently scheduled

Andrew Davies commented that verbal updates had been provided up to now as it was felt that this was the most appropriate way of informing Members, however reports would be provided in future.

11. **Health and Wellbeing Board update**

Andrew Davies updated Members regarding Health and Wellbeing Board (HWB) developments, reporting that the Shadow HWB May meeting had discussed the direction of travel with regard to the public health transfer. In respect of the Joint

Strategic Needs Assessment that was feeding into the HWB strategy, working groups had been created to cover a range of areas following feedback received from the consultation. Consultation on the HWB strategy would take place over the summer of 2012. Andrew Davies advised that he would provide reports at future meetings for this item.

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

Members noted the suggested work programme for 2012-13.

13. **Date of next meeting**

It was noted that the next meeting of the Health Partnerships Overview and Scrutiny Committee was scheduled for Wednesday, 18 July 2012 at 7.00 pm. Andrew Davies advised that a pre-meeting would take place at 6.15 pm.

14. **Any other urgent business**

None.

The meeting closed at 9.55 pm

S KABIR
Chair