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Health Partnerships Overview and Scrutiny Committee

Wednesday, 16 February 2011 at 7.00 pm
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	Baker	BM Patel
Daly	Sheth	Van Kalwala
Hector	Aden	Al-Ebadi
Kabir	Mitchell Murray	Moloney

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www.brent.gov.uk/committees

The press and public are welcome to attend this meeting

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members

Item Page

1 Declarations of personal and prejudicial interests

Members are invited to declare at this stage of the meeting, any relevant financial or other interest in the items on this agenda.

2 Deputations (if any)

3 Minutes of the previous meeting 1 - 6

4 Matters arising (if any)

5 Primary Care Services in Brent update 7 - 18

NHS Brent's report sets out the position with GP services in each of the Brent GP clusters (and commissioning consortia) – Willesden, Kingsbury, Wembley, Kilburn and Harness. The report acknowledges that succession planning is an area that the GP clusters have all considered, but one that requires further work. NHS Brent is giving assurance that it is dealing with this issue and that it is aware of and agreed a number of changes to primary care in the next six months – these are detailed in the report. There are two further potential changes expected, but these are not agreed with contractors and so information on these is not included.

Ward Affected: All Wards; ***Contact Officer****:* Andrew Davies, Policy and Performance

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6 GP Commissioning Pathfinder - verbal report

7 Public Health White Paper 19 - 26

The Health Partnerships Overview and Scrutiny Committee has asked for a briefing paper on the Public Health White Paper, *Healthy Lives, Healthy People*, which was published on the 30th November 2010. The White Paper contains more detail on the reforms to public health services in England that were originally set out in *Equity and Excellence – Liberating the NHS*. The most significant change for local government is the transfer of public health responsibilities to councils to be funded by a ring fenced

budget to be allocated based on relative health inequalities and deprivation. Shadow arrangements will be put in place from April 2012, with full responsibilities being formally handed over from April 2013.

The council will be submitting a formal response to the Public Health White Paper before the deadline on the 8th March 2011. It should be noted that since the Public Health White Paper was published, the Health and Social Care Bill has been put before parliament. That clarifies some of the points in the White Paper and this report has encompassed some of the key points in the bill, as well as the White Paper. The Health Partnerships Overview and Scrutiny Committee is advised to consider the implications for public health services and make recommendations to be included in the council's final response to the Public Health White Paper

Ward Affected: All Wards; ***Contact Officer****:* Andrew Davies, Policy and Performance

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8 Khat in Brent 27 - 30

Members of the Health Partnerships Overview and Scrutiny Committee have asked for a report from NHS Brent on Khat use in the borough. Members have concerns about the prevalence of Khat use in parts of Brent and were keen to know more about the problems associated with this drug. The NHS Brent paper is attached at appendix 1 to this cover note.

Since the request was made for the report, officers in the Strategy, Partnerships and Improvement Unit have been approached by members suggesting that a task group is established to investigate in more detail the use of Khat in Brent and the consequences it has on users and their families. There is capacity within the unit to support this work if the Health Partnerships Overview and Scrutiny Committee want to establish a task group.

Ward Affected: All Wards; ***Contact Officer****:* Andrew Davies, Policy and Performance

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9 Fuel Poverty and Health Scrutiny Task Group report 31 - 74

This report sets out the findings and recommendations of the Fuel Poverty and Health Task Group that are being presented to the Health Partnerships Overview and Scrutiny Committee for its endorsement.

Ward Affected: All Wards; ***Contact Officer****:* Andrew Davies, Policy and Performance

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10 Health services for people with learning disabilities task group 75 - 82

The Health Partnerships Overview and Scrutiny Committee has asked for an update on the implementation of the recommendations arising from the health services for people with learning disabilities task group. The task group was carried out in 2009/10 and its findings were reported to the Executive in September 2010. The Overview and Scrutiny Committee agreed to set up a task group to consider concerns amongst carers about the difficulties that people with learning disabilities face when accessing health services.

Ward Affected: All Wards; ***Contact Officer****:* Andrew Davies, Policy and Performance

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11 Childhood Immunisation task group 83 - 92

The Health Partnerships Overview and Scrutiny Committee has asked for an update on the implementation of the recommendations arising from the Childhood immunisation task group. The task group was carried out in 2009/10 and its findings were reported to the Executive in April 2010. The task group's recommendations, the original responses from NHS Brent and the latest update are included at appendix 1 to this report. Appendix 2 contains information on the latest immunisation performance in the borough, broken down into GP cluster group

Ward Affected: All Wards; ***Contact Officer****:* Andrew Davies, Policy and Performance

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12 Health Partnerships Overview and Scrutiny Committee Work Programme 93 - 104

Ward Affected: All Wards; ***Contact Officer****:* Andrew Davies, Policy and Performance

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13 Any Other Urgent Business

Notice of items to be raised under this heading must be given in writing to the Democratic Services Manager or his representative before the meeting in accordance with Standing Order 64.

14 Date of Next Meeting

The next scheduled meeting of the Committee is on 5 April 2011.

Please remember to SWITCH OFF your mobile phone during the meeting.

- The meeting room is accessible by lift and seats will be provided for members of the public.
- Toilets are available on the second floor.
- Catering facilities can be found on the first floor near the Paul Daisley Hall.
- A public telephone is located in the foyer on the ground floor, opposite the Porters' Lodge

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MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
Thursday, 16 December 2010 at 6.00 pm

PRESENT: Councillor Ogunro (Chair), Councillor Hunter (Vice-Chair) and Councillors Adeyeye, Beck, Daly and Kabir

Also Present: Councillors John, Jones and R Moher

Apologies were received from: Councillor Colwill

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

None declared.

2. **Deputations**

None.

3. **Minutes of the previous meeting**

RESOLVED:-

that the minutes of the previous meeting held on 14 October 2010 be approved as an accurate record of the meeting.

4. **Matters arising**

Update on Burnley Road GP surgery

Andrew Davies (Policy and Performance Officer) reported that NHS Brent had given notice that it intended to undertake an open tender process and would be carrying out the appropriate consultation. The committee would be kept informed of progress on this matter. Councillor Jones (Lead Member for Human Resources and Diversity, Local Democracy and Consultation) added that she would be attending a patients meeting on 17 December 2010.

5. **North West London Hospitals NHS Trust Patient Experience report and update on the We Care Patient Experience programme**

Carole Flowers (Director of Nursing, North West London Hospitals Trust) introduced the report before the committee on the We Care Patient Experience Programme, and ongoing patient experience initiatives. She emphasised the commitment to high standards of patient experience and outcomes. The We Care programme had arisen from the feedback received from patients and consisted of three themes –

patients not feeling informed and wanting to be more involved in decisions taken about their care, food service and communication. Carole Flowers added that over one quarter of all staff had so far been trained in the programme. Food service was an issue high on patients concerns. An audit of patients had revealed a difference of opinion on what time of the day they would like their hot meal and so options were being considered for introducing some flexibility into the service. She was pleased to report that there had been a reduction in the number of complaints received concerning rudeness by staff but work was being done to further improve this because it was something taken very seriously by the Trust. Finally, Carole Flowers stated that a lot of the patient feedback came from Harrow residents and she would appreciate any help available for improving the feedback received from Brent residents.

In answer to questions put to Carole Flowers, she stated that very few agency staff were employed by the Trust but when they were they were expected to adhere to the nursing code of conduct and any breaches of this were reported back to the agency. Regarding the training of staff, it was hoped to reach a level of at least 75% of staff trained by mid 2011 and to assist this an e-learning package was being developed. The nutrient levels of meals were checked by the dieticians, with build-up drinks also being available and patients were encouraged to bring in their own favourite foods. She expressed regret that it was not possible to offer a greater choice for the second meal of the day even though the meals met the national nutritional standards. Councillor Daly felt that the national guidelines were not sufficient and that more needed to be done to increase the nutritional value of the meals provided.

With reference to real time patient feedback, Carole Flowers was asked what was being done to improve the response rates to some of the questions. She replied that a key aspect was for staff to walk round wards and pick up problems as they arose. The initiative needed to be better publicised and some of the documentation improved.

Carole Flowers was thanked for the report and her attendance at the Committee.

6. **Brent GP commissioning pathfinder**

Dr Jahan Mahmoodi was present to report that the application for pathfinder status had been submitted in November 2010 but had not been successful in the first wave of applications. More work was needed to show how flexibility was being maintained across the localities, to demonstrate more fully how the GP consortium worked with the Council and a fuller outline on how each practice was signed up to it. Everybody involved understood their responsibilities in putting together a re-submission which was planned to be presented the following week. In the meantime, the GPs were keen to be involved in developing the vision for commissioning services. They were represented on the Clinical Directorate Committee which sat high in the PCT hierarchy and wanted to be part of the Health and Well Being Board. In answer to a question from the Chair of the committee, Dr Mahmoodi explained the process behind the election of a clinical director to each of five localities who would lead them over the next two years.

Councillor John (Leader of the Council) reported that meetings had been held with the GPs and a scenario planning event held on Friday 10 December had proved to be very interesting and useful. She felt that positive relationships were being developed which would be needed to make the arrangements work for Brent. The establishment of a Health and Well Being Board would help cement these relationships. Councillor R Moher (Lead Member for Adults, Health and Social Care) added that the day had been very challenging and had emphasised to her the impact each side had on the other. Marcia Saunders (Chair, NHS Brent) thanked the Council for its contribution to the day.

Martin Cheeseman (Director of Housing and Social Care) explained that terms of reference for the Health and Well Being Board had been drafted and ideas shared with a view to establishing a shadow board in January 2011. The membership would comprise Executive members, GPs, officers from the PCT and Council officers. It was anticipated that the Government would set out their views more fully on where the board was expected to be placed but it was now unlikely to come under the overview and scrutiny regime.

RESOLVED:

that regular reports be made back to the Health Partnerships Overview and Scrutiny Committee on the establishment and operation of the Health and Well Being Board.

7. **Update on Brent Community Services**

Mark Easton, (Chief Executive, NHS Brent) introduced the report before the committee which provided an update on the creation of an Integrated Care Organisation (ICO) incorporating Ealing Hospital and community services in Brent, Ealing and Harrow. He said that the project was now in its final stages to make the ICO happen. In January 2011, NHS London would be considering the proposal. Mark Easton referred to the reservations about the proposed transfer of Brent Community Services put forward by the Council. He stated that these would be taken into account but he added that from feedback he had received it was likely that the application would be approved because it was presented as a robust business case and because of the timetabling implications. However, there was a desire to deal with the reservations expressed by the council and to this end three ideas had been proposed. One was to provide for a Brent councillor observer on the ICO Board, another was to provide a role for the Health and Well Being Board to review community services and the ICO's plans to improve them and the third was to provide reassurance that resources would not be transferred out of Brent.

Mark Easton referred to the information provided on children's health services and the approach taken to safeguarding that had been provided as requested by members at their October meeting. He acknowledged that budgetary information also requested had not been provided and undertook to forward this to the Council.

In answer to a question on why the proposed Council observer could not have voting status, Mark Easton explained that positions on the ICO Board were subject to a formal appointments process and so any such suggestion would need to be considered at that level. Members asked that this be pursued.

Some members of the committee were concerned at the consultation process carried out and the apparent lack of consultation with officers of the council. It seemed to them that the process had not been as transparent as it could have been. Having submitted its comments on the proposals it was felt that the Council should have received a response to these even if it was to explain that the options were not available. Mark Easton responded that there had in fact been discussions with council officers but he accepted that he may not have been as assiduous as he could have been in ensuring information was shared.

In summary, the committee was advised that the Brent and Harrow PCTs were merging. The budget for Brent Community Services would however still be held as a separate Brent budget and the ICO would appoint a director for community services so there would be a strong link between the two bodies. This arrangement would retain a borough focus and ensure quality of service with the NHS Chief Executive holding a statutory responsibility for the service.

It was accepted that the committee's work in this area was now complete and that members would be informed of the decision of NHS London.

RESOLVED:

(i) that the update on Brent community services and the creation of the Integrated Care Organisation be noted;

(ii) that the view of the committee that the status of the proposed Council position on the ICO Board should be upgraded to a voting role be put forward;

(iii) that the decision of NHS London on the establishment of the ICO be conveyed to members of the Health Partnerships Overview and Scrutiny Committee as soon as it is known.

8. **Respite care services in Brent for people who are carers**

Mark Easton (Chief Executive, NHS Brent) gave apologies for absence from Javina Sehgal (Head of Joint Commissioning, NHS Brent) and introduced the report which updated the committee on respite support for people who are carers in Brent.

Questions were asked on the provision made for young carers and on what the average period of respite care was. It was asked whether the provision was made in fixed periods of time or if an allocation was determined which the family group could take as they wished. Mark Easton undertook to ensure members were provided with more information on these two areas.

9. **Recommendations to the Planning Committee**

Andrew Davies (Policy and Performance Officer) referred to the positive decision of Planning Committee taken on 20 October 2010 regarding the issue of restricting the number of hot food takeaways in close proximity to schools.

RESOLVED:

that the decision of Planning Committee to refer the determination of planning applications for hot food takeaways for consideration as part of the preparation of the Development Management Policies be noted.

10. **Recommendations to the Brent Pension Fund Sub-Committee**

Andrew Davies (Policy and Performance Officer) referred to the decision of Brent Pension Fund Sub-Committee taken on 30 November 2010 regarding the issue of investments in tobacco firms.

RESOLVED:

that the decision of Brent Pension Fund Sub-Committee to reaffirm the policy of the council of non-political or administrative interference with investment decisions or involvement with companies in which the fund managers have acquired shares on behalf of the fund be noted.

11. **Work programme**

The following further additions to the work programme were made:
Development of GP commissioning
Establishment of Health and Well Being Board
Briefing on the Public Health White Paper

12. **Any Other Urgent Business**

None.

13. **Date of Next Meeting**

It was noted that the next meeting of the Health Partnerships Overview and Scrutiny Committee was scheduled for 16 February 2011.

The Chair wished all those present a happy Christmas.

The meeting closed at 7.15 pm

B OGUNRO
Chair

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	Health Partnerships Overview and Scrutiny Committee 16th February 2011 **Report from the Director of Strategy, Partnerships and Improvement**
For Action	Wards Affected: ALL

Primary Care Services in Brent Update

1. Summary and recommendation

1.1 Members of the Health Partnerships Overview and Scrutiny Committee have asked for a report from NHS Brent on GP services in the borough. There were two issues in particular that the committee had concerns over – the first is succession planning and preparing for GP retirements, particularly post 2013 when the NHS Commissioning Board will become responsible for primary care contracting. Secondly, the committee wants to be kept informed of developments with the Brent GP commissioning consortia – a separate item is on the committee's agenda dealing with this issue.

1.2 NHS Brent's report sets out the position with GP services in each of the Brent GP clusters (and commissioning consortia) – Willesden, Kingsbury, Wembley, Kilburn and Harness. The report acknowledges that succession planning is an area that the GP clusters have all considered, but one that requires further work. NHS Brent is giving assurance that it is dealing with this issue and that it is aware of and agreed a number of changes to primary care in the next six months – these are detailed in the report. There are two further potential changes expected, but these are not agreed with contractors and so information on these is not included.

1.3 The Health Partnerships Overview and Scrutiny Committee should use this opportunity to question officers from NHS Brent on the succession planning issues, and in particular, how these will be addressed once responsibility for primary care contracting passes to the NHS Commissioning Board. Representatives from Brent GP commissioning consortia will also be at the meeting and should be asked for their views on this issue and how they plan to ensure services are maintained in future years.

1.4 It is recommended that the Health Partnerships Overview and Scrutiny Committee question officers from NHS Brent on their report on primary care

services in Brent and assure themselves that adequate measures are in place to deal with succession planning issues.

Contact Officers

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NHS Brent Primary Care – Update

Purpose of Paper

The Overview and Scrutiny Committee requested a paper that covered:

- Retirements and any changes to Primary Care
- How issues such as access will be managed under the new commissioning arrangements

The paper provides the current context to GP Commissioning Consortia and Primary Care Contracting and provides a snap shot of how each of the Consortia are developing in relation to Primary Care. It also details any planned changes to primary care within the Borough in the next six months.

Context

There are currently seventy one practices across the Borough. Over the last few years five distinct localities have emerged across the Borough and these have now formed into GP Commissioning Consortia. The five consortia; Wembley, Willesden, Kilburn, Kingsbury and Harness operate both as individual clusters as well as a federation where they operate as a collective to make some commissioning decisions. The Brent Federation have recently been successful in gaining pathfinder status as part of the second wave of applicants. The pathfinder status is intended to help support the development of the consortia.

As indicated above five consortia have emerged within Brent and each has its own view of delivering primary care, improving the delivery of primary care services and of succession planning. It is also important to note that each of the consortia are at different stages within their development. Succession planning is an area that clusters have all considered but that further work needs to be undertaken on. However assurance can be given that NHS Brent is aware of and has included details of all agreed changes to primary care in the next six months. It should be noted that there are two potential changes expected but these are not agreed with Contractors and therefore it is not yet possible to detail these.

The Health Bill has detailed proposals regarding the establishment of the NHS Commissioning Board to become effective in 2013. Until this point PCTs retain the statutory responsibility for primary care contracting, however, from April 2012 this will be managed under a sector team for North West London. The sector team will have the responsibility for all primary care (GP, Dental, Pharmacy and Optometric) contracts. There is a debate regarding what will constitute contacting and where the split between contracting and commissioning will occur. What is clearly emerging through this debate will be the need for GP Commissioning Consortia to play a key role in driving up the quality of primary care provision and in assessing need. An Outcomes Framework has been produced by NHS London in conjunction with a number of clinical and management stakeholders and is going through the final sign off processes at the moment. The Outcomes Framework will be used and implemented by the Sector Team and it is envisaged will become a useful framework for each of the GP Commissioners to use in driving up standards of primary care within their consortia. The indicators within the framework are detailed in Appendix One.

Willesden

The clinical directors in post are Dr Sarah Basham and Dr Cherry Armstrong. There are eleven practices within Willesden. Willesden are operating an effective board structure with representation from each of their practices at meetings. In relation to primary care the leads will be focusing on meeting with each of their practices and discussing a plan that reflects the particular practices issues; whether this is referral management, improving access to the practice or prescribing. The cluster intends to use benchmarked data for Brent, London and other areas with similar demographics as a comparator to drive performance.

There is currently one planned change to primary care services within Willesden over the next six months:

- Burnley Road Practice

NHS Brent Board confirmed that the practice should be advertised on the open market. The Board also confirmed that the homeless element of the service should be provided through a local enhanced service within the Borough.

Sessions have been held with patients regarding the specification for the registered list. The engagement period finishes on the 31.3.11. Following that the specification will be signed off by the PCT and it is intended that the advert goes out on the 7/2/11.

Kingsbury

The clinical director in Kingsbury is Dr Ajit Shah. There are sixteen practices in Kingsbury. Kingsbury have developed a cluster structure that includes a regular all practice meetings and a Board that meets regularly to discuss items. The cluster has focused on the performance bonds that have been in place this year and has used these as a mechanism for focusing on specific areas, engaging with practices and driving up performance. This is evident for example in the immunisation data which shows that the cluster is currently achieving above or close to the target in the majority of the immunisations.

Immunisation	Age 1 DTaP/ IPV/Hib	Age 2 MMR	Age 2 Hib Men C Booster	Age 2 PCV Booster	Age 5 DTa P IPV Booster	Age 5 MMR2
Kingsbury performance as at Q3	95%	93%	90%	89%	86%	90%
Target	92%	95%	92%	92%	95%	95%

In terms of enabling practices to work more closely together the cluster are considering buddying arrangements. In terms of succession planning the cluster are now considering how to manage any retirements and work with one another ahead of this occurring.

For Kingsbury premises is one of the most challenging issues. NHS Brent and GPs have been working together to explore various options for a new locality health centre: the preferred option (based on financial and non-financial benefits appraisal) was one development at Roberts Court, to house three or more practices (including Willow Tree, Fryent Medical Centre and Stag Lane). The Outline Business Case is

being finalised next week with practices within the scope of the development but there remains a significant affordability gap. We will need to identify how this additional cost could be funded within existing budgets.

There is one planned change in Kingsbury over the next three months:

- Girton Road Medical Centre.

Dr Banerjee has provided NHS Brent with notice to cease providing GMS services with effect from the 31.3.2011. this means that NHS Brent must re-provide services for those patients registered with Girton Road Medical Centre. As at 1st January 2011 the total number of patients registered with the practice was 1938.

NHS Brent has considered all the options available to it and discussed these with the Kingsbury Board. Given the size of the list the preferred option is to disperse the list. This means that patients would be given the option of re-registering with a practice of their choice; it is most likely that this will be within the local area.

NHS Brent has written to patients inviting them to attend one of two meetings (lunchtime and evening) to discuss the option of dispersal, understand any concerns related to this and find ways of best supporting patients to re-register.

NHS Brent will then write to the full list again with details of the practices in the surrounding area, how to re-register and when this must be done by. NHS Brent will also work with Girton Road Medical Centre to ensure the most vulnerable patients have re-registered.

Wembley

The clinical directors in post are Dr Ashwin Patel and Dr Jahan Mahmoodi.
There are fifteen practices within Wembley. Wembley are operating an effective board structure with representation from each of their practices at meetings. The clinical directors use their Board meetings as an opportunity to highlight key performance areas to their constituent practices and work with practices to understand why performance has not reached particular thresholds. They have used this methodology to drive up standards within primary care. Historically Wembley has performed poorly in relation to access standards but both the practices and cluster have actively participated in making changes to improve both the access patients have to their practices and the overall experience.

Outcome Measures	Practices with more than 72 per 1,000	5 day opening / half-day closing	Access to Recept-ionist 45+ hrs pw face to face & phone	Extended Hours	OOH Voice mail updated	Using CAB	Advanced booking 4 weeks	Text Implemented	Information Screen installed
Measure	80%	100%	90%	95%	100%	100%	95%	75%	50%
Status July 10	20%	26%	53%	80%	0%	73%	33%	0%	0%
Status Jan 11	53%	60%	100%	100%	73%	93%	100%	73%	100%
%increase	33%	34%	47%	20%	73%	20%	67%	73%	100%

There is one planned change in Wembley over the next six months:

- GP Unit & Sudbury Surgery application to become a social enterprise

Currently both the above practices are managed by Brent Community Services. Brent Community Services have served notice to NHS Brent as they no longer wish to provide GP services as part of their portfolio of services. NHS Brent began a competitive procurement last year but this was halted on legal advice following an application from the above to become a social enterprise. The practices made an initial application to the PCT which the Board supported but with the recommendation that the practices considered a merger on to a single site due to the financial viability and sustainability over the term of a five year contract.

The practices are currently developing their Integrated Business Plan which is due for submission in mid February 2011. If this is successful they will move into shadow form and the two practices propose merging to the Sudbury Primary Care Centre at the start of May.

NHS Brent has met with patients from the GP Unit twice through this process and various concerns have been flagged by patients in relation to the merger. These have been fed back to the right to request applicants and have been noted by ourselves. We have written to all patients inviting them to attend a specific meeting regarding the merger where we will focus in on this and understand better any concerns and run through what support we can offer patients through the merger. Patients will be offered a choice and should they not wish to travel to Sudbury Primary Care Centre will be offered the option of re-registering with a practice that is more convenient for them.

Kilburn

The clinical director in Kingsbury is Dr Amanda Craig. There are fifteen practices in Kilburn. Kilburn have developed a cluster structure that includes regular Board and cluster meetings. Kilburn cluster have been working closely together over a number of years and within their cluster have formed networks of practices. These networks of practices provide each other with day to day support, support in times of crisis and provide some services on behalf of another practice within the network. The Cluster is focusing on building on these networks and strengthening the governance that is in place between them to further develop the range of services being delivered within Kilburn practices.

The cluster has also focused on driving up standards within primary care and uses cluster meetings as an opportunity to discuss this. The cluster has led much of the Access, Choice and Experience programme and has seen step changes in the numbers of practices where it is possible to book four weeks in advance and now only have one practice that is open less than 45 hours per week. The cluster has also worked on pathway redesign and developed and tendered an MSK pathway. Kilburn has developed a strong ethos of peer support, review and challenge and uses cluster meetings to provide clinical training, review significant events, peer review referrals and discuss new pathways.

The cluster has been working with NHS Brent on an Outline Business Case for a new locality health centre in the South of the cluster, which would house the following practices together within one site: Kilburn Park, the Medical Centre, Peel Precinct, Blessing Medical Centre. As with Kingsbury there remains a significant affordability gap for which funds need to be identified to enable a development to go ahead.There

are no planned changes to primary care provision within the cluster in the next six months.

Harness GP Cooperative

The clinical directors in Harness GP Cooperative are Dr Ethie Kong and Dr Sami Ansari. There are fourteen practices within Harness GP Co-Operative. Harness mainly covers practices within Harlesden there are also a group of practices in the north of the Borough that are part of the cooperative and represent a third of Harness.

Harness has been working as a cluster for a number of years and has well developed systems of support within the cluster. Harness focus is on supporting practices to achieve excellent outcomes and does so through running clinical education sessions, providing management support to practices and offering support to newly qualified GPs. There are established buddying practices who offer support to one another in terms of providing services on behalf of one another and provide support to each other in times of crisis. There are three groups of practices working in a buddying arrangement one for the north of Harness, one for the east and one for the southern practices within Harness.

Harness' approach to driving up standards both in primary care and in relation to referral and prescribing management has been to meet with individual practices to discuss and agree a tailored action plan which is then delivered by the practice through support from the various networks within Harness.

Harness has been closely involved in the Access, Choice and Experience Programme and improvements can be seen in many aspects of access into practices with all but one practice open 45 hours per week and all but two practices able to book patients up to four weeks in advance of their appointment. Improvements have also been achieved in relation to experience with all but one practice offering a text messaging service, life channel available in all practices and patient participation groups operating.

There are no planned changes to primary care provision within the cluster in the next six months.

Appendix One

General Practice Outcome Standards

Outcome Domain	Number	Standard	Definition
Preventing People from Dying Prematurely – Cancer	1	One year cancer survival rates for breast cancer and lung cancer.	**Appropriate as an indicator of Consortia performance.** Reported one year relative cancer survival rates for breast cancer and lung cancer.
Preventing People from Dying Prematurely – Cancer	2	Cancer prevalence.	**Appropriate as an indicator of Consortia performance.** Reported versus expected prevalence for cancer.
Preventing People from Dying Prematurely – Cancer	3	Cervical screening.	**Appropriate as an indicator of general practice performance.** The percentage of patients aged from 25 to 64 whose notes record that a cervical smear has been performed in the last five years.
Preventing People from Dying Prematurely – Prevention	4	GP recorded smoking (Whole population).	**Appropriate as an indicator of general practice performance.** The percentage of patients per GP practice whose smoking status is recorded in the previous 15 months.
Preventing People from Dying Prematurely – Long Term Conditions	5	GP recorded smoking (Long-term conditions).	**Appropriate as an indicator of general practice performance.** The percentage of patients with selected long term conditions (LTCs), whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the previous 15 months.
Preventing People from Dying Prematurely – Stroke and TIA	6	Atrial fibrillation prevalence.	**Appropriate as an indicator of Consortia performance.** Reported versus expected prevalence atrial fibrillation.
Preventing People from Dying Prematurely – Communicable Diseases	7	Immunisation uptake.	**Appropriate as an indicator of general practice performance.** The percentage of children who complete

			immunisation by the recommended age. To include rates of children who have been immunised at age 1 (DTaP/IPV/Hib) and age 2 (PCV Booster, Hib/MenC and a completed course of MMR).
Preventing People from Dying Prematurely – Communicable Diseases	8	Influenza immunisation uptake.	**Appropriate as an indicator of both general practice and Consortia performance.** The percentage of at risk patients aged over 65 who have a record of influenza immunisation in the preceding September to March period.
Enhancing Quality of life for people with long term conditions – Respiratory Disease	9	Chronic obstructive pulmonary disease (COPD) prevalence.	**Appropriate as an indicator of general practice performance.** Reported versus expected prevalence for Chronic Obstructive Pulmonary disease.
Enhancing Quality of life for people with long term conditions – Respiratory Disease	10	Asthma prevalence.	**Appropriate as an indicator of Consortia performance.** Reported versus expected prevalence for asthma.
Enhancing Quality of life for people with long term conditions – Heart Disease	11	Diabetes prevalence.	**Appropriate as an indicator of Consortia performance.** Reported versus expected prevalence for diabetes for people aged 17 and over.
Enhancing Quality of life for people with long term conditions – Heart Disease	12	Coronary heart disease prevalence (CHD). Work ongoing to develop triangulation with prescribing data.	**Appropriate as an indicator of general practice performance.** Reported versus expected prevalence for Coronary heart disease.
Enhancing Quality of life for people with long term conditions – Mental Health	13	Dementia prevalence.	**Appropriate as an indicator of Consortia performance.** Reported versus expected prevalence for dementia.
Enhancing Quality of life for people with long term conditions – Prescribing Management	14	Monitoring safe, rational and cost effective prescribing in general practice.	**Appropriate as an indicator of general practice performance.** Increase safety of prescribed non-steroidal anti-inflammatory drugs by reducing use of diclofenac and cox-2 inhibitors.

Helping People to Recover from Episodes of Illness or Following Injury – Unscheduled Care	15	Emergency hospital admission rates for specific chronic conditions usually managed in primary care.	**Appropriate as an indicator of Consortia performance alongside reporting general practice level data.** Rate of emergency hospital admissions for selected LTCs as a proportion of total number of patients per GP practice with selected LTCs. NHS Comparators LTCs to be included: Angina, Asthma, Congestive heart failure, COPD, Diabetes complications, Hypertension, Iron deficiency anaemia, Nutritional deficiencies.
Helping People to Recover from Episodes of Illness or Following Injury – Unscheduled Care	16	A&E attendances.	**Appropriate as an indicator of Consortia performance alongside reporting general practice level data.** The rate of A&E attendances per 1000 patients on GP register.
Ensuring People Have a Positive Experience of care – Quality of care	17	After consultation how well did you understand / feel better able to cope?	**Appropriate as an indicator of general practice performance.** Percentage of patients who answered 'yes', 'yes definitely' or 'yes, to some extent' to selected questions in the GP survey, as a proportion of total patients who responded to those questions.
Ensuring People Have a Positive Experience of care – Quality of care	18	Satisfaction with overall care received at surgery.	**Appropriate as an indicator of general practice performance.** Percentage of patients who reported being satisfied with overall care received at the surgery.
Ensuring People Have a Positive Experience of care – Quality of care	19	Patients changing practice without changing address.	**Appropriate as an indicator of general practice performance.** Percentage of patients who changed GP practice without changing address. (Needs to be tested and query established)
Ensuring People Have a Positive Experience of care – Continuity of Care	20	Ability to see a specific GP or Practice Nurse if wanted.	**Appropriate as an indicator of general practice performance.** Percentage of patients who are satisfied with the frequency of seeing a preferred doctor at the surgery.
Ensuring People Have a Positive Experience of care – Access to primary care	21	Advanced appointments. Satisfaction with opening hours.	**Appropriate as an indicator of general practice performance.** Access to Primary Care.

		Ease of getting through on the phone.	
Treating and Caring for People in a Safe Environment and Protecting them from Avoidable Harm – SUI, Incident and complaint monitoring	22	Significant event reporting (One and three year targets).	**Appropriate as an indicator of Consortia performance.** All practices should complete a minimum of 3 reviews in the preceding year and twelve in the preceding 3 years, regardless of practice list size.

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	Health Partnerships Overview and Scrutiny Committee **16th February 2011** **Report from the Director of Strategy, Partnerships and Improvement**
For Action	Wards Affected: ALL

Public Health White Paper – *Healthy Lives, Healthy People*

1. Introduction

1.1 The Health Partnerships Overview and Scrutiny Committee has asked for a briefing paper on the Public Health White Paper, *Healthy Lives, Healthy People*, which was published on the 30th November 2010. The White Paper contains more detail on the reforms to public health services in England that were originally set out in *Equity and Excellence – Liberating the NHS*. The most significant change for local government is the transfer of public health responsibilities to councils to be funded by a ring fenced budget to be allocated based on relative health inequalities and deprivation. Shadow arrangements will be put in place from April 2012, with full responsibilities being formally handed over from April 2013.

1.2 The council will be submitting a formal response to the Public Health White Paper before the deadline on the 8th March 2011. It should be noted that since the Public Health White Paper was published, the Health and Social Care Bill has been put before parliament. That clarifies some of the points in the White Paper and this report has encompassed some of the key points in the bill, as well as the White Paper. The Health Partnerships Overview and Scrutiny Committee is advised to consider the implications for public health services and make recommendations to be included in the council's final response to the Public Health White Paper.

2. Recommendations

2.1 It is recommended that the Health Partnerships Overview and Scrutiny Committee considers the Public Health White Paper, *Healthy Lives, Healthy People*, and brings together any comments it wishes to recommend for inclusion in the council's consultation response to the White Paper.

3. Healthy Lives, Healthy People

3.1 The Public Health White Paper, *Healthy Lives, Healthy People*, is clear that public health has resulted in the biggest improvements to peoples' health in the UK – clean water and air, enhanced nutrition and mass immunisation programmes have had a profound impact on the health of the nation. But health inequalities continue to persist – people living in the poorest areas of the country will on average die 7 years earlier than those living in more wealthy areas and spend up to 17 more years living with

poor health. The Government is starting from the position that the current system is not up to the challenge of addressing our most ingrained health inequalities and that a new approach to public health is needed.

3.2 The Government's approach to public health will:

a. protect the population from health threats;

b. empower local leadership and encourage wide responsibility across society to improve everyone's health and wellbeing, and tackle the wider factors that influence it;

c. focus on key outcomes, doing what works to deliver them, with transparency of outcomes to enable accountability through a proposed new public health outcomes framework;

d. reflect the Government's core values of freedom, fairness and responsibility by strengthening self-esteem, confidence and personal responsibility; positively promoting healthy behaviours and lifestyles; and adapting the environment to make healthy choices easier; and

e. balance the freedoms of individuals and organisations with the need to avoid harm to others, use a 'ladder' of interventions to determine the least intrusive approach necessary to achieve the desired effect and aim to make voluntary approaches work before resorting to regulation.

3.3 The Government is looking to build on an evidenced based approached to improving health, throughout an individual's life:

- Starting Well – giving children the best start in life
- Developing Well – delivering better outcomes for children and young people
- Living Well – Encompassing all of the factors that contribute to health such as housing, transport, planning and the natural environment
- Working Well – Promoting work as providers of good physical and mental health
- Ageing Well – Helping People to live longer, more active lives

3.4 In order to deliver the Government's vision there will be significant changes to the public health system, which is to be made up of two parts – the creation of Public Health England and the transfer of some public health responsibilities to local government.

4. Public Health England

4.1 Public Health England (PHE) will be created within the Department of Health and be accountable to the Secretary of State for Health. It will hold the ring fenced public health budget, estimated to be around £4bn (although the Government is still does not know what the final amount will be). PHE will bring together the health protection functions, the regional Directors of Public Health and the Public Health Observatories. It will work with local government, the NHS and other agencies to prepare and respond to emergency threats and to build partnerships for health. It will have a local presence in the form of Health Protection Units (HPUs).

4.2 The main roles for Public Health England will be:

- providing public health advice, evidence and expertise to the Secretary of State and the wider system, including working with partners to gather and disseminate examples of what works;
- delivering effective health protection services;
- commissioning or providing national-level health improvement services, including appropriate information and behaviour change campaigns;
- jointly appointing DsPH and supporting them through professional accountability arrangements;
- allocating ring-fenced funding to local government and rewarding them for progress made against elements of the proposed public health outcomes framework;
- commissioning some public health services from the NHS, for example via the NHSCB; and
- contributing internationally-leading science to the UK and globally, in areas such as biological standards and control, dangerous pathogens, and incident response.

4.3 Responsibility for health protection and preparing for health emergencies will remain at a national level to be carried out by Public Health England.

5. Local government responsibilities

5.1 The Health and Social Care Bill includes the duty for upper-tier and unitary local authorities to take steps to improve the health of their population. It is proposed that this new responsibility would be in place from the 1st April 2013.

5.2 The Government believes that by embedding public health within local government it will be easier to create local solutions to meet varying local health needs. It will also enable joint approaches to be taken with other local government services and with key partners to tackle health inequalities.

5.3 The Government has stated that it intends to keep to a minimum the constraints as to how local government fulfils its public health role and spends its new budget. However, funding will be ring fenced and an outcomes framework is in place which will influence how money is spent. There will be payment for progress made against elements of the Public Health Outcomes Framework. The White Paper makes it clear that it expects local government to use its freedoms to be innovative in the way that it tackles health issues. Commissioning is expected to be prominent in the delivery of public health services, using a range of public, private and voluntary sector providers, rather than councils delivering services themselves.

5.4 An additional point for London is that the Secretary of State has invited the Mayor of London and London boroughs to develop proposals on how they can collectively work together to improve health in London. London Council's Leaders' Committee has agreed that there should be a 3% top slice of public health funding from London boroughs to the Mayor to lead on pan-London issues.

6. Directors of Public Health

6.1 The Government will require Directors of Public Health to be employed in upper-tier councils to lead local public health efforts, a role that can be shared with other councils if agreed locally. They will be jointly appointed by the local authority and the Secretary of State for Health (this has been clarified in the Health and Social Care Bill, rather than the Public Health White Paper). Directors of Public Health will be

professionally accountable to Chief Medical Officer, not the local authority Chief Executive, and will also be part of the Public Health England professional network. The Secretary of State for Health will have significant influence over this post as he/she will have to be consulted should the local authority want to dismiss their director of public health. The SoS will also be able to direct a local authority to investigate if he/she considers that the director may be failing to deliver in respect of certain functions.

6.2 Directors of Public Health will:

- Promote health and wellbeing within local government
- Provide and use evidence in relation to health and wellbeing
- Advice and support GP consortia on the population aspects of the NHS service
- Develop an approach to improve health and wellbeing locally including promoting equality and tackling health inequalities
- Work closely with Public Health England health protection units (HPUs) to provide health protection, as directed by the Secretary of State
- Collaborate with local partners on improving health and wellbeing, including GP consortia, other local Directors of Public Health and local businesses.
- Prepare an annual report on the health of the local population

7. Funding and commissioning for public health

7.1 The Department of Health has published a separate consultation on the funding and commissioning routes for public health which contains details on how the Government's proposals will be implemented. It is proposed that:

- The new public health system will be funded by a ring fenced budget within the overall NHS budget. The amount estimated to be set aside for public health is around £4bn – this figure is based on public health spending in 2009/10, although the baseline spend on public health is still to be determined.
- Public Health England will allocate ring fenced budgets, weighted for inequalities to upper tier local authorities. The council's Chief Executive will be the accountable officer for this budget, not the Director of Public Health. The budgets are to be used for funding improvements in population health and wellbeing and some non-discretionary services, such as open access sexual health services. There will be scope to pool budgets locally to support public health work and there will be flexibility for local areas to determine how best to use the budget to address health needs.
- To incentivise action to reduce health inequalities the Government will introduce a new health premium, which will apply to the part of the local public health budget which is for health improvement. Local authorities will receive an incentive payment, or premium, for services that depend on the progress made in improving the health of the local population, based on elements of the proposed outcomes framework. If services aren't leading to health improvement the premium will be withheld. This will be funded from the overall public health budget and it is not additional funding.
- There will be shadow allocations made to local government for 2012/13, with allocations introduced in 2013/14. The NHS Operating Framework for 2011/12 sets out the operational arrangements for managing the transition.

8. Services

8.1 Public Health England will be responsible for funding and ensuring the provision of services such as health protection, emergency preparedness, recovery from drug dependency, sexual health, immunisation programmes, alcohol prevention, obesity, smoking cessation, nutrition, health checks, screening, child health promotion including those led by health visiting and school nursing, and some elements of the GP contract (including the Quality and Outcomes Framework (QOF)) such as those relating to immunisation, contraception, and dental public health.

8.2 Some services will be delegated to local public health functions, others will be commissioned by the NHS Commissioning Board and some (such as the national purchasing of vaccines) will be commissioned or provided directly by Public Health England.

8.3 Information on which services will be commissioned by local government has been included in the consultation on the funding and commissioning of public health services. They are:

- Sexual health services - apart from contraceptive services commissioned via GP contract
- Physical activity - to address inactivity and other interventions to promote physical activity, such as improving the built environment and maximising physical activity opportunities offered by the natural environment
- Obesity - local programmes to prevent and address obesity, e.g. delivering the National Child Measurement Programme and commissioning of weight management services
- Seasonal mortality – local initiatives to reduce excess deaths
- Accidental injury prevention – local initiatives such as fall prevention
- Public mental health – mental health promotion, mental illness prevention and suicide prevention
- Drug misuse services – prevention and treatment
- Alcohol misuse services – prevention and treatment
- Tobacco control – local activity, including stop smoking services, prevention activity and enforcement
- NHS Check Programme – assessment and lifestyle interventions – local authorities will commission the NHS to provide the programme, and the NHS will commission any further testing or treatment that results.
- Health at work – local initiatives
- Children's public health 5 -19 The Healthy Child Programme for school age children, including school nurses and health promotion and prevention interventions by the multiprofessional team. Immunisation, screening and public health for the under-fives will be commissioned by the NHS Commissioning Board.
- Community safety and violence prevention and response
- Social exclusion – support for families with multiple problems
- School immunisation programmes, such as teenage booster.
- Dental public health, epidemiology and oral health promotion – supported by PHE in terms of the coordination of surveys[1]

9. Health and Wellbeing Boards

9.1 The Department of Health has proposed a new role for local government to encourage coherent commissioning strategies, promoting the development of

[1] LGIU Briefing – January 2011

integrated and joined up commissioning plans across the NHS, social care, public health and other local partners. Ultimately, this should deliver better health and wellbeing outcomes, better quality of care, and better value for money, with fewer overlaps or gaps in provision, and different services working together.

9.2 The Health and Social Care bill includes details on the establishment of health and wellbeing boards in every upper-tier local authority. Health and wellbeing boards are intended to lead on improving the strategic coordination of commissioning across NHS, social care, children's services and public health. The main functions of health and wellbeing boards will be to:

- encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner,
- provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements in connection with the provision of such services,
- encourage persons who arrange for the provision of health-related services in its area to work closely with the health and wellbeing board,
- encourage persons who arrange for the provision of any health or social care services in its area and persons who arrange for the provision of any health-related services in its area to work closely together.

9.3 GP commissioning consortia will be required to consult with health wellbeing boards when drawing up their annual plan. They will also be statutory partners for councils in establishing Joint Strategic Needs Assessments and subsequent strategies which emerge from the assessments when carrying out their functions.

9.4 If the Health and Social Care Bill is passed in its current form the boards will be established as a committee of the local authority with statutory membership consisting of:

- at least one councillor
- directors of adult services, children's services and public health
- a HealthWatch representative
- a representative from each of the partner GP commissioning consortia
- other members as appropriate, including a representative from the NHS Commissioning Board where JSNAs and related strategies are being considered.

9.5 The Government hopes that health and wellbeing boards can be used to promote the best use of public resources through close working relationships between local authorities and the NHS, to further integrate health with adult social care, children's services (including education) and wider services, including disability services, housing, and criminal justice agencies. There should be sufficient flexibility in the legislative framework for health and wellbeing boards to go beyond their minimum statutory duties to promote joining-up of a much broader range of local services for the benefit of their local populations' health and wellbeing.

10. Public Health Outcomes Framework

10.1 The Public Health Outcomes Framework will sit alongside the proposed NHS Outcomes Framework and Social Care Outcomes Framework. The Public Health Outcomes Framework will cover five broad domains:

- Health protection and resilience: protecting people from major health emergencies and serious harm to health
- Tackling the wider determinants of health: addressing factors that affect health and wellbeing
- Health improvement: positively promoting the adoption of healthy lifestyles
- Prevention of ill health: reducing the number of people living with preventable ill health
- Healthy life expectancy and preventable mortality: preventing people from dying prematurely

11. Building on the White Paper

11.1 The Department of Health will publish a range of documents linked to the White Paper in the coming year:

Winter 2010/11

- Health Visitors – The Government has already announced it intends to recruit an additional 4,000 health visitors.
- Mental Health
- Tobacco Control – the White Paper refers to possible initiatives, such as blank cigarette packaging and a ban on advertising tobacco at the point of sale. Consultation on these proposals will follow.

Spring 2011

- Public Health Responsibility Deal – Rather than nagging individuals and businesses to become healthier, the Government believe that sustained behaviour change will only come about with a new approach – genuine partnership. A key component of this approach is the Public Health Responsibility Deal. The Government is working collaboratively with business and the voluntary sector and have established five networks on food, alcohol, physical activity, health at work and behaviour change. The Public Health Responsibility Deal will be launched in early 2011 and should include agreements on further reformulation of food to reduce salt, better information for consumers about food and promotion of more socially responsible retailing and consumption of alcohol.
- Obesity
- Physical activity
- Social marketing
- Sexual health and teenage pregnancy
- Pandemic flu

Autumn 2011

- Health protection, emergency preparedness and response

11.2 Other related documents that will be published by other government departments including a paper on alcohol pricing and taxation and the Welfare White Paper.

12. Conclusions

12.1 There are a number of issues that members of the Health Partnerships Overview and Scrutiny may want to consider when discussing the merits of the Public Health White Paper:

- Are the proposals radical or localist? Publishing a national Public Health Outcomes Framework suggests central government is keen to retain control of services provided by local government rather than allowing services to develop independently to meet local need.
- How much scope will local government be given to develop public health services or will it be required to commission services stipulated by central government? Similarly, will ring-fenced public health budgets limit the impact that local government can have on public health, particularly integration with mainstream local government services?
- Will adequate levels of funding be transferred to local government to provide and commission services – there has been media coverage in relation to this issue in North West London suggesting that significant reductions are being made to public health budgets in the sector.
- Is there potential for confusion around the director of public health accountabilities in the current proposals and what impact could this have?

12.2 Officers from the local authority and NHS Brent will be at the committee meeting to answer members' questions on the Public Health White Paper.

Background Papers – *Healthy Lives, Healthy People* - Public Health White Paper

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	Health Partnerships Overview and Scrutiny Committee **16th February 2011** **Report from the Director of Strategy, Partnerships and Improvement**
For Action	Wards Affected: ALL
Khat in Brent	

1. Summary and recommendation

1.1 Members of the Health Partnerships Overview and Scrutiny Committee have asked for a report from NHS Brent on Khat use in the borough. Members have concerns about the prevalence of Khat use in parts of Brent and were keen to know more about the problems associated with this drug. The NHS Brent paper is attached at appendix 1 to this cover note.

1.2 Since the request was made for the report, officers in the Strategy, Partnerships and Improvement Unit have been approached by members suggesting that a task group is established to investigate in more detail the use of Khat in Brent and the consequences it has on users and their families. There is capacity within the unit to support this work if the Health Partnerships Overview and Scrutiny Committee want to establish a task group.

1.3 Officers from NHS Brent will be at the meeting to answer members questions on this issue. It is recommended that the Health Partnerships Overview and Scrutiny Committee question them on the work that is taking place to help Khat users in the borough and consider whether they want to establish a task group to look at this issue in greater detail.

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Khat in Brent

The Overview and Scrutiny Committee asked for a report on Khat use in Brent, as there are concerns that this is causing significant problems in the East African communities in Brent.

1. Introduction

Khat use is not an illegal substance and is not specifically recorded on the National Drug Treatment Monitoring System (NDTMS). Khat will be recorded under '*other'* as the priority has been to focus on problem drug use and illegal drugs. Khat is openly available in shops in the Church End area which is where the majority of people of Somalian origin reside.

2. Information available on use in Brent

There will be local statistics recorded through our third sector agencies who work with these communities, in particular EACH who have Somali speaking members of staff. However, this will only give information on those accessing services rather than a full scale indication of the problem which is also linked to mental health, access to primary care as well as mainstream treatment provision. EACH reported that for 2010/11 there were 17 referrals to their agency, with 15 on the current agency case load and some of these cases are linked to child protection and other substance misuse interventions such as alcohol related misuse.

3. Brent DAAT Plans

The 2010 National Drug Strategy now places an emphasis on the new localism agenda and for partnerships to set local priorities in relation to substance misuse. These will reinforce the activity already being undertaken by local agencies and reference will be included into the 2010/11 Adult Treatment Plan

- The DAAT will improve access to services for those affected by Khat through the development of the Cobbold Road Treatment and Recovery Service which will offer a range of treatment interventions including assessment and triage services, structured day programmes, one to one working, counselling services and onward referral to clinical and residential services.
- A Khat support group is already offered through Addaction via Cobbold Road with outreach and engagement services to be undertaken by CRI Brent Outreach and Engagement Team (BOET).
- Counselling Services for BAME communities are already provided through EACH. In 2011-12, these will be provided through two sites (Wembley Centre for Health and Care and the Cobbold Road Treatment and Recovery Service) will further provide support and counselling for Khat users and their families.
- Funding will be sought in partnership with Brent Council Community Safety Unit to develop a work programme with the Help Somalia Foundation for a Peer Mentoring Project with Somalian youth in the

Church End area to raise awareness of Khat misuse and to work with outreach and engagement services to improve awareness of local treatment provision and access to GP practices.

4. Background Information on Khat

What is Khat?
Khat (Catha edulis) is a flowering shrub native to northeast Africa and the Arabian Peninsula. Individuals chew Khat leaves because of the stimulant effects, which are similar to but less intense than those caused by abusing cocaine or methamphetamine.

What does Khat look like?
When fresh, Khat leaves are glossy and crimson-brown in colour, resembling withered basil. Khat leaves typically begin to deteriorate 48 hours after being cut from the shrub on which they grow. Deteriorating Khat leaves are leathery and turn yellow-green in colour.

How is Khat used?
Khat typically is ingested by chewing the leaves — as is done with loose tobacco. Dried Khat leaves can be brewed in tea or cooked and added to food. After ingesting Khat, the user experiences an immediate increase in blood pressure and heart rate. The effects of the drug generally begin to subside between 90 minutes and 3 hours after ingestion; however, they can last up to 24 hours.

Who uses Khat?
The use of Khat is accepted within the Somali, Ethiopian, and Yemeni cultures, and in the United States Khat use is most prevalent among immigrants from those countries. Abuse levels are highest in cities with sizable populations of immigrants from Somalia, Ethiopia, and Yemen, including Boston, Columbus, Dallas, Detroit, Kansas City, Los Angeles, Minneapolis, Nashville, New York, and Washington, D.C. In addition, there is evidence to suggest that some non-immigrants in these areas have begun abusing the drug.

What are the risks?
Individuals who abuse Khat typically experience a state of mild depression following periods of prolonged use. Taken in excess Khat causes extreme thirst, hyperactivity, insomnia, and loss of appetite (which can lead to anorexia). Frequent Khat use often leads to decreased productivity because the drug tends to reduce the user's motivation. Repeated use can cause manic behaviour with grandiose delusions, paranoia, and hallucinations. (There have been reports of Khat-induced psychosis.) The drug also can cause damage to the nervous, respiratory, circulatory, and digestive systems.

Andy Brown
Head of Substance Misuse Services
Brent DAAT

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	Health Partnerships Overview and Scrutiny Committee 16th February 2011 **Report from the Director of Strategy, Partnerships and Improvement**
For Action	Wards Affected: ALL
Fuel Poverty and Health Task Group – Final Report	

1.0 Summary

1.1 This report sets out the findings and recommendations of the Fuel Poverty and Health Task Group that are being presented to the Health Partnerships Overview and Scrutiny Committee for its endorsement.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to endorse the Fuel Poverty and Health Task Group's recommendations for them to be passed to the council's Executive and to local NHS trusts for approval.

3.0 Details

3.1 The final report of the Fuel Poverty and Health Task Group is attached at appendix 1. The task group was established to look at the effect that fuel poverty has on peoples' health in Brent. It has been demonstrated in various research projects that fuel poverty and its consequences can have a major impact on physical and mental health and well being. There are also specific factors in Brent that led to the selection of this topic, such as the high proportion of housing in the private rented sector (where the proportion of households in fuel poverty is highest), the relative deprivation of the borough, particularly income deprivation and the general health inequalities that exist in Brent

3.2 This work was part of a wider scrutiny project in North West London that is looking at the relationship between housing and health inequalities. Funding has been provided by the Centre for Public Scrutiny to support this work, and Brent's report will be used in a tool kit to assist other councils carrying out housing and health inequalities scrutiny reviews. The other boroughs taking part in this work, and their work areas were:

- Health and the Built Environment – Hounslow and Hammersmith and Fulham
- Fuel Poverty/Energy Efficiency – Brent and Ealing
- Overcrowding – Kensington and Chelsea and Westminster
- Overcrowding and its impact on children's educational – Hillingdon

3.3 In order to carry out their review the Fuel Poverty and Health Task Group:

- Carried out a review of literature and discussions with housing and health providers on the links between fuel poverty and health;
- Reviewed the means (i.e. grants and income maximisation advice) currently available to both residents and landlords to promote energy efficiency and reduce fuel poverty, of the various agencies involved, and what the take up of these services are;
- Reviewed fuel poverty and affordable warmth strategies currently in place and best practice examples;
- Discussed fuel poverty and health with local energy agencies;
- Held discussions with housing departments and providers on the actions used to promote energy efficiency in social and council housing, and how private sector households in fuel poverty are targeted and reached;
- Discussed with GPs and local health service providers referrals to advice on fuel poverty and affordable warmth. They also considered hospital admissions data for illnesses connected to cold homes and fuel poverty, including the costs to the health service of these admissions;
- Consulted with residents by carrying out a survey to learn more about the effects of fuel poverty on peoples' health and wellbeing.

3.4 The members of the task group were:

- Councillor Janice Long (chair)
- Councillor Margaret McLennan
- Councillor Wilhelmina Mitchell-Murray
- Councillor Claudia Hector
- Councillor Reg Colwill
- Councillor Michael Adeyeye

3.5 The task group has developed 13 recommendations that it hopes can be endorsed by the Health Partnerships Overview and Scrutiny Committee. The members of the task group are of the view that these recommendations can make a positive contribution to addressing fuel poverty in Brent. The recommendations address the following subject areas:

- advice and information
- improving energy efficiency of the housing stock and reducing fuel bills
- working with landlords; and
- working with the NHS

3.6 The key learning points from the review were:

- There is much work happening in Brent to tackle fuel poverty. Brent is fortunate to have a local charity, Energy Solutions that works on fuel poverty issues in our borough and brings an expertise to this issue.

- Commitment from the health service in Brent to tackle fuel poverty is mixed. There are some very committed individuals who are working extremely hard to give the issue a higher profile. But the local NHS does not regard fuel poverty as a corporate priority.

- As with many issues, especially in the current financial climate, fuel poverty cannot be the responsibility of one organisation – it has to be tackled in a collaborative way by the council, NHS, voluntary sector and private sector. The role of the energy firms could be increasingly important as grant funding (such as Warm Zones) is being cut. Energy firms will be expected to step in and provide funding for carbon reduction and energy efficiency measures in the home, which will help alleviate fuel poverty.

- Income maximisation is key to addressing fuel poverty. Fuel poverty is another facet of general poverty. The importance of giving people (especially the elderly and vulnerable) the means to afford to heat their home cannot be overstated. If people are entitled to benefits but they are not claiming them they need to be given the assistance to do this.

3.7 The task group believes that the key challenges to address fuel poverty are:

- Replacing the funding for fuel poverty mitigation work, as Warm Zone funding has been significantly reduced following the Comprehensive Spending Review. Will funding be replaced by energy companies, and will it be available for fuel poverty mitigation or to reduce carbon emissions from households, as the two are different?

- Ensuring that frontline staff are aware of fuel poverty and any referral network put in place to help signpost people to advice and guidance where needed.

- Getting organisational buy-in to fuel poverty as an issue to ensure support for initiatives to address it from the council, NHS, voluntary and private sector companies in Brent.

4.0 Financial Implications

4.1 None

5.0 Legal Implications

5.1 None

6.0 Diversity Implications

6.1 None

7.0 Staffing/Accommodation Implications (if appropriate)

7.1 None

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Fuel Poverty and the impact it has on health

Health Partnerships Overview and Scrutiny Committee Task Group

February 2011

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Chair's Foreword – Councillor Janice Long

As I write this foreword the UK is experiencing an extended cold spell for the second year running. It's currently -1° Celsius in Harlesden – bitterly cold, and has been for some days now. Whilst many of us can escape the bitter temperatures by retreating to our warm homes, for a significant number of people in Brent this just isn't possible because they are in fuel poverty.

In simple terms fuel poverty is "the inability to afford to adequately heat the home". There could be many reasons for this, including low income, the size of the home and under occupancy, the price of fuel and energy inefficient homes. Our task group has looked at the causes of fuel poverty and the impact that it is having on health in Brent. We've also investigated the work that is being done to tackle fuel poverty in our borough, with particular focus on how the local health service is involved in this work.

It has been demonstrated in various research projects that fuel poverty and its consequences can have a major impact on physical and mental health and well being. Fuel poverty affects how people are able to cope with COPD and other respiratory problems. Flare ups of these illnesses can be exacerbated by the general state of the home, such as cold homes, cleanliness, clutter, living in one room and other social factors such as diet. These are issues associated with poverty, not just fuel poverty. There are knock on effects on general life as people become more confined to their home, or one room. They go out less, exercise less and therefore their health and wellbeing can deteriorate.

Although there is much good work happening to address fuel poverty in Brent, the task group believes that more could be done particularly working with the local NHS. Engaging health services on this issue is crucial to make the links between fuel poverty and the impact on health. Reducing fuel poverty will benefit local people and all public service providers in Brent and the task group hopes that the local NHS will actively engage on fuel poverty initiatives in the future.

We've made a number of recommendations that relate to the local NHS – both North West London Hospitals NHS Trust and NHS Brent. The task group would like the local NHS to work with Energy Solutions, a local charity working to reduce fuel poverty, to develop a referral pathway for patients who are suspected of being in fuel poverty. One of the things that struck me during the review was the frontline staff, who are working with people in their homes, will come across people in under-heated, damp accommodation on a regular basis – people who are likely to be in fuel poverty. They need a place to refer those clients for appropriate advice and support and in Brent we have to come up with a way of making this happen. A referral pathway is the first step to take with this.

Throughout the review the importance of partnership working was stressed to the task group. Tackling fuel poverty cannot be the responsibility of one organisation – it has to be addressed in a collaborative way by the council, NHS, voluntary sector, housing landlords and the private sector. Experiencing the weather that we are currently reinforces my view that this is an issue that needs urgent attention if the health and wellbeing of many of our residents isn't going to be further affected.

Councillor Janice Long
6th December 2010

Executive Summary

It has been demonstrated in various research projects that fuel poverty and its consequences can have a major impact on physical and mental health and well being. Brent Council's Health Partnerships Overview and Scrutiny Committee established this task group to look at the effect that fuel poverty has on peoples' health in Brent.

Fuel poverty is "the inability to afford to adequately heat the home". A household is said to be in fuel poverty if it needs to spend more than 10% of its income on fuel. In 2008, the number of households in fuel poverty in the UK was estimated to be around 4.5 million which is approximately 18% of all households. It has been difficult for the task group to quantify the number of households in Brent in fuel poverty. Data released by government has a significant time lag and by most estimates, likely to be below the true level of fuel poverty in the borough. Although the true amount of fuel poverty in Brent is uncertain, 20% has been a common figure that the task group has heard.

The impacts of fuel poverty on health and wellbeing are multiple. Fuel poverty and the affect of a cold home can lead to or exacerbate the following health conditions and social issues:

- Heart attack and stroke
- Chronic obstructive pulmonary disease (COPD) and respiratory infections
- Asthma
- Worsening arthritis
- Falls and other accidents
- Mental health problems
- Heat or eat choices
- Children's education can suffer as a result of asthma attacks or recurrent respiratory infections leading to days off school

Work is taking place in Brent to tackle fuel poverty. We are fortunate to have a local charity, Energy Solutions that works on fuel poverty issues in our borough. As well as providing fuel debt advice, Energy Solutions will carry out home visits to check whether people are eligible for grant funding to pay for fuel poverty mitigation measures, such as cavity wall insulation or loft insulation. The task group heard many positive things about Energy Solutions, but it is also aware of how stretched their resources are. Changes to grant funding allocations, which are detailed in the report, could lead to increased demand for Energy Solutions services – there will be less funding to spend on fuel poverty mitigation, meaning that more people could fall into fuel debt or suffer the health and wellbeing consequences of being in fuel poverty.

The task group's recommendations are split into four main areas –

- advice and information
- improving energy efficiency of the housing stock and reducing fuel bills
- working with landlords; and
- working with the NHS

Although there is good work happening to address fuel poverty in Brent, the task group believes that more could be done. Engaging the local NHS on this issue is crucial to make the links between fuel poverty and the impact on health. Reducing fuel poverty will benefit local people and all public service providers in Brent and the task group hopes that the local NHS will actively engage on fuel poverty initiatives in the future. Indeed, the task group believes that NHS investment in schemes to tackle fuel poverty could ultimately lead to cost savings if fewer people suffer ill health as a result of living in warmer homes. At this time of

unprecedented financial pressure, the task group believes that effort should be made to invest in ill health prevention to reduce spending on treatment.

In order for this to happen buy-in to fuel poverty work is needed from the top of the local NHS, as well as the council. The task group is recommending that the council works with partners to produce an affordable warmth strategy in order to develop a coherent and focussed plan to tackle fuel poverty in the borough. In addition to this, the Local Strategic Partnership will be encouraged to take up fuel poverty as one of its areas of work to bring together the council, the local NHS and voluntary sector to work through ways to better use resources to tackle this problem.

There are two other areas where the task group hopes action can be taken. The first is in relation to a comprehensive referral network for people in fuel poverty. The task group was told that many frontline NHS and council staff see people in their homes who are likely to be in fuel poverty. Knowing where to refer those people for help is crucial. The task group is recommending that partners work with Energy Solutions to try and put in place a comprehensive referral network so that staff can confidently refer people they suspect of being in fuel poverty to a place where they will receive informed advice and guidance.

Secondly, the task group is keen that the council does all it can to encourage landlords to ensure their properties are as fuel efficient as possible. This doesn't just require enforcement, but can be done in other ways. The task group has recommended that the council continues to require landlords to provide properties with at least a D rating under the Energy Performance Certificate system before it is used for temporary accommodation or housing for people placed by the council. The task group wants the council to demonstrate its commitment to improving the standard of accommodation in Brent, starting with the private sector accommodation it uses.

Above all the report makes clear that tackling fuel poverty cannot be the responsibility of one organisation – it has to be tackled in a collaborative way by the council, NHS, voluntary sector and private sector. The task group hopes that organisations in Brent can work together to address this issue that is having such a detrimental impact on the lives of many local people.

Recommendations

The task group's recommendations are:

Recommendation 1 – The task group recommends that Energy Solutions and Brent Council's Voluntary Sector Team work with advice providers in Brent to develop a consistent and co-ordinated fuel debt advice service in Brent.

Recommendation 2 – The task group recommends that Brent Council's Housing Policy Team works with Energy Solutions and local RSLs to help broker an agreement for Energy Solutions to be compensated for providing fuel debt advice for housing association tenants in Brent.

Recommendation 3 – The task group recommends that within the next 12 months officers in the council's Environmental Projects and Policy Team investigate the possibility of setting up a home insulation scheme in Brent based on the Slough model, working with an appropriate private sector provider and learning from good practice in other boroughs.

Recommendation 4 – The task group recommends that the council does not arrange for installation of pre-payment energy meters in its properties or properties used for temporary accommodation and instead refers the tenants and residents that request this service to Energy Solutions for advice on energy efficiency and fuel debt.

Recommendation 5 – The task group recommends that officers in the council's Environmental Projects and Policy Team works with officers from NHS Brent and North West London NHS Hospitals Trust to resurrect the planned fuel poverty and health campaign and implement this in Brent.

Recommendation 6 – The task group recommends that the council continues to require landlords to provide properties with at least a D rating under the Energy Performance Certificate system before it is used for temporary accommodation or housing for people placed by the council. This standard should be enforced even if pressure on private sector properties increases as a result of changes to housing benefit rules, and if the council needs to use properties outside of Brent to place people.

Recommendation 7 – The task group recommends that Brent Private Tenants Rights Group presents the findings from its mystery shopping of landlords to the appropriate overview and scrutiny committee to see if the council should be taking additional action as a result of this work.

Recommendation 8 – The task group recommends that NHS Brent and GPs work to include a question on fuel poverty in their screening of over 75s, to help track the extent of the problem and to refer them to appropriate advice. This could be done on a trial basis and if successful rolled out across the borough.

Recommendation 9 – The task group recommends that staff from NHS Brent and North West London NHS Hospitals Trust work with Energy Solutions, supported by the council, to develop an appropriate referral pathway for patients who are suspected of being in fuel poverty. The referral pathway should involve as wide a range of organisations as possible and could build on the Hot Spots scheme that already exists in Brent. Energy Solutions should be appropriately funded by the NHS for facilitating a referral network.

Recommendation 10 – The task group recommends that North West London NHS Hospitals Trust investigates the possibility of running fuel poverty advice sessions with Energy Solutions at their respiratory clinics. Energy Solutions should be funded to carry out this work.

Recommendation 11 – The task group recommends that Brent Council, with partners, develop an affordable warmth strategy for Brent to enable the borough to develop a coherent and focussed plan to tackle fuel poverty within existing resources.

Recommendation 12 – The task group recommends that Brent Council considers the feasibility of undertaking a stock condition survey in order to produce a more accurate picture of fuel poverty in the borough and a basis from which to chart measures put in place to tackle it.

Recommendation 13 – The task group recommends that Brent's Local Strategic Partnership hosts a fuel poverty event to begin to address the wider issues outlined in this report and to promote the partnership approach involving the council, NHS and voluntary sector to bring more people out of fuel poverty.

Introduction

Brent Council's Health Select Committee (now known as the Health Partnerships Overview and Scrutiny Committee) established a task group to look at the effect that fuel poverty has on peoples' health in Brent. It has been demonstrated in various research projects that fuel poverty and its consequences can have a major impact on physical and mental health and well being. There are also specific factors in Brent that led members to select this topic, such as the high proportion of housing in the private rented sector (where the proportion of households in fuel poverty is highest), the relative deprivation of the borough, particularly income deprivation and the general health inequalities that exist in Brent – there is a nine year difference in life expectancy between males in Harlesden in the south of Brent and Northwick Park in the north. Members were interested to know how fuel poverty contributes to health inequalities in Brent.

This work is part of a wider scrutiny project in North West London that is looking at the relationship between housing and health inequalities. Funding has been provided by the Centre for Public Scrutiny to support this work, and Brent's report will be used in a tool kit to assist other councils carrying out housing and health inequalities scrutiny reviews. The other boroughs taking part in this work, and their work areas were:

- Health and the Built Environment – Hounslow and Hammersmith and Fulham
- Fuel Poverty/Energy Efficiency – Brent and Ealing
- Overcrowding – Kensington and Chelsea and Westminster
- Overcrowding and its impact on children's educational – Hillingdon

Given that this was part of a wider review looking at the links between housing and health, it was important that fuel poverty was picked up as an issue.

Review methodology

In order to carry out their review the fuel poverty and health task group:

- Carried out a review of literature and discussions with housing and health providers on the links between fuel poverty and health;
- Reviewed the means (i.e. grants and income maximisation advice) currently available to both residents and landlords to promote energy efficiency and reduce fuel poverty, of the various agencies involved, and what the take up of these services are;
- Reviewed fuel poverty and affordable warmth strategies currently in place and best practice examples;
- Discussed fuel poverty and health with local energy agencies;
- Held discussions with housing departments and providers on the actions used to promote energy efficiency in social and council housing, and how private sector households in fuel poverty are targeted and reached;
- Discussed with GPs and local health service providers referrals to advice on fuel poverty and affordable warmth. They also considered hospital admissions data for illnesses connected to cold homes and fuel poverty, including the costs to the health service of these admissions;
- Consulted with residents by carrying out a survey to learn more about the effects of fuel poverty on peoples' health and wellbeing.

The task group interviewed the following people during their work:

- Jeff Bartley, Environmental Projects and Policy Manager
- Matt Sheen, Energy Solutions
- John Palmer, Sustainability Manager, North West London Hospitals NHS Trust

- Tony Hirsch, Head of Housing Policy
- Jacky Peacock, Executive Director, Brent Private Tenants Rights Group
- Maria Buxton, Respiratory Physiotherapist Consultant, North West London Hospitals NHS Trust
- Margaret Magee, Annalisa Tonge, Monica Bowles and Sandra Henry – Short Term Assessment, Rehabilitation and Reablement Service, North West London NHS Hospitals Trust
- Perry Singh, Assistant Director Housing Needs/Private Sector Housing and Phil Mitchell, Head of Enforcement Service, Private Housing Services
- Simon Bowen, Acting Director of Public Health

Task group membership

The task group members were:

- Councillor Janice Long (chair)
- Councillor Margaret McLennan
- Councillor Wilhelmina Mitchell Murray
- Councillor Claudia Hector
- Councillor Michael Adeyeye
- Councillor Reg Colwill

The task group was supported by Andrew Davies, Policy and Performance Officer.

National Context

Definition of Fuel Poverty

In simple terms, fuel poverty is "the inability to afford to adequately heat the home"[1]. A household is said to be in fuel poverty if it needs to spend more than 10% of its income on fuel. However, it is worth noting that there is some debate about the most appropriate definition of fuel poverty, dependent on which version of income is used to calculate prevalence. For example, the Greater London Authority has found that when using a 'residualised' measure of income (a measure of income which excludes housing costs) the incidence of fuel poverty in London rose to 24% or 760,000 households in 2008, which is considerably more than the government's 'full income' definition which gives a rate of 10%.[2] Despite the different definitions when the task group refers to fuel poverty it is talking about households spending 10% of their income on fuel (which is the government's definition).

Number of households in fuel poverty

In 2008, the number of households in fuel poverty in the UK was estimated to be around 4.5 million, a rise of around 0.5 million from 2007. This represents about 18% of all households. The UK figure is based on latest figures for England and Scotland, along with extrapolated estimates for Wales and Northern Ireland, which are both based on earlier figures.[3]

Table 1 - Fuel Poverty in England and the UK

[1] National Energy Action definition
[2] 'Fuel Poverty in London: Figures and Tables illustrating the challenge of tackling fuel poverty', Greater London Authority, September 2008, p16
[3] Annual report on fuel poverty statistics 2010 – Department of Energy and Climate Change

Fuel poverty (millions of households)	1996	1998	2001	2002	2003	2004	2005	2006	2007	2008
England (all)	5.1	3.4	1.7	1.4	1.2	1.2	1.5	2.4	2.8	3.3
Vulnerable households	4	2.8	1.4	1.2	1	1	1.2	1.9	2.3	2.7
UK (all)	6.5	4.75	2.5	2.25	2	2	2.5	3.5	4	4.5
Vulnerable households	5	3.5	2	1.75	1.5	1.5	2	2.75	3.25	3.75

What causes fuel poverty?

There are four main causes of fuel poverty. They are:

- Low income
- Size of home and under occupancy
- Price of fuel or the inability to access cheaper fuel
- Energy inefficient homes

Income

Given that fuel poverty is linked to deprivation it is unsurprising that there is a heavy concentration of fuel poverty amongst lower income households, with the lowest 30% of income households accounting for nearly 90% of fuel poverty in England. In recent years, increasing fuel prices have led to a gradual rise in the rate of fuel poverty amongst the higher income deciles. Historically households in these deciles were only fuel poor because of a very high modelled bill, through under occupying their dwelling, or having a very inefficient dwelling, price rises in recent years now mean that there are more fuel poor observed in the higher income deciles.

Size of home and under occupancy

The small number of occupants in a house compared to the size of a house often leads to fuel poverty. The government has identified that households in the worst degree of fuel poverty tend to occupy accommodation that is significantly large in area, especially single, elderly people. Under occupancy occurs mainly where children have left home or a spouse has died leaving one person in a house larger than necessary for their needs, but where they are often reluctant to move.

Impact of rising fuel prices

The biggest contribution to increasing fuel poverty between 2007 and 2008 was rising fuel prices. Although incomes nationally rose between 2007 and 2008, this rise was at a slower rate than between 2006 and 2007, possibly influenced by the economic slowdown. This is likely to continue into 2009, putting greater pressure on households to remain out of fuel poverty, particularly if the cost of energy continues to increase. Prices have risen at a rate well above that of income since 2004 and this has caused fuel poverty to rise from around 1.2m households in England to 3.3m in 2008.

Between 1996 and 2005, prices for domestic energy had risen more slowly than general inflation. However, between 2004 and 2009, annual price increases for energy outstripped general price increases. For example, in 2006 the RPI put general inflation at around 3% but domestic energy prices increased by nearly 25% contributing to the rises in fuel poor households. Fuel prices are also predicted to rise through 2010/11. For example, Scottish

and Southern Energy is upping its gas tariff by 9.4% for its 3.6 million customers from 1st December 2010, with other energy providers likely to do the same.[4]

Energy efficiency

In addition to raising household incomes and looking at the costs of energy bills, it is also very important to improve the energy efficiency of the home. Heat is lost from the home in a number of ways:

- 35% is lost from a standard home through walls.
- 25% is lost through roofs
- 15% through floors
- 15% through doors
- 10% through windows.

There are a number of measures that can be installed in the home to reduce heat loss and lower energy bills including:

- Draught proofing
- Cavity wall insulation
- Loft insulation
- Double/secondary glazing
- In addition, installing a high efficiency boiler and controls will also help to reduce costs.

Households living in private rented accommodation have higher likelihood of living in fuel poverty – 16% of households in private rented accommodation are in fuel poverty compared with 11% in other tenures. However, the housing tenure with the greatest number of people in fuel poverty is owner occupied housing. Two thirds of households in fuel poverty own their own home.[5] Fuel poverty is also more likely to affect older people. The charity National Energy Action (NEA) estimates that 50% of the fuel poor are over 60 years old.[6] Action to tackle fuel poverty should be aimed at older owner occupiers and the private rented sector in order to have the biggest impact.

Effects of fuel poverty

Fuel poverty has a number of detrimental effects which can't be understated. A low income household may try to maintain a comfortable temperature in their home, but could fall into fuel debt as a result. Being in debt to energy companies and dealing with the consequences of this can lead to stress for the individuals concerned.

Fuel poverty has a physical impact on the condition of homes if householders try to minimise their fuel bills. Inadequate heating can lead to some or all of the following problems:

- Condensation, dampness and mould growth
- Deterioration of the property
- Increased maintenance and repair costs
- Reduction of the asset value of the property

There is little doubt that cold housing is a health risk. The Marmot Review, "Fair Society, Healthy Lives", neatly summarises the importance of a warm home. The review says that

[4] The Guardian – 29th October 2010
[5] Fair Society, Healthy Lives – The Marmot Review
[6] National Energy Action presentation at Ealing Council – May 2010

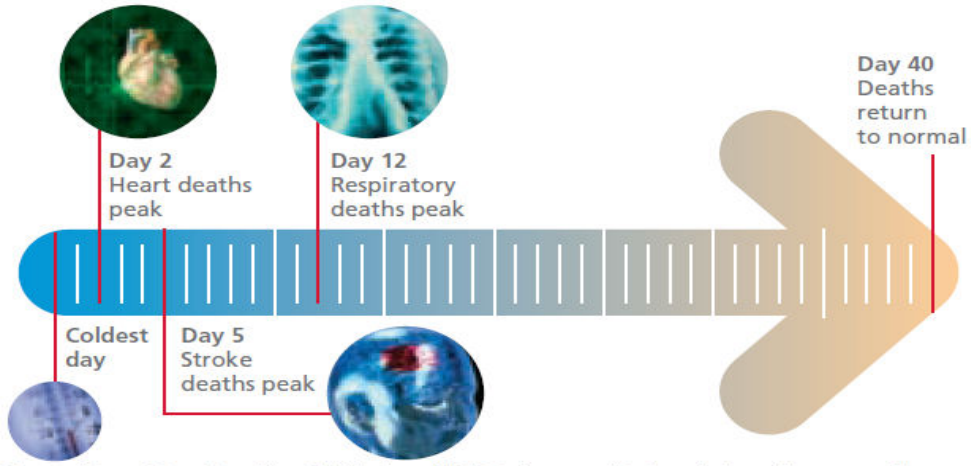
cold is believed to be the main cause of extra winter deaths that occur each year between December and March. Winter deaths continue to happen in the UK despite government policies to reduce the number of cold homes and prevent the risk of ill health due to cold among families with children, older people and those with a disability or long-term illness.[7] Between December 2008 and March 2009 there were 36,700 additional deaths in England and Wales.

Most winter deaths are unnecessary and preventable. Much colder countries than the UK, such as Finland and Russia, have lower levels of excess winter mortality. Compared with colder countries, at the same outdoor temperature living rooms in the UK are colder and bedrooms are less likely to be heated.[8]

The main illnesses associated with fuel poverty are cardio vascular disease and childhood asthma. North West London NHS Hospitals Trust reports that during the winter months (October to March) admissions for the illnesses associated with the cold are around 300 a month higher than the average during the summer months. Whilst not all of them will be connected to cold homes or fuel poverty, winter has the greatest proportional effect on respiratory disease.

The chart below shows what happens following a cold snap, and the impact it has on respiratory conditions in the days immediately following the coldest day in a given spell. As can be seen, the full impact of cold weather can take over a month to work itself through, with death rates only returning to normal levels 40 days after the coldest day.

Box 3: Cold weather death sequence



Source: Adapted from Donaldson GC, Keatinge WR. Early increases in ischaemic heart disease mortality dissociated from and later changes associated with respiratory mortality after cold weather in south east England. *Journal of Epidemiology and Community Health* 1997; 51(6): 643–8

The impact of illnesses and the social effects associated with fuel poverty are set out below:

- **Heart attack and stroke** - Blood pressure rises in the elderly following exposure to temperatures below 12°C. The risk of heart attacks and strokes increases with increasing blood pressure.

- **Chronic obstructive pulmonary disease (COPD) and respiratory infections** - Temperatures below 16°C are thought to lower resistance to respiratory infections.

[7] Fair Society, Healthy Lives – The Marmot Review
[8] Fuel Poverty and Health – A guide for primary care organisations, and public health and primary care professionals

Damp leads to growth of mould and fungi that can cause respiratory infections. The cold impairs lung function and is an important trigger of broncho-constriction in COPD.

- **Asthma** - Damp leads to growth of moulds and fungi that can trigger attacks. The cold impairs lung function and is an important trigger of broncho-constriction in asthma.

- **Worsening arthritis** - Cold, damp environments worsen the symptoms of arthritis.

- **Falls and other accidents** - A cold home increases the risk of falls amongst elderly people. There is also an increased risk of accidents due to loss of strength and dexterity in the hands.

- **Mental health problems** - Cold and damp housing has also been associated with increased mental health problems. Stress levels can increase due to fuel debt and other financial problems. People can become more socially isolated. Householders that are economising are less likely to socialise outside of their homes, while they may also be embarrassed to invite their friends into a cold, damp home. Such isolation can lead to depression and is also a risk factor for coronary heart disease.

- **Heat or eat?** - Choices may need to be made between spending on healthy food and on fuel bills, with the result being poor diets or a cold home. This can eventually lead to increased long-term health risks of cancer and coronary heart disease.

- **Children's education** - School days can be lost as a result of asthma attacks or recurrent respiratory infections, and in many cold homes only some rooms are heated, resulting in children not having a quiet space in which to concentrate on homework. This in turn can lead to reduced academic achievement and potentially excluding them from a range of life opportunities.

Research has been carried out which has shown that improvements in housing conditions have a positive impact on health and wellbeing, including lower rates of mortality, improved mental health and lower rates of contact with GPs. Significant improvements in health-related quality of life were found in a randomised controlled trial of home insulation, which concluded that targeting home improvements at low-income households significantly improved social functioning and both physical and emotional well-being (including respiratory symptoms). It has been argued that the decent homes standard has been one of local governments' biggest public health programmes in recent years, improving the thermal comfort of thousands of homes.[9]

Fuel Poverty in Brent

Housing is responsible for 30% of carbon emissions in Brent[10] and so improving energy efficiency is important for the environment as well as to improve living conditions and the health and wellbeing of local people. The housing stock in Brent is made up of the following tenures[11]:

- Owned outright – 25%
- Buying on a mortgage – 31%
- Renting from the council – 9%

[9] Professor Michael Marmot – LGA Conference November 2010
[10] Shaping the Future of Housing in Brent – Housing Strategy 2009-2014
[11] Mori, Place Survey, 2008-09

- Renting from a Housing Association/Trust – 12%
- Rented from a private landlord – 20%

The Marmot review identified households in private rented accommodation as being more likely to be living in fuel poverty, this issue is particularly important for Brent, which has a relatively high number of properties in the private rented sector. Additionally. 56% of households are either owner occupiers or in the process of buying their home, using a mortgage. People who own their homes can often end up in fuel poverty, particularly older people in large, under occupied homes. The decent homes standard that applies to council properties and RSL properties has led to an improvement in the fuel efficiency and comfort of these properties. In Brent, the vast majority of social housing meets the decent homes standard.

Fuel poverty is closely linked to deprivation. The risk of a household being in fuel poverty rises sharply as income falls.[12] Whilst areas of Brent are relatively affluent, parts of the borough continue to experience high levels of deprivation. Brent is ranked 53rd out of 354 boroughs in the Index of Multiple Deprivation (IMD) 2007 (1 = Most Deprived, 354 = Least Deprived). This means that Brent is in the 15% most deprived local authorities in the country. Brent is also the most deprived borough in North West London.

Income deprivation is a major issue in Brent which will be contributing to fuel poverty in the borough. Brent has one of the lowest average annual incomes compared to the rest of London. In 2009 the average household annual income for Brent residents was £31,430; this was a decrease from the 2008 figure of £33,026. Brent has the 3rd lowest average income levels in London and there are 21,504 households in Brent (20.4%) that have an average annual income of £15,000 or less.[13]

Specific data on fuel poverty in Brent has recently been published by the Department for Energy and Climate Change, although the figures are from 2006, as can be seen in the table below, 10.2% of households in Brent are said to be in fuel poverty, the third highest in London. The graph at appendix 1 shows the levels of fuel poverty in all London boroughs.

Table 2 - % of Households in Fuel Poverty (2006)[14]

Local Authority	Percentage of Homes in Fuel Poverty
Kensington and Chelsea	12.6%
Westminster	11.3%
Brent	10.2%
Newham	9.8%
Redbridge	9.6%
Enfield	9.1%
Harrow	9.1%
Bexley	8.9%
Ealing	8.8%
Waltham Forest	8.7%

[12] Fair Society, Healthy Lives – The Marmot Review
[13] Brent Evidence Base 2010
[14] Annual report on fuel poverty statistics 2010 – Department of Energy and Climate Change

Although these are the official fuel poverty statistics, the task group heard from a number of witnesses that there could be as many as 20% of households in the borough affected and it is likely that this is an underestimation.

Households with low SAP ratings

The Standard Assessment Procedure or SAP rating is used to give a measure of the overall energy efficiency of a dwelling. The higher the SAP rating the more energy efficient the dwelling will be. The information that Brent has on SAP ratings is a little out of date as a housing stock condition survey hasn't been carried out in the borough for some time. However, the Private Sector Housing Strategy: 2005-2010 contains comprehensive information on SAP ratings from 2003.

In 2003, the average SAP rating for Brent was 52. An estimated 7.4% of dwellings had a SAP of below 30. Owner-occupied (no mortgage) dwellings showed the lowest mean SAP rating, the highest being for RSL dwellings. However, according to the Brent Council Environment Report: 2005-2009, the SAP rating for BHP properties had improved to 65.[15]

Typically the older the dwelling, the lower the SAP rating. Dwellings built pre-1964 had an average SAP of around 50. The highest mean SAP is found in dwellings built post-1964. Most properties in the borough were built prior to 1964.

SAP ratings vary between different types of households. Households living in the least efficient homes (that is in a home with a SAP rating of 30 or less) tended to:

- live alone – 37.8% of the least efficient homes contain only one person, whereas only 27.5% of all households are single person households.
- be elderly – 31.9% of the least efficient homes only contain elderly people, 16.9% of all households are only older people.
- have special needs – 13.2% of the least efficient homes contain someone with a special need compared with 10.6% of all households.
- have low incomes – the average gross earned income of households in the least energy efficient homes is £17,355 compared with £23,028 for all households[16].

Energy Solutions have provided the council with estimated SAP ratings for private sector housing in Brent up to 2010. These do not differentiate between properties in the private rented sector and those that are owner occupied.

Table 3 – Estimated SAP ratings for private sector dwellings in Brent

Year	SAP Rating
April 2006	56
April 2007	58
April 2008	59
April 2009	59.4
April 2010	68

SAP ratings in the borough appear to be improving although there is a significant increase from 2009 to 2010 which is being investigated to ensure this is accurate, and if it is, to understand why there has been such an improvement.

[15] Brent Council's Environment Report: 2005-2009
[16] Brent Private Sector Housing Strategy: 2005-2010

Key Findings

Fuel Poverty Services in Brent

It has been difficult for the task group to establish a reliable figure for the number of people living in fuel poverty in Brent. Statistics on fuel poverty are either unreliable or out of date – the government has produced information (table 2 above), but although the data was released in 2010 it relates to 2006. Councils survey residents each year for NI 187 – "Tackling fuel poverty: Percentage of people receiving income based benefits living in homes with a low and high energy efficiency rating", but nobody interviewed by the task group thought that this data was robust or accurate. As many as 20% of Brent's population could be in fuel poverty and this may even be an underestimation of the problem. The survey carried out for the task group shows that over 30% of respondents consider themselves to be in fuel poverty (see appendix 3). The areas of Brent most likely to be affected by fuel poverty are likely to be the most deprived areas of the borough. However, there will be pockets of fuel poverty across Brent. For example, older people living in larger houses in the north of Brent that are under-occupied – in crude terms, "asset rich, cash poor".

The fuel poverty and energy action charity National Energy Action believe that there are four key steps to eradicating fuel poverty. They are:

- Income maximisation
- Price of energy
- Energy efficiency
- Working with landlords

The task group has investigated the efforts that are being made in Brent to eradicate fuel poverty, focussing on these four areas.

Income maximisation

Many people interviewed by the task group believed that raising income is crucial to tackling fuel poverty, especially for elderly people living on fixed incomes. If people are entitled to benefits they should be claiming them. However, around £4.5bn income related benefits went unclaimed by pensioners in the UK in 2008/09 and almost half of owner occupiers in the UK didn't claim the pension credit they are entitled to. [17] It has been suggested to the task group that an income maximisation project focussing on the over 75s would help some of the most vulnerable people in the borough to heat their homes adequately in winter.

Often people need advice to enable them to claim the benefits they're entitled to. Brent Council has contracted its fuel poverty advice work to Energy Solutions. Energy Solutions is based in Brent and has a charitable section which delivers energy advice and fuel poverty services to local residents and a separate consultancy business which delivers a range of professional services related to energy efficiency and sustainability across North West London. Housing and Community Care and Environment and Neighbourhood Services provide funding to Energy Solutions for their work on fuel poverty. There is one member of staff working full time on fuel poverty issues, plus one part time member of staff. Three other members of the staff provide additional administrative, strategic and fundraising/accounting support as required for the delivery of the fuel poverty services. Energy Solutions uses established links and partnerships to refer clients to the local Job Centre Plus or the DWP/Pension Service for a free benefit entitlement check to ensure their incomes are maximised. This is an important part of the debt advice service. It is interesting to note that

[17] Joseph Roundtree Foundation Website – www.poverty.org.uk

of those people on benefits who responded to the task group's fuel poverty survey only 21% had received a benefits entitlement check (see appendix 3).

Energy Solutions has established a fuel debt advice service for vulnerable people living in Brent. The service is open to residents of all tenure and occupancy types. Energy Solutions helps people to secure debt right offs, advocate on the client's behalf with utility suppliers where disputes around billing and metering arise and ensure people are on the most appropriate billing tariff for their circumstances. They will also help people switch from electric to gas heating – electric heating can be three times more expensive. Since April 2010 Energy Solutions has been in contact with over 500 residents about their fuel bills or energy use, carried out 217 home visits and secured over £23,000 of fuel debt write offs.

The task group was informed by Energy Solutions that attempts to work with other organisations that may provide fuel debt advice, such as the Brent Citizens Advice Bureau, had not been successful. Fuel debt advice is a specialist area of advice and Energy Solutions would be keen to engage other advice providers to work with them to provide a more co-ordinated and consistent service in Brent. The task group agrees with this and recommends that Energy Solutions works with Brent Council's Voluntary Sector Team to engage other advice providers on this issue and develop a co-ordinated fuel debt advice service for Brent.

Recommendation 1 – The task group recommends that Energy Solutions and Brent Council's Voluntary Sector Team work with advice providers in Brent to develop a consistent and co-ordinated fuel debt advice service in Brent.

Housing associations have been keen to take up the fuel debt advice provided by Energy Solutions for their tenants. However, to date, it has not been possible to agree a service level agreement to ensure that Energy Solutions are compensated for this work (Energy Solutions will not charge the client). Energy Solutions would like to develop an SLA with interested RSLs and the task group would encourage this. The task group recommends that the Housing Policy Team helps to broker an agreement between Energy Solutions and local RSLs for the provision of fuel debt advice for housing association tenants in Brent.

Recommendation 2 – The task group recommends that Brent Council's Housing Policy Team works with Energy Solutions and local RSLs to help broker an agreement for Energy Solutions to be compensated for providing fuel debt advice for housing association tenants in Brent.

Grant funding

When the task group began their work looking at fuel poverty in Brent, there were two main grants available to people wishing to improve the energy efficiency of their home:

- Warm Front provides grants for heating and insulation to people in receipt of certain qualifying benefits. Warm Front is a national scheme and operates with central annual budget which is allocated on a first come first serve basis.
- London Warm Zones provide insulation and heating and is available free to people classed as being in the "priority group". For all other clients, classed as the 'Able to Pay' (ATP), the scheme provides a range of energy efficiency services at heavily discounted rates. Warm Zones is 50% funded by EDF Energy under their CERT obligation funding and 50% by the GLA's Target Funding Stream (TFS). The Warm Zone grant allocation for Brent is spent each year and there is always a waiting list of people wanting heating and insulation measures. Energy Solutions has negotiated successfully with other west London boroughs in the scheme to spend their funding, where it is known there will be an underspend. Up to June 2010, 2,600 homes in Brent had benefited from a Warm Zones grant, most of it spent on cavity wall

insulation and loft insulation. More homes have benefited from cavity wall insulation in the north of the borough than the south.

It is worth noting that neither Warm Front or Warm Zones are emergency services, should heating systems fail altogether. There is also a national shortage of heating and insulation installers which leads to a back log of improvement works.

Energy Solutions administer these grants in Brent. Most, but not all of the people advised by Energy Solutions live in the private sector, either in their own home or in rented accommodation. Referrals generally come from word of mouth although Energy Solutions target people living in the private rented sector and landlords to encourage them to take up the grants available for improvements to the home. However, despite this we know that take up of grants among tenants renting in the private sector is very low. Around 4-5% of the Warm Zones jobs carried out each year in Brent are in this sector, the rest carried out in properties owned by the occupier.

The Government's Comprehensive Spending Review confirmed that funding for Warm Front would be cut from £340m per year to £110m per year, although the scheme will run until 2012/13. This will obviously affect the amount of funding that will be available in Brent and will be detrimental to those in fuel poverty who are eligible for this grant, but will miss out on improvements to their home as a result of this reduction. The future of London Warm Zones is also unclear because of cuts to the London Development Agency. Energy firms will be expected to provide grant funding to replace reductions in Warm Front funding through the Energy Company Obligation and the introduction of the Green Deal in 2012 to improve energy efficiency and warmth of homes, but it is not clear how much money will be available. Energy companies are also required to put in place carbon reduction programmes, but this is different to alleviating fuel poverty.

There is a greater number of grants available to reduce carbon emissions rather than tackle fuel poverty. Bringing people out of fuel poverty can, in some cases, actually lead to higher CO2 emissions and it is not the same as carbon reduction. For instance, if a household is brought out of fuel poverty by increasing their income they may use more domestic energy because they can afford to do so. This will increase their CO2 emissions. This is why income maximisation work needs to dovetail with projects to improve the energy efficiency of homes in Brent.

Other councils have successfully used grant funding from energy companies to the private sector to roll out a comprehensive fuel poverty mitigation programme, which also contributes to reducing climate change. For example, Slough Borough Council is running its Energy Care Scheme. This scheme offers free home energy inspections to all Slough residents. The council has sourced funding for private householders to have loft and/or cavity wall insulation at reduced prices or for free, depending on their circumstances.

Slough Council engaged a private sector firm to carry out this work. The private company, endorsed by the local authority will go to houses, door to door, selling discounted insulation provided through grant funding. This approach has worked in Slough, with over 4,000 homes benefiting from loft or cavity wall insulation as part of this scheme. But it does require a communications campaign to make it work and there is a risk to the council in that the firm endorsed to do this needs to be reputable and deliver a good service. That said the task group believes that the approach could be tried in Brent. The task group recommends that officers consider whether a similar scheme can be established in Brent within the next 12 months.

Recommendation 3 – The task group recommends that within the next 12 months officers in the council's Environmental Projects and Policy Team investigate the possibility of setting up a home insulation scheme in Brent based on the Slough

model, working with an appropriate private sector provider and learning from good practice in other boroughs.

Price of energy

As stated above, the biggest contribution to increasing fuel poverty in recent years has been rising fuel prices. Fuel poverty dropped significantly from 1996 to 2004 (table 1) because of work done to help raise incomes (for example, the introduction of the minimum wage). Since then, fuel poverty has increased as fuel prices have risen significantly above the level of inflation. Using different methods of paying for energy could help residents to save money and alleviate fuel poverty.

The task group was informed by a number of people interviewed that pre-payment meters were one of the most expensive ways to pay for energy, but they are common in the private rented sector in Brent. Unfortunately many are installed at the request of tenants to help them budget, perhaps unaware that they are more expensive than a normal meter. Nationally the number of people in fuel poverty using a pre-payment meter has fluctuated in recent years. In 2003 and 2004 the rate of fuel poverty was greatest amongst those paying for their electricity and gas by pre-payment meters. However, in 2005, fuel poverty rates amongst households using pre-payment meters were similar to those amongst households paying via standard credit for both gas and electricity. This remained the case in the period between 2005 and 2008 for electricity and in the period 2005 to 2007 for gas. In 2008, those households on gas pre-payment meters again had a slightly higher rate of fuel poverty (23 %) than those on standard credit (20%).[18]

Organisations such as Energy Solutions will work with residents to secure the most appropriate method of payment and try to reduce bills where possible, including switching away from pre-payment meter. The task group was told that pre-payment meters are not used in Brent Housing Partnership properties or private sector properties used by the council for temporary accommodation, but tend to be more widely used in privately rented HMOs so it is easier for tenants to split their fuel bills. The task group was pleased to learn that the council insists that properties have regular gas and electric meters when they are being used for temporary accommodation and hopes that this policy continues.

The energy supply industry and campaigning agencies disagree over the link between prepayment meter use and fuel poverty. The industry maintains that prepayment is simply one of a wide range of payment options – one that is appropriate and beneficial to certain consumers. Charities such as NEA take the view that a payment method that incurs additional costs and encourages rationing is a choice made out of necessity.[19]

Despite the conflict between the energy industry and campaigners we know that households paying for their energy by direct debit are less likely to be in fuel poverty than those paying by prepayment meter (just over 10% of households that pay for their energy using direct debit are in fuel poverty, compared to 23% for those using gas prepayment meter).[20] And whilst budgeting may be easier when using a pre-payment meter, the disadvantages such as the meter being set to collect arrears before fuel can be supplied, outweigh the benefits. The task group would like the council to advise tenants not to switch to pre-payment meters on budgeting grounds because of the cost, and to seek advice on paying for energy and income maximisation from Energy Solutions instead.

[18] Annual report on fuel poverty statistics 2010 – Department of Energy and Climate Change
[19] National Energy Action Website – Debt and Disconnection
[20] Annual report on fuel poverty statistics 2010 – Department of Energy and Climate Change

Recommendation 4 – The task group recommends that the council does not arrange for installation of pre-payment energy meters in its properties or properties used for temporary accommodation and instead refers the tenants and residents that request this service to Energy Solutions for advice on energy efficiency and fuel debt.

The fuel poverty survey results showed that only just over half of respondents had changed their energy supplier to reduce the cost of their bill, a relatively easy way of saving money by looking for the best deals on domestic energy. Additionally, more than 35% of respondents are not using the cheapest payment methods for their fuel – direct debit or online billing. Again, these are relatively simple ways of saving money that don't require significant investment by council's or other statutory organisations – they are heavily advertised by the energy firms themselves. It is a concern that many people are still not taking advantage of the best deals available to reduce their energy costs.

Energy efficiency

One of the key aims of climate change mitigation work is to encourage households to change their behaviour and use less energy. Brent Council has been working with the Local Government Improvement and Development who have funded a scheme to provide energy meters to householders to enable them to monitor their energy consumption. By providing people with evidence of their energy use they are more likely to take action to reduce it. This device has helped participants reduced their energy consumption by around 15% because they are more energy conscious and recognise ways to save energy. The task group believes that behaviour change is as important as infrastructure improvements.

Brent council did have plans to run a campaign on the link between fuel poverty and health, to raise awareness of the issue. However, this is now on hold as the funding for this was to come from Performance Reward Grant, which has been removed by the coalition government. This task group is disappointed by this. Given that improvements to health benefit all public services the task group believes that health service partners as well as the council should consider running this campaign jointly. The campaign would have cost £??? to fund, and the council should work with local health partners to see if it can be resurrected, perhaps through the Health and Wellbeing Steering Group. The task group recommends that the council works with colleagues in the health sector (NHS Brent and North West London NHS Hospitals Trust) to resurrect the fuel poverty and health campaign and implement it if possible.

Recommendation 5 – The task group recommends that officers in the council's Environmental Projects and Policy Team works with officers from NHS Brent and North West London NHS Hospitals Trust to resurrect the planned fuel poverty and health campaign and implement this in Brent.

Improving the energy efficiency of the existing housing stock is huge and expensive problem. Around 90% of properties that will be standing in 2050 have already been built – therefore retro fitting existing properties is crucial to mitigate climate change and improve the energy efficiency of properties. There is a shortfall in grant funding to carry out all the improvements that are needed, whilst solutions to tackle hard to treat housing, such as external cladding, are prohibitively expensive for many households. Regeneration areas may benefit from energy efficiency measures, especially new build properties, but this will only account for a small proportion of properties in Brent. Retro fitting properties in the rest of the borough is a significant issue.

Many properties in Brent are not suitable for some of the more common energy efficiency measures particularly properties classified as "hard-to-treat". For example, homes with solid walls cannot be fitted with cavity wall insulation. There are also a large number of flats in the Brent, which often have flat roofs and therefore loft insulation cannot be installed. The task

group was informed that around 60% of properties in Brent are classed as “hard to treat”. Making changes to the fabric of privately rented homes to improve energy efficiency is not possible without the landlord’s permission, which isn’t always easy to obtain. There has been more progress in improving the energy efficiency of homes in the public sector then in the private rented sector. Brent Housing Partnership and RSLs have made significant investments in their properties under the Decent Homes Standard. Generally the public sector is more aware of its obligations to provide appropriate thermal comfort in homes than landlords in the private sector. However, the link between social housing and deprivation is well established, so whilst the energy efficiency of their properties may be higher than in the private sector, social housing tenants are vulnerable to rising fuel prices. Income maximisation is important for social housing tenants to ensure they don’t fall into fuel poverty.

Planning standards are generally focussed on carbon reduction rather than reducing fuel poverty. Planning regulations ensure that new build properties meet modern energy efficiency standards, but we know that new-build properties are in a considerable minority in the borough. Whilst it is important they meet the latest standards, new build properties will not resolve Brent’s fuel poverty issues.

There are projects in Brent that are working with residents to give them advice on energy efficiency and refer them to appropriate support when needed. Brent Hot Spots, managed by Energy Solutions is a good example of this. Brent Hotspots aims to ensure more low income households in Brent have warm safe homes and can cope with the increasing cost of energy bills. Hot Spots is a cross-referral initiative which operates by engaging front line practitioners, such as the fire service, benefit agencies and social care agencies, as referrers of vulnerable and hard-to-reach households primarily into sources of energy efficiency assistance and advice, income maximisation and home safety services.

The task group was informed that Energy Solutions had tried to involve the local NHS in Hot Spots without success to date. This is unfortunate given the number of vulnerable people seen on a regular basis by health visitors, district nurses, GPs and hospital staff. Involving the NHS in Hot Spots would strengthen the links between energy efficient warm housing and better health and is something the task group feels should be pursued. It should be noted that in interviews with frontline health care staff they were often frustrated at not knowing where people could be referred for advice if they were unable to adequately heat their home. Involvement in Hot Spots could help to resolve this issue.

Fuel poverty is a priority for the Brent Private Tenants Rights Group. BPTRG are hoping to secure funding for a fuel poverty campaign coordinator. They are backing the approach and campaign used by Friends of the Earth, who are arguing for better use of Energy Performance Certificates in privately rented homes to raise awareness of energy efficiency and fuel poverty. Friends of the Earth are promoting the idea that any property rated F or G on their Energy Performance Certificate (i.e. the lowest energy efficiency rating) should not be rented privately, although for this to become law primary legislation from parliament would be required.

Brent Private Tenants Rights Group believe that only a small number of private sector tenants in Brent are aware of the grants that are available to them to improve their homes. Of the private tenants that do apply for grants, BPTRG believe that the majority are elderly and living in regulated tenancies (i.e. tenancies that have been running since before 1989). These people are not expecting to move and so are more likely to apply for the grants on offer. People with short hold tenancies may feel that it isn’t worth applying because they won’t be in the property long enough to receive the benefit. There are also fears over security of tenancy. Some tenants fear rent increases as a result of improvements to property, not realising that housing benefit will cover the rise in many cases.

Working with landlords

Brent's private rented sector has increased considerably in recent years. There are around 20,000 privately rented properties in Brent, which accounts for approximately 20% of properties in the borough. Working with landlords as a group has become more difficult due to the increase in the number of non professional landlords, who because of easy access to buy-to-let mortgages have been able to become landlords in far greater numbers.

Encouraging landlords to think about fuel poverty and the impact that this has on their tenants is a challenging issue and one that isn't unique to Brent. This situation isn't helped by the fact that grant funding for fuel poverty related improvements are only available to the tenant and not to the landlord. It is the tenant's responsibility to apply for funding, but they need the landlord's permission to carry out any work on the property.

The task group was told that many tenants won't access the available funding for a variety of reasons, including:

- Tenants are worried about the consequences if they apply for funding and approach their landlord for permission to alter the property. They fear a rent increase, because of improvements that will be made to the property, or possibly eviction because they have suggested the property is substandard.
- Not all tenants are aware of the grants that are available to them.
- Tenants are unaware of their rights which are protected in legislation and won't approach their landlord about making improvements to their property.

There are separate incentive schemes that aim to encourage landlords to improve the quality of their property. Landlords can claim a £1,500 tax credit for work on their home via a scheme known as the 'Landlords Energy Saving Allowance (LESA). However, £1,500 isn't regarded as a big enough incentive and it relies on landlords declaring income from rented homes in the first place. Landlords don't personally benefit from any improvement in a way that owner occupiers do when they improve their homes, either though reduced energy bills or a warmer home. Take up of this offer is low across the country.

Specific work with landlords to address energy efficiency in the private rented sector is one of the council's Environmental Projects and Policy Team's objectives, but this work has been delayed because of the loss of PRG. This work will now begin in 2011/12.

Energy Performance Certificates are a requirement for all rented properties (except HMOs) and provide information on the energy efficiency of the property. An EPC has to be available for tenants to see before they move into a property, but often tenants will have to ask to see this. Brent Private Tenants Rights Group believe that very few landlords offer to show tenants the EPC prior to them accepting the property, and it is doubtful that many tenants know they have a right to see it. If the legislation around EPCs was rephrased so that landlords had to produce the EPC when advertising the property, prospective tenants would have a much better idea of the sort of property they will be renting and the likely energy bills.

The task group was encouraged that the council insists that properties used for temporary accommodation are rated at least D on their Energy Performance Certificate. However, as pressure for affordable private sector accommodation increases as changes to benefit rules take hold, the council may feel that it has to compromise on this to secure accommodation for homeless families and for families that can no longer afford to remain in their current rented property. However, the task group believes that the council needs to be setting standards for private landlords to adhere to and recommends that the D rating remains a condition of use for homeless accommodation in the private rented sector, to ensure landlords maintain their properties with a reasonable level of thermal comfort. This should be

the case even if the council uses properties outside of Brent because of the impact of the changes to the housing benefit rules.

Recommendation 6 – The task group recommends that the council continues to require landlords to provide properties with at least a D rating under the Energy Performance Certificate system before it is used for temporary accommodation or housing for people placed by the council. This standard should be enforced even if pressure on private sector properties increases as a result of changes to housing benefit rules, and if the council needs to use properties outside of Brent to place people.

It is Trading Standards responsibility to enforce the EPC regime, but the task group was informed that they don't regard it as a priority. Brent Private Tenants Rights Group would like to start mystery shopping landlords to see if they have their EPC. If a landlord can't produce an EPC they could be reported to Trading Standards because they are breaking the law. The task group supports BPTRG in this work and hopes that the council is able to support this initiative. The task group recommends that once BPTRG has carried out their mystery shopping it reports the results to the appropriate overview and scrutiny committee for members to consider the findings and decide whether the council should be taking more action, via Trading Standards, against landlords for not having Energy Performance Certificates.

Recommendation 7 – The task group recommends that Brent Private Tenants Rights Group presents the findings from its mystery shopping of landlords to the appropriate overview and scrutiny committee to see if the council should be taking additional action as a result of this work.

Enforcement is an issue in Brent, as the number of privately rented homes has increased but the number of enforcement officers has fallen. All of the work Private Housing Services does is reactive as they do not have the capacity to carry out proactive work around energy efficiency and thermal comfort. Around 900 referrals are received by Brent Private Housing Services each year, the majority of them connected to cold and inadequate heating.

Local authorities have the power to tackle deficiencies in properties, including poor insulation and ventilation. The 2004 Housing Act gave councils the powers to tackle poor housing, setting out statutory minimum standards that are required in the private sector. Additionally, the Housing Health and Safety Rating System helps evaluate the potential risks to health and safety from deficiencies identified in dwellings.

The task group is realistic about enforcement services – it does not anticipate the council being able to invest extra resources into Private Housing Services to enable proactive enforcement for hazards in the private rented sector. This is not feasible in the current financial climate where spending on services is to reduce. However, as the enforcement service is reactive it is important that tenants are aware of their rights, that they are able to report perceived hazards to the council and that they are able to seek advice from organisations such as Energy Solutions. Enforcement is important, but it is not going to be the solution to all fuel poverty issues in Brent.

Fuel Poverty and health

There is a great deal of evidence that that fuel poverty has a detrimental impact on health. National Energy Action states that people living in fuel poor households are likely to suffer from a number of serious health and wellbeing issues, such as heart attack and stroke, COPD and respiratory infection, asthma, worsening arthritis and they are more likely to

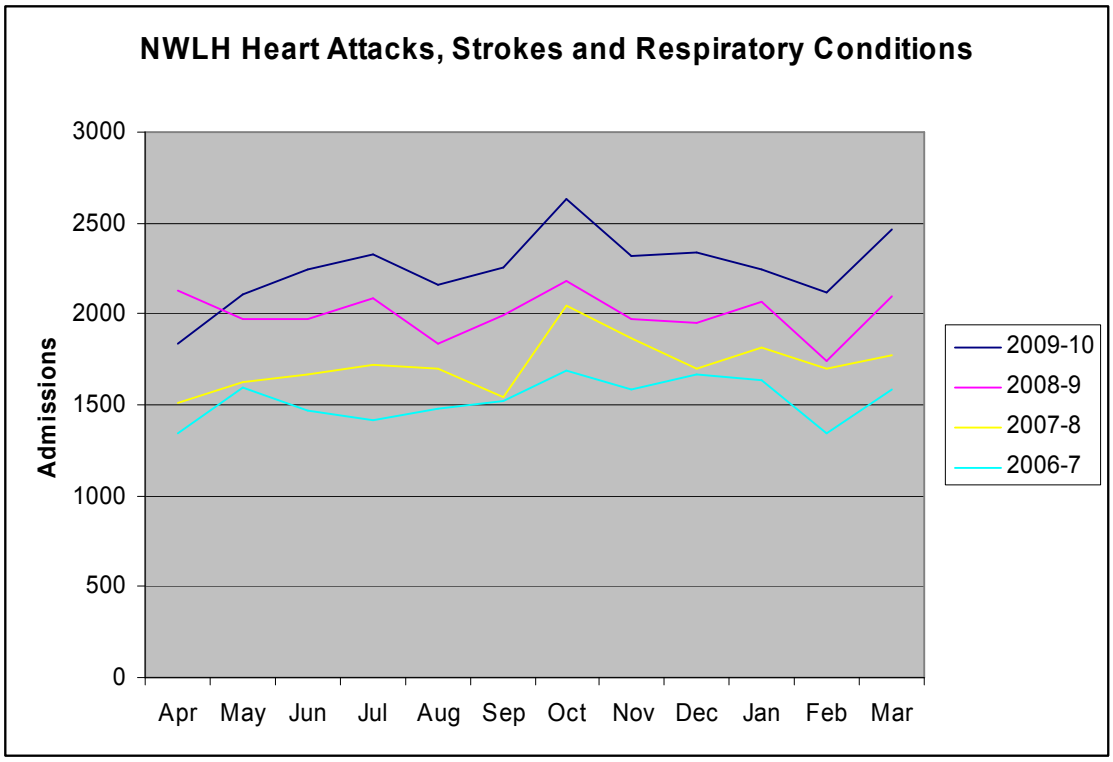
suffer falls and other accidents in the home.[21] Fuel poverty and cold homes is also thought to contribute to mental health problems, children's absence from school because of increases in asthma and illness, which obviously has an impact on educational attainment. Child poverty is also an issue associated with cold homes, because of the link to general poverty.

The task group heard a range of views about the relationship between fuel poverty and ill health. The group spoke to a Respiratory Physiotherapist from North West London NHS Hospitals Trust during their work. Her view was that COPD and other respiratory problems are not normally caused by the cold, but that temperature affects how patients are able to cope with those diseases. Flare ups can be exacerbated by the general state of the home, such as the temperature, cleanliness, clutter, living in one room and other social factors such as diet – i.e. issues associated with poverty, not just fuel poverty. There are knock on effects on general life as people become more confined to their home, or one room. They go out less, exercise less and therefore their health and wellbeing can deteriorate. The Respiratory Physiotherapist believes that damp conditions in the home are worse for respiratory conditions then cold, but both are symptoms of fuel poverty. What is difficult to assess is whether flare ups of respiratory conditions that result in hospital admission are as a direct results of temperature (hot or cold), although it is likely to be a contributing factor.

An important point was made to the task group by the Respiratory Physiotherapist - the majority of her patients are living in homes that aren't helping their condition, i.e. they're cold and damp and they are also living in the most deprived parts of Brent. This is further anecdotal evidence of the link between deprivation and ill health. A large proportion of patients also smoke, which is the single largest preventable cause of death and illness, responsible for over 80,000 deaths per year in England.[22] The health impact of fuel poverty needs to be seen in the context of the borough's deprivation and other factors that influence health and wellbeing, such as smoking.

Data from North West London NHS Hospitals Trust shows that admissions from heart attacks, strokes and respiratory infections to NWL Hospitals peak in October and March (see graph below). During the winter months (October to March) admissions for the three illnesses associated with the cold are around 300 a month higher than the average during the summer months. When the human body cools down, the blood thickens. As a result it becomes harder to pump leading to issues such as stroke and heart attack. How many of the people admitted are living in fuel poverty is unknown, but it is striking that there is such an increase during winter months.

[21] National Energy Action presentation at Ealing Council – May 2010
[22] Brent Tobacco Control Strategy 2010-2013



As mentioned earlier in this report, excess winter mortality rates in the UK are worse than a number of European counties that experience colder winters – the only exception to this is Ireland (see Table 4 below). There will be many reasons for this, but fuel poverty is likely to be one of them. European countries could be more prepared for winter, including having adequate insulation in homes, so that people are living in warmer conditions than in the UK.

Table 4 – Excess winter mortality as % increase over non-winter deaths[23]

Country	Excess winter mortality as % increase over non-winter deaths
Ireland	21%
England	**19%**
Wales	**17%**
Scotland	**16%**
Mean	16%
Austria	14%
Belgium	13%
France	13%
Denmark	12%
Netherlands	11%
Germany	11%
Finland	10%

Data on excess winter deaths in Brent has been published by the Association of Public Health Observatories. As Table 5 below shows, excess winter deaths in Brent are below the England value. Although this is encouraging (and could be the result of having a lower proportion of older residents than other areas), the council and partners should not be

[23] National Energy Action website

complacent about the effect of cold homes and fuel poverty. It should also be noted that data relates to the years 2004-2008. They do not include the winter of 2009/10.

Table 5 – Excess winter deaths in Brent

Profile Year	Data Year	Local value	England value	Local count per year
2009	Aug 04 - Jul 07	11.3	17.0	57
2010	Aug 05 - Jul 08	10.0	15.6	17

The task group was interested in how local NHS staff view fuel poverty and whether it is ever considered when treating patients. A range of views and opinions were received in interviews which suggests that in Brent awareness is patchy. As expected, those staff that spend time in peoples' homes often encounter households living in less than ideal conditions, displaying signs that are consistent with fuel poverty such as living in one room, heating only one room and leaving the rest of the house unheated and physical signs such as damp. Front line staff report that in their experience it was mainly elderly single people who were in fuel poverty. This is in line with national statistics on fuel poverty. Staff also believed that people living in their own homes in fuel poverty were harder to help than those living in local authority or RSL accommodation, because staff could contact the landlord relatively easily if they came across problems with social rented properties.

However, despite being aware of fuel poverty and significant numbers of people living in poor quality accommodation, frontline staff are not sure where to turn in order to try to help people who need advice on their housing and energy situation. None of the frontline staff interviewed were aware of Energy Solutions or the Brent Hot Spots scheme. Some staff reported housing problems to social workers, but this can be time consuming and social workers may not be best placed to assist with housing and energy issues. At other times the landlord was contacted to try and ensure problems were dealt with. Despite the concern of front line staff, they have such big caseloads that there simply isn't time for them to follow up housing related problems.

The task group was told by a number of people that partnership working between the council, health sector and voluntary sector on fuel poverty issues could be better, but there is common ground. North West London NHS Hospitals Trust and NHS Brent recognise this is an issue, but has committed little funding and few resources to tackling it. The council considers fuel poverty to be a significant issue and it is a separate strand in our climate change strategy; we also fund Energy Solutions to carry out its fuel poverty work, although there is a need to do more.

There are issues that the task group would like to see acknowledged and addressed. North West London NHS Hospitals is not addressing fuel poverty with patients admitted with illnesses associated with cold, although there are staff within the trust who are keen to work on this issue (notably the trust's head Respiratory Nurse). There is also no referral pathway for people who are in fuel poverty and have been admitted to the one of the trust's hospitals with a cold related illness.

The situation with regard to primary care and knowledge of fuel poverty is more complex. GPs are to become commissioners of health services, but their engagement in this issue isn't clear. The task group used a Brent GP practice to distribute a questionnaire on fuel poverty, but one of the GPs at the practice had acknowledged that although housing often comes up in patient consultations, fuel poverty is seldom mentioned. She suggested that in

screenings for over 75s a question on heating/fuel poverty could be added to help track the extent of the issue and also to refer people for advice if necessary. The task group supports this idea and recommends that all Brent GPs considers this.

Recommendation 8 – The task group recommends that NHS Brent and GPs work to include a question on fuel poverty in their screening of over 75s, to help track the extent of the problem and to refer them to appropriate advice. This could be done on a trial basis and if successful rolled out across the borough.

There are projects in Brent that bring together fuel poverty advice and health services. Energy Solutions have run fuel poverty advice sessions at health clinics organised by the Harness GP cluster. These have taken place at immunisation clinics, general health check clinics and baby clinics. In the past the advice sessions were held on a regular basis, but funding and staff time has been an issue more recently and so their regularity has decreased. This is the sort of initiative that the task group would like to see more of. However, it may require a financial commitment from the health service, which to date, hasn't materialised. Funding for current advice sessions comes from the Energy Solutions regular grant funding.

Plenty of people such as housing officers, those delivering meals on wheels, GPs, district nurses and health visitors have the opportunity to identify excess cold in the home or signs of fuel poverty. It would be useful if households could be referred somewhere that they will be able to receive help for their problem. Energy Solutions would be the obvious place, but this would require a financial input from the NHS to pay for this service. Although the NHS is under intense financial pressure investment in fuel poverty prevention could ultimately become a saving if it results in fewer hospital admissions. The task group would like NHS Brent and North West London Hospitals to work with Energy Solutions, supported by the council, to develop an appropriate referral pathway, at least as a pilot, to see how fuel poverty and health issues can be addressed. The Hot Spots scheme is already in place from which to build a referral pathway. A referral pathway should involve as wide a range of partners as possible so that there is a better chance that those who need help are identified and referred.

Recommendation 9 – The task group recommends that staff from NHS Brent and North West London NHS Hospitals Trust work with Energy Solutions, supported by the council, to develop an appropriate referral pathway for patients who are suspected of being in fuel poverty. The referral pathway should involve as wide a range of organisations as possible and could build on the Hot Spots scheme that already exists in Brent. Energy Solutions should be appropriately funded by the NHS for facilitating a referral network.

The task group heard a number of practical suggestions that could be implemented to address fuel poverty. One suggestion that could be taken forward by North West London Hospitals would be to run fuel poverty sessions at chest / COPD clinics, where large numbers of patients with respiratory problems could be reached in one go. The task group recommends that this is taken forward, again on a trial basis.

Recommendation 10 – The task group recommends that North West London NHS Hospitals Trust investigates the possibility of running fuel poverty advice sessions with Energy Solutions at their respiratory clinics. Energy Solutions should be funded to carry out this work.

Addressing fuel poverty

The task group heard from the witnesses that it interviewed and through considering examples of good practice effective ways of addressing fuel poverty that could be replicated

in Brent. What is clear is that the causes and effects of fuel poverty have an impact across a range of services and it cannot fall to one organisation to tackle this in isolation. It is clear to the task group that the council, NHS Brent, North West London NHS Hospitals Trust and the local voluntary sector all have a crucial role to play in addressing fuel poverty. Much good work is already happening in Brent – Energy Solutions were praised by those the task group interviewed, but there needs to be better partnership working between the council, the voluntary sector and the local NHS on this issue.

First and foremost, the task group recommends that the council and partners to prepare an up to date affordable warmth strategy for Brent. Brent does have a Fuel Poverty Strategy, but it was developed in 2005 and a number of people interviewed felt that it is out of date and needs to be refreshed. Having an up to date strategy will enable the borough to develop a coherent and focussed plan to tackle fuel poverty within existing resources. The strategy should also include some of the information that the task group has already identified as being useful to benchmark progress in tackling in fuel poverty, such as up to date SAP ratings – Islington has a thorough Affordable Warmth Strategy that includes information on the percentages of households in fuel poverty broken down into numerous categories including ward, housing tenure, housing age, type of housing, number of residents, ethnicity and support needs.[24] Any strategy would also need to be developed in partnership with the local NHS and voluntary sector partners.

Recommendation 11 – The task group recommends that Brent Council, with partners, develop an affordable warmth strategy for Brent to enable the borough to develop a coherent and focussed plan to tackle fuel poverty within existing resources.

It is important that any affordable warmth strategy has an accurate baseline from which to monitor progress. Islington has carried out a stock condition survey which has provided detailed information on SAP ratings in the borough. Harrow has also comprehensive data on SAP ratings, plus targets for improvement (see appendix 2). As well as improving energy efficiency, if these targets are met the council will be working towards reducing fuel poverty. The task group recommends that Brent looks into the feasibility of a stock condition survey in order to produce a more accurate picture of fuel poverty in the borough and a basis from which to chart measures put in place to tackle it. The stock condition survey will also provide information that can be used to target fuel poverty work, such as that in the Islington Affordable Warmth Strategy.

Recommendation 12 - The task group recommends that Brent Council considers the feasibility of undertaking a stock condition survey in order to produce a more accurate picture of fuel poverty in the borough and a basis from which to chart measures put in place to tackle it.

One of the ways that fuel poverty could be given greater prominence in Brent would be to include this issue on an LSP agenda. This approach was used in Slough to raise the profile of fuel poverty with a wide range of partners. If the LSP in Brent was to take up this issue it would bring together the council, PCT, Hospital Trust, fire service, and the voluntary sector to work on the issue. As has been stated previously, although work is happening across Brent to tackle fuel poverty, the links with health aren't as strong as they could be. Other practical arrangements don't yet exist, such as an effective referral network from hospital or GP to places where people can seek assistance for fuel poverty issues. Bringing these issues to the attention of a range of decision makers in Brent could focus organisations on the effects of fuel poverty.

[24] Islington Affordable Warmth Strategy 2009 (see - http://www.islington.gov.uk/DownloadableDocuments/Environment/Pdf/AWS_web_version.pdf for more information)

Slough set up an LSP sponsored workshop event to bring together people with an interest in fuel poverty. Brent could so the same, inviting representation from Age Concern, Energy Solutions, Brent Council Environmental Health, Sustainability, Housing Service Strategy/Grants, NWLH Hospitals, NHS Brent commissioning and public health to start addressing the wider issues associated with fuel poverty and developing a referral network. Ultimately, if work addressing fuel poverty is to gain greater momentum than it already has then it will need to become a priority for the leaders of the council, PCT and hospital trust. This is why the LSPs influence could be really crucial.

Recommendation 13 – The task group recommends that Brent's Local Strategic Partnership hosts a fuel poverty event to begin to address the wider issues outlined in this report and to promote the partnership approach involving the council, NHS and voluntary sector to bring more people out of fuel poverty.

Conclusions

The fuel poverty and health task group is encouraged that there is much good work going on in Brent to tackle fuel poverty. Having an organisation such as Energy Solutions in our borough is clearly a good thing and the group wishes that more could be done to support their work. What is clear is that despite concerns about fuel poverty and the impact on health, commitment to addressing it across the NHS is patchy. However, Brent is in a fortunate position that it has networks in place for the NHS to buy into, such as Hot Spots. Developing a resourced referral network would be the task group's first priority.

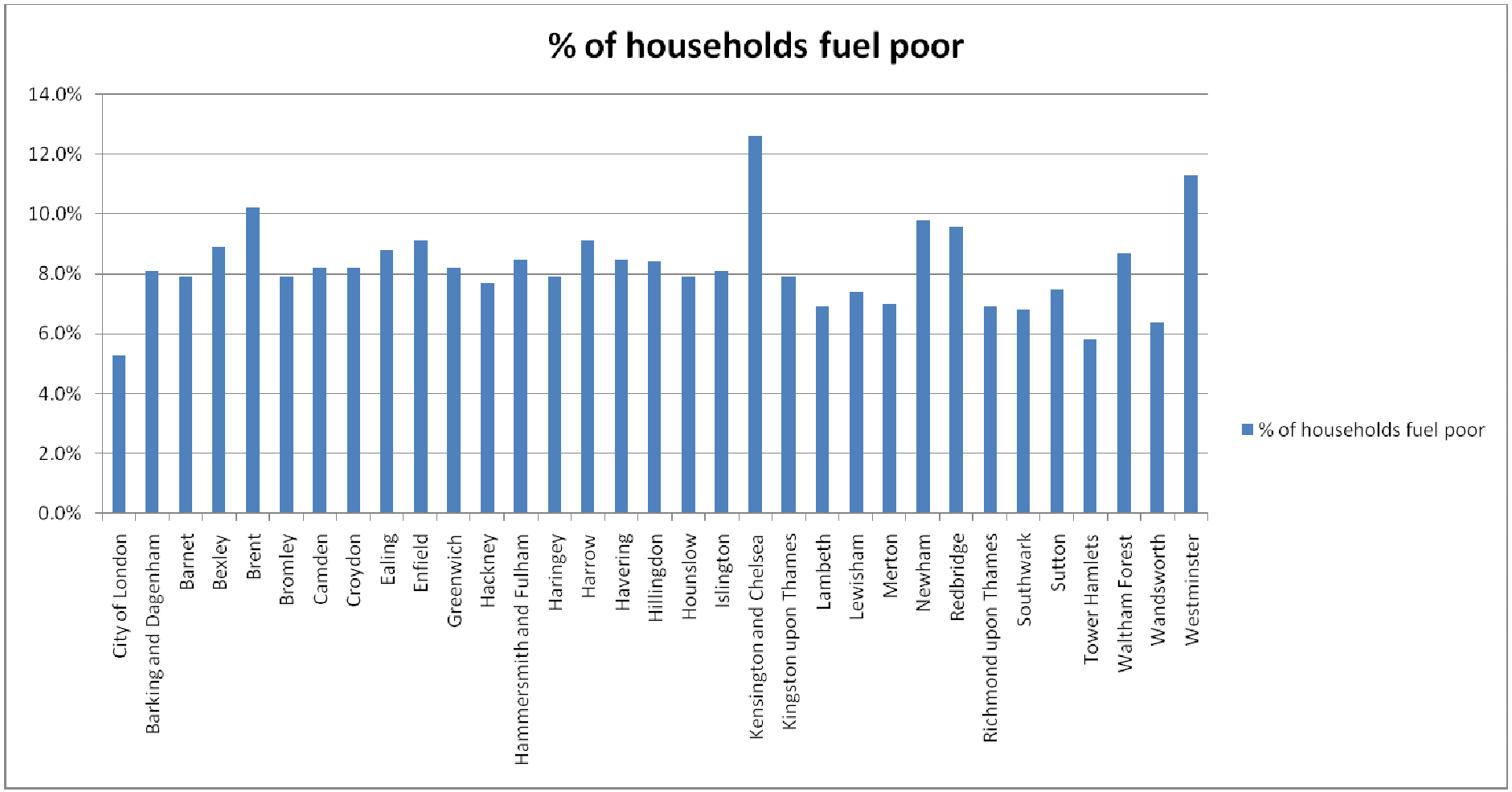
It is also important that the progress of the Brent's fuel poverty work can be tracked. The need for an accurate baseline for SAP ratings in the borough is clear, to help monitor the impact of initiatives and also target those initiatives in the right areas and to the right people. An affordable warmth strategy would provide the framework from which to take forward fuel poverty work in the future.

The task group believes that implementing a comprehensive referral network for people in fuel poverty will help to address the problems in Brent. Frontline staff need to know where to refer people who are living in a cold home and are unable to afford to adequately heat it. The task group is recommending that partners work with Energy Solutions to develop the referral network, but this requires partnership working and proper engagement from the council and NHS. Importantly, Energy Solutions needs to be fully resourced to do this work.

Above the task group is convinced that tackling fuel poverty cannot be the responsibility of one organisation – it has to be tackled in a collaborative way by the council, NHS, voluntary sector and private sector. The task group hopes that organisations in Brent can work together to address this issue that is having such a detrimental impact on the lives of many local people.

Appendix 1

% of Households in Fuel Poverty (2006) – Department for Energy and Climate Change



Appendix 2

SAP Ratings – Harrow

Note: SAP rating is a standard assessment procedure for measuring the energy efficiency of housing. Scores range from 0 to 100. Higher scores are better.

Sector	% of housing stock	Average SAP rating		
		Current	2015 target	2020 target
Owner occupier	77	49	69 solid walls 83 cavity walls	91
Council owned	6	65		
Housing Association	4.4	?		
Private renting	12	49		
Other	0.6	?		

	2008/09	2009/2010	2010/2011		2009/2010
SAP less than 35	20.14%	Target 18%	Target 15%		Actual XX%
SAP greater than 65	14.48%	Target 16%	Target 20%		Actual YY%

Appendix 3

Housing and Health Inequalities Scrutiny Review

Fuel Poverty in Brent Questionnaire

During the review the task group published a fuel poverty questionnaire and placed it on the council's consultation tracker from 17th September 2010 until the 8th October 2010for people to fill in. It was also sent to all members of the Brent Citizens Panel and the Brent Local Involvement Network. Copies were also distributed at the Beechcroft Medical Centre in Wembley Park and the Church of the Ascension in Wembley. A total of 136 questionnaires were returned. Although this is not a representative survey, it does provide some interesting points on fuel poverty in Brent. The results are analysed below.

1. Do you live in Brent?

	Number	**Percentage**
Yes	132	97.1%
No	4	2.9%
	136	

Comment – Although four people who responded to the survey did not live in Brent, their results have been included in the questionnaire analysis.

2. What type of housing do you live in?

	Number	**Percentage**
Owner occupied (including buying with a mortgage)	91	67.9%
Private rented accommodation	17	12.7%
Renting from the council (Brent Housing Partnership)	11	8.2%
Renting from a Registered Social Landlord	7	5.2%
Other	8	6%
	134	

Comment – The proportion of homes owned outright or being bought with a mortgage in Brent is 56%, whilst renting from the council accounts for 9% of homes, renting from an RSL

12% and renting from a private landlord 20%[25]. The numbers in the survey are not in line with these percentages, with those owning their own property or buying using a mortgage over represented and those renting (in all sectors) under represented.

3. Do you live in a:

	Number	**Percentage**
House	96	70.6%
Flat	33	24.3%
Bungalow	1	0.7%
Maisonette	4	2.9%
Other	2	1.5%
	136	

Comment – The number of people living in a house is over represented in this survey, with the actual number of houses in the borough accounting for 54% of homes compared to 46% for flats.[26] This information is almost 10 years old and the likelihood is that since the 2001 census the percentage of flats has increased in Brent.

4. How many bedrooms does your property have?

	Number	**Percentage**
1	18	13.3%
2	18	13.3%
3	63	46.6%
4	29	21.5%
5+	7	5.2%
	135	

Comment – The relatively high number of three and four bedroom properties can be accounted for because of the high proportion of respondents who live in a house.

5. How many people live in your home?

[25] Mori Place Survey 2008/09
[26] 2001 Census

	Number	Percentage
1	39	28.8%
2	35	25.9%
3	22	16.3%
4	18	13.3%
5	11	8.1%
6+	10	7.4%
	135	

Comment - The average household size in Brent in 2007 from an independent study was 2.7 persons per house, an increase from 2.5 found in a similar survey in 2005[27]. However, the largest proportion of households in Brent are single person households, although their number is falling.

6. What is your postcode?

Postcode	Number	Percentage
HA0	19	14.8%
HA1	2	1.6%
HA3	15	11.7%
HA9	64	50%
NW2	5	3.9%
NW6	1	0.8%
NW9	10	7.8%
NW10	10	7.8%
SW6	1	0.8%
SE14	1	0.8%
	128	

Comment – The large number of correspondents from the HA9 postcode area is explained by the number of respondents from the Beechcroft Medical Centre in Wembley Park. 72 patients filled in the survey, the majority of whom lived in the HA9 postcode area.

[27] Mayhew Associates, *Brent population estimation, household composition and change, 2007* http://intranet.brent.gov.uk/bv1nsf.nsf/24878f4b00d4f0f68025663c006c7944/3f1e2c9bf9112e428025742e003b2b5b!OpenDocument

7. In order to keep warm in your home, especially in the winter, do you? (Some respondents ticked more than one answer):

	Number	**Percentage (out of 136 respondents)**
Only have the heating on in one room	29	21.3%
Use electric fires, fan heaters, oil filled radiators or bottled gas heaters rather than central heating	22	16.2%
Have the curtains closed in the daytime to keep the heat in	29	21.3%
Block ventilation passages to prevent drafts	28	20.6%
Wear lots of clothes or use blankets and hot water bottles to stay warm	54	39.7%
Other (please state)	44	32.4%

Comment – The answers to this question demonstrate that people will use a variety of methods to keep warm, with many respondents indicating they did more than one of the above to stay warm, especially in winter. One answer was almost twice as common as the others - clearly more people wear lots of clothes, use blankets or hot water bottles than anything else. Having said that, a good proportion of respondents didn't answer this question at all indicating they do not have any issues with warmth in their homes. Of those that indicated "other", use the central heating was the most common response.

8. Have you or any of the people you live with suffered from the following illnesses, which are associated with fuel poverty and cold homes? **(Some respondents ticked more than one answer):**

	Number	**Percentage (out of 136 respondents)**
Heart attack	11	8.1%

Chronic obstructive pulmonary disease (COPD) e.g. chronic bronchitis or emphysema	9	6.6%
Respiratory infections	20	14.7%
Asthma	27	19.9%
Worsening arthritis	31	22.8%

Comment – Worsening arthritis was the most common response, but this could be to do with age as well as fuel poverty. Information the task group has received in its interviews suggests fuel poverty, but particularly damp, will exacerbate these conditions but may not directly cause them.

9. If you receive benefits, have you ever received a benefits entitlement check to ensure that you are receiving all of the benefits you are entitled to?

	Number	**Percentage**
Yes	21	21.6%
No	76	78.4%
	97	

Comment – The response to this question is worrying, suggesting more could be done to ensure people are maximising their incomes. This is crucial if people are to move out of fuel poverty. Some of those interviewed by the task group believe that income maximisation is more important in addressing fuel poverty than improving the energy efficiency of the home. People have to have the means of paying their energy bills and this is something that the task group should consider in their recommendations.

10. If the answer to Q9 above was yes, which organisation carried out your benefits entitlement check?

	Number	**Percentage**
Brent Council	15	65.2%
Citizens Advice Bureau	1	4.3%
Age Concern Brent		

Warm Front		
Other (please state)	7	30.4%
	23	

Comment – It is difficult to draw conclusions from this question as the number of respondents was so low. “Others” included family members and “the DHSS”.

11. Have you ever changed energy supplier to reduce the cost of your energy bill?

	Number	**Percentage**
Yes	64	51.6%
No	60	48.4%
	124	

Comment – Whilst it is encouraging that just over 50% of respondents have changed their energy supplier to reduce the cost of their bill, almost 50% haven’t. This is a relatively simple way of reducing energy costs and again, could we be doing more to make people aware of this option?

12. How do you pay your energy bills?

	Number	**Percentage**
Pre payment meter	9	6.8%
Cash or cheque	19	14.4%
Debit or credit card	20	15.2%
Direct debit	77	58.3%
Paperless billing online	7	5.3%
	132	

Comment – Pre payment meter is the most expensive method of paying for energy and these are generally found in HMOs. The low number of respondents from the private rented sector may explain the low number of people using a pre payment meter. Direct debit and paperless billing is the cheapest way to pay for energy, accounting for over 60% of respondents. However, more than 35% of respondents are using more expensive payment methods and this is a worry.

13. Have you changed the way you pay for energy to reduce your energy bill? For example, switching to pay by direct debit

	Number	**Percentage**
No	69	60.5%
Yes	45	39.5%
	114	

Comment – Of those that answered this question, many indicated that they had switched to paying by direct debit. The majority had not switched the way they paid, some saying that they had always paid by direct debit.

14. Have you ever carried out alterations to your home to make it more energy efficient, such as cavity wall insulation or draft proofing or installing a new boiler?

	Number	**Percentage**
No	63	50.8%
Yes	61	49.2%
	124	

Comment – Of those that responded positively to this question, the most common work carried out on the home was the installation of loft insulation, double glazing and new boilers. Four people said they had had cavity wall insulation on their home.

15. If you have carried out alterations to your home, did you receive a grant for this work?

	Number	**Percentage**
No	78	82.1%
Yes	17	17.9%
	95	

Comment – Most people had not had any grant funding to do their work. Of those that had one person had their grant from Warm Front and one person from Warm Zone.

16. If you live in private rented accommodation, has your landlord ever upgraded your house to improve energy efficiency?

	Number	Percentage
No	26	72.2%
Yes	10	27.8%
	36	

Comment – It is difficult to draw conclusions from this question. The majority of those that answered it also indicated on their return that they did not live in private rented accommodation.

17. A household is said to be in fuel poverty if it has to spend more than 10% of its income on fuel to sustain satisfactory heating. On the basis of this definition, do you think your household is in fuel poverty?

	Number	Percentage
Yes	38	32.5%
No	73	62.4%
Don't know	6	5.1%
	117	

Comment – According to Department of Energy and Climate Change statistics, in 2006 10.2% of households in Brent were fuel poor.[28] This was the third highest in London behind Kensington and Chelsea and Westminster. According to this survey, over 30% of respondents consider themselves to be in fuel poverty. Although this is a self selecting survey and not statistically robust, it is surprising that a significant number of respondents consider themselves to be in fuel poverty when compared to government statistics. This 30% figure is more in line with the estimates of those interviewed and also reflects the levels of general poverty in Brent, with which fuel poverty is closely associated. Income levels in Brent are relatively low (3rd lowest in London) and over 21,500 households in Brent have an annual income of less than £15,000 per annum. Against this background it is likely that fuel poverty is higher than 10.2% although the true figure is not known.

[28] Department of Energy and Climate Change – Local Authority Fuel Poverty Levels 2006

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	Health Partnerships Overview and Scrutiny Committee **16th February 2011** **Report from the Director of Strategy, Partnerships and Improvement**
For Action	Wards Affected: ALL

Health Services for People with Learning Disabilities Task Group Follow Up

1.0 Summary

1.1 The Health Partnerships Overview and Scrutiny Committee has asked for an update on the implementation of the recommendations arising from the health services for people with learning disabilities task group. The task group was carried out in 2009/10 and its findings were reported to the Executive in September 2010.

1.2 The Overview and Scrutiny Committee agreed to set up a task group to consider concerns amongst carers about the difficulties that people with learning disabilities face when accessing health services.

1.3 The members of the task group were Councillor Eddie Baker, Councillor Ruth Moher and Councillor Emily Tancred, who chaired the group.

1.4 The task group took evidence from a wide range of witnesses including:

- Chief Executive, Brent MENCAP
- Assistant Director for Community Care, Brent Council
- Head of Service for People with Learning Disabilities
- Head teacher, Hay Lane School
- Head of Diversity, Brent Council
- Brent Carers
- Deputy Director, NHS Brent
- Deputy Director Partnership Commissioning, NHS Brent
- Support for Living Project in Ealing.

1.5 During the task group's work Brent carers reported a number of on-going difficulties when using services such as hospitals, dentists, GP's and opticians. There can be a lack of awareness about learning difficulties and a failure to implement reasonable adjustments which would make these services accessible to all patients.

1.6 The task group found that there is a project in Ealing called Treat Me Right! that has developed a range of measure to improve the experience for patients with learning disabilities when they use Ealing Hospital. They have produced information in easy to read formats, such as the complaints policy and admission information as well as

provide staff training on working with people with a learning disability. One of the main recommendations of the task group is that NHS Brent develops a similar model for Brent Hospitals.

1.7 The final recommendations of the task group can be found as an appendix to this report, with the original comments from service areas and an update since the recommendations were accepted.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee consider the update on the health services for people with learning disabilities task group and question officers on the progress made to date in implementing the recommendations

Background Papers:

The health services for people with learning disabilities task group report is available on request.

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Access to health services for people with learning disabilities – task group recommendations follow up

Recommendation	Original Response	Update	Officer Responsible
1. That NHS Brent implements a project – similar to the Treat me Right project developed by Support for Living in Ealing Hospital.	**Treat Me Right Project -** Funding has been identified to develop a local service which will work within local hospital settings to provide training to hospital staff on the needs of people with learning disabilities and to introduce an accessible Hospital Passport Booklet for all people with a learning disability accessing acute care, identifying their needs and wishes so that services that can better understand and meet the patient's needs. Interest in proving this service has been shown by Support for Living who run this project in neighbouring Ealing. Local providers have also shown interest in delivering the service. The Partnership Board have agreed that interested parties will be invited to submit expressions of interest which will be evaluated by the Sub group of the Partnership Board. It is hoped that the new service will be in place by November.	Expressions of interest have been received from local providers to run this service. Members of the Health Sub Group of the Learning Disability Partnership Board evaluated the proposals and Brent Mencap has been awarded the contract. The new service will deliver on the following priorities. • The roll out of accessible patient passports and increased health action planning • Production of accessible information • Training for G.Ps and staff in the acute sector • Framework for service user and carer feedback on health services The new service has started and training for GP's and other health professionals has been delivered by Brent Mencap, supporting people with learning disabilities as trainers.	Deputy Director, Partnership Commissioning NHS Brent and Brent Council
2. That there are specific actions to address the		The actions in the Obesity Strategy will cover all groups with people with Learning	Head of Health Improvement

needs of people with learning disabilities in the Brent Obesity Strategy and other health promotion strategies.		Disabilities. The PCT will work with key stakeholders for people in LD to ensure opportunities for people with LD are maximised.	NHS Brent
3. That the Health Select Committee monitor the implementation of the NHS Brent learning disability self assessment framework and improvement of statutory functions such as dentists.	**Carer and Service User Involvement -** NHS London had identified that one of the main areas of progress within NHS Brent's recent Self Assessment Performance Framework was how well service users and carers were supported to input into the general planning and development of new health services. There is now a health action sub group of the Learning Disability Partnership Board with user and carer representation which will drive forwards and monitor the delivery of the Health Action Plan which has been agreed with NHS London. A sub group of the Learning Disability Partnership Board is being formed which will have a role in developing learning from the outcomes processes from complaints and incidents involving people with learning disabilities so that a consistent approach is implemented and monitored across agencies. Through this group quarterly learning disabilities thematic reports on safeguarding and complaints will be reported to the Learning Disabilities Partnership Board. **Health Self Assessment Performance**	The Health Action Plan has been updated in the light of the outcomes of the Health Self Assessment framework and agreed with NHS London. A report has been submitted to the NHS Brent Trust Board on the outcomes of the Health Self assessment and the actions for improvement. The Health Action Plan has been signed off locally at the Learning Disability Partnership Board. The Health Sub Group has carer and senior PCT management representation and continues to monitor, update and steer the implementation of the Health Action Plan, reporting on progress to the Learning Disability Partnership Board. A Sub Group of the LD Partnership Board has been established to look at outcomes of complaints and other quality/safeguarding issues. A progress report on the Health Action Plan	

	Framework - The existing Health Action Plan will be updated in the light of the outcomes of the recent self assessment and taken to the Joint Executive Team and the Sub Group of Learning Disability Partnership Board for approval in August. The targets and actions have been accepted by NHS London as a good strategy for improvement and they will monitor the delivery of the Plan. **Ensure reasonable adjustments and access to health services** - Work has already taken place linking Primary Care and the Specialist Community Team in reviewing GP reporting requirements and mechanisms to enable the Community team to play a more active role in monitoring and updating the information held on the GP Registers and provide training for GP practices. A better system for the recording and monitoring of health screening is also being developed. This has resulted in a large improvement in the number of annual health checks completed and NHS Brent is now above the national average. The Health Action Plan contains a target to improve the number of annual health checks to 100% by 2013. The admission and discharge arrangements for vulnerable people accessing acute hospital care and appropriately working with families and individuals to meet and understand their individual needs will be improved by the appointment of an acute liaison nurse for people with learning disabilities who has been	has been submitted to NHS London in January 2011. An audit will be undertaken of progress against identified areas for improvement in the annual Health Self Assessment Framework process which is due to begin in March 2011 to be submitted to NHS London in June 2011. The number of annual health checks continues to increase and GP information held on registers is improving with the training programme and links with community nurses. The role of the acute liaison nurse is in place and agreement has been given to publicise access to annual health checks and the role of the acute liaison and community nurses in GP surgeries on TV's through Life Channel	

	commissioned to work with the North West London acute sector. This role will ensure robust care pathway's for individuals into acute care ensuring that people's needs are properly identified and meet.		
4. That information is gathered on residents that have a learning disability to ensure that they receive targeted appropriate services.	**Local Population Needs Analysis -** There is an need to improve the information available in Primary Care regarding people with learning disabilities and their family carers, and their particular health needs through the use of existing data collection processes. Work is currently underway on a specific project to produce a more comprehensive health needs assessment of the local population of people with learning disabilities. This involves working across Public Health and Primary Care using information generated from GP Registers under the Directly Enhanced Service. This will be completed by October. Work has also been commissioned to develop an Autism Strategy by October which will contain a local needs analysis of this specialist area across mental health and learning disabilities services, including information on people in transition from Children's to Adults Services. Both of these pieces of work will feed into a Joint Commissioning Strategy which is also being developed in tandem by November.	The Autism Strategy has been developed and is out for consultation. It contains local population needs analysis of people with Autism and the gaps in service provision. A draft Joint Health and Social Care Strategy for Adults with Learning Disabilities has just been completed and will be out for further consultation at the end of February 2011. This contains wider local population needs analysis of adults with learning disabilities in Brent.	
5. That the go-ahead is	The Council is committed to the prevention	Both the Autism Strategy and the draft Health	

given to the council project to look at transitions from children's to adult services for people with disabilities - as a matter of urgency. The appropriate Overview and Scrutiny Committee should monitor the progress of this work.	agenda across the whole of Adult Social Care. The current eligibility threshold for Adult Social Care is set at meeting the needs of those people with substantial and/or critical needs and this applies to all client groups. Given the current financial position that Council's are facing it will be important to ensure that there remains equity of access for all client groups across Adult Social Care.	and Social Care Commissioning Strategy address the projected needs of children coming through to adult's services, care pathways and improvements in transition planning.	

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	Health Partnerships Overview and Scrutiny Committee 16th February 2011 **Report from the Director of Strategy, Partnerships and Improvement**
Childhood immunisation task group follow up	

1.0 Summary

1.1 The Health Partnerships Overview and Scrutiny Committee has asked for an update on the implementation of the recommendations arising from the Childhood immunisation task group. The task group was carried out in 2009/10 and its findings were reported to the Executive in April 2010.

1.2 Brent Council's Health Select Committee established the Childhood Immunisation Task Group because councillors were concerned about the low immunisation rates in the borough. Childhood immunisation rates in Brent for 2008/09 were reported to be below target for all of the immunisations in the national immunisation programme except human papilloma virus vaccine and tetanus, diphtheria and polio booster.

1.3 Childhood immunisation against illnesses such as measles, mumps, polio and diphtheria are crucial to protect the long term health of young people in our borough. Immunisation has the most robust evidence in terms of safety, efficacy and cost effectiveness of all healthcare activities, but there have been long standing problems in achieving good levels of coverage in London. Brent has been no exception to the London-wide trend of low immunisation rates.

1.4 The task group was keen to investigate how NHS Brent and partners, including the council, were addressing immunisation performance to ensure young people received the correct vaccinations to prevent the unnecessary spread of disease. It should be added that as well as looking at childhood immunisation, the task group felt it could not ignore the swine flu vaccination programme even though this would be aimed at a much wider population group than children. Swine flu was a significant issue at the time that the task group was agreeing terms of reference and so it was included in the remit of the work.

1.5 Although the task group has made a number of recommendations that it felt would help to improve immunisation services in Brent, members were encouraged by the efforts that NHS Brent were making to improve the immunisation service during the course of the review. There was a genuine commitment from the organisation to

improve immunisation rates in the borough and stop the spread of diseases that are clearly preventable. A significant data clean-up project has been took place which was crucial if Brent was to increase immunisation rates. Maintaining accurate data is of paramount importance so that progress can be maintained.

1.6 NHS Brent is responsible for delivering the childhood immunisation programme in Brent, but the task group believed that a partnership approach with children's centres and schools would be beneficial and ensure greater coverage. For this reason the task group has made a number of recommendations relating to children's centres and schools to help facilitate the immunisation programme.

1.7 The task group's recommendations, the original responses from NHS Brent and the latest update are included at appendix 1 to this report. Appendix 2 contains information on the latest immunisation performance in the borough, broken down into GP cluster groups.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee consider the update on the childhood immunisation task group and question officers on the progress made to date in implementing the recommendations.

Background Papers:

Childhood immunisation task group report – this is available on request.

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Childhood Immunisation Task Group Recommendation Follow Up – February 2011

Recommendation	Original Response	Update	Officer Responsible
1. The task group recommends that NHS Brent ensures resources are available so that an accurate CIS database can be maintained beyond the life of the current data clean-up project.	It is recognised by NHS Brent that maintaining the improvements in data quality is a vital part of the improvement process. Consequently, Brent Community Services will ensure that the resources are available to maintain a minimum of 95% match between CIS and Exeter is maintained. The match between the two systems is a key performance indicator which is reported monthly.	The data quality has improved because we are now using data directly from Exeter and DBS. Cleansing of data is ongoing and is reviewed regularly.	Director of Public Health
2. The task group recommends that NHS Brent reports back to the Health Select Committee in December 2010 on the information held on the CIS database and the Exeter database to ensure that there is at least a 95% match between the two.	The match between the two systems currently exceeds 95%. The performance in December 2010 will be reported to the Health Select Committee.	Data quality is being maintained by CIS is now not a source of data that we take a feed from. The data cleansing is focused on ensuring that the children who are not a match with Exeter are resident within the Borough to ensure efforts are focused on the NHS Brent responsible population.	Director of Public Health
3 - The task group recommends that immunisation results for each GP practice in Brent are published quarterly on the NHS Brent website to help improve accountability	A RAG (Red, Amber, Green) rated report covering all practice's and BCS performance is published to all GP practices and BCS monthly. Publishing the report on the NHS Brent website will be discussed by the programme board.	The General Practices Brent Reporting Portal (GP-BRP) has been available to all practices and BCS since September 2010. Monthly and/or quarterly reports are available and rated (Red, Amber, Green) covering all practices and BCS performance.	Director of Public Health
4. The task group	At this stage of the improvement programme,	The HPV team have started looking at	BCS.

recommends that NHS Brent starts to use the accurate CIS database to consider where there is underperformance in the immunisation service. For example, are there geographical or ethnicity trends that can be used as the basis for an effective immunisation promotional campaign.	underperformance is being targeted on a practice basis. Analysis by ethnicity, for instance, would require a further piece of work to extract this data from GP records, as it does not exist in CIS.	ethnicity trends relating to non- compliance especially for Faith schools. NHS Brent has incentivised practices to meet the immunisation targets set out in its CSP through a performance bond. Clusters are using pump priming funding to look at how they can target children/families that continually do not attend and find ways of achieving the child's immunisation.	Director of Public Health GP Immunisation Clinical Leads
5. The task group recommends that all staff employed by NHS Brent are given an overview of the benefits of vaccination as part of their induction programme. This should include information on childhood vaccinations and the adult flu vaccination. Training should be given to medical and non-medical staff working in frontline positions, and should be extended to GP receptionists.	Nurses and GPs already have access to vaccination update training which is offered twice a year. Responsibility for training non-medical staff is that of the individual GP practice.	The original response remains as it is. BCS has completed a half day vaccination update training for nurses and admin staff in Brent in January 2011.	
6. The task group	This message is reinforced at every	This message is reinforced at every	

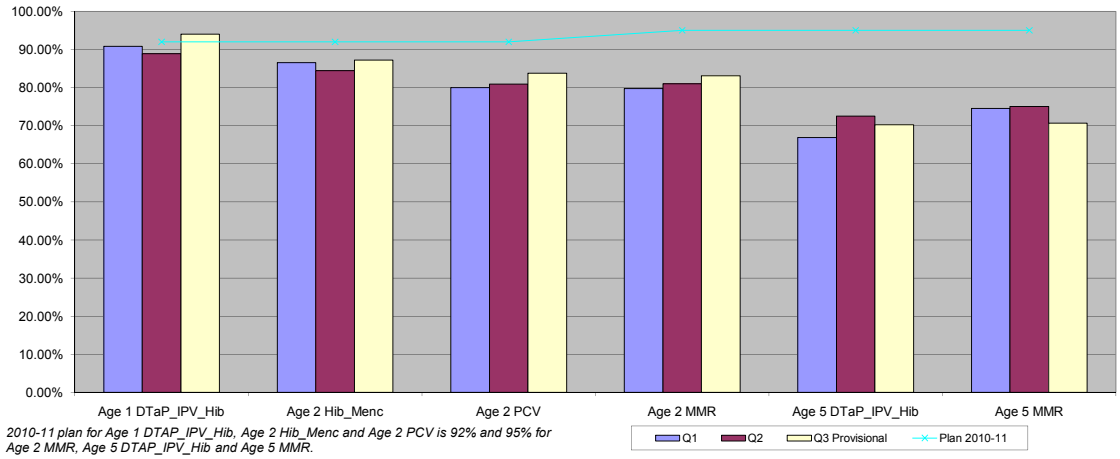
recommends that as part of the induction training on immunisations, it is made clear to NHS Brent staff and employees at GP surgeries that there is no link between the MMR vaccine and autism so that they are able to communicate this message to members of the public, should they be asked about this subject.	opportunity and NHS Brent will continue to do so.	opportunity and NHS Brent will continue to do so	
7. The task group recommends that NHS Brent carries out a childhood immunisation promotion campaign once an analysis of the CIS database has been completed and more is known about the children who have not had the vaccines they need. A campaign could be tied into vaccination clinics at children's centres (see recommendation 8 below).	The programme board is starting to look at what will be required to implement an effective promotion campaign. We are currently planning meetings with Health Trainers to begin working with focus groups to understand some of the issues that prevents parents vaccinating children.	As part of the performance bond clusters have been incentivised to look at improving immunisation data rates as well as continuing to report data. Two clusters have started to look at, and test, clinics being run outside of the GP Practice setting. This will be followed up with the two clusters to see how successful this has been.	Director of Public Health
8. The task group	Operating an immunisation catch up	As part of the performance bond clusters have	Director of Public

recommends that vaccination clinics are trialled at five children's centres in Brent (one in each locality) to assess demand and popularity. One of the trials should be carried out at the weekend to see if there is demand for services outside core hours. As well as providing immunisations, health visitors should be available at the clinics to speak to parents about vaccinations and answer any questions that they have. The clinics could be timed to take place during a vaccination campaign (see recommendation 7 above).	programme is part of the current 2010/11 improvement plan, however, given the failure of these clinics during the MMR catch up campaign means that we will have to design and test the delivery of any clinic carefully before rolling them out.	been incentivised to look at improving immunisation data rates as well as continuing to report data. Clusters provided plans showing that they would be providing additional clinics outside of "normal" afternoon sessions. This will be followed up to see how successful this has been.	Health
9. The task group recommends that children's centres collect information on the immunisation status of each child that it registers. This information should be passed to a health visitor for follow up with the	Information presented at these types of contacts is not always available or accurate and currently we are expecting GPs to collect this data at registration and BCS to collect the data for children that are not registered with a GP. It is already within the BCS contract for them to check immunisation status at every opportunity and vaccinate when required.	We will explore the role of children's centres in opportunistic immunisation as part of the joint work we doing with Brent Council, GP Commissioners and the ICO. We will be able to provide a further update in later in 2011.	Borough Director.

parents if the child has not received the vaccinations in the childhood immunisation programme.			
10. The task group recommends that each school in Brent has a member of staff (such as a school nurse) who is able to advise parents and teachers on the benefits of immunisation. This member of staff should be invited to attend NHS Brent immunisation training to ensure their knowledge is kept up to date.	School Nurses are available at each school and are there to advise and support parents to get there child immunised. The HPV programme has introduced a further team that operates specific sessions promoting HPV vaccination to female pupils, parents and teachers.	Completed. No further update.	
11. The task group recommends that teachers in Brent are given an opportunity to attend immunisation training by NHS Brent so that they are better placed to advise parents on immunisation and the diseases that vaccines work to prevent.	NHS Brent will review what training is currently given to teachers and whether any further training is necessary.	This activity has not happened.	
12. The task group	NHS Brent will investigate this	There is a form given by school nurses to	

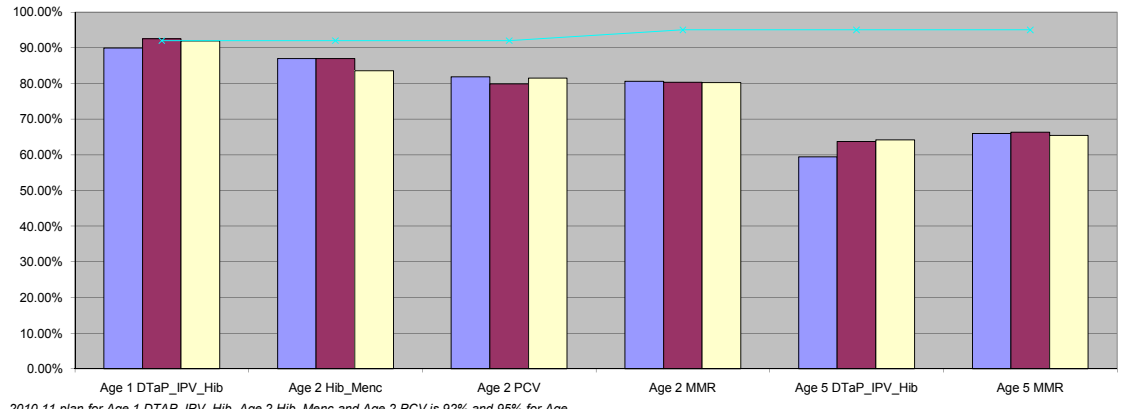
recommends that parents are asked to provide information on their children's immunisation status when they fill out their school admission form. This information would be disclosed on a voluntary basis and passed to the school nurse for follow up with the parent if necessary.	recommendation further with school nurses and teachers.	parents of children about to begin school to provide information on their children's immunisation status. There is currently no capacity within the school nursing team to follow up on forms that are not returned.	

Harness Cluster- Q1, Q2 and Provisional Q3 2010-11 childhood immunisation rates



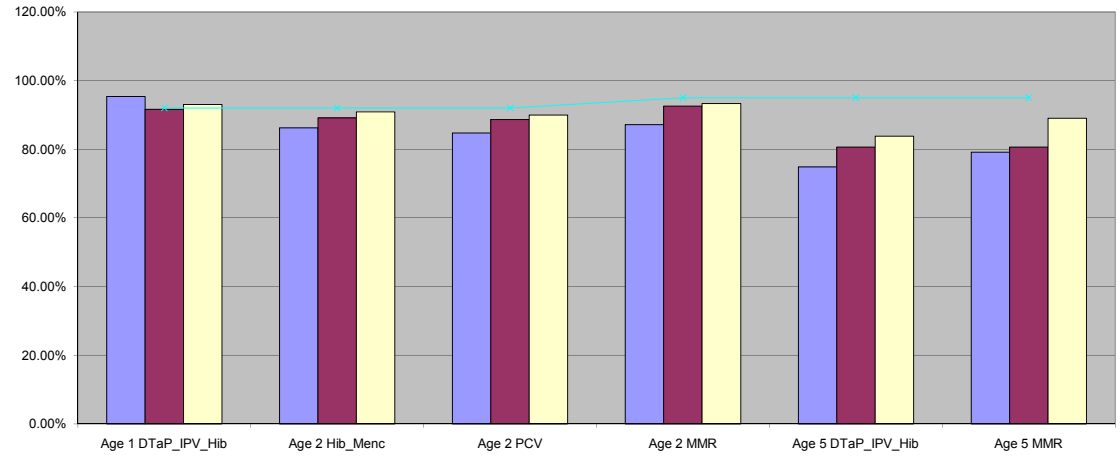
2010-11 plan for Age 1 DTAP_IPV_Hib, Age 2 Hib_Menc and Age 2 PCV is 92% and 95% for Age 2 MMR, Age 5 DTAP_IPV_Hib and Age 5 MMR.

Kilburn Cluster-Q1, Q2 and Provisional Q3 childhood immunisation rates

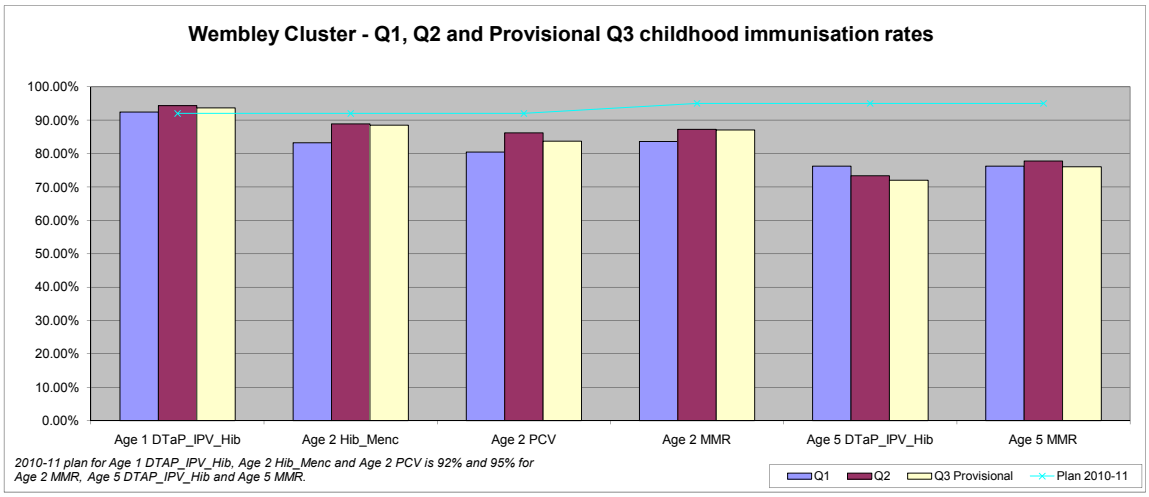


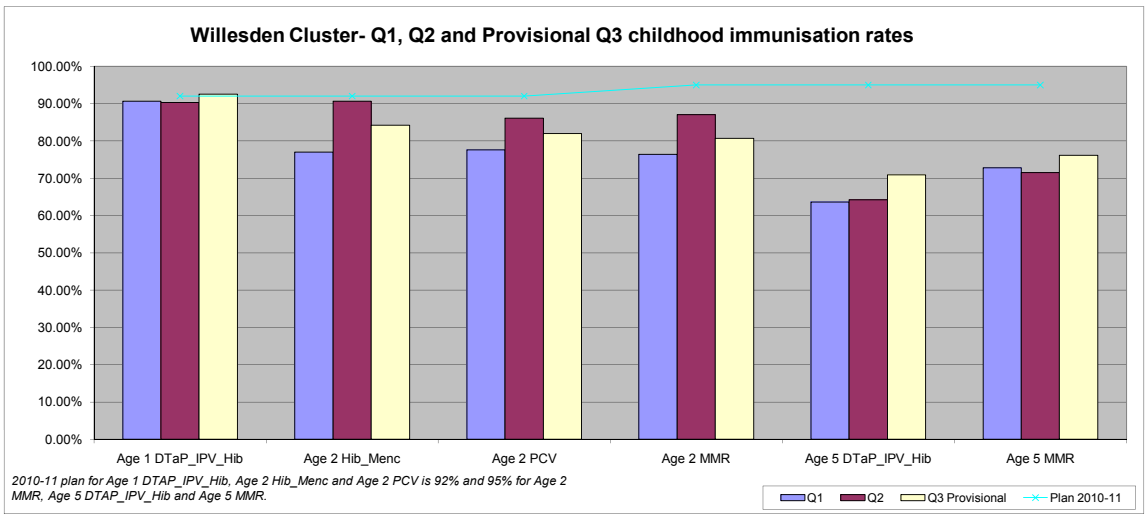
2010-11 plan for Age 1 DTAP_IPV_Hib, Age 2 Hib_Menc and Age 2 PCV is 92% and 95% for Age 2 MMR, Age 5 DTAP_IPV_Hib and Age 5 MMR.

Kingsbury Cluster- Q1, Q2 and Provisional Q3 childhood immunisation rates



2010-11 plan for Age 1 DTAP_IPV_Hib, Age 2 Hib_Menc and Age 2 PCV is 92% and 95% for Age 2


Wembley Cluster - Q1, Q2 and Provisional Q3 childhood immunisation rates
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Age 1 DTaP_IPV_Hib
Age 2 Hib_Menc
Age 2 PCV
Age 2 MMR
Age 5 DTaP_IPV_Hib
Age 5 MMR
2010-11 plan for Age 1 DTAP_IPV_Hib, Age 2 Hib_Menc and Age 2 PCV is 92% and 95% for Age 2 MMR, Age 5 DTAP_IPV_Hib and Age 5 MMR.
Q1
Q2
Q3 Provisional
Plan 2010-11


Willesden Cluster- Q1, Q2 and Provisional Q3 childhood immunisation rates
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Age 1 DTaP_IPV_Hib
Age 2 Hib_Menc
Age 2 PCV
Age 2 MMR
Age 5 DTaP_IPV_Hib
Age 5 MMR
2010-11 plan for Age 1 DTAP_IPV_Hib, Age 2 Hib_Menc and Age 2 PCV is 92% and 95% for Age 2 MMR, Age 5 DTAP_IPV_Hib and Age 5 MMR.
Q1
Q2
Q3 Provisional
Plan 2010-11

Health Partnerships Overview and Scrutiny 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 council.	Report noted. The committee will follow up the implementation of strategy in April 2010.

	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	The council's response to Equity and Excellence – Liberating the NHS, was endorsed by the Health Partnerships Overview and Scrutiny Committee.

		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.	The committee noted the report but asked for additional information on services in Brent, including: • Services for those who have been victim of rape • Sexual health outreach services • Information on the number of married teenagers who become pregnant or seek terminations, if this is available
	Public Health Annual Report	NHS Brent will present details of the Annual Public Health Report for the committee to consider and comment on.	Report not discussed, but distributed to the committee for information.
	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.	The committee made the following recommendation to NHS Brent regarding the registered patient list at the Burnley Practice (i.e. not the homelessness service): • That NHS Brent carries out an open tender process for the Burnley Practice registered patients service. This is to ensure that the service continues to be delivered from Willesden Centre for Health and Care and to avoid dispersal of existing patients in an area which already has fewer GPs per head of population than other areas of Brent.

	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.	It was agreed that: • The committee does not endorse NHS Brent's preferred option for Brent Community Services, integration with Ealing Hospital Trust and the creation of an ICO. Instead, it agreed to endorse Gareth Daniel's letter, sent to Mark Easton on the 21st September. • It agreed to continue an on-going dialogue with NHS Brent on this issue. They have asked for a report to their next meeting (on the 16th December) on other options for Brent Community Services for their consideration. This report should contain some budgetary information on BCS, including spend on each of the services delivered by the organisation.
	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.	Report noted.
	Tobacco Investments	Issue raised under any other business by Councillor Ann Hunter.	The following recommendation has been passed to the Brent Pension Fund Sub Committee: *The Health Partnerships Overview and Scrutiny Committee recommends that the Brent Pension Fund Sub-Committee reconsiders the investments that Brent Council has in tobacco firms. The overview and scrutiny committee does not believe that the council should be investing pension fund money in companies that make profits at the expense of peoples' health and that it contradicts the council's work to promote tobacco control and smoking cessation. The committee is encouraged that other councils, such as Harrow, have taken a decision to disinvestment from these firms and hopes that*

			the council can follow their lead particularly as Brent is launching its Tobacco Control Strategy on 29th November. Attached is a letter from Cllr Ann Hunter who raised the matter, which was printed in the Willesden and Brent Times on 21st October.

Meeting Date	Item	Issue for committee to consider	Outcome
16th December 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".	Report noted – the committee will see the results of the Trust's In Patient Survey when they are available – currently pencilled in for April 2011, but this may change.
	Brent GP commissioning pathfinder	Brent GPs are planning to set up a commissioning consortium as part of the government's pathfinder programme. This is to encourage GPs to begin commissioning health services for patients as soon as possible. Brent GPs have requested that they attend the committee to explain to members what their plans are and how it will affect commissioning in Brent.	The committee noted the update and have asked for regular progress reports on the establishment of the GP Commissioning Pathfinder, beginning in February 2011.
	Brent Community	The committee has agreed to continue an	Mark Easton agreed to:

	Services	ongoing dialogue with NHS Brent and Ealing Hospital Trust on the proposals for Brent Community Services. The committee has asked for a further report setting out alternative options for Brent Community Services for their consideration. This report should contain budgetary information on BCS, including spend on each of the services delivered by the organisation, as well as information on safeguarding services.	(i). report back to the committee NHS London's decision on the future of Brent Community Services (ii). provide the committee with information on the organisations budget. (iii). pursue the request that the council be given a place on the ICO board, with voting rights.
	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.	Report noted.
	Recommendations to the Planning Committee	The Committee made a recommendation to the Planning Committee in March 2010 in relation to the proliferation of hot food take away shops near secondary school premises. The committee should follow up the Planning Committee's response to the recommendation, after it has been considered in October 2010.	This reference was considered at the Planning Committee on 20th October. The resolution agreed was as follows; RESOLVED:- (i) that the proposed Local Development Scheme timetable at Appendix 3 be endorsed and recommended to Executive that it be agreed for submission to the Secretary of State and the Mayor of London. (ii) that the appropriate way forward for reviewing the Council's approach to the determination of planning applications for hot-food takeaways was to undertake this as part of the preparation of the Development Management Policies DPD.

	Recommendation to the Brent Pension Fund Sub Committee	The following recommendation was passed to the Brent Pension Fund Sub Committee: *The Health Partnerships Overview and Scrutiny Committee recommends that the Brent Pension Fund Sub-Committee reconsiders the investments that Brent Council has in tobacco firms. The overview and scrutiny committee does not believe that the council should be investing pension fund money in companies that make profits at the expense of peoples' health and that it contradicts the council's work to promote tobacco control and smoking cessation. The committee is encouraged that other councils, such as Harrow, have taken a decision to disinvestment from these firms and hopes that the council can follow their lead particularly as Brent is launching its Tobacco Control Strategy on 29th November. Attached is a letter from Cllr Ann Hunter who raised the matter, which was printed in the Willesden and Brent Times on 21st October.* The committee will be updated on the council's position regarding tobacco investments.	The Brent Pension Fund Sub-Committee considered the committee's recommendation on the 30th November and agreed: "that its fund managers will take investment decisions on the basis of the best interests of the Fund, which is held for the best interest of beneficiaries, thus re-affirming the policy of the Council of non-political or administrative interference with investment decisions or involvement with companies in which the fund managers have acquired shares on behalf of the fund".

Meeting Date	Item	Issue for committee to consider	Outcome
16th February 2011	GP services in Brent	The committee has requested a report on GP services in Brent following consideration of the Burnley Practice issue. The report should contain information on the spread of GPs in Brent and the steps taken by NHS Brent to mitigate the effects of GP retirement.	
	GP Commissioning Pathfinder	Update on progress in setting up Brent's GP commissioning consortia. This will be a regular item for the committee.	
	Public Health White Paper	A report on the implications of the Public Health White Paper will be presented to the committee for members to provide their comments before the council's response is submitted.	
	Khat in Brent	Cllr Jack Beck has requested that the committee look at the issue of Khat use in Brent. A report on this issue will be requested from NHS Brent to set the context for this issue and to prompt discussion. Organisations working with Khat users and the East African population in Brent will also be invited to attend the committee to explain to members how Khat is affecting local people.	
	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.	
	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.	
	Immunisation Task Group	Six month follow up of the immunisation task group in December 2010, to see how the recommendations have been implemented.	

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.	
	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.	
	Belvedere House	Central and North West London Mental Health Foundation Trust has offered to host a visit at Belvedere House, where it provides day services for adults with mental health problems. The trust has been reviewing the services provided at Belvedere and this will be an opportunity for members to better understand those changes. A report will also be presented to the committee in April 2011 on the work that has been taking place since this issue was originally considered by Health Select Committee in March 2010.	

Items to be timetabled

Item	Issue	Possible date
Section 75 partnership	The council and Central and North West London NHS Foundation Trust are entering	

arrangements for mental health services	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.	
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.	
Smoking Cessation	The committee wants to keep track of this issue and will receive regular service 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.	
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.	
North West London NHS Hospitals In Patient Survey results	The results of the annual In Patient Survey will be presented to the committee in July 2011. This follows on from previous discussions on the trust's We Care Programme, which members wanted to follow up.	
Plans for the future of North West London NHS Hospitals Trust and Ealing Hospital Trust	North West London NHS Hospitals Trust and Ealing Hospitals Trust have taken the initial steps towards a merger, commissioning consultants to see if a business case can be made for such a move. The Health Partnerships Overview and Scrutiny Committee wants to be kept informed of developments as this project progresses.	

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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