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Health Partnerships Overview and Scrutiny Committee

Tuesday, 26 July 2011 at 7.00 pm
Committee Rooms 1 and 2, Brent Town Hall, Forty Lane, Wembley, HA9 9HD

Membership:

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

For further information contact: Toby Howes, Senior Democratic Services Officer
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www.brent.gov.uk/committees

The press and public are welcome to attend this meeting

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Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members

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1	**Declarations of personal and prejudicial interests**	
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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 NHS Brent GP access update - quarter 4 results — 7 - 12

NHS Brent has provided a report on GP access satisfaction results for 2010/11, as requested by the Health Partnerships Overview and Scrutiny Committee. When members last looked at this issue in April 2011, members were keen to see that improvements would be made in GP satisfaction measures by quarter 4, as NHS Brent felt that the Access, Choice and Experience (ACE) programme should be delivering improved satisfaction by the end of 2010/11.

Ward Affected: All Wards;

Contact Officer: Andrew Davies, Policy and Performance
Tel: 020 8937 1609
andrew.davies@brent.gov.uk

6 GP list validation exercise — 13 - 28

NHS Brent has submitted an update on the GP list validation exercise. As well as preparing a report on the issue, it has also provided a letter sent to all Brent GPs on the process and a spreadsheet showing how many patients have been removed from practice lists since the exercise began. At the committee meeting it is hoped that a figure on the number of re-registrations to practices can be provided, but this information is not available at the time of publishing the report.

Ward Affected:	All Wards;	***Contact Officer**:* Andrew Davies, Policy and Performance Tel: 020 8937 1609 andrew.davies@brent.gov.uk

7 Update on GP commissioning in Brent 29 - 34

NHS Brent has provided an update on the progress being made with GPs on establishing commissioning groups in Brent, as requested by the Health Partnerships Overview and Scrutiny Committee. As well as providing an update on the work of the clinical commissioning groups (previously known as GP commissioning consortia), the paper also summarises the main changes that have been made to the Health and Social Care Bill following the Government's listening exercise and the report of the NHS Future Forum.

Ward Affected:	All Wards;	***Contact Officer**:* Andrew Davies, Policy and Performance Tel: 020 8937 1609 andrew.davies@brent.gov.uk

8 Health and Wellbeing Board update

Members will receive a verbal update on this item.

Ward Affected:	All Wards;	***Contact Officer**:* Andrew Davies, Policy and Performance Tel: 020 8937 1609 andrew.davies@brent.gov.uk

9 Paediatric Services at Central Middlesex Hospital 35 - 46

NHS Brent and North West London Hospitals NHS Trust have asked to present a paper to the committee on plans for paediatric services at Central Middlesex Hospital. An update on the service is attached.

Ward Affected:	All Wards;	***Contact Officer**:* Andrew Davies, Policy and Performance Tel: 020 8937 1609 andrew.davies@brent.gov.uk

10 North West London NHS Hospitals in patient survey results 47 - 60

The Care Quality Commission (CQC) National In patient survey 2010 results have been published for North West London Hospitals NHS Trust. When members considered the 2009 results and a report on the We Care programme, it was requested that the 2010 results be reported to the Health Partnerships Overview and Scrutiny Committee when they were available.

Ward Affected: All Wards; ***Contact Officer***: Andrew Davies, Policy and Performance
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11 North West London Hospitals NHS Trust Budget and Annual Plan 61 - 68

The Health Partnerships Overview and Scrutiny Committee has asked for a report from North West London Hospitals NHS Trust on its budget position for 2011/12. This follows concerns about the level of savings that the trust will be required to make during the financial year. Members should consider the presentation by the Chief Executive of the hospital trust and consider how the cost pressures will affect services provided by the trust. In particular, members should ask questions around the savings plan that will be implemented to make £18.55m of savings, and how these will be delivered.

Ward Affected: All Wards; ***Contact Officer***: Andrew Davies, Policy and Performance
Tel: 020 8937 1609
andrew.davies@brent.gov.uk

12 Health Partnerships Overview and Scrutiny work programme 69 - 76

The work programme is attached.

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 meeting of the Heath Partnerships Overview and Scrutiny Committee is scheduled for Tuesday, 20 September 2011 at 7.00 pm.

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, 9 June 2011 at 7.00 pm

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

Also Present: Councillors Cheese, Crane, John, McLennan and R Moher

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

   None made.

2. **Minutes of the previous meeting**

   RESOLVED:-

   that the minutes of the previous meeting held on 5 April 2011 be approved as an accurate record of the meeting.

3. **Matters arising**

   Fuel Poverty and Health Scrutiny task group

   The committee heard that the Fuel Poverty and Health task group reported to the Executive in April 2011 and the recommendations were accepted. The issue would be followed up later in the year.

   Access to GP Services in Brent

   It was confirmed that Jo Ohlson (Brent Borough Director, NHS Brent and Harrow) had received the satisfaction data which was being validated and should be ready for the July meeting. It was noted that information on changing GPs without changing address had been circulated to members.

   IT Systems

   The Assistant Director (Community Care) confirmed that problems relating to IT systems incompatibility hindering the exchange of sensitive data between the council and the NHS were being resolved and interim arrangements were in place.

4. **Order of business**

   The committee agreed to change the order of business so as to take early in the meeting the items relating to NWLH NHS Trust Quality Account and the item of urgent business relating to the GP list validation exercise.

5. **North West London Hospital NHS Trust Quality Account**

Catherine Thorne (Director of *Governance*, NWLH NHS Trust) in introducing the report advised that every trust was required to produce a Quality Account, which is a statement of quality relating to the services provided by that NHS trust and to allow organisations the opportunity to comment.

The report before members was the account for 2010-2011 and, while welcoming the content, questions were raised on the opportunity to monitor past concerns specifically in relation to maternity services, in the absence of historical information; the lack of improvement in complaints handling. The committee heard that the NHS London review into maternity services would form the basis of a report to the committee in September and would allow the recommendations to be looked at in the context of services. The committee was assured that, the incidence of neo natal death was very low and the link sometimes made between neo natal death and infant death were not correct. On complaints handling, it was accepted that performance should be better. Where complaints involved more than one agency it took longer to gather statements. Many complaints to the trust were complex involving many staff working different duty rotas, which also delayed the production of a formal response. Concern was expressed over the lack of improvement in local patient indicators relative to the national picture in areas relating to nurses, care and treatment. These were worse than the national figures and members felt it would be helpful to have an indication of how far the trust's performance was from the national average. It was agreed that average figures would be included in future however it was noted with some disappointment that the local response rate was low - only 800 patients responded to the In Patient survey on which the figures were based. Members were pleased to note the good work that had taken place in connection with stroke care.

Members were invited to contribute any further comments to be included in the submission to be prepared in consultation with the chair and vice chair.

RESOLVED:

that the Quality Account provided by North West London NHS Hospitals Trust be noted and authority be delegated to the chair to submit a response by the deadline of 14 June 2011.

6. **Any Other Urgent Business - GP list validation exercise**

Circulated to members in advance of the meeting was a briefing paper prepared by NHS Brent on the GP list validation exercise which was being conducted. There was a difference of over 100,000 between the census population and the registered list in NHS Brent and concern had been expressed that the validation exercise may not have been as fair and effective as it could have been.

Jo Ohlson (Brent Borough Director, NHS Brent and Harrow) advised the committee that list validation was not an unusual exercise. During 2007/10 a list validation exercise had been carried out resulting in some patients being removed. However 118,000 had not responded to letters and these were now subject to a further validation exercise. Ms Ohlson outlined the detail of the correspondence that was

subsequently sent out (which included a translation offer) and the level of replies received. 38,000 people had not responded to letters from the PCT and were due to be removed from GP lists. The gap between registered patients and residents of 100,000 was the highest in the country. Ms Ohlson advised that discussions were taking place on steps to be taken to assist vulnerable people and she assured the committee that practices would not be penalised for reinstating patients.

With the consent of the meeting Mr Irvin Van Colle, chair of the Kingsbury GP Consortium patient and public involvement forum questioned the extent to which the process was open and fair and made reference to one practice that was losing 25% of its patients. He acknowledged the importance of accurate lists but felt that reinstatement of patients would create a huge amount of unnecessary work and suggested that decision should be deferred on any practice that was likely to lose more than 5% of its patients. Mr Van Colle put that there could be many reasons why people had failed to respond to letters including not having English as a first language and that the removals should cease until the methodology had been reviewed.

Rob Larkman (Chief Executive, NHS Brent and Harrow) stressed the importance of accurate patient lists to help ensure that funding was being invested in the right areas. He stated that the methodology used was standard and in recognition of the sensitivities safeguards would be introduced for vulnerable people and those whose first language was not English. Further letters would be sent out. The Chief Executive indicated that practices adversely affected financially would be supported once the process was complete.

Members sought and received assurances that every effort would be employed to avoid removing vulnerable people and that requirements would be waived to reinstate them as easily as possible if necessary. Jo Ohlson offered to report back on the outcome. She advised that approximately £700,000 would be saved so far from the numbers removed accepting that this figure could reduce with re-registration.

Members heard that that there seemed to be some inconsistency between the policy and experience of practices involved in the validation process. Vulnerable patients had been removed from lists sooner than expected although Jo Ohlson confirmed that vulnerable patients on medication would be safeguarded and were also likely to exist on community records and therefore not included in the validation exercise. She stressed the need for practices to respond urgently to notifications and not wait to appeal against removals until the last minute.

The committee heard that patients presenting themselves as unwell would be seen irrespective of whether they were registered and there was also the walk-in centre in Wembley in case of emergency. The committee heard that lessons were being learned from this experience. It was acknowledged that the process would have benefitted from taking place over a longer period of time, the diversity of Brent's population needed tobe taken into account and addressees to be clearly warned not to ignore correspondence.

The committee accepted NHS Brent's assurances that where patients had been removed from lists this had been justifiable and in any event re-registration was not

complicated. The intention to consider reviewing lists on a more regular basis was noted.

The Chair certified this item as urgent in view of the level of public concern and as the deadline for removing patients from GP lists was on the 9 June.

RESOLVED:

that the briefing paper from NHS Brent on the GP list validation exercise be noted and an update on the be exercise presented to the next meeting.

7. **Plans for the future of North West London NHS Hospitals Trust and Ealing Hospital Trust**

Simon Crawford (North West London NHS Hospitals Trust) introduced the report which set out progress on the possible merger of North West London NHS Hospitals Trust and Ealing Hospital Trust. Consideration was still being given to the benefits of a merger which it was believed would provide an opportunity to improve the quality and standard of health care delivered by the trusts. The eventual aim would be to have larger, more specialised teams, improved efficiency, avoid duplication and spread good practice. Significant financial savings were also anticipated. A Strategic Outline Case had been approved and work had now started on an Outline Business Case and at the same time Clinical Working Groups have been established comprising senior clinicians and GP representatives from the three boroughs to develop the clinical vision for the new organisation and options for configuration. The engagement process would include GPs and other stakeholders including patients, staff and individual groups.

Members raised questions on the impact of the current discussion over government health reforms and sought assurances that changes would be clinically driven and services protected. Simon Crawford assured that quality remained a key consideration, that health and well-being would set the agenda and the intention that the merged organisation would be in a better position to deliver. Questions were also raised on the possibility of improving estate utilisation through private finance initiatives to generate income and the risks involved and assurances were given that there would be full consultation on any proposals. The committee were also advised that an options appraisal had been requested and alternatives to merger would be considered.

Members noted that a further report would be submitted in September and it was suggested that consideration be given to a meeting being convened of the scrutiny committees of the three boroughs concerned to further discuss the proposals.

RESOLVED:

that the report be noted.

8. **GP Commissioning Consortia update and primary care issues in Brent**

Jo Ohlson (Brent Borough Director, NHS Brent and Harrow) introduced the regular report on GP commissioning. She reminded the committee that GP commissioning consortia have been long established in Brent and was unlikely to be affected by

the current 'pause' in the government's Health and Social Care Bill. Ms Ohlson outlined the individual commissioning plans developed by each of the five consortia to implement the Quality, Innovation, Productivity and Prevention Plan in 2011/12.

In discussion, Jo Ohlson emphasised that GP pathfinder consortia had a high level of commitment. The recent government announcements of the formal involvement of nurses in consortia was not a new development in Brent. She acknowledged that there would be difficult decisions ahead with both the council and health service working with reduced resources which emphasised the need for increased partnership working. It was noted that one of the initiatives that GP commissioners were working on was urgent care and ways of offering more choice for patients and families at home during end of life care. Jo Ohlson referred to barriers that would need to be overcome to make progress in this area and the need to up-skill professionals. The committee heard that a more holistic approach was required and agreed on the need to have appropriate care plans in place to avoid unnecessary hospital admissions. Current financial challenges reinforced the need for health care reform and the committee noted that NHS London was pushing for rapid delegation to consortia. Alison Elliott (Assistant Director, Community Care) agreed with the suggestion mental health was an area for joint collaboration and confirmed that work was taking place with the PCT and GP commissioning colleagues to improve the service.

On the future and feasibility of the Stag Lane Clinic, Jo Ohlson reported on the poor state of the buildings and the possibility of savings through the renegotiation of the contract. She would be able to report further towards the end of July.

9. **Khat Task Group Scope**

Councillor Hunter (Chair, Khat task group) advised that the Khat task group had met twice and had also met community workers. A 'Check before you chew group' had been established and there had been input from the community at the outset. She drew attention to the task group's scope appended to the report from the Director of Strategy, Partnerships and Improvement.

RESOLVED:

that the Khat task group's scoping document be noted and the final report submitted to the September meeting of this committee.

10. **Work Programme**

The committee had before it the work programme for 2011/12 for comment which was based on issues that had arisen from previous meetings. The following were suggested for inclusion:

- the role of community pharmacists
- the Shadow Health and Well Being Board
- end of life palliative care and strategy
- mental health care

11. **Date of Next Meeting**

It was noted that the next meeting would be taking place on 26 July 2011.

12. **Any other business**

Members' attention was drawn to a meeting to discuss the NHS taking place at the Town Hall on Sunday 12 June organised by Barry Gardiner, MP.

The meeting closed at 9.00 pm

SANDRA M KABIR
Chair

Health Partnerships Overview and Scrutiny Committee
26th July 2011

Report from the Director of Strategy, Partnerships and Improvement

For Action

Wards Affected: ALL

NHS Brent GP Access Update – Quarter 4 Results

1.0 Summary

1.1 NHS Brent has provided a report on GP access satisfaction results for 2010/11, as requested by the Health Partnerships Overview and Scrutiny Committee. When members last looked at this issue in April 2011, members were keen to see that improvements would be made in GP satisfaction measures by quarter 4, as NHS Brent felt that the Access, Choice and Experience (ACE) programme should be delivering improved satisfaction by the end of 2010/11.

1.2 The main issues highlighted in the report from NHS Brent are:

- For the indicators relating to “access”, every indicator has shown an overall improvement from 2009/10 to 2010/11, although the split by consortia shows that performance has not improved across all indicators in all consortia.
- For the indicators relating to “experience”, every indicator has shown an overall reduction in satisfaction in Brent from 2009/10 to 2010/11 except “clean, comfortable place to be in”.
- It should be noted that the results for the “choice” element are yet to be released.

1.3 Members should note that the ACE programme has finished and as a result there isn’t the resource to prepare specific GP practice scores against each indicator, which had been presented to the committee in April 2011.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee should consider the report provided by NHS Brent on the GP satisfaction survey results and question officers from the PCT on how they intend to keep working with GPs to improve patient satisfaction with GP services in the borough.

Background Papers:

NHS Brent GP Access Update – Quarter 4 Results

Contact Officers:

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NHS Brent GP Access Update – Quarter 4 Results

This paper follows on from the last paper reviewed by the OSC who requested the Quarter 4 results from the MORI survey once these were available. These have now been released for both Access and Experience.

Access:

The results, split by Consortia, are shown below with the variance summarised in the final table. This shows that in overall terms access indicators have improved compared to the year before. The split by consortia demonstrates that respondent's view of performance has not improved across all indicators in all Consortia.

2009/10	Harness	Kilburn	Kingsbury	Wembley	Willesden	Brent	England
Able to see a doctor fairly quickly	72.80%	71.74%	77.61%	73.62%	73.81%	73.96%	80.03%
Able to book ahead for an appointment with a doctor	64.29%	68.77%	58.75%	62.60%	65.45%	63.92%	71.38%
Satisfaction with opening hours	76.90%	77.80%	72.96%	73.19%	73.43%	74.88%	81.49%
Able to see a preferred doctor	60.03%	58.46%	62.92%	60.85%	58.26%	60.29%	62.36%
Ease of getting through on the phone	57.84%	65.08%	58.16%	61.05%	63.60%	60.89%	67.94%
Overall	**66.37%**	**68.37%**	**66.08%**	**66.26%**	**66.91%**	**66.79%**	**72.64%**

2010-11	Harness	Kilburn	Kingsbury	Wembley	Willesden	Brent	England
Able to see a doctor fairly quickly	74.49%	73.43%	75.30%	73.18%	73.34%	74.00%	78.77%
Able to book ahead for an appointment with a doctor	66.86%	70.69%	59.22%	64.89%	63.71%	65.29%	71.02%
Satisfaction with opening hours	80.84%	76.26%	72.75%	72.93%	73.93%	75.56%	80.45%
Able to see a preferred doctor	62.20%	58.20%	65.92%	63.37%	59.48%	62.01%	62.73%
Ease of getting through on the phone	63.20%	64.71%	58.17%	65.95%	66.25%	63.51%	69.22%
Overall	**69.52%**	**68.66%**	**66.27%**	**68.06%**	**67.34%**	**68.07%**	**72.44%**

Variance between 2010-11 and 2009-10	Harness	Kilburn	Kingsbury	Wembley	Willesden	Brent	England
Able to see a doctor fairly quickly	1.70%	1.69%	-2.31%	-0.44%	-0.47%	0.04%	-1.26%
Able to book ahead for an appointment with a doctor	2.58%	1.92%	0.47%	2.29%	-1.73%	1.36%	-0.36%
Satisfaction with opening hours	3.94%	-1.54%	-0.22%	-0.26%	0.50%	0.68%	-1.04%

Able to see a preferred doctor	2.17%	-0.26%	3.00%	2.52%	1.22%	1.71%	0.37%
Ease of getting through on the phone	5.36%	-0.37%	0.01%	4.90%	2.65%	2.62%	1.28%
Overall	3.15%	0.29%	0.19%	1.80%	0.43%	1.28%	-0.20%

RAG rating key

Colour	Meaning
Green	Positive variance
Amber	Less variance than England variance
Red	Greater variance than England variance

Experience:

The results, split by Consortia, are shown in the tables below. It should be noted that satisfaction with experience indicators has fallen at a national level. Respondents view of experience indicators has fallen against every indicator with the exception of the indicator “clean, comfortable, friendly place to be” which has shown a small improvement.

2009/10	Harness	Kilburn	Kingsbury	Wembley	Willesden	Brent	England
access and waiting	67.78%	68.84%	68.23%	69.46%	68.03%	68.51%	77.11%
safe, high quality, coordinated care	71.50%	71.30%	69.80%	67.40%	68.40%	69.80%	75.40%
better information, more choice	62.01%	61.38%	60.41%	60.15%	59.51%	60.80%	63.06%
building relationships	75.65%	74.61%	74.77%	73.10%	73.48%	74.40%	80.22%
clean, comfortable, friendly place to be	56.54%	54.96%	54.60%	54.34%	55.21%	55.11%	59.87%
Overall patient experience	66.70%	66.22%	65.56%	64.89%	64.93%	65.72%	71.13%

2010/11	Harness	Kilburn	Kingsbury	Wembley	Willesden	Brent	England
access and waiting	64.23%	64.06%	62.75%	66.12%	63.36%	64.18%	72.30%
safe, high quality, coordinated care	71.74%	70.44%	69.21%	67.21%	69.22%	69.67%	75.02%
better information, more choice	61.44%	59.77%	58.55%	58.75%	60.68%	59.85%	62.15%
building relationships	75.13%	73.46%	72.73%	72.19%	72.91%	73.36%	79.33%
clean, comfortable, friendly place to be	58.07%	54.98%	54.55%	54.24%	55.11%	55.47%	59.97%
Overall patient experience	66.12%	64.54%	63.56%	63.70%	64.25%	64.51%	69.75%

Variance between 2010-11 and 2009-10	Harness	Kilburn	Kingsbury	Wembley	Willesden	Brent	England
access and waiting	-3.55%	-4.78%	-5.48%	-3.34%	-4.67%	-4.33%	-4.81%
safe, high quality, coordinated care	0.24%	-0.86%	-0.59%	-0.19%	0.82%	-0.13%	-0.38%
better information, more choice	-0.57%	-1.61%	-1.86%	-1.40%	1.17%	-0.95%	-0.91%
building relationships	-0.52%	-1.15%	-2.04%	-0.91%	-0.57%	-1.04%	-0.89%
clean, comfortable, friendly place to be	1.53%	0.02%	-0.05%	-0.10%	-0.10%	0.36%	0.10%
Overall patient experience	-0.57%	-1.68%	-2.00%	-1.19%	-0.67%	-1.22%	-1.38%

RAG rating key

	Positive variance

	Less variance than England variance
	Greater variance than England variance

Next Steps:

1. Consortia Clinical Directors being informed of results.
2. Discussion to be held on considering what programme or further interventions could be implemented that would drive a continued improvement within the access indicators and work to improve the satisfaction indicators.

Health Partnerships Overview and Scrutiny Committee
26th July 2011

Report from the Director of Strategy, Partnerships and Improvement

For Action

Wards Affected: ALL

GP List Validation Update

1.0 Summary

1.1 NHS Brent has submitted an update on the GP list validation exercise. As well as preparing a report on the issue, it has also provided a letter sent to all Brent GPs on the process and a spreadsheet showing how many patients have been removed from practice lists since the exercise began. At the committee meeting it is hoped that a figure on the number of re-registrations to practices can be provided, but this information is not available at the time of publishing the report.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee should consider the update on the GP list validation exercise and question officers from NHS Brent on developments that have occurred since this issue was last considered in June 2011.

Background Papers:

Overview and Scrutiny - List Validation Update
Letter from NHS Brent and LMC to Brent GPs
Removals by practice spreadsheet

Contact Officers:

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Overview and Scrutiny - List Validation Update

Introduction

NHS Brent has run a list validation programme over the last eight months that focused on following up 120,000 non responders to a previous programme.

This paper is intended to provide a further update to members, detail next steps and highlight the initial learning from the programme.

Update

The majority of the patients who had not responded, and for whom practices were unable to confirm were registered using the agreed criteria, FP69 flags elapsed on the 9th June 2011. Further patients have continued to be removed after the 9th June where the 6 month period has elapsed. The last flag is due to be removed by the end of July 2011.

Due to the volume that were being removed the IT systems took ten days to process the deductions meaning that final information was not available until the end of June on the exact numbers of patients, by practice, who had been removed as a consequence of the programme.

A spreadsheet is attached to this paper which details by practice the number of FP69 flags that were set as an actual number and as a percentage of their list size as at 1st April 2011 and the number of patients that were removed as an actual number and as a percentage of their list size again as at 1st April 2011.

It is evident that in some practices there were considerable numbers of FP69 flags confirmed with a huge amount of activity taking place in the last week or so ahead of the 9th June deadline. For some practices however the number removed remains relatively high. NHS Brent is currently undertaking a financial analysis of the impact to all practices as a consequence of the programme.

As a consequence of the volume of patients that were removed a number of actions have been agreed with the Local Medical Committee. The joint letter that has been sent to all practices is included with this report. The actions agreed include:

1. Writing to all patients that have been removed as a consequence of the programme to inform them that they are no longer registered and how to go about re-registering. Please note letters will not be sent to any patient removed as a result of undelivered mail.
2. Agreement that if a patient re-registers with the same practice before the 31.3.12 the practice will be reimbursed for any lost capitation payment. No reimbursement will be made from the 1.4.12.
3. That for an agreed list of vulnerable patients who have been removed as a part of this programme practices can look back over a years period, as opposed to six months, to confirm contact with the practice.
4. Agreement over re-registration processes.

In response to this reports are being set up on the Exeter system to enable us to track re-registrations by practice so that we can generate any payments accurately and also to track the re-registration rate.

The information on the first month is not yet available due to the length of time it has taken to close the quarter for GP Practices and staff leave during July. The information will be available in August.

Initial Lesson Learnt

Part of the agreement reached with the Local Medical Committee is that practices will be invited to a workshop to discuss the issues that arose during the programme and agree lessons learnt. This will be set up during August.

Initial learning from a PCT perspective includes:

1. Improve phasing i.e. bulk setting over more than a three month period.
2. Ensuring that for any programme that is run that there is a protocol for dealing with non responders so that the number left never reaches 120,000.
3. Additional information out to practices regarding any list validation exercise.

Next Steps

The following next steps are planned:

1. Financial impacts to be calculated based upon information within attached spreadsheet.
2. Deputy Borough Director to work with clinical directors and relevant practices to understand impact and whether this questions the viability of any practices.
3. For any practices where this is the case work with clinical directors and practices to consider what the mitigating plan maybe and consider what transitional funding might be needed to support this.
4. Put forwards a case to Brent Executive Management Team around any transitional funding requirements (if required).
5. Letter to go to all those patients who were removed from a general practice as a consequence of this programme.
6. Track re-registrations.
7. Set up workshop for learning and feed this into the London wide List Validation work that is underway currently.

Londonwide LMCs
The professional voice of London general practice

NHS
Brent

116 Chaplin Road
Wembley
Middx, HA0 4UZ
tessa.sandall@brentpct.nhs.uk

Dear Practices

This letter is to update you and provide information about various mechanisms that have been agreed with the LMC to support you over the next few months following the List Validation Exercise.

The majority of FP69s expired on the 9th June. **It is essential that practices accept the deductions as they come through on to their clinical systems. All the processes below are reliant on the deductions being accepted.**

The following actions have been agreed:

1. Letter to all Deducted Patients

A letter will be sent to all patients that have been deducted as part of this list validation exercise.

The letter will indicate that the patient is no longer registered with their practice and that they should take steps to re-register. The letter will explain that the patient can re-register at their existing practice or at any other practice; the NHS Choices website will be included. The content of this letter will be agreed with the LMC before it goes out to patients.

2. Re-registering deducted patients

2a) Re-registering vulnerable Patients *(definition of vulnerable patients is provided on page 2)*

We understand that there have been concerns that vulnerable patients may have been removed from their GP practice as a consequence of this exercise. It has been agreed that practices will be able to check back twelve months from the date the FP69 flag was set, using the agreed criteria to determine whether or not the patient should remain deducted or should be re-registered.

Example –

Patient X flag set 9th December 2010. Patient X flag expired 9th June 2011. Practices can now check back to 9th December 2009 using agreed criteria to confirm if there has been contact with the practice.

If the practice finds that a patient who has been deducted has had contact within 12 months from when the flag was set, the practice will:

i) Complete a GMS1 form on behalf of the patient and retain this at the practice. Please note that these patients do **not** need to sign this GMS1 form.

ii) Re-register the patient through the registration screen. Practices should put the following message in the GP Message screen:

The agreed criteria for confirming a patient as still registered are:

- A prescription issued within 6 months of the flag being set.
- The patient being seen within 6 months of the flag being set.
- A letter received from the patient within 6 months of the flag being set.
- A telephone conversation, that is documented within the patients notes, within 6 months of the flag being set.

Please record in the notes on the FP69 Flag the form of evidence that is being used to remove it. You only need insert the following note:

- Prescription
- Face to Face
- Telephone

Vulnerable patient re-reg: seen on xx/xx/xx (the date should be the date used on the GMS1 form)

Practices should review the deductions and undertake the above actions where appropriate within three months from the 27.6.11

The list of vulnerable groups is as follows:

No fixed abode
Homeless
Patient (adult or child) with live (or closed within 12 months of flag being set) safeguarding issue.
Severe Mental Illness as coded on the QOF register
Dementia
Learning Disability
Palliative Care

Substance/Alcohol misuse
Housebound over 65

2b) Re-registering non-vulnerable patients

If a patient who does not fall within the above listed ‘vulnerable’ categories wishes to re-register, the practice should do the following:

i) Complete the GMS1 form which should **include** a patient signature and this should be retained at the practice.
ii) Complete the clinical system re-registration process and ensure that they include the following message in the GP Message screen:

Re-reg: seen on xx/xx/xx (the date should be the date used on the GMS1 form)

Practices should ensure they follow their practice protocols when re-registering patients. Practices are not required to submit any additional information when re-registering these patients unless the patients address has changed in which case information should be provided as normal.

3. Lost capitation payments

Practices will need to accept the deductions for patients as they come down the link.

NHS Brent will reimburse practices for the capitation payment only in respect of patients who have been removed as part of this list validation exercise who then re-register with the same practice **before 31.3.12**.

Practices will **not** be reimbursed lost capitation payments for any patients that re-register with the same practice **from 1.4.12 onwards**. NHS Brent will track this through the Exeter system on a monthly basis.

4. Patient Notes

Practices should **not return any deducted patients’ notes (paper or electronic) for 3 months** following deduction, **unless notes are requested via GP-links from** the FHS/21 building because the patient has:

Registered with another GP

Moved to another health authority area

Other stated reasons

In the event of the above practices should return notes (electronic and paper) in the normal way and timeframe.

NHS Brent and the LMC will review the situation with the notes at the end of month 3 (by end September) and will communicate with practices as to when they should start returning deducted patients' notes who have not re-registered.

NHS Brent has agreed to look at what further support can be offered to practices that have been financially destabilised as a consequence of this process. Further information will be released regarding this, once the data on the actual number of deductions is available by practice and analysis of this has taken place.

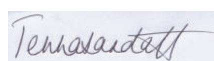
NHS Brent appreciates that the exercise has caused practices increased workload and would like to take the opportunity to thank you for your time in relation to this. We would also like to re-iterate the apology regarding the technical error that occurred as a consequence of new software being uploaded by Connecting for Health.

We also believe that there have been lessons learnt on both sides through this exercise and we will be writing to practices to invite them to attend a workshop to capture this information.

Please do ensure that this letter is acted on. If you have any queries regarding it please contact Tessa by email (tessa.sandall@brentpct.nhs.uk) and she will contact you.

Alternatively, if you have any concerns about the implementation about this process, please contact your LMC, Sarah Bedding, Committee Liaison Executive, sbedding@lmc.org.uk in the first instance.

Yours sincerely



Tessa Sandall	Dr P Chatlani	Dr H Clark
Deputy Borough Director	Brent LMC Chair	Medical Director/LMC Secretary

E Code	Practice	overall number of flags set	Overall Total Deducted at 24 June 11	List size as at 1.4.11	percentage set against list size
WILLESDEN CONSORTIUM					
E84011	ST ANDREWS MEDICAL CENTRE	1236	630	4268	28.96
E84021	THE WILLESDEN MEDICAL CENTRE	2515	1266	10502	23.95
E84086	WALM LANE SURGERY	1903	1356	8082	23.55
E84656	ROUNDWOOD PARK MEDICAL CENTRE	564	234	3325	16.96
E84665	NEASDEN MEDICAL CENTRE	1451	1133	7796	18.61
E84690	CREST MEDICAL CENTRE	773	495	4572	16.91
E84704	ST GEORGES MEDICAL CENTRE	603	321	2694	22.38
Y00206	BURNLEY PRACTICE	465	232	3044	15.28
E84036	GLADSTONE MEDICAL CENTRE	2499	747	8481	29.47
E84708	THE VILLAGE MEDICAL CENTRE	774	43	2286	33.86
WEMBLEY CONSORTIUM					
E84066	HAZELDENE MEDICAL CENTRE,	12	10	3254	0.37
E84084	THE BEECHCROFT MEDICAL CENTRE	1209	575	5356	22.57
E84649	THE SURGERY BRENT TPCT Vale Farm	14	1	3026	0.46
E84668	KENTON MEDICAL CENTRE	405	304	2936	13.79
Y01090	SMS MEDICAL PRACTICE	406	195	2239	18.13
E84638	ALPERTON MEDICAL CENTRE	719	87	5193	13.85
E84083	LANFRANC MEDICAL CENTRE	1185	706	6611	17.92

E84017	SUDBURY & ALPERTON MEDICAL CENTRE	1329	487	8310	15.99
E84685	SUDBURY COURT SURGERY	715	481	5012	14.27
E84063	LANCELOT MEDICAL CENTRE	519	277	6602	7.86
E84051	STANLEY CORNER MEDICAL CENTRE	864	528	5384	16.05
E84678	PRESTON MEDICAL CENTRE	636	455	3750	16.96
E84669	THE EAGLE EYE	303	264	2314	13.09
E84626	THE SUNFLOWER MEDICAL CENTRE	493	438	2706	18.22
			HARNESS CONSORTIUM		
E84031	BRENTFIELD MEDICAL CENTRE	1801	1080	9732	18.51
E84028	THE STONEBRIDGE PRACTICE	358	127	4917	7.28
E84029	HARNESS HARLESDEN	403	85	2012	20.03
E84030	AKSYR MEDICAL PRACTICE	1002	462	6080	16.48
E84637	HILLTOP MEDICAL PRACTICE	3	0	1891	0.16
E84074	FREUCHEN MEDICAL CENTRE	1342	844	6394	20.99
E84624	PARK ROAD SURGERY	559	229	2011	27.80
E84645	ACTON LANE SURGERY	434	76	3270	13.27
E84013	CHURCH END MEDICAL CENTRE	2181	987	8045	27.11
E84076	OXGATE GARDENS SURGERY	1084	459	6180	17.54
E84701	Pearl Medical Practice	562	282	2556	21.99
E84067	CHURCH LANE SURGERY	956	733	8953	10.68
E84026	BUCKINGHAM ROAD SURGERY	1287	527	5615	22.92
E84709	WEMBLEY PARK DRIVE MEDICAL CENTRE	850	114	8513	9.98

E84635	The Surgery	406	52	3434	11.82
			KILBURN CONSORTIUM		
E84025	LONSDALE MEDICAL CENTRE	2160	726	14365	15.04
E84042	KILBURN PARK MEDICAL CENTRE	1490	719	7679	19.40
E84667	THE BLESSING MEDICAL CENTRE	164	11	2290	7.16
E84702	WILLESDEN GREEN SURGERY	527	310	3025	17.42
E84080	STAVERTON SURGERY	1233	928	7983	15.45
E84035	THE MEDICAL CENTRE	544	2	2203	24.69
E84006	THE LAW MEDICAL GROUP PRACTICE	1901	902	14476	13.13
E84012	THE WINDMILL MEDICAL PRACTICE	894	590	6988	12.79
E84077	THE SHELDON PRACTICE	668	400	2738	24.40
E83654	Lever Medical Centre	770	699	3010	25.58
E84056	THE CLARENCE MEDICAL CENTRE	671	629	2546	26.36
E84705	CHAMBERLYNE ROAD SURGERY	627	478	2723	23.03
E84674	CHICHELE ROAD SURGERY	1083	82	5723	18.92
E84696	PEEL PRECINCT SURGERY	303	183	1919	15.79
E84023	PARK HOUSE MEDICAL CENTRE	774	520	5689	13.61
			KINGSBURY CONSORTIUM		
E84002	Forty Willows	85	55	6582	1.29
E84620	PRESTON ROAD SURGERY	923	399	5126	18.01

E84684	THE TUDOR HOUSE MEDICAL CENTRE	391	246	2566	15.24
E84699	KING'S EDGE MEDICAL CENTRE	477	425	4280	11.14
E84706	FRYENT MEDICAL CENTRE	544	326	2260	24.07
E84078	STAG LANE MEDICAL CENTRE	13	11	3079	0.42
E84033	CHALKHILL FAMILY PRACTICE	1034	549	4757	21.74
E84032	ELLIS PRACTICE	1654	552	6670	24.80
E84020	THE STAG-HOLLY ROAD PRACTICE	498	375	2868	17.36
E84048	THE FRYENT WAY SURGERY	1031	536	8393	12.28
E84015	THE WILLOW TREE FAMILY DOCTORS	1505	769	10804	13.93
E84007	UXENDON CRESCENT SURGERY	747	417	5440	13.73
E84049	BRAMPTON HEALTH CENTRE	382	368	1730	22.08
E84661	PRIMARY CARE MEDICAL CENTRE	233	57	3091	7.54
E84003	PREMIER MEDICAL CENTRE	687	252	4222	16.27
Totals	**Totals**	**58146**	**29586**	**348349**	**16.69**

percentage removed against list size
14.76
12.05
16.78
7.04
14.53
10.83
11.92
7.62
8.81
1.88
0.31
10.74
0.03
10.35
8.71
1.68
10.68

5.86
9.60
4.20
9.81
12.13
11.41
16.19
11.10
2.58
4.22
7.60
0.00
13.20
11.39
2.32
12.27
7.43
11.03
8.19
9.39
1.34

1.51
5.05
9.36
0.48
10.25
11.62
0.09
6.23
8.44
14.61
23.22
24.71
17.55
1.43
9.54
9.14
0.84
7.78

9.59
9.93
14.42
0.36
11.54
8.28
13.08
6.39
7.12
7.67
21.27
1.84
5.97
8.49

Health Partnerships Overview and Scrutiny Committee
26th July 2011

Report from the Director of Strategy, Partnerships and Improvement

For Action

Wards Affected: ALL

Update on GP commissioning in Brent

1.0 Summary

1.1 NHS Brent has provided an update on the progress being made with GPs on establishing commissioning groups in Brent, as requested by the Health Partnerships Overview and Scrutiny Committee. As well as providing an update on the work of the clinical commissioning groups (previously known as GP commissioning consortia), the paper also summarises the main changes that have been made to the Health and Social Care Bill following the Government's listening exercise and the report of the NHS Future Forum.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee should consider the update on the Brent clinical commissioning groups and the Health and Social Care Bill and question GPs and officers from NHS Brent on the progress being made in moving toward clinician led commissioning.

Background Papers:

Update on GP commissioning in Brent - July 2011

Contact Officers:

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NHS
Brent

Brent Health Overview and Scrutiny Committee

Update on GP commissioning in Brent

July 2011

1. Update on Pathfinder activities - Delegated budgets

1.1 In June 2011, the Federation applied for delegated budgets. This is the first step towards achieving authorisation as a Clinical Commissioning Group. The Federation have applied for delegation of the following budgets to be held at consortium level:

- Prescribing
- Direct access
- Outpatients.

Harness consortium has also applied for the budget for elective care and Kilburn for community physiotherapy.

1.2 As a Federation, they have applied for community paediatrics and community budgets. These two budgets will be held at Federation level as there is insufficient information to monitor and control the budget at consortium level. However we have agreed with the PCT to develop shadow budgets for these areas plus mental health so that we can move to consortium level budgets in 2012/13.

1.3 North West London cluster was anticipating being able to delegate all budgets to pathfinder consortia by the end of Quarter 3 but Brent GP Federation is concerned to move at a realistic pace in which they can learn the appropriate skills. The Federation will review their appetite for taking on more delegated budgets in August.

1.4 NHS Brent and NHS Harrow Boards will consider the Federation's application at its meeting on 28 July. If approved, budgets will be devolved from September 2011. While formal delegation of budgets is important, Clinical Directors are already deemed accountable for budget performance and implementation of QIPP as part of our current GP commissioning governance arrangements.

2. Amendments to the Health and Social Care Bill

2.1 Following the Government's listening exercise on the Health and Social Care Bill, the NHS Future Forum published their recommendations on the future for NHS modernisation. The Government published its response on 20 June, setting out the changes it intends to make in response to the recommendations. On 27 June, the Government published a set of briefing notes to accompany Government amendments tabled for consideration by a House of Commons Public Bill Committee. Below we have highlighted those areas that have implications for GP commissioning.

Clinical Commissioning Groups

2.2 Commissioning consortia will continue to be groups of GP practices, but a number of changes have been made to provide greater assurance that commissioning will involve patients, carers and the public and a wide range of doctors, nurses and other health care professionals. To reflect this stronger emphasis on wider professional

involvement in commissioning decisions, the Government will use the term "Clinical Commissioning Group" to describe these local NHS organisations.

2.3 Clinical Commissioning Groups will have a duty to promote integrated health and social care around the needs of users and their boundaries would not normally cross those of local authorities.

2.4 Clinical Commissioning Groups will be expected to have a name that uses the NHS brand and has a clear link to their locality. Clinical Commissioning Groups must commission all urgent and emergency care within their boundaries, and are also responsible for any unregistered patients who live in their area.

2.5 Clinical Commissioning Groups will have flexibility to work in partnership when commissioning services, for example with other groups, local authorities and the NHS Commissioning Board. But as public bodies, they will be unable to delegate their statutory responsibility for commissioning decisions to private companies or contractors.

GOVERNANCE AND ACCOUNTABILITY FOR CLINICAL COMMISSIONING GROUPS

2.6 Every Clinical Commissioning Group will have a governing body with at least two lay members, one with a lead role in championing patient and public involvement, the other with a lead role in overseeing key elements of governance such as audit, remuneration and managing conflicts of interest. One of the lay members will undertake either the role of Deputy Chair or Chair of the governing body. If Deputy Chair, the lay member would take the Chair's role for discussions and decisions involving a conflict of interest for the Chair.

2.7 Clinical Commissioning Groups will have to include at least one registered nurse and one doctor who is a secondary care specialist but not employed by a local provider. Governing bodies will be required to meet in public and publish their minutes, and Clinical Commissioning Groups will have to publish details of contracts with health service providers.

TIMETABLE FOR ESTABLISHING THE NEW COMMISSIONING SYSTEM

2.8 Primary Care Trusts will cease to exist in April 2013. However, Clinical Commissioning Groups who are not authorised to take on any part of the commissioning budget in their local area will not be required to take this on until they are ready and willing to do so.

2.9 By April 2013, GP practices will be members of either an authorised Clinical Commissioning Group, or a 'shadow' commissioning group, i.e. one that is legally established but operating only in shadow form, with the NHS Commissioning Board commissioning on its behalf. No individual GP will need to get involved in the work of a commissioning group if they don't want to.

2.10 Clinical Commissioning Groups that are ready and willing by April 2013 could be authorised to take on full budgetary responsibility. Some will only be authorised in part. Others will only be established in shadow form. This will be determined through a robust process of authorisation, run by the NHS Commissioning Board, with input from emerging Health and Wellbeing Boards and local clinicians through a senate.

2.11 There a Clinical Commissioning Group is not able to take on some or all aspects of commissioning, the local arms of the NHS Commissioning Board will commission on its behalf

2.12 The Primary Care Trust "cluster" arrangements will be reflected in the local arrangements of the NHS Commissioning Board. Those local arrangements will be established before PCTs are abolished.

WIDER CLINICAL INVOLVEMENT AND ADVICE

2.13 Clinical networks of experts, including patient and carer representatives, that exist in areas like cancer care will be retained and they will be given a stronger role in commissioning, supporting the NHS Commissioning Board and local Clinical Commissioning Groups.

2.14 "Clinical Senates" will be established to give expert advice to Clinical Commissioning Groups on how to make patient care fit together seamlessly in each area of the country. To support the better integration of services, they will include public health specialists as well as adult and child social care experts. Clinical senates will have a formal role in the authorisation of Clinical Commissioning Groups. In addition, the Clinical Senates will have a key role in advising the NHS Commissioning Board on whether commissioning plans are clinically robust and proposed major service changes.

HEALTH AND WELLBEING BOARDS (HWB) / LOCAL AUTHORITIES

2.15 Health and Wellbeing Boards will have a new duty to involve users and the public. HWBs will be involved throughout the process as Clinical Commissioning Groups develop their commissioning plans, and there will be a stronger expectation, set out in statutory guidance, for the plans to be in line with the local Health and Wellbeing Strategy. HWBs will have a clear right to refer plans back to the group or to the NHS Commissioning Board for further consideration.

2.16 HWBs will have a stronger role in promoting joint commissioning and integrated provision between health, public health and social care. They will be given a formal role in authorising Clinical Commissioning Groups. The NHS Commissioning Board will have to take HWBs' views into account in their annual assessment of commissioning groups.

2.17 Health and Wellbeing Boards discharge executive functions of local authorities, and should operate as equivalent executive bodies do in local government. It will be for local authorities to determine the precise number of elected members on a Health and Wellbeing Board, and they will be free to insist upon having a majority of elected councillors.

2.18 HWBs will be subject to oversight and scrutiny by the existing statutory structures for the overview and scrutiny of local authority executive functions. The existing statutory powers of local authority overview and scrutiny functions will continue to apply.

PATIENT AND PUBLIC INVOLVEMENT

2.19 The NHS Commissioning Board and Clinical Commissioning Groups will have a duty to involve patients, carers and the public in commissioning decisions and will require commissioning groups to consult on their annual commissioning plans to ensure

proper opportunities for public input. They will have to involve the public on any changes that affect patient services, not just those with a “significant” impact.

INTEGRATION OF SERVICES

2.20 Clinical Commissioning Groups will have a duty to promote integrated services for patients, both within the NHS and between health, social care and other local services.

3. Next Steps

3.1 Over the coming months, we will consider what changes we may need to make to current governance arrangements supporting GP commissioning prior to establishing shadow Clinical Commissioning Groups.

3.2 The Brent GP Federation will continue to update the Overview and Scrutiny Committee on amendments to existing arrangements.

Jo Ohlson, Borough Director - NHS Brent
Dr Ethie Kong & Dr Sami Ansari, Clinical Co Directors – Harness Consortium
Dr Amanda Crag, Clinical Director – Kilburn Consortium
Dr Ajit Shah, Clinical Director - Kingsbury Consortium
Dr Ashwin Patel & Jahan Mahmoodi, Co Clinical Directors - Wembley Consortium
Dr Sarah Basham & Dr Cherry Armstrong, Co Clinical Directors - Willesden Consortium

Health Partnerships Overview and Scrutiny Committee
26th July 2011

Report from the Director of Strategy, Partnerships and Improvement

For Action

Wards Affected: ALL

Paediatric Services at Central Middlesex Hospital

1.0 Summary

1.1 NHS Brent and North West London Hospitals NHS Trust have asked to present a paper to the committee on plans for paediatric services at Central Middlesex Hospital. As members will be aware, CMH used to provide an overnight children's service (based on six beds) on Rainbow ward. Following a successful public consultation in early 2010, the local NHS established two consultant led Paediatric Assessment Units (PAUs) at both Northwick Park Hospital (NPH) and Central Middlesex Hospital (CMH) and centralised the inpatient (overnight) service at NPH. The aim of the reconfiguration was to reduce unnecessary admissions and improve the links with community child health services.

1.2 In summer 2010, NHS Brent commissioned Care UK to establish an urgent care centre (UCC) at CMH. The new unit opened on 28th March 2011 and provides a 24/7 GP model of care. As part of its service specification, the UCC is expected to see 75% of all children seen at CMH. In order to support this target, the UCC is staffed by a paediatric trained nurse on 24/7 basis. In addition all GPs and nurses are qualified in level 3 safeguarding.

1.3 The CMH UCC has been operational since 28th March 2011. Although it has only been open for three months, the impact on the PAU at CMH has been significant.

1.4 In January the average number of PAU attendances per week was 215. As illustrated in the table below this number has fallen to just 30.6 per week (4 April to 4 July 2011). This represents an 85.7% reduction in demand.

1.5 Total activity (over a 24 hour period) for the NWLH paediatric service (i.e. provided by PAU in hours and A&E out of hours) is also very low as the UCC has absorbed on average 87% of paediatric demand since opening.

1.6 As a result of the decline in use, the PAU is costing the local NHS a significant amount of money and there are issues relating to staffing – some staff are said to be

concerned about becoming "de-skilled" because of the low level of admissions to the PAU at CMH.

1.7 To resolve this, it is proposed that:

- The paediatric assessment function is absorbed into the Care UK UCC service;
- The NLWH PAU service is decommissioned at CMH; and
- The paediatric outpatient service and Brent Sickle Cell service would remain at CMH
- all assessment and day care beds will be centralised with the inpatient service at NPH.
- There would not be a specialist paediatric emergency service at CMH. Children who attend the UCC/A&E department would be either seen by a GP, ENP or A&E doctor.
- Patients requiring specialist opinion or overnight care would be transferred to Northwick Park by the Trust's internal ambulance service.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee should:

- Consider the report provided on the proposals for paediatric services at Central Middlesex Hospital and question officers on the plans.
- Decide whether the proposed changes constitute a significant variation in service which would require a formal NHS consultation with stakeholders following the industry standard, 12 week, full public consultation.

Background Papers:

Paediatric Services at Central Middlesex Hospital – a report from NHS Brent and Harrow and North West London NHS Hospitals Trust

Contact Officers:

Phil Newby, Director of Strategy, Partnerships and Improvement
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Andrew Davies, Policy and Performance Officer
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NHS Harrow

NHS Brent

The North West London Hospitals NHS Trust

Report to: **Brent Health Select Committee**

Report from: **The North West London Hospitals NHS Trust**
NHS Brent
NHS Harrow

Date of meeting: **26 July 2011**

RE: **Paediatric Services at Central Middlesex Hospital**

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1. Purpose of report

To describe the impact of the Brent Urgent Care Centre on paediatric services at Central Middlesex Hospital (CMH) and propose a new model of care for consideration by the Health Select Committee (HSC).

2. Background

CMH used to provide an overnight children's service (based on six beds) on Rainbow ward. Following a successful public consultation in early 2010, the local NHS established two consultant led Paediatric Assessment Units (PAUs) at both Northwick Park Hospital (NPH) and Central Middlesex Hospital (CMH) and centralised the inpatient (overnight) service at NPH. The aim of the reconfiguration was to reduce unnecessary admissions and improve the links with community child health services.

The PAUs have been open since October 2010 and Rainbow ward now closes at 10pm every night. The LAS now take all 999 calls to Northwick Park instead of CMH. This system has been working well over the past six months.

There was no adverse media coverage during both the consultation and implementation phases. NHS partners believe that this is a result of the smooth management of the process, excellent joint working across the local NHS and widespread public support for the proposals.

In summer 2010, NHS Brent commissioned Care UK to establish an urgent care centre (UCC) at CMH. The new unit opened on 28th March 2011 and provides a 24/7 GP model of care. As part of its service specification, the UCC is expected to see 75% of all children seen at CMH. In order to support this target, the UCC is staffed by a paediatric trained nurse on 24/7 basis. In addition all GPs and nurses are qualified in level 3 safeguarding.

The remaining 25% of children who cannot be seen by UCC staff are referred to the CMH PAU. The small number of children requiring specialist paediatric care out of hours (OOH) will be transferred to Northwick Park by the Trust's internal ambulance service.

3. Current position

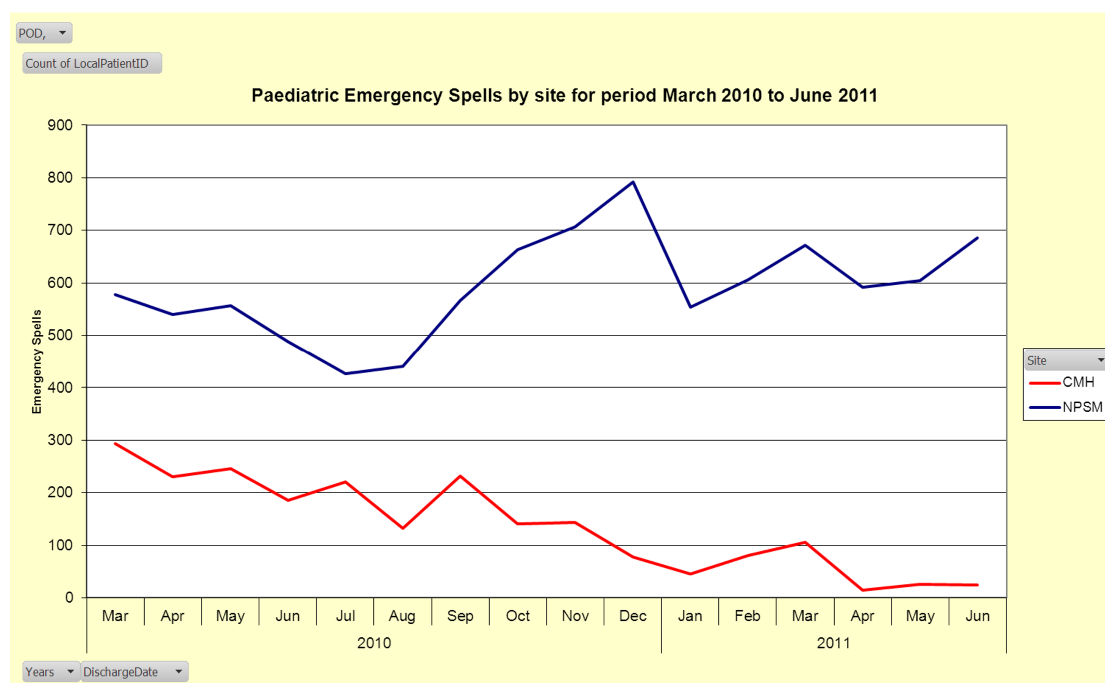
3.1 Impact on patients admitted at CMH and NPH

The PAU at CMH has been operational since 18th October 2010. Although patients can be admitted to the PAU, overall there has been a significant reduction in the number of emergency patients admitted at CMH. This is positive as it corresponds with the original plan (to reduce admissions).

In the first weeks following implementation there was a corresponding growth in admissions at NPH. Following a fall in December, this trend is increasing once more (ie January to June 2011) but at a lower rate. This is welcome because A&E attendances have generally remained stable while adult admissions have grown (notably LAS journeys).

In other words both NPH and CMH continue to see the same number of patients arriving via A&E/UCC but less patients are now being admitted to the hospital (eg as an overnight stay).

Chart 1 Emergency spells (incl. observations) at CMH and NPH March 2010 – February 2011



The chart above demonstrates that:

- The average number of children admitted has fallen from 7.1 per day to 2.3 per day (68% reduction) at CMH since October;
- The average number of children admitted at NPH has increased from 16.6 to 21.1 per day (for the same period). This represents a 27% increase.

3.2 Impact of the UCC on the CMH PAU

The CMH UCC has been operational since 28th March 2011. Although it has only been open for three months, the impact on the PAU at CMH has been significant.

In January the average number of PAU attendances per week was 215. As illustrated in the table below this number has fallen to just 30.6 per week (4 April to 4 July 2011). This represents an 85.7% reduction in demand.

Total activity (over a 24 hour period) for the NWLH paediatric service (ie provided by PAU in hours and A&E out of hours) is also very low as the UCC has absorbed on average 87% of paediatric demand since opening.

Central Middlesex Hospital					
Week No.	Week Commencing	Total attendees PAU	Total attendees A&E OOH	Total attendees UCC	% of all activity seen by UCC
1	04/04/2011	46	10	350	84%
2	11/04/2011	33	10	289	85%
3	18/04/2011	31	9	323	88%
4	25/04/2011	36	8	344	87%
5	02/05/2011	31	9	291	86%
6	09/05/2011	37	9	306	85%
7	16/05/2011	27	8	293	88%
8	23/05/2011	36	7	306	86%
9	30/05/2011	18	4	279	92%
10	06/06/2011	25	7	254	87%
11	13/06/2011	31	6	299	88%
12	20/06/2011	26	8	269	87%
13	27/06/2011	27	3	328	91%
14	04/07/2011	25	13	324	88%
	Average	*30.6*	*7.9*	*303.9*	*87%*

Admissions to the CMH PAU (for observation and treatment) have also fallen significantly from an average of 18 admissions per week (Jan – March 2011) to just 4.6 per week (see table below).

Week No.	Week Commencing	PAU Admissions
1	04/04/2011	10
2	11/04/2011	2
3	18/04/2011	2
4	25/04/2011	3
5	02/05/2011	7
6	09/05/2011	8
7	16/05/2011	2
8	23/05/2011	3
9	30/05/2011	6
10	06/06/2011	2
11	13/06/2011	6
12	20/06/2011	6
13	27/06/2011	3
	Average	*4.6*

3.3 Impact on staff and potential risk to patient safety

Both medical and nursing staffing working on the PAU have raised concerns that they are becoming deskilled as a result of the reduced demand. On most days there are more staff working in the PAU than patients. There have already been a number of resignations amongst nursing staff.

The Trust is concerned that it will become increasingly difficult to retain staff in the PAU given the current lack of demand. This is already creating difficulties in effectively staffing the unit. The Trust is concerned that further loss of staff (which has already been mooted) will impact on ensuring that correct standards of quality and safety, are maintained, potentially putting both patients and staff at risk.

3.4 Financial impact of the UCC

The current direct costs of providing the PAU at CMH are £716k pa (excluding overheads) or £13,769 per week. The full breakdown is included in the table below.

	Current Direct Cost of PAU service at CMH
Costs	**£'000s**
Medical	230
Nursing	441
Non Pay	16
Drugs	29
Additional transport for relatives	0
TOTAL	716

As described in section 3.2, the PAU has treated the following patients since the UCC opened at the end of March:

Week No.	Week Commencing	Total attendees PAU	PAU Admissions
1	04/04/2011	46	10
2	11/04/2011	33	2
3	18/04/2011	31	2
4	25/04/2011	36	3
5	02/05/2011	31	7
6	09/05/2011	37	8
7	16/05/2011	27	2
8	23/05/2011	36	3
9	30/05/2011	18	6
10	06/06/2011	25	2
11	13/06/2011	31	6
12	20/06/2011	26	6
13	27/06/2011	27	3

Note: total attendance data will also include the total number of admissions.

If the following income assumptions are applied, the financial viability of the PAU can be assessed:

- PAU/A&E attendance - £120 (incl. MFF)
- Admission for observation £739 (incl. MFF)

Week	Date	Total attendees PAU	Income	Total admissions PAU	Income	Total income
1	04/04/2011	46	£ 5,520	10	£ 7,390	£ 12,910
2	11/04/2011	33	£ 3,960	2	£ 1,478	£ 5,438
3	18/04/2011	31	£ 3,720	2	£ 1,478	£ 5,198
4	25/04/2011	36	£ 4,320	3	£ 2,217	£ 6,537
5	02/05/2011	31	£ 3,720	7	£ 5,173	£ 8,893
6	09/05/2011	37	£ 4,440	8	£ 5,912	£ 10,352
7	16/05/2011	27	£ 3,240	2	£ 1,478	£ 4,718
8	23/05/2011	36	£ 4,320	3	£ 2,217	£ 6,537
9	30/05/2011	18	£ 2,160	6	£ 4,434	£ 6,594
10	06/06/2011	25	£ 3,000	2	£ 1,478	£ 4,478
11	13/06/2011	31	£ 3,720	6	£ 4,434	£ 8,154
12	20/06/2011	26	£ 3,120	6	£ 4,434	£ 7,554
13	27/06/2011	27	£ 3,240	3	£ 2,217	£ 5,457

As demonstrated in the table below the PAU is now losing on average £6,629 per week (direct costs less direct income). This loss would be greater if 28% overheads were applied to the costs.

Table Comparison of direct costs vs. direct income for PAU activity (April 2011)

			Cost of service	Total income		Var.
1	04/04/2011		£ 13,769	£ 12,910		-£ 859
2	11/04/2011		£ 13,769	£ 5,438		-£ 8,331
3	18/04/2011		£ 13,769	£ 5,198		-£ 8,571
4	25/04/2011		£ 13,769	£ 6,537		-£ 7,232
5	02/05/2011		£ 13,769	£ 8,893		-£ 4,876
6	09/05/2011		£ 13,769	£ 10,352		-£ 3,417
7	16/05/2011		£ 13,769	£ 4,718		-£ 9,051
8	23/05/2011		£ 13,769	£ 6,537		-£ 7,232
9	30/05/2011		£ 13,769	£ 6,594		-£ 7,175
10	06/06/2011		£ 13,769	£ 4,478		-£ 9,291
11	13/06/2011		£ 13,769	£ 8,154		-£ 5,615
12	20/06/2011		£ 13,769	£ 7,554		-£ 6,215
13	27/06/2011		£ 13,769	£ 5,457		-£ 8,312
				Average		*-£ 6,629*

4. Proposed way forward

In light of reduced demand and the adverse impact it has had on staffing and the Trust's financial position, the CMH PAU is considered clinically and financially unviable. As a result of reduced demand, the service is losing approximately £345k pa (based on a straight line forecast) and the position is likely to deteriorate further as the UCC service matures and sees increased numbers of patients.

It is therefore proposed that:

- The paediatric assessment function is absorbed into the Care UK UCC service;
- The NLWH PAU service is decommissioned at CMH; and
- The paediatric outpatient service and Brent Sickle Cell service would remain at CMH

This proposal would result in all assessment and day care beds being centralised with the inpatient service at NPH.

This would mean that the Trust would not have a specialist paediatric emergency service at CMH. Children who attend the UCC/A&E department would be either seen by a GP, ENP or A&E doctor.

Patients requiring specialist opinion or overnight care would be transferred to Northwick Park by the Trust's internal ambulance service.

5. Risks

The Reconfiguration Team (made up of doctors, nurses and managerial staff) has identified the following as the most significant risks to the Trust in achieving the proposed reconfiguration:

i) Very sick child arriving at CMH;
ii) Delayed transfer for child from CMH to inpatient unit;
iii) Loss of nursing staff who will not wish to transfer to NPH for the centralised service;
iv) Unable to support the need for high quality care for sickle cell patients transferred to NPH
v) Lack of specialist support for children receiving surgical care in ACAD

The reconfiguration team has developed the following risk assurance framework which is monitored on a monthly basis.

Risk name	Description/impact of risk	Impact	Likelihood	Risk rating	Mitigation
Failure to manage a very sick child arriving at CMH	UCC and A&E staff unable to manage complex children who self-present	3	1	3	• The UCC specification requires the service to deploy a paediatric trained nurse on (24/7). All GPs and nurses must be qualified in level 3 safeguarding. • All permanent (ie non locum) nursing and medical staff in CMH A&E have attended APLS/PILS training. • Nursing and medical staff began rotating between CMH A&E and paediatrics from September 2010 to ensure there was cross fertilisation and better integration. • A&E transfer matrix in place to support CMH staff to ensure that patients are quickly and safely transferred. • St Mary's have agreed to accept the rare critically unwell child (column 5 of the matrix) who arrives at CMH. CMH A&E staff will contact LAS control room (as per LAS' critical

Risk name	Description/impact of risk	Impact	Likelihood	Risk rating	Mitigation
					transfer protocol). • The LAS will continue to take all 999 calls to Northwick Park instead of CMH.
Delayed transfer for child from CMH to inpatient unit	A child waits longer than 60 mins for a transfer to an inpatient unit	2	4	8	• Service standards agreed with the Trust's private ambulance service so that patients do not wait inappropriately. This system is currently well established for emergency surgery and has been operating in paediatrics since October 2010; and • A&E transfer matrix in place to support CMH staff to ensure that patients are quickly and safely transferred.
Unable to support the need for high quality care for sickle cell patients transferred to NPH	The current paediatric service may be undermined as patients requiring overnight care are transferred to NPH. NPH staff too inexperienced to manage the patients overnight.	2	2	4	• The majority of children using the CMH service are seen and discharged on the same day and will not require transfer; • Combined training programme in place for nursing and medical staff to ensure necessary skills transfer.
Loss of nursing staff who will not wish to transfer to NPH	Staff currently based at CMH will not want to work overnight at NPH	3	1	3	• Senior nursing staff have been actively involved in the design of the clinical model. • Staff concerns that they are becoming deskilled (due to reduced demand) and therefore recognise the need to centralise service.
Lack of specialist support for children receiving surgical care in ACAD	Surgeons may not want to admit children to ACAD without on-site specialist paediatric back up at CMH	TBA	TBA		**TBA**

5. Involvement and engagement

5.1 Local Overview and Scrutiny Committees (OSCs)

The local health economy recommends that the HSC should consider active stakeholder engagement regarding any proposed changes to service configuration in line with Section 242 of the National Health Service Act 2006 – involvement of the public and patients in the planning and development of reconfiguration proposals. This should include developing the evidence base to support the proposal meeting the four tests (see below).

5.2 Four new tests

In addition the local NHS will satisfy the four new tests laid out in the Revised Operating Framework (2010/11):

- Support from GP commissioners
- Strengthened public and patient engagement
- Clarity on the clinical evidence base; and
- Consistency with current and prospective choice.

The approach is summarised in the table below:

Test	Action
Support from GP commissioners	• Meetings have been held with GP representatives from both Brent and Harrow.
Strengthened public and patient engagement	• Trust staff to meet with Brent and Harrow LINkS • Trust to engage with local press and seek support for new GP led model of care for children at CMH • Trust team to engage with local community groups (Brent Sickle Cell Association, Brent Carers etc.)
Clarity on the clinical evidence base	• Demonstrate the reduced demand for the PAU service and the level of service provided by the UCC for children
Consistency with current and prospective choice	• Demonstrate the reduced demand for the PAU service and the negligible impact on choice.

5.3 The views of local GPs

Local GPs recognise the impact of significantly reduced demand at CMH for children's acute services. GPs we have spoken to, have all recognised that the current arrangements for the PAU are not sustainable both financially and clinically and are keen to ensure that key stakeholders are fully informed about the proposed changes.

6. Recommendation

6.1 The Health Select Committee is asked to support the recommendation that:

- The paediatric assessment function is absorbed into the Care UK UCC service;
- The NLWH PAU service is decommissioned at CMH; and
- The paediatric outpatient service and Brent Sickle Cell service would remain at CMH

6.2 The HSC are asked to agree the level of engagement proposed with key stakeholders outlined above, in line with section 242 of the NHS Act 2006.

David Cheesman
Director of Strategy
The North West London Hospitals NHS Trust

Jo Ohlson
Borough Director
NHS Brent

July 2011

Health Partnerships Overview and Scrutiny Committee
26 July 2011

Report from the Director of Strategy, Partnerships and Improvement

Wards Affected:
ALL

North West London Hospitals NHS Trust In Patient Survey Results and 'We All Care' report

1.0 Summary

1.1 The Care Quality Commission (CQC) National In patient survey 2010 results have been published for North West London Hospitals NHS Trust. When members considered the 2009 results and a report on the We Care programme, it was requested that the 2010 results be reported to the Health Partnerships Overview and Scrutiny Committee when they were available.

1.2 The report provided by North West London Hospitals NHS Trust includes:

- The key issues highlighted in the 2010 national in-patient survey results
- A number of initiatives undertaken during 2010/11 to improve the patient experience
- Planned actions for 2011/12

1.3 The Trust reports that improving the experience of patients continues to be a highpriority but that the results of the national in-patient survey remain disappointing, although there has been an improvement from the 2009 results.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to consider the report provided by North West London Hospitals NHS Trust on their in-patient survey results and question officers from the trust on the work it is doing to improve the patient experience.

Background Papers:

Patient Experience and 'We All Care' Report

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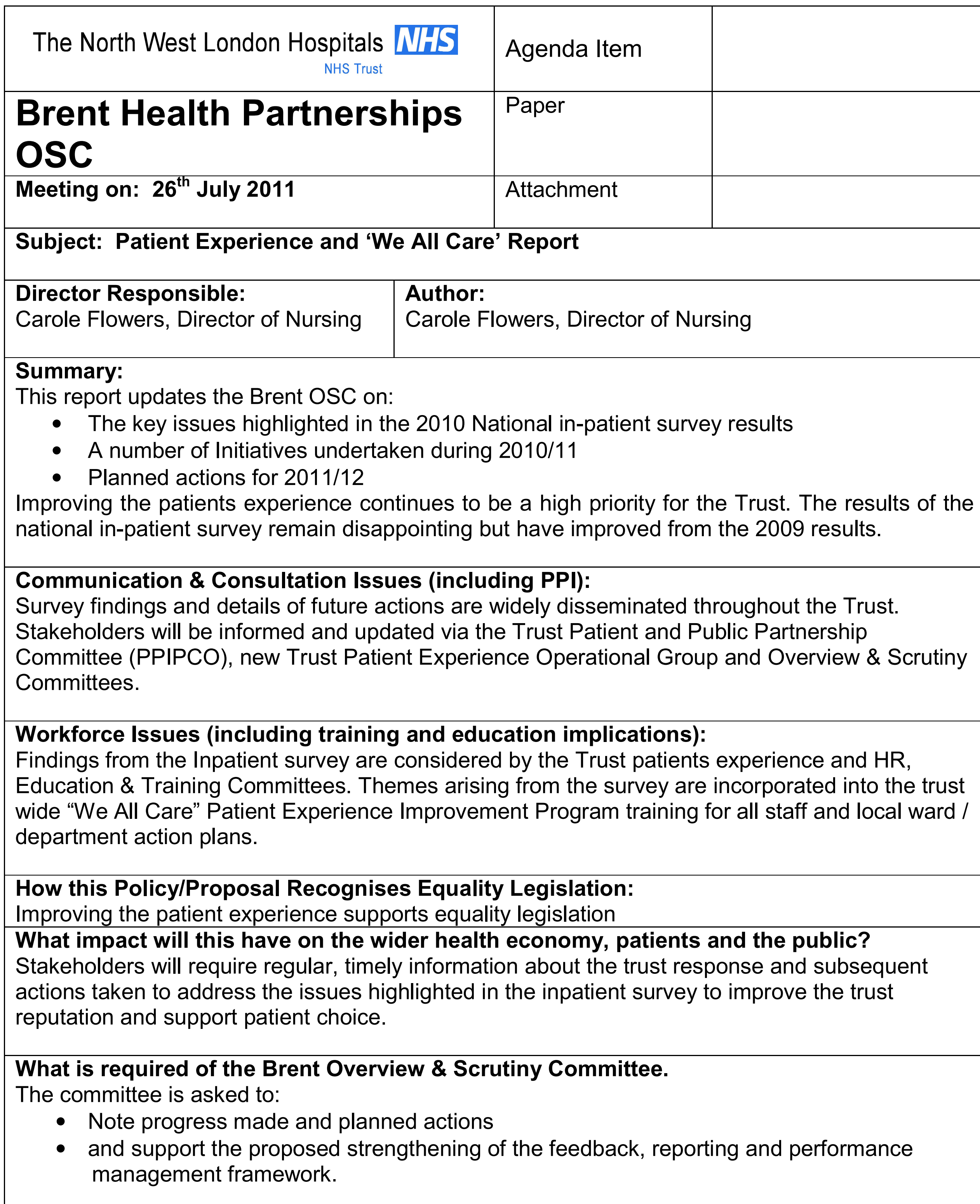


The North West London Hospitals NHS Trust	Agenda Item	
Brent Health Partnerships OSC	Paper	
Meeting on: 26th July 2011	Attachment	

Subject: Patient Experience and 'We All Care' Report

Director Responsible: Carole Flowers, Director of Nursing	**Author:** Carole Flowers, Director of Nursing

Summary:
This report updates the Brent OSC on:

- The key issues highlighted in the 2010 National in-patient survey results
- A number of Initiatives undertaken during 2010/11
- Planned actions for 2011/12

Improving the patients experience continues to be a high priority for the Trust. The results of the national in-patient survey remain disappointing but have improved from the 2009 results.

Communication & Consultation Issues (including PPI):
Survey findings and details of future actions are widely disseminated throughout the Trust. Stakeholders will be informed and updated via the Trust Patient and Public Partnership Committee (PPIPCO), new Trust Patient Experience Operational Group and Overview & Scrutiny Committees.

Workforce Issues (including training and education implications):
Findings from the Inpatient survey are considered by the Trust patients experience and HR, Education & Training Committees. Themes arising from the survey are incorporated into the trust wide "We All Care" Patient Experience Improvement Program training for all staff and local ward / department action plans.

How this Policy/Proposal Recognises Equality Legislation:
Improving the patient experience supports equality legislation

What impact will this have on the wider health economy, patients and the public?
Stakeholders will require regular, timely information about the trust response and subsequent actions taken to address the issues highlighted in the inpatient survey to improve the trust reputation and support patient choice.

What is required of the Brent Overview & Scrutiny Committee.
The committee is asked to:

- Note progress made and planned actions
- and support the proposed strengthening of the feedback, reporting and performance management framework.

Patient Experience Report

This report provides information on the 2010 National in-patient results. Also examples of initiatives undertaken during the year as part of the 'We All Care' programme to continually improve the patient's experience.

1. National In Patient Survey results (2010)

Introduction

The Care Quality Commission (CQC) National In patient survey 2010 results were published on 21st April 2011.The results for NWLH are based on 333 respondents (41%) compared to 357 (52%) last year. This accounts for 0.34% of our admissions during 2010/11.

Of interest is the demographic breakdown of those who completed the national survey:

- NWLH received feedback equally from 50% female and 50% male patients. 'All trusts' benchmark reports slightly more feedback from females at 54%
- Age group breakdown suggests that slightly more NWLH patients aged 66 and older responded to the survey at 54% compared to the 'All trusts' benchmark which is 51%.
- Ethnicity, there are number of ethnic categories listed but NWLH responses were from 58% white ethnic group compared to the 'All trusts' benchmark of 91% white and 24% Asian or Asian British compared to the 'All trusts' benchmark of 2% Asian or Asian British.

This is the eighth national survey of adult in-patients services. It involved 162 acute and specialist NHS trusts. There were responses from more than 66,348 patients (69,000 last year) with an average response rate of 50%. Patients were eligible for the survey if they were aged 16 years or older, had at least one overnight stay and were not admitted to maternity or psychiatric units.

The CQC National In Patient report is presented in two formats:

1. The first format is a detailed Trust report that is made available to the Trust by the agency commissioned by NWLH to undertake the audit.

2. The results of the surveys are provided to the Care Quality Commission who publish on their website a summary of how well the Trust is performing under categories of either being "better", the "same as", or "worse" than other trusts. This means that a lay audience does not need to interpret the statistical details, though they can choose to if interested.

NWLH scores to survey questions

NWLH results are better when compared to last year impacting on three of the ten question themes compared to five last year see table overleaf.

NWLH 2010 results when compared to the 2009 results have improved in 40 of the questions, remained the same in 1 question and need to improve in 27 questions where performance worsened, although in many areas only marginally.

Public Summary Report – At a glance

North West London Hospital Results

For questions about:	Comparison with other Trusts 2010	Comparison with other Trusts 2009	Comparison with other Trusts 2008
The A&E department	The Same	The Same	The Same
Waiting lists and planned admissions	The Same	The Same	The Same
Waiting to be admitted to a ward bed	The Same	The Same	The Same
The hospital and ward	The Same	The Same	Worse
Doctors	The Same	Worse	The Same
Nurses	Worse	Worse	Worse
Care and treatment	Worse	Worse	Worse
Operations and procedures	Worse	Worse	The Same
Leaving hospital	The Same	The Same	The Same
Overall views and experiences	The Same	Worse	Worse

Each healthcare organisation received scores out of 10, based on the responses given by their patients'. A higher score is better. The results from each trust take into account the age and sex of respondents, and whether their admission to hospital was planned or an emergency, compared with the age and sex of all people across England that returned the questionnaire. This helps to remove any differences between the results from trusts that may simply be due to differences in the type of people responding. However ethnicity is not factored into the results

Improving performance

There are 40 questions in which the trust has made positive improvement.

Areas for most attention:
These are outlined in the three areas categorised where the trust continued to score worse than other trusts

- Nurses
- Care and treatment
- Operations and procedures

Outlined below are a number of questions where the Trust performance requires improvement.

- Were you involved as much as you would want to be in your care?
- How much information about your condition and treatment was given to you?
- Did the hospital staff do everything they could to help control your pain?
- Were you told how you could expect to feel after you had the operation or procedure ?
- Did a member of staff tell you about any danger signals you should watch for?
- Were you offered a choice of food?
- Where you given enough privacy when discussing your condition or treatment?
- Did you feel you were involved in the decisions about your discharge from hospital?

Benchmarking

The CQC cautions that it is extremely important that any comparisons across the results from different trusts are made appropriately, and can only say that trusts are 'significantly worse' or 'significantly better' than the national average. The CQC cannot say much more about the score itself, because it is taken from a sample of patients rather than from *all* patients at each trust. For this reason the CQC strongly advises against focusing on the scores when looking across the results from different trusts.

There are currently no national benchmark survey results or league tables, however the Trust has reviewed the CQC Inpatient Survey reports of some other Trusts in North West London, see results below:

Questions	NWLH	Imperial College	Hillingdon	Ealing
The A&E department	The Same	The Same	Worse	The Same
Waiting lists and planned admissions	The Same	The Same	The Same	The Same
Waiting to be admitted to a ward bed	The Same	The Same	The Same	Worse
The hospital and ward	The Same	The Same	The Same	Worse
Doctors	The Same	The Same	The Same	The Same
Nurses	Worse	The Same	Worse	Worse
Care and treatment	Worse	The Same	Worse	The Same
Operations and procedures	Worse	The Same	The Same	Worse
Leaving hospital	The Same	The Same	The Same	The Same
Overall views and experiences	The Same	The Same	The Same	The Same

Comparison between NWLH survey results and other NHS London Hospitals

For questions about:	NWLH Score	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
The A&E department									n/a	n/a							n/a						
Waiting lists and planned admissions																							
Waiting to be admitted to a ward bed																							
The hospital and ward																							
Doctors																							
Nurses																							
Care and treatment																							
Operations & procedures																							
Leaving hospital																							
Overall views and experiences																							

1 Imperial
2 Barnet and Chase Farm
3 North Middlesex
4 West Middlesex
5 Hillingdon
6 Ealing
7 UCL
8 Royal Marsden
9 Royal Brompton and Harefield
10 Kings College
11 Homerton
12 Guys & St Thomas's
13 C&W
14 Royal Free
15 St George's
16 RNOH
17 Newham
18 Kingston
19 Mayday
20 Barking, Havering & Redbridge
21 Lewisham
22 Barts and The London

2011/12 CQUINN performance

As can be seen from the aggregate scores presented below the Trust's performance slightly deteriorated in the National In-Patient Survey results (2010) that related to these questions.

QUESTION	2009	2010
Q 41 Were you involved as much as you wanted to be in decisions about your care and treatment?	**65.3**	**62.1**
Q 44 Did you find someone on the hospital staff to talk to about your worries and concerns?	**49.3**	**51.8** ↑
Q 45 Were you given enough privacy when discussing your condition and treatment?	**78.8**	**76.5**
Q 64 Did a member of staff tell you about medication side effects to watch for when you went home?	**38.3**	**40.4** ↑
Q 69 Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	**69**	**66.9**
Aggregate Score	**60.1**	**59.5**

Positives

- Improved score of 76.5% for ' were you given enough privacy when discussing your condition or treatment'
- Improved score of 66.9% for ' Were you told who to contact if you were worried about your condition'

Issues

- Full impact of related projects not seen within year as many started 6-8 weeks before 2010 survey undertaken.
- High staff vacancy rates and use of temporary staff.
- Technical delay to implementation of 'Real time patient feedback' device, which supports local feedback based on the national questions to inform local actions and monitor performance improvement of Trust wide actions.
- Historic issues for the Trust e.g. Reputation management, External perception of the Trust, negative local publicity, poor response rates to patient survey

Mainly seen / managed as a nursing work stream, although some multidisciplinary ownership; need to engage more with all healthcare professionals

2. Examples of 'We All Care' initiatives undertaken during 2010/11

Delivering 3C's- compassionate care, consistency & communication training

The training has been reviewed to incorporate the RCN dignity training and is being rolled out to all staff. Emphasis is placed on issues raised at training sessions and also patient stories. These include meeting and greeting patients and relatives, giving appropriate information at the right time, showing compassion, listening and dealing with concerns, reassuring patients and treating them as individuals.

The Matrons are currently undertaking a Dignity audit of their areas to identify issues that need to be addressed to improve the patient experience. Results will be available in August 2011. A 3 day module commencing in October 2011 has been developed in conjunction with North West London University to explore these issues in greater depth and raise staff awareness of the importance of getting these things right to ensure a positive patient experience.

The next steps are to re-launch and rebrand the programme as 'We All Care', establish a Patient Experience Board with Divisional leads responsible for patient experience in August 2011 and for staff to sign a contract of responsibility at training to promote buy in and sustainability.

Real time patient feedback

The Trust has rolled out forty hand held patient feedback devices and 6 kiosks are due to be installed shortly, across both sites. They will house the National In-Patient and Outpatient surveys. Patients and relatives will be encouraged to use them whenever they want to comment on the services. They will also be asked to complete a survey on their discharge. The aim is to provide the Trust with real time information on the total patient experience. Results will be displayed on Patient Experience Boards in all areas. There will also be specialised surveys for Stroke, Accident and Emergency, Paediatrics and relatives in Intensive and Neonatal Care. The system enables staff to access a variety of reports which can be used for monitoring feedback and identifying where problems are.

Outpatient Satisfaction Survey

The Trust has implemented monthly surveys to ascertain how patients feel about their experience in outpatients .The surveys started in January 2011 and to date have shown that 91% of patients rate the overall care as excellent or very good. Results are collated and returned to the General Managers for dissemination and action.

Positive Comments include:

"Very organised and caring department"

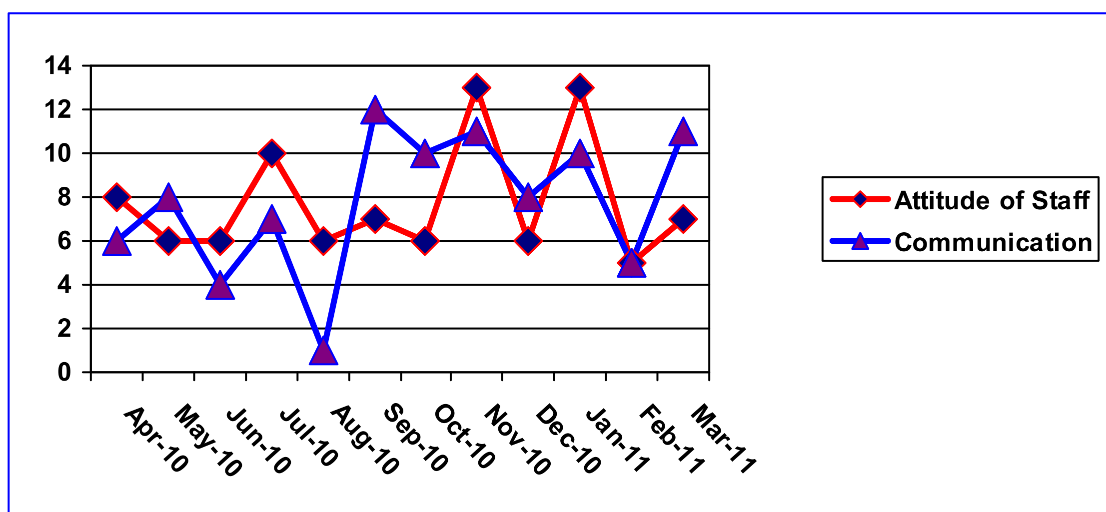
"They have treated me with respect and given me my confidence back".

Voluntary services

The role of Patient Companion has been developed for volunteers to undertake. It has been piloted on Dryden ward and has proved to be very successful and is now being implemented throughout the Trust. Companions help patients to use the patient feedback devices, assist with feeding patients and provide companionship. There are now more volunteers to meet and greet patients and relatives in main reception and outpatients and the role has been extended to Accident and Emergency. A new Mystery Shopper programme is being rolled out to include the Good Loo Guide and monitoring dignity, attitude and behaviour in all areas throughout the Trust.

Complaints and Compliments

One of the key elements of the 3C and Dignity training is to raise staff awareness of how attitude and communication influence patient's perception of their treatment and care



Communication/ information given to patients (13%)

In the previous year, communication was the third highest subject, accounting for **12%** of complaints received. This has increased slightly to **13%** during the year 1st April 2010 to 31st March 2011. This has overtaken the percentage of complaints related to staff attitude which has now dropped to 3rd place.

Work is taking place to improve information to patients which are listed below:

- Improving the Patient information letter which will be sent to elective patients as well as being available on the wards.
- Launch a new in-patient information leaflet
- Discharge coordinators are being employed to meet with patients and their relatives to ensure that the discharge information is complete and understood.
- A discharge information card for patients is being developed.
- Under medicines management, the role of the pharmacists will be stepped to include seeing patients at discharge to explain the tablets, their functions and possible side-effects and cautions that may be required.
- "We All Care" is being re-launched to incorporate all staff, clinical and non-clinical.

- "Together We Care" is currently being piloted on Fletcher and Fielding wards. This involves the nurses, on admission of the patient, meeting with both the patient and the relatives and establishing the level of care that the relatives may wish to be involved in. Many relatives are the patient's main carer and this would allow them to remain included in caring for them if they so wished.

Attitude of staff (12%)

This is a slight decrease on the previous year when 14% of complaints received were related to staff attitude. It had been hoped that complaints in relation to staff attitude would have reduced as the ongoing result of the 'We Care' programme, which was intended to re-establish a culture of caring and compassion for patients in the busy ward environment.

More recently a workshop related to customer service and attitude took place. Managers as well as staff from all disciplines were invited to take part to discuss issues and methods by which to improve customer service, one of which is the development of expected attitudes and behaviours of staff and patients. In addition the Trust 2011/12 objectives includes undertaking a review of customer care programmes delivered to staff who work on Trust premises and to agree a minimum standards. It is hoped that these initiatives will reduce the number of complaints about staff attitude and the number of complaints that praise staff attitude, compassion and caring will continue to increase and echo the examples given below.

- "the care I received was compassionate, efficient, prompt and professional at all times…… I am a retired nurse and extremely proud of the NHS and all it has to offer. I feel the service I received in ACAD epitomises 1st class patient-centred care."

- "the professional way you all carry out your duties is 1st class but what makes the difference is the love, care and compassion you show to those in your care."

Nursing, Midwifery and Allied Health Professionals Strategy

The Strategy was launched in December 2010 and establishes a clear direction to develop and deliver seamless, appropriate, knowledgeable and skilled practitioners to support high quality care. One of the key work streams of the strategy is Patient Experience offering a better patient experience by:

- Empowering patients to have more choice and control by providing responsive and personalised care
- Involving patients and their carers in decision-making about their care and treatment
- Respecting the privacy and dignity of our patients
- Listening, learning and taking action from all feedback
- Providing patients and carers with an opportunity to participate in discussion and consultations regarding care delivery and future service planning
- Enhancing previous work on the 'We all Care' initiative to focus on improving care and compassion
- Developing a carer's strategy

Care of Patients with Dementia

An audit of dementia patients on Fletcher, Dryden and Evelyn wards in March 2011. The results demonstrated that although essential needs of patients were being met, patients with dementia required a higher level of input which was not being met at all times due to lack of resources. All staff undertake Basic Dementia Awareness training on Trust Induction, which is in line with National Guidelines

Next Steps

- Develop a passport for patients with dementia and their carers
- Rollout enhanced training,
- Involve families in care to improve resources
- Recruit more patient companions

A working group has been established to progress and develop the above aims. This will link to the Carer's Strategy which is also being developed with patient and carer involvement

Nutrition and Protected Mealtimes

The Trust re-launched Protected Mealtimes in April 2011. The aim is to ensure that patient's nutritional needs are met and nurses are able to assist patients with feeding and monitor their food intake. Nutritional assessment continues to be audited to improve compliance and the Trust is working with G4S to improve the patient catering service.

Stroke Focus Group

The Group was set up to find out from patients how they felt about the service they received at in-patients and identify areas for improvement. There have been a number of developments including:

- Information folders for Aphasic patients
- The key worker role has been reviewed
- The Trust has developed an educational DVD for patients post stroke and their families in conjunction with Harrow Council

Learning Disability Passport

The Trust is working with Harrow PCT and Harrow Association of Disabled and Mencap to develop a Patient Passport to be used when the patient is in hospital. The passport contains essential , individualised information about the patient which is invaluable for staff caring for them. It will also improve communication between the Acute and Primary Care sector. Brent Mencap is facilitating a rolling programme of workshops to raise staff awareness of caring for patients with a Learning Disability

The Patient & Public Involvement & Partnership Committee

The Terms of Reference have been reviewed in order to encourage wider external participation and sharing of information across a number of sectors. Progress and developments will be included in the next report.

Patient information Group

- The group has reviewed 27 new leaflets in 2010/11.
- A new " Coming into Hospital" booklet to be sent to all elective patients prior to admission and will be available on all wards is being implemented
- Eido has been made more accessible to medical staff by adding a link to the intranet home page
- Following last year's patient information audit, patient information has been added to the Trust register due ti insufficient resources to continually monitor and update information

The way forward

The findings of the national in-patient, out-patient, cancer, other national surveys and other local feedback such as patient stories, observation of care and mystery shopping, complaints trends and will be used to inform the patient experience delivery plan for the year ahead.

Acute Trusts with scores in the upper quartile will be approached to support shared learning which will influence actions in the Trust action plan. A concerted effort will be made to make a real difference to the patients experience in the five questions linked to CQUIN performance target to reduce the risk to the trusts income.

The "We Care" program will be strengthened to ensure that continued implementation and further roll out is effective. Local progress will be supported and performance managed via an updated patient experience dashboard. Progress will be monitored monthly by an operational group and reported to the Trust Patient and Public Partnership Committee (PPIPCO**),** Trust Executive Committee and Trust Board.

3. Details of some of the many initiatives to improve performance

- Establishment of an operational Patient Experience Board, which will include divisional performance management.
- Establish divisional PPI Leads to monitor and support action plans
- All clinical areas mush have a local patient experience action plan
- 'Matrons' (nursing) ward rounds
- Revised staff discharge checklist
- Patient discharge card
- New in-patient information booklet
- Patient information / communication plan
- Pharmacy Project progression and impact
- Continuation of patient Stories at Trust Board – learning and understanding what went wrong and how we can improve
- Launch of NWLH Charter (attitudes & behaviour) – ' Working together and in partnership'
- Focus on communication with vulnerable client groups e.g. Learning Disability Passport, Stroke Group
- Real Time Patient feedback devices in all clinical areas
- Increased feedback via patient's stories, observations of care, audit and mystery shopping to monitor compliance and inform actions.
- Patient Experience Action Plan 2011/12 to identify key work streams and build upon previous years' work and progress
- Dignity Training

In Summary

Improving the patients experience continues to be a high priority for the Trust. The results of the national in-patient survey remain disappointing but have improved from the 2009 results. Work continues to continually improve the patient experience in all Trusts settings and specialties.

Trust wide and local progress will be supported and performance managed via an updated patient experience dashboard and performance will be reported to the Trust Board.

Health Partnerships Overview and Scrutiny Committee
26th July 2011

Report from the Director of Strategy, Partnerships and Improvement

Wards Affected:
ALL

North West London Hospitals NHS Trust Budget and Annual Plan

1.0 Summary

1.1 The Health Partnerships Overview and Scrutiny Committee has asked for a report from North West London Hospitals NHS Trust on its budget position for 2011/12. This follows concerns about the level of savings that the trust will be required to make during the financial year. A set of presentation slides has been provided, which will be introduced by Fiona Wise, Chief Executive of the hospital trust. Members will note that the trust is facing cost pressures of over £37m in 2011/12 and has a put in place a savings plan to achieve £18.55m of those savings. The remainder will be met by NHS North West London Support and £9.7m attributed to the Annual Plan.

1.2 Members should consider the presentation from Fiona Wise and consider how the cost pressures will affect services provided by the trust. In particular, members should ask questions around the savings plan that will be implemented to make £18.55m of savings, and how these will be delivered.

2.0 Recommendations

2.1 Members of the Health Partnerships Overview and Scrutiny Committee are recommended to consider the North West London Hospitals NHS Trust budget position and question officers from the trust on how they will achieve their savings plan and what impact this could have on services.

Background Papers:

North West London Hospitals Annual Plan Presentation

Contact Officers:

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North West London Hospitals

Annual Plan

The North West London Hospitals NHS
NHS Trust

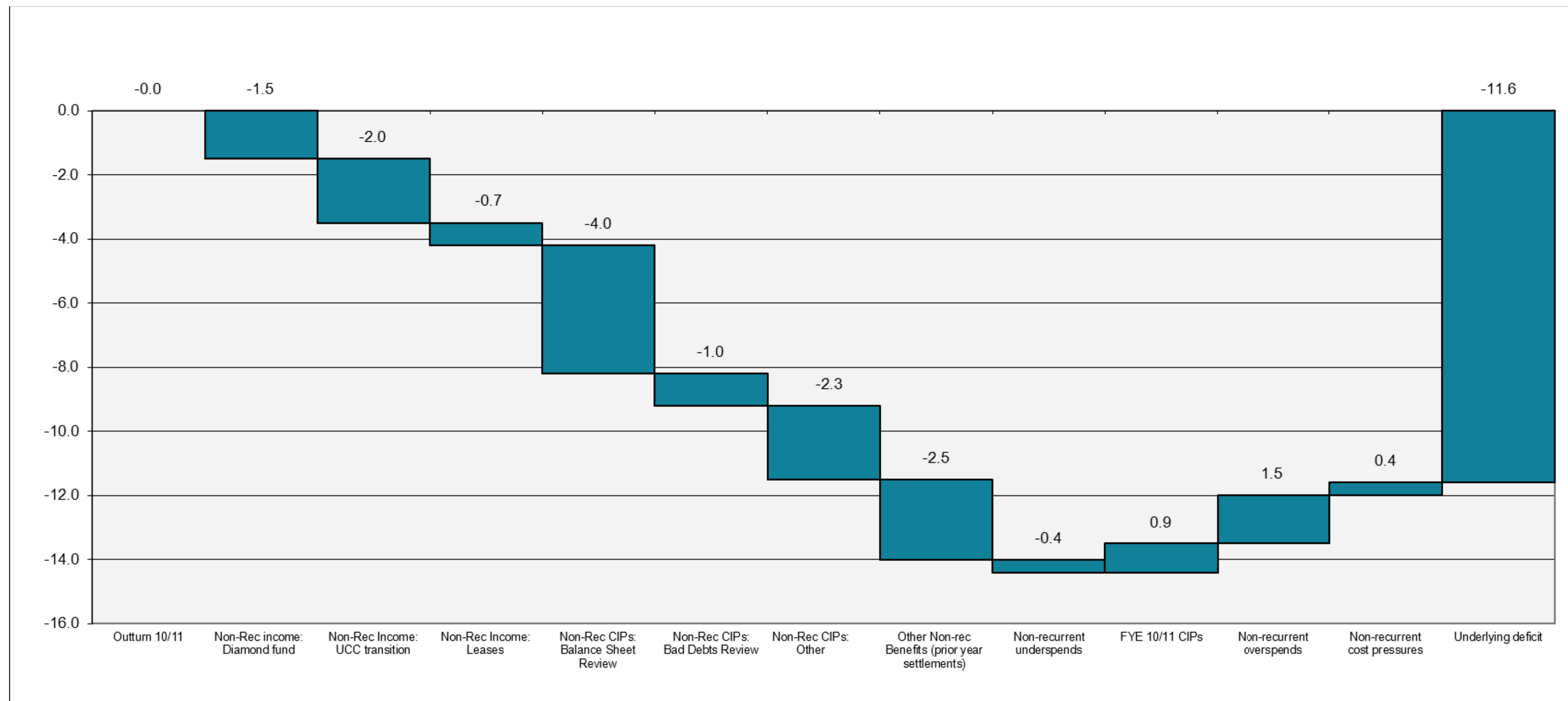
Trust performance

- New CEO appointed in 2007 with new team over following years
- Delivered £65.3m CIP over 3 years
- Imbalance between income and expenditure since 2002/03
- Delivered financial control targets consistently since 2007/08 but need sustainable solutions
- Strengthened governance arrangements
- Moved out maternity 'special measures' – demand now outstrips supply

Care Quality Commission Performance for the past four years				
National Priorities	**2007/08 RAG Status**	**2008/09 RAG Status**	**2009/10 RAG Status**	**20010/11 RAG Status**
18 week referral to treatment waiting times	N/A	G	G	G
Cancer diagnosis to treatment waiting times	G	G	G	G
Cancer urgent referral to first outpatient appointment waiting times	G	G	G	G
Cancer urgent referral to treatment waiting times	G	G	G	G
Clostridium difficile infections	R	G	G	G
Engagement in clinical audits	N/A	G	G	G
MRSA bacteraemias	R	G	G	G
Participation in heart disease audits	N/A	G	G	G
Quality of stroke care	N/A	G	G	G
Smoking during pregnancy and breastfeeding initiation rates	N/A	G	G	G
Existing Commitments				
A&E waiting times	R	G	G	A
Access to genito-urinary medicine (GUM) clinics	G	G	G	G
Cancelled operations	R	R	R	R
Delayed transfers of care	R	G	G	G
Ethnic coding data quality	R	G	G	G
Inpatients waiting longer than the 26 week standard	G	G	G	G
Outpatients waiting longer than the 13 week standard	G	G	G	G
Rapid access chest pain clinic waiting times	G	G	G	G
Revascularisation waiting times	G	G	G	G

The North West London Hospitals NHS
NHS Trust

Underlying Position 2010-11



The North West London Hospitals NHS

NHS Trust

Trust 2011-12 pressures

Description	£m
2010/11 underlying deficit	(11.60)
4% Gershon savings built into PbR tariff	(14.40)
2010/11 pressures	(10.12)
IFRS impact	(1.20)
Emergency re-admissions cost (net)	(2.45)
Net contract negotiations	1.52
Private Patient Income	1.00
CIP required	(37.25)

Trust Budget 2011-12

Item	£m
Open savings from Plan	37.25
Other	0.3
Saving required to balance	37.55
Saving Plan 2011-12	18.55
Remaining Deficit Plan Submitted	18.70
NHS NWL Support	9.00
Annual Plan	9.70

The North West London Hospitals NHS
NHS Trust

QIPP 2011-12

Area	£m
Divisions	6.80
Central Plans	6.80
Smaller items	0.65
Back Office	1.00
LOS	0.75
Outpatients	0.75
Unidentified	1.80
Minimum Savings Requirement	**18.55**

Health Partnerships Overview and Scrutiny Committee

2011/12 Work Programme

Meeting Date	Item	Issue	Outcome
9th June 2011	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.	Report noted. The issue will come back to the committee in Sept or Nov, during the public consultation. There may also be an opportunity to meet informally with the Programme Board during the summer. Joint scrutiny with Ealing and Harrow is also a possibility.
	North West London Hospitals NHS Trust Quality Accounts	The Quality Account from the Hospital Trust will be presented to the committee to give members an opportunity to add its comments prior to submission to the Care Quality Commission.	The committee has sent its response to NWL Hospitals on their Quality Account.
	GP Commissioning Consortia Update and Primary Care Issues in Brent	The committee has asked for an update from the Brent GP Commissioning Consortia to be presented to each meeting so that councillors can be kept informed of progress and key issues. In addition, the committee will receive reports on the following primary care issues in the borough: • An update on the Burnley Practice tender exercise • A report on the situation at Stag Lane clinic, and whether any progress has been made in securing a permanent solution to the issues regarding the building, or a replacement.	Report noted. There are a number of issues that the committee has picked up on: • Mental health commissioning – how plans for joint commissioning with the council are progressing. • Health and social care integration • A request for a report on GP commissioning plans in July 2011, including these two issues • Burnley Practice – will be reported back to the committee if list dispersal is the only option
	Khat Task Group	The terms of reference for the group will be presented to the	Agreed by the committee.

	Terms of Reference	committee for approval.	
	GP list validation exercise	Request for information on the GP list validation exercise following concerns raised by patients and GPs over the process.	Agreed to follow up in July 2011 with a report from NHS Brent setting out how the project has gone, what lessons have been learned and the number of patients that have re-registered following their removal from the GP lists.

Meeting Date	Item	Issue	Outcome
26th July 2011	GP Patient Access Survey Results – Q4 2010/11	The committee is keen to follow up the results of the ACE programme to see what impact it has had on patient satisfaction with access to GP services in Brent. NHS Brent has previously reported that they expected improvement by Q4 2010/11 and so members have asked to see the Q4 results, which should be available for June 2011.	
	GP list validation exercise	Following the meeting in June 2011, the committee has requested a report from NHS Brent setting out how the project has gone, what lessons have been learned and the number of patients that have re-registered following their removal from the GP lists.	
	GP Commissioning Consortia Update	The committee has asked for an update from the Brent GP Commissioning Consortia to be presented to each meeting so that councillors can be kept informed of progress and key issues. For July, members have requested that the report includes information: • Mental health commissioning – how plans for joint	

		commissioning with the council are progressing. • Health and social care integration	
	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.	
	Central Middlesex Hospital Urgent Care Centre	The North West London NHS Hospitals trust has asked to place a report on the committee's agenda on their plans for the paediatric assessment unit at Central Middlesex Hospital. They are considering a proposal to merge the unit with the Urgent Care Centre at the site. The Health Partnerships Committee should consider whether a public consultation is needed on this plan and comment on the proposals.	
	North West London NHS Hospitals Trust Budget	The Hospital Trust has set a budget for 2011/12 which anticipates a deficit of £19m. The committee is keen to know what the implications are for the trust and patients and how the deficit is likely to be addressed through the year.	
	Health and Wellbeing Board Update	The committee has asked for an update from the Health and Wellbeing Board to be reported to each committee meeting.	

Meeting Date	**Item**	**Issue**	**Outcome**
20th September 2011	Integrated Care Organisation Report	The committee has requested a report on the progress of the ICO, since its creation in April 2011. The report should focus on how the ICO has strengthened its leadership in Brent and is addressing the issues highlighted by the council during consultation on its creation. This report should come to the committee in September 2011.	
	Public Health Transfer to Brent	The chair of the committee has asked for a report on the work being done to prepare for the transfer of public health services to the	

	Council	council. A One Council project will take place to ensure the transfer happens within the Government's timetable and to ensure that the service meets Brent's specific needs once it is integrated within the council.	
	North West London Hospitals Maternity Services	There have been widely reported issues at the maternity unit at Northwick Park Hospital in recent months and NHS London has carried out a review of maternity services across London. Officers from the trust should be invited to attend the committee to report to members on the incidents that have taken place and how they have been addressed.	
	Plans for the future of North West London NHS Hospitals Trust and Ealing Hospital Trust	The committee will have an opportunity to respond to the public consultation on the proposed merger. This could be deferred to November 2011, or possibly subject to joint scrutiny with Ealing and Harrow.	
	GP Commissioning Consortia Update	The committee has asked for an update from the Brent GP Commissioning Consortia to be presented to each meeting so that councillors can be kept informed of progress and key issues.	
	Health and Wellbeing Board Update	The committee has asked for an update from the Health and Wellbeing Board to be reported to each committee meeting.	
	Joint Strategic Needs Assessment	The committee has asked that the JSNA is brought to a future meeting, so that members can be given an overview of the borough's key health needs. The joint health and wellbeing strategy that will be developed after the JSNA will outline the council and health commissioners plan to tackle the health issues facing people in Brent.	
	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.	

	Brent LINk Annual Report	The Brent LINk will present their annual report to the committee for discussion and comment.	

Meeting Date	**Item**	**Issue**	**Outcome**
29th November 2011	Central Middlesex Hospital Urgent Care Centre	The Urgent Care Centre has opened at Central Middlesex Hospital. The committee has asked for a report setting out progress and performance issues in the first six months of operation for the UCC.	
	Sickle Cell and Thalassaemia Services Report	The Committee has asked for a report Sickle Cell and Thalassaemia services at North West London NHS Hospitals Trust. The committee will invite sickle cell patient groups to attend for this item to give their views on services in the borough. This follows a previous report on changes to paediatric in patient arrangements at NWL Hospitals. Members are keen to know how sickle cell patients have been dealing with this change.	
	Brent Tobacco Control Strategy	The committee would like to follow up the Brent Tobacco Control Strategy, to check the progress of its implementation. It is also interested in specific issues, such as the licensing of shisha bars, to see how this issue is being addressed in Brent.	
	Fuel Poverty Task Group	Recommendation follow up on the task group's review.	
	Health Visitor numbers	Councillor Mary Daly has asked for an item on the way that NHS Brent is responding to the Government's commitment to increase Health Visitor numbers.	
	Breast Feeding in Brent	Following a report in March 2011 on the borough's Obesity Strategy, the committee has requested a follow up paper on the Breast feeding service in the borough. Members were particularly interested in the role of peer support workers and how mothers are able to access breast feeding services. The committee would also like to have accurate data on breast feeding initiation and prevalence in Brent.	
	GP Commissioning	The committee has asked for an update from the Brent GP Commissioning Consortia to be presented to each meeting so that	

	Consortia Update	councillors can be kept informed of progress and key issues.	
	Health and Wellbeing Board Update	The committee has asked for an update from the Health and Wellbeing Board to be reported to each committee meeting.	

Meeting Date	Item	Issue	Outcome
7th February 2012	Role of community pharmacists	The chair is keen to look at community pharmacists in Brent, and how their role in delivering health services can be best utilised. She also wants to look at the way that different elements of the health system, such as GPs and social care work with pharmacists in the borough.	
	Mental health services in Brent		
	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.	
	Patients Association Presentation	The Patients Association has offered to give a presentation on patient experience in Brent, based on their evidence and personal testimonies. The committee should decide whether it wishes to take up this offer.	
	GP Commissioning Consortia Update	The committee has asked for an update from the Brent GP Commissioning Consortia to be presented to each meeting so that councillors can be kept informed of progress and key issues.	
	Health and	The committee has asked for an update from the Health and	

	Wellbeing Board Update	Wellbeing Board to be reported to each committee meeting.	

Meeting Date	Item	Issue	Outcome
27th March 2012	End of life / palliative care in Brent	The committee has asked for a report on end of life care in Brent. Members are keen to look at how the End of Life Strategy is being implemented and to know what services exist in Brent and how effective they are in delivering care.	
	GP Commissioning Consortia Update	The committee has asked for an update from the Brent GP Commissioning Consortia to be presented to each meeting so that councillors can be kept informed of progress and key issues.	
	Health and Wellbeing Board Update	The committee has asked for an update from the Health and Wellbeing Board to be reported to each committee meeting.	

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