Public Document Pack

Health Partnerships Overview and Scrutiny Committee

Tuesday 27 March 2012 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	Ketan Sheth	Van Kalwala
Hector	Aden	Al-Ebadi
Ogunro	McLennan	Oladapo
RS Patel	Naheerathan	Oladapo

For further information contact: Toby Howes, Senior Democratic Services Officer 020 8937 1307, toby.howes@brent.gov.uk

For electronic copies of minutes, reports and agendas, and to be alerted when the minutes of this meeting have been published visit:
www.brent.gov.uk/committees

The press and public are welcome to attend this meeting

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members

Item Page

1 Declarations of personal and prejudicial interests

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

2 Deputations (if any)

3 Minutes of the previous meeting held on 7 February 2012 1 - 10

The minutes are attached.

4 Matters arising (if any)

5 Health services for people with Learning Disabilities - A report from Brent MENCAP 11 - 38

The reports are attached.

6 Planned Care Initiative 39 - 44

NHS Brent has requested that an item on their Planned Care Initiative is included on the Health Partnerships Overview and Scrutiny Committee agenda in order for members to be informed of the project and scrutinise proposals.

7 Waiting list information 45 - 52

The Health Partnerships Overview and Scrutiny Committee has asked that NHS Brent provides information on hospital waiting times in Brent. This request has been made following concerns that waiting times are

increasing across a range of services and that organisations are struggling to meet the NHS's four hour A&E target and 18 week referral to treatment target.

8 Public Health Transfer Update 53 - 58

A report updating the committee on Public Health transfer is attached.

9 Shaping a Healthier Future Update 59 - 94

The reports are attached.

10 Proposed merger of North West London Hospitals NHS Trust and Ealing Hospital NHS Trust 95 - 104

An update on the proposed merger of North West London Hospitals NHS Trust and Ealing Hospital NHS Trust is attached.

11 GP Commissioning Consortia update

Members will receive a verbal update on this item.

12 Health and Wellbeing Board update

Members will receive a verbal update on this item.

13 Date of next meeting

The next scheduled meeting of the Committee will be confirmed at the full Council meeting on 16 May 2011.

14 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.

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

MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
Tuesday 7 February 2012 at 7.00 pm

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

Also Present: Councillors Gladbaum, Hashmi, Kansagra and McLennan

An apology for absence was received from: Councillor Beck

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

None declared.

2. **Minutes of the previous meeting held on 29 November 2011**

RESOLVED:-

that the minutes of the previous meeting held on 29 November 2011 be approved as an accurate record of the meeting.

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

None.

4. **North West London NHS Hospitals Trust/Ealing Hospital Trust merger**

Andrew Davies (Performance and Policy Officer, Strategy, Partnerships and Improvement) introduced the item and confirmed that following on the meeting in November 2011, the chairs and vice chairs of Brent, Ealing and Harrow health scrutiny committees had met with representatives from Ealing Hospital Trust and North West London Hospitals NHS Trust on 24 January 2012 to discuss concerns raised in a letter sent to both trusts at the previous meeting. Andrew Davies referred to the main issues to emerge from the second meeting as outlined in the report and advised that the Chair of this committee was seeking to send a further letter to the trusts outlining the committee's views on the merger.

The Chair then invited Simon Crawford (SRO, Organisational Futures Project) to make some opening remarks. Simon Crawford advised that following the presentation of the outline business case to Members in November 2011, the final business case was due to be put to both trust boards in March 2012.

Members then discussed the item. Councillor Daly sought clarification regarding the amount that the 15% back office savings would represent and she also

commented that there was real concern amongst GPs about the proposed merger. She suggested that the relationship between the NHS and the public was deteriorating and that management should pay more heed to the concerns of both residents and front line NHS staff. Councillor Hunter enquired how the increase in community services would be resourced and commented that the viability of service changes needed to be considered. Councillor Colwill commented that residents wanted both hospitals in Brent to remain open after the merger and he sought assurances that this would be the case. He also asked what views the GPs had on the proposed merger.

The Chair sought assurances that there were sufficient funds to provide the transition of service provision to the community and stressed the importance of not compromising on providing a service to those who most needed it.

Mansukh Raichura (Chair, Brent LINk) was invited to address the committee. He confirmed that Brent LINk had already submitted a response to the proposals and stated that there was significant opposition to health reforms in general and concern about the impact on patients. He emphasised the need for a joined-up approach in undertaking these changes.

In reply to the issues raised, Simon Crawford advised that the outline business case submitted included plans by the commissioners to reduce acute services, with a third of its budget being re-invested in an integrated community and acute services. Members heard that the final business case needed to demonstrate the viability of the merger and that no major service changes were planned on any of the sites. The commissioners were to put together a plan to specify what services each site would provide and an earlier report had included four possible case scenarios which were to be consulted upon. Simon Crawford acknowledged that the changes presented a challenge, however a collaborative approach would be taken to provide more healthcare in the community in order to reduce demand on the already strained resources in hospitals. The strategy would include support provisions for implementing changes which would also be subject to negotiations between relevant partners. Simon Crawford acknowledged that there was some opposition within NHS generally to commissioning groups and changes, however the merger between the two trusts had been proposed prior to the health reforms as there was clinical and empirical evidence in support of this move.

David Cheesman (North West London NHS Hospitals Trust) added that Northwick Park Hospital was a particularly busy one, whilst Central Middlesex Hospital was a private finance initiative and liable for rent payments for the next 30 years and so would remain open for at least this period. He felt that the merger would make both trusts stronger in light of the commissioning changes to come.

Rob Larkman (Chief Executive, NHS Brent and Harrow) confirmed that any service changes would be subject to consultation. He explained that the overall direction included developing out of hospital services and stated that the scale of the changes both locally and nationally was a challenge for all.

Dr Mark Spencer (Medical Director) stated that the merger would ensure that funds were not lost in respect of the changes from acute to community provision and the trusts would be in a stronger shape together. He also felt that GPs overall were in favour of the merger, although some understandably had individual concerns

regarding their jobs, although it was acknowledged that it would lead to service improvements.

Ethie Kong (GP) added that every effort would be made to ensure that the changes made were in the interest of Brent residents.

The Chair requested that monthly updates to Members on the merger continue and she confirmed that this would remain a standing item on the committee's agenda.

5. **North West London - shaping a healthier future**

Rob Larkman introduced the report and explained that the North West London NHS budget of £3.5bn was under pressure and changes to service provision were required. Although schemes such as the Short Term Assessment, Rehabilitation and Reablement Service (STARRS) had improved the transition of patients between acute hospital services and community service, more changes were still needed, whilst hospitals in North West London also needed to perform better in a number of areas. Members noted that health services needed to be localised where possible, centralised where necessary and integrated across health, social care and local authorities where it improved patient care. Members then noted the timetable for the consultation and that a Joint Health Overview and Scrutiny Committee would be set up to provide external scrutiny.

Dr Mark Spencer added that a pre-cursor to these changes had started two years ago and it was intended to provide a series of quality changes to health provision.

Councillor Daly sought further details with regard to the legislative implications of the changes and commented that when the original Government legislation was approved, it was not envisaged that there would be such wholesale changes to health provision. She asked that if external consultation was undertaken, to what extent did it take place and she felt that it was important that the individual health overview and scrutiny committees of each borough concerned retained their scrutiny role to oversee the changes. Concern was expressed that hospital care needed by older persons and diabetics was to be reduced and details were sought as to how the 24% reduction in cost of care for these groups as outlined in the integrated care pilot could be achieved. Councillor Daly requested that the peer review paper for the pilot scheme, the community strategy and costings of the project be supplied and she asked how many hospitals and beds were due to close.

Councillor Hunter also expressed concern that the Joint Health Overview and Scrutiny Committee would be the sole delegated scrutiny body and that there would not be a role for the individual health and overview scrutiny committees. She stated that it was important to scrutinise on both a local and North West London wide level and she asked whether this arrangement was certain or remained a proposal. Councillor Colwill sought assurance that proper safeguarding measures were in place.

The Chair referred to paragraph 4.5 in the supplementary report and sought further information with regard to the role of the individual health overview and scrutiny committees. She commented that most individual health and overview scrutiny committees would wish to provide input regarding proposals within their own borough and asked what the next steps were with regard to the creation of the Joint

Health and Overview Scrutiny Committee. The Chair queried why the Health and Wellbeing Board was not formally involved in the scrutiny process even though the council was to have more public health responsibilities. Information on the membership of the hospital working groups was also sought.

Dr Mark Spencer advised that NHS North West London comprised of eight primary care trusts working together. The actual budget reduction for older persons and diabetics acute hospital services was around £1bn over five years, representing approximately 13%. Where people did not require hospital care, this would help reduce costs, however there would not be a reduction in care services. With regard to the integrated care pilot, Dr Mark Spencer explained that this was an example of a scheme operating in inner London. An interim report would be made available in the next six months, however the number of bed/hospital closures were yet to be outlined as modelling of the scheme continued. It was likely that all sites would remain open, however some services may change at some sites. The committee noted that the hospitals working group was chaired by a GP and the intention of the group was to consider what standards needed to be set for provision outside hospitals. Although savings needed to be made, it was intended to improve the quality of care across the whole of health services whilst ensuring the appropriate safeguarding measures were in place. Detailed information was being requested from the clinical groups to help put together the proposals for changes. There would also be further discussion on the roles of both the Joint and individual health overview and scrutiny committees at the meeting on 29 February.

Rob Larkman advised that it had been proposed that a Joint Health Overview and Scrutiny Committee undertake an external scrutiny role, however scrutiny activity undertaken by individual health overview and scrutiny committees could be discussed. Similarly, it was expected that health and wellbeing boards would also provide input and undertake informal scrutiny, however their role could also be discussed further.

Andrew Davies advised that legislation was quite clear in setting out the scrutiny role of a joint health overview and scrutiny committee. If a joint committee was not created, Members needed to be aware that the individual health and overview scrutiny committees may not retain any formal scrutiny role on this issue and this should be taken into consideration when discussing the role of committees.

Ethie Kong added that a recent example of upskilling GPs included them being trained to administer and monitor insulin use.

6. **Joint Strategic Needs Assessment consultation**

Andrew Davies presented this item and explained that some emerging themes had been raised during the presentation at the last committee meeting. The Joint Strategic Needs Assessment (JSNA) was being consulted upon until 23 March and feedback could be provided through the council's website. The JSNA was looking at what health arrangements were working well, what ones could improve and what measures could be undertaken in tackling inequalities. Focus was also being given on the major causes of mortality. Andrew Davies welcomed any suggestions to add topics which it felt were missing from JSNA. A meeting with Brent LINk would also take place during the consultation period.

Mansukh Raichura commented that it was important that Brent LINk had sufficient time to advise people that a meeting was taking place and discussions would take place with Andrew Davies in respect of this.

The Chair felt that it may be beneficial to consult pharmacists who played an important role in the community. The committee agreed to a suggestion from the Chair that it would be useful for Members to undertake a separate session on the JSNA to help inform them and to suggest any particular areas of interest to them.

7. **Khat task group - final report**

Councillor Hunter, the Chair of the khat task group, introduced the item and explained that the group had heard a wide cross-section of views concerning khat and also had read a number of Government reports on the matter. The task group had made nine recommendations as set out in the report that it had considered both practical and useful to pursue and these would also be put to the Executive for formal approval. Councillor Hunter commented that khat use was often associated with Somalians who were unemployed, particularly with those who arrived in the UK earlier and who may have English language difficulties that limited their employability. The task group was not advising on a khat ban and it was noted that this was not within the scope of the committee and this would be a matter for the Government to consider. Furthermore, a Government report published in 2005 had concluded that there was not sufficient evidence to ban khat. Councillor Hunter acknowledged that there were some within the Somalian community in Brent who had hoped that khat could be banned, whilst others had felt that criminalising khat use would worsen matters. The committee heard that the London Borough of Hillingdon had undertaken a similar study on khat last year and had concluded that banning khat was not a solution to concerns raised.

The Chair then invited Abukar Awale, who had participated in task group activities, to address the committee. Abukar Awale introduced himself as a community engagement officer and as an ex khat addict. Abukar Awale asserted that khat was responsible for damaging communities and that the majority of those attending meetings organised by the task group supported the banning of khat. Whilst it was acknowledged that there were some moderate khat users, Members heard that there were around 520 young males in West London who suffered from mental health issues as a result of khat use. Abukar Awale also cited The Netherlands as an example of a country that had outlawed khat, even though it was well-known for its tolerance to drugs. He asked that the voices of those wanting khat to be banned be heard and that felt that it was within the councillors' scope to support this.

The Chair invited Dr Muna Ismail, who had carried out a scientific study on khat, to address the committee. Dr Muna Ismail explained that she had carried out a PhD in khat use and was continuing research on this at post-doctorate level. She drew Members' attention to a document she had produced that was circulated at the meeting and advised that at present there was no conclusive evidence with regard to the question of khat being damaging to human health and there was a clear need for further scientific research to be undertaken. Members noted that there was not much evidence at present that there a high percentage of chronic habitual khat users. Dr Muna Ismail explained that she had undertaken a comparison of khat with cannabis where a lot more research documents were available and it was noted that The Netherlands had recently tightened legislation over cannabis use.

She requested the committee's support in asking for further research to be undertaken about khat.

Phil Sealy, a former Brent councillor, was also invited to address the committee. Phil Sealy advised that the Brent Community Health Council had previously requested that the issue of khat use be looked into and commented that there had been a similar acceptance amongst some from the West Indian community concerning cannabis use. He felt that there needed to be serious commitment into tackling khat use in the same way there had been towards cannabis which had proved particularly damaging to the West Indian community.

Councillor Gladbaum, another member of the task group, also spoke to the committee. Councillor Gladbaum stated that the task group had spoken extensively with the Somalian community and had undertaken considerable research before producing its findings. She stated that initially she had been in support of banning khat, however since being involved in the task group, she now felt that criminalising it would not be beneficial and would disadvantage some in the Somalian community.

Hussein Hersi, representing the Red Sea Foundation, also addressed the committee and stated that khat was used by diverse members of the Somalian Community. He felt the task group had produced a well-balanced report and thanked them for their work with the Somalian community.

During discussion by Members, Councillor Daly commented that the damage to health by tobacco could clearly be seen, however because it had been in existence for so long, outlawing it was virtually impossible. She felt that consideration needed to given as to what effects khat use had on the Somalian community and that appropriate steps needed to be taken if was seen to be damaging. Councillor Colwill concurred with Phil Sealy in relation to the harmful effects of cannabis and action had been taken against tobacco use after the council had passed a motion to ban smoking in council buildings. He felt that as the Somalian community had voiced serious concerns about kat use, along with the recent banning of it in The Netherlands, that it would be appropriate to put pressure on the Government to take action against khat use. He also felt that the task group should continue with its work to look further into khat use.

In reply to some of the issues raised, Councillor Hunter advised that there was no evidence from mental health centres to suggest that khat was a contributor to mental health illnesses. During discussions with the task group, those who did not wish for a khat ban had stated that they did not think there were any links to it leading to harder drugs use or crime. Councillor Hunter stated that one of the limiting factors at present was the lack of resources to carry out the necessary statistical research on khat use. A World Health Organisation report published in 2007 had concluded that khat was not physically addictive. Councillor Hunter acknowledged that there had been mixed views expressed by the Somalian community in respect of khat use, however khat also played a role within this community and was used in a wide variety of occasions, including weddings. She reiterated that it was not within the scope of the task group or the committee to ban khat use in Brent.

Councillor Hunter advised that in addition to the nine recommendations in the report, a further two recommendations were to be added in relation to requesting that more research be undertaken by relevant agencies about khat use and that a conference be organised in Brent about khat for all stakeholders. Andrew Davies (Policy and Performance Officer, Strategy, Partnerships and Improvement) added that he would devise the wording of the two additional recommendations and circulate to Members.

RESOLVED:-

(i) that the recommendations of the khat task group in the report, and in addition the two additional recommendations as outlined below and subject to finalised wording, be endorsed:-

- more research be undertaken by relevant agencies about khat use
- that a conference be organised in Brent about khat for all stakeholders

(ii) that these recommendations be passed to the Executive for approval.

8. **Diabetes task group scoping document**

Andrew Davies advised Members that a diabetes task group had been suggested as a result of emerging findings from the JSNA. Agreement of the scope of the task group was sought and Members should indicate if they also wanted to be involved in the task group. The committee agreed the scope of the task group and both the Chair and Councillor Colwill confirmed that they would be members of the task group. Andrew Davies advised that he would be contacting the main opposition political group regarding what member they would like to put forward to be on the task group.

RESOLVED:-

(i) that a tackling diabetes in Brent task group be created;

(ii) that Councillors Kabir and Colwill be members of the task group, and a third member from the main opposition political group is to be confirmed.

9. **Clinical Commissioning Group update**

Ethie Kong introduced this item and advised that the Clinical Commissioning Group (CCG) comprised of five localities (consortiums) and was working on developing primary care in Brent. Out of hospital services and prevention and promotion initiatives, such as immunisations and breast screening, was also being considered.

The Chair asked whether patients' representative group, such as the Kingsbury one which she recently attended, were not presently resourced and she enquired if the CCG could assist on this matter. She also suggested that the CCG could report back to each patients' representatives group. Councillor Hunter concurred with this suggestion and felt that meetings on this level could be piloted.

In reply, Ethie Kong advised that each consortium has its own patients forum and resources came from the locality concerned. There was a small budget to support

this and she advised that patients had the right to insist that this was provided. Ethie Kong also suggested that a Brent wide residents group could be created to discuss common issues. The CCG had also identified care for diabetic patients as a priority in Brent and Ethie Kong suggested they would be happy to contribute to the work of the diabetes in Brent task group.

10. **Health and Wellbeing Board update**

Andrew Davies advised that the Shadow Health and Wellbeing Board was taking a leading role with regard to the JSNA which would help inform the Health and Wellbeing strategy. A number of major health sector issues were being considered, including the out of hospital care strategy and some of the Board's work overlapped with this committee.

Councillor Hunter sought clarification on whether there was any decision in respect of opposition political group representation on the board. In reply, Phil Newby (Director of Partnerships, Strategy and Improvement) advised that consideration of the Board's composition was still being discussed and was subject to what shape the health service would take. There remained uncertainty on a number of major issues and the composition of the Board would not be confirmed until these had been resolved. Andrew Davies advised that the Health and Social Care Bill seemed to suggest that proportional representation could be provided, however it also referred to there being no requirement to provide this as was presently the case.

11. **Health Partnerships Overview and Scrutiny Committee work programme**

Andrew Davies advised that discussions with the Chair and Vice Chair of the committee would take place as to what items would appear on the agenda of the next meeting as there were a large number of topics that had been suggested. Councillor Daly suggested that information on waiting lists, including initial referrals and planned surgery, should be a standing item on future agendas. Councillor Hunter felt that a task group on female genital mutilation was needed and she requested that this should be added to the work programme.

12. **Date of Next Meeting**

It was noted that the next meeting of the Health Partnerships Overview and Scrutiny Committee was scheduled to take place on Tuesday, 27 March at 7.00pm. The Chair confirmed that a pre-meeting would start at 6.30 pm.

13. **Any Other Urgent Business**

None.

The meeting closed at 9.30 pm

S KABIR

Chair

This page is intentionally left blank

	Health Partnerships Overview and Scrutiny Committee 27th March 2012 **Report from the Director of Strategy, Partnerships and Improvement**
For Action	Wards Affected: ALL

Health services for people with Learning Disabilities – A report from Brent MENCAP

1.0 Summary

1.1 Brent Mencap has campaigned locally to reduce health inequalities, promote better understanding of the needs of people with learning disabilities and engage with health service partners on providing services for people with learning disabilities. Nationally it is known that people with learning disabilities have greater levels of health need and receive a poorer service from healthcare providers than the general population.

1.2 Brent MENCAP has run a project in the borough with the aim of removing barriers to local people with learning disabilities receiving the right healthcare and support from local NHS services by providing information, specialised training and advice.

1.3 The project covered a number of areas:

- Learning disability awareness training for Brent NHS senior managers, General Practitioners (GPs) and practice staff
- Training including consumer trainers (with a learning disability) for acute hospital, community and mental health trust staff
- Participation in the local Health Action Group, and leading the group from August 2011
- Regular information stalls at NHS sites
- Focus groups to gather patient stories, and learn from people's experience of local healthcare
- Mystery patient visits to acute healthcare settings
- Evaluation of the effectiveness of the project, in terms of training outcomes, action plans implemented and changes in attitude and working practice.

1.4 A full report, setting out the details of the project and its main findings are included on the committee's agenda. An easy read version has also been published. Among the

issues highlighted in the report in relation to health services for people with learning disabilities in Brent were:

- Communication between doctors and patients could be improved, as well as issues around dignity and understanding and using appointment booking systems
- 104 people attended GP practice training on working with people with learning disabilities, 40% of whom were GPs; 115 people attended training from Northwick Park and Central Middlesex Hospital. However, there were issues connected to the training, such as difficulties in advertising it to NHS staff, sessions being cancelled due to lack of participants and trainers turning up to find that there were no participants
- Hospital signage at CMH and Northwick Park needs to be improved for people with learning disabilities
- Proactive volunteers were helpful towards mystery shoppers at Northwick Park Hospital

1.5 The report contains a number of recommendations, which the Health Partnerships Overview and Scrutiny Committee should consider endorsing. Members may wish to ask MENCAP how they can help to ensure their recommendations are implemented by local healthcare organisations:

- Secure commissioner and senior management commitment to further training within Brent NHS and across GP practice and hospital settings (including medical staff and consultants) with targeted expectations for staff to attend
- Consider use of LD 'champions' in wards and departments with dedicated time (through CPD) to ensure availability of appropriate resources and implement projects to ensure 'reasonable adjustments' are made.
- Review signage at hospitals and healthcare centres together with service user groups, to include pictures and symbols where possible
- Identify funds to review healthcare leaflets and work together with service user groups and speech and language therapists to provide accessible versions, e.g. 'Your stay'
- Continue to build on links between primary and acute and specialist Learning Disability services. There are encouraging signs with the GP practice LD link nurse model and the new Acute Liaison Nurse role in North West London Hospitals trust.
- Continue to build links with service user and self advocacy groups and organisations for specialist resources and advice.
- Encourage people with learning disabilities to take part in patient forums, with appropriate support.

1.6 Members are reminded that the Health Partnerships Overview and Scrutiny Committee has previously carried out a task group on health services for people with learning disabilities. This project has addressed a number of concerns raised in the task group's report about services received by people with learning disabilities.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to consider the Brent MENCAP report on health services in Brent for people with learning disabilities and decide how it wishes to support MENCAP with this work.

Contact Officers

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

Phil Newby
Director of Strategy, Partnerships and Improvement
Tel – 020 8937 1032
Email – phil.newby@brent.gov.uk

This page is intentionally left blank

Brent Health Action Project

People with learning disabilities - healthcare for all?

December 2011

The national picture - healthcare for people with learning disabilities:

Health inequalities experienced by people with learning disabilities are well documented within the literature (ref 1-8). Research also shows that despite having considerably greater health needs, people receive poorer support from mainstream health services (Elliot et al, 2003). Formal reports and government strategy have served to highlight these inequalities and proposed new ways of working to address these. Nationally, an independent inquiry into access to healthcare for people with learning disabilities was established under Sir Jonathan Michael's leadership in May 2007, following the publication of the (Royal) Mencap report 'Death by Indifference' (2007), which described the experiences of six people who died whilst under the care of the NHS. A further report, 'Six Lives'(2008)- the Health Ombudsman and Local Government Ombudsman's report into these six deaths, are' a damning indictment of NHS care for people with a learning disability. They confirm the findings in the 'Death by Indifference' report of the widespread failure by health professionals to provide the proper level of care and highlight an appalling catalogue of neglect of people with a learning disability', Mark Goldring, Chief Executive, Royal Mencap. The Disability Rights Commission Formal Investigation into equal treatment had also raised questions about the quality of healthcare for people with learning disabilities who were physically ill.

The inequalities evident in access to health care, in the view of the recent study by Emerson et al (2011) are 'likely to place many NHS Trusts in England in contravention of their legal responsibilities defined in the Equality Act 2010, the Mental Capacity Act 2005 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. At a more general level, they are also likely to be in contravention of international obligations under the UN Convention on the Rights of Persons with Disabilities.'

Organisational barriers

A range of organisational barriers to accessing healthcare (nationally)have been identified, cited in Emerson et al (2011) These include:

- scarcity of appropriate services;
- physical barriers to access;
- failure to make 'reasonable adjustments' in light of the literacy and communication difficulties experienced by many people with learning disabilities;
- lack of expertise and disablist attitudes among healthcare staff;
- 'diagnostic overshadowing' (e.g. symptoms of physical ill health being mistakenly attributed to either a mental health/behavioural problem or as being inherent in the person's learning disabilities).

The project:

In the light of the above national picture, Brent Mencap has campaigned locally to reduce health inequalities, promote understanding of the particular needs of people with learning disabilities and engage with their health service partners. Funding was secured from the Learning Disability Development Fund through the Learning Disability Partnership Board to continue and expand existing training across primary and acute healthcare settings. The project ran from January to December 2011 with the aim to remove barriers to Brent people with learning disabilities receiving the right healthcare and support from local NHS services by providing information, specialised training and advice.

The project covered a number of areas:

- Learning disability awareness training for Brent NHS senior managers, General Practitioners (GPs) and practice staff
- Training including consumer trainers (with a learning disability) for acute hospital, community and mental health trust staff
- Participation in the local Health Action Group, and leading the group from August 2011
- Regular information stalls at NHS sites
- Focus groups to gather patient stories, and learn from people's experience of local healthcare
- Mystery patient visits to acute healthcare settings
- Evaluation of the effectiveness of the project, in terms of training outcomes, action plans implemented and changes in attitude and working practice.

Three types of training have been given:

- **GP training, involving GPs and practice staff.** This has focused on giving information and statistics about learning disabilities, highlighting current good practice and legislation, and outlining the expectations for this service user group in the Learning Disability Health Action plan of the local Brent NHS.
- **Hospital training, involving clinical and non clinical staff.** This has been delivered in partnership with consumer trainers, raising learning disability awareness, highlighting good practice and promoting action planning to change current practice.
- **Training at Community Health Centres, involving clinical and non clinical staff** (as above).

Healthcare in Brent for people with learning disabilities - the patients' voice.

Now, we hear the patients' view at first hand:

Visiting the Doctors: The main issues are about **communication**: "The doctor should ask the right questions." "The wording is hard to understand." "They won't explain medical words or write them down" - "oh, you won't know what it means". "Doctors explain on their terms rather than our

terms." "Doctors may talk nicely – in the end nothing happens." "Some people are not very good explaining in plain language."

Issues of **respect** and **understanding of learning disability:** "In my childhood I felt like a piece of meat. I saw a lot of Doctors." "When I saw the doctor she made me angry as she thought I only wanted the sick note. I was in pain. She did not take me seriously. It's really horrible when they don't take you seriously."

"At the Work Capability Assessment they commented on how well dressed I was. They make assumptions that people with learning disabilities can't dress or do things for themselves."

"I got upset with the diagnosis of mental retardation. It upset me a lot." (It's the wording). "People don't understand certain disabilities."

Making appointments at the Doctors: Issues include the **booking systems** and **length of time** needed to get a reply: "If you ring up you must call early." Some people felt it can take a long time before someone answers the phone. People did not like that the call is expensive- an issue if you are on benefits.

Outpatient and inpatient hospital visits: Issues again include **communication**, **understanding of learning disability** and treating people with **respect**: "Staff often speak with a loud voice in hospital. This is patronizing and makes you feel upset." "They don't always keep up-to date records. The nurses ask (the same questions) all the time." "Different hospitals should pass on notes to each other." "I broke my toe, had to wait a long time. They seemed annoyed because it was something minor to them at Central Middlesex but not at Northwick Park. They made you feel welcome not made me feel like an idiot." "In lots of cases the doctors don't seem to believe me. It's really annoying. I once had an electric shock, they thought I meant heart attack." And a comment that sums up the frustrations and feeling of powerlessness:

> ***"Slow, slow (lots of waiting around) but the doctor – quick, quick, quick and he is gone."***

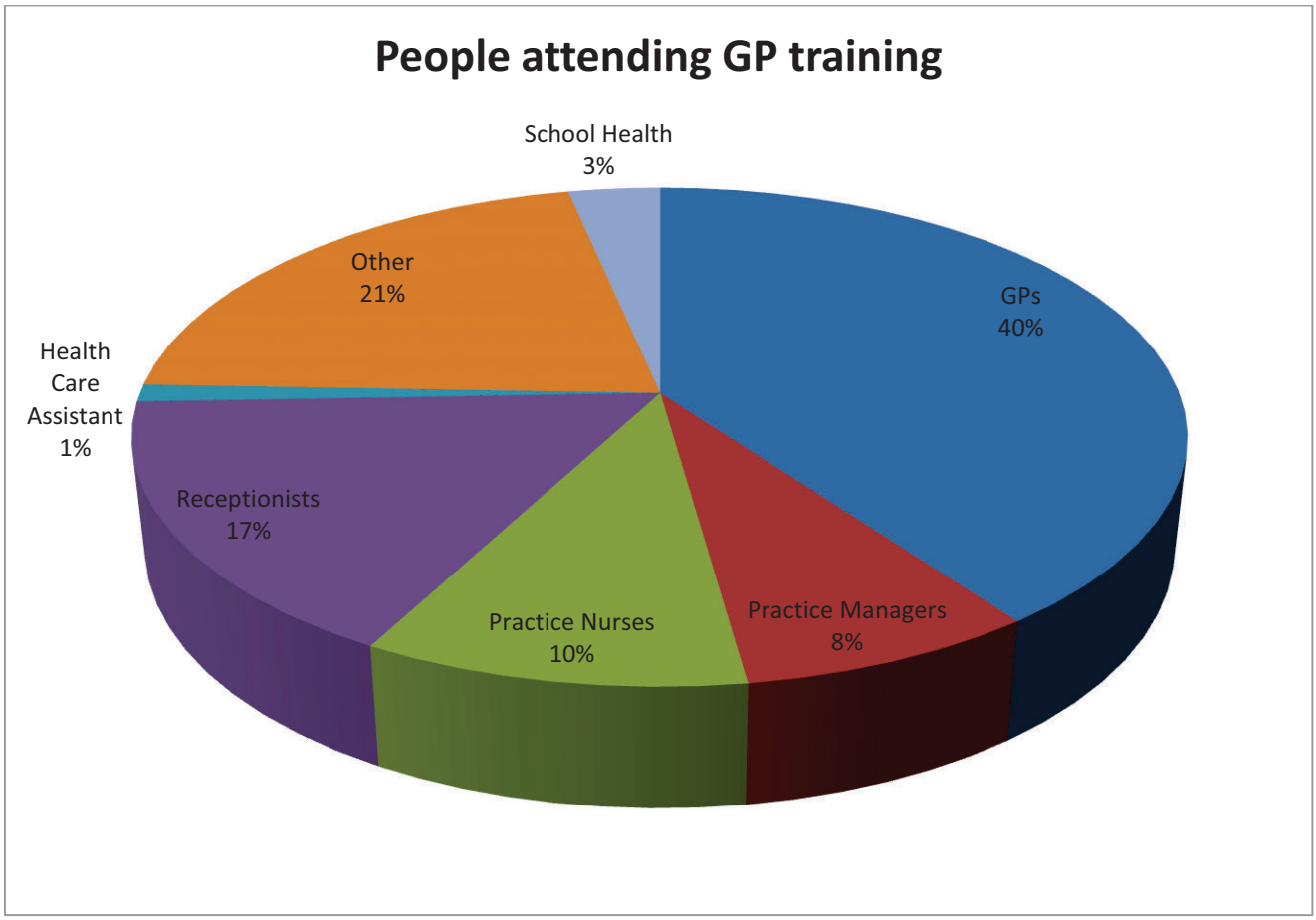
The training- GPs and practice staff

Who has done the GP training?

104 people have attended GP training on Learning Disability awareness. In addition 30 GP registrars attended a shorter workshop. Just under half of these people have been GPs, with other staff from the practices broken down as follows, (Table 1).Considering there are around 70 GP practices in Brent, this is roughly an average of one person attending per practice. In reality, the picture is of course, more varied, with some practices embracing the training and sending a good number of staff, and others, not represented at all. There has been a reasonable representation from all areas of the practice which should promote team understanding of the issues raised. Trained Practice

Managers can make a difference in how the surgery runs, and how appointments are made. Front line staff such as receptionists can be aware of communication and other issues for people, and the nurses and doctors, can have an understanding of what they can do to support people to get good health care. The good number of GPs is encouraging as with their time commitments, they can be difficult to access for training.

Table 1

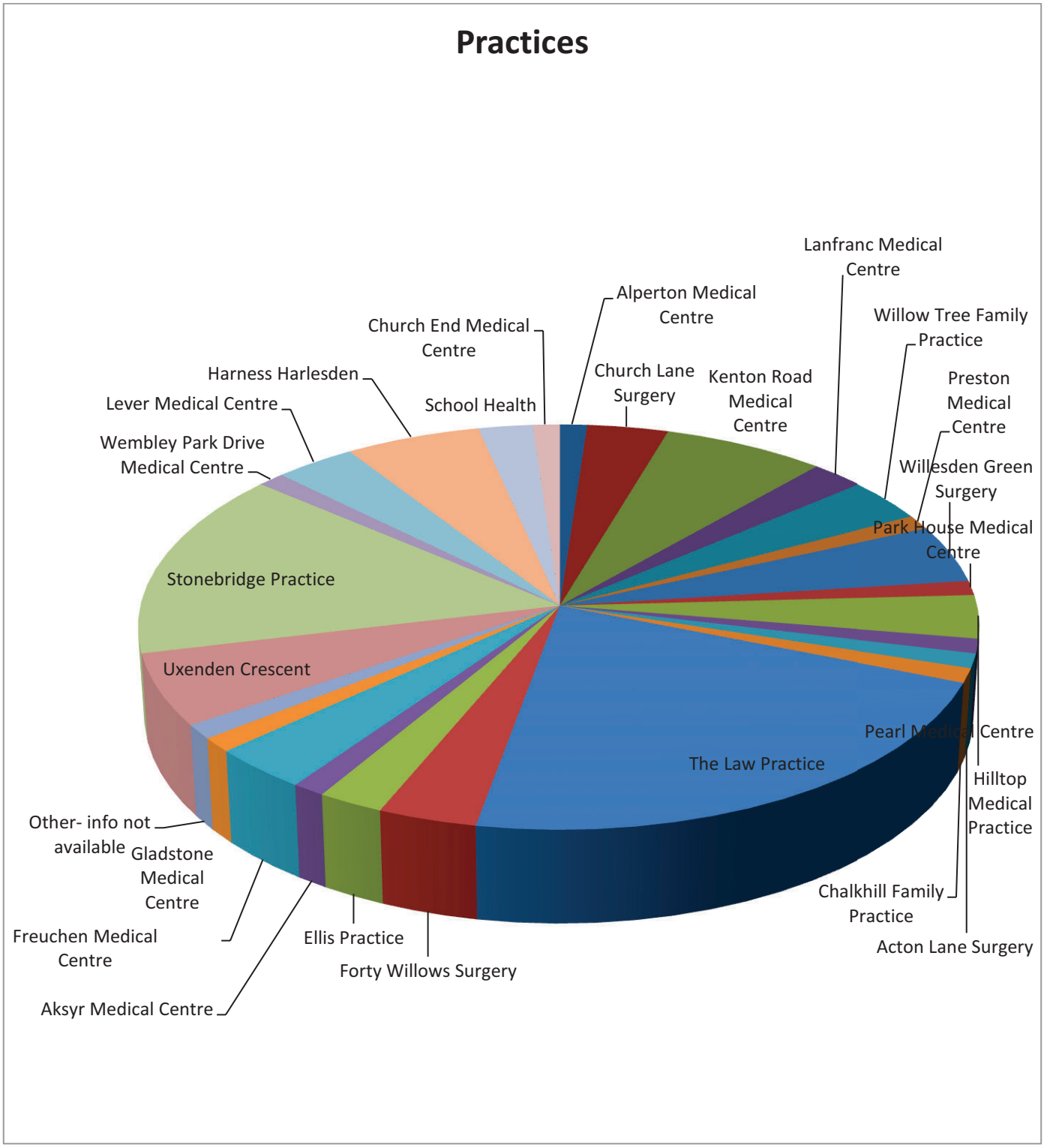


N=80

Where are people from?

The people attending training are from the following GP surgeries and medical centres (Table 2).

Table 2

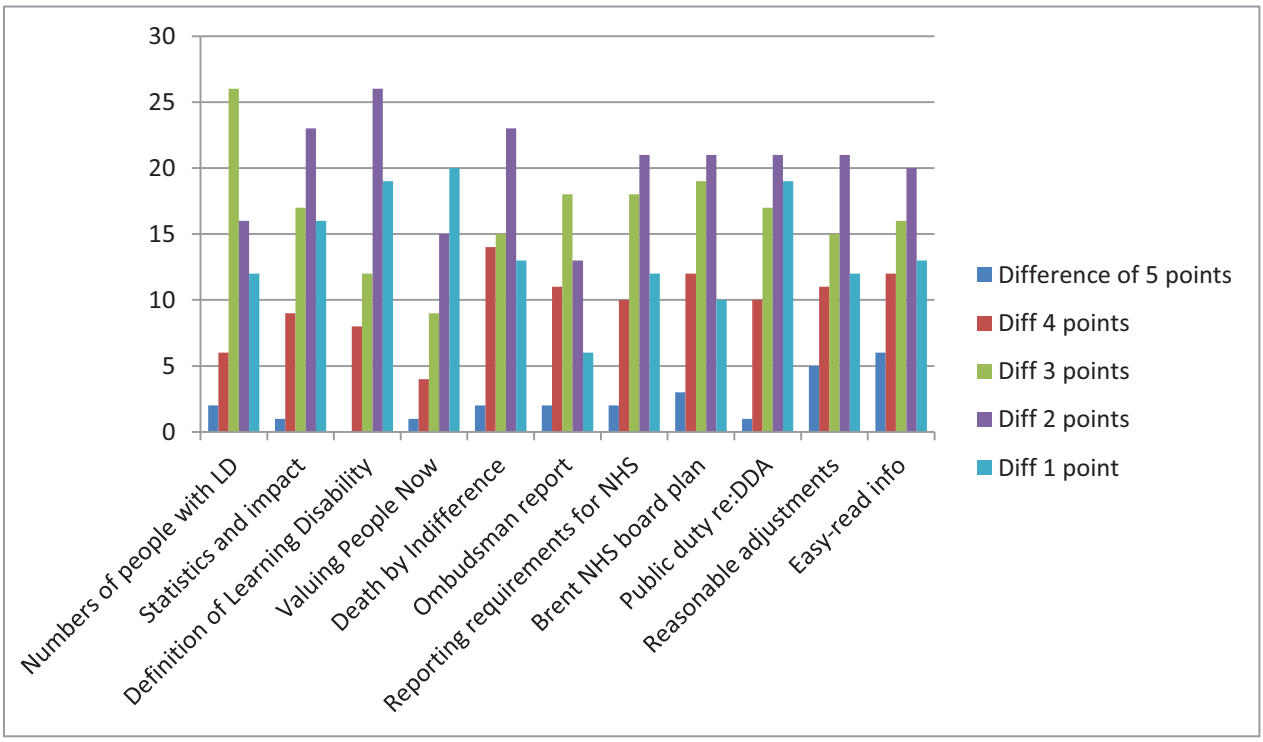


Results:

The staff were asked to complete a brief questionnaire comparing their knowledge before and after the training. There are differing results which show people starting with different amounts of knowledge and experience. This means that those starting from a point of 'reasonable knowledge' may move to 'full knowledge' by the end of the training- a difference of two points. The majority of the participants show an increase in their scores after training, particularly for specific learning disability reports e.g. Ombudsman report, and 'Death by Indifference', and also in practical suggestions about ways to make 'reasonable adjustments' and easy-read information.(Table 3).

Changes pre and post training: Table 3

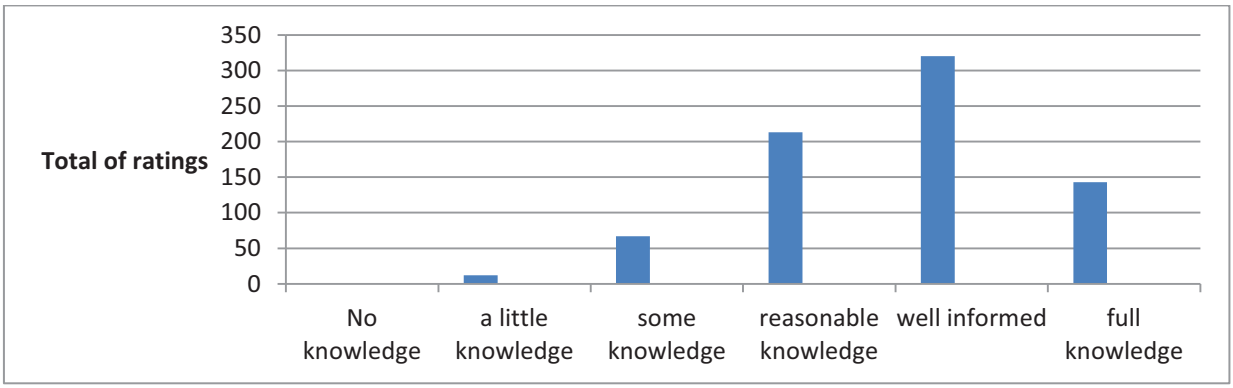
[1]



[1] LD –Learning Disability
DDA -Disability Discrimination Act

80 participants were asked to rate 11 areas of the training (total 880 ratings) and the majority of scores at the end of training show that they had 'reasonable' to 'full knowledge'. (Table 4) This is very encouraging and shows that the training has been well targeted and presented.

Final scores at end of training: Table 4



Follow up to GP training:

Ten participants were followed up by telephone after their training to assess the value of the training and to ask if they had made any changes as a result of the training (environmental or communication). The follow up included reception staff, Practice Nurses, GPs, and Practice Managers.

All participants felt that the training had been useful and had covered what they wanted. The most helpful areas were highlighting awareness of people with learning disabilities, how to communicate well, ensuring that a proper range of services are offered, ensuring that people's health needs are not overlooked. Following the training, reception staff reported changes to appointment bookings, booking an early appointment, or one at the end of surgery, ensuring people are 'fast tracked', if anxious in the waiting room, or given a quiet area to wait. A Practice Manager explained that they were developing longer, more specialist appointments. This is encouraging and works towards the benchmark ***'Flexible appointment systems'***[2]

All participants spoke of modifying their communication, giving examples such as not asking leading questions, finding out what people would like to be called, and generally giving more time. When asked if they had changed anything in the workplace, some said that they hadn't yet! A few talked about ordering easy- read literature and changing their entrance and exit signs for clearer ones. When asked who they would contact for learning disability advice, some spoke of the Learning Disability team although one practice expressed frustration about not being able to be put through to a LD liaison nurse when requested. This had taken some persistence and repeated phone calls, but they now had a named contact with whom they were very happy .

[2] Healthcare for vulnerable people, NHS London: benchmark of Best Practice. September 2010.

It became apparent on the training that not all GPs were aware of Safeguarding issues[3] and some have since completed training in this area. Brent Mencap also sends regular information and updates to GP practices by email.

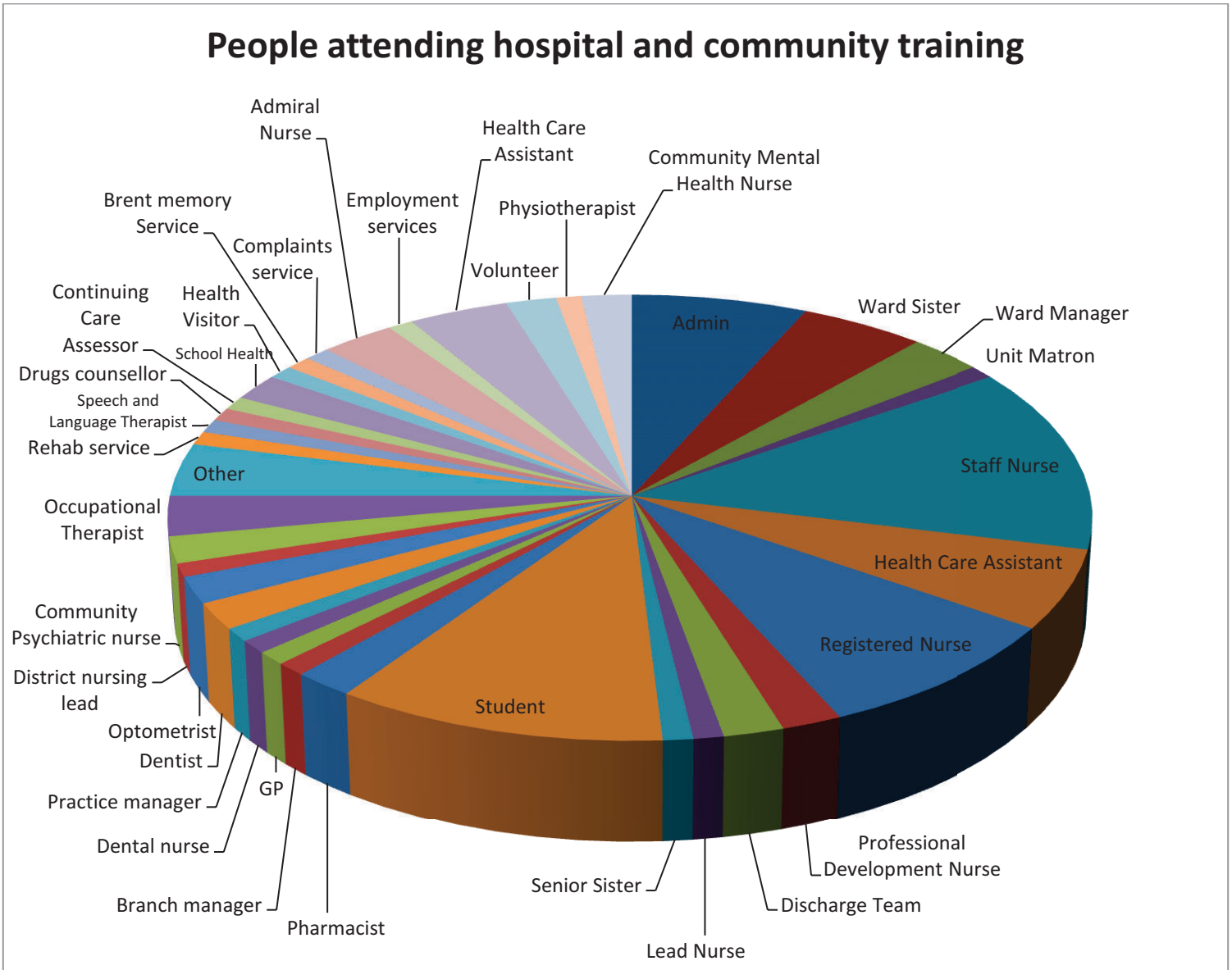
Who has done the hospital and community training?

A total of 115 people have attended training at both Central Middlesex and Northwick Park Hospitals and community centres for health and care. Their roles can be broken down as follows: (Table 5.)

This is in some ways an encouraging sample as it includes a good mix of staff at all levels including both those delivering front line care and those in management positions. Senior clinical/managerial staff can lead and influence others and be at the forefront of changing the way that things work, while those in daily contact with patients, need to have the awareness and information to prevent people being disadvantaged. In terms of numbers however, it is a poor representation, considering the number of employees in these services. Further training needs to continue to involve people at all levels. The highest proportion of attendees were staff nurses, registered nurses and students. The training does show a lot of gaps in community staff, e.g. therapists, dentists, optometrists etc due to the very slow pick up rate of training within Brent NHS and very low attendance. There is also a significant gap in medical hospital staff and consultants.

[3] Safeguarding Vulnerable Adults. Sept 2006.

Table 5


People attending hospital and community training
Admiral Nurse
Health Care Assistant
Community Mental Health Nurse
Brent memory Service
Employment services
Physiotherapist
Complaints service
Volunteer
Continuing Care
Health Visitor
Ward Sister
Ward Manager
Assessor
School Health
Unit Matron
Drugs counsellor
Admin
Speech and Language Therapist
Staff Nurse
Rehab service
Other
Occupational Therapist
Health Care Assistant
Community Psychiatric nurse
Registered Nurse
District nursing lead
Student
Optometrist
Dentist
GP
Practice manager
Professional Development Nurse
Dental nurse
Senior Sister
Discharge Team
Branch manager
Pharmacist
Lead Nurse

What did people think of the training?

An almost total majority described the training as either 'good' or 'very good', being satisfied that the course covered what they wanted. They highlighted particular areas such as the involvement of people with learning disabilities as trainers as very useful, and enjoyed the role play situations in particular. Many gave particular mention to hearing the user experience at first hand, and how powerful this was. Practical suggestions such as the 'Getting It Right' User Charter and Hospital Passports were thought to be good ideas as well as an Acute Nurse Liaison role.

In this training, participants were asked to identify an action plan that they could carry out back in the workplace. The action plans contained the following themes:

Information – making use of the information learnt on the course, further study, passing on information to colleagues, encouraging others to attend the course and making sure that carers had relevant information.

Environment- changing waiting space, displaying accessible information, safety issues e.g. increasing lighting, offering a choice of seating, making sure wheelchair is available, and displaying the Getting It Right charter as a positive message.

Communication- adapting own and others communication, using easy words and pictures, providing communication tools, e.g. symbols, picture menu cards, accessible complaints leaflet, allowing time for people with learning disabilities to express themselves and make choices

Procedural- adapting booking systems e.g. end of session appointments, double appointments, booking regular doctors, use of hospital passport (when finalised), knowing who to contact for specialist advice.

Rights and respect- ensuring people's needs are understood, ensuring enough information is given for person to consent, (or not), assessing people's needs well and responding immediately, being more aware of different factors that contribute to a person's behaviour.

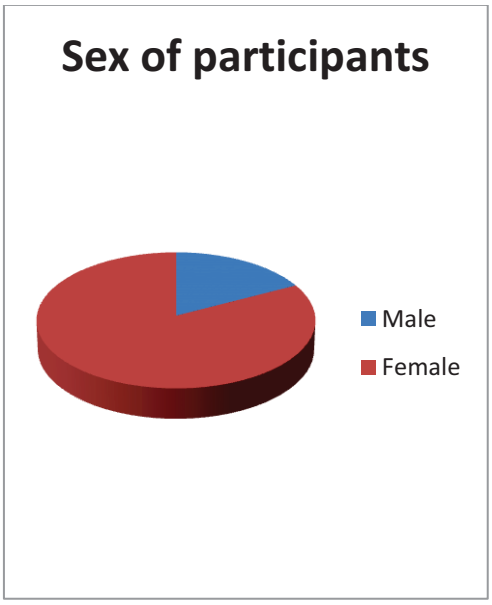
Other- making people aware of Learning Disability Liaison Nurse.

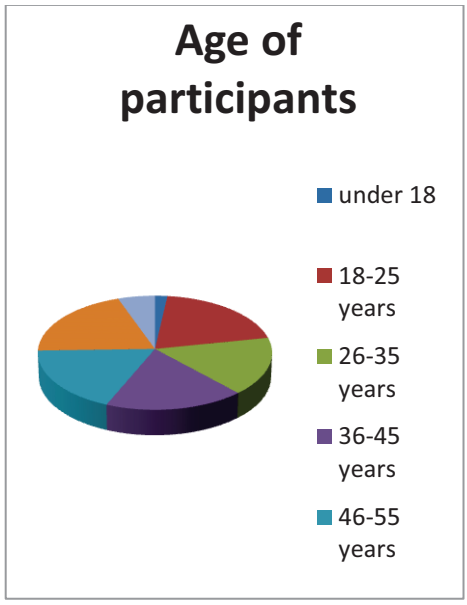
Follow up by telephone to 20 participants produced a varied response. Where quick practical tasks had been suggested, e.g. putting up the 'Getting It Right' charter, these had, in the most part, been actioned. In one case, the manager had set up a specific notice board area for information which staff had been accessing. They also talked of having information available for carers. Two managers had sent staff on further training, although one had not received further training dates through the hospital. One respondent who agreed to set up picture menu cards was waiting for another colleague to attend the training and to do a joint project. A pharmacist had identified people with a learning disability and spent extra time going through their medication with them and using pictures where appropriate and also passing this on to colleagues. Some reported not having day to day contact with patients, but encouraging colleagues to attend the training and passing on skills learnt. Some talked of adapting their own communication and being generally more aware of issues facing people with learning disabilities.

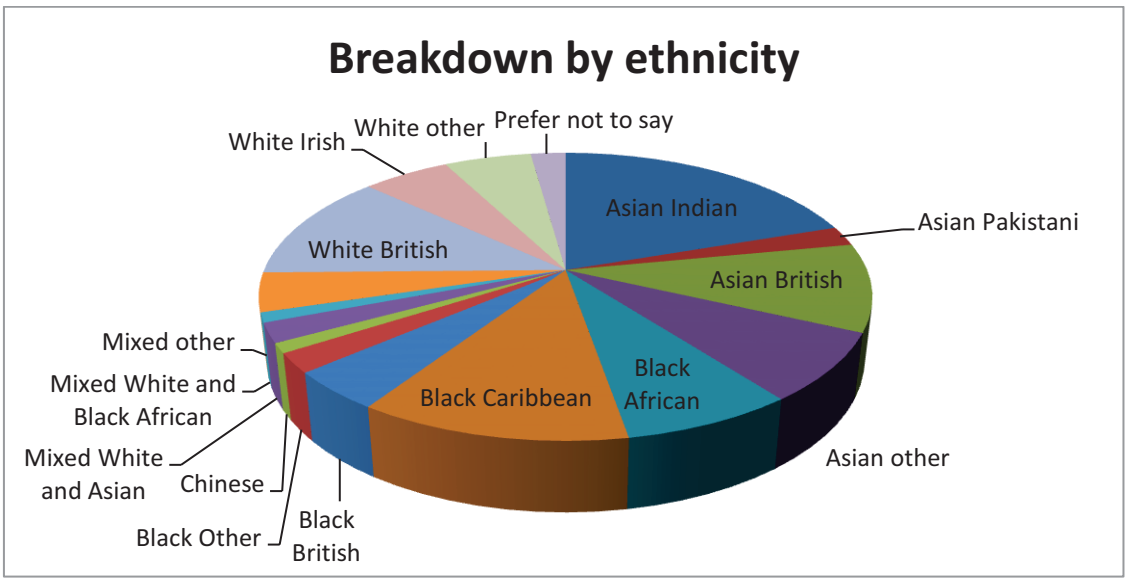
Time to follow through good ideas and goodwill from the training seemed to be a recurring theme, with dental staff reporting looking for easy read information relevant to their area and not being able to find any. (The project was able to provide links to this.) Another respondent talked of visiting the Mencap offices to look at resources, but again time was given as a reason for actions not being completed. Some of the more recent training participants (November and December 2011) had action plans with action dates after the end of the project.

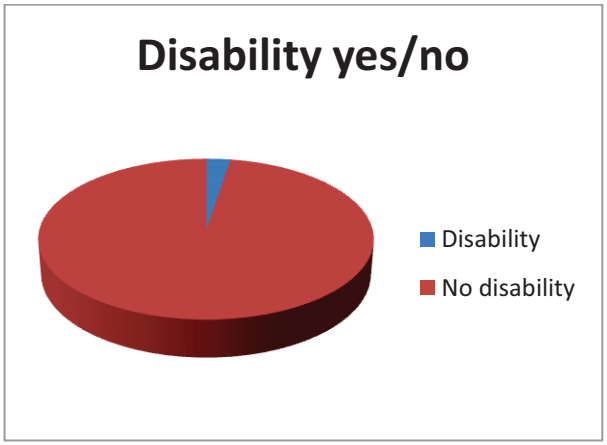
In conclusion, those who have attended the training all talked of the positive impact it had. There seems to be some progress in highlighting awareness of learning disability but actions requiring planning time and searching for resources are definitely losing out to competing priorities and time pressures. The use of Learning Disability 'champions' in departments, given appropriate time through Continuing Professional Development (CPD) to move forward practical and resource based projects specific to that department could be a way forward. In hospitals, the Acute Learning Disability Liaison Nurse could be an important link for these 'champions'.

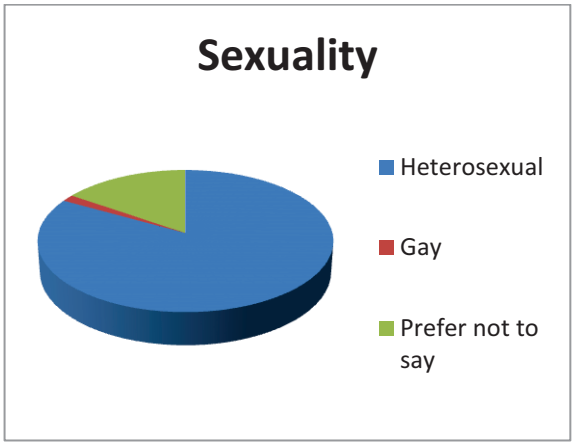
Breakdown by diversity data (total training)











Challenges to the project

There have been considerable difficulties in take- up of the training offered. Administrative issues such as room booking and availability of staff have significantly limited how many have been able to attend so far. Sessions have been cancelled due to there being insufficient numbers, and at times, the trainers have presented for the training to find no participants at all. This has had a significant effect on the project, and in particular on the consumer trainers' morale. For some, this is their first experience of paid work, for which they have been well trained and have made a considerable commitment of their time and effort. It is difficult not to interpret this as 'not being important enough'.

It has proved difficult, particularly within Brent NHS to gain responses from those responsible for training programmes, and to secure commitment even to publicise events, and to ensure attendance. There is interest to attend from ground level staff, but the commitment is needed from first line and senior managers to release staff, and training leads to support the training. The ability to affect this situation remains within the organisations themselves and will continue to affect the raising of awareness for this group of people and ultimately, their healthcare outcomes.

Mystery patient experiences:

Two 'mystery patient' visits took place during the project at Central Middlesex (CMH) and Northwick Park (NWP) hospitals. Information was also collected from individual experiences, at the GP, as inpatients and from outpatient visits. Themes from these will now be highlighted in relation to the standards expected in the Benchmark of Best Practice document: Healthcare for vulnerable people, (2010)[4] ***highlighted in italics.***

'***Healthcare environmental signage is clear and unambiguous'***

Hospital signage relies almost entirely on reading the written word, also the use of specialist terms, e.g. maxillo-facial, audiology. A few symbols are available for non clinical areas e.g. toilet and cafe, and helpfully, tube stations. This lack of easy-read information excludes people who do not read

[4] Healthcare for vulnerable people, NHS London: benchmark of Best Practice. September 2010.

from accessing the same information as everyone else. In one instance at CMH, the mystery patient was given reasonable (verbal) directions from reception to 'blood tests', but on exiting the lift, was confronted by a barrage of written signage, with no symbols or explanation. The mystery patients reported feeling 'confused', 'lost' and 'left out'.

Explanations for waiting procedures at both hospitals in the departments visited, (outpatients and blood tests) were written only, without pictures, symbols or even arrows to assist understanding. E.g. *'To help maintain patient confidentiality please queue here at the blue barrier and wait to be called.'* Our mystery patient commented: "you would be embarrassed not knowing what to do next." " You wouldn't be able to come here on your own." A person who does not read is immediately at a disadvantage, and may even miss their appointment due to a lack of understanding of the system. In an already potentially stressful situation, this can unnecessarily raise anxiety levels. People with learning disabilities will not be the only people disadvantaged by such reliance on written information.

'All information provided for the public domain has an agreed accessible version designed in partnership with self advocates and Speech and Language Therapists.'

On requesting information at the blood tests clinic (CMH), although members of staff were helpful, we were told that there was no such material available. In general, patient information on the walls was mostly in writing only, some pictures were available in some areas e.g. diabetic clinic. Although this was a good start, and made our mystery patients feel a bit more included, the pictures did not conform to 'easy-read' principles, e.g. giving the same information as the words.

The PALS service (CMH) was a helpful contact, operating an accessible, open door policy. We asked if there were any easy-read leaflets with pictures available about a hospital stay. The staff member took our details and got back to us, unfortunately saying that there was not anything available specific to that hospital but directed us to other nationally produced information, appropriate to people with learning disabilities. This is clearly a gap in hospital resources, particularly as the hospital website talks about a leaflet 'Your stay'- which provides an ideal opportunity for an accessible version using pictures, with information local to the hospital.

A highlight of one of the visits was the Macmillan Cancer Care advice and support service (NWP). Helpful staff and volunteers knew about and provided appropriate, learning disability specific easy-read information on cancer.

'All staff receive learning disability focused training.'

This is obviously the aim of this project. While there are examples of particular areas achieving good attendance on the training, in other areas, attendance has been poor, with sessions cancelled. There has been no representation from (hospital)medical staff and consultants, a significant gap. This standard is currently not being met.

Positives from the mystery shopping:

- **Proactive volunteer helpers at reception at Northwick Park.** These people approached the 'mystery patient' before they reached the reception desk and asked if they needed any assistance. They spoke to the person with a learning disability and not just the carer, and

gave clear and helpful directions to the department needed. The mystery shopper commented, " they were friendly, polite and reasonable". "It was a lovely welcome."

- '**Reasonable adjustments' made at the cafe (CMH).** When asked to pour away some of the mystery patient's hot drink as it was too full for them to manage without spilling, the staff member suggested a larger cup and went to find one.

Mystery patient feedback: (questionnaires) This is a very small sample size, but each experience is a valued one and provides feedback as a patient story.

Doctor's surgery (5 questionnaires)
All participants found reception staff helpful.
50% of the Doctors introduced themselves by name.
3 participants had a health action plan that the Doctor used.
The majority of people felt that the Doctor spoke to them, as well as their carer.
The majority felt that the Doctor explained treatment before giving it.
The majority explained the choices available about their treatment.
Not all patients felt they were given time to ask any questions they might have.
Only one patient was given written information in a format that they could understand.
Half of the respondents said that there was no pictorial information on the walls at the surgery.

Hospital (outpatients) covering ACAD, ENT, Orthopaedic (4 questionnaires)
The majority found their way to the appointment
Some pictures were seen on hospital wall signs e.g. toilet
Some people were helped with directions, particularly the receptionist
Most people felt that their carer was talked to, and not them.
Most people were told who people were and what job they did.
Most people had treatment explained before it was given, but with one exception.
Most people did not use long words to explain things, with one exception.
All people felt they were given a choice about their treatment.
Not everyone was given the chance to ask questions
No one received easy-read information about their condition or treatment.

Specialist hospital (outside Brent)
A very negative experience was reported, with a person experiencing poor communication, lack of understanding of disability, no opportunity to ask questions, no explanation of options or consent to treatment. This is being followed up as a formal complaint.

Dentist (1 questionnaire)
Overall, this was a fairly positive experience, although there was a lack of preparation or explanation before treatment and no time to ask questions. Again no easy-read information was available.

In conclusion:
There have been many strands to this project, starting with the patient voice, implementing the training across different parts of the local NHS, and reviewing the impact, from individual NHS staff

and from mystery patient one-off visits. There has been a patchy response, with some practices and wards committing strongly to the programme, ensuring a majority of their staff attend, and others where there is less commitment. Where training is provided free of charge, and using 'expert patient'-type models, (consumer trainers) and there is commitment in the board plan (NHS Brent)it is difficult to understand the lack of take up of the training.

Although some patient stories provide an encouraging view of people's experience of their local healthcare, which we celebrate, there are other examples that demonstrate that there is still some way to go. Attitude change is always difficult, particularly across large and disparate organisations, but it begins with knowledge, information and understanding, and in this case, inclusion of the expertise of people with learning disabilities themselves.

Good beginnings have been made in this project, but commitment at senior and commissioning level within local healthcare organisations is needed to build on this positive start. It is important that individual gains and small changes in practice are rolled out more widely, with senior support and endorsement, and the resources necessary to effect change.

Recommendations:

- Secure commissioner and senior management commitment to further training within Brent NHS and across GP practice and hospital settings (including medical staff and consultants) with targeted expectations for staff to attend
- Consider use of LD 'champions' in wards and departments with dedicated time (through CPD) to ensure availability of appropriate resources and implement projects to ensure 'reasonable adjustments' are made.
- Review signage at hospitals and healthcare centres together with service user groups, to include pictures and symbols where possible
- Identify funds to review healthcare leaflets and work together with service user groups and speech and language therapists to provide accessible versions, e.g. 'Your stay'
- Continue to build on links between primary and acute and specialist Learning Disability services. There are encouraging signs with the GP practice LD link nurse model and the new Acute Liaison Nurse role in North West London Hospitals trust.
- Continue to build links with service user and self advocacy groups and organisations for specialist resources and advice.
- Encourage people with learning disabilities to take part in patient forums, with appropriate support.

Cathy Lenton

Project Evaluator

December 2011

References

1. Lakhani, M., Bates, J.,(1999) *Needs of patients with learning disabilities are not being met.* British Medical Journal **318** 26 June 1999

2. Barr, O.,_ Gilgunn, J., Kane, T., Moore, G., (1999*) Health screening for people with learning disabilities by a community learning disability nursing service in Northern Ireland. Journal of Advanced Nursing* **29** 6 1482-1492

3. Graham, K., (2001) *Better health care and learning disability*. Nursing Times **97** 8 39-41

4. Matthews, D., (2002) *Learning disabilities: the need for better health care*. Nursing Standard **16** 39 40-41

5. Turner, S., Moss, S., (1996) *The health needs of adults with learning disabilities and the Health of the Nation strategy.* Journal of Intellectual Disability Research **40** 5 438-450

6. Bollard, M., (1999*) Improving primary healthcare for people with learning disabilities*. British Journal of Nursing **8** 18 1216-1221

7. Elliot, J., Hatton, C., Emerson, E., (2003) *The health of people with learning disabilities in the UK: evidence and implications for the NHS*. Journal of Integrated Care **11** 3 9-17

8. Williamson, A., (2004) *Improving services for people with learning disabilities*. Nursing Standard **18** 24 43-51

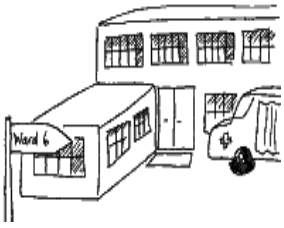
9. Michael, J., *Healthcare for All: Report of the Independent Inquiry into Access to Healthcare for People with Learning Disabilities*. 2008, Independent Inquiry into Access to Healthcare for People with Learning Disabilities: London.

10. Mencap, *Death by Indifference*. 2007, Mencap: London.

11. Parliamentary and Health Service Ombudsman and Local Government Ombudsman, *Six lives: the provision of public services to people with learning disabilities*. 2009, Parliamentary and Health Service Ombudsman and Local Government Ombudsman: London.

12. Disability Rights Commission, *Equal Treatment - Closing the Gap*. 2006, Disability Rights Commission: London

13. Emerson E, Baines S, Allerton L and Welch V (2011a) *Health inequalities and people with learning disabilities in the UK*: 2011. Improving Health and Lives: Learning Disabilities Observatory. http://www.improvinghealthandlives.org.uk/publications.

 	We know that in the UK, people with learning disabilities have more health problems than other people.
	We also know that they do not get the healthcare from doctors and hospitals that they need.
 	In Brent, people with learning disabilities told us that some people get a good service from their doctors and from hospitals.
	Other people say that the doctors use difficult words, don't give them a chance to ask questions and treat them differently.
 	Some people feel that hospitals do not understand their needs, and do not always treat them with respect.

Brent Mencap was given some money to do a project about this. The money came from Brent Learning Disability Development Fund.

The project had 4 things to do.

1. 

1. Train people who work in hospitals, in the community and Doctors' surgeries about understanding learning disabilities.

2. 

2. Talk to people about what they thought about their healthcare

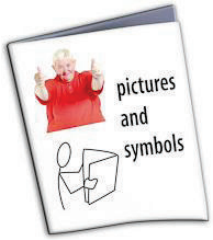
3. 

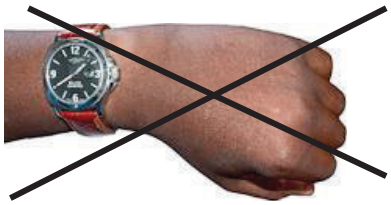
3. Put on information stalls, giving out leaflets and talking to health workers about learning disability

4. 

4. Visit hospitals as 'mystery patients' to look at how easy it was to find their way around and how they were treated.

	8 people with learning disabilities were paid as 'consumer trainers' to do this work together with Claudia Feldner and Ann O'Neill.
 **80** 	The results: 80 people who work in Doctors' surgeries have had training about learning disabilities.
 **115** 	115 people who work in hospitals and in the community have had training about learning disabilities.
 	People liked the training and found it helpful.
	People said that they knew more about people with learning disabilities at the end of the training.

	People talked about things they would do differently now, to make things better for people with learning disabilities.
	We telephoned them to ask what they had changed because of the training.
	Some people had put up the 'Getting It Right' charter on the wall in the hospital.
	Some people had looked for easy-read information to give out to people.
	Some managers had made sure that their staff went on the learning disability training.

	A lot of people talked about trying to communicate better with people with learning disabilities.
	Some people said that they had not had time to change things.
 	Next, we visited Central Middlesex and Northwick Park hospitals with people with learning disabilities (‘mystery patients’) to see for ourselves what has changed.
	We found the signs very confusing, with not many pictures or symbols.
	We got lost!
	We asked for easy read information or leaflets about staying in hospital and about having a blood test- but there weren’t any at the hospital.

PALS - Patient Advice and Liaison Service

NWP – Northwick Park Hospital

BUT-

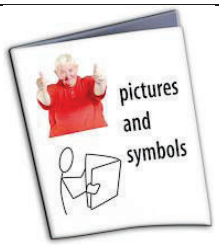
- We found the PALS officer helpful and friendly,
- We were given easy-read information about cancer from the Macmillan Centre (NWP)
- We found the volunteer helpers at reception at NWP very helpful and friendly.

We had problems in getting people who work in health services to come along to the training. We need health services to help to change this.

What needs to be different?

- More people need to do the training so that they can understand people with learning disabilities better.

- Health workers need to be given time by their managers to make changes happen.

	• Hospitals and other healthcare places need to make their signs easier to understand using pictures or symbols.
	• Easy-read information needs to be available in all areas - not just cancer care.
	• Health staff need to use the hospital passport.
	If you want the full report  telephone Brent Mencap on: 020 8451 5278  or email: claudia@brentmencap.org.uk

With thanks to Photosymbols and Change Picture Bank for the pictures.

This page is intentionally left blank

	Health Partnerships Overview and Scrutiny Committee 27th March 2012 **Report from the Director of Strategy, Partnerships and Improvement**
For Action	Wards Affected: ALL
Planned Care Initiative	

1.0 Summary

1.1 NHS Brent has requested that an item on their Planned Care Initiative is included on the Health Partnerships Overview and Scrutiny Committee agenda in order for members to be informed of the project and scrutinise proposals.

1.2 The Planned Care Initiative complements the PCTs plans to provide services outside hospital where possible. There are three strands to the project:

- A peer review of referrals by GPs to specialist services
- Entering into a competitive dialogue with providers around providing some outpatient services at lower costs in a community setting
- Working with GP practices to provide services either at their practice or in networks that are a natural extension of primary care e.g. joint injections.

1.3 Full details on this project are included in the report provided by NHS Brent.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to consider the report on NHS Brent's Planned Care Initiative and question officers on the proposals.

Contact Officers

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

Phil Newby
Director of Strategy, Partnerships and Improvement
Tel – 020 8937 1032
Email – phil.newby@brent.gov.uk

NHS Brent Briefing paper for the Brent Health Overview and Scrutiny Committee on commissioning new Community Cardiology and Ophthalmology Services

1.0 Introduction

1.1 NHS Brent, in support of the emerging Brent Clinical Commissioning Group, has identified a number of specialities traditionally provided in an outpatient setting that it wishes to re-commission to be provided within the community.

1.2 **This paper:**

- Provides a commissioning context and some background information on both cardiology and ophthalmology services commissioned by NHS Brent.
- Describes the procurement approach.
- Identifies the benefits in terms of quality, innovation and productivity.
- Outlines the proposed consultation approach.

2.0 Background

2.1 The NHS faces an unprecedented challenge in terms of improving both the quality of care and also productivity. The NHS must save £20 billion nationally, as a result of improved technology, the cost of medications and due to increased demands through longevity.

2.2 The emerging Clinical Commissioning Group is committed to improving services for Brent patients. We want to encourage innovation, improve both productivity and quality, and develop better patient-centred models of care that are delivered closer to patients' homes. The first stage is a commissioning process to create new community-based outpatient cardiology and ophthalmology services. In order to achieve this, services need to be redesigned and commissioned in a manner that ensures that the provider best suited to delivering those aims is aligned.

2.3 NHS Brent has started a procurement process for two specialities: cardiology and ophthalmology. The new services will start in the autumn of 2012.

2.4 The approach will be to procure the services through *competitive dialogue*. Most procurements have traditionally followed the *invitation to tender* route. That is, the organisation outlines what they want in the form of a detailed specification and seeks submissions from those that wish to provide it, whereby the bidder is selected based upon price, quality and other suitability considerations. Whereas, competitive dialogue allows the organisation to work with interested parties to design the specification. This approach is more innovative and allows a more tailored specification to develop. Once a final specification has been developed then selected bidders can submit a tender.

2.5 There are several advantages to this. The opening up of the development of the specification with potential bidders will allow bidders to draw up on their experience and knowledge to ensure that a bespoke solution is created for Brent. Many bidders would have experience of delivering such services elsewhere and will be well placed to work with clinical commissioners to design a high quality service model.

2.6 At this stage, we cannot articulate the configuration of the new services, as competitive dialogue will help us design this. However, the following considerations are pertinent:

- Patients with complex needs may continue to receive their treatment within a hospital setting. Once we have developed a final draft of the specification, we will work with clinical specialists to establish if the proposed model is clinically safe and appropriate.
- The dialogue phase will assist us in clarifying the percentage of current activity that will be taken out of the hospital setting.
- The service may be provided by someone other than the current provider. Whilst we cannot be specific about those that have expressed an interest, we can clarify that existing acute trusts, local GPs and private companies have expressed an interest.
- Most of the services will be provided within a community setting. We will work with the bidders to identify economies of scale for delivery. That is, some sub-specialities may need to be delivered in one location, whereas others could be delivered at several locations within Brent (especially when the sub-speciality is high volume and less complex).

3.0 Implications

3.1 *Quality*

3.11 The contract will be patient-focussed and will include Patient Reported Outcome Measures (PROMs). PROMs refer to self-completed questionnaires given to patients to assess their self-reported health status before and after certain elective healthcare interventions funded by the NHS.

3.12 The health status information collected from patients by way of PROMs questionnaires before and after an intervention provides an indication of the outcomes or quality of care delivered to NHS Patients. Changes in health status as measured by PROMs, controlling for variation in patient characteristics and the influence of other factors, are attributed to the healthcare delivered to the patient by the Provider and the wider healthcare system. This outcomes data can be used in a variety of ways to assess the quality of care delivered to NHS patients by Providers.

3.13 Patients in other PCT areas have reported increased satisfaction where outpatient services have been provided in community settings. Patients have reported:

- A preference to be seen within community facilities, as opposed to hospitals.
- Increased satisfaction with booking appointments.
- Greater efficiencies in being seen on time.

3.2 *Innovation*

3.21 The *Competitive Dialogue* approach will allow us to work with potential providers to develop the specification, rather than presenting one that we have drafted earlier. Experience of working with providers including clinicians to co-create solutions has led to more

collaborative and flexible relationships, rather than adversarial dynamics that have sometimes typified contractual relationships.

3.22 Through designing contracts and performance measures that are outcome focussed (rather than output focussed), the provider will be able to work with the commissioners to continuously improve the service offering. Through concentrating on achieving outcomes, we are aiming to achieve highest patient satisfaction and better outcomes at a lower cost.

3.3 *Productivity*

3.31 The ophthalmology procurement could release £1m per year of resources and the cardiology procurement could release £0.8m. This will contribute to our savings programme and invest in other services such as supporting carers and increasing the number of funded health visitors.

3.32 *Consultation*

3.4 NHS Brent aims to undertake a formal consultation regarding the service change, which is due to start in April or May 2012. The outcome of the consultation will influence the final draft of the specification.

3.41 In addition to formal consultation, there will be targeted involvement activity with key stakeholders, including patients. We will use our current patient and public involvement mechanism to speak with Brent residents to help shape the future services. In addition, we will work with and involve key stakeholders to ensure that we manage the change process effectively.

4.0 Recommendations

4.1 Members are asked to:

- Consider the contents of this report.
- Consider how and when they wish to be updated regarding progress.

On Behalf of the Brent Clinical Directors:

Harness-	**Dr Ethie Kong and Dr Sami Ansari (Co-Directors)**
Kilburn-	**Dr Mandy Craig**
Kingsbury-	**Dr Ajit Shah**
Wembley-	**Dr Jahan Mahmoodi and Dr Ashwin Patel (Co-Directors)**
Willesden-	**Dr Sarah Basham and Dr Cherry Armstrong (Co-Directors)**

This page is intentionally left blank

	Health Partnerships Overview and Scrutiny Committee 27th March 2012 **Report from the Director of Strategy, Partnerships and Improvement**
For Action	Wards Affected: ALL

Waiting List Information

1.0 Summary

1.1 The Health Partnerships Overview and Scrutiny Committee has asked that NHS Brent provides information on hospital waiting times in Brent. This request has been made following concerns that waiting times are increasing across a range of services and that organisations are struggling to meet the NHS's four hour A&E target and 18 week referral to treatment target.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee should consider the report provided on hospital waiting times and question officers on the issues raised in the report.

Contact Officers

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

Phil Newby
Director of Strategy, Partnerships and Improvement
Tel – 020 8937 1032
Email – phil.newby@brent.gov.uk

This page is intentionally left blank

Briefing paper for on Elective Waiting Times

for all Brent Patients

1.0 Introduction

1.1 NHS Brent as a commissioner for hospital services is responsible for ensuring that patients wait within nationally set targets. Until 2011/12, the target was that patients should wait no longer than 18 weeks between referral from GP to treatment. The target in 2011/12 is 95% of patients should be seen in outpatients within 18.3 weeks and that 95% of patients should have been seen within 23 weeks. Currently 95% of Brent patients are seen from referral to treatment within 23.84 weeks.

1.2 The target for incomplete pathways for patients still waiting for treatment at the end of January 2012 is the 95th percentile, which is 21.4 weeks.

2.0 Performance

2.1 This paper provides information on average waiting time in weeks for outpatients and inpatients – Appendix 1. It also shows the trend of the 95th percentile between April 2010 and January 2012. Appendix 1 shows performance graphs.

3.0 Implications

3.1 The average waiting time for patients to start treatment is relatively short. The average waiting time for outpatients is approximately 15 weeks, whereas the target is 18 weeks. The range of inpatients is between 18 – 25 weeks and Central Middlesex Hospital have produced a Recovery Plan that will ensure that the time period is a maximum of 23 weeks (which is the national target).

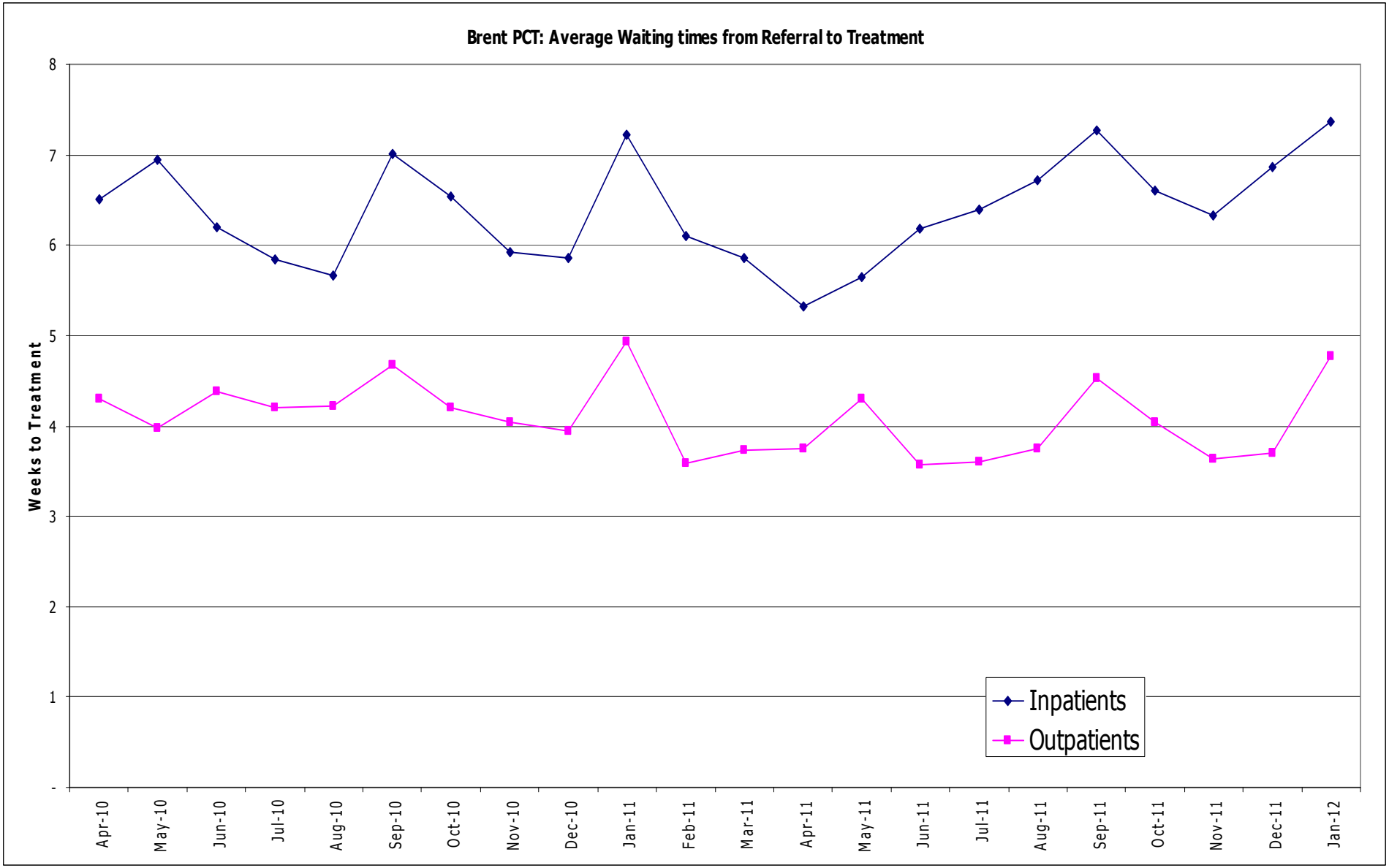
4.0 Conclusion

4.1 Members are asked to:

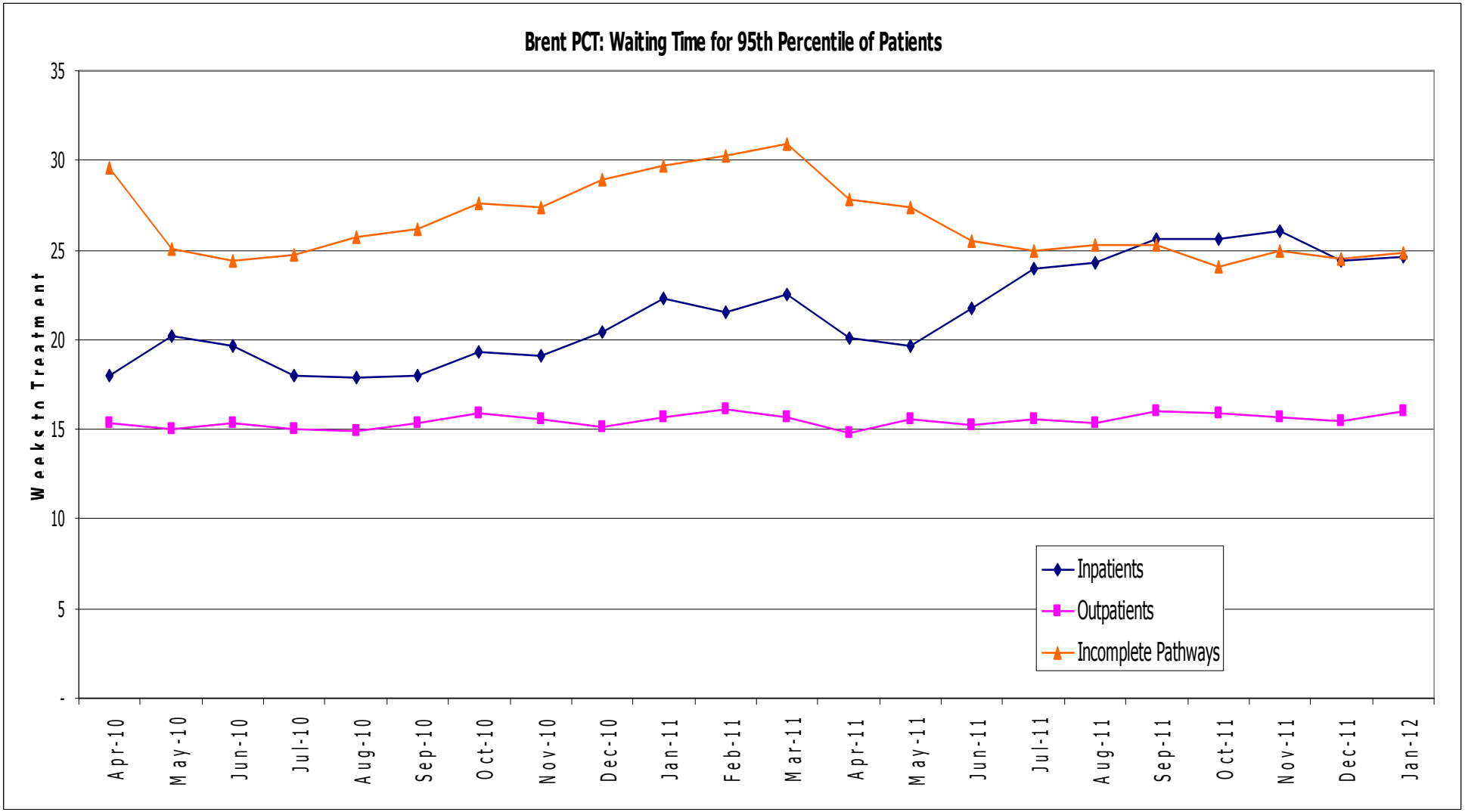
- Note the contents of this report
- Give an indication of when they would like a further update

On Behalf of the Brent Clinical Directors:

Harness- Dr Ethie Kong and Dr Sami Ansari (Co-Directors)
Kilburn- Dr Mandy Craig
Kingsbury- Dr Ajit Shah
Wembley- Dr Jahan Mahmoodi and Dr Ashwin Patel (Co-Directors)
Willesden- Dr Sarah Basham and Dr Cherry Armstrong (Co-Directors


Brent PCT: Average Waiting times from Referral to Treatment
Weeks to Treatment
8
7
6
5
4
3
2
1
-
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Inpatients
Outpatients

Brent PCT: Percentage of Patients seen in 18 Weeks from Referral to Treatment
100.0%
95.0%
90.0%
85.0%
Weeks to Treatment
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Inpatients
Outpatients


Brent PCT: Waiting Time for 95th Percentile of Patients
Weeks to Treatment
35
30
25
20
15
10
5
-
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Inpatients
Outpatients
Incomplete Pathways

This page is intentionally left blank

	Health Partnerships Overview & Scrutiny Committee 27th March 2012 **Report from the Director of Strategy, Partnerships & Improvement**
For Action	Wards Affected: ALL

Public Health Transfer Update

1. Summary

1.1 The Health Partnerships Overview and Scrutiny Committee has requested an update on the transfer of public health functions from NHS Brent to the council. This report sets out the developments in the transfer to date and the national policy context. As things stand, council's will formally take on their public health responsibilities on the 1st April 2013, subject to the successful passage through Parliament of the Health and Social Care Bill 2011.

1.2 At the committee meeting, Phil Newby, Director of Strategy, Partnership and Improvement (and Transfer Project Sponsor), Simon Bowen, Acting Director of Public Health and Andrew Davies, Policy and Performance Officer (Project Manager) will be present to answer questions about the transfer.

2. Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to:

(i). Consider the update on the public health transfer

(ii). Question officers from the council and NHS Brent on the progress to date with the transfer and the plans to develop a new public health service in Brent during the transition year in preparation for the council taking on responsibilities from 1st April 2013.

3. Detail

3.1 Local government responsibilities

3.2 The Government originally published its plans for public health in the White Paper, *Healthy Lives, Healthy People* and these have been confirmed in the Health and Social Care Bill 2011. Subject to parliamentary approval of the Bill, each upper tier local authority will take on the duty to improve the health of people in its area and with it, acquire many of the public health services currently the responsibility of the NHS. Councils will be funded by a ring fenced budget that will be allocated based on relative health inequalities and deprivation to deliver public health services. The Government believes that by embedding public health within local government it will be easier to create local solutions in order to meet varying local health needs. It will

also enable joint approaches to be taken with other areas of local government's work and with key partners to tackle health inequalities.

3.3 Once the transfer takes place, local government will be expected to put health and wellbeing at the heart of everything it does. This will mean:

- Including health in all policies so that each decision seeks the most health benefit for the investment, and asking key questions such as "what will this do for the health and wellbeing of the population?" and "will this reduce health inequalities locally?"
- Encouraging health promoting environments, for example, access to green spaces and transport and reducing exposure to environmental pollutants
- Supporting local communities – promoting community renewal and engagement, development of social networks (in particular for young families and children, and isolated elderly people), and the Big Society. This will bring a focus on what a healthy population can do for the local community, not least in terms of regeneration
- Tailoring services to individual needs – based on a holistic approach, focusing on wellness services that address multiple needs, rather than commissioning a plethora of single issue services.

3.4 It's acknowledged that local political leadership will be critical in ensuring that public health receives the focus it needs across local authorities.

3.5 Already local government fulfils its new duty in a number of ways, such as through the provision of leisure services, through the planning system, and in providing services such as housing. Ensuring the health needs of disadvantaged communities are addressed will be central to the new responsibilities.

3.6 It has taken some time since the publication of the Public Health White Paper and Health and Social Care Bill to clarify local government responsibilities, the Public Health Outcomes Framework and the budget allocation for public health that council's will be receiving. This has meant that local authorities haven't been clear about exactly what it is they will be taking on, what they will be expected to deliver and the amount of money available to do it. Despite the recent publication of the baseline spending estimates for public health and the Outcomes Framework, important information in relation to both is still missing, such as the way that the Health Premium will work (the Health Premium is funding that will be allocated to council's based on achievement against performance indicators in the Public Health Outcomes Framework) and how priorities will be set using the Public Health Outcomes Framework.

3.7 However, commissioning responsibilities have become clearer and we now know that local government will be responsible for the following services:

- Tobacco control and smoking cessation services
- Alcohol and drug misuse services
- Public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people)
- **The National Child Measurement Programme**
- Interventions to tackle obesity such as community lifestyle and weight management services
- Locally-led nutrition initiatives
- Increasing levels of physical activity in the local population

- **NHS Health Check assessments – assessments will be mandated, provision of lifestyle advice and interventions will not be but there is an expectation that there will be adequate follow up following an assessment**
- Public mental health services
- Dental public health services
- Accidental injury prevention
- Population level interventions to reduce and prevent birth defects
- Behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- Local initiatives on workplace health
- Supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
- **Comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)**
- Local initiatives to reduce excess deaths as a result of seasonal mortality
- **The local authority role in dealing with health protection incidents, outbreaks and emergencies – council's will be mandated to ensure plans are in place to protect the local population. CCG will have a duty of cooperation with local government on health protection**
- Public health aspects of promotion of community safety, violence prevention and response
- Public health aspects of local initiatives to tackle social exclusion
- Local initiatives that reduce public health impacts of environmental risks.
- **Provide population level healthcare advice to CCGs and the NHS**

3.8 Those services in **bold will be mandatory for local government**. Other services will discretionary, but guided by the Public Health Outcomes Framework, the local JSNA and Health and Wellbeing Strategy.

3.9 The Government has a number of expectations with regard to local government's public health service responsibilities:

- Services should meet the needs of disadvantaged and vulnerable groups
- Local authorities should work with CCGs to integrate across clinical pathways where ever possible
- Local government should commission rather than directly provide these services, engaging local communities and the third sector where possible and adopting a diverse provider model where possible.

3.10 Apart from the mandatory services and the Government's expectations set out above, council's will be free to develop a public health service that best meets the health and wellbeing needs of the borough. The new Joint Strategic Needs Assessment has been drafted and consultation closed on the 23rd March 2012. A new health and wellbeing strategy for Brent is to be developed which will identify those needs. Clearly the Outcomes Framework will also influence the shape of the new service and its priorities for health improvement. This is why council's need to know how priorities from the Outcomes Framework will be selected and whether council's will get to do this, or if Government will set national priorities or whether it will be a mixture of local and national priorities.

3.11 The public health system

3.12 There are three other elements of the new public health system. A number of public health services are to remain an NHS responsibility. The NHS Commissioning Board will be responsible for the following public health services:

- Abortion services
- Sexual assault services including sexual assault referral centres
- Promotion of early diagnosis services
- Public health services for children under 5, including health visiting, the Healthy Child Programme and the Family Nurse Partnership – Local government will assume responsibility for these services by 2015.
- Commissioning Child Health Information Systems
- Immunisation services
- Screening services
- HIV treatment services

3.13 The second element is the establishment of Public Health England which will take on the responsibilities of a number of agencies that are to close, such as the Health Protection Agency and Drug Treatment Agency, provide specialist health protection services including, coordination of outbreak control, and access to national expert infrastructure as and when necessary and provide national public health leadership. Finally, the Department of Health will retain a budget for and manage national public health "campaigns".

3.14 The role of the Director of Public Health

3.15 The Health and Social Care Bill has safeguarded the Director of Public Health role. They will play a crucial role in ensuring that the public health needs of the borough will be recognised in all aspects of the council's services. Each local authority must, appoint a Director of Public Health. This post can be shared with other councils where it makes sense to do so. Further guidance on the appointments of DPHs is to be published and will build on the existing appointments process, which is consistent with Faculty of Public Health standards and includes the use of appointments advisory committees and faculty assessors.

3.16 Funding

3.17 The baseline spending estimate for public health (the amount that Brent Council would have been allocated for 2012/13 if it was taking on responsibilities) is £16,007,000. This figure has been worked out on the basis of spending in 2010/11. NHS Brent estimated this to be £17,891,000. The revised figure takes into account changes in commissioning responsibilities that have been made since the NHS Brent figure was worked out – abortion services and some contraceptive services will not become local government responsibilities, reducing the amount of funding that will transfer to the council. Similarly, the revised figure does not include income to public health from Government departments other than the Department of Health. This means that over £1m is not included in the revised figure as it is income from the Home Office for drug treatment services. Officers are working through the implications of the baseline estimate. The allocation for public health for local government won't be finally confirmed until December 2012, but the baseline estimate is to be used for planning purposes.

3.18 The overall settlement for public health is £5.2bn, but as can be seen in the table below, only £2.2bn will be allocated to local government.

Organisations	Estimated baseline expenditure	Uplifted to 2012-13
Local Authorities	£2.1bn	£2.2bn
NHS Commissioning Board	£2.0bn	£2.2bn
Public Health England	£210m	£210m
Department of Health	£620m	£620m
Total	£5.0bn	£5.2bn

3.19 Work in Brent

3.20 Brent has been engaged in two strands of work to develop a new model of public health for the borough. Firstly, the public health transfer has been added to the One Council Programme. A project board has been established, its members are:

- Phil Newby, Director of Strategy, Partnerships and Improvement (Project Sponsor)
- Alison Elliott, Assistant Director of Adult Social Care
- Cathy Tyson, Assistant Director of Policy
- Andrew Davies, Policy and Performance Officer (Project Manager)
- Jo Ohlson, Borough Director, NHS Brent
- Simon Bowen, Acting Director of Public Health
- Imran Choudhury, Consultant in Public Health

3.21 Analysis has taken place looking at the performance of the existing public health services, its budgets, contract obligations, staff numbers etc, in order to build up a baseline of local activity. An initial view has been taken by the Public Health Transition Project Board on the future model for public health, looking at what should be done in borough and what could be shared with other boroughs, or through integrated health and social care commissioning arrangements. This needs to be further refined, but the local model is starting to emerge.

3.22 What develops locally will be influenced by what emerges with regard to health and social care integration and joint commissioning. But another factor at play is the work of the West London Alliance, led by Andrew Howe, Director of Public Health in Harrow, to see what scope there is for a West London public health service. Brent is keen to share public health responsibilities where it makes sense to do so and is in discussions with other boroughs about sharing the procurement of some services.

3.23 The Public Health Transfer Project has a number of dependencies, not least the future commissioning arrangements for health and social care services. Much of Brent's public health budget that will be transferring to the council is spent on commissioned "health" services, such as drug and alcohol treatment services and sexual health services. Logic suggests that public health is included in any joint health and social care commissioning arrangement that the council signs up to rather than developing separate commissioning arrangements. The time taken to develop joint commissioning arrangements has meant that it has not yet been possible to finalise the model for public health that Brent will implement.

3.24 By the end of March 2012 councils and PCTs will be expected to agree a public health transition plan and a memorandum of understanding to manage the transfer. Whilst the plan doesn't have to include a definitive version of the new model for public health, or details on staff transfers, it is hoped that there is more clarity about

the emerging health and social care commissioning landscape which can be reflected in the transition plan.

3.25 In the coming months it will become clearer how public health teams and staff are to be integrated into the council. There will be full consultation with affected staff and Trade Unions on the transfer and decisions over structure and the model in Brent will be approved by members so they are clear how the new service will operate and be run once it is transferred to the local authority. At this stage, as the preferred model and structure is not finalised it would be inappropriate to go into details because of the need to follow the process and ensure staff are informed and consulted.

4. Conclusions

4.1 The Health Partnerships Overview and Scrutiny Committee should consider this update and question officers on progress with the transfer of public health functions to the council. Further updates can be presented to the committee later in the year, so that members are able to scrutinise plans for the emerging model and service.

Contact Officers:

Phil Newby, Director of Strategy, Partnership and Improvement
Tel – 020 8937 1032
Email – phil.newby@brent.gov.uk

Simon Bowen, Acting Director of Public Health, NHS Brent
Tel – 020 8795 6747
Email – Simon.Bowen@brentpct.nhs.uk

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

	Health Partnerships Overview and Scrutiny Committee 27th March 2012 **Report from the Director of Strategy, Partnerships and Improvement**
For Action	Wards Affected: ALL
Shaping a Healthier Future Update	

1.0 Summary

1.1 Members will recall that at the Health Partnerships Overview and Scrutiny Committee on the 7th February 2012 Rob Larkman, Chief Executive of NHS Brent and Dr Mark Spencer, Medical Director at NHS North West London, gave a presentation on the Shaping a healthier future project. Shaping a healthier future is NHS NWL's plan to reconfigure health services in the cluster, in both the acute and primary care sectors. A public consultation on the proposals is to take place from June 2012. At present the project is in the pre consultation stage, where options for change are being developed.

1.2 Since the committee's last meeting a further briefing with health scrutiny councillors in North West London has taken place. A meeting was held on the 29th February 2012, attended by Cllr Ann Hunter (representing the Health Partnerships OSC) where members received an update on the project. The slides from this meeting are included as an appendix to this report.

1.3 As well as receiving an update on the project, members had the opportunity to discuss the establishment of a Joint Health Overview and Scrutiny Committee for North West London to scrutinise the proposals. The majority of boroughs in the cluster have informally committed to taking part in a JOSC, although the details and arrangements for its operation are still to be worked out. An update will be provided verbally at the committee on the 27th March.

1.4 At this stage members are asked to note the progress with the Shaping a healthier future project, and the arrangements being put in place to form a North West London Joint Health Overview and Scrutiny Committee to scrutinise the proposals once consultation begins in June 2012.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to consider the slides provided by NHS North West London on the Shaping a healthier

future project and note the progress to date. An update on the establishment of a Joint Health Overview and Scrutiny Committee for North West London to scrutinise the proposals will be reported verbally at the meeting.

Contact Officers

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

Phil Newby
Director of Strategy, Partnerships and Improvement
Tel – 020 8937 1032
Email – phil.newby@brent.gov.uk

HOSC briefing session

Anne Rainsberry, Chief Executive
Dr Mark Spencer, Medical Director
Daniel Elkeles, Programme Director
29 February 2012

Shaping a healthier future

NHS
North West London

Welcome

Anne Rainsberry, Chief Executive

Shaping a healthier future

NHS North West London

Agenda

1. Welcome and purpose of meeting

2. Update on programme since last meeting
   - Feedback from 15 February event
   - Clinical standards and service delivery models
   - Out of Hospital standards

3. JHOSC powers and remit
   - JHOSC/HOSC powers
   - Timelines
   - Principles of engagement and engagement to date

5. Discussion and next steps

Update on *Shaping a healthier future*

Daniel Elkeles, Programme Director

Shaping a healthier future

NHS North West London

Stakeholder engagement event – 15 February

- More than 200 patients, clinicians and public representatives attended the engagement event at Lords Cricket Ground
- Event attendees were generally accepting of the case for change and there was strong acceptance of the clinical standards with a desire to increase their scope in certain areas
- There was enthusiasm displayed towards our plans for the transformation of Out of Hospital services with a request for further information and reassurance around their deliverability and timing
- An event report is being prepared capturing all feedback from the day and this will be used to inform the evaluation of options for change and the ongoing development of clinical and out-of-hospital standards

Stakeholder engagement event – 15 February

Feedback from patients, patient representatives and members of the public:

Patients, patient representatives and public at the morning session indicated they were pleased to be involved in the discussions at this early stage.
Main points raised included;

- Transport and access to services is a major concern
- Need for clarity about resource for the programme and £1bn funding gap
- Must be a 'real' opportunity to influence change and not a tick-box exercise
- Need for clarity around EHT/NWLHT merger and how this relates to the programme

Stakeholder engagement event – 15 February

Feedback from clinicians:

Clinicians at the afternoon session raised some concerns about the overall pace and scale of change, particularly as this is taking place through a period of transition.

They highlighted some reservations about whether proposed standards are deliverable:

- Proper integration of health and social care will need careful handling and committed joint-working; as will sharing of resources between hospital and out-of-hospital providers

- Integrated IT systems are essential in order to facilitate integrated working and this will also present a significant practical challenge.

Stakeholder engagement event – 15 February

Feedback from patients and clinicians:

Throughout both sessions, attendees emphasised the importance of integrating with other aspects of acute care, eg. mental health work, cancer services, end-of-life care. They also expressed the importance of ensuring plans are followed through in their entirety.

When looking at the evaluation criteria for the options for change, ‘Quality of Care’ was selected as the most important criteria by attendees at both the morning and afternoon session. This was followed, in both sessions, by ‘Patient Experience’.

Clinical standards

Dr Mark Spencer, Medical Director, NHS NWL

Dr Mike Anderson, Medical Director, C&W

Shaping a healthier future

NHS North West London

What has the programme done so far on acute vision and clinical standards?

- Clinical Board has agreed the vision and reviewed a long list of clinical standards, selecting the most important standards
- Reviewed service dependencies across services to design service models
- Focussed further on areas that impact the configuration of hospitals in North West London
  - Emergency Surgery
  - Maternity
  - Paediatrics (Children)
- Separate clinical groups have discussed Paediatrics and Maternity and agreed visions

The basis for our vision of care in the future

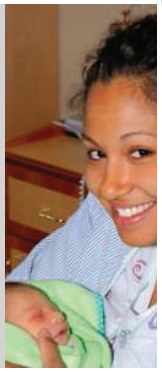
Three overarching principles underpin our vision for care

1. **Localising** routine medical services means better access closer to home and improved patient experience
2. **Centralising** most specialist services means better clinical outcomes and safer services for patients
3. Where possible, care should be integrated between primary and secondary care, with involvement from social care, to ensure **seamless** patient care

Acute visions for specific areas

A&E and Emergency Surgery

Maternity

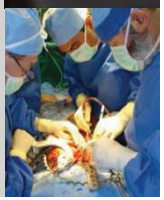


Children

- Patients that require basic urgent care should **be able to access**, **their own GP** (if this is not feasible, through a neighbouring GP practice or an Urgent Care Centre)
- If patients need to go to hospital, they should have **quick access to high quality urgent care through an A&E** backed up by appropriate services, e.g.
  - 24/7 Emergency Surgery and intensive care
  - Diagnostic services needed to assess their condition
- Patients should be able to receive the best quality care delivered by the right person **regardless of the time or day of the week**

Acute visions for specific areas

A&E and Emergency Surgery



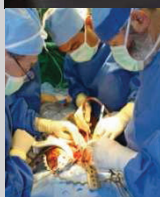
Maternity

- Expectant mothers should have the **choice** to deliver their baby in a hospital or in the home environment if it is appropriate
- If expectant mothers are at risk or have a complicated birth they need to have **immediate access to supporting services** such as emergency surgery, anaesthetics and other services
- Expectant mothers should be able to receive the best quality care delivered by the right person **regardless of the time or day of the week**

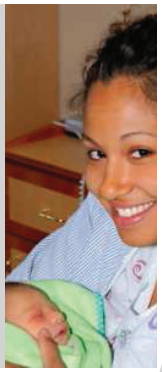
Children

Acute visions for specific areas

A&E and Emergency Surgery



Maternity



Children

- Parents and those responsible for children who require urgent care should **be able to access, their own GP** (when this is not feasible, through a neighbouring GP practice or an Urgent Care Centre)
- When it is necessary to go to hospital, children should have **quick access to high quality paediatric care** and care decisions should be made by a **senior and experienced** clinician regardless of the time of day or day of the week

We have been identifying clinical standards for acute care

Standards definition

- **The standards describe what we expect hospitals to deliver in order to improve the quality of care and outcomes for patients**
- **They could be related to:**
  - Clinical staff availability
  - Clinical staff level of experience
  - Patient experience
  - Volume of service
  - Etc.

Work has been conducted prior to this programme…

- **Clinical Working Groups**
  - Work in 2009/10 established a set of principles
- **Cluster**
  - Compiled list of clinical standards for certain pathways in the Commissioning Strategy
  - Identified a reduced list of standards that were core to specific pathways
  - Worked with clinicians to begin identifying standards that could be used to support commissioning on quality
- **NHS London**
  - Reviewing standards that could be used to support delivery of high quality care across London

For this work, only standards that impact clinical configuration are being reviewed

Emergency Surgery and A&E standards (1/2)

EXAMPLE

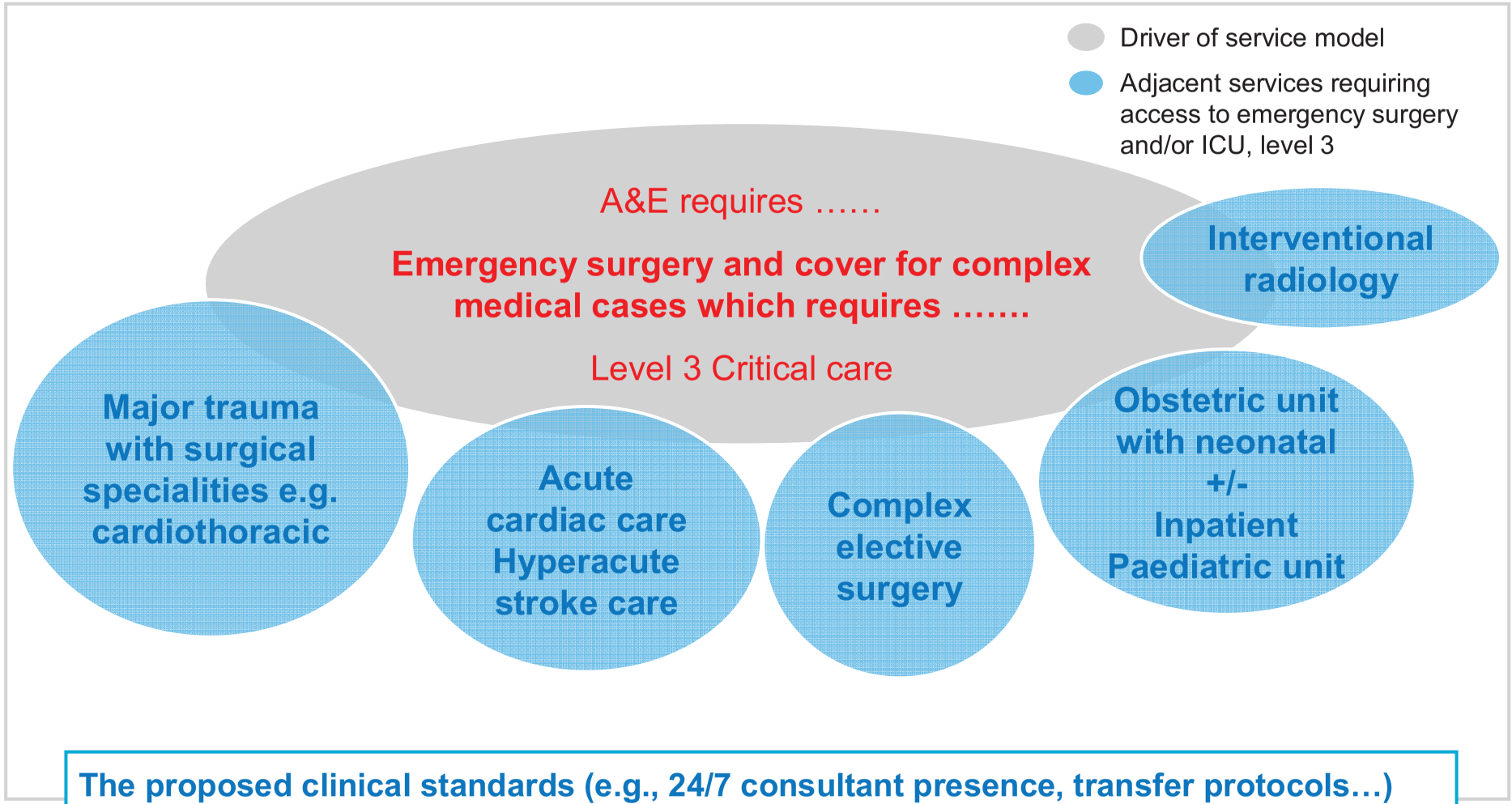
Access to Senior and Specialist Skills	▪ All emergency admissions seen and assessed by relevant consultant within 12 hours of decision to admit or within 14 hours of arrival time ▪ When on-take for emergency/acute medicine and surgery, a consultant and their team to be completely freed from any other clinical duties/ elective commitments that prevent them from being immediately available ▪ Any surgery conducted at night should meet NCEPOD requirements and be under the direct supervision of a consultant surgeon ▪ All hospitals admitting emergency general surgery patients should have access to an emergency theatre immediately and aspire to have an appropriately trained consultant surgeon (e.g. laparoscopic) on site within 30 minutes, day or night ▪ All hospitals admitting medical and surgical emergencies should have access to all key diagnostic services (e.g. interventional radiology) in a timely manner 24/7 to support clinical decision making ▪ Single call access for mental health referrals should be available 24/7 with an aspired maximum response time of 30 mins

Shaping a healthier future

There is more detail on other examples in the handouts

NHS North West London

Interdependencies between services help determine what service delivery models are clinically viable

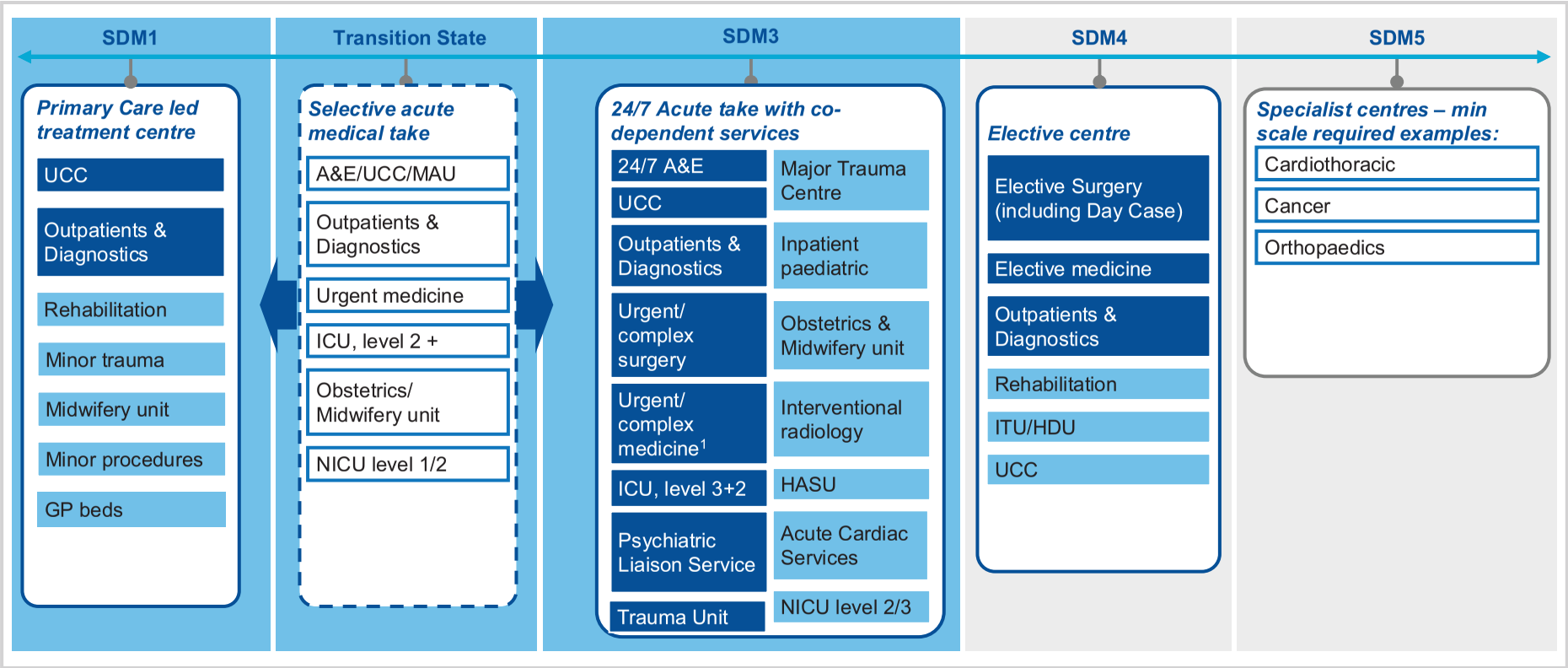


The proposed clinical standards (e.g., 24/7 consultant presence, transfer protocols…) inform some service interdependencies and drive creation of the options

Service Delivery Models will form the basis of viable configuration options

Optional service
Essential service

Range of services delivered in different Service Delivery Models (SDM)



1 Patients who have medical conditions which require a very broad range of co-located medical specialties to be managed (e.g., multi system comorbidities), or have rare or very severe forms of disease (e.g., extremely brittle asthma); also provides support for surgical patients with complex co-morbidities

Shaping a healthier future

NHS North West London

Shaping a healthier future

The vision for Out of Hospital care

Shaping a healthier future

NHS
North West London

Background

Across NWL, CCGs have identified the critical opportunities to delivering high quality and cost effective care outside of hospital to improve care for patients as well as support the wider changes required across the health economy.

The Standards support and drive the changes required to secure high quality and productive care outside of hospital by:

- Setting our **aspirations for the future** and outline the changes required over the next 3-5 years;
- Focusing on the areas that will **drive how services are delivered** by **all out of hospital providers**;
- Shifting care delivery from reactive unplanned care to **more proactive planned care;**
- Emphasising **the central role of the GP** in the coordination and delivery of out of hospital care and **going beyond current contractual obligations** of all out-of-hospital providers.

Process for developing the Standards

An iterative process has been underway to develop the Standards with a wide range of stakeholders across the health and social care community and patients and the public in NWL

Core Team development of the Standards	Key groups within the NWL programme governance	Engagement with patients and the public	Engagement with the wider clinical community
▪ Core Team developing the Standards includes **NWL Medical Directors**	▪ Work overseen by the **Out-of-Hospital Working Group**, comprising CCG chairs, Acute Trusts, Community Trusts, Social Care ▪ Detailed review by **NWL Clinical Board** ▪ Detailed input from **NWL CCG chairs** individually	▪ Detailed workshop session with **more than 150 patient and public representatives** on 15 February ▪ Detailed input from **NWL Patient and Public Advisory Group** (PPAG)	▪ Detailed workshop session with **more than 100 NWL clinicians** on 15 February ▪ Standards to be shared more widely across CCGs as part of developing local plans

Progress to date

The Standards consist of four key domains, with a total of 13 proposed standards for quality in out-of-hospital care. Detailed work is currently underway on developing metrics and a NWL patient survey to monitor performance.

Individual Empowerment & Self Care	Individuals will be provided with up-to-date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and wellbeing
Access, Convenience & Responsiveness	Out of hospital care operates as a seven-days-a-week service. Community health and care services will be accessible, understandable, effective and tailored to meet local needs. Service access arrangements will include face-to-face, telephone, email, SMS texting and video consultation.
Care Planning & Multidisciplinary Care Delivery	Individuals using community health and care will experience coordinated, seamless and integrated services using evidence-based care pathways, case management and personalised care planning. Effective care planning and preventative care will anticipate and avoid deterioration of conditions
Information & Communication	With an individual's consent, relevant parts of their health and social care record will be shared between care providers. Monitoring will identify any changing needs so that care plans can be reviewed and updated by agreement. By 2015, all patients to have online access to their health records

Next steps

Next steps focus on agreeing the proposed Standards, aligning the standards with CCG local plans for out-of-hospital care, preparing for implementation and performance monitoring

- Presentation of draft standards to NWL Clinical Board (1 March) and NWL Reconfiguration Programme Board (15 March)
- Wider circulation to CCGs and alignment with local out-of-hospital plans, including implementation and investment required (by end March)
- Development of an innovative approach for measuring performance and outcomes, including a NWL patient survey to capture feedback from individuals through a variety of channels (March-April)
- Continued engagement with key groups to ensure the Standards and patient outcomes are widely understood (March-April)

JHOSC powers

Daniel Elkeles, Programme Director

Shaping a healthier future

NHS North West London

Why form a JHOSC?

- This is one of the largest reconfigurations planned in London: 8 boroughs, 2 million people, 9 acute and 5 specialist hospital sites, 423 GP practices, 2 mental health and 4 community care providers
- The plans need to be scrutinised as a cross-boundary integrated programme, and not as individual plans divided by borough or other boundaries
- Plenty of precedent in London of this working very effectively – *Healthcare for London* programme on stroke and trauma across the capital actually had a pan-London JHOSC representing all 33 local authorities; *A picture of Health* in SE London had a JHOSC representing all four boroughs
- A JHOSC is required under legislation where any proposed health changes affect more than one local authority area – it has more power than individual HOSCs and other scrutiny bodies such as Health and Wellbeing Boards and Healthwatch

What a JHOSC can do

(Health and Social Care Act 2001, Regulations 2002, Directions and Guidance 2003)

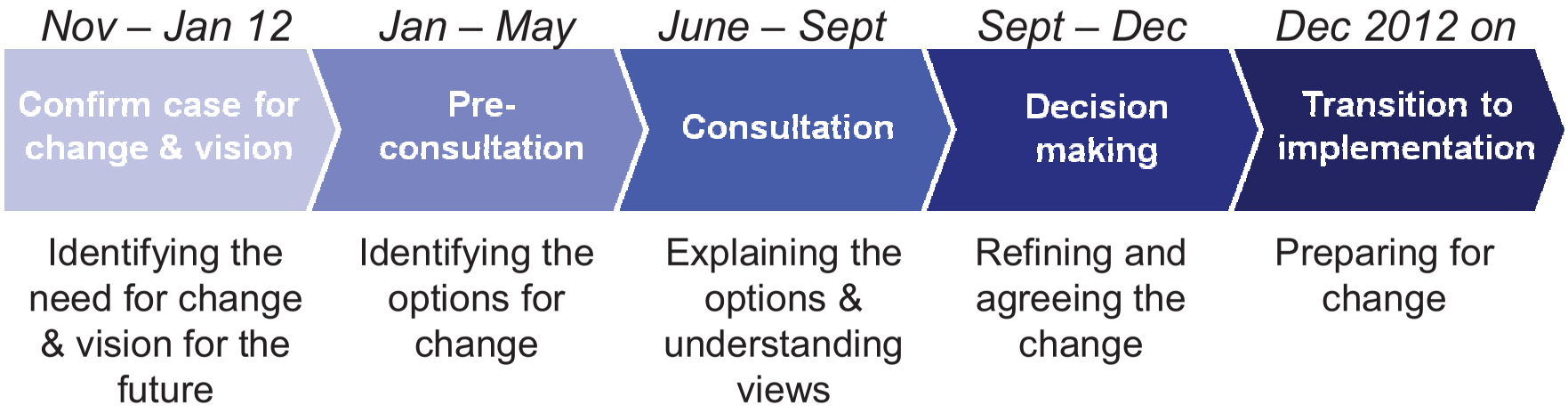
- Make comments on proposals across a wider area through delegated authority by individual HOSCs
- Require the local NHS body to provide information about the proposals in any of the 8 boroughs
- Require an officer of the local NHS body to attend to answer questions in relation to any of the proposals
- Require a response from the NHS to any queries within 28 days
- Make comments on the proposed option (s) to take to consultation and on the consultation plan, including the length of the consultation period
- Produce a single report which should aim to consider the proposals from the perspective of all boroughs affected but should aim to be consensual. This does not preclude each OSC from responding to the consultation individually
- Good practice suggests running costs are shared among all participating Local Authorities

What a JHOSC cannot do

- Undertake any functions beyond those agreed by the individual Local Authorities who appointed it
- Replace the right of individual HOSCs to refer
- Comprise members who do not reflect the political balance of the appointing Local Authorities – unless members of all authorities involved agree to waive that requirement

Programme timeline and key milestones

Our high level proposed timeline:



Next major milestone:

23 March – Second clinical and public engagement event

A chance to discuss and refine the options for change

Required timeline for JHOSC formation

- The programme timeline means that a JHOSC should ideally form as soon as possible so that there is ample time to discuss proposals as they are developed
- At the 15 March Programme Board, the 'medium list' of options will be discussed
- The next Programme Board meetings are on 12 April and 10 May – consultation will start in June
- The JHOSC should meet 8-10 days before each Programme Board to allow time for its comments to be taken into account and reflected in any meeting papers
- Sufficient time then needs to elapse for views on the consultation plan to be taken into account – especially on options for consultation and how these are included in the consultation document, which then needs to be printed and distributed
- This means any JHOSC needs to form **by the end of March** if its views are formally to influence the consultation plan as required in the Act

Proposed HOSC/JHOSC timeline and briefing sessions

Meeting	Date	Purpose	Proposed discussion points
Informal HOSC briefing	16 Jan *(complete)*	▪To brief OSCs on programme	▪Case for change ▪Requirement to form JHOSC
Informal HOSC briefing	29 Feb	▪ To consider outputs of 16 Feb Prog Board mtg and 15 Feb engagement event ▪ To inform Prog Bd mtg on 15 March	▪Clinical standards (inc OOH) ▪Service models ▪Process and timeline for JHOSC formation and engagement
First briefing of newly formed JHOSC	w/c 2 April	▪ To consider outputs of 15 Mar Prog Board mtg ▪ To inform Prog Bd mtg on 12 April	▪Draft short list of options ▪Benefits framework
JHOSC	w/c 30 April	▪ To consider outputs of 12 April Prog Board meeting ▪ To inform Prog Bd mtg on 10 May	▪Short list of options ▪OOH strategies ▪Draft consultation plan
JHOSC	w/c 14 May	▪ To consider outputs of 10 May Prog Board mtg ▪ To inform Prog Bd mtg on 24 May	▪PCBC / consultation options ▪Draft consultation document ▪Draft consultation plan

Engagement to date and principles

Anne Rainsberry, Chief Executive

Shaping a healthier future

NHS North West London

Engagement with individual HOSCs to date

HOSC	Meeting	Notes
Kensington & Chelsea	25 JAN	Mark Creelman attended. Further information & clarification needed around the formation of a JHOSC
Ealing	26 JAN	Jenny Durandt (Ealing CCG) attended. Programme not discussed CCG Chair, Mohini Parmar, will present commissioning intentions on 8th March
Westminster	6 FEB	Andrew Pike, Karen Broughton & Mark Spencer attended Programme and requirement to form a JHOSC discussed
Brent	7 FEB	Rob Larkman and Mark Spencer attended Further clarification requested on distinction between programme and merger
Harrow	7 FEB	Daniel Elkeles attended Discussed the case for change and requirement to form a JHOSC.
Hounslow	14 FEB	Programme did not attend but now invited to attend possibly 20 March
Hillingdon	22 FEB	Mark Spencer and Nick Relph attended
H&F	22 FEB	Tim Spicer attended

Our principles of engagement

Throughout this programme, our lead clinicians and programme leaders are committed to

- **listening** to our patients and staff throughout the process
- **consulting** openly and transparently with all interested parties about our plans
- **responding** to all requests for meetings or information
- so long as those requests are **relevant**, **reasonable**, and provide us with a **reasonable timescale** within which to respond or arrange a meeting

In the specific case of HOSCs/JHOSCs

- responses are required within 28 days
- we would commit to meeting monthly and to consider any views submitted 8-10 days prior to any Programme Board meetings

Discussion / next steps

Shaping a healthier future

NHS North West London

	Health Partnerships Overview and Scrutiny Committee 27th March 2012 **Report from the Director of Strategy, Partnerships and Improvement**
For Action	Wards Affected: ALL

Proposed merger of North West London Hospitals NHS Trust and Ealing Hospital NHS Trust

1.0 Summary

1.1 Members will recall that at the previous meeting of the Health Partnerships Overview and Scrutiny Committee councillors asked that a letter be sent to North West London Hospitals NHS Trust and Ealing Hospital NHS Trust setting out the committee's views on the plans for the two organisations to merge. This was done and approved by the chair and vice chair of the Health Partnerships OSC. The letter is included as an appendix to this report for members' information. North West London Hospitals NHS Trust has responded to the letter, and their response is included as an appendix.

1.2 The next milestone in this project will be the publication of the Full Business Case for the merger. This will be presented to the two hospital trust boards at the end of March 2012. As the FBC is unavailable for the scrutiny committee meeting, a briefing note has been prepared setting out the developments with the project since the committee met in February 2012. This is also included as an appendix to this covering note for information. Details on the Full Business Case can be presented to a future meeting if members want to consider this.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to note the letter sent to the hospital trust boards in February 2012 on the merger proposals and the briefing note that has been provided for information. A report on the Full Business Case should be requested if the committee wants to consider this when it meets next.

Contact Officers

Andrew Davies
Policy and Performance Officer
Tel – 020 8937 1609

Email – andrew.davies@brent.gov.uk

Phil Newby
Director of Strategy, Partnerships and Improvement
Tel – 020 8937 1032
Email – phil.newby@brent.gov.uk

Contact Officer:
Andrew Davies
Strategy, Partnership & Improvement
Room 221, Brent Town Hall
Forty Lane, Wembley
Middlesex HA9 9HD

TEL 020 8937 1609
FAX 020 8937 1050
EMAIL andrew.davies@brent.gov.uk

WEB www.brent.gov.uk

16th February 2012

Mr Peter Coles
Acting Interim Chief Executive
North West London Hospitals NHS Trust
Northwick Park Hospital
Watford Road
Harrow
HA1 3UJ

Dear Peter

Proposed merger of North West London Hospitals NHS Trust and Ealing Hospital NHS Trust

The Health Partnerships Overview and Scrutiny Committee has spent a significant amount of time in recent months considering the proposal to merge North West London Hospitals NHS Trust and Ealing Hospital NHS Trust. This is an important development in the North West London health sector and an issue which has warranted our attention and scrutiny. The committee is conscious that there isn't going to be a formal public consultation on this matter, but I have been asked to write on the committee's behalf setting out our views on the plans so that these can be presented to the trust's boards when they consider the Full Business Case for the merger.

The Health Partnerships Overview and Scrutiny Committee understands the clinical and financial reasons driving the merger proposal. The arguments are persuasive and it is clear to members that a merged organisation has a greater chance of meeting the quality requirements commissioners will expect in the future. However, there are concerns that at this time when the future commissioning landscape in North West London is still unknown there are no guarantees that what emerges from the "Shaping a Healthier Future" project will lead to a sustainable future for the merged trust. We would not want the merger to go through only for the new trust to face similar clinical and financial problems that the separate trusts are currently dealing with.

In our committee meetings and in the informal meeting with Harrow and Ealing scrutiny councillors, a number of concerns about the merger and the implications for patients have been raised. Some of these remain, including:

- Patients could be required to travel longer distances to access services. Although it is hoped that more services will be delivered in community settings away from the main hospital sites, access could be a problem for some patients depending on how services are reorganised. We hope that this issue is monitored and expect the trusts take into account the impact of its plans on patients travel times.

- Increased investment in community services is crucial for the success of the merged organisation. Although the principle of investing one third of savings from the acute sector into

community services had been explained (with a possibility that the proportion of reinvestment into community services changes when the Full Business Case is developed), implementation of this policy is of great importance to members. Already we are hearing informally that community services are struggling to cope with demand. Expecting them to do more without making the necessary investments in staff, equipment and technology will lead to a worse service for patients, increases in patient dissatisfaction and ultimately greater pressure on hospitals as services in community settings fail to prevent admissions. Again, the committee will be looking to the new trust to provide evidence of its plans for investment in community services.

- Concerns about Northwick Park's ability to cope with an increase in patients, particularly to A&E have been highlighted throughout discussions on the merger. The merger will leave the new trust with three A&Es – it is not unreasonable to assume that at least one of these will close leaving the remaining units to absorb a greater workload. Councillors would like assurance that Northwick Park can cope with an increase in patients. Making better use of Central Middlesex Hospital and expanding the range of services delivered from the site would be welcomed by the committee. It has been suggested that it could become a planned care centre, where it is not competing for resources with emergency services. Members would welcome this development if it ensures a viable future for Central Middlesex Hospital and takes some of the pressure off Northwick Park.

- An Equalities Impact Assessment hasn't been published with the Outline Business Case. This raises a number of concerns, not least how the merger proposal could have an impact on vulnerable groups who are more reliant on hospital services than others. Without a thorough assessment of the equalities implications of the merger, we are concerned that there could be unforeseen consequences that have a detrimental impact on service users. This should be remedied when the Full Business Case is published, which we hope will contain an Equalities Impact Assessment.

The work on the merger has taken place independently of NHS North West London's work on service change. We understand that for modelling purposes four service change scenarios have been included in the Outline Business Case to demonstrate that the merged organisation would be clinically and financially sustainable if service changes take place and it loses income. There are no guarantees that NHS North West London will want to continue commissioning the range of services it does from a merged trust and that one of the four models, or a variation thereof, could be implemented at some stage. Commissioners have endorsed the Outline Business Case and the trusts are confident that the Full Business Case will be endorsed when it's published. We also understand that you will be working with commissioners to promote the benefits of integrated community and acute services. But until commissioner's work on "Shaping a Healthier Future" is complete, there will be a degree of uncertainty about the acute service landscape in Brent and members are concerned about this. Although the two processes are separate, to councillors it seems that the success of the new trust will be dependent on the "Shaping a Healthier Future" project, as this will have such a significant impact on the acute sector in North West London.

I hope that this letter can be presented to the boards of both North West London NHS Hospitals Trust and Ealing Hospital NHS Trust when they consider the Full Business Case for the merger. If you have any questions about the points raised please do not hesitate to get in touch.

Yours sincerely

Councillor Sandra Kabir
Chair, Health Partnerships Overview and Scrutiny Committee, Brent Council

Cc Julie Lowe, Chief Executive, Ealing Hospital NHS Trust
Simon Crawford, SRO, Organisational Futures Project
David Cheesman, Director of Strategy, North West London Hospitals NHS Trust
Mansukh Raichura, Chair, Brent LINk
Councillor Ann Gate, Chairman, Health and Social Care Scrutiny Sub-Committee, Harrow Council
Councillor Abdullah Gulaid, Chair, Health and Adult Social Services Standing Scrutiny Panel, Ealing Council

This page is intentionally left blank

Ealing Hospital NHS Trust

Trust Headquarters
Ealing Hospital, Uxbridge Road
Southall, Middlesex
UB1 3HW
Tel: 020 8967 5492

The North West London Hospitals NHS Trust

Trust Headquarters
Northwick Park Hospital
Watford Road
Harrow, HA1 3UJ
Tel:020 8869 2002

Wednesday 7 March 2012

Councillor Sandra Kabir
Chair, Health Partnerships Overview and Scrutiny Committee
Brent Council, Brent Town Hall
Forty Lane
Wembley
Middlesex HA9 9HD

Dear Councillor Kabir

Proposed merger of Ealing Hospital NHS Trust and The North West London Hospitals NHS Trust

Thank you for your letter dated 16 February regarding the Health and Social Care Scrutiny Sub-Committee's response to the proposed merger of The North West London Hospitals NHS Trust and Ealing Hospital NHS Trust.

Can I firstly take this opportunity to thank you and your panel members for engaging with us on the proposals and enabling us to have thorough discussions about the proposed merger. We look forward to continuing to work with you as we move forward.

I note the issues you raise and that your members understand the clinical and financial reasons driving the merger proposal. We also believe a merged organisation has a greater chance of meeting the quality requirements and standards patients and commissioners will expect in the future.

I was not planning on addressing all the specific issues you raise in your letter, given that these have been discussed previously, but I would like to re-iterate our commitment to ensuring that any transport and access issues which arise from the merger are adequately addressed.

In terms of your concerns relating to Northwick Park Hospital's ability to cope with any additional patients as a result of the merger, you will appreciate there are no current plans to transfer significant numbers of patients as a result of the merger. NWLH is, however, in the process of implementing a number of measures to improve capacity as a result of recent increases in demand for emergency services and also the development of more specialist services such as stroke.

For example, the Trust is looking at how it can transfer more work to Central Middlesex to free up capacity at Northwick Park Hospital and is opening a new re-modelled 24/7 urgent care centre at Northwick Park Hospital. The Trust has also recently been successful in securing provisional agreement for additional capital monies, subject to submission of a business case, to enable building improvements to the Northwick Park A&E department.

Whilst the merger is not making the case for significant services changes, I hope the above provides assurance regarding measures being taken now to improve capacity at the Northwick Park Hospital site.

I note you raise the issue of an equality impact assessment and I can confirm that an initial equality analysis has been carried out on the Outline Business Case (OBC) and will be included in supporting documentation of the Full Business Case (FBC). In the lead up to the merger, a full equality impact assessment will also be carried out on the FBC.

We are aiming to present the FBC to both Trust Boards at the end of March. Your letter will be included in the supporting papers submitted to the Boards as part of the consideration process. Subject to approval by the two Trust Boards, the FBC will then be submitted to NHS London and the Department of Health for final approval, along with all the stakeholder letters we have received.

We will of course ensure that you are sent a link to our websites once a copy of the FBC becomes publicly available and would also welcome the opportunity to discuss the business case at one of your future meetings which is in the process of being organised.

Yours sincerely,

Peter Coles
Interim Chief Executive

cc. Julie Lowe CEO, Ealing Hospital NHS Trust and Simon Crawford, SRO for Organisational Futures Programme

Ealing Hospital NHS Trust | The North West London Hospitals NHS Trust

Brent Health Partnership Overview and Scrutiny Committee

Update for meeting on 27 March 2012

Organisational futures: Proposed merger of Ealing Hospital NHS Trust with The North West London Hospitals NHS Trust

---

The following provides an update for members of the Brent Health Partnership Overview and Scrutiny Committee regarding the proposed merger of Ealing Hospital NHS Trust with The North West London Hospitals NHS Trust.

Full Business Case

The merger programme team submitted the Full Business Case (FBC) with embedded appendices and supporting documentation, including the Long Term Financial Model (LTFM), key strategies and Post Implementation and Integration Plans (PMIIPs) to NHS London on 9th March in line with the revised submission deadline.

The FBC updates the Outline Business Case (OBC), ensuring that any material changes to financial assumptions are incorporated and further refines the case for change. It sets out plans for developing the new organisation, demonstrating readiness for day one and describing the path to full integration. It also documents the assurance processes undertaken by both organisations to enable existing Trust Boards to discharge their duties and to provide necessary information to the Board of the new organisation.

The next milestone is the presentation of the FBC to both Trust Boards on 29th March for approval. Assuming the FBC gains approval from Trust Boards it will formally be reviewed by the NHS London Board and the NHS North West London Board prior to submission to the Department of Health Transactions Board in May/early June. Following the submission to NHS London on 9th March they have begun their assurance process which also completes end of March 2012.

The proposed merger date is 1st July 2012.

Simon Crawford
Senior Responsible Officer, Organisational Futures Programme Board
15 March 2012

This page is intentionally left blank