MINUTES OF THE COMMUNITY AND WELLBEING SCRUTINY COMMITTEE
Tuesday 9 July 2019 at 6.00 pm

PRESENT: Councillor Ketan Sheth (Chair), Councillor Colwill (Vice-Chair) and Councillors Ethapemi, Gill, Hector, Knight, Shahzad, Stephens and Thakkar, and co-opted members Ms Dinah Walker and Mr Simon Goulden.

Also Present: Councillors Hirani and Farah

Apologies were received from: Councillors Askwith, Mr A Frederick and Ms J Roberts

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

Apologies for absence were received as follows:

- Councillor Afzal (Councillor Gill attending as substitute)
- Councillor Shahzad
- Mr Fredericks (Co-opted Member)
- Reverend Helen Askwith (Co-opted Member)
- Mrs Jean Roberts (Appointed Observer)

2. **Declarations of interests**

Personal Interests were declared as follows:

- Councillor Gill - employed as a Psychiatrist by Central and North West London NHS Foundation Trust.
- Councillor Sheth – Lead Governor, Central and North West London NHS Foundation Trust
- Councillor Ethapemi – spouse employed by the NHS.

3. **Deputations (if any)**

There were no deputations received.

4. **Minutes of the previous meeting**

RESOLVED: that the minutes of the previous meeting held on 17 April 2019 be approved as an accurate record of the meeting.

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

There were no matters arising.

6. **Substance Misuse Service**

Councillor Hirani (Lead Member for Public Health, Culture and Leisure) introduced the report on the Substance Misuse Service from the Director of Public Health. The report provided details of the Integrated Treatment, Recovery, Wellbeing and Substance Misuse service model; commissioning arrangements; provider performance; and, the work of B3, the service user council for Brent run by and for local residents directly affected by problematic drug and alcohol misuse. Councillor Hirani advised that the responsibility for Public Health had been transferred to local government following the Health and Care Act 2012. Despite year on year reductions to the public health grant, Brent's Substance Misuse service was considered to be an example of best practice, particularly in relation to the inclusion of peer support.

Andy Brown (Head of Substance Misuse) provided a brief overview of the key themes of the report, advising that data provided via the National Drug Treatment Monitoring System (NDTMS) estimated that there were: 2,310 opiate and/or crack users; 1,752 opiate users; 1,331 crack users; and 3,169 problem alcohol users in Brent. This data suggested that approximately only a third of active drug users and a fifth of problematic alcohol users were engaged with treatment services in Brent - this was broadly in line with national figures.

Discussing 'The New Beginnings service', Andy Brown advised that this new service model had been developed in conjunction with B3, responded to areas of local new or under met need, and rebalanced the divide between clinical services and non-clinical support such as outreach, criminal justice services and recovery support. The new service model had been fully mobilised by 1 April 2018. With the change in service provider there had been a transfer of staff, clients and case files from across five organisations into a single performance management and reporting system led by the new provider, Westminster Drugs Project (WDP). As was expected the transfer led to a temporary drop in performance, in part due to data cleansing through the bringing together of records from different organisations, but this was improving and remained higher than the national averages across a number of areas.

Radha Allen (Project Co-ordinator) and Amina Gariba (B3 Volunteer) then delivered a short presentation to the committee on the work of B3, which as previously highlighted, was an entirely peer-led service, designed and run by service users, and funded directly by Brent Council. B3 provided peer-led support and opportunities for service users and volunteers to develop new skills and qualifications. B3 also operated an out-of-hours' weekend drop-in service for people struggling with substance misuse issues. Moving forward, B3 had recently established an outreach programme to help sign-post individuals not engaging with treatment services.

The Chair thanked the Lead Member, officers and representatives of B3 for the introduction and invited questions from the committee.

In the subsequent discussion, the committee queried how the council was assured that the key objectives of the substance misuse service were being met. Members queried the strategy for engaging hard to reach cohorts and questioned what barriers existed for accessing services. Queries were raised regarding the protocol

for prescribing substitute drugs or drugs which reduced the urge to misuse substances. Further comment was sought on performance of the new service model against the previous model and members requested clarification regarding treatment completion rates. In concluding their questioning, the committee queried what the emerging challenges were for the service going forward.

In response to the committee's queries, Councillor Hirani explained that the Cabinet received quarterly performance statistics which included key indicators for the substance misuse service. Furthermore, Andy Brown measured performance as part of the contract management. Tom Sackville (Interim Head of Services WDP) advised that a monthly meeting was held between WDP, the Council and B3 to discuss performance and allow the service to be held to account by service users. With regard to engaging hard to reach cohorts, the committee was informed that WDP had an outreach service through which relationships were built with communities to help broaden awareness of the services available. WDP also worked with a range of council services and the criminal justice service to identify and engage potential service users.

Ruben Seetharamdo (Sector Manager, CNWL NHS Trust) highlighted that Central North West London NHS Foundation Trust was the clinical partner within the New Beginnings Service. Based at the Willesden Centre for Health and Care, the clinical element of the service undertook a holistic assessment of service users, encompassing physical and mental health needs. This assessment included whether there was a need for medication to be prescribed and whether in-patient services were needed to support a service user to detox. Brent had a very good community detox pathway, supported by a 12-week recovery day programme. Dr Melanie Smith (Director of Public, Brent Council) emphasised that there were no barriers in terms of policy or funding to the prescription of necessary clinical treatments. Ruben Seetharamdo advised that such treatments included campral acamprosate and antabuse (disulfiram). In response to a further query, Ruben Seetharamdo explained that the NHS was not able to prescribe implants as these were not licensed but could prescribe oral medication.

In response to members questions, Andy Brown confirmed that performance had declined when the substance misuse services were integrated under the new service model. This had been expected, in part due to the amalgamation of case-loads from the previous 5 providers which removed the potential for duplication of figures. There had been a focus on raising performance in line with key performance indicator targets. Tom Sackville confirmed that no service users had been prevented from accessing services as a result of the change of service model. Dr Melanie Smith emphasised that all parties had been acutely aware of the risks in recommissioning the service under the new model and this had therefore been monitored very closely. Public Health England had been interested to note the speed at which Brent had been able to raise performance following the implementation of the new model.

Andy Brown advised that effective treatment was usually measured as the completion of the 12-week programme, but often service users continued to access services for a longer period, reflecting the reality that this was often a longer process. The numbers of service users re-engaging with services within a six-month period was measured. Councillor Hirani advised that moving forward, outreach remained an ongoing challenge for the service.

The Chair thanked everyone for the contribution to the discussion and noted that during the discussion the committee had requested that the following be provided:

- an estimation of when service performance models would return to pre-service integration levels.

The committee subsequently **RESOLVED** to note the treatment and recovery services available to residents with problems of drug and alcohol misuse.

7. Childhood Obesity: Members' Scrutiny Task Group

Councillor Thakkar introduced the report proposing that the committee establish a task group on childhood obesity as per the terms of reference and membership detailed in the scoping paper attached as Appendix A to the report. The committee was reminded that levels of childhood obesity in Brent were among the worst in the country. It was intended that the task group would focus on four key areas: the NHS, local government and public services; external environment; and, home and parental engagement. With regard to membership, it was highlighted that a member of the Brent Youth Parliament would be asked to join the task group as a co-opted member.

The Chair thanked Councillor Thakkar for her introduction to the report. The committee subsequently **RESOLVED:**

i) To agree the details of the scoping paper attached as Appendix A to the report from the Assistant Chief Executive.

ii) To establish a task group as per the terms of reference and membership detailed in the scoping paper attached as Appendix A to the report from the Assistant Chief Executive.

8. Central Middlesex Hospital - Urgent Care Centre Changes in Operating Hours

The Chair welcomed colleagues from Brent Clinical Commissioning Group (CCG) to the meeting and noted that two members of the committee had conducted a site visit to the Urgent Care Centre at Central Middlesex Hospital to aid scrutiny of the proposals contained in the published report.

At the invitation of the Chair, Rashesh Mehta (Assistant Director, Integrated Urgent Care, CCG) introduced the report from the Brent CCG setting out a case for changing the operating hours of the Urgent Care Centre (UCC) at Central Middlesex Hospital (CMH). The committee was reminded that all CCGs had a statutory responsibility to ensure that the services they commissioned provided good value for money, were efficient and met local need. With regard to the UCC at CMH, it was explained that there were very few patients presenting between midnight and 8am. Irrespective of usage however, the provider of the UCC was required to have a full complement of staff. It was therefore considered an

inefficient use of resources to deliver UCC services overnight at CMH. Brent CCG had considered three different options for the opening hours of the UCC: closing the UCC 8pm to 8am; closing between 10pm and 8am; and, closing between midnight and 8am. The latter had been selected as the preferred option. The CCG had carried out a series of engagement activities on the proposals with the public and other stakeholders, including the Brent Equality Engagement and Self-care (BEES) committee, Healthwatch, CVS Brent, members of the Carers Board and ran a bespoke workshop to include voluntary sector organisations and patients. Summaries of feedback received were provided in the report. The Governing Body of Brent CCG had subsequently considered the proposals on 25th June and approved them, subject to receiving confirmation of approval from the LNWHT A&E Delivery Board.

Sheik Auladin (Chief Operating Officer) advised that Brent CCG was required to make savings where value for money was not being achieved. The CCG had a deficit of £9million in the current year. It was clarified that all eight North West London CCGs were in deficit and recovery plans were in place at both a North West London level and local CCG level. It was simply not justifiable to continue to invest the level of resources at the CMH UCC site given the level of usage and the clear patient preference for sites which co-located UCCs and Accident and Emergency services.

The Chair thanked Brent CCG colleagues for the introduction to the report and subsequently invited questions from the committee.

Members questioned how the identified £450k per annum savings would be better directed in primary care. Clarification was sought regarding required staffing levels and the redistribution of the staffing resource. Members questioned comparative levels of use at the other UCC sites in Northwick Park and further queried whether anticipated population growth had been considered. The committee asked what consideration was given to the impact of additional travel of those redirected to alternative UCCs. Members questioned how out of hours GP services factored into the proposed service provision for the borough. The committee sought commitment to undertake the potential mitigating actions identified in the report, should the change in opening hours go ahead, to be implemented in a transition period, including patient transport between locations and a free phone to 111. In concluding their questioning, the committee questioned what feedback had been provided by GPs on the proposals.

In response to the queries raised, Sheik Auladin advised that the savings achieved by reducing the opening hours of the CMH UCC, which is commissioned by the CCG, would form part of the aforementioned recovery plan for Brent CCG. However, the CCG had planned for increased activity at other sites accordingly. It was clarified that a certain staffing complement was required to operate a UCC, irrespective of activity at the site, and it was considered a more robust option to redeploy that staffing resource across the five North West London UCC sites. The average attendance figure for CMH UCC between the hours of midnight and 8am for 2018/19 was 1 patient per hour. Comparative figures for the UCC at the Northwick Park site were approximately 40 to 60 patients over the same period and the West Middlesex University Hospital saw averages of approximately 36 patients. Both sites were co-located with A&E departments.

Addressing the committee's query regarding population size, Sheik Auladin advised that data drawn from the census estimated Brent's population at approximately 340,000. This was expected to grow by a further 40,000 over the next five years. However, data from the Brent GP register reflected a population size of approximately 380,000. Unfortunately, the funding provided to the Brent CCG was calculated in relation to the census data. All decisions taken by the Brent CCG about the capacity of local services therefore took into consideration the fact that the population size was in fact already far in excess of the official figure.

With reference to the risks and mitigation section of the report, the committee was advised by Dr MC Patel (Chair, Brent CCG) that it was unlikely that the costs of an overnight patient transport service sited at CMH could be justified as an efficient use of resources. It was clarified that anyone too unwell to travel to an alternative site should be directed as appropriate by the 111 service. If urgent, an ambulance would be called to take the patient to A&E. The 111 service could also arrange for a home visit by a doctor if deemed necessary. The installation of a free-phone at the CMH site through which patients could contact the 111 service was considered a reasonable mitigating action and would be explored further.

Commenting on the consultation with GPs, Dr MC Patel confirmed that engagement had thus far been at a client level. GPs fully understood the proposed change and the rationale. It was confirmed that the Clinical Directors of the CCG unanimously supported the proposal detailed in the report. Ian Niven (Healthwatch) advised that the CCG had received feedback from Healthwatch on the proposals as part of the consultation and engagement activity that had already taken place. The committee was further informed that a recent piece of work had been undertaken by Healthwatch which surveyed GP practices. The results of this survey suggested a low knowledge of the range of services available and it was crucial that this was addressed.

The Chair thanked everyone for their contribution to the meeting and confirmed that as reflected in the discussion held, the committee agreed that sufficient public involvement had taken place in relation to the proposal to reduce opening hours at the Urgent Care Centre at Central Middlesex Hospital.

The committee subsequently **RECOMMENDED** that the following mitigating actions detailed at section 4.1.5 of the report for consideration be pursued:

i) The provision of overnight patient transport service based on-site between 12 midnight and 8am for a set period of time after the change of hours.

ii) Installation of a free-phone outside the UCC which goes straight through to 111 between 12 midnight and 8am.

9. Palliative and End of Life Care in Brent

At the invitation of the Chair, Rashesh Mehta (Brent CCG) introduced the report on Palliative and End of Life Care services in Brent. The report described End of Life (EOL) service provision in Brent and explained that a recent suspension of in-patient services at the Central London Community Healthcare Trust (CHCLT) Pembridge hospice provided an opportunity to review Brent's EOL strategy. This

review would encompass an evaluation of system capacity and demand for community specialist palliative care services, as well as consideration of whether the Pembridge hospice service was of sufficient quality, was clinically safe and provided good value for money.

Rashesh Mehta further explained that an independent review of the Pembridge hospice service based outside the borough as well as other local services had already been conducted by the commissioner of the service, Central London CCG. The resulting review report detailed a number of options, but recommended the procurement of one lead provider in the community for specialist palliative care services. The review also recommended that that the in-patient provision at Pembridge hospice could be reduced, given that all displaced patients had been accommodated by other hospice providers within existing capacity.

Sheik Auladin (Chief Operating Officer, Brent CCG) advised that since the suspension of services at Pembridge hospice, Brent CCG had been engaging with local providers about potential options moving forward. It was emphasised that currently, Brent CCG paid the full contract sum, despite the suspension of in-patient services at Pembridge hospice. There were three other providers of community specialist palliative care services for Brent patients in North West London, all of whom provided a high standard of service and value for money. If the Pembridge hospice service was permanently decommissioned, this would allow for re-investment in other providers. The committee was therefore asked to comment on potential options as identified in the report for the provision of EOL services in Brent to feed into the Brent CCG review and subsequent further engagement with residents and providers. As Brent CCG was moving towards a single North West London CCG structure and a new collaborative way of working between providers and commissioners, it was highlighted that due consideration needed to be given to the impact on providers across North West London of any proposed service changes in Brent.

The Chair thanked Rashesh Mehta and Sheik Auladin for the introduction to the item and invited questions from the committee.

The committee raised a number of queries regarding the circumstances leading to the suspension of in-patient services at Pembridge hospice and exploring alternative solutions to continuing these services at the site. Members sought assurance that the other three providers of hospice services for Brent patients had sufficient safeguards against similar circumstances. The committee questioned the robustness of conclusions drawn with respect to the capacity of the three remaining providers, seeking particular comment on ability to expand capacity with projected increases in demand. Clarification was sought regarding the option to pursue a tri-borough arrangement, rather than a Brent specific service. Noting the intention to expand community based palliative care services, members questioned how fragmentation would be prevented as the nature of the service developed. Further details were sought regarding consultation with service users and their families around arrangements for hospice based palliative care services. Members concluded their questioning by seeking confirmation that if Pembridge hospice were to be decommissioned, the savings by Brent CCG would be re-invested in other providers ensuring the continued provision of such services for Brent residents.

Responding to the queries raised, Sheik Auladin, advised that the specialist palliative care consultant at Pembridge hospice had resigned in late July 2018 and the provider had been unable to recruit to this position. This meant that there was not appropriate specialist palliative care clinical supervision of the in-patient unit and this service had therefore been suspended. There had been no proactive action from the provider to make arrangements for the provision of appropriate clinical supervision since this time. Brent CCG was confident in the resilience of the other three providers, who had staffing support from hospitals with which they were partnered, an arrangement that was absent from the Pembridge hospice contract. Rashesh Mehta explained that Brent CCG was content with the capacity of the existing providers and was confident that the providers would be able to accommodate additional capacity with additional resource, if and when required.

Jonathan Turner (Brent CCG) informed the committee that with the move towards a single North West London CCG and in consideration of patient flows across borough boundaries, any change to commissioned services in Brent would have an effect on service provision to patients in surrounding areas. It was therefore essential that an aligned approach be pursued with neighbouring CCGs to support connectivity in service delivery across North West London.

Dr MC Patel (Chair, Brent CCG) advised that the nature of palliative care services had changed significantly over the past few decades with more conditions treated out in the community, supporting patients to remain in their own homes when desired. However, there remained a very important role for hospices which provided a fantastic service to Brent patients and it was important that the Brent CCG invested in both forms of service delivery.

The committee further heard that there had been a degree of engagement with patients and their families with regard to hospice services in Brent. Four focus groups had been held across all providers to discuss service development and improvement and specific issues relating to Pembridge hospice. Greater engagement was planned pending the Brent review of EOL. All patients and families who had been affected by the suspension of in-patient services at Pembridge had been consulted. Patients had felt saddened at the prospect that the service would not be available going forward but had also felt that the provision of a seamless service across all competencies was an aspiration that should be worked towards.

Sheik Auladin confirmed that if Pembridge hospice were to be decommissioned, the £1.4million currently invested would be redirected to other hospice provision, whilst at the same time ensuring that services provided had appropriate clinical supervision. It was emphasised that the £1.4m was not considered a saving and did not form part of the CCG's recovery plan.

The Chair thanked everyone for their contribution to the discussion.

The committee subsequently **RECOMMENDED**:

That Brent CCG:

i) undertake engagement with Brent residents, stakeholders and existing providers (St Luke's Hospice, St John's and Elizabeth Hospice and Marie-

curie Hospice Hampstead) regarding the proposal to decommission services at Pembridge hospice and reinvest in the remaining providers, assessing whether there was sufficient capacity to meet local need and projected service demand.

ii) explore a tri-borough arrangement with the relevant CCGs if it was subsequently determined following the engagement recommended at i) that there was insufficient capacity across the three existing providers to meet local need or there was strong objection to the proposal to re-invest in the remaining providers.

That the Cabinet:

iii) review the position with regard to land adjacent to St Luke's Hospice, with a view to supporting possible expansion of the hospice at a future date.

10. **Community and Wellbeing Scrutiny Committee Work Programme 2019/20 Update**

RESOLVED that the contents of the Update on the Committee's Work Programme 2019-2020 report, be noted.

11. **Any other urgent business**

None.

The meeting closed at 8.33 pm

Councillor Ketan Sheth
Chair