MINUTES OF THE COMMUNITY AND WELLBEING SCRUTINY COMMITTEE
Wednesday 24 March 2021 at 6.00 pm

PRESENT: Councillor Ketan Sheth (Chair), Councillor Colwill (Vice-Chair) and Councillors Aden, Daly, Ethapemi, Lloyd, Sangani, Shahzad and Thakkar, and co-opted members Rev. Helen Askwith, Mr Simon Goulden and Mr Alloysius Frederick. ***All members were present in a remote capacity.***

Also Present: Councillors M Butt and McLennan

1. **Apologies for absence and clarification of alternate members**

Apologies for absence were received as follows:

- Councillor Hector

2. **Declarations of interests**

Personal Interests were declared as follows:

- Councillor Sheth – Lead Governor for Central and North West London NHS Foundation Trust
- Councillor Shahzad – spouse employed by NHS
- Councillor Ethapemi – spouse employed by NHS
- Councillor Thakkar – Health and Social Care Co-ordinator for Complex Patient Management Group
- Councillor Sangani – employed by a Medical Centre
- Mr Simon Goulden – spouse governor for Sinai Jewish Primary School
- Mr Alloysius Frederick – Chair of governors for St Gregory's Catholic School and governor for Newman College

3. **Deputations (if any)**

There were no deputations received.

4. **Minutes of the previous meetings**

RESOLVED:-

that the minutes of the previous meeting held on 24 November 2020 and 19 January 2021 be approved as an accurate record of the meetings.

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

There were no matters arising.

6. **A&E Performance at Northwick Park Hospital and St Mary's Hospitals**

The Chair invited Simon Crawford (Director of Strategy and Deputy Chief Executive, London North West Healthcare NHS Trust (LNWHT) to introduce the item for discussion.

Simon Crawford began by highlighting that the past year had been unusual because of responding to COVID-19 and the challenges in the NHS and at Northwick Park in particular. He explained that 3 March 2020 was when Northwick Park had their first patient admitted with COVID-19. The hospital was under great challenge and one of the hardest hit in the early wave of the pandemic, and there was a need to respond significantly during that early wave in March and April 2020 to ensure the hospitals were not overwhelmed with presentations. This meant treating patients coming through A & E differently depending on their presentations of symptoms, learning new processes and procedures around PPE, infection control, treatment modalities and then standing down elective procedures and processes and focussing the whole response of the hospital to COVID-19. In particular, patients coming through A & E and those most critically unwell needing access to critical care beds. As part of that response beds were increased from 22 to a maximum of 50 critical care beds in Northwick Park Hospital and significantly increased High Dependency Unit (HDU) capacity from 18 beds pre-Covid to 33. This presented a logistical issue such as getting more monitors, equipment and retraining staff to support those beds. Protected pathways were also introduced such as green pathways for those without COVID-19 and red for those with COVID-19. Staff protected patients as best as possible from getting infected within the hospital. In the first wave of COVID-19 the majority of elective care was stood down, but during the second wave and using the learning from the first wave Central Middlesex Hospital and the independent sector maintained 20-30% of elective activity. Cancer patients were also seen at the Royal Marsden Clinic, London Clinic and Cromwell Hospital. Maternity services continued to be offered and there had been 4,000 births during the period.

Jon Baker (Divisional Clinical Director for Emergency and Ambulatory Care, Northwick Park Hospital) highlighted that Northwick Park Hospital was now number one in London for A & E performance and third in the country, which he noted was a huge difference to where it was when he started working there, particularly given Northwick Park was one of the busiest hospitals in London most days. He advised the Committee that Northwick Park now delivered prompt emergency care and received most ambulances, dealing with those the quickest compared to the rest of London. He felt that there was partner working end to end with the pathway starting at the front door and nurse consultants who had helped overhaul the pathways of moving ambulance patients through the system. This included what was nationally known as same day emergency care, managing patients in a more comfortable speedy environment where patients who would have in the past been admitted overnight were now seen in a large emergency floor and could leave the same day. The majority of patients presenting to A & E were medical emergencies such as heart attacks and strokes, with 6 medical consultants responding in the centre of the hospital to those. Covid patients could be seen virtually which helped with the flow to deal with the most sick patients.

Professor Frances Bowen (Interim Divisional Director of Medicine and Integrated Care, Imperial College Healthcare NHS Trust) advised that St Mary's Hospital was not able to report performance in league tables at the moment as they had been piloting new standards, but similar to Northwick Park during the first and second waves of COVID-19 had ensured rapid assessment of patients in the emergency department with a good change of pathways with Vocare and Urgent Treatment Centres to ensure potentially high risk patients were in one area. There had been a large expansion of the same day emergency care pathways and redeployment, such as surgeons who were not doing elective activity during the first wave taking on minor injury patients. In the second wave of COVID-19 therapists and neurologists were used to support the response. They had supported other hospitals who were a few weeks ahead in terms of responding to the COVID-19 waves through ambulances being diverted to who was able to take the next ambulance and enable early offloading of patients. She advised that collaborative working worked well together and there had been some good learning and now a better understanding of responding to the virus, meaning the following winter the sector would be well prepared.

The Chair thanked the health colleagues for their introductions and invited the Committee to raise comments and questions, with the following issues raised:

The Committee noted that all but time critical planned care had been cancelled and queried what was meant by time critical and how many appointments had been cancelled as a result. Simon Crawford advised that all elective procedures had been cancelled at the Northwick Park site but some activity was diverted to Central Middlesex Hospital. Northwick Park had still conducted emergency surgery for people coming through A & E and arrangements were put in place with the independent sector such as BMI The Clementine Churchill Hospital to maintain the most urgent cancer treatments in both waves of the virus. There was now more elective activity at Central Middlesex Hospital and Northwick Park had began bringing elective activity back. Frances Bowen advised that at St Mary's Hospital they only operated on the most extreme traumas and outpatients were maintained virtually during the first and second waves of the pandemic.

Simon Crawford advised that the plan for LNWHT regarding elective activity was to return to September 2020 elective activity by the end of June 2021 as part of the Integrated Care System (ICS) planning framework across NWL and to return to pre-Covid activity, dependent on any further waves, by late autumn. This was also the case for St Mary's Hospital. In relation to cancer care and treatments, Simon Crawford advised that they had focused in terms of the highest priority patients and tried to maintain access to services for cancer patients. This had not necessarily been done within the Trust as the Trust had arrangements in place with BMI The Clementine Churchill Hospital, Harrow on the Hill and The Royal Marsden to source high priority procedures, so the Trust had managed to maintain delivery of cancer services for Priority 2, 14-day, cancer patients. Frances Bowen advised that St Mary's Hospital had managed a huge amount of priority 2 work and urgent cardiac and non-cancer work. All cancer specialities had been managed equally with no particular speciality disadvantaged. Lesley Watts (Chief Executive for the North West London Integrated Care System) added that across London there was a set of emerging principles for elected programmes which would change how things were done in the future. She advised that as that work was iterated across London and North West London it would be brought back to the Committee, with the aim being to ensure equality of access across the patch particularly in Brent.

The Committee noted the improvement in performance from the first wave of the pandemic to the second wave and asked what impact the second wave had on people needing operations. Simon Crawford acknowledged that the second wave had not been easier than the first wave but they did have the benefit of the learning from the first wave, meaning the sector was better organised for treatment, modalities, PPE, systems and collaborative working. Frances Bowen added that the second wave at Imperial College London and St Mary's Hospitals was very difficult and beds increased to 150, with extremely tired staff. The hospital had continued with urgent cancer endoscopy and urgent cancer operations during the second wave. The hospital had been balancing the intensive care needs of patients with patients that were in acute respiratory units as well as doing urgent care which had been a lot to do. Some treatments trialled in the second wave had been really beneficial so outcomes for patients during the second wave were outstanding.

In response to Committee members asking if there were any teething problems from the pilot of the 111 time slots, Frances Bowen advised that the pilot had only been booking around 4-5 slots per day and it had not made much difference to the workflow through the emergency department. The pilot had not been as successful as the initial launch suggested it might be and they had not been informed of any issues around waiting times.

Discussion was held regarding the potential for digital exclusion as a result of virtual clinics. Jon Baker advised that the majority of emergency work came through the emergency

department rather than virtually, then if possible a patient could be followed up virtually. If a patient had come into hospital and was assessed as well enough to go home they could be sent home with an oximeter to measure oxygen levels and could call with any issues. If a patient was not able to use the device they would either be kept in hospital or managed in a different way to ensure there was no discrimination.

In relation to staffing, the Committee noted the recent Panorama documentary focusing on comparisons in the Coventry Hospital now and a year ago and that a number of staff had left, and asked how the hospitals in North West London were getting on in that respect. The Committee heard that Northwick Park had done a lot of work with staff since the crisis and focused a huge amount of work on wellbeing in what had been a highly stressful period. Jon Baker reflected that some staff were more used to high pressure situations such as staff within the emergency team and were therefore more ready but they had been conscious many staff had moved across the trust into different areas and therefore those staff were being provided support. Frances Bowen added that at St Mary's Hospitals a lot of staff had been redeployed and there was a focus on staff wellbeing and allowing staff some rest.

The Committee queried whether the hospitals had seen an increase in admissions to A&E due to domestic abuse or mental health issues. Jon Baker advised that sadly they did see people coming through the department due to mental health issues or domestic abuse and felt that was the case for most shifts he worked. The past few weeks had seen a heavy spike in presentations of mental health issues and there were teams to support this in the community and the Trust and a domestic abuse advisor within the department. In addition there was a youth support service at St Giles' Trust commissioned by Brent Council and psychiatric liaison nurses worked parallel with clinicians at the front door. Robyn Doran (Chief Operating Officer, Central and North West London NHS Trust) added that there had also been an increase in presentations at Central North West London NHS Foundation Trust that week in particular with a lot more children and young people presenting and more adults who were not known to the service. It was acknowledged that COVID-19 had impacted on the number of people who had never been seen in services before and the rise in children and young people presenting was suggested to be linked to young people going back to school.

The Committee asked for assurance that health partners were embedding new ways of working to ensure performance targets continued to improve going forward. Simon Crawford agreed it was important those ways of working were embedded, and across the ICS they had learnt the importance of working together in a joined up way. He assured the Committee LNWHT were embedding new practices and ensuring those were sustained and highlighted the acute medical model at Northwick Park with changes to the front door and the way patients were assessed. In response to COVID-19 a lot of attention had been given to discharge planning and consultant timings and supporting in a robust way which was becoming embedded into the normal way of doing things. Frances Bowen added that they had learnt how to flip pathways so that emergency pathways could become high, medium or low risk, could move structures and staff around and could confirm they had areas they could safely bring patients in for elective operations. She felt that COVID-19 had brought on a speed of transformation that many had never seen previously, with learnings from the first wave transferred to the second wave and consultants working together deployed to the front door and embedded in STP, pathways, discharges and communities. She advised that the process of allowing staff to recover and ensure these new processes were embedded had been hugely beneficial to people coming through the front door.

The Chair drew the item to a close and invited the Committee to make recommendations, with the following RESOLVED:

i) To note the performance report.

7. **Primary Care and GP Services in Brent and Care Quality Commission (CQC) Ratings**

Jonathan Turner (Borough Lead Director (Brent), CCG) introduced the report which provided information on standards and ratings in GP services in the Borough as rated by the CQC. The report covered the evolving landscape of primary care, the role of CQC, a summary of ratings in the Borough and how the CCG was working with practices to support them. He advised that satisfaction was generally good but there were variations and it was important as part of the work as an Integrated Care System (ICS) to address that variation. As well as GPs' core role as consultants at the start of a patient's NHS journey GPs also participated in extended primary care services such as screenings and vaccinations / immunisations, and co-ordinated with social care, the voluntary sector and the acute sector for referring and managing patients.

In relation to how the contracting mechanism worked for GPs, Jonathan Turner advised that generally the more patients a GP surgery had the more funding it would get. This was topped up through the quality and outcomes framework which had been a mainstay of general practice for 20 years. He advised that the key development in the last few years had been Primary Care Networks (PCNs) which had changed the way some practices came together as a group to support each other and consolidated some of the back office functions to standardise care. He pointed to page 44 of the report which set out the configuration of PCNs in Brent and which practices were within them, who was responsible and the clinical leads. Part of the CCGs role was to support the development of integrated care, the coming together as PCNs and the work with community nursing to ensure patients were being managed effectively as part of a whole system approach. The Committee heard that Brent was "underdoctored" in relation to GPs in the workforce with the workforce changing over time as more salaried roles become the norm and GPs took on more roles, with physios and pharmacists playing a bigger role for a more effective skills mix within practices. The additional roles and reimbursements scheme brought in by the NHS paid practices to bring in those additional roles to better support Musculoskeletal (MSK) conditions, aches and pains and those otherwise needing a referral so that they could be dealt with more quickly. A recruitment and retention programme was being introduced to ensure Brent got more qualified and experienced GPs. Jonathan Turner advised that there was a demographics challenge in Brent in relation to the number of people living in the Borough which had increased over the 20 year period and was concentrated in particular wards. As well as this the population was ageing with an increased number of people living for longer including in frail older people and people with complex comorbidities.

In relation to the CQC process, Jonathan Turner advised that every GP had an annual regulatory review which would inform how frequently that practice was reviewed depending on the rating of the annual review. Those rated inadequate or requiring improvement were therefore inspected more regularly. He advised that GPs were independent contractors not employed directly by the NHS therefore it was their responsibility to get into a better rating position but that there was a supporting role for the CCG such as running regular training workshops, conducting mock CQC inspections, supporting PCNs to provide dedicated support to individual practices and commissioning 1 to 1 support from external providers to address issues arising from CQC inspections. Part of the CCGs wider role within the ICS was addressing unwarranted variations so there was now a dashboard to look at a range of different care related metrics across practices and address unwarranted variation.

Fana Hussain (Assistant Director of Primary Care, CCG) advised the Committee that the report was a "moment in time" document and the situation changed regularly. The Committee heard that some very good practices on the list had been devastated to receive the report on CQC ratings but had taken the reports on board and made a lot of strides and changes. An area of development identified as a result of CQC ratings for PCNs in the

Borough was the requirement to have documented policies that everybody was aware of. The CCG worked closely with the CQC and this enabled the CCG to have open discussions with GPs over where their practice was going in the future.

Bethenie Woolfson (CQC) informed the Committee she had seen a positive improvement in the highest risk practices in Brent which had meant some ratings had gone up from inadequate to requires improvement. She advised that there was still a long way to go but the CQC were very pleased with that work. She mirrored comments that the CCG and CQC had a positive relationship and worked well together, engaging positively with practices. The Committee heard the CQC was moving towards a risk based approach as a regulator and at the moment were not conducting annual reviews but were using a transitional approach assessing the information held on a provider to decide whether to inspect, meaning frequency of inspection would not be used going forward.

Lesley Watts (Chief Executive for the North West London Integrated Care System) added that the ICS were trying to consolidate its oversight together with CQC in some sectors, which was already being done with major providers through oversight programs which the CQC sat on. The intention was to do that with primary care colleagues. She felt that there was a need to be more systematic within the system that assured the ICS that they were well sighted on issues which would allow for a programme of improvement.

The Chair thanked health colleagues for their introductions and invited members of the Committee to ask questions in relation to the report, with the following issues raised:

Members of the Committee highlighted that they had received complaints from constituents around changes in patient's medication to cheaper alternatives, and there was concern this would result in less effective treatment. Lesley Watts assured the Committee that any medication prescribed by GPs were approved drugs, and usually the generic cheaper alternatives were exactly the same tablet and constitution but was the recommended medication regarding price. She advised that if there was a particular reason a patient needed a particular medication rather than the generic medication then the GP could prescribe that at their discretion if they had justification. She highlighted to the Committee that every penny spent on more expensive medications that did the exact same thing was money that could not then be spent on surgery or more GPs and nurses, and advised that the prescribing of generics was incredibly carefully controlled nationally. Dr M C Patel (NWL CCG) added that there was a Prescribing Committee which looked at papers and guidance from NHSE.

The Committee highlighted Table 1 of the report, in particular section 6.1 which stated Neasden Medical Centre and Greenhill Park Surgery had ratings of 'requires improvement', and queried whether there was any correlation between deprivation or affluence and the result of a CQC rating that mitigated or complemented the result. Lesley Watts acknowledged that the aim should be to ensure there was absolutely no correlation in ratings and deprivation and that people in the most deprived areas often needed the best services and in many deprived areas did get that. Bethenie Woolfson did not believe there was a correlation. She advised there were trends across the whole system in North West London which were often related to the governance of GPs and not the area or patients of the GP. She acknowledged there may be instances where fewer GPs were available in deprived areas but usually a poorer rating was linked to the clinical leadership and governance of the practice.

In relation to national studies of patient satisfaction, the Committee queried when the surveys took place in Brent and what the outcomes were. Fana Hussain advised that the national patient survey was conducted every year and was currently underway. Satisfaction in Brent currently was at 76%, and varied across practices, for example one practice had 94% satisfaction.

Regarding screenings and immunisations, the Committee heard that the immunisation programme was conducted through a core recall system operating nationally, as was breast cancer screening. All practices would have their own systems for calling patients due for immunisation. The immunisation rates had improved in Brent, but during the pandemic there had been less uptake of cervical sitology due to patients feeling reluctant to go into practices.

The Committee asked how much locally was spent on health services. Jonathan Turner advised that there was £550m allocated for Brent which included the whole acute system and all mental health providers, not just general practice. Sheik Auladin added that the delegated budget for primary care was £110m per year which gave an idea of the level of spending in the CCG compared to other areas.

Some concern was raised regarding employment practices due to the increased number of GPs employed by one partner. Jonathan Turner highlighted that GPs were independent contractors but also part of the NHS family. He explained that employment practices had changed over the years with an expansion of salaried posts which he expressed were perfectly legitimate ways of working, which some GPs preferred as it meant they did not have the same level of responsibility for the admin and running of the practice and could concentrate on clinical work. He advised the Committee that if there were concerns or issues around general practice and employment it would be for that individual practice to resolve, with the CCG becoming involved only where necessary. Dr MC Patel added that increasingly younger GPs were doing portfolio type work where they worked as GP and did a couple of other different sessions a week and a lot of younger GPs did not want to take on that additional responsibility so practices were relying on salaried staff and those who wanted to work part time. He felt that partnerships should be encouraged.

The Committee had concerns about access to GPs, including digital access and exclusion. Fana Hussain advised that GP access was monitored on a monthly basis. The NHSE website published a number of appointments available and the data for February 2021 had been reviewed which had shown Brent practices continued to provide GP access digitally, face to face and by appointment. Sheik Auladin (NWL CCG) advised that during the first wave of the pandemic there had been a lot of e-consultation but during the second wave GPs had seen patients through a mixture of e-consultation and on a face to face basis, therefore patients without access to IT were able to see their GP. A conversation was had regarding who councillors could contact in relation issues with residents accessing GPs, with the advice being to contact the GP in the first instance through their complaints procedure and let the CCG know. CCG colleagues agreed to provide a formalised contact for the specific purpose of giving councillors a place to go for resident GP concerns. The CQC added that from April 2021 they would be looking at GP access in Brent and encouraged anyone to share their experiences of access via the CQC website which could be done anonymously.

It was highlighted that due to COVID-19 relatives were not allowed to attend hospitals with patients, and the Committee queried what support was available from GPs for patients going for hospital treatments or urgent care who may rely on relatives to help them communicate, such as those with a language barrier. Lesley Watts advised that visiting was being looked at currently in all acute hospitals across London to put something in place, but there were always exceptional circumstances to consider, so if there were specific needs or a patient was end of life visiting was allowed.

Committee members highlighted that they had received information from residents that there had been a couple of incidences of “list cleansing” where patients had expected COVID-19 vaccination calls and had not received them as they had been removed from the list for not visiting their doctor for so long. Lesley Watts confirmed that any patient in the

appropriate cohorts could be vaccinated whether they were referred by their GP or not and could book an appointment through one of the vaccination hubs. The Committee highlighted that this message could be better publicised to ensure people in the relevant cohorts were not waiting for their invitation from their GPs. Lesley Watts agreed to talk with the vaccination lead the following day regarding messaging on this and work with Council Officers for communications.

As there were no further questions, the Chair thanked Committee and invited recommendations, with the following recommendations RESOLVED:

i) To note the contents of the reports and receive assurance on the management and support structures in place to improve standards of care in GPs in Brent.

8. GP Access Members' Scrutiny Task Group Scoping Paper

Councillor Mary Daly introduced the report which enabled members of the Committee to commission a task group on GP and primary care accessibility in the borough of Brent. She explained that the paper had been inspired by Councillor Abdi Aden's constituent experiences in Stonebridge in relation to accessing GP services during the pandemic. Councillor Daly felt that the task group should look at comparisons of the more affluent wards in Brent and North West London and the investment precedent in those wards, including the number of GPs per head and a few other agreed indicators, which may or may not show the degree of equity within primary care. She also thought there should be comparisons of the best and worst GP surgeries in the Borough. She expressed that she looked forward to the first meeting to distil further what the group wanted to look at in the task group sessions..

The Chair thanked Councillor Daly for introducing the scoping paper and invited those present to ask questions, with the following issues raised:

Dr M C Patel (NWL CCG) agreed that looking at comparisons of deprived and affluent wards and good and bad practices would be a useful activity. He highlighted that the scoping paper was based on a paper from 2010 and some factors were relevant but others were not, therefore suggested the group worked together with primary care to look at outcomes as well as access, to develop something with significant meaning that was helpful to GPs, Brent Council, members and constituents.

Sheik Auladin (NWL CCG) reiterated that they were happy to work with the Council on the task group. He advised that a lot of work had been done by the Integrated Care System (ICS) around North West London primary care and levelling up in Brent. He informed the Committee that a lot of investment was coming to Brent as part of that process and there was a need to ensure that was reflected in any discussions on primary care going forward. Jo Ohlsen (Accountable Officer, NWL CCG) emphasised this, expressing that they wanted to be assured in North West London that they were reducing health inequalities within and across boroughs. She highlighted that as part of the merger to a single CCG they had agreed they would move investment from some more affluent parts in North West London to places like Brent, and the first area that was being done was diabetes and mental health. Jo Ohlsen would share the data the group were seeking which would influence where changes were made. In response, the Committee highlighted the importance of not creating a 2 tier set of patients, for example ensuring that if digital access tools were used for the treatment and monitoring of diabetes patients the same treatment and monitoring was available for patients without that type of access.

The Committee also wanted the task group to explore what services Primary Care Networks (PCNs) would provide and the number of doctors attributed to different areas, and consider the pre and post covid environment in their discussions.

The Chair moved on to invite Committee members to make recommendations, with the following recommendations RESOLVED:

i) To agree the scope of the scrutiny task group review including the membership and terms of reference as set out in Appendix 1 of the report.

9. **Any other urgent business**

Contract with AT Medics

The Chair advised the Committee that he would be taking an additional item under any other urgent business in accordance with Standing Order 60. The item was in relation to the APMS contracts that were held by AT Medics. The item was considered urgent as it had been discussed at the Brent CCG meeting the previous week, resulting in considerable interest amongst residents and councillors.

Jo Ohlson (Accountable Officer, NWL CCG) explained that there were 2 APMS contracts in Brent held by AT Medics. An APMS contract had more detail and KPIs than other GP contracts. AT Medics had approached the CCG at the end of the previous year to seek consent for a change of control. As a result the control had moved to Operose which was a British based company dealing with healthcare. As Accountable Officers across London it was agreed this would be looked at collectively in relation to seeking legal advice and due diligence, including looking at their financial standing and other governance measures. A number of assurance were sought from AT Medics, who the contract remained with, and they concluded there would be no change to the services being provided or to the staff providing them throughout London. Assurance was also sought that the current directors would remain involved in the service, and although they would no longer be statutory directors they would be directors on Operose and involved in the management of the practices. Jo Ohlsen advised that if there were any changes in relation to service provision or concerns about services having changed as a result of the change in control that would be picked up by Fana Hussain (Assistant Director of Primary Care, CCG) and her team who would continue to manage those contracts.

The Chair thanked Joe Ohlson for providing the background information and invited members of the Committee to ask questions, with the following issues raised:

The Committee queried why the change was taking place if nothing would change regarding the services or financially. Jo Ohlson clarified that the APMS contract had not been given up but that there had been a change in the owner of AT Medics, therefore no TUPE indications applied. In relation to the reason behind the change, Jo Ohlson advised she had met with the Chief Executive of AT Medics across London and in their view there was a benefit in coming together with Operose for the skills they had around population health management. She confirmed it was a decision for AT Medics to make regarding who they wanted to work with and the CCGs job was to be assured they would continue to provide the services to the same standard as they were currently doing and hopefully improve them. She added that AT medics was rated good by the CQC and had gone into areas that were difficult to provide services and recruit to and been able to do that.

In relation to Operose's financial standing, the Committee expressed concerns at their most recently submitted accounts records. Jo Ohlson advised that due diligence had been completed and they had been assured that they were fit to hold the contract and added that any concern in that regard would be followed up immediately. In relation to the CCGs ability to control the change of contract, the Committee were advised that the CCG were being sought their consent and there was no legal reason or basis in which they could have stopped the change in control as there had been no change to the service provided. The

ability to consult or insist on consultation was limited also as there was no substantial change of service to patients and that would leave the CCG open to questioning every practice merger. Jo Ohlson assured the Committee that the CCG would continue to ensure the services patients had received would continue and monitor in the way they would monitor any other practices in Brent to ensure services were delivered.

The Committee raised concerns about data privacy with Operose. Jo Ohhlson explained that they had requested a cast iron guarantee there would be no sharing of data outside of the UK which they had received and if there was any transgression of that it would be picked up.

The Committee acknowledged that this was a difficult and unusual situation but felt that there was not enough time or information present to understand the issue in full. As a result, the Chair drew discussions to a close and invited the Committee to make recommendations, with the following RESOLVED:

i) To request that the CCG provide a written briefing note to the Chair in relation to the matter and to respond to questions as submitted by the Committee within that note. The Committee then delegates to the Chair to take a view as to whether the matter requires a further scrutiny of the matter following that briefing note.

The meeting closed at 8:02 pm

COUNCILLOR KETAN SHETH, CHAIR