MINUTES OF THE HEALTH SELECT COMMITTEE
Thursday, 12th July 2007 at 7.00 pm

PRESENT: Councillor R Moher (Chair) and Councillors Baker (part), Detre (part), Jackson, Hashmi (alternate for Leaman) and Hirani (alternate for Castle).

Apologies for absence were received from Councillors Leaman, Crane and Castle.

1. **Election of Chair**

In the absence of both the Chair and Vice Chair of the Health Select Committee, in accordance with Standing Order 58 of the Council's Constitution, the Committee elected another member to act as Chair for the duration of the meeting;

RESOLVED:-

that Councillor R Moher be elected to chair the meeting.

2. **Change to the Order of Business**

In the agenda circulated prior to the meeting, the *'North West London Strategy – Update and Next Steps'* and *'London Wide Review – the Darzi Report'* were listed separately as items 8 and 9 respectively. However, it was agreed that discussion on both items would be taken together under item 8.

3. **Declarations of Personal and Prejudicial Interests**

There were none.

4. **Minutes of Previous Meeting – 5th June 2007**

RESOLVED:-

that the minutes of the meeting held on 5th June 2007 be received and approved as an accurate record.

5. **Matters Arising**

There were none.

6. Healthcare Commission Annual Health Check Process

Following introductions, Maggie Pryce (Senior Assessment Manager, Healthcare Commission) explained that she had been invited to attend the meeting to discuss the Healthcare Commission (HCC) Annual Health Check Process, with particular reference to how the Committee could effectively respond to the 'self declarations' submitted by local trusts.

Those present were advised that under the Annual Health Check process, each trust was required to assess their performance against Department of Health (DoH) core standards. Relevant third parties, such as local authority health scrutiny committees and patient and public involvement forums (PPIFs), would then be asked to comment on the declarations, following which a number of trusts would be selected for inspection. Whilst some trusts were inspected because they were deemed to be at risk of undeclared non-compliance, others would be picked on a random basis. It was further noted that the inspection process had almost concluded for the current year, and the overall HCC assessment would be made publicly available in October 2007.

Given the usually close working relationship between local authorities and their partner health trusts, it was stressed that health scrutiny committee contribution was an important strand of the Annual Health Check process. With this in mind, Ms Pryce advised that the most useful comments were specific and evidence based, giving a view as to why it was thought a standard had or had not been met. It was further noted that information on the specific areas of health scrutiny covered by a committee was useful. Finally, members were referred to the Centre for Public Scrutiny publication, *'Substantial variations and developments of health services; a guide'*, as providing helpful information regarding the roles and responsibilities of health scrutiny committees.

Following a request for clarification, the steps taken if a trust declared non-compliance or insufficient assurance of compliance against a standard were outlined. Particular attention was drawn to the fact that in such circumstances, a trust would be required to establish an action plan, which would subsequently be monitored by the HCC. However, if still deemed to be non compliant, a range of options were available, including the issuing of statutory notices and, in the most extreme cases, placing a trust on special measures. Members were also reminded that poorly performing trusts received points which in turn lowered their quality of standard rating. Further to a question raised, it was explained that the financial aspect of the Annual Health Check Process was conducted by the Audit Service.

Mansukh Raichuria (Chair, Brent tPCT PPIF) felt that the current assessment regime did not take into account the significant degree of joint partnership working between the health and social care sectors. He was advised that at present social care inspection was the responsibility of the Commission for Social Care Inspection (CSCI), although there were plans for this organisation to be merged with the HCC by 2009.

7. **Public Health Annual Report 2005/06**

Simon Bowen (Deputy Director of Public Health, Brent tPCT) provided a presentation on the Public Health Annual Report 2005/06, and introduced the item by explaining that each primary care trust was under a statutory duty to produce such a report. He further advised that the 2005/06 report covered both an overview of health in Brent, as well as specific themes that had been identified for the year; gambling, drugs and alcohol and sexual health.

With reference to a number of graphs illustrating population trends and health outcomes across the borough, it was explained that overall health in Brent was similar to or better than the national average. Nevertheless, attention was drawn to the significant gaps in life expectancy between the north and south of the borough, and the relatively low uptake of some preventative services in certain areas. It was further noted that rates of infectious diseases and diabetes were higher than the national average. One Committee member asked a specific question regarding diabetes, and was informed that whilst the number of deaths from the disease in Brent was actually quite low, in percentage terms it was higher than average. Finally, Mr Bowen outlined the recommendations from the Public Health Annual Report 2005/06, emphasising that perhaps the most important of these involved working jointly with the Council to produce a health and wellbeing strategy to reduce health inequalities.

Committee members were then given the opportunity to ask questions regarding the report. Commenting on the specific sexual health theme covered in the report, the Chair asked whether any specific research had been conducted to investigate why rates of Chlamydia in Brent were rising at a time when those for Gonorrhoea were falling. In response, it was advised that improved testing techniques, as well as the introduction of a screening programme in the borough, might have contributed to the increasing figures for Chlamydia. Further to a query raised, it was also clarified that whilst the breast cancer screening service for Brent had been briefly suspended, it had now been reopened.

There followed a question about the impact of the usage of Khat, which was redirected to Martin Cheeseman (Director of Housing and Community Care) in his capacity as the Chair of the local Drugs and

Alcohol Action Team (DAAT). It was explained that whilst there was a lack of hard data, anecdotal evidence indicated a growth in the use of Khat amongst parts of the local population, and consequently work was being carried out to tackle the problem. Further to a question from the Chair about the numbers of drug users in the borough not currently receiving treatment, Mr Cheeseman acknowledged that there had been a significant increase in the number of people receiving treatment for drug addiction in Brent, but pointed out that the problem was one common across all urban areas. On a more general level, he was of the opinion that the Health and Wellbeing Strategy jointly being developed by the Council and Brent tPCT would help to provide more detailed data at ward level. Phil Newby (Director of Policy and Regeneration) endorsed this point, adding that it would be important to ensure that annual reporting was carried out on the strategy.

One Committee member felt that there was a need for a greater focus on preventative health, particularly in areas such as diabetes, and was informed that the tPCT had an action plan in place on this issue, which would also be taken forward as part of the Health and Wellbeing Strategy. Concern was expressed about the need for health information to be translated into language easily understood by the public, and Mr Bowen explained that this could be done as part of the Health and Wellbeing Strategy.

8. **North West London Strategy – Update and Next Steps**
London Wide Review – the Darzi Report

Members had before them a copy of the latest version of the strategy produced by the North West London sector, covering Brent, Harrow, Hillingdon, Hounslow, Ealing, Kensington and Chelsea and Westminster. Fiona Wise (Chief Executive, North West London Hospitals NHS Trust) explained that since its publication in May 2007, the North West London Strategy update report had in many respects been superseded by *'The case for change – Healthcare for London: A framework for action'*, the first stage of the review being conducted by Sir Ara Darzi on behalf of NHS London. This report had only been made publicly available the day before the current meeting.

Those present were advised that the Darzi Review would be considered by the London Strategic Health Authority (SHA) in September 2007, and would also be subject to public consultation. Noting that one of the key points made by Darzi was the need to provide healthcare in specialist centres rather than hospitals where possible, it was stressed that different ways of working would be required in the future. Particular attention was also drawn to joint plans between Hammersmith Hospitals NHS Trust, St Mary's NHS Trust and Imperial College London for the establishment of an Academic Health Science Centre (AHSC).

A question was raised about the possible funding implications of implementing the Darzi recommendations. In response, it was advised that it was thought that the proposals would result in savings rather than any increased costs.

Overall, whilst emphasising that there were no plans for hospital closures in Brent, Ms Wise felt that there needed to be a shift towards a commitment the provision of care over the site at which it was provided[1]. This view was similarly endorsed by Simon Bowen, who commented that this approach was one that was already being taken in Brent, where a number of models of care had been recognised as good practice.

9. **Work Programming 2007/08**

James Sandy (Policy and Performance Officer) provided a presentation for members on potential areas of interest for the Committee for the municipal year 2007/08. He began by noting that along with the Chair, he had recently attended a meeting of Councillors in Westminster regarding the AHSC. Whilst explaining that in terms of patient numbers, this development would have a relatively low impact on Brent, members were reminded that the AHSC might nevertheless have an effect.

It was also explained that the Health Select Committee had the power to set up two task groups. One such group had already been established to consider the issue of NHS finances, and members were advised that they might wish to consider establishing a second task group on another issue. It was also clarified that task group work was usually carried out over a 6 month period, and therefore it would only be logistically possible for one further task group to be arranged during the current municipal year.

Members were advised that the health scrutiny did not necessarily have to be limited to the traditional committee style meetings. Instead, other options included site visits, focused meetings centring on a particular issue or ‘Challenge Panels’. It was further explained that these panels had recently been introduced by a neighbouring local authority and were aimed at giving members the opportunity to call relevant individuals and organisations in for questioning on health scrutiny topics.

Following a query about the possible need for the Committee to conduct further scrutiny on the Brent tPCT financial problems, Phil Newby (Director of Policy and Regeneration) replied that rather than continuing discussion on this issue at committee level, members had

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[1] **As amended at the meeting of the Health Select Committee on 23rd October 2007.**

agreed to establish task group on NHS Finances to examine this issue separately.

Given that unfortunately the number of Committee members absent from the current meeting, those members present discussed whether it would be appropriate to take work programming decisions. Diabetes, asthma and dentistry were identified as possible themes for task group work, and it was generally felt that rather than agree the second task group at the current meeting, officers should put together a scope document covering each of the three themes, with a view towards a final decision being taken at the next meeting of the Health Select Committee.

The Committee also expressed their thanks to Councillor R Moher for chairing the meeting.

RESOLVED:-

(i) that diabetes, asthma and dentistry be identified as possible themes for a further task group of the Health Select Committee;

(ii) that a scope document be produced by officers covering each of the themes identified in (i), with a view towards members taking a decision on the topic for a second task group at a future meeting of the Committee.

11. Date of Next Meeting

It was noted that the next meeting of the Health Select Committee would take place on Tuesday, 23rd October 2007.

12. Any Other Urgent Business

There was none.

The meeting ended at 8.45 pm.

R MOHER
In the chair