MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
Tuesday 19 March 2013 at 7.00 pm

PRESENT: Councillor Kabir (Chair), Councillor Hunter (Vice-Chair) and Councillors Colwill, Gladbaum, Harrison, Hector, Hossain and Leaman

Also present: Councillors Cheese and John

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

None declared.

2. **Deputations**

Sarah Cox was invited to speak. She informed the Committee that Ealing Borough Council had referred the Shaping a Healthier Future proposals to the Department for Health and felt that Brent should also make a referral. Sarah Cox felt that if all of the planned closures and proposed alternatives were to be put in place the NHS service would not be able to meet all the needs of local people and expressed concern that the most vulnerable would suffer, particularly in light of the high taxi costs to travel to Northwick Park from particular areas of the borough. She continued to express concern regarding the non-specific treatment rooms, fearing privatisation of the health service and an uncertain legacy for future generations.

3. **Minutes of the previous meeting**

RESOLVED:-

that the minutes of the previous meeting held on 29 January 2013 be approved as an accurate record of the meeting.

4. **Matters arising**

Brent Pension Fund Committee
The Committee thanked the Brent Pension Fund Committee for amending the Statement of Investment Principles to reflect the Committee's recommendation to not directly invest in tobacco companies.

Health Visitors
It was clarified that although there had been success in attracting applicants, some vacancies still remained. It was explained that the offer had not been improved and an update could be provided at a future meeting.

Tackling Diabetes in Brent Task Group – Final Report

It was clarified that the report had been viewed by the Shadow Health and Wellbeing Board but not the Executive. Councillor Hirani (Lead Member Adults and Health) agreed to send a reminder.

Accident and Emergency performance and activity at Northwest London Hospitals NHS Trust
It was confirmed that the 111 telephone service was currently taking 'out of hours' redirected from GP services. The service was currently going through an assurance process before being rolled out to the public to ensure that it would be able to meet demand. It was highlighted that it was always envisaged to be a two stage roll out, with the same information being provided to the public as with the out of hours service. It was agreed that an update would be provided at a future meeting.

Public Health Transfer Update
It was explained that the Director of Public Health post had not yet been advertised but was a priority recruitment. Councillor Hirani (Lead Member of Adults and Health) informed the Committee that the post would now be a permanent position rather than a fixed year contract. The Committee noted that Alison Elliott, Director Adult Social Care had left the Council to take up the position Director of People at Portsmouth Council. The Committee thanked her for her contributions and wished her well for the future.

Brent LINk Annual report 2011/12 and 2012/13
It was explained that the commissioning process for Brent Health Watch that will replace Brent LINk at the end of March had been completed with a consortium of voluntary organisations led by Brent Mencap. Part of its role will be to act as a network of networks, working with other organisations, consulting the public and acting as a consumer champion and providing an information and advice service, action and expertise.

5. Incident involving pathology service for Brent and Harrow PCTs

Pauline Johnson (Interim Head of Quality and Safety, Brent CCG) informed the Committee that TDL had been contracted to provide a pathology service on behalf of Brent PCT, Harrow PCT and North West London Hospitals since May 2012. She explained that serious concerns were raised in December 2012 by Dr Patel, such as skewed results, results being grouped differently and results being filed without requiring actioning. It was noted that further complaints and concerns were received including abnormal potassium and calcium levels as well as missing second sample results. Following a thorough investigation, among the root causes for the issues found were; the introduction of a new IT system and a malfunctioning robotic arm. Other contributory factors were found such as lack of communication with GPs, organisational, training and human errors. Dr Patel felt that the committee should feel reassured by the alertness of GPs and as a result; no patients came to any harm.

Members expressed their concern that an incident of this nature could occur again and highlighted that they did not feel reassured that the issue could reoccur. It was queried whether all patients had been contacted. Dr Patel explained that as well as GPs individually contacting patients with abnormal results for re-tests, TDL had also

re-examined any irregular results with patients outside of normal ranges to be alerted.

It was queried whether the machines had been tested and what quality control checks were in place to avoid such incidents. Dr Patel informed the Committee that the machines used by TDL were used nationwide successfully. Alternative reagents had been used which altered some of the reference ranges despite reference ranges requiring to be standardized by the Department of Health. Dr Patel felt that the failures in equipment and issues caused by changes to the IT infrastructure could not have been foreseen. Members queried the lack of communication with GPs and felt that it was unacceptable that training was not provided in advance. Dr Patel agreed that communication should have been greater and GPs would be informed of future procurements and the timescales entailed. It was noted that the IT system presented results in a standardised way as agreed with the Department for Health and following concerns raised by Brent GPs, this system would be taken back at a national level and addressed before being cascaded down to GPs.

The report circulated was an interim report with a full report and action plan due to come back before the Committee. It was explained that many lessons had been learnt and action already taken to address issues, as well as a proactive and vigilant approach undertaken to avoid future reoccurrences. Hourly checks were taking place until the pathologists had full confidence in the system. It was clarified that a nine month embedding period existed within the contractor to address any issues early on, after which severe financial penalties could be served upon TDL. Dr Patel highlighted that some of the errors were human errors particularly in terms of incorrect form filling. Ethie Kong explained the use of forums and the knowledge shared between practitioners. She continued to highlight that training was given to the pilot practices which had trialled the system successfully however acknowledged that training may not have been received by all.

Members thanked all for the update and requested that the final report be sent to the Committee as soon as it was available.

RESOLVED:-

Members noted the report.

6. **Shaping a Healthier Future**

Rob Larkham gave a presentation highlighting the background to the shaping a healthier future initiative and the proposals that were currently being consulted upon. He drew members' attention to the vision to localise care, integrate care and a centralised consistent access to senior doctors and for specialist skills to be accessible and developed with the ultimate vision to save lives. He continued to highlight previous concerns highlighted by the Committee such as; the low satisfaction levels of primary care services; acute services being closed before alternative provision was successfully up and running; and that service provision could not remain as it was and should be reconfigured to secure a better, sustainable future for patients. The programme of change would take three to five years with option A receiving the most support and least opposition. As a result of

the feedback received several changes had been made including; development of the out of hospital strategies, a developed vision, governance process and pathways for urgent care centres; and a review and re-run of the financial, estates and capital investment analysis. Rob Larkham highlighted the specifications for urgent care centres and the types of problems they would treat. The decisions of the Joint Committee of Primary Care Trusts (JCPCT) on the 19 February were explained and how they intended to move beyond the core offering of services. The future configuration of major and local hospitals were clarified with Northwick Park being a major hospital offering A&E provision and central Middlesex being classified as a local hospital addressing urgent care, outpatients and diagnosis.

The proposed governance structure to oversee implementation was highlighted although it was confirmed that Ealing Borough Council had referred the plans back to the secretary of state which would delay the overall process whilst the independent review panel reconsidered the proposals. A clearly laid out process would be followed for key decision making before any changes were implemented. He continued to highlight the activities for the out of hospital programme, where community facilities could potentially be based and the work carried out by CCGs to deliver the out of hospital programme.

Rob Larkham explained that there was a £28m backlog of maintenance investment and a further £20m investment required at Northwick Park hospital to enable a 20% increase in maternity births, 15% increase maternity general, 23% increase neonatal activity and 33% increase in critical care activity. A capital programme of works including expansion of the A&E department, refurbishing of existing theatres as well as creating four new theatres and a new 10 bed ITU extension was required to enable the capacity increases outlined. Central Middlesex hospital would be a local and elective hospital with a £9m investment required. Rob Larkham concluded that all changes would be subject to the litmus test of whether change of services would be safer than the current provision.

Members noted the high level of detail included within the presentation and report. Members queried whether urgent care was currently being provide on a 24/7 basis due to the difficulties in recruitment. It was clarified that the provision of urgent care was reduced due to the positions not being attractive to experienced GPs and being more desirable to younger doctors who had not yet chosen an area in which to settle and develop their own practices. Members queried the extended journey times to major hospitals amongst plans to reduce the ambulance service. It was noted that the ambulance service was critical in enabling the plans and in response to anecdotal evidence provided by Councillor Cheese regarding lack of porters and ambulance staff, Rob Larkham informed the Committee that a £20m investment in the ambulance service was proposed to increase capacity and remodel the service to improve efficiency. Following queries it was explained that the greater the delay, the greater the risk to being able to sustain the correct level of surgical expertise at smaller sites and potential for services becoming unfit in the future. Members asked what controls were in place to ensure all changes did not have a detrimental effect during implementation. Rob Larkham reassured members that each decision would be mapped out against the key decision process and safety must be satisfied at each stage with work between existing and new providers taking place to enable an improved NHS and not a privatised service. Following queries regarding the timeline, it was noted that this had not been fully agreed due to the finalisation of proposals being required and investments to be confirmed, it was however hoped

that investments in the out of hospital service would start later in the year. Jo Ohlson explained that closer working relationships with CCGs, social services and voluntary organisations was needed to offer out of hospital services to reduce the pressure on Northwick Park hospital for patients who did not necessarily need hospitalisation. Members queried whether there was adequate staffing to support the primary care hubs throughout the borough. Jo Ohlson stated that a pilot would commence in April where a central hub would provide additional appointments following a £1m investment for six months, with the intention of a further £4m and the intention of six hubs being created overall, including a proposed site in Kingsbury.

Councillor Hector proposed the following motion:

"It is arguable that closing A&E at local hospitals could be appropriate if the ambulance service had been expanded so that people could be taken direct to the relevant specialist hospital. I understand that the cuts to the ambulance service that began 2 years ago are continuing. This is unacceptable. We cannot agree to this. We are therefore referring back the report 'Shaping a Healthier Future' to the Secretary of State."

Councillor Hector reiterated her concerns that the directions of the changes were heading towards privatisation and that the ambulance service should be invested in rather than cut.

The following alternative motion was proposed:

"Brent Council's Health Partnerships Overview and Scrutiny Committee notes that the London Borough of Ealing has already referred Shaping a Healthier Future to the Secretary of State. Given the scale of the changes, it is right that these proposals are thoroughly examined by the Secretary of State along with the Department for Health. The Committee wishes to further raise our concerns with current A&E capacity regardless of future changes to services and seeks assurances that services will not be reduced or closed unless changes in infrastructure prove to deliver successful outcomes for residents."

The original motion was not seconded and failed, with the alternative motion being seconded and carried.

RESOLVED:-

Members noted the report

7. Emergency Services at Northwick Park and Central Middlesex Hospitals

It was reported that Northwick Park hospital's emergency department was experiencing capacity issues partly due to the closure of Central Middlesex hospitals emergency department, LES conveyances and an increase in patients from the Harrow area. Work was currently being carried out with CCG colleagues to explore the increase in patients and whether alternative health care provision was available to non-emergency cases. A project board had been set up with stakeholders to address how it could rearrange the emergency services across the

two sites. It was noted that ambulances were able to unload and enable patients to be treated contrary to the anecdotal evidence previously heard. It was noted that the JCPCT had agreed the shaping healthier future programmes and following investment; Northwick Park hospital will have an emergency service with multifunctional treatment rooms able to accommodate the increased capacity and demand. An additional 25 bed ED department would also be built to allow quick assessments by specialist teams.

Members felt that the possible influx could be due to patients being unable to be seen by their GP and choosing to attend A&E. It was explained that a change in patient culture was needed to address this issue and hoped that the increased capacity from the primary care hubs would address this, with expressions of interests for hosting hubs taking place next week. It was queried whether out of care treatment fully addressed patients' needs and if not was this likely to lead to them attending A&E. It was explained that further work needed to be done into the care provided at nursing homes and patients being admitted for a short while to avoid unnecessary journeys and reduce pressure on emergency services.

RESOLVED:-

Members noted the report and asked for further updates on the implementation plans and timetable.

8. **North West London Hospitals and Ealing Hospital Merger**

It was explained that there had been few changes since the last update with timelines remaining the same and a merger being able to take place in April 2014 at the earliest subject to approval. It was noted that the referral by Ealing Borough Council on the Shaping Healthier Futures did not necessarily delay the business case and back office functions were currently being shared, reducing duplication and making it easier to work across both sites. It was highlighted that progress in 2012/13 had been slow with savings targets likely to be achieved through non recurrent solutions and future saving targets remaining high. Commissioning negotiations would take place next year with potential budget gaps still needing to be bridged. Greater clarity for the savings target in 2013/14 would be achieved following the sign off of contracts at the end of the month.

RESOLVED:-

Members noted the update

9. **Tackling Violence Against Women And Girls in Brent task group**

Kisi Smith-Charlemagne, Policy Officer, gave a brief overview of violence against women and girls in Brent including female genital mutilation (FGM), honour based violence (HBV) and forced marriages (FM). The Policy Officer continued to highlight the scope of the task group including the reasons why it was being explored, what the main issues were, what the review should cover and what the review could achieve. It was highlighted that there was a lack of awareness amongst victims that FGM, HBV and FM were all illegal practices and carried jail sentences, resulting in under reporting of crimes. It was explained that the main issues to cover included; highlighting and educating communities about reporting, improving access to

support as well as protecting women and girls at risk. Potential partners were outlined within the scoping document to help achieve the nine outcomes including;

- Work with partners to ensure that pathways for reporting risks and offences committed are clear, easy and stress free for women and girls.
- Educating our communities about the changes in law, the human rights breaches and the consequences of such breaches – through Schools, GP's partners and voluntary groups such as FORWARD and IKWRO.
- Informing the Brent Violence Against Women Action Group (VAWAG) strategy currently being developed
- Supporting the wok being carried out by the Brent FGM Steering Group

The Chair informed the committee that Councillors Harrison, Hunter, John, Kabir and McLennan had expressed an interest on being a member of the task group.

Councillor John highlighted the widespread practices of these crimes against women and the previous lack of awareness of the issue. She noted the recent heightened awareness, particularly the government's target to eradicate the practices within five years. Councillor John hoped that the task group would receive full support to address the issues amongst the Brent community.

RESOVLED:-

That the task group membership consists of Councillors Harrison, Hunter, John, Kabir and McLennan.

10. **Public Health transfer**

Andrew Davies, Policy and Performance Officer informed the Committee that the public health transfer would commence on 1 April 2013 and was approved by the Executive the previous week. He continued to explain that 22 public health staff would be transferred, split across three departments with a Director of Public Health for Brent only, based in Adult Social Care. It was noted that 16 out of the 22 posts had been filled with further recruitment to take place after Easter. The Policy and Performance Officer explained that the public health contracts process had been misleading and was currently awaiting confirmation from the Department of Health that the contracts had been approved. The Council would also be responsible for various aspects of the acute contracts including an open access sexual health service; including where persons wishing to be tested could be seen at any GUM clinic across the country and the costs would be charged to the borough where the person was resident. This was a demand led service and was therefore a larger area of risk with reserves budgeted to address any fluctuations.

Members queried whether the buildings vacated by transferring staff would be used and it was confirmed that these would be utilised by CCG colleagues. It was queried whether the recruitment process of the Director of Public Health had commenced. It was explained that this recruitment had not yet started due to the job advert requiring sign off and classified as a senior staff appointment. It was felt that the recruitment would not take place prior to Easter and an appointment was unlikely to be made before the end of April. Members queried why there was such a high level of risk associated with sexual health contracts. The Policy and Performance Officer explained that the service transferred was new to the Council and required a large proportion of the budget. Being a demand led service, any

fluctuation could create budget pressures hence the high level of risk. Members queried the Council's responsibility in terms of epidemics and pandemics. It was explained that the guidance surrounding infection control was vague, with the Director of Public Health being required to bring together agencies to address any pandemics but if a pandemic arose at a national level, then it was hoped national guidance would be circulated.

RESOLVED:-

Members noted the report.

11. **End of life palliative care in Brent**

The report gave an overview of palliative care provision in Brent and the end of life care strategy which sought to reduce the number of patients dying in hospitals. Cherry Armstrong, GP, informed the Committee that 64% of people in Brent currently passed away in hospital opposed to only 19% at home. The end of life care strategy sought to reduce the number of patients dying in hospitals by investing in the following areas; end of life register to coordinate social and health care, building up workforce capacity and capability through increased training, supporting primary care clinicians in increasing capacity and capability, and working with contract leads and stakeholders. It was highlighted that a multi-disciplined approach with all involved in providing the care of the patient was required.

Four sites across Brent offered specialist end of life provision including St John's Hospice, St Luke's Hospice, Pembridge Unit and Marie Curie all of which were funded by the NHS block contracts. It was noted that the end of life care strategy was essential to ensure that the patients choice was shared and that a central communication portal allowed information sharing and for patients choices to be carried out. The Liverpool Care Pathway was used to ensure a good formal pathway of care for all where an equitable model of care could be used wherever the patient was dying. An after death review would also take place to ensure the family received a good level of support and to explore if improvements could be made, ensuring a proactive rather than reactive approach. The approach was holistic taking into account patient's wishes, culture and religious beliefs.

Mike Howard, Chief Executive of St Luke's Hospice informed the Committee of the services the charity provided and the types of patients they cared for. The Hospice provided a day and medical centre, hospice at home service and training of health care professionals providing care predominantly for cancer patients but also for other terminal diseases. Mike Howard felt that the charity provided a greater level of service than that commissioned and relied heavily on donations to meet the funding demand which, contrary to the suggestion he felt was being made that it was 100% funded by the NHS, was nearer to 33% funded. To enable the Hospice to offer the level of care it did it currently relied on the help of 850 volunteers and community services. Additional services provided by the Hospice included after death support for the family, psycho social support as well as providing university accredited training.

Members noted the greater need for palliative care with an aging population but queried how this could be achieved in the current financial climate and how the

success of the scheme would be measured. Cherry Armstrong explained that the scheme was currently still in the infancy stages of training and had not been fully rolled out so the success of the scheme could not yet be measured. There was currently anecdotal evidence from GPs highlighting greater communication and awareness of patients care as well as planning care.

Members queried how the costs of a patient choosing to stay at home would be managed. It was explained that the hospices would provide the relevant care if it was suitable for the patient to remain at home and services such as respite would also be available to the carers and in house care providers sent round. It was noted that if a patient was to be placed in hospital this would also be of a cost and the scheme did not necessarily reduce costs but realigned costs to enable patients not to pass away in hospital. Members queried what health and social care would be provided and at what cost. It was explained that all health care costs provided would be free of charge, however any social care services would have the usual social care costs. The type of care provided would be dependent upon the needs of the patient and the carers but would also focus on pain relief to make sure no patient was uncomfortable or in pain. Members queried the period of the strategy. It was clarified that the strategy would be rolled out in April and be used indefinitely to enhance local service provision. Members were disappointed with the lack of detail in the report and requested that an updated and more detailed report be provided following the roll out. A copy of the Brent End of Life Strategy was requested to be circulated to members of the committee.

RESOLVED:-

(i) Members noted the report;
(ii) That an update report be provided.

12. **Khat Task Group update**

Andrew Davies, Policy and Performance Officer provided an update on the Khat task group, drawing attention to the overlap of advice from the advisory council on the misuse of drugs findings and the difficulties engaging café owners and members of the public.

RESOLVED:-

Members noted the update

13. **Work programme**

RESOLVED:-

Members noted the work programme

14. **Any other urgent business**

None.

15. **Date of next meeting**

The date of the next meeting will be confirmed at the Annual Full Council meeting on 15 May 2013.

The meeting closed at 10.15 pm

S KABIR
Chair