Public Document Pack

Health Partnerships Overview and Scrutiny Committee

Tuesday 9 October 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)	Cheese	Ms Shaw
Colwill	Baker	Kansagra
Gladbaum	Ketan Sheth	Van Kalwala
Harrison	Naheerathan	Singh
Hector	Aden	Al-Ebadi
Hossain	Ogunro	RS Patel
Leaman	Sneddon	Clues

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

recycle for Brent

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members

Item		Page
1	**Declarations of personal and prejudicial interests** Members are invited to declare at this stage of the meeting, any relevant financial or other interest in the items on this agenda.	
2	**Deputations (if any)**	
3	**Minutes of the previous meeting**	1 - 10
4	**Matters arising (if any)**	
5	**Care UK Urgent Care Centre - Serious Incident Report** This item was deferred from the meeting in July 2012 because Care UK were not in attendance and because the report provided focussed on safeguarding issues rather than an explanation of what caused the problems at the UCC and how they have been addressed. A further report now attached, has been provided by NHS Brent and Care UK representatives will be present at the committee meeting on the 9 October for this item.	11 - 22
6	**Accident and Emergency Services at Central Middlesex Hospital** This report from North West London NHS Hospitals Trust provides information to members of the Health Partnerships Overview and Scrutiny Committee on the position regarding A&E services for their consideration and comment.	23 - 28
7	**North West London NHS Hospitals Trust and Ealing NHS Hospital Trust merger update** The attached report updates members on the latest position regarding the merger of North West London NHS Hospitals trust and Ealing Hospital Trust which was expected to be completed by January 2013.	29 - 32

8	**Shaping a Healthier Future - Health Partnerships OSC response (to follow)**	
9	**Sharing a Director of Public Health and proposed structure for the Brent Public Health Service**	33 - 46
	This paper sets out the business case for Brent and Hounslow's proposal to share a DPH as well as the proposed structure for public health and how staff will be integrated into the current officer structure once it transfers to Brent Council from NHS Brent takes place.	
10	**Health Partnerships Overview and Scrutiny Committee Work Programme**	47 - 56
11	**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.	
12	**Date of Next Meeting**	
	The next scheduled meeting of the Committee is on 27 November 2012.	

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
Wednesday 18 July 2012 at 7.00 pm

PRESENT: Councillor Kabir (Chair), Councillor Hunter (Vice-Chair) and Councillors Gladbaum, Harrison, Hector, Hossain and Leaman

Also present: Councillors Cheese, Hashmi, Hirani (Lead Member for Adults and Health) and R Moher (Deputy Leader/Lead Member for Finance and Corporate Resources).

An apology for absence was received from: Councillor Colwill

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

None declared.

2. **Minutes of the previous meeting held on 30 May 2012**

RESOLVED:-

that the minutes of the previous meeting held on 30 May 2012 be approved as an accurate record of the meeting, subject to the following amendments:-

Page one, under 'Also present', replace 'Councillor Mistry' with 'Councillor Hirani.'
Page one, under 'Others present': Add Dr Ethie Kong (Chair, Clinical Commissioning Group).

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

Recruitment of health visitors in Brent and Accident and Emergency waiting times

The Chair confirmed that information had been provided in respect of Councillor Hunter's query concerning domestic violence in an earlier recruitment of health visitors report and a request from the Chair for information in respect of the number of ambulance transfers and their transfer times for Central Middlesex and Northwick Park hospitals.

4. **Brent Improving Access to Psychological Therapies Service**

Dr Anupama Rammohan (Improving Access to Psychological Therapies [IAPT] Service) gave a presentation on the IAPT Service and explained that the main aims of the programme were:-

- Delivering evidence-based and time-limited psychological therapies for people with depression and anxiety disorders
- Increased access to services and treatments
- Increases health and wellbeing

- Patient choice and high levels of satisfaction
- Timely access
- Improved employment benefit and social inclusion

Dr Anupama Rammohan confirmed that more than 75% of primary care trusts were participating in the programme with only one trust in London not involved since the programme had been rolled out. She drew Members' attention to the IAPT programme's targets and key performance indicators as set out in the presentation. The clients who were treated by the service included those with mild to moderate anxiety and/or depressive orders and they were managed within a primary care setting. The clients benefitted from short term psychological interventions and the service did not focus on those with complex needs, risk issues or social problems. Dr Anupama Rammohan informed the committee of the treatments on offer, including 'Step 2', a telephone based service including guided self-help, brief intervention and group workshops with psychological wellbeing practitioners. 'Step 3' involved individual and group cognitive behaviour therapy (CBT) and counselling. Members heard that there had been 6,350 referrals to the service between December 2010 to May 2012, the second highest in North West London and the fifth highest in London overall. Service challenges included a high volume of referrals, waiting times and severity and the complexity of client cases affecting recovery rates whilst only having limited resources.

With regard to patient satisfaction, Dr Anupama Rammohan advised that the service user satisfaction survey evaluated in December 2011 revealed that 95% of service users felt involved in making choices about their treatment all or most of the time and 92% felt that they received the help they needed and happy with the care they had received. A key area of dissatisfaction was waiting times for initial contact, however service users were satisfied with waiting times for subsequent appointments. A GP satisfaction survey evaluated in March 20120 showed that 93% of GPs surveyed used the service often or very often and 82% were clear about the service criteria. Overall, GPs were satisfied with the service, however a key area of dissatisfaction was waiting times. Dr Anupama Rammohan confirmed that service directions for 2012 included improving quality in outcomes, communication, service processes and data recording.

Katherine Fraser-Jackson, a patient of the programme, was invited to address the committee to share her experiences. Katherine Fraser-Jackson explained that she had been diagnosed with an anxiety disorder in 2010 which had affected her Masters studies. Her GP had referred her to the service in 2010 following her being made redundant and having problems being able to sit through job interviews. Katherine Fraser-Jackson felt that short term psychological interventions had limited effect and that some patients had felt they had lacked service once they had been discharged from Brent Mental Health Service. She commented that she had been surprised when she had learnt at a Carers Forum that a psychological therapies service existed and felt that it needed greater publicity and that the service should be expanded in future.

Robyn Doran (Director of Operations) advised that initially it had been decided to take psychological services from a higher to a lower stream and that NHS London provided IAPT with trainees. However, increasing the number of IAPT workers would be at the expense of higher stream workers in the borough where there were

already limited resources, although it was acknowledged that demand for lower stream services was also increasing.

Tes Tesfa-Michael (Service Lead) stated that there had been five members of staff when IAPT commenced in 2010, however there would be twelve members by September 2012. She advised that those patients whose conditions had deteriorated could ask their GP to re-refer them back to the service and in future self-referrals would be available.

During discussion by Members, Councillor Gladbaum enquired how long the service was funded for and what was the annual budget provision. She also asked if the service linked up to other services such as adolescent services, particularly as early intervention had proven to be effective and anxiety and depression can be recurring events.

At this point, Councillor Leaman declared an interest as an employee of Young Minds, however he did not consider the interest prejudicial and remained present to consider this item. Councillor Leaman enquired if there were any transition processes between Brent Children and Adolescent Mental Health Service (CAMHS) and adult IAPT, or did such cases need to be re-referred. In noting that IAPT was under resourced despite the demand, he asked how this situation was being managed and what reassurances could be given with regard to reducing waiting times.

Councillor Hunter expressed surprise that action had not been taken earlier to reduce waiting times as this was a key factor and she expressed concern that the recovery rates were both lower than the London and national average.

The Chair suggested that the scope of the service's future could be discussed with the council as there were a number of inter-related issues that the council was also concerned with, such as housing.

In reply to the issues raised, Tes Tesfa-Michael informed Members that the initial IAPT budget had been £500k, although this would subsequently be increased to around £800k once the new budget was transferred and the contract was on a rolling basis. A new initiative was to be introduced which would involve closer work between IAPT and Brent CAMHS and a clearer process was to be drawn up to ensure that those who were to become adults would have access to help at an earlier stage. The IAPT Board was also making changes to ensure complex cases were thoroughly monitored and referred back to the Board where appropriate, including cases where there had not appeared to be a sufficient recovery. Improvements to the supervision of cases from the outset would also be undertaken. Tes Tesfa-Michael advised that recovery rates had improved recently and were around 41% at the last quarter. She added that boroughs that were performing better recovery rates, such as Westminster, had much larger resources than Brent.

Robyn Doran advised that the current rolling contract was a duration of three years and there was no indication that this would be terminated. IAPT also worked closely with the Primary Care Trust who invested in the service moderately and a good working relationship existed with partners. It was implicit within the contract about what the expected waiting times should be and these would be achieved

through re-designing the service and reducing bureaucracy. Robyn Doran advised that issues raised by the committee would be fed back to the Board.

Dr Anupama Rammohan explained that it would not be productive to reduce waiting times by cutting the amount of time for each appointment as this would fail to address the problems surrounding cases and would likely mean patients making even more appointments. Members also heard that a number of the cases also involved long term problems.

The Chair requested that this item be discussed at a future meeting updating Members on progress in improving the service.

5. **Care UK Serious Incident**

Mary Cleary (NHS Brent) introduced the item and confirmed that the Care UK investigation report submitted on 6 June had identified three major failings, these being:-

- There being poor handover procedures in relation to the high turnover of staff
- Governance issues, particularly in respect of escalations not being picked up
- Concerns about the robustness of Care UK's safeguarding procedures, staff's understanding and implementation of the safeguarding process and procedures and the need to undertake regular audits to validate staff's compliance with their duty of care in terms of safeguarding.

Mary Cleary stated that NHS Brent had been impressed by Care UK's honesty whilst carrying out the investigation and under the terms of the contract they had 28 days to comply to address the three failings. Consideration was being given about extending joint pathways and tightening up processes and discharge notices would be provided to GPs within 48 hours. A full action plan for safeguarding was to be implemented and would be overseen by a designated doctor and nurse. During the course of the investigation, Care UK had also undertaken an unannounced inspection. Members heard that Brent NHS was satisfied that the matter had been investigated thoroughly and raised awareness of a number of key issues.

Councillor Harrison asked if steps were being taken to address the high staff turnover. Councillor Leaman enquired if Brent NHS was satisfied at the speed of reporting by Care UK once a problem had been identified.

The Chair enquired why a Care UK representative had not attended this meeting and whether consideration was being given with regard to fining Care UK or re-tendering the Urgent Care Centre (UCC) contract.

In reply, Mary Cleary advised that Care UK had indicated that they would be unable to attend this meeting. In respect of staff turnover, this had been resolved at senior management level although problems in recruiting GPs remained and locum cover was needed. However, increased pay for GPs working in UCCs in London may assist in addressing this matter in future. Mary Cleary advised that Brent NHS had not initially been satisfied by Care UK's reporting of problems once they had been identified and these should have been reported earlier, however the new processes would lead to a better flow of information. Members noted that Care UK could not

be fined under the current terms of the contract, however changes to the contract were being considered.

The Chair requested that this item be deferred to the next meeting in order to give opportunity to ask questions to a Care UK representative on this matter and to provide to Members through Andrew Davies a copy of the Care UK report published on 6 June.

6. **North West London Hospitals NHS Trust and Ealing Hospital NHS Trust merger - Full Business Case**

David Cheesman (Director of Strategy, North West London Hospitals NHS Trust) introduced the item and explained that the Executive summary was currently in draft form which did not differ significantly from the previous draft. NHS London was broadly in support of the proposals but with conditions as outlined in the report, including securing funding of £96.5m additional funding from NHS Commissioners and the Department for Health. It was anticipated that the merger would be completed by January 2013 at the earliest.

Dr William Lynn (Consultant Physician, Ealing Hospitals NHS Trust) added that the clinical strategy involved bringing together community services into the same team to help facilitate out of hospital care and both clinical and acute services would be located together. No service changes were proposed in the merger's business case, however it was possible that the outcome of the shaping a healthier future programme may result in some changes later. Dr William Lynn advised that the business case was viable if there were to be no changes to services, however in the event that there were, the Trust would be in a better shape to accommodate these. The committee noted that the Cooperation and Competition Panel had decided that the merger presented no bar to competition.

Councillor Hunter queried why £96.5m costs were associated with the merger and was this inclusive of the £72m savings. Councillor Harrison enquired whether any service changes resulting from the shaping a healthier future would require additional financial resources. Councillor Leaman asked if the top slicing of PCT funding would have any impact on services.

The Chair enquired who would fund the merger costs and whether this would impact upon services and did Northwick Hospital remain in deficit.

In reply, David Cheesman advised that the £72m savings would be made within two years of the merger being implemented. The £96.5m merger costs were a one-off cost to help fund transitional support arrangements and provide the necessary liquidity for the Trust to achieve foundation status. Transitional costs included those associated with an IT merger, changes to the switchboard system and any redundancies. The Department of Health, North West London cluster of health trusts and the Strategic Health Authority would provide the funding for the merger costs and there would be no impact on services. One of the benefits of the merger was the recurring savings that would be made on an annual basis and in effect the merger was a 'spend to save' initiative. David Cheesman advised that the merger would make it easier to accommodate any changes to services, although at this stage it could not be predicted whether the shaping a healthier future programme would lead to such changes. Members noted that Northwick Park Hospital

remained in deficit and action was being taken to remedy this before proceeding with implementation of the merger.

The Chair requested that an update be provided on this item at the next meeting and that if any significant information emerged prior to this, that it be sent to Andrew Davies to disseminate to Members.

7. **Shaping a healthier future consultation**

Dr Mark Spencer (Brent NHS) presented this item and confirmed that the public consultation on shaping a healthier future was launched on 2 July. From the week starting 23 July, around 410,000 consultation leaflets would be distributed and there would also be road shows visiting all the boroughs involved.

During discussion, Councillor Hector stated that residents had expressed concern that since the closure of Accident and Emergency (A and E) services at Central Middlesex Hospital, they would require longer journeys to Northwick Park Hospital. She also sought clarification as to what services would be provided at Central Middlesex Hospital. Councillor Leaman sought views as to what services should be provided at Central Middlesex Hospital and at what stage had it been decided that A and E services were not viable at this location. Councillor Hunter acknowledged the model of care in respect of the major hospitals, however she expressed concerns that there would be pressure on waiting times at Northwick Park Hospital and she asked if there was confidence that the additional demand could be met. Councillor Gladbaum, in noting the preference for Option A in the consultation document, asked if there was flexibility within the consultation process to express preferences for the other options and she enquired whether there were any other public meetings planned in the borough apart from the one listed on 31 July. She also requested that all consultation responses be documented and evaluated.

The Chair confirmed that the public meeting scheduled for 31 July would take place between 1pm – 9pm at Patidar House and all were encouraged to attend and she asked what was planned for the meeting. In respect of UCCs, the Chair enquired whether all provided the same service.

In response to the issues raised, Dr Mark Spencer advised that the public meeting on 31 July would include a series of presentations, videos and question and answer sessions. He advised that patients who were seriously injured in the south of the borough were most likely to be transferred to the A and E at St Mary's Hospital in Paddington. Steps were taken to ensure that any patient was sent to a site with the most relevant services depending on the nature of the problem. Dr Mark Spencer advised that Central Middlesex Hospital would provide non-emergency elective care and also the UCC, however the UCC contract would be reviewed to consider what could be provided in future. The committee heard that an A and E unit at Central Middlesex Hospital could not be sustained because it lacked the range of support services to assist such facilities.

Dr Mark Spencer was confident that the success of the UCC at Central Middlesex Hospital would help Northwick Park Hospital cope with demand and there would also be an increase in bed capacity at Northwick Park Hospital. All UCCs needed to perform to an agreed standard, although there may be some variation of services available at individual UCCs, however all UCCs had measures in place to ensure

rapid transfer to A and E units. In respect of the consultation, Dr Mark Spencer advised that it would finish on 8 October and there would be an independent analysis of the responses and it was noted that there would be at least two public meetings for each borough involved. In addition, groups could request that NHS representatives attend a meeting to provide information on shaping a healthier future.

The Chair requested that councillors from each borough involved be offered sessions on shaping a healthier future and she added that the committee's task group on this item would also provide a response to the consultation.

8. **Brent Tobacco Control Service - progress report**

Simon Bowen (Acting Director of Public Health) introduced this item and advised that positive feedback had been received from the CLearR model assessment for excellence in local tobacco control and the assessment had indicated that it was impressed with the range of activities on offer. The Tobacco Control Cessation Service had exceeded targets and made significant progress, however action needed to be taken with regard to protecting frontline services. Simon Bowen added that smoking remained the single largest cause of preventable deaths and it was important that the work of the Brent Tobacco Control Service continued to be supported.

Councillor Hunter enquired whether shisha smoking was high amongst young people and in comparison to cigarette smoking and what action was being taken to reduce smoking for these age groups. Councillor Gladbaum commented that the Brent Youth Parliament had produced a film about the dangers of shisha smoking. Councillor Leaman asked if the Brent Tobacco Control Service linked up with IAPT patients in respect of smoking.

The Chair commented that chewable tobacco was also an issue in the borough and that it was littering pavements.

In reply, Alison Wilson (Tobacco Control Officer, Brent Tobacco Control Service) advised that both cigarette and shisha smoking was high amongst the young in Brent, with shisha smoking becoming a growing trend. An audit of young smokers in Brent had been undertaken and the next one was due in two years to identify any changes in smoking habits. Brent Tobacco Control Service also worked with universities in tackling smoking amongst students, whilst schools were being approached with regard to being sent teaching packs. Alison Wilson advised that research was being undertaken with regard to the potential harmful effects of chewing tobacco and it was noted that Brent Tobacco Control Service had funded Brent Youth Parliament's film about shisha smoking.

Simon Bowen added that any service or organisation was welcome to work with the Brent Tobacco Control Service, whilst the College of North West London had also been approached with a view to setting up smoking cessation advice sessions.

Councillor Hunter then referred to the committee meeting on 14 October 2010 where the committee had requested that the Brent Pension Fund Sub-Committee reconsider the investments that the council had in tobacco firms. The Brent Pension Fund Sub-Committee had subsequently responded by stating that it was

unable to interfere with the actions of Trust Fund managers in respect of this. Councillor Hunter recommended that the Brent Pension Fund Sub-Committee reconsider this issue and that it consider the CLeaR Model Assessment for Excellence in Local Tobacco Control and a report from ASH on local authority pension fund investments in tobacco companies.

Members then agreed the recommendations as set out below.

RESOLVED:-

(i) that in the light of Brent's recent CLeaR Award for excellence in local tobacco control presented at the House of Commons on 15 May 2012, the Brent Pension Fund Sub-Committee reconsiders its decision to continue investing in tobacco companies. This policy is at odds with the council's work on tobacco control and the support that it gives to the Tobacco Control Alliance and Smoking Cessation Team in the borough;

(ii) that in considering recommendation 1, the Brent Pension Fund Sub Committee considers two reports - the CLeaR Model Assessment for Excellence in Local Tobacco Control, which is an assessment of the work of Brent's Tobacco Control Alliance; and, a report from ASH on local authority pension fund investments in tobacco companies, which deals with both the question of ethical versus financial considerations, and the issue of non-interference with fund managers' decisions, both of which reasons were given in the previous reply from the Brent Pension Fund Sub-Committee in November 2010 for not disinvesting in tobacco companies; and

(iii) that the Brent Pension Fund Sub Committee notes that although investment in Tobacco Companies in Brent is around £2.5 million, the estimated cost to Brent of smoking, as shown in the graph on page 9 of CLeaR report is some £57.9 million. The number of annual tobacco-related deaths in Brent, as set out in Brent's Joint Strategic Needs Assessment is 230.

9. Kenton Medical Centre update - information item

The Chair advised that Brent NHS was attempting to contact the three vulnerable patients who had not yet re-registered at an alternative practice to urge them to do so. At a previous meeting, the committee had requested that those patients who had not yet re-registered be written to and an update on progress be presented at this meeting. Members had before them an update for information purposes only. It was noted that Andrew Davies would be seeking clarification in respect of Willesden Medical Centre.

10. Health Partnerships Overview and Scrutiny Committee work programme

The Chair reminded Members that if they wanted any items added to the work programme that they should discuss this with Andrew Davies. Councillor Leaman referred to recent motions agreed by Full Council on 9 July 2012 in respect of mental health and he requested an update on progress with regard to these at a future meeting of this committee.

11. **Any other urgent business**

None.

12. **Date of next meeting**

It was noted that the next meeting of the Health Partnerships Overview and Scrutiny Committee was scheduled for Tuesday, 9 October 2012 at 7.00 pm. The Chair advised that there would be a pre-meeting starting at 6.15 pm.

The meeting closed at 8.55 pm

S KABIR
Chair

This page is intentionally left blank

Health Partnerships Overview and Scrutiny Committee
9 October 2012

Report from the Director of Strategy, Partnerships and Improvement

For Action

Wards Affected: ALL

Care UK Urgent Care Centre - Serious Incident Report

1.0 Summary

1.1 The Health Partnerships Overview and Scrutiny Committee have requested a report from NHS Brent on the serious incident reported by Care UK at the Urgent Care Centre at Central Middlesex Hospital. The serious incident was recorded when Care UK become aware of a queue of 6,000 patients who had not been discharged from their systems. Upon investigation it has become clear that many of these patients had been sent for x-ray but it could not be confirmed that the radiology reports had been reviewed for missed pathology. In addition, discharge notifications had not been issued to GPs for these patients. This presented a risk that patients were not properly diagnosed and that potential problems had not picked up in a timely fashion.

1.2 Councillors will recall that this item was deferred from the meeting in July 2012 because Care UK were not in attendance and because the report provided focussed on safeguarding issues rather than an explanation of what caused the problems at the UCC and how they have been addressed. A further report has been provided by NHS Brent and Care UK representatives will be present at the committee meeting on the 9 October for this item.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to consider the report from NHS Brent on the serious incident at the Care UK Urgent Care Centre and question representatives from the PCT and Care UK on the action they have taken since the identification of the issues connected to radiology.

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

Care UK Urgent Care Centre Serious Incident – Summary Report

This report summarises the position in August 2012 regarding the serious incident (SI) that was identified at the Brent Urgent Care Centre (UCC) in March 2012.

Following the declaration of the SI, an investigation team was convened to undertake a Root Cause Analysis of the incident to establish root causes and identify lessons learnt. The team was Chaired by Dr Sami Ansari, Clinical Director, NHS Brent and supported by Ms Terilla Bernard, Locality Improvement Manager, NHS Brent. The report was written by Ms April King, Clinical Governance lead for Care UK.

This report to the Brent Health Overview and Scrutiny Committee is set out in the following sections:

Section 1: Summarises the background of the incident and the findings of the Root Cause Analysis investigation undertaken by Care UK.

Section 2: Sets out the steps taken to follow up with patients affected by the incident and progress on this to date

Section 3: Sets out the steps taken to deal with the child protection concerns arising from the incident and subsequent investigation

Section 4: Sets out the actions taken by NHS Brent to date and ongoing monitoring arrangements

Section 1: Background of the incident and findings of the Root Cause Analysis investigation undertaken by Care UK

Brent Urgent Care Centre (UCC) became operational on 28th March 2011. It is situated at the front of the Central Middlesex Hospital (CMH) Emergency Department. The service provides urgent primary care services to patients with minor illness or injury. Brent UCC does not provide an X-ray service. All radiology patients are referred to the X-ray department of the Central Middlesex Hospital, within the same building, who perform the x-ray and send the patient back to the UCC for first line clinical review.

Detection of the incident

On the 6th of March 2012, the newly appointed Local Medical Director for Brent UCC advised the General Manager that he had noticed a significant number of outstanding x-ray cases on the IT system. The General Manager put measures in place to have these patients' radiology records clinically reviewed and their discharge notes faxed to the GPs. As a result of this activity on Wednesday 14th March 2012 Brent UCC received a phone call from a patient's GP surgery enquiring as to, why patient discharge summaries, dating back to August 2011, were only being sent out in March 2012.

Further examination of the issue identified there were 5978 records on the IT system which had not been closed appropriately; all relating to patients who had had an X-rays which dated back to start of the service on the 28th March 2011.

Aspects of processes relating to the incident were previously raised on five separate occasions set out in the table below:

Date	Issue raised
14th July 2011	Clinical Systems Training Administrator first identified the x-ray queue stood at 2083 cases waiting to be faxed out. There was no confirmation these reports had been clinically reviewed and validated.
18th August 2011	As part of the Care UK Governance Patient Safety Review of the radiology process it was identified there was no formal process for reviewing all the radiology reports, only the red flags were being reviewed on an ad hoc basis.
August 2011	Central Middlesex Hospital PACS team identified and informed the Interim Service Manager at Brent UCC that the PACS reports were not being printed off
September 2011	Care UK Interim Local Medical Director queried the x-ray queue with the previous General Manager and the new Service Manager. The interim Medical Director was informed it was the fax queue and it was nothing to worry about.
21st November 2011	Business Systems trainer identified the high number of patients on the x-ray queue (4500). This was reported to the previous General Manager and the new Service Manager.

On none of these occasions was the identified problem reported onto Care UK's Incident Management system.

The incident was reported formally on the following dates:

Date	Report
19th March 2012	The incident was recorded on Care UK's internal incident reporting data base (Datix).
30th March 2012	The General Manager informed NHS Brent
4th April 2012	The incident was recorded on the STEISS system

Care and Service Delivery Problems:

Brent Process Flows – Patients returning from Diagnostics:
A review of the radiology pathway using the reactive barrier analysis tool has been undertaken and identified the following barriers were working correctly.

- The PACS system identified the number of PACS reports not being printed off. This was identified by CMH who highlighted the issue to Brent UCC (CMH) staff in August 2011.

- Brent UCC (CMH) IT System does not allow the radiology patients' discharge records to be dispatched to the patients' GP until the following actions have been taken:
    - The radiology report has to be scanned into the system.
    - The clinical review box has to be ticked complete.

The barriers in place identified the numbers of radiology x-rays/reports waiting to be reviewed and printed. These barriers were also a vital tool to aid the day to day monitoring of the radiology process. From performing this review it is evident the barriers were working correctly, although the pathway itself was not being followed, and the process control tools were not being used effectively.

Lack of knowledge of the radiology process/root cause
A fundamental lack of knowledge of the radiology process led to miscommunication and staff not following the correct radiology process. A review of the radiology pathway with the Double Analysis tool has been undertaken and identified when the radiology pathway was not being followed.

Contributory Factors considered:

Induction/training: The three senior members of management, who were in post between service commencement and November 2011, did not undergo training of the radiology process at time of induction. Neither did they have any training at a later date. The Interim Service Manager (in post from 25/07/2011 – 31/09/2011) also did not receive training on the radiology pathway on commencement in the role.

Lack of clinical leadership: Initially in the staffing model there had not been a lead nurse. This was recognised as an oversight and Care UK have appointed a Lead Nurse and a Deputy Lead Nurse who work across the Brent UCC and the Ealing UCC.

There were also concerns raised in relation to the Medical leadership at Brent UCC in June and July 2011 both internally and externally, although it is not considered that this lead directly or indirectly to the incident. However a stronger Medical Leader may have lead to a more forceful escalation. The original Medical Director's contract was not renewed following the probationary period. An Interim Medical Director was put into post from September 2011 to February 2012. A permanent Medical Director was in post until September 2012 but has now left the organisation and a new appointment has been made.

Service Management: Concerns were raised regarding the original service manager's performance and this person left the company at the beginning of July 2011.

The Governance Patient Safety Review Audit (radiology process) the issues highlighted in this audit were identified in the final Governance Patient Safety Review Audit Report (August 2011). From this report an action plan was written by the previous General Manager. The previous General Manager was responsible for the implementation and the monitoring of the audit actions by the Senior Management Team at Brent UCC. The actions in relation to the radiology process were marked off as complete when they had not been. There were also several versions of the action plan, but none of the documents were version controlled, making it difficult to ascertain any progress.

Culture within Brent UCC: A Care UK Medical Director from a different region interviewed the doctors at Brent UCC, in confidence, to establish their views on the situation. This process did not raise any issues considered to have contributed to this SI.

Root Causes
Induction/training: The three senior members of management: who were in post between service commencement and November 2011, did not undergo training on the radiology process at time of induction. Neither did they have any follow up training. The Interim Acting Service Manager who was in post between August and October 2011 did not receive training of the radiology pathway.

Lack of knowledge of the radiology process: As they did not receive training on the radiology pathway, Brent UCC Senior Management Team members did not have a clear understanding of the radiology process. This led to miscommunication at every level and resulted in staff not following the correct process.

The Governance Patient Safety Review Audit (radiology process)
The issues identified in the Governance Patient Safety Review Audit (radiology process) undertaken in August 2011 and the associated actions were not implemented by the Senior Management Team at Brent UCC or monitored despite an action plan that indicated actions had been completed.

Assurance
A number of the checks and balances were put into place including:

- Audit plans
- Mandatory training plan and monitoring
- KPI monitoring
- Internal "CQC compliance audit"

However none of these assurances identified the risk of the incident and subsequently two specific reports have been developed to monitor process control. In addition a wider review of Care UK's governance framework has been commissioned by them to make recommendations about how the approach can be strengthened.

Lessons learnt by Care UK

- To ensure the correct calibre of Senior Management personnel and Senior Clinical Staff are in post prior to service commencement.
- The importance for all staff including Interim and Management Team to attend all clinical pathways sessions at induction.
- The importance of all Locum/agency staff to have a proper local on site induction of the clinical pathways.
- The need for a documented operational daily, weekly, monthly tasks framework. Closer operational monitoring for newly mobilised services to ensure processes are adhered to.
- For all Service Mangers and Deputies to be trained in incident identification reporting, investigation – Datix DIFF 2 training.
- To ensure where there is high usage of locum staff that robust inductions are in place, which have to include induction to the clinical pathways.
- For Brent UCC (CMH) Service Managers to have greater ownership of their Governance agendas within their service.

Lessons learnt in relation to Safeguarding Children processes by Care UK

- There needs to be greater accountability for all staff in relation to the ownership of Safeguarding, this cannot just be the responsibility of Brent UCC (CMH) Safeguarding Nursing Lead.
- The current local procedures in place for checking the Child Protection Plan Lists are time consuming and allow for human error.
- All Locum/Agency staff should only be hired with correct level of safeguarding training (GP's and Nurse Practitioners Level 3).

Recommendations

1. Review the recruitment processes for Senior Operational Staff and Senior Clinical Staff when starting new services in new service areas.
2. Implement robust training on the radiology process at Brent UCC from first contact to discharge for all staff including the Brent UCC management team.

3. Implement robust induction programme which includes the radiology process for all Locum/Agency staff.
4. Develop an operational process to ensure the radiology reports are reviewed by a competent clinician on a daily basis.
5. An operational process to be devised to ensure all radiology reports are scanned into the patient's notes and then ticked off as complete on the IT system.
6. To devise a detailed operational "daily, weekly, monthly procedures resource file" to ensure the knowledge transfer is secure and that operational monitoring of all processes is carried out.
7. For all newly mobilised services to have a "post go live IT test/audit" of patient pathways at regular intervals i.e. monthly for the first three months and then bi monthly for next six months and then quarterly. This is to be conducted by Care UK Business Systems Team.
8. Datix DIFF Two training to be mandatory for all Service Managers and their deputies to attend.
9. To reduce the service dependency on the use of locum staff.
10. Senior Management at Brent UCC to take ownership for their service's governance objectives.
11. IRMER (radiology guidelines) update training for all clinical staff referring to radiology.

Recommendations related to Safeguarding Children

1. Robust induction programme which includes the radiology process and the safeguarding referral pathways for all Locum/Agency staff.
2. Reinforce requirement for the Child Protection Plan lists (CPPL) to be checked.
3. Change "CPPL Check" to a mandatory field or a pop up box to ensure completion on the IT patient system.
4. Ensure all Locums are provided with the appropriate safeguarding children policies & referral procedures.
5. Ensure all staff undertake /refresh required Safeguarding training at the appropriate level. (All doctors and nurse practitioners Level three – Health Care Assistants Level 2, Admin Level 1).

Arrangements for shared learning

The details of potential risks for errors and failings will be shared with other sites within the organisation that use the Adastra IT patient system to raise awareness of possible breaches and to embed more robust processes and procedures.

The lessons learned and recommendations will be shared with the following teams and meetings within Care UK

- Care UK's IT and Business Systems teams
- Care UK Board Governance Sub-Committee Meetings (including Chairman & Chief Executive)
- Healthcare Divisional Directors' Board Meeting
- The Regional Directors' Operational Meetings
- The Health Care Integrated Governance Group
- Care UK IT & Business Systems teams
- Clinical meetings locally at Brent UCC
- Primary Care Lead Nurse Forum
- Medical Leads Forum

Section 2: Steps taken to follow up with patients affected by the incident and progress on this to date

Clinical Review:
At the point of identification of the incident there were a total of 5978 patients' electronic radiology reports on the X-ray queue of the Brent UCC IT patient system. There was no evidence or assurance these patients' radiology reports had been reviewed by a doctor at Brent UCC.

A process was put in place for these x-ray reports to be clinically reviewed by a competent team of radiographers and doctors. The cases were then categorised using the following traffic light system.

Category	Number	Description
Red	• 97	• Confirmed fracture/ other pathology which may have altered the course of treatment given.
Amber	• 153	• An abnormality identified but on review of patient consultation notes, appropriate care was provided.
Green	• 5728	• No fracture or abnormality identified and treated appropriately at time of consultation.

The red patients have been contacted using a three stage process as follows:

Stage 1 – Contacting Patient	Brent
• Patient received at least 3 attempted telephone contacts • GP contacted to confirm/obtain further contact details, where held • "Contact us" letter sent by registered post	3
• Invalid telephone contact details identified • GP contacted to confirm/obtain further contact details • "Contact us" letter sent by registered post	1
• Invalid telephone contact details identified • No GP details held / patient deregistered • "Contact us" letter sent by registered post	3
Sub Total	7
• Patient successfully contacted and moved to stage 2	90
Total	**97**

Categorisation of remaining patients

Category	Definition	Nos of Patients
Mild	Missed abnormality No adverse consequences anticipated	5
Moderate	Missed abnormality Potential ongoing symptoms anticipated	2

Severe	Missed abnormality Potentially life threatening or severely disabling outcome anticipated	0

Tele Consultations

Stage 2 – Tele Consultations	Brent
Closed - no further action Including patients treated appropriately at the time of presentation.	59
Face to Face Consultation required Patients who require a face to face follow up consultation who we are attempting to contact to book an appointment.	6
Managed by Alternative Provider Patients who are undertaking treatment with an external provider.	1
GP Referral required Referral required to be actioned by GP	2
Advised to see GP, if required	3
Sub Total	**71**
Patients moved to Stage 3 Patients who have been contacted and were booked a Face to Face Follow Up appointment	19
Total	**90**

Face to Face Consultations

Stage 3 – Face to Face Consultations	Brent
Closed - no further action	8
To go back to GP, if required	0
Referral required – non fracture clinic	2
Referred to Fracture Clinic	9
Total	**19**

The GPs of the 11 patients who required onward referral have been notified.

At the time of writing this report only one patient has contacted Care UK to complain. This complaint was made verbally and related to the process undertaken to contact them and has been logged and resolved by Care UK.

NHS Brent has requested that Care UK follow up on the 9 patients who required onward referrals to ascertain the outcomes for those patients. At the time of writing this report (24th Sept 2012) this information has not yet been received by NHS Brent.

Section 3: Safeguarding issues and steps taken to deal with the child protection concerns arising from the incident and subsequent investigation

Clinical Review - for vulnerable adults over 18 years of age:
From the clinical review there was one "red" categorised patient who was identified as living in a care home. On further review of the consultation notes there were no safeguarding concerns identified.

Clinical Review - for patients less than 18 years of age:
Within the overall cohort of 5,978 attendances, children (under the age of 18) accounted for 1564 of this total. A part of the clinical review included identifying those children/young people who attended Brent UCC and had an x-ray from 28th March 2011 (service commencement) to 14th March 2012. The aim of this review was to identify those children/young people in particular those who had a supervision order (SO) in place and were on the Child Protection Plan List (CPPL).

Child Protection Plan List
Brent UCC CMH currently receives Child Protection Plan lists (CPPL) from the following Social Services Departments:

- Brent
- Ealing
- Hounslow

As there is no national Child Protection Plan List, Brent UCC has been unable to cross match any child who is on a list outside of the lists that we are currently provided.

Brent UCC failed to adhere to the agreed policy (Safeguarding Children – Brent Urgent Care Centre April 2011). A number of issues were identified as part of the SI investigation in particular the identification, logging, and onward referral processes that require tighter and more robust management and auditing programme by Care UK.

One contributing factor of Care UK failing to check patients at presentation was the format in which the CPP List was being received. The CPP List from Ealing Local Authority was being sent in a paper format. However, this issue was not flagged by Care UK and the NHS Brent Designated Professionals were not informed of any issues when NHS Brent carried out the CPPL audit in November 2011.

Care UK reviewed all of the children against the CPP lists available and found the following matches:

	Brent CPPL	**Out of Area (Ealing CPPL)**
Exact Match - Name and date of birth matched	2	2
Near Match - date of birth mis match	0	1
Patient who attended more than once	0	0
“Fuzzy Search” - Name but no date of birth on Non LAC Legal Status List.	1	0

As shown above, Brent CPPL matched two patients with an "exact match" and one patient through a "fuzzy search" as this child was entered on the “Non LAC Legal Status List” where date of birth is not recorded, therefore, an exact match couldn’t be made, the search indicated that they may be on the list; on further investigation it was found that Brent LA had no record of this child, therefore, CUK have not been able to

onward refer this patient to the LA. The Ealing children identified have been notified to Ealing LA.

From this review, there are lessons that can be learnt to ensure that going forward the Brent UCC can assure the commissioner the appropriate checks are in place which can be evidenced. In addition, it has identified a number of issues which contributes toward the potential failure of the process although this falls outside of Care UKs control (please refer to recommendations action plan).

NHS Brent Designated Professionals have visited the Brent UCC and reviewed all processes with the staff. An action plan on safeguarding is in place and under regular review.

Section 4: Actions taken by NHS Brent to date and ongoing monitoring arrangements

- To issue a remedial notice to Care UK under S57 of the contract in respect of the failure to adhere to the safeguarding requirements and policies
- To issue a remedial notice to Care UK under S57 of the contract in respect of the failure of internal governance arrangements
- To issue a remedial notice to Care UK under S57 of the contract in respect of the failure to implement the pathway for x-rays
- To add additional KPIs to the contract in respect of:
    - Discharge Notifications to GPs by 8am of working day following attendance
    - Notification of children to HV/SN of by 8am of second working day following attendance
    - % of re-attenders not registered with a GP
- To agree a full action plan with Care UK to ensure delivery of all recommendations within 2 months
- To monitor progress against the actions required to implement recommendations of the SI report at monthly contract meetings
- To write to all Brent GPs to summarise the findings of the investigation and advise on the actions been taken

The above actions have been undertaken. The action plan has been completed by Care UK within the required timescales and evidence submitted by them to support this. The completed action plan was reviewed in detail at a contract review meeting on 20th September 2012. Following this meeting and following review of the evidence submitted NHS Brent consider that all appropriate steps have been taken by Care UK to resolve the issues identified by the review of the incident and the remedial notice has been closed.

NHS Brent will continue to closely monitor performance and will revisit the issues raised by the review such as training levels and adherence to safeguarding procedures on a regular basis through contract monitoring arrangements and site visits.

In addition, from July 2012 NHS Brent is attending the monthly clinical governance meetings between Care UK and staff from NWLHT. The group is reviewing a number of clinical pathways and jointly reviewing the management of individual cases (not related to this SI).

Mary Cleary
Deputy Borough Director
NHS Brent

Health Partnerships Overview and Scrutiny Committee
9 October 2012

Report from the Director of Strategy, Partnerships and Improvement

For Action

Wards Affected: ALL

Accident and Emergency Services at Central Middlesex Hospital

1.0 Summary

1.1 Councillors will recall that in November 2011 North West London NHS Hospitals Trust closed the Accident and Emergency Department from 7pm to 8am at Central Middlesex Hospital. The reasons for this were:

- There had been a significant reduction in the number of patients using A&E services at Central Middlesex Hospital following the opening of the Urgent Care Centre in April 2011. Numbers had fallen from 200 patients a day on average to 70 patients a day and normally only one or two people an hour between 7pm and 8am.
- Because of low patient numbers A&E staff were no longer seeing enough patients to maintain their clinical skills and expertise. When doctors left the Trust, it was becoming increasingly difficult to recruit permanent replacements.
- The onset of winter meant that the Trust felt it needed to take action to avoid a shortage of A&E doctors available during the night.

1.2 The closure was temporary pending a review of the service at the hospital. North West London NHS Hospitals Trust has provided the Health Partnerships Overview and Scrutiny Committee with a report on the position regarding A&E services for their consideration and comment.

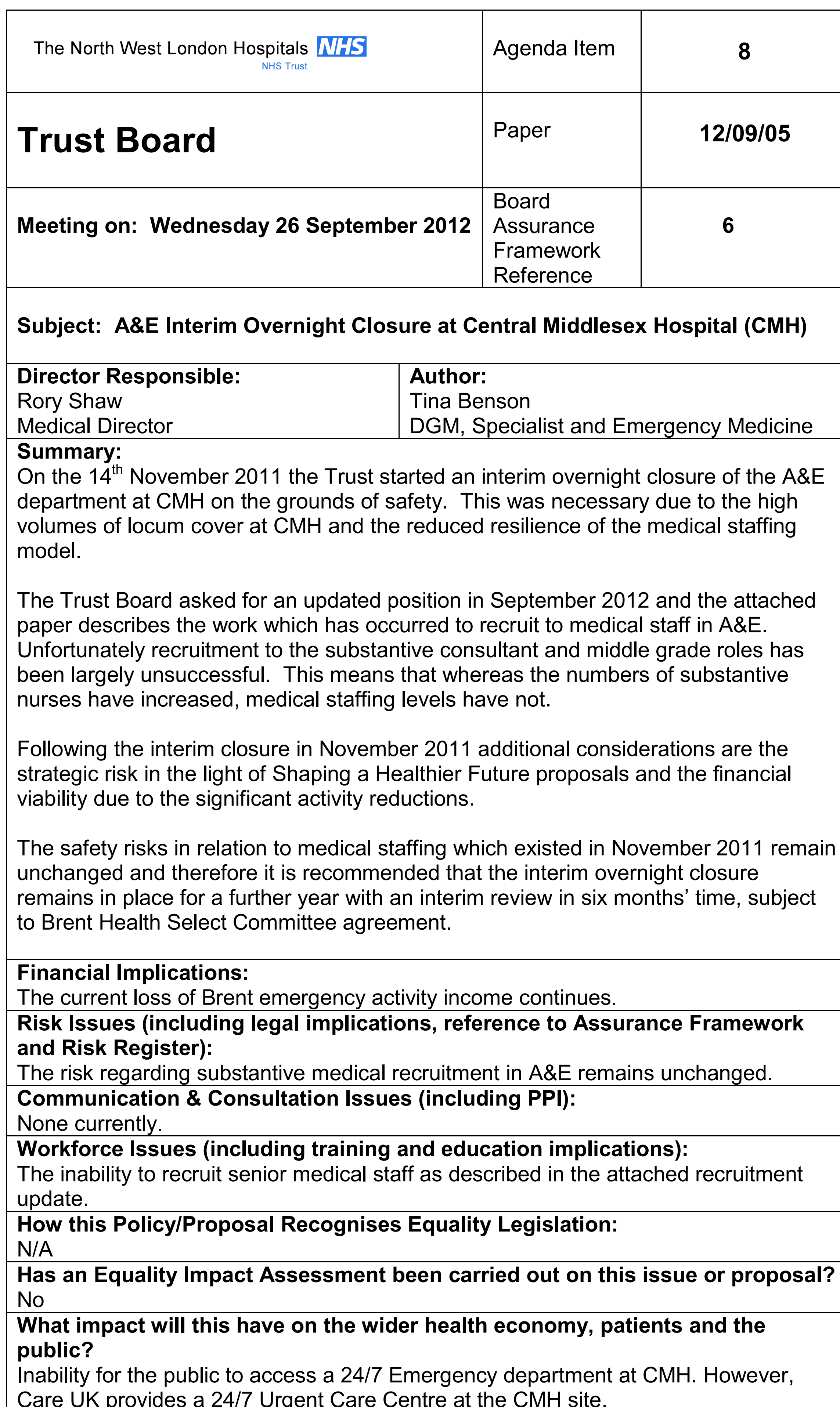
2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to consider the report from North West London NHS Hospitals Trust and question officers from the Trust on their proposals for Accident and Emergency Services at Central Middlesex Hospital.

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



The North West London Hospitals NHS Trust	Agenda Item	8
Trust Board	Paper	**12/09/05**
Meeting on: Wednesday 26 September 2012	Board Assurance Framework Reference	**6**

Subject: A&E Interim Overnight Closure at Central Middlesex Hospital (CMH)

Director Responsible: Rory Shaw Medical Director	**Author:** Tina Benson DGM, Specialist and Emergency Medicine

Summary:

On the 14th November 2011 the Trust started an interim overnight closure of the A&E department at CMH on the grounds of safety. This was necessary due to the high volumes of locum cover at CMH and the reduced resilience of the medical staffing model.

The Trust Board asked for an updated position in September 2012 and the attached paper describes the work which has occurred to recruit to medical staff in A&E. Unfortunately recruitment to the substantive consultant and middle grade roles has been largely unsuccessful. This means that whereas the numbers of substantive nurses have increased, medical staffing levels have not.

Following the interim closure in November 2011 additional considerations are the strategic risk in the light of Shaping a Healthier Future proposals and the financial viability due to the significant activity reductions.

The safety risks in relation to medical staffing which existed in November 2011 remain unchanged and therefore it is recommended that the interim overnight closure remains in place for a further year with an interim review in six months' time, subject to Brent Health Select Committee agreement.

Financial Implications:
The current loss of Brent emergency activity income continues.

Risk Issues (including legal implications, reference to Assurance Framework and Risk Register):
The risk regarding substantive medical recruitment in A&E remains unchanged.

Communication & Consultation Issues (including PPI):
None currently.

Workforce Issues (including training and education implications):
The inability to recruit senior medical staff as described in the attached recruitment update.

How this Policy/Proposal Recognises Equality Legislation:
N/A

Has an Equality Impact Assessment been carried out on this issue or proposal?
No

What impact will this have on the wider health economy, patients and the public?
Inability for the public to access a 24/7 Emergency department at CMH. However, Care UK provides a 24/7 Urgent Care Centre at the CMH site.

What is required of the Trust Board?
The Trust Board is asked to approve the continuation of the current interim overnight closure for a period of 12 months.

Emergency Department (ED), Recruitment Update September 2012

1. Consultants

Substantive: - 2 adverts have been placed since November 2011, one for 5 ED consultants and one for 2 joint appointments between ITU and ED. Unfortunately the response to both these adverts was poor and there were insufficient suitably qualified practitioner to move forward to the interview phase. A further advert is due in the British Medical Journal for the roles above in the next two weeks, in addition we will be advertising in Eastern Europe and for a joint post with Ealing Hospital NHS Trust. The team will be putting in place additional Acute medicine consultants to fast track the obvious medical patients through the ED.

Locum: - Currently we have a number of regular consultant locums who have substantive NHS jobs at other Trusts. We will have a rolling advert for these locums on going which support regular sessional work. Unfortunately these members of the team are only able to commit to approximately two sessions per week.

2. Middles Grades/ Junior doctors

Substantive: - An advert was placed on NHS jobs for 10 posts to which we had 90 applicants, 15 were invited to interview, unfortunately none passed the interview process which included clinical workstation assessments. A further advert in the British medical journal is currently open and closes the end of this week. Interviews will be held week commencing 2nd October 2012

We have received several CV's from agency, 2 are possible employees, and these will also be interviewed on the upcoming recruitment day.

We are in the process of translating an advert ready for publication in Eastern Europe.

Locum: - The current quality and reliability of locum middle grades is poor. The consultant body are currently looking at how to improve the quality and management of these medical staff.

3. Nursing staff

Substantive: - Two very successful recruitment days have been held in July and August appointing to all the current vacancies at a band 5 and 6 level with both newly qualified nursing staff and experienced ED nurses. A single vacancy remains at band 7 level and a secondment to a band 8a.

Locum: - Reliance on Bank and agency staff will significantly diminish over the coming 3 months as the new starters come in to post.

4. Administration staff

Substantive: - The team has currently 2.5 vacancies which are about to go out to advert.

Locum:- There has a been heavy reliance on bank admin staff due to insufficient posts in the budget to cover all areas (NPH ED; CMH ED and AAU) 24/7, this cost pressure is being minimised by reconfiguring shifts and staff across all units mentioned above, matching staffing levels to workload. For example ED at CMH overnight will be managed remotely by the NOH ED admin team.

Tina Benson
DGM
September 2012.

Health Partnerships Overview and Scrutiny Committee
9 October 2012

Report from the Director of Strategy, Partnerships and Improvement

For Action

Wards Affected: ALL

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

1.0 Summary

1.1 Councillors have asked for an update on the proposed merger between North West London NHS Hospitals Trust and Ealing NHS Hospital Trust. At the committee's previous meeting in July 2012, members were told that NHS London was broadly supporting the merger proposals but that there were some issues to resolve, such as the funding of £96.5m from NHS Commissioners and the Department for Health to support the merger and provide transitional support. It was reported that the merger would be completed by January 2013 at the earliest.

1.2 Because of the importance of this issue, the chair of the committee has asked that a report updating members on the latest position regarding the merger be presented to the committee at the October meeting.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee should consider the update on the proposed merger between North West London NHS Hospitals Trust and Ealing Hospital Trust and question officers on the progress being made.

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

Friday 28 September 2012

Update on the proposed merger of Ealing Hospital NHS Trust and The North West London Hospitals NHS Trust for Brent Health Partnership Overview and Scrutiny Committee

---

This report provides an update on the proposed merger of Ealing Hospital NHS Trust (EHT) and The North West London Hospitals NHS Trust (NWLH).

The Full Business Case

The final Full Business Case (FBC) has been submitted to NHS London to the agreed timetable (10 September 2012). It continues to show that new organisation will deliver a 1% surplus of £5.2m by 2015/16.

The content of the FBC remains largely the same as when we published the draft version in June but has been updated to reflect feedback from NHS London and the due and careful enquiry process. Some of the key changes are highlighted below.

- Updated executive summary to reflect the revised timetable for merger which is now planned for 1 April 2013
- Updated performance information to incorporate April - June 2012 (chapter 3)
- Latest position with NHS North West London commissioning strategy and consultation on Shaping a Healthier Future (chapter 4)
- Technical updates to the finance chapter to take into account the latest operating plans and a refreshed narrative to reflect feedback on the draft FBC (chapter 8)
- Some refinements to chapter 9 on governance in line with feedback and a clearer Board subcommittee structure
- Some refinements to chapter 11 on integration and implementation plan
- A summarised version of the updated implementation plan to reflect a 1st April 2013 merger date (appendix 11.2).

The following standalone documents were also submitted to NHS London:

- The Equality, Diversity and Human Rights Action Plan
- The merger implementation plan from the workstreams.

The NHS London assurance process and the due and careful enquiry (DCE) refresh have now both re-commenced with a target completion date of early October. Assuming these processes progress as planned the final FBC and the final DCE will be presented to Trust Boards for approval in mid-October at exceptional Board meetings followed by the NHS London Board on 25 October. The Trusts are now working to the proposed merger date of April 2013.

Shadow Board

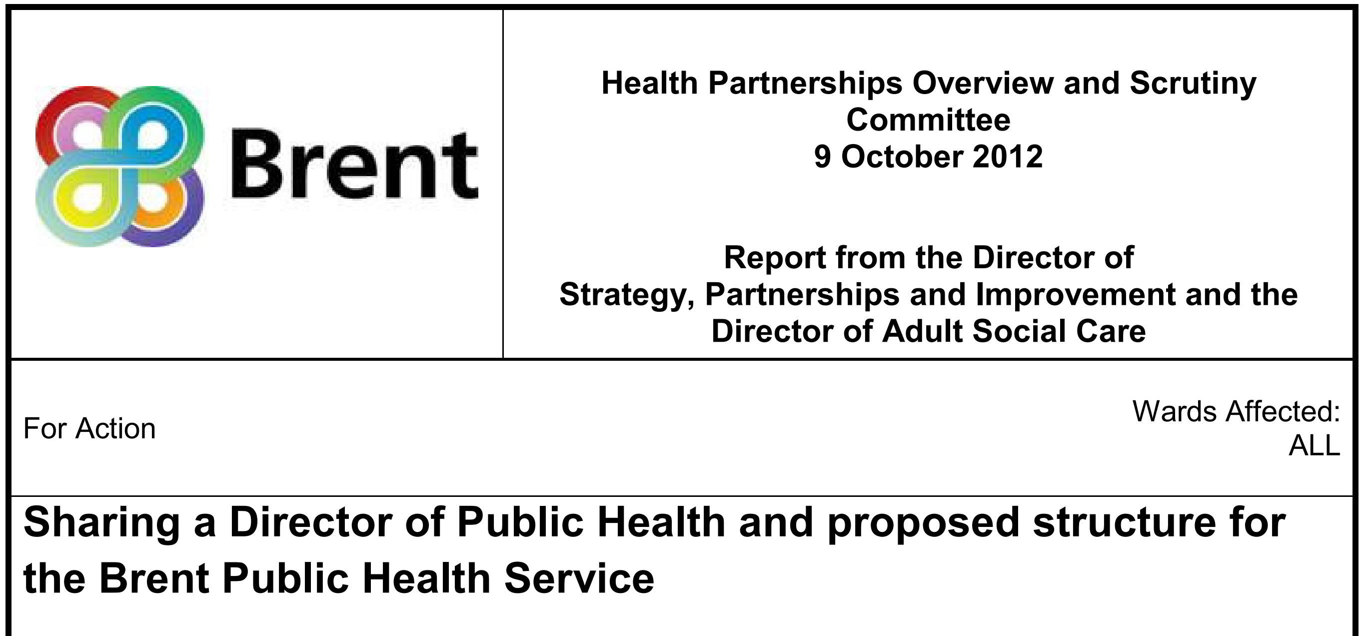
To ensure we are in the best possible place for day one of the new organisation and beyond, we are moving towards as much joint working as is possible and sensible ahead of the merger.

An important part of this is creating a shadow board, which both Trust Boards have agreed to do in phases, and we established a joint shadow executive team in September. These are temporary arrangements and there will be a separate process to appoint to substantive roles in the merged organisation at a later date. The focus of the shadow executive team will be on progressing the merger and future planning for the new Trust, so that the transition is as smooth as possible.

Julie Lowe and David McVittie continue in their roles as chief executives of Ealing Hospital NHS Trust and The North West London Hospitals NHS Trust.

Following both Trust Boards' approval of the final Full Business Case a full shadow board will be established. This will include a designate chairman and non-executive directors.

Simon Crawford, Senior Responsible Officer
Ealing and North West London Organisational Futures Programme



Health Partnerships Overview and Scrutiny Committee
9 October 2012

Report from the Director of Strategy, Partnerships and Improvement and the Director of Adult Social Care

For Action

Wards Affected: ALL

Sharing a Director of Public Health and proposed structure for the Brent Public Health Service

1. Summary

1.1 The passing of the Health and Social Care Act has confirmed that from 1 April 2013 local government will take on responsibility for health improvement and with it many of the services currently delivered by public health teams based in PCTs. Already local government fulfils its new duty of health improvement 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.

1.2 Rather than a wholesale transfer of public health to local government, the public health system is to be split into four separate parts. Local government will be responsible for a range of new services including:

- **The National Child Measurement Programme**
- **NHS Health Check assessments**
- **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)**
- **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**
- **Provide population level healthcare advice to CCGs and the NHS**
- 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)
- Interventions to tackle obesity such as community lifestyle and weight management services
- Local initiatives that reduce public health impacts of environmental risks.

1.3 Those services in bold will be mandatory – the council will have to provide them. It should also be noted that this is not a complete list of responsibilities.

1.4 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 some public health services such as HIV treatment services, screening services and immunisation services. A new, national public health body, Public Health England, is to be established 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 and will 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. The Department of Health will also retain a budget for and manage national public health "campaigns".

1.5 The total budget for the public health system is likely to be around £5.2bn, but local government as a whole will receive £2.2bn, less than 50% of the total public health budget. Despite being publicised as a transfer to local government, the reality is that this is only a partial transfer of public health to councils.

1.6 That said the transfer of services that are coming to local government gives Brent an opportunity to mainstream health improvement work across the council and make health improvement the authority's core business. Brent intends to embrace this vision by integrating public health within existing council teams and not "lifting and shifting" the current public health team. This will help reinforce the message that health improvement is the responsibility of the whole council and its partners, not just public health staff.

1.7 As part of taking on health improvement duties and the responsibility for public health services, the legislation is clear that councils should appoint a Director of Public Health who will be added to the list of statutory chief officers in the Local Government and Housing Act 1989. The DPH has to be a trained specialist in public health (although not necessarily from a medical background) and will be appointed jointly with the Secretary of State for Health (in reality, with Public Health England acting on the SoS's behalf).

1.8 Whilst each council has to have a DPH, the post can be shared with other councils where it makes sense to do so. Brent Council has been open to sharing a DPH since the proposals in the NHS White Paper, *Healthy Lives, Healthy People* made it clear that local government would be taking on public health responsibilities. Brent is keen to share a DPH with a council that shares its vision for public health and intends to integrate public health services within its council. Initially the council was engaged in discussions with Harrow, Barnet and Hounslow Councils about the possibility of sharing a DPH, but it quickly became clear that Harrow and Barnet had very different ideas for public health and how they would implement the new functions in their borough. As a result, Harrow and Barnet have agreed to share a DPH and Brent and Hounslow have continued to work together on developing their plans for a shared DPH.

1.9 Guidance from the Department of Health and Local Government Association suggests that council's could share a DPH where they already have a shared management team or shared boundaries. Brent and Hounslow don't share a

boundary, but the two councils do share a vision for public health. This is far more important if a shared DPH is to be successful in helping to deliver health improvement in each borough than the need to share a boundary.

1.10 Brent and Hounslow think that it makes sense on a number of levels to share a DPH and take advantage of the opportunities that it will bring. A shared DPH will give the borough a greater outlook and interflow of ideas to tackle health inequalities, learning as they will from the best in Brent and Hounslow (and London) and applying those ideas in our borough. A shared DPH will have more influence across West London, working for two boroughs, to drive through opportunities for collaboration and integration with partners to improve services and outcomes for residents. They will also be able to foster a common response to the big issues affecting our boroughs, such as a population that's living longer, with multiple long term conditions that require better management, and working in two areas with sizable BME communities facing significant health related challenges.

1.11 This paper sets out the business case for Brent and Hounslow's proposal to share a DPH as well as the proposed structure for public health and how staff will be integrated into the current officer structure once it transfers to Brent Council from NHS Brent takes place.

2. Recommendations

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

(i). Endorse the proposal for Brent to share a Director of Public Health with Hounslow Council

(ii). Endorse the proposed integrated structure for the public health service in Brent as set out in this report.

2.2 This report will be considered by the Executive on the 15th October 2012.

3. Report

3.1 A vision for Public Health services in Brent and Hounslow

3.2 Local authorities will take on a number of mandatory public health requirements from the 1st April 2013, which have been addressed in developing a model for public health in Brent and Hounslow. Local authorities will have statutory responsibilities for the following key domains of public health

- Health improvement
- Health protection
- Healthcare public health
- Improving the wider determinates of health

3.3 Council's will also have to commission (or provide) the following mandatory services:

- The National Child Measurement Programme
- NHS Health Check assessments

- Comprehensive sexual health services, including testing and treatment for sexually transmitted infections
- Plans to protect the local population in the case of a health related emergency
- Population level healthcare advice to CCGs and the NHS

3.4 A new National Public Health Outcomes Framework has been developed with the intention of refocusing the whole system around the achievement of positive health outcomes for the population and reducing health inequalities. The framework is focused on the following two overarching health outcomes to be achieved across the public health system:

- Increased healthy life expectancy
- Reduced differences in life expectancy and healthy life expectancy between communities

3.5 The supporting public health indicators are grouped into four domains:

- Domain 1 – Improving the wider determinates of health
- Domain 2 – Health improvement
- Domain 3 – Health protection
- Domain 4 – Healthcare public health and preventing premature mortality

3.6 Brent and Hounslow Councils have developed a shared vision for public health and identified the areas where the two boroughs are closely aligned on their thinking concerning structures and expected outcomes from the public health service.

3.7 Both Brent and Hounslow Councils agree:

- There is logic in bringing the key elements of public health back into local government. The function can be reconnected with the core health improvement work carried out by local authorities and there will be greater co-ordination of health improvement activity once services are transferred to local government.
- That public health is not just the responsibility of a Public Health Team or the DPH, but that it is a council wide responsibility and that all service areas should contribute to improving the health and wellbeing of local people.
- That in order to mainstream public health, officers from the existing Public Health Teams should be integrated in existing council teams and departments to make best use of the additional resources and expertise available to local authorities.
- That public health spending should be realigned to focus more on the wider determinants of health, tackling health inequalities and preventing ill health rather than treating ill health. Resources will be re-orientated away from the treatment of ill health to preventative services.
- That every contact with customers should count, and that all frontline officers (not just those in public health) should be deliverers of health improvement services or advice, either directly or through sign posting to the right service.
- That both council's should work with communities to help them to make healthy choices to prevent the onset of ill health.

3.8 In order to deliver the vision for public health it is important that the structure and support around the DPH is in place. Brent and Hounslow's ideas around the role, the

integrated public health service and the resources available to support the DPH are set out below.

3.9 The Director of Public Health – A new role for new times

3.10 Brent and Hounslow have the same ambition for the Director of Public Health role. The DPH's key function will be to understand and enhance the health of people in Brent and Hounslow. They will be clear on the link between economic success and good health and develop a clear, targeted, long term strategy that ensures health and social care, education, housing, employment and economic policies and infrastructure are shaped in ways which deliver maximum improvements in health and wellbeing.

3.11 The DPH will be central to the promotion of health improvement, tackling health inequalities and focussing council and health services on ill health prevention activities. The DPH will be the borough's advocate for health and wellbeing, using their influence to persuade service providers to contribute to the health improvement agenda. The public health budget in Brent will be around £16m, a significant amount of money. But this is dwarfed when compared to the council's overall budget and the NHS budget in Brent – combined this is close to £1bn. A successful Director of Public Health will work with decision makers in the health service and the council to use this resource on health improvement and ill health prevention activities. This will have a far greater impact than the use of public health resources alone. The DPHs ability to influence other organisations to deliver health improvement services will be central to the success of the person appointed to the role.

3.12 The Director of Public Health's role will be one of influence and strategic leadership rather than the traditional line management and budget responsibility. We want to ensure the DPH is freed up to work with key decision makers to push the council's health improvement agenda. The status that the DPH will have, as the borough's health improvement champion will mean that they are well placed to assert their professional views to a variety of organisations such as healthcare providers, voluntary sector groups and community groups to secure health improvement in Brent. The fact that the council is at the centre of local partnership working extends the remit and opportunity for the Director of Public Health.

3.13 There will be a number of ways in which they will be able to effectively carry out their influencing role:

3.14 ***Advice to Brent CCG and Brent Council*** - The Director of Public Health will provide advice and guidance to the Brent and Hounslow Clinical Commissioning Groups and the councils' service directors on health improvement and tackling health inequalities. They will be supported to do this work by the council's public health intelligence team – in Brent we plan to have two public health consultants and two public health analysts to support the DPH deliver their advice and guidance role. A memorandum of understanding has been developed between the council and CCG setting out how the relationship between the two will work and what each organisation can expect from the other. It has been proposed that:

3.15 Brent Council will:

- Provide specialist public health advice to the CCG
- Make public health intelligence resources available in support of clinical commissioning activities.
- Assess the health needs of the local population, and how they can best be met using evidence-based interventions (via the production and updating of the JSNA)
- Ensure the reduction of health inequalities are prioritised in the commissioning of services
- Provide specialist public health advice to the emerging Joint Health and Social Care Commissioning Vehicle.

3.16 Brent CCG will:

- Consider how to incorporate specialist public health advice into decision making processes, in order that public health skills and expertise can inform key commissioning decisions.
- Utilise specialist public health skills to target services at greatest population need and towards a reduction of health inequalities
- Contribute intelligence and capacity to updating the JSNA

3.17 The Director of Public Health will be responsible for this element of the MOU and working with the CCG to embed public health advice and guidance in commissioning decisions. The council will require an individual who is able to bring their professional authority and influencing skills to the fore in order to work with the CCG effectively.

3.18 ***Statutory member of the Brent Health and Wellbeing Board*** - The NHS Operating Framework for 2012/13 says that Health and Wellbeing Boards should provide local system-wide leadership across health, social care and public health. The Director of Public Health will be a statutory member of the Health and Wellbeing Board, working with Executive councillors, council directors and Clinical Commissioning Group colleagues to set the strategic direction for health and wellbeing in Brent. As a public health specialist the DPH's advice will be particularly important as links are made between the council and NHS's efforts to tackle health inequalities. The DPH will have an overview of services in Brent and be well placed to advise on changes that can be made to improve the borough's health.

3.19 ***Voting Board Member of the Health and Social Care Commissioning Joint Venture*** – Brent Council with Brent Clinical Commissioning Group has ambitions to set up a joint commissioning vehicle, to lead the commissioning of health, adult social care, children's social care and public health commissioning in Brent. Whilst this organisation won't be established by the time public health transfers to the council, we are already preparing for this by realigning commissioning functions. Public health commissioning will transfer into adult social care, as commissioning activity is concentrated in one place within the council.

3.20 The Director of Public Health will be based in our Adult Social Care Department, reporting to Brent's Director of Adult Social Services. In time, as plans for the joint commissioning vehicle are realised, the DPH will become a voting board member of the joint venture board. It is possible that in time the head of the joint venture could be the statutory Director of Public Health. By putting the DPH at the heart of

commissioning activity they will be well placed to ensure that public health aims and objectives are delivered across the range of health and social care services in Brent and that every opportunity is taken to design in health improvement to service specifications.

3.21 ***Director of Public Health's Annual Report*** - The Health and Social Care Act makes it a statutory requirement for the Director of Public Health to produce an annual report on the health of the local population, and for the local authority to publish it. The DPH's annual report will give them an opportunity to promote the public health agenda and highlight issues of concern if they feel that the council, CCG or any other healthcare provider is not fulfilling their health improvement responsibilities. The annual report should become an important milestone, highlighting as it will areas where health improvement work is succeeding and areas where it is not. Brent wants this report to become required reading for members and officers working on the health improvement agenda. The independence of the DPH to be able to criticise or praise is crucial, and one of the reasons that the DPH will not be directly responsible for service management.

3.22 ***Influence beyond the council and Clinical Commissioning Group*** - The DPH, through the Health and Wellbeing Board and joint commissioning vehicle, will be well placed to influence the actions of the council and Clinical Commissioning Group to ensure that they are delivering the borough's health and wellbeing priorities and addressing identified health needs. However, it is just as important that the DPH is able to use their authority and professional skills to influence the work of health service providers (such as North West London Hospitals NHS Trust), voluntary sector organisations and community groups. The final membership of the Health and Wellbeing Board is not yet settled but it is likely that the voluntary sector and health service providers will be represented, which will open up channels for the DPH. But, again, the DPHs ability to network and influence others will be crucial.

3.23 The DPH will need to be able to build effective relationships with organisations, both formal and informal, in order to convince them of the need to deliver health improvement services. For example, greater integration of public health interventions such as referral to smoking cessation teams from North West London Hospitals would help to deliver health improvement benefits and lessen the burden on acute trusts in the longer term. Brent is aiming to deliver an integrated health and social care service – the DPH will be crucial in persuading other organisations to sign up to this and deliver services which contribute to tackling health inequalities.

3.24 Brent already has an officer level governance structure to implement the borough's health and wellbeing strategy - the Health and Wellbeing Steering Group, which has representation from acute service providers and the voluntary sector. Whilst officers will need to work to improve the added value of the group, relationships are already there. But, the onus will be on the DPH to build relationships to promote the benefits to organisations of tackling health inequalities, using their abilities to influence informally as well as ensure health improvement activity is part of the normal commissioning cycle so that services are tailored to help tackle Brent and Hounslow's health inequalities. The DPHs professional standing will help them "in" to

organisations with the backing of the Health and Wellbeing Board, but the DPH will have to ensure organisations sign up to our ambitions for health improvement.

3.25 Arguments in favour of retaining a Director of Public Health for Brent

3.26 Whilst sharing a Director of Public Health is the preferred option, there are arguments in favour of appointing a DPH for Brent only and retaining the status quo. A DPH for Brent would be able to focus solely on matters concerning the borough and help consolidate public health services within the council following the transfer from NHS Brent. A single DPH would have the same responsibilities to the council, CCG and Health and Wellbeing Board and will be central to the promotion of health improvement and tackling health inequalities – the core roles and responsibilities will not change and it is understandable why other boroughs want to have a person in post focussed only on their area. But a single DPH is unlikely to have influence and reach of a joint appointment. A joint DPH will have influence across two boroughs and speak on behalf of two boroughs when working with others in North West London. Nor will a single DPH be able draw on the best practice and support of two public health functions as the DPH in Brent and Hounslow will be able to do.

3.27 A DPH covering one borough is going to appeal to seasoned public health professionals who will be used to focussing their efforts in one area. Sharing a DPH is becoming more common (Harrow and Barnet and Camden and Islington for example) but it is not the norm. However, it is also true to say that few Director of Public Health jobs will be like the one envisaged for Brent and Hounslow, where the focus is as much about relationship building, the ability to influence others and working in partnership as the technical and specialist public health requirements needed to carry out the role. By recruiting a shared DPH Brent and Hounslow are demonstrating their commitment to bringing a fresh approach to the disciple that will appeal to those ambitious to work in areas where there is huge potential to make real differences to peoples lives.

3.28 Practical arrangements for a shared Director of Public Health

3.29 The practical arrangements around the shared DPH post need to be agreed, but Brent and Hounslow have begun discussions on how they might work. The post will be shared, 50/50 between the two organisations, despite the differences in population size and budget. Both councils expect the DPH to be present in their borough for part of the working week, but won't be too ridged on the number of days that they have to be physically present in each borough. This is in line with Brent's approach to flexible working, where staff will be expected to manage their own time effectively, but also to take opportunities to work from home given the staff to desk ratio that will be in place in the new Civic Centre. Informally, Brent and Hounslow have agreed that Brent will be the employer of the shared DPH and Brent will also lead the recruitment process.

3.30 Of more importance is the work that the DPH will be doing, to make sure their time is balanced between working for Brent and working for Hounslow. Objectives will be set for the DPH by their line manager, based on priorities in the borough's Health and Wellbeing Strategy. They will take strategic leadership for health improvement in

each borough, and like other senior officers, will be responsible for co-ordinating a portfolio of work to ensure the borough meets its health and wellbeing objectives. Brent and Hounslow will have to jointly manage the DPH's workload to ensure it is balanced and that both boroughs have the public health leadership they require. It is likely that the DPH and their line managers will need to meet collectively to agree a work programme and to manage the DPH's performance.

3.31 By sharing a DPH, clearly there is a financial saving to Brent and Hounslow (although it should be noted that the current DPH in Hounslow works part time). Given that the funding allocation for public health is currently unknown, but that there is a real possibility that funding will reduce if the Government's proposed formula for public health funding is introduced, the council has to look at opportunities to reduce costs where it can.

3.32 Future of Public Health Services – the new Public Health Structure

3.33 Beyond sharing a DPH, Brent and Hounslow have considered the statutory requirements that will be placed on councils and feel that the best way to improve the public health offer is to integrate public health functions within existing teams in the local authorities – neither council intends to "lift and drop" the existing public health team and create a "Department of Public Health". In order to deliver improvements to health inequalities and deliver the Government's vision for health improvement, removing the silos between public health and local government are key. Integrating functions and activity in the most appropriate teams within the local authority should help to mainstream public health activity and deliver health improvement.

3.34 Brent's model for public health splits the service into three main areas – Health Intelligence, Public Health Commissioning and Health Improvement. The structure in the council is smaller than that which has been in place in NHS Brent. This is partly to do with concerns about future funding. But it is primarily a reflection of the fact that the council already has a number of staff in post working on health improvement activity. Integrating public health staff means that the council can take the opportunity to reduce duplication of roles and reduce management posts, as public health will be line managed within existing teams.

3.35 Services currently delivered by public health staff will be reviewed and possibly re-commissioned. The council is also taking the opportunity to look again at commissioning intentions, and redesign services. A report on contracts and commissioning will be presented to the Executive in November 2012.

3.36 The three public health areas will focus on the following activity –

- **Health intelligence** – A small team working on health intelligence will be integrated in the council's Corporate Policy Team. The main responsibilities of this team will be to support the DPH to provide population level healthcare advice to the CCG and council commissioners, lead on the council's JSNA and Health and Wellbeing Strategy and any other health needs assessments. The team will complement the council's existing data and intelligence functions.
- **Public Health Commissioning** – Public Health Commissioning will be integrated into the council's Adult Social Care Department. This will be a temporary

measure, as the council in partnership with NHS Brent and the Brent CCG is working towards the establishment of a Brent Commissioning Joint Venture, which will be responsible for commissioning health, social care and children's services in the borough. Public health commissioning will be included in the joint venture as commissioning expertise is pooled in one place to help secure integrated services where possible. Public health officers in the council's Adult Social Care Department will commission services such as drug and alcohol treatment services, sexual health and smoking cessation services The Director of Public Health will be included in this part of the structure, reporting to the Director of Adult Social Care. In time, as plans for the joint venture are realised the DPH will be a voting member of the JV board.

- **Health Improvement** – Health Improvement will be integrated into the council's Environment and Neighbourhood Services Department where staff will work with services such as our Sports Service, Trading Standards and Environmental Health on programmes to address health and wellbeing issues such as obesity, improving uptake of physical activity, and tobacco control. The public health staff will bring with them expertise that complements our existing service offer.

3.37 Hounslow's ambition to integrate public health staff within its departments mirrors Brent's and they are a taking a similar approach to integration within their teams. A shared DPH compliments the structure of the teams in the two organisations.

3.38 Line management of public health staff in Brent will be carried out by service managers in the departments where staff are located and not by the DPH. We want the DPH to focus on their influencing role and retain their independence from service management. However work plans and priorities will be set in collaboration with the DPH to ensure staff are working on priority areas as defined by the borough's Health and Wellbeing Strategy. By jointly setting public health staff objectives with service managers the DPH will be able to ensure health improvement is mainstreamed within council teams.

3.39 Neither Brent nor Hounslow Council is ruling out the possibility of sharing services and further posts in the future. This will be considered in more detail once both authorities have embedded their arrangements for public health. Brent and Hounslow will look to the joint DPH to lead this work, and bring forward ideas for further integration. We see the shared DPH as the start of a process of integration and closer working arrangements.

3.40 Governance of public health

3.41 It is important that public health activity within the council is joined up and co-ordinated, and that the public health outcomes framework and priorities in the Health and Wellbeing Strategy taken forward. The Director of Public Health will have a strategic leadership role and will be expected to ensure that the three arms of public health – Health Intelligence, Health Improvement and Public Health Commissioning – are working together effectively. They will also need to reinforce health messages across the council.

3.42 A governance structure will need to be set up so that the DPH is able to carry out this role properly, building on the existing Health and Wellbeing Steering Group and reporting to the Health and Wellbeing Board. Additional working groups maybe required, based around the priority areas in the Health and Wellbeing Strategy, or the domain areas in the Public Health Outcomes Framework. Building an effective governance structure for public health is one of the activities in the public health transition plan. Arrangements will be put in place before the transfer on 1st April 2013 to enable the DPH to take forward the health improvement agenda.

3.43 Conclusion

3.44 Brent and Hounslow Councils are committed to sharing a Director of Public Health. Our shared vision for the post and the similarities between our structures for public health make this a viable proposition. Issues around borough boundaries should be ignored. What's more important is that both councils are determined to make this arrangement work and that it should be seen as the beginning of a fruitful partnership based around our health improvement responsibilities and tackling health inequalities in both boroughs.

3.45 This arrangement will give new focus to the role of Director of Public Health and moves it from a peripheral position in the machine of the NHS to front and centre of a partnership model which aims to fundamentally improve the health and wellbeing of Brent and Hounslow's communities. We strongly believe that sharing as DPH will give each borough opportunities that would not exist if we had a single DPH, such as a greater outlook and interflow of ideas to tackle health inequalities, more influence across west London to push for integrated services and joint commissioning and greater co-ordination in the commissioning of services between health and social care within Brent and Hounslow. If Brent and Hounslow get this right, the model of council's working in partnership and sharing posts and services, even where they don't share boundaries, could become a model that becomes common throughout local government.

4. Legal Implications

4.1 Pursuant to s30 of the Health and Social Care Act 2012 each Local Authority must appoint, jointly with Secretary of State, a Director of Public Health who will have responsibility for the exercise by the authority of its functions relating to public health. The Director of Public Health will be required to prepare an annual report on the health of the people in the area of the Local Authority and the Local Authority will be required to publish that report. Section 300 and Schedules 22 and 23 of the Health and Social Care Act 2012 make provision for rights and liabilities with regard to property and staff respectively to be transferred between the relevant bodies. Regulations as to the exercise by Local Authorities of certain Public Health functions are yet to be issued by the Government.

4.2 The current proposal is for the Council to directly employ the DPH to undertake work for both ourselves and Hounslow. The Council has the power to employ the DPH directly and then enter into an arrangement with Hounslow that provides for them to

undertake to accept liability for half of the costs involved in the appointment and employment of the DPH as well accepting half of the liabilities that are inherently present when staff are employed directly. The Council's position as direct employer would therefore be protected by indemnities that would be entered into to ensure an equitable risk share in the joint arrangements.

4.3 The staff who would form the main body of the function will be employed directly by Brent and Hounslow respectively. There is no proposal at this stage for any staff sharing arrangement to be entered into for anyone other than the DPH. The staff that will comprise the public health functions will become employees of the Council. Currently they are employees of the NHS and the mechanism for those staff to change employer will be through either a traditional TUPE transfer or a Transfer Order made by the Secretary of State which has a similar effect to a TUPE transfer.

4.4 In any event transferring staff would have the right to retain their contractual terms and conditions and the Council would also have to make appropriate pension provision, the precise nature of which has yet to be decided. The costs involved in the transfer will be met by the transfer of the public health budget from the NHS to the Council.

5. Finance Implications

5.1 The budget transfer as at 1st April 2013 remains uncertain but is projected to be in line with the PCT return to the Government in February 2012 suggesting spending of around £16m based on 2010/11 baseline estimates.

5.2 NHS Brent's public health allocation for 2012/13 is £17.3m, which leaves a gap of around £1.3m in funding. In planning for 2013/14, this degree of uncertainty and lack of clarity is unhelpful and will introduce ambiguity in the budgets.

5.3 To further complicate matters, the government has set up an advisory committee to look at the resource allocation (ACRA) and they have developed a formula for calculating allocations which, if implemented, could lead to a further reduction in funding for Brent of around 16% to around £13.5m

5.4 ACRA's formula for allocating public health resources is based on the standardised mortality ratio for those under 75 years of age. Analysis work has shown that the proposed formula is fundamentally flawed, as it will reduce spending in the country's most deprived areas and increase it in the least deprived areas.

5.5 Historic levels of spending on public health are higher in more deprived areas because the level of need is greater, a flaw that has been recognised by PCTs and which has been advised to Government. Authorities in those areas, which includes Brent, consider that they should not be penalised due to previous spending patterns in preventative services in the past.

5.6 The population figure used in calculating the ACRA formula is 252,105, where as the first results from the 2011 census have been published and they show that Brent's population has increased to 311,200, a difference of 59,000. This would suggest underfunding of approximately £3.2m.

5.7 Taking all the above into account, budgets are currently being developed, together with staffing structures based on the £16m allocation figure but mindful that should the ACRA view prevail, the service will need to be managed within the lower sum. Confirmation of funding is due from Government in October 2012 and proposal will be presented to Executive in November 2012 for ratification.

5.8 It should also be noted that within this £16m total, two services (sexual health and health checks) are entirely demand-led and account for 41% of the total budget. This introduces a significant risk factor which is being managed through the establishment of a reserve of £500,000 per annum set aside from the £16m.

5.9 Negotiations are ongoing regarding the transfer of staff and any associated redundancy costs. Whilst Brent's position remains that these should be picked up by the NHS prior to the transfer of functions, a risk remains that some may need to be met be the Council post-transfer and a proposed reserve of £250,000 will be set aside by the Department to cover this eventuality.

5.10 There are not expected to be any capital requirements arising from this transfer

6. Diversity Implications

Contact Officers

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

Alison Elliott, Director of Adult Social Care
Tel – 020 8937
Email – Alison.elliott@brent.gov.uk

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

This page is intentionally left blank

Health Partnerships OSC

Work Programme 2012-13

Meeting Date	Item	Issue	Outcome
30th May 2012	Recruitment of health visitors in Brent	Following consideration of a report on the recruitment of health visitors in Brent in March 2012, members agreed to follow up with Ealing Hospital ICO their plans to recruit and train more health visitors in line with the Government's plans to increase the number of health visitors in England.	Members noted the number of vacancies in health visiting posts in Brent and have requested a follow up paper in six months time (November meeting) to follow up on the recruitment and retention of health visitors.
	Planned Care Initiative – ophthalmology and cardiology services in Brent	NHS Brent brought a paper to the committee in March 2012 on their plans to re-commission services for ophthalmology and cardiology in Brent. At the meeting in March 2012, members agreed to follow up two issues with NHS Brent at their May 2012 meeting: • The consultation plan for the two services • The consultancy costs associated with the retender of cardiology and ophthalmology services	Report noted, along with the concerns of Brent LINk about the consultation process.
	A&E Waiting Times in Brent	The Committee considered a report on waiting times at its meeting in March 2012. That report was missing information on A&E waiting times, and so a second paper has been requested – members have asked for a report on A&E waiting times for the committee's May meeting, and to invite representatives from NWL Hospitals to attend for this item to account for performance in A&E. The report should include information on ambulance transfers from CMH to Northwick Park Hospital.	The members noted the report and requested some additional information from NWL Hospitals: • A request for a breakdown of what happens to patients who attend A&E – i.e. the proportion admitted, treated

			and discharged etc. • The transfer time from ambulance to A&E – i.e. the time patients wait in ambulances before being seen in A&E. • Information on the longest length of time people are waiting in A&E above the four hours • Treatment times for those seen in A&E compared to those seen in the UCCs
	X-ray records at Central Middlesex Hospital Urgent Care Centre	NHS Brent is investigating a serious incident at Central Middlesex Urgent Care Centre. 6000 patients sent for x-ray but Care UK, the Urgent Care Centre provider, cannot confirm whether the radiology reports have been reviewed for missed pathology or whether discharge notifications have been issued to GPs. The committee will be presented with a report on the investigation into this incident and steps being taken to ensure that it doesn't happen again.	The root cause analysis of the incident will be presented to the next committee meeting and representatives from Care UK will also attend to answer questions on this issue.
	Primary Care Update in Brent	The committee will receive a report setting out an update on two medical centres in the borough: • Willesden Medical Centre, which is considering relocating to Willesden Hospital. • Kenton Medical Centre, which is to close	Members requested a follow up report in July 2012 setting out how many patients have been re-registered and where they have re-registered since notice was served on the Kenton Medical Centre.
	Shaping a healthier future	NHS North West London is to start consulting on plans for major service changes in the cluster. Although a JOSC has been set up to scrutinise the changes, Health Partnerships	The committee has agreed to set up a separate meeting to scrutinise the Out of Hospital

		OSC will also be able to scrutinise the proposals affecting Brent. This will be standing item on the committee's agenda for the duration of Shaping a Healthier Future. Focus at this meeting will be on Brent's Out of Hospital Care Strategy.	Care Strategy in full and respond to the consultation. This will be done once it is clear when consultation on the strategy is to begin.

Meeting Date	Item	Issue	Outcome
18th July 2012	Brent Tobacco Control Strategy	The committee would like to follow up the Brent Tobacco Control Strategy, to check the progress of its implementation. It is also interested in specific issues, such as the licensing of shisha bars, to see how this issue is being addressed in Brent.	Members have recommended that the Brent Pension Fund Sub-Committee considers again its tobacco investments, and referred the Clear Assessment Report and ASH report on pension investments to the committee for consideration.
	Kenton Medical Centre	The committee has asked for a follow up report after considering the Primary Care Update in May 2012. They are interested in Kenton Medical Centre and how many patients have been re-registered, and where they have re-registered since notice was served on the practice that it was to close. NHS North West London has been asked to provide this paper.	Report noted. Members have asked for an update on what has happened to the three vulnerable patients being helped to reregister with another practice.
	Serious Incident at CMH	NHS Brent and Care UK will provide their report on the serious incident at the CMH UCC, concerning the missed pathology on radiology reports.	Report deferred until October as Care UK was not present.
	Shaping a healthier future	Members have requested information on the Shaping a Healthier Future plans for acute trusts in Brent, focussing on plans for Northwick Park Hospital and Central Middlesex Hospital, as well as St Mary's (a hospital used by residents in the south of Brent). The committee will also need to consider	The committee has agreed to form a working group to prepare a response to Shaping a Healthier Future by the 8th October.

		how it will respond to the consultation, bearing in mind the NWL JOSC.	
	NWL Hospitals and Ealing Hospital Trust merger – Full Business Case	An Executive Summary of the Full Business Case will be presented to the committee for comment and scrutiny.	Report noted, but it was agreed to take an update on this at the October committee meeting.
	Brent's Improving access to psychological therapies scheme	The committee has requested a report on the Brent IAPT scheme which has been in place since December 2010. Members would like the report to include information on: • How the scheme is functioning for both children and adults • The referral process • Average waiting times for treatment from the point of referral • GP attitudes to the scheme	It was agreed to follow up with CNWL in October 2012 on the mental health provision on offer for people with more complex mental health needs, to get a better understanding of the services available and how the realignment of resources into IAPT has affected services for patients with more complex needs.

Meeting Date	Item	Issue	Outcome
9th October 2012	Serious Incident at CMH	This item was deferred from the July meeting as Care UK weren't represented. NHS Brent and Care UK will provide their report on the serious incident at the CMH UCC, concerning the missed pathology on radiology reports.	
	A&E at Central Middlesex	Update on the service, following closure of overnight A&E.	
	NWL Hospitals and Ealing Hospital Trust merger –	This was requested by members in July 2012, so that they are kept informed of the project as the merger progresses.	

	Update following approval of the Full Business Case		
	Shaping a Healthier Future	For approval of the committee’s response to the Shaping a Healthier Future consultation.	
	Sharing a DPH	Report on plans for the role of the DPH and outline structure for comment and recommendations for the Executive.	

Meeting Date	**Item**	**Issue**	**Outcome**
27th November 2012	Recruitment of health visitors in Brent	At the committee’s meeting in May 2012, members agreed that they would receive a progress report from Ealing Hospital ICO on the recruitment of health visitors in Brent and their progress in meeting the Government’s target for health visitors in England.	
	Health needs of People with Learning Disabilities	Brent MENCAP has carried out work with NHS Brent to train GPs, hospital staff and community staff about the health needs of PWLD. A report was presented to the committee in March 2012 setting out the results of the project and some of the key challenges facing those with learning disabilities accessing healthcare. It was agreed to follow up this work in November 2012 to look at two issues: • The NHS health check day being organised by NHS Brent, which will involve MENCAP • How MENCAP has been able to build on the initial project to train NHS staff members on working with people with	

		learning disabilities.	
	Time to change pledge	Progress report on how the council is responding to the Motion to Council in July 2012 on the Time to Change Pledge.	
	Diabetes Task Group	The final report of the diabetes task group will be presented to the committee for endorsement before going to the council's Executive for approval.	
	Mental Health Services in Brent	Following a previous agenda item on IAPT services, the committee want to follow up with CNWL on the mental health provision on offer for people with more complex mental health needs, to get a better understanding of the services available and how the realignment of resources into IAPT has affected services for patients with more complex needs.	
	Health Watch in Brent	Update on progress on the development of Health Watch in the borough. The committee has also asked for an overview of the patient involvement work happening in Brent at present – for information only.	

Meeting Date	**Item**	**Issue**	**Outcome**
29th January 2013			

Meeting Date	**Item**	**Issue**	**Outcome**
19th March 2013			

Meeting Date	Item	Issue	Outcome
TBC	Out of hospital care strategy	As part of the Shaping a Healthier Future work, Brent will be preparing an Out of Hospital Care Strategy. The committee will consider the strategy and respond to the consultation.	
TBC	Diabetes and physiotherapy services – plans to re-commission services in Brent	NHS Brent plans to re-commission diabetes and physiotherapy services in the borough. The committee should consider the plans for the new services, as well as the consultation plan.	
TBC	NWL Hospitals and Ealing Hospital Trust merger plans	The hospital trust merger is progressing and a Full Business Case will be available in May 2012. The committee needs to decide how it wishes to scrutinise plans for the merger, which will be built into the work programme. Follow up will also happen once the merger is approved to ensure services aren't affected during the transition period.	
TBC	Housing Advice in a Hospital Setting	Care and Repair England has produced a report on integrating housing advice into hospital services. Brent Private Tenants Rights Group would like to bring this report to the committee to begin a conversation on the best way to take this forward in Brent.	
TBC	Role of community pharmacists in improving health and wellbeing	The chair is keen to look at community pharmacists in Brent, and how their role in delivering health services can be best utilised. She also wants to look at the way that different elements of the health system, such as GPs and social care work with pharmacists in the borough.	
TBC	Mental health services in Brent	Report to committee on 29/11/11 may provide basis for further enquiries about mental health services. Chair of the committee has suggested support for carers of those with mental health problems.	

TBC	Health Inequalities Performance Monitoring	The Health Select Committee should make health inequalities a major focus of its work in 2010/11. As part of this, a performance framework has been developed to monitor indicators relevant to the implementation of the health and wellbeing strategy, which relate to the reduction of health inequalities in the borough. This framework will be presented to the committee twice a year, with a commentary highlighting key issues for members to consider.	
TBC	Sickle Cell and Thalassaemia Services Report	The Committee has asked for a report Sickle Cell and Thalassaemia services at North West London NHS Hospitals Trust. The committee will invite sickle cell patient groups to attend for this item to give their views on services in the borough. This follows a previous report on changes to paediatric in patient arrangements at NWL Hospitals. Members are keen to know how sickle cell patients have been dealing with this change.	
TBC	Fuel Poverty Task Group	Recommendation follow up on the task group's review.	
TBC	Breast Feeding in Brent	Following a report in March 2011 on the borough's Obesity Strategy, the committee has requested a follow up paper on the Breast feeding service in the borough. Members were particularly interested in the role of peer support workers and how mothers are able to access breast feeding services. The committee would also like to have accurate data on breast feeding initiation and prevalence in Brent.	
TBC	End of life / palliative care in Brent	The committee has asked for a report on end of life care in Brent. Members are keen to look at how the End of Life Strategy is being implemented and to know what services exist in Brent and how effective they are in delivering care.	
TBC	TB in Brent	Added at the request of the committee (meeting on 20th Sept 2011).	
TBC	GP access	In December 2011 the results of the six monthly patient survey	

	patient satisfaction survey results	will be published. Members should scrutinise the results with Brent GPs to see how their initiatives to improve access are reflected in patient satisfaction.	
	A&E Waiting Times	Follow up from information provided in July 2012 – the chair has asked to include this on the work programme.	

Current Task Groups

Diabetes Care in Brent – The task group is looking at services to prevent and treat diabetes in Brent and will report its findings before the end of 2012.

Future Task Groups

Female Genital Mutilation – to investigate whether this practice is prevalent in Brent, to examine the impact on victims, to see what preventative work takes place in the borough and to highlight this issue to those working with young people who are potential victims.

This page is intentionally left blank