MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
Wednesday 24 July 2013 at 7.00 pm

PRESENT: Councillor Daly (Chair), Councillor Hunter (Vice-Chair) and Councillors Harrison, Hector, Hossain and Ketan Sheth

Also present: Councillors Butt, Cheese and Mitchell-Murray and health representatives Tina Benson, David Cheeseman, Jon Knott, Ethie Kong, Rob Larkman, Sarah Mansuralli and Ian Winstanley

Apologies for absence were received from: Councillors Colwill and Leaman

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

None declared.

2. **Minutes of the previous meeting**

Councillor Hunter informed the Committee that she had raised with Democratic Services that the health attendees be recorded as present on the minutes for information and courtesy. Members also raised concern was also raised that the minutes for the Pathology item did not record the response from the CCG and Dr Patel about whether TDL were accredited.

Councillor Hector highlighted that her request to amend the minutes of the meeting held on 19 March 2013 were not recorded and that Councillor Cheese's comments should be reflected as " Councillor Cheese knows from contacts examples of patients waiting hours on the ranks outside Northwick Park Hospital with staff going out to treat them on the rank."

RESOLVED:-

that the minutes of the previous meeting held on 11 June 2013 be approved as an accurate record of the meeting subject to the following amendment:

(i) Page 2, first and third paragraph to be amended to reflect that samples should be transported in temperature controlled containers

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

Sexual and Reproductive Health Service in Brent

It was clarified that sexual health prevention would be referred to as sexual health promotion in future.

4. **Brent CCG: Commissioning Intentions**

Sarah Mansuralli, Brent CCG informed the Committee that the report set out the work plan for 2013/14, objectives and approach, providing an overview of how budgets would be allocated. The report highlighted quality innovation and productivity plans as well as the way health services were commissioned and how the decision to procure services was taken. It was explained that there were three ways in which health services could be procured; rolling and varying existing contracts, "any qualified provider" and through a traditional tendering process. Under the NHS reforms, transactional support would be provided in terms of managing contract performance, business intelligence and supporting decisions to enable implementation by the CSU (Commissioning Support Unit). It was explained that there was a new interface of working with the CSU and although a few teething problems these were overcome through good governance and working relationship with the CSU.

Rob Larkman, CCG highlighted that the commissioning process was cyclical, where priorities were formed through consultation with public providers and the local authority and services commissioned to meet the needs of residents.

During discussion, members queried how the requirement to consult on commissioning decisions had been fulfilled. Rob Larkman informed the Committee that previous contracts such as out patient services were brought to the Committee for consultation. He clarified that the contracts for cardiology and ophthalmology were currently at the preferred provider stage and therefore some information was not available as it was commercially sensitive. Members queried the reliance on GPs to carry out additional cardiology and ophthalmology services. It was clarified that the bids were from secondary care providers moving into the community. Members highlighted that the contract specification appeared generic and appeared to suggest that there would be fewer first and second appointments for cardiology and ophthalmology and whether this represented a cut in the service. Ethie Kong clarified that the service would be complemented by those provided in primary care, resulting in the patient being able to receive greater services such as diagnostics and ECGs at a surgery rather than needing to be referred to hospital. Investment in cardiology equipment was taking place to offer an enhanced primary care service. In response to queried regarding other enhanced services provided, Ethie Kong explained that some GPs offered diabetes clinics with individual cases being supported and managed where appropriate. Enhanced services for ophthalmology included enhanced diagnostic checks through tracking high blood pressure rather than following the tradition route of referring to a hospital for basic checks. Ethie Kong highlighted in response to questions that she did not have specific data relating to the number of patients who had been referred to hospitals for ECGs but agreed to provide the Committee with a copy of the recent CCG investment study. Following queries in relation to the recent GP survey results and the lack of access to detailed data through the survey website, Ian Winstanley agreed to provide full data for Brent CCG and Brent GP practices broken down and analysed in a similar way to the survey received by the Committee several years ago. It was agreed that this information would be passed to the Committee, as the basis for an agenda item on G.P access at the next meeting. Ethie Kong informed the Committee that all 67 GP surgeries in Brent had signed up to receive investment and therefore all surgeries should have the same equipment to enable GPs to carry out service beyond the original contract. Following queries on how much had been invested, it

was agreed that this information would be provided. In response to queries when all surgeries would have the ECG machines, it was confirmed that all machines had been ordered however they would not be used until GPs had received appropriate training and if members had any specific surgeries they had queries on then specific information could be provided outside the meeting. Members queried how they intended surgery extended operating hours to work. It was explained that the extended operating hours linked to the GP locality service where each locality would have an extended practice in which GPs had a share. It was agreed that a detailed report would be brought to a future meeting for the Committee to explore GP access further. In response to queries regarding enhanced ophthalmology it was explained that all bids would include the ability for GPs to consult an optometrist prior to referring a patient and being able to refer directly as well as be supported by consultants to manage patients. Ian Winstanley felt it would be suitable for the providers once appointed to present the enhanced service offered to the Committee. Members queried diabetic retina screening and it was confirmed that this was the commissioning responsibility of NHS England and therefore CCG representatives would not have detailed information available for the Committee.

Members drew the CCG representative's attention to concern that stakeholders and residents had not been adequately consulted on the proposed commissioning arrangements. Sarah Mansuralli informed the panel that the CCG regularly consulted the public and patients and the commissioning arrangements specifically required that consultation took place. It was clarified that the procurement process required a statutory consultation with patients, the residents and patient representation on procurement panelsFwave, with the EDEN Committee ensuring that the CCG fulfilled its statutory consultation duties. In response to queries regarding rolling over existing contracts, it was clarified that following the establishment of the JSNA needs assessment and priorities, three waves of commissioning were agreed, with the next wave not commencing until the previous wave was completed. Wave 1 was the commissioning of cardiology/ophthalmology services; wave 2 is musculoskeletal/ rheumatology /trauma and orthopaedics/gynaecology; wave 3 is any other remaining services. It was explained that the majority of contracts were rolled over in line with NHS England Planning guidance with adjustments for QIPP embedded into contracts and budgets where possible. Contracts that required adjustment were negotiated early in the commissioning cycle to enable acute contract activity and investment. Sarah Mansuralli informed the Committee that procurement often took place due to poor provider performance, opportunity to commission innovative models of care, opportunity to provide services closer to home and potential to achieve better value for money. Ian Winstanley informed the Committee medical consultants were worked with to ensure best practice was sought and consulted as part of the process as well as undertaking the statutory consultation process. Rob Larkman clarified that consultation was embedded within the commissioning governance arrangements and consulted partners and stakeholders as well as the EDEN consultation group, going beyond the required statutory consultation. Rob Larkman agreed to provide the Committee with a list of consultees for cardiology and ophthalmology procurements. The Committee queried the provider for services where a reprocurement exercise had taken place and whether these services were suitable. It was confirmed that the existing service provider had received the decommissioning notices and continued to provide service until an appointment was made. It was explained that the current service provider had reapplied for the contract and audits had been carried out to ensure there had been no impact on

service delivery and to ensure patient safety. It was explained that the decision to reprocure occurred after the current service provider were unsure whether they would be able to meet the needs of the CCG following dialogue so it was agreed to test the market. It was clarified that a competitive dialogue was required to ensure that the CCG delivered the best service in terms of changes to technology and efficiencies. Rob Larkman informed the Committee that the service currently provided did not support patients close to home and was to be reoccurred to improve the service to individuals through the quality received and improved access. Members queried whether the improvements to service were based on GPs taking on additional work and whether this was feasible. It was clarified that this was dependent on the model procured from the competitive dialogue but GPs were to be looked at within the process. In response to queries regarding the improved health outcomes priority, it was explained that £13m will be invested into services through the assistance of QIPP to improve services such as dementia and learning disabilities, with a large quantity of the investment being released in 2013/14. In relation to the shaping healthier futures initiative, it was felt that the investment proposals supported the scheme due to the shift of providing out of hospital care enabling a safer sustainable service in hospitals. It was clarified that the investment was in line to support out of hospital services and to comply with legal standards, testing the market was required.

RESOLVED:

(i) That the report be noted
(ii) That a copy of the CCG investment study be provided
(iii) Information be provided regarding the level of investment in GP surgeries'
(iv) Information on Brent CCG and Brent GP practices broken down and analysed to be sent to the Committee based on the latest survey results
(v) A report be provided on the extended opening hours of GP surgeries
(vi) A list of consultees be provided to the Committee

5. Emergency Services at North West London Hospitals

Tina Benson, Director of Operations, informed the Committee that the report addressed the emergency care pathways, the work required to enable improvements and the strategies that had already been put in place. It was reported that there had been a positive impact with the target for 95% of A&E patients to be seen within four hours being met for the past two months. It was reported that there were no incidents of patients being treated in the ambulance in June and an average of two cases per week where patients had to wait in the ambulance for 30 minutes. It was clarified that bed capacity was a key issue in the A&E department and to cope with surges in demand, a lower occupancy level was required. Concern was expressed regarding the bed occupancy level in the future winter months and weekly meetings were taking place between CCG and GP representatives to ensure pathways were in place to enable more bed spaces to be released in the A&E department. Tina Benson drew the Committees attention to a non compliance of section 19 of the Health Social Care Act 2008 following an unannounced visit by the CQC. It was explained that the non compliance related to a do not resuscitate form that had not been countersigned by the consultant and an action plan had been put in place to address this. Internal audits had been carried

out successfully. St Marks had been revisited by the CQC and found to be compliant and Northwick Park Hospital was awaiting a revisit from the CQC to assess its compliance.

During discussion, members queried the use of Central Middlesex Hospital. It was explained that the hospital was being used proactively with an increase in conveyances and a maintained 24 hour urgent care centre. It was reported that the emergency department operated from 8am-7pm with patients being seen by the urgent care centre after 7pm. It was highlighted that an enhanced recovery service was offered at Central Middlesex Hospital that enabled a faster recovery rate and increased survival rate for surgery on fractured hips.

Jon Knott, London Ambulance Service informed the Committee that there had been a 6.2% increase in admittance to Central Middlesex Hospital and a decrease at Northwick Park, demonstrating the successful support of Northwick Park Hospital. It was highlighted that there had been an increase in accessing alternative services rather than calling an ambulance. It was also pointed outthat a number of residents located in the South of the borough werebeing taken to St Mary's Hospital. Members queried why residents from the Harlesden ward despite living in close proximity to Central Middlesex Hospital were taken to St Mary's. Jon Knott explained that each hospital provided different services and specialisms and it may be more appropriate in certain cases to bypass the local hospital and go to one that had a centre of excellence. Members queried the "non conveyed" figures for ambulance attendances and how these arose. It was confirmed that one of the reasons that patients may not be conveyed would be if they have passed away. Other reasons would be that it was not necessary to convey them because they could be treated on site, or that the patient had been miscategorised. It was explained that if it was unclear what category a case should be placed in at the time a call was taken they would always be placed in the higher category.

During discussion members queried whether an increase in service had been seen due to the recent heat wave. Tina Benson informed the Committee that Brent had been largely unaffected by the heat wave and due to good performance, had been able to assist other hospitals that were struggling to meet demand. In response to queries regarding the number of consultants at weekends, it was explained that this had not yet happened although an advert was placed seeking five consultants and hoped to have them in place by October to add support at weekends. In response to diverted ambulance en route to the maternity department, it was clarified that some ambulances are directed to go elsewhere either due to preference of pressures at the hospital. In response to queries regarding the new A&E department at Northwick park Hospital and whether this would require extra doctors, it was clarified that it was due to be completed in May 2014 and would be the same size but adjacent to the theatres and designed to improve flow creating efficiencies and increased nursing staff. In response to queries regarding high ED users, it was explained that a group had been established to review the data and governance arrangements with work being undertaken with GPs regarding the top 2000 callers and what action can be taken to stop them attending hospital where appropriate.

RESOLVED:

That the report be noted

6. **Pathology Incidents: Update**

Ian Winstanley, CCG, gave an overview of the governance and quality framework and the process undertaken. He highlighted that there were internal and external processes which the lab followed including external quality assurance testing and internal controls to assure results in the appropriate scales. Ian Winstanley drew member's attention to the local clinical assurance process overseeing three organisations and the regulatory framework clinical governance overview to assure quality of services.

Dr Patel informed the Committee that the application for accreditation for the service had been sent off and was currently awaiting appropriate resource from the accreditation authority to visit the pathology service and highlighted that a detailed response from TDL had been sent to the Chair of the Health Partnership Overview and Scrutiny Committee. Members highlighted the response at the previous Committee implying that the service had been accredited. It was clarified that at the last Committee they were under the impression that the accreditation was completed however subsequently they had received information that it was still awaiting inspection. Rob Larkman explained that TDL was an accredited company and for a local service to become accredited it first had to go live. Members expressed concern that a major incident had occurred and that the service may not be safe or effective and despite the service being in place since May 2012, accreditation had not been obtained. Dr Patel said he would resend a copy of the response regarding the TDL framework to the Chair. Members expressed concern about monitoring of the service and queried what had been done to improve monitoring. Dr Patel acknowledged that the monitoring was not robust enough and following a meeting with TDL and hospital consultants robust monitoring was put in place. As a consequence of the incident a national issue was highlighted regarding the reporting and changes were being made nationally as a result. It was explained that discussions were taking place with the client to explore what options were available for temperature controlled transportation of conveyancing samples. Members continued to express concern that the service was not yet accredited and requested that the item be brought back to the next Committee. Ian Winstanley invited members to visit the lab to see how it functioned and to alleviate concerns.

RESOLVED:

(i) That members noted the report
(ii) That the item be placed on future agendas until accreditation was secured

7. **Central Middlesex Hospital UCC Incident: Update Report**

Ian Winstanley, CCG, informed members that following the X-ray incident in October 2012, the provider had been contacted to ensure that all patients potentially affected had been located and contacted. He was pleased to inform the Committee that the remaining 11 patients had been contacted and the incident could be formally closed. During discussion it was noted that approximately 30 cases needed further investigation. It was clarified that no additional funding had been provided to the company to carry out the investigatory work and it was clarified that no other service had been affected by the potential reallocation of

budgets by the provider. Following concerns that the public purse may have been used to carry out the investigatory work; Ian Winstanley offered to invite the providers to a future meeting. Members requested that a short report be provided for the next meeting confirming whether further treatment had been required by any of the affected patients and what improvements had been made to the monitoring of the contract.

RESOLVED:

(i) Members noted the report
(ii) That an update report be provided at the next meeting

8. **Healthwatch Progress Update**

Ann O'Neill, Health Watch Brent, provided an update to the Committee on recent activity including getting up and running, membership, community engagement and relationship building. It was noted that although community directors had now been elected, they were taking steps to get a young director and to involve younger people in general. Ann O'Neill reported that work was being undertaken on gathering views at outreach meetings and it was felt that although there was a lot happening in the health service, the public were not aware of it. Issues were reported on a particular GP centre, audiology service and dementia service and it was noted that further work was required regarding each of these areas. Healthwatch Brent hoped to hold a focus group regarding the CQC consultation with the aim of making residents feeling comfortable and able to report and issues or concerns that they have regarding health providers. Ann O'Neill informed the Committee that the membership had now increased to 60 with the next steps requiring the recruitment of a coordinator; provide training at the end of August or September and to build links with other HealthWatch organisations.

During discussion members queried whether a diverse range of people were getting involved at various outreach meetings. It was explained that members tended to be over 30 years old although specific information was not available for the meeting. During discussion it was explained that the website was a standard template provided by Healthwatch England and was proving difficult to customise. It was noted that the director biographies were currently being uploaded and that they hoped to have the website completed by mid September.

RESOLVED:

That the report be noted

9. **Health Partnerships Overview and Scrutiny work programme 2013-14**

The Chair invited members of the Committee to comment on the work programme.

RESOLVED:

That the following items to added:

(i) Access to GPs – Current and future
(ii) Current diabetes services and future commissioning

10. **Any Other Urgent Business**

In response to queries as to whether Brent was going to submit a response in relation to the Independent Reconfiguration Panel regarding the Shaping Healthier Futures initiative it was confirmed that the Leader of the Council had sent a response.

The Chair informed the Committee that she had requested information regarding the cost of interim/agency staff on the NHS and confirmed a cost of £24,000 per month. The Chair requested details of how many of the interim staff were managers. It was clarified that names could not be provided but the CCG would collate a list of posts. Sarah Mansuralli explained that it had been previously difficult to recruit to senior roles and was pleased to informed the Committee that recruitment of two senior posts would commence this week with a further two posts to follow.

11. **Date of Next Meeting**

RESOLVED:

It was noted that the next scheduled meeting would take place on 8 October 2013.

The meeting closed at 9.15 pm

M DALY
Chair