MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
Tuesday 8 October 2013 at 7.00 pm

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

Also present: Councillors Cheese and Hirani (Lead Member for Adults and Health)

An apology for absence was received from: Councillors Harrison

NHS representatives present: Tina Benson (Director of Operations, North West London NHS Hospitals Trust), David Cheesman (Director of Strategy, North West London NHS Hospitals Trust), Mark Creelman (Brent Customer Account Director, North West London Commissioning Unit), Rob Larkman (Chief Officer, Brent, Ealing, Harrow and Hillingdon Clinical Commissioning Group), Ethie Kong (Chair, Brent Clinical Commissioning Group), Sarah Mansuralli (Assistant Chief Operating Officer, Brent Clinical Commissioning Group) Jo Ohlson (Chief Operating Officer, Brent Clinical Commissioning Group), Julie Sands (Deputy Head of Primary Care – North West London, NHS England) and Ian Winstanley (Assistant Chief Operating Officer, Brent Clinical Commissioning Group)

Brent Council officers present: Mark Burgin (Policy and Performance Officer, Strategy, Partnerships and Improvement), Toby Howes (Senior Democratic Services Officer, Legal and Procurement), Phil Porter (Interim Director, Adult Social Services) and Melanie Smith (Director of Public Health, Adult Social Services)

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

None declared.

2. **Minutes of the previous meeting held on 24 July 2013**

RESOLVED:-

that the minutes of the previous meeting held on 24 July 2013 be approved as an accurate record of the meeting, subject to the following amendment:-

- Page 1, under ‘Also present’, add ‘Councillor Hirani (Lead Member for Adults and Health).

3. **Matters arising**

Brent Clinical Commissioning Group: commissioning intentions

In reply to queries from Members, Rob Larkman (Chief Officer, Brent, Ealing, Harrow and Hillingdon Clinical Commissioning Groups) confirmed that a list of consultees for cardiology and ophthalmology procurements and a copy of the Brent

Clinical Commissioning Group (CCG) investment study had been provided to the Committee.

4. **GP and Primary Care Access and Service Provision**

Julie Sands (Deputy Head of Primary Care, North West London NHS, NHS England) introduced the first report on access to primary medical services in Brent. She informed the Committee that the national GP patient survey 2012-2013 had been analysed to identify what areas were in need of improvement. In Brent's case, there had been a considerable variation in GP practices across the borough in relation to patient access, both in terms of practice opening times and in how patients rated access. This was an issue that was mirrored across England and was of some concern. Julie Sands advised that the national Assurance Framework, developed by NHS England, bought together a range of demographic and performance issues about practices, including reported patient satisfaction on accessing GP services, and this information would be used to identify and manages practices where there were concerns about the level of service provided. NHS England would carry out an investigation into the underlying reasons for any concerns or dissatisfaction with a particular practice and depending on the circumstances of each case, the course of action to address this may involve encouraging best practice with other high performing practices in the locality, taking remedial action or in more serious situations or where the problems had continued in the longer term, using contractual levers such as breach notices and control sanctions.

Referring to the Standard General Medical Services Contract in the second supplementary agenda, Julie Sands advised that this was nationally prescribed. However, there was no specific criteria in respect of access provision. Members noted that there was a range of different kinds of contracts that the provider may have with the NHS, however every effort was made to encourage practices to offer enhanced services, although this was optional. Members noted the types of contract and the services offered by each practice in Brent as set out in the first supplementary agenda.

Jo Ohlson (Chief Operating Officer, Brent CCG) then presented the second report on supporting practice improvement and primary care development that detailed the outcome of the Access Choice and Experience (ACE) programme and the work of Brent CCG since April 2012. An update on the outcome of patient satisfaction rates was also included, comparing results with 2009/2010, 2010/2011 and 2012/2013 respectively. It was noted that the biggest improvement in Brent was satisfaction in being able to get through to a practice by phone. Jo Ohlson advised that there had also been some improvement in being able to obtain an appointment reasonably quickly. However, in respect of satisfaction with the opening hours of GP practices, this had seen a slight reduction and this mirrored the trend nationally.

With regard to Brent CCG support to improving care, the following strategies had been developed to underpin this:-

- Supporting development and implementation of practice improvement plans
- Investing in additional primary care capacity
- Transforming primary care as part of developing out of hospital services

Jo Ohlson explained that Brent CCG worked with practices to ensure that they were fully compliant with their improvement plans when they registered with the Care Quality Commission in April 2013. The CCG had also invested £500,000 per annum for 2012/2013 and 2013/2014 to improve practice premises in areas such as control of infection and accessible premises for people with disabilities. In order to increase capacity and patient satisfaction, Brent CCG was commissioning additional bookable appointments via a patient's GP practice in five locality centres on a pilot basis for six months and involved GP and nurse appointments availability between 15:00 and 21:00 hours Monday to Friday and 09:00 to 21:00 on Saturdays. In addition, members heard that there were a number of work streams to develop out of hospital services, including identifying the need to create locality centres in Kingsbury and South Kilburn. It was noted that NHS England had already approved funding for a locality centre in Kingsbury. Jo Ohlson added that Brent CCG was working with the support of the North West London Strategy and Transformation Team to develop an outline business cases for Central Middlesex Hospital (CMH) to be a hub plus for primary and community services, including specialist diagnostic services, outpatients and GP services and for Wembley and Willesden Centres for Health to be hubs with extended community services. The eight North West London CCGs were also developing outcomes and standards that all out of hospital providers would be required to meet and these would complement standards in the national contract.

Members then discussed the item and raised a number of issues. A member commented that although there had been some improvements in the most recent survey compared to previous surveys, there remained considerable variation in patient satisfaction of GP practices, including within a particular locality. She sought further details as to what levers and sanctions could be used, including where there had been breaches of contract. Another member commented that as hospital services were being reduced, GP practices should be offering more services and she asked for the most recent data on the uptake of the pilot scheme in some practices offering additional appointments with GPs and nurses. Confirmation was sought that all Brent GP practices were subject to the Quality and Outcomes Framework and when would the Primary Care Assurances Framework apply. In respect of performance, details were sought on the number of practices in Brent identified as poor performers and what action had been taken to date to address this. Furthermore, it was enquired whether poor performance could often be attributed to poor leadership. It was also asked whether single partner practices were more likely to be performing poorly than larger practices. A member asked how performance was being benchmarked with other local authorities. In respect of the patient survey, it was asked how difficult it was to take resultant action because of the level of robustness of information that had been obtained from it.

A member referred to appendix two of the report, covering additional enhances services being offered by GPs, and expressed concern on the lack of practices providing services for diabetes, especially as this condition was relatively high in Brent and she asked for an explanation as to why this was the case. She also felt that the lack of practices making claims in respect of cardiology services was not encouraging. Another member noted the lack of practices offering psychological therapy services and enquired whether they were being encouraged to opt in to this service. Another member commented that with the additional pressure on GP practices following changes to the NHS and the commissioning being undertaken and the reduction in budgets for services such as cardiology, what action was being

taken to ensure improvements to services in such areas. Confirmation was also sought in respect of the variation of charges for ECGs and the reasons for these, particularly as the fees for ECGs undertaken by hospitals was considerably higher than those done by GP practices.

In reply to the issues raised by members, Julie Sands advised that the practice contracts does not specify particular targets but states that practices must meet the reasonable needs of patients and show evidence of this. Where practices appear to be under performing, NHS England investigates the reasons for this and also draws on other information, which if revealing serious issues, provides it with greater leverage to take action. Where practices have been identified as having some weaknesses, initially a remedial notice that would include an action plan would be issued. If this did not address the issue or it was more serious, then a breach of contract notice would be issued, or, in the most serious of situations, the contract could be terminated. However, in the majority of cases, practices responded positively in working to address concerns and collaborate with NHS England to achieve desirable outcomes. Practices were also encouraged to consider alternative ways of providing services in order to facilitate improvements, such as using other technologies to be accessible to patients, including e-mail. Members noted that the programme of action for those practices identified as having some concerns had recently commenced and the first practice would be visited this week.

Julie Sands advised that eight practices had been identified as first priority for the need for action, with a further six practices categorised as second priority. In the past, there had been a correlation between poorer performing practices and smaller practices, however this was not so apparent now and indeed there were some larger practices in North West London that were having difficulties. Julie Sands advised that there had been some changes to the patient survey since the initial one in 2009, with the language softened to encourage responses, although this sometimes led to more vague feedback. She informed members that comparisons between practices in Brent and with other London boroughs could be provided, adding that sharing data between practices with similar demographics would be particularly useful.

Julia Sands confirmed that practices in Brent had been subject to the Quality and Outcomes Framework since 2004. The Primary Care Assurances Framework had been published in May 2013 and was in the process of being rolled out across England.

Jo Ohlson advised that the pilot scheme offering additional appointments had started in September and the data from the first week had shown an uptake of between 30% and 50%, although nurse consultations had a lower uptake that those with GPs. As a result, the possibility of offering nurse consultation up to two weeks in advance and sharing nurses across practices was being looked at. Jo Ohlson added that selected practices from Wembley and Kingsbury localities had commenced the pilot scheme this week and the initial data for this would be provided to Mark Burgin (Policy and Performance Officer, Strategy, Partnerships and Improvement). The committee heard that the practices who were participating in the pilot scheme were not receiving additional funds, so it would be difficult for them to employ more staff to help them offer services for the extra hours provided.

Jo Ohlson advised that Brent CCG was working with the practices identified to seek improvements and the concerns raised were not generally attributable to weak management. Many practices also faced especially challenging circumstances and patient satisfaction with access did not necessarily correlate with the opening hours as some areas were more demanding than others. Members noted that there were no shared patient records between practices and their hubs and there was also variation between how each locality transferred this information. In respect of funding reductions for some specialist services such as cardiology, Jo Ohlson stated this may result in the reduction of follow up appointments in some cases, however she informed members that she would seek more information on this and respond to this query. With regard to diabetes services, Jo Ohlson explained that the role of GP practices was primarily to identify the condition and refer accordingly, rather than provide on-going clinical support and a number of practices in Brent already provided this. Diabetes services remained available in hospitals and because of the rise of this condition in Brent, consideration would be given to expanding the service in this setting. Members heard that the claims submitted from practices as detailed in appendix two were from quarter one of 2013-2014 and a number of practices had submitted claims since then. Whilst practices may want to offer particular services, sometimes this was not feasible due to capacity limitations and it was part of the commissioning teams' role to provide practices the appropriate support.

Ethie Kong (Chair, Brent CCG) emphasised the importance of working with patients to improve access to services and of being sensitive to the needs of the local community. She advised that some practices were unable to offer ECGs so would refer patients to a hospital whose fees are higher. However, investment and training to provide ECGs was available for practices and if they already had the necessary equipment, they were obliged to offer this service. Ethie Kong added that practices' uptake of ECG equipment in Brent was quite good.

Sarah Mansuralli (Brent CCG) advised that as some practices did not have sufficient space to provide certain services, arrangements were made to ensure that hubs within localities could provide these.

5. Brent CCG: Wave 2 Commissioning

With the agreement of the Chair, Irwin Van Colle (Chair, Kingsbury Patient Participation Group) addressed the committee. Irwin Van Colle began by stating that overall the Equalities, Diversity and Engagement (EDEN) Committee was a highly successful organisation and that in Kingsbury, most of the GP practices sent delegates to the Patient Participation Group meetings. Members heard that Brent CCG were in consultation with the EDEN Committee over constitutional matters, and whilst there had been some agreement, such as in complaints, differences of opinion remained in respect of commissioning. In particular, the EDEN Committee was against any proposals for their abolition as apparently had been suggested by the CCG on 25 September 2013 and there were competing views as to how consultation should be undertaken. EDEN Committee members also felt that the CCG was sometimes simply informing them of their intentions rather than consulting fully with them. Irwin Van Colle advised that the EDEN Committee was requesting than an open, borough-wide conference involving the CCG, the council, the EDEN Committee and patient participation groups be undertaken on extending

public and patient engagement and the committee was asked to help facilitate the creation of this conference.

With the agreement of the Chair, Julia Kirk (Co-Founder, CMH Rheumatology Patient's Support Group) addressed the committee. Julia Kirk stated that she was a rheumatology patient at CMH and attended the hospital every two months. Members heard that the Support Group was dismayed that Brent CCG had not consulted anyone before issuing a decommissioning notice on 28 March 2013 to North West London Hospitals Trust (NWLHT) confirming that musculoskeletal (MSK) services including rheumatology would cease on 1 October 2013. Upon the Support Group hearing of this in August 2013, Julia Kirk stated that she had sent a letter of complaint to Brent CCG detailing the lack of consultation and indicating that they wished the CMH rheumatology clinic and other services to continue at the Trust. Brent CCG had responded by stating that a consultation was not required and as a result, she had sent a complaint to the Health Ombudsman at stage two of the complaints procedure. She was aware that at least 50 other Support Group members had submitted their complaints to Brent and Harrow CCGs respectively. Julia Kirk outlined the details of the complaints as set out in her written statement and requested that Brent CCG withdraw the decommissioning notice on 28 March 2013, stop the tendering process, request active dialogue between Brent CCG, NWLHT and patients to help design services based on patient needs and ensure that future services continue to operate at CMH and Northwick Park Hospital (NPH).

The Chair then invited Sarah Mansuralli to introduce the report. Sarah Mansuralli advised that Brent CCG's intention to commission new pathways for outpatient specialities stemmed from the Commissioning Strategy Plan for 2009-2014. CCG's key intentions included commissioning of services to improve the health and wellbeing of its patients, secure sustainable care to receive up to date, high quality, cost effective care and ensure these services were effectively commissioned within CCG's financial resource limits. However, these aims faced a number of challenges, including a growing population in Brent and the need for more planned care as the current model was not affordable to meet future demand. There was also a need to transform care at primary, community and social levels. Sarah Mansuralli drew members' attention to the next steps as set out in the report. She stated that the concerns of patients over commissioning was understood and action would be taken to reassure them. She advised that an integrated impact assessment and full consultation would be undertaken and regular feedback would be provided to the Health Partnerships Overview and Scrutiny Committee and the EDEN Committee and there would be patient representation during the procurement process. Members heard that the CCG would respond to Julia Kirk's complaint and patients and the public would be encouraged to participate in the consultation.

During discussion by members, it was commented that patients tended to prefer that the same service provider remained as continuity offered the advantages of retaining familiarity and providing assurance. It was noted that there had been a change of provider for cardiology services and concerns were expressed with regard to consultation. A member commented that the change of provider to the Royal Free Hospital for cardiology services would impact upon out patient services. She added that there were also issues in respect of CCG's interpretation of communication as evidenced by the disagreement with regard to the EDEN

Committee and its future. Another member enquired whether TUPE arrangements for staff applied where there was a change of provider. It was asked whether the driver for commissioning of services was due to changes to the model of care. A description of the current rheumatology service and its financial budget, including details of the different levels of service, was sought and what aspects of this service were subject to commissioning. In addition, an explanation of the criteria used to decide what was suitable for commissioning was requested and it was asked whether the current provider had submitted a bid.

In respect of paragraph 5.4 in the report concerning Any Qualified Provider (AQP) and competitive tendering, a member sought clarification as to whether an existing provider could be considered as first choice where the contract was working well. Where there was to be a change of provider, information on the viability of the existing service was needed. Another member commented that retaining the same service and provider was not necessarily always beneficial and she acknowledged that the current model of care could not meet future demand and there needed to be more planned care. In respect of the consultation, she sought comments on what steps would be taken to ensure that a fair representation of the different points of view were reflected in the feedback recorded.

Councillor Hirani (Lead Member for Adults and Health) addressed the committee and enquired whether continuity of service contributed to the criteria during the commissioning process. He added that changes may lead to local providers no longer being used and also service integration could be compromised by having different providers for in an out of hospital patient care. Councillor Hirani also sought clarification with regard to CCG's level of engagement with the EDEN Committee.

In response to the issues raised, Sarah Mansuralli confirmed that the awarding of cardiology services to the Royal Free Hospital had been subject to full procurement procedures and patient representatives had been on the Procurement Panel overseeing this. The outcome of the procurement had identified the Royal Free Hospital as being capable of providing the best service overall. Sarah Mansuralli stated that a report on consultation concerning cardiology services had been to a previous meeting of the Health Partnerships Overview and Scrutiny Committee. Consultation on the second wave of commissioning was yet to formally proceed, however Brent CCG was committed to consult thoroughly and to undertake an impact assessment. An independent provider would be appointed to organise the consultation. It was noted that there had also been some initial engagement with stakeholders and more details of the consultation were to follow.

Sarah Mansuralli advised that rheumatology services was an acute service operated collectively by the North West London Hospitals Trust, the Imperial Hospital and the Royal Free Hospital, with the location of where patients were treated determined by GP referral. Members noted that both out and in patient care was provided, although spend details were currently unavailable. Sarah Mansuralli informed the committee that commissioning of rheumatology services was only taking place in respect of the out patients service and would involve consultation with both providers and patients. She added that commissioning was being undertaken because of the changes to the model of care required due to the rise in demand that the current arrangements would not be able to cope with in future. Commissioning would also ensure that the quality of care provided was sufficient

and it was intended to create an integrated service for MSK services with trauma and orthopaedics, rheumatology and gynaecology services in order to improve quality of care and outcomes, reduce duplication and streamline services. There was evidence nationally that integrating such services improved outcomes for MSK and examples in Thurrock and Basildon were cited. Sarah Mansuralli advised that the awarding of an organisation to undertake the integrated impact assessment would be completed by the end of October 2013.

Jo Ohlson advised that consideration would be given as to what services would be appropriate to be provided in out of hospitals settings and what should remain in hospitals. Members heard that cardiology services would remain in hospitals and quite possibly the more complicated of rheumatology services too. There would also be discussion of ensuring smooth transitions where there were changes to the way services were operated. Jo Ohlson informed the committee that there had been discussions with the North West London NHS Hospitals Trust in continuing to provide rheumatology services, however ultimately an agreement could not be reached. In respect of the procurement process, she emphasised the importance in treating all potential providers equally and if undue importance was attached to continuity this would unfairly favour the current provider. The selection criteria would also be discussed with patients groups and the way in which potential providers interacted with partners when surgery was required and what level of choice they offered would also be assessed. Jo Ohlson stressed that NPH would remain a fully functional hospital whilst the future role of CMH would be subject to the shaping a healthier future programme. Jo Ohlson advised that there was a full commitment to engage with the EDEN Committee and the objective was to increase engagement with patients and the public. Retention of a Brent-wide group was desired and it was important that this group was representative. Jo Ohlson advised that this did not necessarily mean that the EDEN Committee would not continue and future arrangements were still being discussed.

David Cheesman (Director of Strategy, North West London NHS Hospitals Trust) advised that North West London NHS Hospitals Trust had lost out in the commissioning process to provide cardiology services by one point and he questioned why this provided sufficient basis for the service to be transferred to a different provider.

Mark Creelman (Brent Customer Account Director) added that where services were under review, this tended to facilitate moves towards a procurement exercise and by doing so this would stimulate competition through competitive dialogue.

The Chair requested that an update be provided to the committee at a future meeting concerning rheumatology services, including budget details that would incorporate budget information on the different levels of service. She also requested more information in respect of best practice and that representatives responsible for ensuring this be invited to a future meeting to respond to members' questions. Furthermore, the Chair asked that details of risk assessments that had been undertaken or would happen be provided and information on the viability of existing services where there was a change of provider. The Chair also requested information on the costs of commissioning and de-commissioning of services in respect of cardiology.

6. **Pathology Service Serious Incident: Update Report**

Ian Winstanley (Assistant Chief Operating Officer, Brent Clinical Commissioning Group) introduced the report that provided an update with regard to the investigation into the serious incident involving the pathology service. This report focused on the aspect of the investigation concerning the pathology courier service, which although not directly associated with problems described in the root cause analysis, it had appeared that transportation and delivery times played a role in the variation of potassium levels. This is because they added to the instability of the samples due to fluctuation in temperature during storage at the GP practice or, and possibly in addition, during transportation in the laboratory both in summer and winter. Ian Winstanley advised that the task and finish group analysing this issue had concluded that the courier company should create best practice for storage of sample guidelines for GP practices. In addition, the courier company was requested to pilot a hub and spoke process where bikes collect from practices and travel a significantly shorter distance to a hub where samples would be transferred to a temperature controlled van to take the samples to the laboratory. It was intended that these measures be in place by the third week of October 2013 and initial findings would be reported to the CCG and a future meeting of the Health Partnerships Overview and Scrutiny Committee.

During members' discussion, confirmation on whether the pathology service provider was accredited yet. It was also enquired whether it was feasible for the bikes themselves to have temperature controlled storage.

In reply, Ian Winstanley advised that Clinical Pathology Accreditation (CPA) had changed the criteria for accreditation. However, the service provider had remained in constant contract with the CPA and had applied for accreditation under the new criteria and this was awaited. Jon Stewart advised that both NPH and CMH dealt with samples in the same way as any other hospital. He advised that as far as he was aware, there were no pathology courier services that transported samples using bikes with temperature controlled storage because of the difficulties in overcoming the impracticalities involved. Ian Winstanley added that it was not yet known precisely how changes to temperature affected results and GP practice storage arrangements were also being looked at.

7. **Central Middlesex Hospital Urgent Care Centre Serious Incident: Update Report**

Members noted the update report on the Central Middlesex Hospital Urgent Care Centre serious incident.

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

Members had before them the work programme 2013-14 for their consideration. The Chair sought clarification as to whether an update on the wave two commissioning could be provided at the next meeting and what lessons had been learnt in respect of consultation since wave one. In reply, Sarah Mansuralli advised that the service specification would not be ready for consultation until April 2014, however details of the planned consultation and an update could be provided before then. She stated that a number of lessons had been learnt following the wave one consultation and there would be stronger focus on patient and public

engagement. The timescale of the consultation would also be sufficient in length in order to gather all the necessary information.

The Chair requested that the independent provider appointed to organise the consultation be invited to the next meeting of the committee to provide details of their consultation programme and to respond to members' questions. The Chair also requested a paper on how hospitals and GP practices were planning to cope with the problems associated with winter, including the additional demand on services and how many GP practices were using Accident and Emergency and Urgent Care Centre units. In respect of shaping a healthier future, the Chair requested an update on progress particularly in relation to CMH. The Chair also requested that the current diabetes services and future commissioning item include details of all the services, including community services, provided and what finances were available for each of these and how did this service compare with London boroughs with similar profiles. In addition, the Chair asked that a community provider be invited to attend the meeting.

The Chair stated that maternity services in Brent was to be added to the work programme. Councillor Hunter advised that mental health, abortion services and teenage pregnancy were all items of future discussion for the committee.

9. **Date of next meeting**

It was noted that the next meeting of the Health Partnerships Overview and Scrutiny Committee was scheduled to take place on Wednesday, 4 December 2013 at 7.00 pm.

10. **Any other urgent business**

None.

The meeting closed at 9.10 pm

M DALY
Chair