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Health Partnerships Overview and Scrutiny Committee (supplementary reports)

Thursday, 14 October 2010 at 7.00 pm
Committee Rooms 1 and 2, Brent Town Hall, Forty Lane, Wembley, HA9 9HD

Membership:

Members Councillors:	**First alternates** Councillors:	**Second alternates** Councillors:
Ogunro (Chair)	McLennan	Mistry
Hunter (Vice-Chair)	Leaman	Ms Shaw
Adeyeye	Naheerathan	Oladapo
Beck	Clues	Cheese
Colwill		
Daly	Sheth	Van Kalwala
Hector	Aden	Al-Ebadi
Kabir	Mitchell Murray	Moloney

For further information contact: Jonathan Howard - Democratic Services Officer (020) 8937 1362 jonathan.howard@brent.gov.uk

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The press and public are welcome to attend this meeting

Agenda: supplementary to reports already circulated

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The Health Partnerships Overview and Scrutiny Committee will be aware that the government has published its white paper on the future of the NHS, *Equity and Excellence – Liberating the NHS*. The white paper outlines a radical set of proposals for change within the NHS. The council has prepared a response to the white paper, which is included as an appendix to this report. The Health Partnerships Overview and Scrutiny Committee will be given an overview of the main proposals in the white paper and the council's response to them. Officers from NHS Brent will also be able to offer their perspective on the white paper to the committee.

8 Future of Brent Community Services 23 - 36

Supplementary reports: letter from Chief Executive of Ealing Hospital NHS Trust, Chief Executive of NHS Ealing and Chief Executive of NHS Harrow and NHS Brent, responding to members' questions; Option appraisal for future organisational arrangements for Brent Community Services; and Option appraisal matrix for future arrangements for Brent Community Services.

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Supplementary report: Health Partnerships Overview and Scrutiny Committee Work Programme for 2010-11.

13 Public Health Annual Report

This report will be circulated to members separately.

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- The meeting room is accessible by lift and seats will be provided for members of the public.
- Toilets are available on the second floor.
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- A public telephone is located in the foyer on the ground floor, opposite the

Porters’ Lodge

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	Health Partnerships Overview and Scrutiny Committee 14th October 2010 **Report from the Director of Policy & Regeneration**
For Action	Wards Affected: ALL

Equity and Excellence – Liberating the NHS – Brent Council response to NHS White Paper

1.0 Detail

1.1 The Health Partnerships Overview and Scrutiny Committee will be aware that the government has published its white paper on the future of the NHS, *Equity and Excellence – Liberating the NHS*. The white paper outlines a radical set of proposals for change within the NHS, the main points being:

- Patients should be given greater choice over the provider of their treatment and the type of treatment they receive
- An independent NHS Commissioning Board will be established to oversee health commissioning in England
- All acute trusts will become foundation trusts by 2013, giving them greater freedoms
- Health service commissioning will be transferred to GPs. PCTs and SHAs will be abolished.
- Public health budgets and responsibilities will be transferred to local authorities
- Councils will be given the responsibility to promote integration and partnership working within health and social care services

1.2 If implemented, the NHS will go through one of its most comprehensive reorganisations since its foundation. Some significant changes are already beginning to happen, such as the proposals to merge PCTs in North West London to deliver the required management savings (this is a separate item on the committee's agenda). Assuming the White Paper forms the basis of the forthcoming Health Bill, as well as implementing significant structural change the NHS will also have to deliver £20bn of savings by 2014.

1.3 The white paper provides many opportunities for local government such as an enhanced role in healthcare commissioning and responsibility for providing public health services. That said, there are risks in the government's proposals that councils

will need to be cautious of, not least the passing of £80bn of public money to untested GP commissioning consortia.

1.4 There are possible implications for health overview and scrutiny committees. As it stands, the government is suggesting that the statutory powers of health overview and scrutiny committees are transferred to health and wellbeing boards. Currently health overview and scrutiny can refer issues of concern to the Independent Reconfiguration Panel if it believes that proposed changes to NHS services are not in the best interests of local people. If this becomes a function of health and wellbeing boards there could be a conflict of interest as the boards will have a role in co-ordinating commissioning of local health and social care services, as well as scrutinising the decisions it has been involved in making. This brings into question the idea of independent, democratic scrutiny of health and social care services and the proposal in the white paper is not supported by the council.

1.5 The council has prepared a response to the white paper, which is included as an appendix to this report. The Health Partnerships Overview and Scrutiny Committee will be given an overview of the main proposals in the white paper and the council's response to them. Officers from NHS Brent will also be able to offer their perspective on the white paper to the committee.

2.0 Recommendations

2.1 Health Partnerships Overview and Scrutiny Committee considers the implications of the NHS White Paper, *Equity and Excellence – Liberating the NHS* and endorses the council's response to the white paper consultation.

Contact Officers

Phil Newby
Director of Policy and Regeneration
Tel – 020 8937 1032
Email – phil.newby@brent.gov.uk

Andrew Davies
Policy and Performance Officer
Tel – 020 8937 1609
Email – andrew.davies@brent.gov.uk

	Executive **18th October 2010** **Report from the Directors of Policy & Regeneration and Housing & Community Care**
	Wards Affected: ALL

Council response to NHS White Paper *Equity and Excellence – Liberating the NHS*

1.0 Summary

1.1 The government white paper, *Equity and Excellence – Liberating the NHS*, was published on the 12th July 2010. The white paper sets out a radical set of proposals for change within the NHS, including significant structural change and an overhaul of health service commissioning arrangements in England. Primary Care Trusts and Strategic Health Authorities are to be abolished. GP commissioning consortia will be established as statutory bodies and will be responsible for commissioning the majority of health services.

1.2 GP commissioning consortia are to be overseen by an NHS Commissioning Board, which will allocate NHS resources to GP commissioners, hold GP commissioners to account for their performance and quality and also commission community services, such as dentistry and pharmacy as well as specialist services such as maternity services and prison health services.

1.3 Local government is to be given an enhanced role within health service commissioning. It is proposed that local Health and Wellbeing Boards, led by elected councillors, are created to ensure joined up commissioning of local NHS services, social care and health improvement. The boards will provide a strategic overview and promote integration between health and adult social care, children's services and safeguarding. Public health and health improvement functions are to be transferred to local authorities. Councils will become responsible for a ring-fenced public health budget of around £4bn a year. This will be allocated to authorities based on population health need.

1.4 Simplified and extended powers will be introduced to enable joint working between health commissioners and local authorities. Local authorities will lead on Joint Strategic Needs Assessments and on local commissioning plans. The council will also have powers to refer issues relating to service reconfiguration to the Secretary of State for Health and the NHS Commissioning Board if it does not feel the changes are in the best interest of patients or the borough.

1.5 The changes to the health service and the way that services are commissioned will inevitably have an impact on the council's services, particularly those jointly commissioned with the NHS. Officers have already begun discussions with GP commissioners to start building working relationships in preparation for changes to commissioning structures. It is important that the Executive is aware of the proposed changes to health services and responds on behalf of the council to the consultation documents released by the Government to accompany the white paper.

1.6 In addition to publishing the White Paper, the government has released four consultation papers. They are:

- Transparency in outcomes – a framework for the NHS
- Increasing democratic legitimacy in health
- Commissioning for patients
- Regulating healthcare providers

1.7 This report sets out the council's response to the consultation document *Local democratic legitimacy in health*, which has the greatest relevance for the council. There are elements within the *Commissioning for patients* paper which have also been addressed in the response, although this and the other consultation papers are primarily aimed at GPs and the wider NHS.

1.8 The Executive should endorse the council's response to the NHS White Paper. Members will be kept informed of developments within this area of policy in the coming months. A Health Bill will be put before parliament in due course, but Brent intends to be proactive and put in place arrangements that reflect the council's enhanced role in health service commissioning, not least by establishing a shadow health and wellbeing board. Further reports will be brought to the Executive when necessary.

2.0 Recommendations:

(i). The Executive endorses the council's response to the *NHS White Paper, Equity and Excellence – Liberating the NHS*, included at appendix 1 to this report.

3.0 Details

3.1 The white paper, *Equity and Excellence – Liberating the NHS*, published on the 12th July 2010, set out the coalition government's vision for the NHS in England. The proposals contained within it, if implemented, will deliver some of the most radical reforms to the NHS since its formation. The key proposals in the white paper are:

- Patients should be given greater choice over the provider of their treatment and the type of treatment they receive
- An independent NHS Commissioning Board will be established to oversee health commissioning in England
- All acute trusts will become foundation trusts by 2013, giving them greater freedoms
- Health service commissioning will be transferred to GPs. PCTs and SHAs will be abolished.
- Public health budgets and responsibilities will be transferred to local authorities
- Councils will be given the responsibility to promote integration and partnership working within health and social care services

3.2 These changes will be made at a time of unprecedented financial pressure. The NHS is going to have to make up to £20bn of efficiency savings by 2014, including reductions in management costs of 45%. The timetable for implementing the reforms to the health service is also very tight. Because of the fluid environment in which these changes will take place the council has already taken proactive steps to address some of the proposals, particularly the changes to commissioning arrangements. For instance, informal discussions have already been held with GPs to discuss the implications of the white paper.

3.3 Much of the focus since the White Paper was published has been on the changes to health service commissioning, creating GP commissioning consortia and abolishing Primary Care Trusts. This is understandable given the scale of the changes, but there are also considerable implications for local government that need to be understood and addressed. Local government will have a regulatory role with regard to health and social care commissioning through the establishment of Health and Wellbeing Boards that will be responsible for:

- Promoting integration and partnership across areas, including through joined up commissioning plans across the NHS, social care and public health, children's services and safeguarding;
- Assessing the needs of the local population and leading the preparation of the statutory joint strategic needs assessment;
- Supporting joint commissioning and pooled budget arrangements, where all parties agree this makes sense; and
- Undertaking a scrutiny role in relation to major service redesign

3.4 The government is consulting on the establishment of Health and Wellbeing Boards and whether there should be a statutory requirement for upper tier local authorities and GP commissioning consortia to work together on health and wellbeing issues. The council supports both proposals as it believes this will be the best way to ensure partners come together to deliver health services that people in Brent need. The boards should be considered a forum for mutual influence, giving local authorities influence over NHS commissioning and corresponding influence for NHS commissioners in relation to health improvement, reducing health inequalities and social care.

3.5 Assuming Health and Wellbeing Boards are set up as the government intends, GP commissioners will have a duty to be members. The boards would bring GPs together with elected members (who will decide who chairs the board), representatives from adult social care, children's services, public health and patient representatives. GPs might be unfamiliar with this kind of collaborative working, but it is something the council is keen to develop. Indeed, in the consultation response Brent has argued that there should be a mutual duty of cooperation between local authorities and GP consortia to ensure GPs work in partnership with local government. At present the proposals are too one-sided with local government being expected to ensure partnership working takes place. Clearly this has to be the responsibility of local government and GPs if partnership working is to succeed.

3.6 The Health and Wellbeing Board is one of the ways in which the council will influence health and social care commissioning. There are other levers open to the council to influence commissioning and ensure that there is collaboration with GPs. The Health and Wellbeing Board will be able to refer proposals for major service changes to the NHS Commissioning Board and the Secretary of State if it does not believe that the

changes are in the best interest of the borough. Whilst there will be mechanisms in place to try to resolve issues locally, it is an option open to Boards once they are up and running. GP commissioners will need to ensure that Health and Wellbeing Boards are supportive of their plans, that they meet the strategic needs of the borough and that they are in patients' best interests. Indeed, in the consultation response Brent argues that board approval for commissioning plans should be mandatory. The council hopes to develop strong working relationships with GPs to avoid situations where a referral to the secretary of state becomes necessary. Overall Brent Council supports the proposals within the White Paper for joint working and collaboration between health, social care and local government.

3.7 Before GP commissioning can begin, commissioning consortia need to be established and satisfy the NHS Commissioning Board that they are robust enough to take on the risks associated with commissioning. The council and NHS Brent are already working with local GPs to understand how they wish to do this in Brent. It is a concern to the council that GP commissioning consortia boundaries may not match borough boundaries. Brent has benefited from having a co-terminous PCT and it is important that the GP commissioning consortia established in the borough are consistent with our boundaries to ensure local population needs are met, whether this is by a single consortium or multiple consortia. Brent does not support the idea of Brent practices joining consortia based in another borough.

3.8 Councils will assume responsibility for public health functions once the Health Act is implemented. The transfer of public health and health improvement responsibilities to local government will strengthen links with other services that make a real difference to peoples' health such as housing, planning, regeneration, sports and leisure etc. However, local government will need funding to follow the function if it is to deliver a comprehensive public health service.

3.9 It could be argued that the separation of public health from the NHS will mean the NHS no longer sees 'health' as its responsibility, only health care, and it will focus on treating ill health, not preventing it. Brent Council believes that GPs will have a critical role in promoting good health, not just treating ill health. GPs have many opportunities to offer interventions to prevent ill health such as smoking cessation services, which are likely to be run by the local authority. Partnership working to ensure these services are delivered to the people who need them most will be crucial. GPs will see patients at times when they may be open to change – before an operation, after a health scare, when they are feeling ill, or are pregnant. Opportunities to deliver ill health prevention messages and services will only be taken if the NHS sees ill health prevention as part of its core business.

3.10 Overall, Brent's response to the White Paper consultation focuses on a number of key themes. We believe that integrated working and a whole system approach to health and social care is crucial. Genuine steps have to be taken to ensure health and social care services are integrated and are working together for mutual benefit. This means creating an outcomes framework that is requires local government and the NHS to work together to deliver. Statutory Health and Wellbeing Boards, with a duty for local government and GPs to work together will help to achieve these aims. Similarly, Brent supports co-terminosity of borough boundaries with GP consortia so that GPs have an interest in the outcomes of that borough and not diverted by the requirements of working in multiple boroughs.

Conclusions

3.11 The opportunities that the white paper, *Equity and Excellence – Liberating the NHS,* provides local government are multiple and there is little doubt that if implemented through the forthcoming Health Act as intended Brent's role in healthcare commissioning will be broadened and strengthened. This is to be welcomed. That said there are risks in the government's proposals that the council needs to be cautious of, not least the passing of £80bn of public money to untested GP consortia. Within every local authority area existing arrangements for joint commissioning and integrated services will be tested and services could suffer during the transition period. Work will need to continue with NHS Brent and GPs to manage the transition period as new commissioning arrangements are put in place.

4.0 Financial Implications

4.1 The financial implications of the NHS White Paper are still not completely clear. We are unsure whether funding for HealthWatch will be provided by central government. Without this there will be a cost to the council which is not currently budgeted for. At the moment, the budget for commissioning LINks is £185,000 a year and this is paid for from the Area Based Grant. This funding is in place until 31st March 2011.

4.2 Public health responsibilities are to transfer to local government but we are unclear as to the level of funding that will be given to each council. We know that £4bn will be shared between authorities, with allocations based on health need. NHS Brent will spend £2,443,000 on public health in 2010/11, and receive income of £563,000. However, it's not clear what services are included in these amounts and these figures are being clarified. The Public Health White Paper due later this year should have more detail on the services that will become the responsibility of local government.

4.3 Consideration also needs to be given to the financial implications of providing commissioning support to a GP commissioning consortia. Should be council choose to do this, we would need to demonstrate that this was revenue neutral, but preferably, that it generated income for the council or ongoing savings greater than the cost of providing commissioning support.

5.0 Legal Implications

5.1 The publication of the Health Bill with the detailed legal provisions is awaited shortly and this will set out the specific legal implications which are the Government seeks to implement. The Legal and Procurement Department will review the impact of the legislation on its Constitution and any existing contracts with the PCTs under the NHS Act 2006 once it is clear which provisions will pass into legislation.

6.0 Diversity Implications

6.1 None

7.0 Staffing/Accommodation Implications (if appropriate)

7.1 None

Background Papers

Contact Officers

Phil Newby
Director of Policy and Regeneration
Tel – 020 8937 1032
Email – phil.newby@brent.gov.uk

Martin Cheeseman
Director of Housing and Community Care
Tel – 020 8937 2341
Email – martin.cheeseman@brent.gov.uk

Andrew Davies
Policy and Performance Officer
Tel – 020 8937 1609
Email – andrew.davies@brent.gov.uk

Equity and Excellence: Liberating the NHS - Consultation Response

Overview

Brent Council has serious reservations about the proposals in the White Paper in relation to GP commissioning. We agree that local government should be given an enhanced role within health service commissioning, responsibility for providing a strategic overview of commissioning in boroughs and promoting integration between health and adult social care, children's services and safeguarding. Councils should play an active role in health services and it is encouraging that public health services will be brought back under local government control. Local government already provides a number of services that have a huge impact on the health and wellbeing of the population, such as housing, leisure and sport services, planning and regeneration services. Bringing these services closer to public health and mainstream health services has the potential to improve integration, be good for patients and lead to better health outcomes for our population. We urge the government to clarify the level of resource to be allocated to local authorities to meet the proposed public health duties. We also recommend that public health budgets are not ring-fenced so as to enable councils to use the resources to greatest local effect.

We do not support proposals to give GPs responsibility for the bulk of health service commissioning. We have serious concerns about giving untested GP consortia responsibility for spending £80bn of public money at a time when considerable cuts are being made to public spending. This proposal leaves GPs and the health service open to unacceptable levels of financial risk. There is also no clear evidence that giving GPs responsibility for commissioning will lead to improved clinical outcomes.

The reorganisation of the NHS could cost up to £3bn, whilst up to £20bn is to be taken out of the NHS budget by 2014. £3bn is a huge amount of money to spend on restructuring services when there are significant cuts being made to public sector spending. The council believes that at this time the NHS and patients would be better served if more effort was put into making the current system work more efficiently than redesigning health service commissioning and at the same time trying to take £20bn out of NHS budgets.

Brent Council is also concerned about the way that GP commissioning consortia could emerge. We are not convinced it would be in patients' best interests if they develop around the organisational structures of existing primary care trusts given that the White Paper was supposed to signal the end of PCTs. This would also bring into question the need to spend £3bn on reorganising only to recreate a broadly similar structure. The letter from the Secretary of State for Health to GPs on 24th September 2010 encourages GPs to take on more commissioning responsibilities in shadow form and to work with PCTs to make this happen. Our worry is that working with PCTs based on current structures will become the default option, as GPs look for support to help them commission services.

On the other hand, we do not want GP consortia to develop across borough boundaries or to be made up of geographically distant GP practices. This will not help partnership working or integration between health and social care; it would almost certainly lead to deeper division between health and social care services. At present the government is leaving the development of consortia to GPs themselves and not providing clear guidance on issues such as the size of consortia or geographical location. We believe that the government should explicitly guide GPs into forming consortia based around local government boundaries.

We have concerns that patient choice, particularly in primary care or care provided from community settings may be compromised by the government's plans. GPs will be commissioning acute and primary care services. As more services are moved into community settings, GPs will also be directly providing a greater range of services and potentially commissioning from themselves or other practices within consortia. This may have implications for patient choice, as GPs direct patients towards services in which they have a financial interest. There need to be procedures in place to ensure patients' are aware of their rights and that GPs are open about the choices available to patients.

Despite the council's opposition to some of the White Paper proposals, we appreciate that if these changes do take place we need to make sure that health and social care services in Brent are not adversely affected and that we build positive working relationships with GPs. Brent council is committed to improving the health and wellbeing of local people and will continue to work collaboratively with health service partners.

Brent Council's substantive response to the White Paper consultation questions is set out below.

Response to *Local democratic legitimacy in health*

Each consultation document contains a number of questions relating to the policy proposals. Brent's response addresses the relevant questions in each consultation paper.

Q1. Should local HealthWatch have a formal role in seeking patients' views on whether local providers and commissioners of NHS services are taking account of the NHS Constitution?

Response – Brent Council encourages and supports patient and public involvement in health and social care services and welcomes proposals for the establishment of a local HealthWatch. It is important that commissioners and providers of NHS services take account of the obligations contained in the NHS Constitution and ensure that there is a way for patients to bring matters of concern to commissioners if they are not receiving the services that they want, need or are entitled to. An effective patient and public involvement organisation should already feel empowered to seek and express the views of patients in relation to the provision of NHS services whether or not they have a formal role in ensuring that providers and commissioners take account of the NHS Constitution. The council is not convinced that this needs to be formalised. It is something that HealthWatch should be doing without legislation to require it.

Local HealthWatch will need to ensure the views of all patient groups are taken into account especially hard to reach or seldom heard groups. For example, the views of children and young people to be considered. Brent has an effective, vibrant and dynamic Youth Parliament which is represented at Children's Trust level and supports the work of the

Children and Families Overview and Scrutiny Committee. HealthWatch will need to connect with groups such as this to capture the full range of patient views.

Q2. Should local HealthWatch take on the wider role outlined in paragraph 17, with responsibility for complaints advocacy and supporting individuals to exercise choice and control?

Response - The proposal to give HealthWatch responsibility for the complaints advocacy service, to be commissioned by local authorities or National HealthWatch makes sense. If HealthWatch is to be the organisation that people go to with issues relating to health and social care services, then giving them a complaints advocacy role would complement their broader remit. However, it is important that people can continue to use other advocates, such as the CAB or specialist advice and support services and that their legitimacy to support patients is recognised by the NHS. The roles and responsibilities of the local HealthWatch and NHS Patient Liaison Services should also be clarified.

In developing this wider role for HealthWatch, consideration needs to be given to the existing signposting, information and advocacy services provided by Local Authorities to reduce duplication and ensure a more consistent message to consumers. In the case of Children's Services, there is already a requirement to have a Children's Information Service which provides signposting to a range of services for children and families and is only missing the advocacy component of the HealthWatch type role described in the White Paper. Integration of such services could reduce cost, duplication and deliver a consistent consumer message.

HealthWatch should support patients to exercise their right to choice when selecting which health services to use. However, it is important that health service practitioners inform patients of their right to choose providers. When GPs begin to commission services this will become especially important, to avoid scenarios where patients are automatically referred to services in which the GP has a financial interest. There needs to be checks in the system to ensure patients are being informed by practitioners of their right to choose service providers.

Q3. What needs to be done to enable local authorities to be the most effective commissioners of local HealthWatch?

Response – Local authorities are concerned that there won't be sufficient funding to commission HealthWatch services. Funding was provided to commission Local Involvement Network Services but it is not clear whether additional resources will be provided to commission the new service. At present funding for LINks ends in March 2011. It is not reasonable to expect local authorities to fund a new patient and public involvement service, with enhanced duties such as complaints advocacy, in an environment where local government funding is being reduced. There needs to be clarity from central government about how they intend to fund HealthWatch once the current LINk funding comes to an end. It would also be helpful for the government to clarify working arrangements for LINks after April 2011, assuming HealthWatch won't be established by then.

In terms of the commissioning framework and guidance for HealthWatch, Brent believes that boroughs should be able to make their own arrangements to suit local needs and would not want legislation and guidance to be overly prescriptive. We would want to be able to facilitate integration with existing services providing similar services to HealthWatch and have flexibility in how these services are provided. Clarification of the roles and responsibilities of National HealthWatch would also be helpful as the consultation paper includes little detail on this.

Q4. What more, if anything, could and should the Department do to free up the use of flexibilities to support integrated working?

Response - Brent Council believes that there are a number of things that Department of Health can do to support integrated working between health and social care and develop a whole system approach to care. Firstly, health and social care agencies need to be incentivised to work in an integrated fashion. This means designing performance indicators (assuming they continue to exist) that work to promote integration between the two systems. The way that services are funded needs to be changed so that health and social care agencies benefit from changes and improvements to the system. Operating in a financial silo, as the NHS currently does, means that there is little incentive to make improvements to services that result in savings to social care budgets. This has to change and funding needs to be allocated to localities for health and social care so that the benefits (and risks) of service changes are shared. This should lead to closer integration of services, particularly if spending plans are agreed by health and wellbeing boards.

There is also legislation in place that currently allows joint working and integration between health and social care services (Section 75 of the National Health Service Act 2006 for example). It is assumed that existing legislation will be modified to reflect GPs new role in commissioning health services.

Q5. What further freedoms and flexibilities would support and incentivise integrated working?

Response – The bureaucracy of developing pooled budgets to support joint commissioning initiatives has proven problematic in the past due to the risks for either or both organisations. Generally, both LA and NHS organisations have expressed concerns about being fixed into pooled budget arrangements which are perceived to be difficult to end or are in place for too long. Therefore, we propose that commissioning responsibilities for specific care groups could be delegated where appropriate to allow a single organisation to be responsible for the commissioning, procurement and performance management of the service. Delegation will allow increased freedom for a single organisation to progress towards integrated models of care while enabling flexibility for either organisation to review the delegated arrangements to determine whether they continue to be fit for purpose at the end of each contract period.

Q6. Should the responsibility for local authorities to support joint working on health and wellbeing be underpinned by statutory powers?

Response – Statutory powers for local government to support joint working with the NHS on health and wellbeing would be welcomed, but might not lead to deeper integration of health and social care services unless it was underpinned by a statutory responsibility for local government and GP commissioners to work in partnership. Brent Council is concerned that under the government's proposals the onus would be on local government to use its existing skills and experience to support joint working, but in contrast to the duty for GP consortia to work with colleagues in the wider NHS and social care there would be no requirement for GP commissioning consortia to work with local government. Efforts to promote joint working could be frustrated by the unwillingness of GP commissioners to participate, no matter how much effort the local authority puts into to integration. Indeed, there are concerns in local government that the NHS does not engage sufficiently or seriously with local partnership arrangements. As highlighted in Sir Ian Kennedy's report – "Getting it right for children and young people" (21 Sept 2010), despite the concerted effort at policy level to raise the profile

of children and young people's services, this is not matched by the results at operational level due to a culture within the NHS that results in barriers to change and improvement.

The best way to ensure clarity around the expectations for partnership working would be to introduce a mutual duty of cooperation between local authorities and GP consortia. A statutory requirement upon NHS partners to cooperate and work jointly with the Local Authority would serve to strengthen the requirement Brent Council hopes that the government reconsiders this proposal to make it a more balanced and not just rely on local government to make partnership working effective.

Q7. Do you agree with the proposal to create a statutory health and wellbeing board or should it be left to local authorities to decide how to take forward joint working arrangements?

Response – Brent Council agrees with the proposal to establish a health and wellbeing board and is putting in place plans for a shadow health and wellbeing board to begin meeting before the end of 2010. The shadow board will be integrated within our Local Strategic Partnership structure and will engage GP commissioners, public health colleagues, patients group's, representatives from the local acute trust as well as elected members and council officers to work on health and social care issues in Brent.

The council believes that health and wellbeing boards will be the best way to ensure partners come together to deliver health services that people in Brent need. We agree that the boards should be considered a forum for mutual influence, giving local authorities influence over NHS commissioning and corresponding influence for NHS commissioners in relation to health improvement, reducing health inequalities and social care. Without the formal role of a health and wellbeing board and GPs requirement to engage with it, Brent is concerned that opportunities for genuine integration could be missed and that health and social care commissioning becomes fragmented within boroughs.

As we have stated previously, Brent Council would like the government to ensure that GP commissioning consortia are co-terminous with borough boundaries. This is crucial to help integrate health and social care services and not lead to further divisions between the two. If boundaries are not co-terminous the council believes that any consortia with an interest within Brent, even if it covers one or two practice areas, should have a duty to work with the Brent health and wellbeing board. The council believes that there should be full representation from all GP commissioning consortia within Brent's boundaries on its health and wellbeing board.

Q8. Do you agree that the proposed health and wellbeing board should have the main functions described in paragraph 30?

Response – Brent Council has no objections to the functions proposed for the health and wellbeing boards. However, we do think that there are additional functions that could be added to their role. We would like health and wellbeing boards to be responsible for approving GP consortia commissioning plans to ensure they meet the boroughs health needs and the wider strategic plans for health and social care. If the health and wellbeing board is not satisfied that consortia's overall commissioning intentions are in line with the borough's JSNA and in the best interest of patients, the plans could be referred to the NHS Commissioning Board.

The White Paper proposes that councils will assume responsibility for public health functions. If this happens, health and wellbeing boards will need to work with GP commissioners to ensure that commissioning plans reflect the importance of public health and health promotion work. There is a risk that the separation of public health from the NHS will mean the NHS no longer sees 'health' as its responsibility, only health care, and it will focus on treating ill health, not preventing it. Brent Council believes that GPs have a critical role in promoting good health, not just treating ill health. GPs have many opportunities to offer interventions such as smoking cessation services as they see patients at times when they may be open to change – before an operation, after a health scare, when they are feeling ill, or are pregnant. Opportunities to deliver ill health prevention messages and services will only be taken if the NHS sees ill health prevention as part of its core business and this need to be reflected in the NHS outcomes framework. Working in partnership to ensure these services are delivered to the people who need them most will be crucial. The health and wellbeing board will be the best forum for local authorities to engage GPs on these issues. The government should also consider whether the Directors of Public Health should have a role within the governance of GP commissioning consortia to ensure better integration between health care and public health.

Q9. Is there a need for further support to the proposed health and wellbeing boards in carrying out aspects of these functions, for example information on best practice in undertaking joint strategic needs assessments?

Response – Guidance is always helpful on such issues, but Brent does not think that detailed advice on carrying out a JSNA is needed. The council and NHS Brent have already prepared one JSNA (in 2008) and plans to refresh this document in 2011. The council also believes that rather than government set out in details how health and wellbeing board should function, it should be for members of health and wellbeing boards locally to agree terms of reference and working arrangements.

Q10. If a health and wellbeing board was created, how do you see the proposals fitting with the current duty to cooperate through children's trusts?

Response - Sir Ian Kennedy's report (Sept, 2010) sets out nine recommendations which are briefly summarised below:

1. To bring about a more holistic approach to their overall welfare, policy for health well-being and public services relating to children and young people should be brought under one government department. Sir Ian's suggests, but does not insist, that this might be a newly conceived Department of Public Health.
2. Government and national organisations must agree on their respective responsibilities and align services to meet them.
3. Funding for services to children and young people, including the transition to adulthood should be separately identified and allocation to the government department referred to in (1) above.
4. There should be a dedicated Local Partnership for children's health in every local authority area. The report alludes to Children's Trusts as potentially the ideal vehicles for the type of change proposed.
5. This Local Partnership should be locally accountable.
6. The Local Partnership should be able to require a Children's and Young People's Plan to be drawn up and implemented.
7. This plan must set out the agenda for children's health and healthcare.

8. This plan must integrate the children's health and healthcare agenda into the overall plan for all services provided by the Local Partnership.
9. The Local Partnership must ensure that the views of children and young people are sought and taken into account.

Recommendations 4-9 from the Kennedy report reflect current Children's Trust's arrangements. It is therefore important that the proposals set out in the White Paper do not create unnecessary layers of bureaucracy or duplication of existing mechanisms. However, it must also weigh the risk of destabilising existing structures that are effective and delivering measurable improvements in outcomes for children and young people. The White Paper's proposals for health and well being boards may well be the ideal opportunity to strengthen the requirements upon the NHS to ensure sufficient representation, engagement and interest.

It is likely that some form of local partnership focusing on outcomes for children and families will continue. In order to achieve the aim of integrating health services effectively, a strong link between health and children's/family services will be required. Children's health and well being will continue to be a key part of the children's agenda and it will be important to ensure that there are clear lines of accountability with well defined responsibilities for the health and well being board and the children's trust or equivalent partnership arrangements. There is a real and significant risk that the children's/family health agenda could be covered by both, causing duplication, or be given less focus as part of the wider health agenda without a children's board to champion children and families needs.

It is therefore clear that the interfaces between the health and wellbeing boards, the children's trust and local safeguarding children board merit further consideration. The consultation paper indicates that the health and well being board has some role/accountability over children's safeguarding in a broader sense, which appears to duplicate the role of the children's trust and the role of the director of children's services. The government should clarify roles and responsibilities in this area.

Q11. How should local health and wellbeing boards operate where there are arrangements in place to work across local authority areas, for example building on the work done in Greater Manchester or in London with the link to the Mayor?

Response – Brent believes that individual boroughs are best placed to determine local need and establish arrangements to ensure there is joined up working between health and social care services. Brent is already working on a sub-regional procurement project in adult social care services with other west London boroughs, an excellent example of cross borough working that will deliver better services to local people. The Mayor of London does not currently have any policy powers in relation to health we would not want to see this change. Whilst we appreciate that the Mayor has a strategic overview of health inequalities in the capital Brent Council does not see a role for the Mayor or his representatives in local health and wellbeing boards unless he is given significant public health responsibilities (clarification on the services to be transferred to the Mayor would be helpful). Cross borough working arrangements between health and wellbeing boards, where this is necessary, should be agreed by the boroughs affected. We do not believe that there is a role for the Mayor in this. Our preferred option is also for boroughs and GP commissioning consortia boundaries to be co-terminous. We think that this is in the best interest of patients and reduces the need for overly complicated partnership arrangements.

Q12. Do you agree with our proposals for membership requirements set out in paragraph 38 - 41?

Response – Brent Council broadly agrees with the suggested membership of the health and wellbeing boards.

Q13. What support might commissioners and local authorities need to empower them to resolve disputes locally, when they arise?

Response – Brent Council believes that if GP commissioners and the local authority establish good working relationships then most disputes relating to commissioning should be resolved locally without need to refer them to the NHS Commissioning Board or the Secretary of State for Health. There is an acceptance that referral should be the very last resort and we would assume that if local arrangements are working well then there would be very few referrals as has been the case with referrals from overview and scrutiny committees to the Independent Reconfiguration Panel. If local authorities are regularly referring issues to the NHS Commissioning Board this would be a fairly obvious sign that local arrangements are not working and that relationships have broken down. It is up to councils and health service commissioners to ensure that this doesn't happen.

GP commissioners will need to commit to working with health and wellbeing boards and the government should legislate to ensure this happens. It is vital that they use the boards to test commissioning ideas at an early stage to ensure that there is agreement from all sides. Brent has already argued that if GPs become lead commissioners of health services there should be a duty on them to be members of health and wellbeing boards, and this issue gives further weight to this argument. The NHS Commissioning Board may wish to supply mediators to help GP commissioners and local authorities come to a mutually acceptable position and prevent any referral becoming necessary.

Q14. Do you agree that the scrutiny and referral function of the current health OSC should be subsumed within the health and wellbeing board (if boards are created)?

Response – The transfer of statutory health overview and scrutiny powers to health and wellbeing boards will mean that there is a weakening of accountability for health and social care services. One of the strengths of the overview and scrutiny function is its separation from decision making. Health and wellbeing boards are to be responsible for coordinating health and social care commissioning in the borough. They are to have executive powers. Therefore they should not be responsible for scrutinising health and social care commissioning decisions, as there is a conflict of interest and a lack of independent scrutiny. It is important that health scrutiny committees are still able to scrutinise commissioning decisions to ensure these are made in the best interest of patients.

The government should also consider how GPs will be covered by scrutiny arrangements. As independent contractors with the NHS, GPs are not currently subject to overview and scrutiny from local authorities. Will this loophole be closed so that they have to co-operate with scrutiny functions once they become health service commissioners?

Q15. How best can we ensure that arrangements for scrutiny and referral maximise local resolution of disputes and minimise escalation to the national level?

Response – Please refer to the answer to question 13 above.

Q16. What arrangements should the local authority put in place to ensure that there is effective scrutiny of the health and wellbeing board's functions? To what extent should this be prescribed?

Response – Brent Council has reviewed its overview and scrutiny arrangements and set up a Health Partnerships Scrutiny Committee that will scrutinise the borough's effectiveness in tackling health inequalities and partnership working in health and social care. This appears to fit into government thinking on the role of overview and scrutiny in the new health service landscape. It is important that crucial areas such as health inequalities and public health continue to be scrutinised independently by elected members. We do not necessarily think that there needs to be a statutory requirement to have a health scrutiny committee as is currently the case, but that most councils will set up local arrangements to best meet their needs. Health scrutiny committees should also have the powers to scrutinise commissioning decisions, even if referral powers are transferred to health and wellbeing boards. Oversight of the boards will remain important to ensure there is independent, democratic accountability in health and social care commissioning decisions.

Q18. Do you have any other comments on this document?

Response – The recommendations made by Sir Ian Kennedy (Sept 2010) should be considered in the context of the White Paper proposals given the significant and serious concerns highlighted in respect of the NHS, its ability to work effectively in partnership internally and with external agencies and specifically in relation to children's services.

Following on from this, if GP Consortia will not commission services provided by GPs, where does the responsibility for safeguarding lie with regard to GP provided services? This aspect requires further clarification regarding processes and commissioning levels given that Public Health Departments will be transferred to the Local Authority and GP contracts will be managed by the National NHS Commissioning Board.

The consultation paper suggests that maternity and newborn care services will be commissioned by the National NHS commissioning board as well as specialist services to ensure choice across a range of settings and services. However, it is not clear how it will be ensured that these services remain responsible to local need. Further clarity is required on why the NHS commissioning board would take the lead role for commissioning maternity services given that many aspects of maternity services need to be commissioned locally, particularly antenatal and postnatal care. Brent Council would argue that all services should be commissioned at the local level unless there are compelling financial or clinical reasons for it to be done at a regional or national level.

Finally, with regard to Public Health, the definition of public health will need to be redefined in line with its new broader remit. For example, in the context of children's services, public health service could be defined as those provided by health visitors, community midwives and school nurses. Therefore an underlying assumption could be that such roles come under the auspices of local government to better support delivery of integrated services that promote health and well being, provide early intervention and preventative support.

Response to *Commissioning for patients*

Q9. Are there other activities that could be undertaken by the NHS Commissioning Board to support efficient and effective local commissioning?

Response - The Commissioning Board should ensure that local commissioning is undertaken with due regard to public health and preventative medicine and with the active involvement of Directors of Public Health and health and wellbeing boards.

Q11. How far should GP consortia have flexibility to include some practices that are not part of a geographically discrete area?

Response – Brent is firmly of the view that local people would be best served if their GP practice was part of a consortium with firm links to the borough and that preferably consortia boundaries in Brent matched the borough's boundaries. Indeed, we would like the government to ensure consortia boundaries match borough boundaries. We do not think that practices will be well served in terms of quality and support if they are part of a consortium that is primarily based in another borough or geographically distant to Brent. It is also not good for patients. If practices are based away from their consortium but a patient is referred for specialist treatment provided by another practice in that consortium they may face a long journey to receive that service. This isn't going to be in patients' best interests. If GP consortia and Health Watch boundaries do not make sense to local people how can they be expected to engage with them? Equally, if the boundaries of a consortium straddle more than one local authority area this could lead to a greater dislocation of public health and social care provision, again with the greatest impact being felt by patients.

Q12. Should there be a minimum and/or maximum population size for GP consortia?

Response – It is crucial that GP commissioning consortia are sustainable and have the capability and capacity to become effective commissioners and manage the financial risks that will come with the responsibility for spending NHS budgets. Brent believes that consortia will need to be commissioning health services for at least 100,000 patients, but it is more important that consortia are robust organisations able to deliver and commission excellent health services than it is to be overly prescriptive on the population size they need to serve.

Q13. How can GP consortia best be supported in developing their own capacity and capability in commissioning?

Response – Brent Council believes that there is a role for local government in supporting GP commissioning consortia and we are pleased that this option is mentioned explicitly in the White Paper. Local authorities are already experienced commissioning organisations and many will have the skills and capacity to support GPs in their commissioning work. For example, councils are able to provide skills such as demographic analysis, contract negotiation, performance monitoring and financial management. The key issue for Brent is that GPs themselves are able to choose the support they want to develop their own capacity and capability and are not forced into replicating existing systems by current NHS organisations, which is what we feel will happen as the proposals currently stand. GPs should be able to engage local government, PCTs, the private sector or the third sector in their own time to consider the support they need. The government should ensure that attempts to replicate existing structures of support through reformed PCTs does not become

the default position for consortia. The whole purpose of the White Paper was to radically change the way that health services are commissioned, not to replicate the existing system.

That said we are also cautious about private sector involvement in health service commissioning. We do not think that profit should be the driving force in health service provision, but why else would private sector firms be looking to support GP consortia? Our worry is that patients will receive inappropriate services if the private sector supports consortia, as GPs are encouraged to seek low cost solutions to save commissioning budgets, when this might not be in the best interest of patients.

Q14. What support will GP consortia need to access and evaluate external providers of commissioning support?

Response – It is a concern to Brent Council that support for GPs to evaluate external providers of commissioning support may come from existing PCTs. Not only is there a potential conflict of interest as PCTs reform themselves as social enterprises to provide this support, the transition period could also be difficult as the NHS makes the management savings required of it, whilst supporting GPs. At the very least, GPs should receive advice and guidance on evaluating commissioning support from organisations that are not bidding to provide that support to eliminate the potential for conflicts of interest. Strategic Health Authorities or the NHS Commissioning Board may be best placed to provide support to GPs.

Q17. What are the key elements that you would expect to see reflected in a commissioning outcomes framework?

Response – Brent Council believes that a commissioning outcomes framework should not just reflect health services commissioned by GPs, but needs to be used to help integrate health and social care services to deliver a whole system approach to care. Any framework which enhances the silos that separate health and social care will be detrimental to the overall care of people in Brent. The reorganisation of health service commissioning presents the department with an opportunity to enhance the link between health and social care by making this explicit in the outcomes framework. This includes factors such as shared objectives and targets that health and social care will be expected to deliver together. We would also expect to see key public health indicators including smoking and obesity prevalence to help focus GPs on preventing ill health.

Q18. Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?

Response - There are a number of ways in which GPs can be incentivised, but Brent would want to see incentives that are consistent with reducing ill health and improving health inequalities in the borough. We would not support proposals that would lead to GPs retaining commissioning budgets if they are not fully spent. This could encourage under referring to the acute sector even when patients require specialist treatment and might work against broader borough objectives. Brent believes that in order to foster joint working and closer integration between primary care, social care and public health, GPs need to be incentivised in a way that compliments the borough's aims for social care and public health. This includes broad objectives like increasing life expectancy and reductions in morbidity, which should be reflected in consortia commissioning. Linking GP incentives to underspending in their budgets may not be in patients' best interests. The government should involve public health and social care professionals in discussions with GPs about the most appropriate way to

incentivise and reward GPs. The rewards system for GPs and the proposed health framework also needs to compliment the wider adult social care and wellbeing framework.

Q19. What arrangements will best ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?

Response – Brent Council has already argued that through the development of health and wellbeing boards, GP commissioners and the council should be working in partnership to develop a whole system approach to health and social care service provision. This can be further strengthened through the implementation of GP incentives that complement the broader aims of social care and public health. In Brent reducing health inequalities is a priority for both the council and PCT. Effective partnership working between GPs and the council will be crucial if progress in any progress is to be made in this area of work. Therefore, our argument that there should be a mutual duty of cooperation between local authorities and GP consortia would be of benefit to help reduce health inequalities – this isn't something that can be achieved by local government or the NHS alone.

Q24. How can GP practices begin to make stronger links with local authorities and identify how best to prepare to work together on the issues identified above?

Response – Since the White Paper was published Brent Council has been proactive and engaged groups of GPs to discuss the issues connected to GP commissioning, to see what help and support GPs will need and also to consider how the council and GPs will work together from now on. Although the council has reservations about GP commissioning building these informal relationships is an important first step that needs to be taken in preparation for more formal partnerships that are likely to follow once the Health Bill has passed through parliament.

As we have already stated, in preparation for the creation of health and wellbeing boards, Brent is going to put in place shadow arrangements and we would expect GPs to participate in these. Although there will be no requirement for them to do so, it would indicate a willingness to work in partnership with the local authority in the longer term. The sooner that local government and GPs can begin discussing issues relating to health and social care, the more likely that objectives such as integrated working becomes a reality. It will also help us better understand our respective needs and ambitions for health and social care. We hope that the Department of Health will encourage GPs to begin working with local government as soon as possible, including participation in shadow arrangements in the lead up to the abolition of PCTs.

Joint working and integrated commissioning is to become increasingly important as the amount of funding available for health and social care reduces. Services for vulnerable groups are particularly important as they may not be the first priority for GP commissioning consortia. Brent Council believes that local government could take a lead role in commissioning services where it has considerable experience and a proven track record in commissioning, such as mental health, health and wellbeing of homeless people, services for children and young people and services for people with learning disabilities. In some areas, local authorities may wish to delegate commissioning responsibilities to GP commissioning consortia if they have the capacity and expertise to do so. Equally, they may wish to delegate commissioning to sub-regional or supra-regional commissioning groups. In either case this should be for local decision.

Perhaps the greatest challenge to the new NHS will be how to put prevention at the heart of the NHS. The new structures for health and social care will place responsibility for health care and ill health prevention into separate organisations with different outcome frameworks. There could also be different geographical boundaries between organisations that will have to work together. Failing to engage primary care effectively in preventative medicine will impose burdens to the public in terms of ill-health, to GP consortia in terms of a heavier work load and the NHS as a whole in terms of unnecessarily high costs. Ensuring that the two new services (public health and health care) work together effectively must be of the highest priority. As we have already said, proposals for the NHS Outcomes Framework should be reviewed to include specific public health indicators, especially for smoking and obesity which have a huge impact on peoples' health and cost to the NHS.

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08 October 2010

Brent Health Select Committee
Brent Council
Town Hall
Forty Lane
Wembley
Middlesex HA9 9HD

Dear Committee Members

Integrated Care Organisation – Response to questions from the Brent Health Select Committee

Please find enclosed the additional information requested for your further consideration of the plan to create an Integrated Care Organisation (ICO) by bringing together community services in Brent, Harrow, and Ealing with acute services at Ealing Hospital NHS Trust (EHT).

Options Appraisal

On 14/07/2010 the following members of the NHS Brent management team came together as a group to consider the options for externalisaing Brent Community Services (BCS):

Mark Easton, CEO NHS Brent
Dr Carole Amobi, Co-Chair Professional Executive Committee
Jo Ohlson, Director of Primary and Community Care Commissioning
Jonathan Wise, Director of Finance and Performance
Charles Allen, Director of Human Resources and Organisational Development

In light of NHS London's request for NHS Brent to re-confirm its support for the ICO as its chosen vehicle for the externalisation of BCS, the group identified a range of five options in addition to the ICO for consideration, and agreed the criteria by which they would be appraised.

There was then a process of judging of each of the options against the agreed criteria. The discussions that took place were based on the member's knowledge of the organisations concerned, NHS policy framework in this area, and knowledge of NHS London's approach to the externalisation of community services. The group arrived at a consensus score for each criteria following discussion and debate. The group did not request submissions from

the organisations concerned, it did not feel that this would be appropriate as this was not a tendering process but an opportunity for the management team to take stock and re-confirm the direction that the Board had agreed previously.

The attached options appraisal report went to the NHS Brent Board in July 2010. This document together with the scoring sheet, also attached, describes the options that were considered for the future form of BCS, including Brent based options, and the criteria for judging the options. The documents also provide an explanation of the scoring system used, and the outcome of the appraisal.

It should be noted that, although there was a relatively small difference between the options that ranked first and second, the second option, joining another local community provider, is not deliverable because the Inner North West London provider (Central London Community Healthcare) would be unwilling to partner with BCS at this point as it wishes to pursue Foundation status in its present form.

For Brent the ICO provides the only solution that is deliverable within the timescale required by national policies. With EHT as host, the ICO will have a critical mass that will ensure stability. This will mean that if in the future GPs decide to commission some services from other providers, core community services in Brent will not be adversely affected.

The EHT management team has the capability and willingness to shift its focus towards community services. In the short-term, this will ensure the organisation's focus on the delivery of high quality local community services. Over time, this will enable the ICO to deliver more services outside hospital, in the community, and closer to home. With its experience and knowledge of acute services, the management team will be able to sustain, and where needed improve the existing care pathways with other acute providers.

Staff Views

Employee representatives at the JNCC are supportive of the move for BCS to be part of the ICO. Employees have raised concerns about the alternative non-NHS options, which they believe could have a negative impact on their services conditions and pension entitlements. It is not possible to quantify the level of support among employees as requested by the committee. However, the role of staff representatives is to represent the interests of their members, and it is safe to assume that in the absence of any negative views expressed at the JNCC or by individual representatives, employees do not have any significant objections to the proposal. A HR Workstream has been established that is made up of staff representatives and managers from all constituent organisations. Employee's representatives involved in this workstream have not raised any concerns on behalf of staff about joining the ICO. Staffside have confirmed that they are in favour of BCS being included in

the ICO from day one.

The ICO is seen as a good option for BCS employees. They will retain their current conditions and entitlements. The mix of services within the new organisation will mean that there will be strong focus on community services, and the proposed organisation will provide employees with additional career opportunities. There will be no reductions in front line patient services or staff as a result of the merger.

If the ICO is not approved we face a further period of uncertainty, which is likely to last 12-24 months until the position is settled. Community staff who have already been consulted about the proposed merger with Ealing and Harrow would no doubt feel unsettled by this further delay. NHS Brent has no capacity or desire to continue to host community services so in any event from April next year they would need to be hosted by another organisation through a management agreement if this is permissible. Ealing and Harrow community services are already managed by Ealing hospital through this mechanism.

GP Views

A range of briefing material has been supplied to Brent GPs over the last three months. Meetings have taken place with GPs, their Practice-based Commissioning (PbC) groups, the borough wide PbC Executive, and the Local Medical Committee (LMC) lead. The ICO proposal has also been reviewed with the NHS Brent Professional Executive Committee (PEC). During these discussions we have sought to develop GPs understanding of the ICO proposal, to involve them in shaping the operational plans for the ICO so that it meets their needs as future commissioners, and to gain their support for the ICO.

At this time Brent GPs have not arrived at a decision on their support for the ICO proposal. Questions have been raised and answered regarding the proposed model for service delivery and management within the ICO and the scope for local improvements. We understand that there remain two outstanding areas on which GPs have requested additional information for their consideration. GPs have asked for details of the options appraisal that took place in July 2010, and clarification of the services currently delivered to Willesden Hospital by BCS. A response is being prepared to both of these queries. We hope that Brent GPs will be able to confirm their support for the proposal once they have had the opportunity to review this information. It is not possible to confirm the date for the conclusion of this process at this time.

Arrangements for Other Providers in London

Across London a range of solutions for divesting community services from Primary Care Trusts (PCTs) are being implemented with an absolute deadline

of 01/04/2011. Most are integrating with an existing NHS trust acute or mental health service provider.

Please find below a list of community services organisations and the solutions being pursued for their future form.

Camden Community Services – integration with Central and North West London NHS Foundation Trust.

Greenwich Community Services – integration with Oxleas NHS Foundation Trust.

Sutton & Merton Community Services – integration with the Royal Marsden NHS Foundation Trust.

Wandsworth Community Services – integration with St.George's Healthcare NHS Trust.

Kingston Community Service - Social enterprise.

Enfield Community Services – integration with Barnet, Enfield and Haringey Mental Health NHS Trust.

Hillingdon Community Services - integration with Central and North West London NHS Foundation Trust.

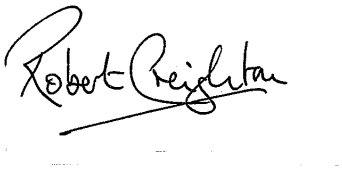
Hammersmith, Westminster, Kensington & Chelsea Community Services – joining together to form an NHS Trust as Central London Community Healthcare.

We hope that with these answers to the Brent Health Select Committee's outstanding questions, the Committee will be able to give their support in principle for the continued development of the plan to create the ICO. We look forward to continued discussions with the Committee on these developments.

Yours sincerely,

Julie Lowe

Julie Lowe
Chief Executive of Ealing Hospital NHS Trust



Robert Creighton
Chief Executive of NHS Ealing

Mark Easton
Chief Executive of NHS Harrow and NHS Brent

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ICO Project 2010:

29th July 2010

Future Organisational Arrangements for Brent Community Services: Option Appraisal

Author:	**Paul Richardson**
Report Date:	**15 July 2010**

1. Purpose

1.1 This paper reports on a further formal appraisal which has been completed within NHS Brent of the options for the future organisation of Brent Community Services. It sets out the factors which have been considered, the range of options which have been evaluated, the evaluation criteria which have been applied and the process followed for completing the exercise.

1.2 The need for this process arises because of the need to confirm the direction of travel for Brent Community Services prior to an assessment by the Competition and Collaboration Panel. PEC and PbC are also being asked to endorse the preferred option.

1.3 The Board is asked to endorse the option appraisal which has been undertaken and to confirm that the preferred option for the future of Brent Community Services (BCS) is to form an Integrated Care Organisation (ICO) with Ealing and Harrow Community Services and Ealing Hospital NHS Trust.

2. Background

2.1 The Board has already discussed the potential future arrangements for BCS on several occasions in the light of national policy directives on the separation of community service provision from other functions of the PCT. An earlier proposal to create an ICO without the inclusion of BCS has now been amended to include these services as a full element of the new organisation from its commencement.

2.2 The proposal to create an ICO will be reviewed by the Cooperation and Competition Panel (CCP) and thereafter must be approved by NHS London and cleared by the Department of Health. All aspects of this approval process require that the participating organisations have undertaken a structured appraisal of the options for the future organisation of community services in the three boroughs and acute services at Ealing Hospital and confirmed that the ICO is their preferred option.

2.3 The Boards of NHS Ealing and NHS Harrow have previously considered and approved an appropriate option appraisal for the earlier ICO plan without the inclusion of BCS at the time of implementation. These organisations are currently in the process of formally affirming that this remains their preferred option with the inclusion of BCS.

2.4 NHS Brent has yet to complete an option appraisal for the future of BCS in a form that would satisfy the Competition and Collaboration Panel. This paper records the process which has now been undertaken. The process needs to be completed and documented before 20th August 2010. This is so that, if the formation of an ICO is confirmed as the preferred option, it will be possible to include NHS Brent's formal decisions in a submission to the CCP in sufficient time for it to make a decision to approve the ICO before the end of 2010.

2.5 In parallel an engagement and communication process is being undertaken to ensure GPs and local authorities understand the ICO proposals and are support of it.

3. Context

3.1 There are a number of external contextual factors which have been considered in undertaking the options appraisal. These have also been identified in the exercises undertaken by NHS Ealing and NHS Harrow. They include the following:

- The agenda set by the Transforming Community Services initiative
- Substantial changes in commissioners requirements for community services to reflect changing demographic profiles and greater focus on care outside acute hospital settings
- Parallel changes in the mix of providers' and their delivery of community services
- Plans for reconfiguration of acute services to achieve more effective concentration of specialist services whilst maintaining outpatient and diagnostic services closer to local communities
- The expectation that all NHS provider organisations will achieve Foundation Trust status within a finite time period
- The latest developments in government policy, giving responsibility for commissioning services to GPs and enhancing the arrangements for the NHS to work in partnership with local authorities
- The uncertainty regarding NHS London's plans for the development of health care services the capital and in particular in the North West sector
- The considerable financial constraints now being applied to public sector spending and expectations of substantially increased productivity within the NHS

4. Organisational Forms

4.1 The appraisal has also included consideration of the different organisational forms for the future provision of community services. The forms currently deemed to be acceptable are:

- A Community Foundation Trust
- Integration in a Foundation Trust
- A Social Enterprise

4.2 The evaluation of options has been influenced in part by their perceived potential for success in achieving one of these forms.

5. Options

5.1 An initial long list of options for the future of BCS comprised the following which were discarded:

- **Do nothing** – unacceptable as it runs counter to national policy
- **Dispersal to Various Providers** – unacceptable because of the failure to retain a strong borough focus and pursue synergies with other community and acute services and possibility of being left with a rump of orphan services
- **Merger with Primary Care Organisation** – not available as there is no sufficiently developed primary care organisation capable of taking on BCS within the timescales required by government policy

5.2 There remained a **short list of five options**, each of which has its own opportunities for the final organisational form to be adopted:

1. Stand-alone Borough-based community services, operating as either a Community Foundation Trust or a Social Enterprise
2. Join with another NHS community service provider (Barnet or Inner NW London) to operate as a Community Foundation Trust
3. Join with an acute hospital trust (North West London Hospitals), later seeking to become a Foundation Trust
4. Join with a mental health provider (Central & North West London NHS Foundation Trust), becoming part of an established FT
5. Join with the community services of Ealing and Harrow and Ealing Hospital NHS Trust to form an ICO, later seeking to become a Foundation Trust
6. Join with Ealing and Harrow Community Services (without EHT), looking to become a community Foundation Trust

6. Evaluation Criteria

6.1 A structured appraisal of the options for future provision must be based on a clear set of predetermined criteria. Building on the work previously

undertaken by NHS Ealing and NHS Harrow, the following were agreed as appropriate for the NHS Brent exercise:

1. **Meets local commissioners and other stakeholders aspirations** – creates incentives to reduce overall use of healthcare services, supports patient choice, maintains safety and quality, attracts GP support
2. **Creates capability to transform local community services** – secures strong clinical leadership, efficient business management, good partnership working
3. **Enhances focus on transforming local community services** – enhances degree of attention given to productivity of community services, able to focus on development of whole care pathways, supports wider healthcare strategies, promotes quality of service
4. **Able to offer/improve services and care pathways in partnerships beyond the local borough** – strategic fit with other sector developments, able to improve service delivery for local population involving providers outside local borough, able to assist delivery to wider populations
5. **Attracts staff to work in local community services** – offers staff benefits, improves potential for recruitment and retention of staff, enhances organisation's reputation for quality
6. **Achieves financial viability and a balanced budget at establishment** – avoids inherited financial problems, meets Monitor's expectations
7. **Supports future financial viability with potential to grow/withstand losses** – able to withstand increased competition from other providers, has potential to win new business, has critical mass to survive loss of services
8. **Creates scope to reduce overheads/inefficiencies** – achieves economies of scale, reduction in corporate service overheads, potential for more effective service redesign
9. **Meets prescribed policy objectives and timescales** – complies with DH, NHS and NHSL requirements, separation of community services by April 2011, reaching FT status by 2013

7. Appraisal Exercise

7.1 The options and evaluation criteria set out above were reviewed and agreed by the NHS Brent Executive Team at its meeting on 14th July. A scored evaluation was then undertaken by the team working as a group. The results of this exercise are set out in the attached table.

7.2 The exercise will subsequently be reviewed by PEC and PbC.

7.3 Throughout these appraisals scoring has been in a range of 1 (very poor) to 10 (excellent) for each specific criterion. It was decided that no weightings should be applied to the criteria used.

7.4 Once completed, the various scores have been collated and an analysis of the overall results prepared. This includes a sensitivity analysis in respect of the preferred option. See Appendix 1.

8. Conclusions and Recommendation

8.1 The scoring shows that the preferred option is the ICO, with joining another community provider as the next most highly rated and joining Ealing and Harrow community services as third. These rankings are all sensitive to relatively small changes in the scorings when compared with the other three options, however it should be noted the second preferred option scored low on deliverablity, largely because the Inner North West London provider has been authorised as a potential FT and would be unwilling to partner with BCS at this point.

8.2 The scoring confirms the Board's previously agreed preferred position and it is asked to re-confirm its support for BCS joining the integrated care organisation with Ealing Hospital and Ealing and Harrow community services.

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NHS BRENT:
FUTURE ARRANGEMENTS FOR BRENT COMMUNITY SERVICES; OPTION APPRAISAL
EVALUATION BY NHSB EXECUTIVE MANAGEMENT TEAM - 14th July 2010

CRITERION / OPTION	BCS STAND ALONE	JOIN CS PROVIDER eg INWL	JOIN ACUTE TRUST eg NWLH	JOIN MENTAL HEALTH TRUST (CNWLFT)	FORM ICO (E&H CS and EHT)	JOIN EALING & HARROW CS
1. Meets local commissioner &stakeholder aspirations	7	5	*1	1	**5**	5
2. Creates capability to transform local community services	4	7	4	1	**6**	5
3. Enhances focus on transforming local community services	4	6	3	1	**6**	5
4. Able to form partnerships beyond local borough	1	7	2	1	**7**	7
5. Attractive to staff	2	6	4	3	**7**	5
6. Achieves financial viability on establishment	6	6	2	7	**6**	5
7. Supports future financial viability	3	6	4	7	**6**	6
8. Scope to reduce overheads/ make efficiency gains	1	7	5	5	**6**	5
9. Meets prescribed policy objectives and timescales	2	1	1	2	**7**	4
TOTAL SCORE	**30**	**51**	**25**	**28**	**56**	**47**

Notes: Scoring out of 10 for all criteria, 1=very poor 10=excellent; no weightings applied; all scores agreed by the team except for that marked *
*** A minority view was expressed that higher scoring of 5 would be appropriate, this made no difference to definition of the preferred options**

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Appendix 2

Health Select Committee Work Programme – 2010/11

Meeting Date	Item	Issue for committee to consider	Outcome
15th July 2010	Health Inequalities in Brent	Report from Acting Director of Public Health. Context on health inequalities in the borough and a good introduction to the main issues that the Health Select Committee will need to address.	Report noted, but will pick up issues raised in work programme throughout the year.
	Obesity Strategy	The committee wants to look at the Obesity Strategy in the summer of 2010, prior to its approval in order to see how obesity in Brent is to be addressed. This follows on from previous reports considering childhood obesity in Brent and the MEND programme.	The committee made the following suggestions for inclusion in the strategy: • More is done to influence food suppliers in the borough, e.g. the supermarkets, rather than only focussing on individuals making a change to their own behaviour. • There is a need for a greater focus on early years' provision given the impact it has on the long term health and wellbeing of children. • The strategy needs to better reflect people's lives, connected to the argument that fast food is tastier, easier and more filling than cooking a healthy meal with fresh ingredients and vegetables which is why people eat it. The committee will follow up the implementation of the strategy in April 2011.
	Tobacco Control Strategy Presentation	The committee will be given a presentation on the Tobacco Control Strategy, currently being developed by NHS Brent and the	Report noted. The committee will follow up the implementation of strategy in April 2010.

		council.	
	Access to health services for people with learning disabilities	Final report of the task group, for committee endorsement once it is available.	Endorsed by the committee and will be passed to the Executive for approval.
	Paediatric Services Implementation Plan	The Health Select Committee spent considerable time in 2009/10 scrutinising plans for changes to paediatric services provided by North West London NHS Hospitals Trust and responding to their public consultation on this issue. The committee should scrutinise implementation plans to assess how this project is running. This could be done in conjunction with the Harrow Overview and Scrutiny Committee, as they were also interested in this subject.	Report noted. Request for information on sickle cell patients in Brent and also to follow up implementation in April 2010.
	Local Involvement Network Annual Report	The LINk should present its annual report to the local overview and scrutiny committee each year. The Health Select Committee receives this in Brent, and will do so again in July 2010.	Report noted.

Meeting Date	Item	Issue for committee to consider	Outcome
14th October 2010	Equity and Excellence – Liberating the NHS	The health white paper, Equity and Excellence – Liberating the NHS sets out radical changes to the way health services are to be commissioned and also the role of	

		local government in health services. The committee will receive a report outlining these changes, which will also summarise the council's response to the white paper consultation.	
	HIV / Sexual Health in Brent	The committee has requested a report on sexual health services in Brent from NHS Brent. Members want to know what services are provided, what the key issues are in relation to sexual health in Brent and specific information on services available for people with HIV.	
	Public Health Annual Report	NHS Brent will present details of the Annual Public Health Report for the committee to consider and comment on.	
	Burnley GP Practice, Willesden Centre for Health and Care	There are concerns that the Burnley GP practice at Willesden Centre for Health and Care is to close. NHS Brent will be asked to provide an update on this issue.	
	Proposals for the creation of an Integrated Care Organisation	The Health Select Committee will receive a report setting out proposals for the creation of an Integrated Care Organisation based at Ealing Hospital Trust. The ICO will bring together Ealing Hospital Trust, Ealing, Harrow and Brent Community Services into one organisation. The committee should comment on the proposals and respond to NHS Brent with their views on this issue.	
	Merger of NWL PCTs	NHS Brent will be asked to update the committee on the plans to merger PCTs in North West London and the implications this	

		has for Brent.	

Meeting Date	Item	Issue for committee to consider	Outcome
16th December 2010	Respite Care	The committee would like a report on respite care arrangements in Brent for people who are carers. NHS Brent will be asked to provide a report on this issue for December 2010.	
	Housing and Health Inequalities Scrutiny Review	The Council is working with 6 other North West London boroughs on a housing and health inequalities scrutiny review. The final review report will be presented to the committee for endorsement.	
	Immunisation Task Group	Six month follow up of the immunisation task group in December 2010, to see how the recommendations have been implemented.	
	Recommendations to the Planning Committee	The Committee has made a recommendation to the Planning Committee in relation to the proliferation of hot food take away shops near secondary school premises. The committee should follow up the committee's response to the recommendation, after it has been considered in October 2010.	
	NWL Hospitals Trust In Patient Survey Results	The committee has considered the results of the in-patient survey each year for the past three years. Results are available in the summer of each year. In addition, the trust has implemented its "We Care" patient experience programme in response to a	

		poor in-patient survey score in 2008/09. Members should scrutinise progress on improving the patient experience at the hospital trust, via the 2009/10 patient survey and an update on “We Care”.	
	Health Inequalities Performance Monitoring	The Health Select Committee should make health inequalities a major focus of its work in 2010/11. As part of this, a performance framework has been developed to monitor indicators relevant to the implementation of the health and wellbeing strategy, which relate to the reduction of health inequalities in the borough. This framework will be presented to the committee twice a year, with a commentary highlighting key issues for members to consider.	

Meeting Date	Item	Issue for committee to consider	Outcome
16th February 2011	Access to health services for people with learning disabilities	The task group’s final report was endorsed by the committee in July 2010. It is good practice to follow up recommendations 6 months after they have been approved to see how they are being implemented. This will happen in February 2011.	

Meeting Date	Item	Issue for committee to consider	Outcome

5th April 2011	Tobacco Control Strategy	Health Select Committee has asked for report back in April 2011 on progress made in the implementation of this strategy, following presentation on key issues in July 2010.	
	Obesity Strategy	The committee has asked for a report back in April 2011 on progress made in the implementation of this strategy, following presentation on key issues in July 2010.	
	Paediatric Services in Brent	North West London Hospitals NHS Trust has implemented the new arrangements for paediatric services in Brent and will update the committee on progress with this in April 2011.	

Items to be timetabled

Item	Issue	Possible date
Section 75 partnership arrangements for mental health services	The council and Central and North West London NHS Foundation Trust are entering into a S75 agreement for the provision of mental health services in Brent. The committee has asked for a report back in July 2010 on progress with this agreement.	October 2010
Belvedere House	That the consultation plan for Belvedere House will be presented to the Health Select Committee early in 2010/11. A visit will also be organised for members to Belvedere House to see the services delivered from the building and better understand the proposals for change. This follows on from discussions on Belvedere at the committee in March 2010.	October 2010
Improving Access to GP Services Task Group	This has been agreed as a task group for 2010/11. The scope of the review will be agreed in July 2010, with the work completed before the end of the municipal year. In addition, the committee should consider an update on access satisfaction results from the latest quarterly satisfaction survey.	October 2010
Smoking Cessation	The committee wants to keep track of this issue and will receive regular service	October 2010

	updates. The next is scheduled for October 2010. The importance of this cannot be overstated as smoking is the biggest cause of premature death and preventable illness in Brent.	
North West London Sector Integrated Strategic Plan	Plans for the acute sector in North West London will be published in the sector ISP. The Health Select Committee should continue to take updates on this plan, as well as respond to consultation, likely to happen towards the end of 2010.	December 2010
Access to Health Sites Task Group	Further follow up on this task group, following a report to the committee in March 2010 which revealed that implementation of the recommendations had been slower than expected.	December 2010

Other issues:

1. Visit to St Luke's Hospice – Health Select Committee would like to accept the offer to visit the St Luke's Hospice in Kenton to understand more about the palliative care services on offer in the borough. This will be arranged for autumn 2010.

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