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Scrutiny Committee

Tuesday 16 June 2015 at 7.00 pm
Conference Hall - Brent Civic Centre, Engineers Way, Wembley, HA9 0FJ

Membership:

Members Councillors:	**Substitute Members** Councillors:
Filson (Chair) Daly Farah Kelcher Miller Stopp Tatler Vacancy	Agha, Hector, Khan, J Mitchell Murray, Nerva, Ketan Sheth and Thomas

Co-opted Members
Ms Christine Cargill
Mr Alloysius Frederick
Dr J Levison
Mr Payam Tamiz
Vacancy (Parent Governor representative)
Vacancy (Parent Governor representative)

Observers
Ms J Cooper
Mrs L Gouldbourne
Ms C Jolinon
Brent Youth Parliament representatives

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The press and public are welcome to attend this meeting

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members.

Item		Page
1	**Declarations of 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	**Introduction to scrutiny from the Chair**	
3	**Deputations (if any)**	
4	**Minutes of the previous meeting**	1 - 10
5	**Matters arising (if any)**	
6	**Paediatric Services in Brent** This joint report produced on behalf of Brent Clinical Commissioning Group (CCG) and London North West Healthcare NHS Trust (LNWHT) provides an overview and summary of Paediatric Services provided to Brent residents. The report summarises current paediatric provision in Brent and sets out the potential impact on Northwick Park Hospital of the changes to paediatric services at Ealing Hospital taking place on 30 June 2016.	11 - 22
7	**Access to Extended GP Services and Primary Care in Brent - Interim Report** This report provides interim feedback on the work of the Scrutiny Task Group focused on Access to Extended GP Services and Primary Care in Brent. The report outlines the task group scope and methodology and provides an overview of emerging findings and recommendations.	23 - 34
8	**Public Health - priorities and progress** As a result of the Health and Social Care Act 2012, local authorities have new responsibilities for public health. This report outlines these responsibilities and how the Council is discharging these.	35 - 46

9 Access to affordable childcare 47 - 58

This report looks at the challenge of providing access to affordable, quality childcare.

10 Future work programme 59 - 60

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.

Date of the next meeting: Tuesday 14 July 2015

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- The meeting room is accessible by lift and seats will be provided for members of the public.

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Brent

MINUTES OF THE SCRUTINY COMMITTEE
Thursday 30 April 2015 at 7.00 pm

PRESENT: Councillor A Choudry (Chair), Councillor Colwill (Vice-Chair) and Councillors Allie, Daly, W Mitchell Murray, Shahzad and Southwood, together with Ms Christine Cargill, Mr Alloysius Frederick and Dr J Levison and appointed observers, Lesley Gouldbourne.

Also Present: Councillors Butt, Crane, Filson, Mahmood and Perrin.

Apologies were received from: Councillor Oladapo and appointed observers Jenny Cooper and Chrissy Jolinon

1. **Declarations of interests**

None declared.

2. **Deputations (if any)**

The Chair advised that a deputation had been received from Mr Grant with respect to the Equalities and HR Policies and Practices Review and draft Action Plan. The committee was informed that in line with advice provided by Brent's Chief Legal Officer, it would not be appropriate to discuss an ongoing legal case. Mr Grant advised that he would not be able to make his deputation under these terms. The committee subsequently agreed not to receive the deputation. Councillor Allie expressed the view that the deputation should be heard.

RESOLVED:

That permission to address the committee be not granted, in accordance with legal advice provided.

3. **Minutes of the previous meeting**

RESOLVED:-

that the minutes of the previous meeting held on 11 March 2015 be approved as an accurate record of the meeting.

4. **Matters arising**

None.

5. **Order of Business**

RESOLVED:

That the order of business be amended as set out below.

6. **Environmental Sustainability Agenda**

Chris Whyte (Operational Director Community services) presented a report to the committee summarising the work undertaken across key service areas to address the issue of sustainability. It was explained that sustainability was a key factor in the development and provision of all services, though there was no longer a single co-ordinating team or strategy. Five key areas were addressed in the report: transport and travel; air quality; in-house carbon management; street lighting and parking; public realm and waste; and parks and biodiversity.

David Thrale (Head of Regulatory Services) addressed the action being taken in Brent regarding air quality. Members heard that Brent had levels of air pollution that occasionally breached the National Air Quality Standards and that this was an issue of importance nationally. The council's Air Quality Action Plan was currently being reviewed and an updated plan would be presented to Cabinet in autumn 2015. It was emphasised that scientific understanding of air quality had significantly improved since the existing action plan had been produced; the impact on health and the types of places and activities that exposed people to pollution was now better understood. The new action plan would therefore have a twin focus on reducing emissions of pollutants and helping individuals and communities better understand how the the risk of exposure could be reduced.

In the subsequent discussion, the committee queried the ways in which the council could effect behavioural change regarding waste and recycling amongst residents and businesses. The committee also questioned how retailers could be encouraged to reduce packaging and the financial benefit for the council of improved recycling rates. Members sought further details regarding relationships with partner agencies, such as TFL and Northwest London Hospitals Trust. With regard to the former, it was queried what work had been done to identify pollution hotspots in the borough, whether there was any correlation with bus routes and how active reporting could be encouraged when buses were left running whilst parked. The committee raised several queries regarding air pollutants and the use of diesel fuel, seeking information on when TFL would be introducing non-diesel buses, how the council would encourage the use of non-diesel private and commercial vehicles, how traffic flow could be improved across the borough and the number of charging points provided in Brent for electric vehicles. Further information was sought regarding the work done with property developers across the borough, in recognition of the challenges for the existing infrastructure of increased road users. Officers were also asked to comment on whether consideration had been given to seeking an extension of the Mayor of London's bike hire scheme. Members requested details of the number of staff responsible for addressing issues of sustainability and whether these were sufficient to support progress in this area.

In response to the queries raised, Chris Whyte advised that a specific team of officers focussed on improving recycling rates and engaging with residents on a day-to-day basis. Businesses were also encouraged to operate sustainably and as

of April 2014, the council had made a recycling service available to all Brent businesses. A further example of the work undertaken in this area was the council's joint lobbying of the packaging industry with other local authorities, which had helped to encourage a significant reduction in the weight of packaging over the past 15 years. Improved recycling rates were realised as a reduction in waste contract costs for the council. Councillor Crane (Lead Member for Environment) added that work was also underway with other local authorities to better understand behaviour around fly-tipping.

Chris Whyte advised that the most polluting form of transport in Brent was rail transport due to the use of diesel fuel. With regard to pollutants from TFL buses, the committee heard from Councillor Crane that he had expressed his concerns regarding the age of the fleet in Brent at recent meeting with TFL Senior Management and had sought the early introduction of the new Routemaster vehicles. This was a desired outcome for all boroughs, though urgent action was being sought for the Kilburn area and the council would continue to press for progress. TFL were experimenting with electric vehicles but it would be a number of years before these were in general use. David Thrale advised that the idling of engines was an offence and fixed penalty notices could be issued.

David Thrale further explained that it was important to continue to encourage the use of petrol, hybrid or electric vehicles and information on the number of electric charging points across the borough could be provided to the committee. However, it was acknowledged that any change over to non-diesel vehicles amongst businesses and the general public was likely to be gradual and it was important to encourage other forms of active travel. A lot of work was undertaken with new developments in brent, including measures such as car free designations and use of parking permits. Businesses were also supported in developing travel plans with an emphasis on sustainability. Councillor Crane advised that the results of a recent consultation on the cycle strategy would be published in a few month's time and the council was exploring a bike hire scheme along with a number of other boroughs. It was understood that there were no current plans to extend the Mayor of London's scheme but the council might wish to pursue this.

Addressing members' queries regarding staffing, David Thrale advised the number of staff who measured air quality and co-ordinated the Air Quality action plan equated to one person and one third full time equivalent manager. However, the number of staff tackling the issue via work with new developments or by exploring active transport amounted to double figures.

The Chair thanked the officers for their presentation to the committee.

RESOLVED:

That an update be provided to the committee regarding the environmental sustainability agenda in six month's time.

7. Future Commissioning intentions of Brent Clinical Commissioning Group

Sarah Mansuralli (Chief Operating Officer, Brent Clinical Commissioning Group) introduced the report on the commissioning intentions of the Brent Clinical

Commissioning Group for 2015/16, which would contribute to achieving improved patient care and patient experience of care across community, secondary and acute health care services. The committee was informed that the commissioning intentions, set out in detail in the report, encompassed four key categories; working with acute providers to ensure that national performance standards were met; investing in out-of-hospital services with a focus on integration with other services and social care; working with partners and providers to reduce hospital emissions; and, proactive work to improve mental health provision for children and adults. It was explained that the intentions had been informed by significant engagement via the health partners forum, and community and voluntary groups. The commissioning intentions had also been discussed at the Brent Health and Wellbeing Board. It was emphasised that there had been no significant change between the commissioning intentions for 2014/15 and 2015/16.

Members' attention was drawn to section three of the report which set out the evidence base underpinning the commissioning intentions. This drew specifically on the Joint Strategic Needs Assessment and the Brent Better Care Fund Plan. Highlighting key challenges that had been identified, Sarah Mansuralli noted that whilst Brent had a relatively young population, it was expected that the population of those aged 65 and above would grow more rapidly than the rest of the population generally. In addition, the Brent CCG medium term financial modelling indicated that the Brent CCG's allocation would not keep pace with the predicted higher demand for services and population growth. The commissioning intentions and their successful delivery was therefore instrumental in ensuring that these challenges were met.

The committee raised several queries in the subsequent discussion. Members questioned the quality of engagement with community groups, emphasised the failure to meet national performance standards in the previous year, questioned what was being done differently to address these issues and sought specific timescales for achieving improvements. It was queried what action was being taken to raise awareness of dementia amongst different communities, including the provision of materials in a variety of languages. A member sought clarity regarding Brent CCG spending for 2014/15, noting that having accounted for commissioning for acute and community care there remained approximately a further £80m unaccounted for. A further query was raised regarding the 2014/15 spending on enhanced GP services and the work undertaken to evaluate their success.

Sarah Mansuralli advised that Brent CVS had been instrumental in supporting the CCG's engagement with different communities and had helped community groups to organise workshops around the proposals. Addressing concerns around national performance standards, Rob Larkman (Accountable Officer) explained that significant investment had been made to support the North West London Hospitals Trust in achieving these standards and there was an agreement between commissioner and provider for those standards to be delivered in the current financial year. Sarah Mansuralli clarified that though the strategic focus of the commissioning intentions had not significantly changed from 2014/15, the detail of the proposals had been amended to reflect lessons learnt, including closer working with providers and earlier intervention to agree remedial action if required. With regard to the operational standard for Referral to Treatment (RTT), it was expected that the 18 week target would be met in the current year, following additional investment in the previous and current years. Trajectory for this target was being

monitored, the results of which were awaited. In response to a query regarding access to GP appointments, Rob Larkman explained that though the CCG did not commission GP services, Brent CCG had been working with NHSE and had invested outside of the GP contract to create GP Hubs throughout the borough. Work was currently underway to achieve a co-commissioning arrangement with NHSE which would enable Brent CCG to have a greater input regarding GP services in the borough. It was clarified that the funds spent on enhanced GP services accounted for out of hours access to primary care and the provision of enhanced services within GP practices to ensure that patients did not have to be referred elsewhere. Addressing concerns regarding CCG spending for 2014/15, Sarah Mansuralli advised there were many areas outside of acute and community care for which the CCG provided funding including services for people with learning disabilities and carer support. The committee was subsequently referred to the report available on the Brent CCG website detailing the full approved budget for 2015/16. Turning to the question on dementia services, Sarah Mansuralli acknowledged that work regarding dementia had focussed on enabling earlier diagnosis which could improve quality of life for those affected and ensure the right care plans were put in place but it was agreed that a specific community focus could be beneficial.

Councillor Daly expressed the view that the committee had been given insufficient time to scrutinise the issue. The Chair advised that a task group report on health would be available in June 2015.

RESOLVED:

That an update be provided to a future meeting of the committee.

8. **Use of Pupil Premium Grant Scrutiny Task group**

Councillor Southwood (Task Group Chair) presented the report of the Task Group on the Use of the Pupil Premium Grant (PPG), highlighted the key findings and drew the committee's attention to the sixteen recommendations detailed in the report. It was explained that the task group had been requested by Scrutiny Committee members in response to the borough priority to improve attainment for disadvantaged pupils. The task group had focussed on analysing the current use of the PPG, understanding attainment gaps, identifying outcomes achieved against national performance and exploring how best practice was shared amongst Brent Schools. Councillor Southwood emphasised that usage of PPG had varied from school to school and it had been recognised that there was no uniform usage that was appropriate for all schools and circumstances. In particular, the Task Group had found a number of innovative and creative usages of the PPG, some of which focussed on non-academic activities and which had instead sought to build confidence or improve social skills. The Task Group had not therefore attempted to specify how PPG should be used but instead had sought to ensure that there was robust decision making being applied and that best practice could be shared. The recommendations of the task group envisioned a key role for the council and the Brent Schools Partnership in aiding the development of a borough-wide, proactive approach to the use PPG, supported by co-ordinated efforts of Brent's community of schools and Early Years Settings, including children's centres. In concluding her presentation, Councillor Southwood reiterated her thanks to the organisations and

individuals that had contributed to the work undertaken by the Task Group, including children and young people, schools and officers of the council.

The committee congratulated the Task Group on the work undertaken and the detailed report produced. During the discussion, further information was sought regarding the use of PPG and whether schools were using it to its best advantage. It was queried whether the scope of the task group had encompassed all of Brent's schools, including academies and how the efforts of the task group had been received by those schools. A member asked whether the opinions of parents and foster carers had been sought. A view was expressed that Brent's schools were failing to address the attainment gaps and the potential contribution that could be made by supplementary schools was highlighted; it was subsequently questioned whether supplementary schools received the PPG.

Councillor Southwood explained that the range of initiatives funded using the PPG had been impressive and the task group had sought to understand how schools were identifying attainment gaps and measuring outcomes and how that had fed into robust decision making. A key issue that had been highlighted by young people who had provided their views to the task group was that of career advice. Students had felt that there needed to be more career advice and guidance available and that this should include specific information on qualifications needed and employment opportunities available. All of Brent's schools had been supportive of the work undertaken by the task group. Brent's children's centres had also been approached and the opportunity had been taken at this point to engage with parents. When exploring issues concerning Looked After Children, the task group had worked with the council as the corporate parent and liaised directly with the Virtual Head. It was explained that supplementary schools did not receive the PPG and rather this was a grant that followed a pupil through their main schooling, including in alternative provision. Councillor Southwood agreed that it was important that the use of PPG in Brent result in more than good examples and that she was confident that the recommendations proposed by the task group would help to create more consistent approach and that this would be reflected in attainment.

The committee thanked Councillor Southwood for her presentation and emphasised the importance of ensuring that appropriate timescales were set for the implementation of the task group's recommendations, subject to their approval by the Cabinet.

RESOLVED:

(i) that the recommendations of the Pupil Premium Task Group be endorsed;

(ii) that subject to Cabinet approval, the committee receive an update on the implementation of the Task Group's recommendations at a future meeting of the committee.

9. **Scrutiny Annual Report 2014/15**

Cathy Tyson (Head of Policy and Scrutiny) advised that the Annual Scrutiny Report before the committee had been drafted for members' consideration. The report provided a summary of the work conducted by the Scrutiny function throughout the year, including task group work, issues raised by the committee and the

recommendations and suggestions of the committee. The 2014-15 report also included an update on the impact made by the scrutiny task groups in the previous and current year. Committee members were invited to submit feedback on the draft report which would be finalised for the end of May 2015.

RESOLVED:

that the draft Annual Scrutiny Report 2014/15 be noted.

10. **Equalities and HR Policies and Practices Review and draft Action Plan**

A report on the Review of Equalities and HR policies and Practices, conducted between October 2014 and January 2015 by the Deputy Leader of the Council, was introduced to the committee by Christine Gilbert (Chief Executive). The review had been wide ranging and had encompassed scrutiny of staffing matters and HR policies and practices within the council. Highlighting the key areas of learning arising from the review, Christine Gilbert advised that there needed to be greater consistency in the application of policy across the council and more BME representation in the council's senior management. It was emphasised that both issues had previously been identified and were included within the council's Equalities Action Plan and Corporate Plan; however, the review had provided additional focus on these issues. Members' attention was subsequently drawn to a draft action plan detailing how the council would address and implement the findings of the review. Members' comments on the draft action plan were invited and it was explained that once finalised, the Corporate Management Team (CMT) would oversee its implementation, with each director undertaking responsibility for a specific strand of work. It was clarified that the delivery of the action plan would be monitored by the new member committee due to be established by the Council at the annual meeting in May 2015. This committee would also be responsible for overseeing progress made towards achieving Excellence in the Equalities Standard for Local Government.

Members welcomed the review. During the subsequent discussion concerns were raised regarding the number of staff failing to receive supervisory appraisals, the implications this had for staff progression and whether managers were using the appraisals as an effective tool to support staff. It was noted that the review reported that more than half of staff members attending two focus groups had not seen a plan for their team or service area and it was queried what action would be taken to address this. The committee further noted that 94 per cent of staff were yet to complete their equalities data on the council's Oracle system. A member emphasised that the recommendations of the action plan needed to be specific and indicate appropriate timescales and budgets to ensure effective delivery. It was queried whether staff had had the opportunity to comment on the draft action plan and whether managers and staff had expressed confidence that the issues identified would be addressed. Clarity was sought on the policy for medical appointments and assurance was requested that this was not considered a reasonable adjustment for disabled employees. The issue of unconscious bias was raised and it was strongly suggested that this form a core element of any training provided around recruitment. Further details were requested regarding the training and support provided to members appointed to the Senior Staff Appointments Sub Committee.

With regard to BME representation at senior management, a member queried how the council compared to other boroughs and whether there was an opportunity to learn from the practices of other local authorities. At the invitation of the Chair, a member of the public queried what action was being taken by the council to improve BME representation in senior management. The committee subsequently queried how the council reached out to and publicised opportunities to BME communities in Brent and whether the new Chief Executive who was shortly due to be appointed would be set a target deadline to ensure this issue was addressed. Councillor Filson, with the permission of the Chair, emphasised that all applicants, irrespective of race, gender or disability, had to feel confident that they would be recruited based on merit and that it would be unlawful for the council to implement quotas.

Responding to the issues raised, Christine Gilbert advised that Brent's monitoring of staff appraisals was very good and the figures highlighted in the review did not reflect current levels. It was likely that as the review had been completed mid-year, a number of staff would not have yet had their appraisals conducted; however, further investigation of this was in process and the outcome would be reported back to the committee. Members further heard that a key priority for the council over the past few years had been to improve planning across the council; the Borough Plan had been developed into a living document, influencing the work of individual teams, and the public had been engaged in the process as never before. The council's Corporate Plan reflected the Borough Plan and was now being translated into the aims and objectives for individual teams and staff members across the organisation. With regard to the completion of equalities data by staff, Cara Davani (Director of HR) advised that the information previously recorded by staff had not transferred across to the council's new Oracle System. A campaign was underway to encourage staff to complete the information, including daily engagement activities; however, staff members were not obliged to disclose this information if they did not wish to. Cara Davani assured the committee that good progress was being made and noted that a similar campaign run in previous years had been very successful.

Christine Gilbert further advised that the every activity on the draft action plan should have a deadline and reiterated that CMT would lead on the delivery. No budgets had been specified as the plan would be implemented within existing staff resources. The committee was assured that there had been significant levels of staff engagement across the council. Equality had been a high priority for the council prior to the review, as reflected in the work undertaken to work towards the Equalities Standard for Local Government and the Investor In People awards. Councillor Butt (Leader of the Council) highlighted that as of 2012 the council had also undertaken to review all HR Policies and Procedures. Such work evidenced the value placed on staff and on ensuring there were appropriate opportunities for progression within the organisation. Cara Davani explained that though it had not been recorded in the action plan, an additional piece of training for all managers had been prepared regarding unconscious bias. It was proposed that this training be delivered by 1 June 2015 and the action plan would be updated to reflect this. It was further clarified that as a result of the review, the council had identified that medical appointments related to a person's disability should not be recorded as sickness. This was distinct from any actions that would be taken by the council to implement reasonable adjustments for an employee with a disability. It was

emphasised that a more proactive approach was now in place regarding identifying if a new employee required any reasonable adjustments to be made to ensure that they could be in place at the very start of a person's employment with the council. Addressing the query raised regarding the support provided to members appointed to the Senior Staff Appointments Sub Committee, Councillor Butt advised that all members and alternates of the sub committee had received extensive training.

Christine Gilbert informed the committee that Brent was in the top quartile for BME representation in senior management amongst London boroughs. The action plan included several proposals to improve the level of representation in Brent, including a graduate programme aimed at Brent residents. Councillor Butt reiterated that it was important to ensure that staff were sufficiently supported to access opportunities for career progression within the council and noted that the action plan included the creation of an innovative mentoring programme to support the development of underrepresented groups. It would take time, however, for improvements to be made and any suggestions by members would be welcome. Councillor Butt confirmed that the recruitment pack for the Chief Executive's position had referred explicitly to Brent's diverse community.

The Chair highlighted the importance of ensuring that there was robust monitoring of the action plan and the committee agreed that an update should be provided on the progress achieved in six month's time.

RESOLVED:

that an update on the implementation of the action plan be provided to the committee in six month's time.

11. **Scrutiny Forward Plan**

The committee was informed that all members would be contacted regarding the forward plan for 2015/16 and a session to prioritise items would be held following the annual council meeting scheduled for May 2015.

Councillor Daly expressed the view that the committee should meet formally to discuss the forward plan for 2015/16 and emphasised her frustration regarding the time allotted to scrutinise Health related items.

12. **Any other urgent business**

None.

The meeting closed at 9.35pm

COUNCILLOR CHOUDRY
Chair

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Paediatric Services in Brent

Report for Brent Overview and Scrutiny Committee Meeting – 16th June 2015

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1 Purpose

The purpose of this report is to provide Brent Overview and Scrutiny Committee (OSC) with an overview and summary of Paediatric Services provided to Brent residents. The report summarises current paediatric provision in Brent and sets out the potential impact on Northwick Park Hospital of the changes to paediatric services at Ealing Hospital taking place on 30th June 2016.

In particular, this report will address a number of specific information requests from OSC members:

- General overview of the services provided, facilities, usage and funding for paediatric services
- Feedback on actions regarding improvement objectives, any changes planned and savings targets
- Any planned change to commissioning of paediatric services and priorities
- The current paediatric bed occupancy at NPH hospital compared with last year
- Occupancy of the special care baby unit compared with last year
- Numbers of children seen at A&E in the last two years
- Have admissions needed to be transferred due to lack of beds and if so how often?
- Is it anticipated that there will be any additional admissions as a result of the transfer of paediatric services from Ealing Hospital. If so, what steps have been taken to manage this situation (for example additional beds, staffing or new services at NPH)?

2 Overview of current paediatric provision in Brent

Brent Clinical Commissioning Group (CCG) commissions acute and community paediatric services from three main providers:

- Acute paediatric services from London North West Healthcare NHS Trust (LNWHT) and Imperial College Healthcare Trust (ICHT)
- Other specialist acute paediatric provision is commissioned at other hospitals including Great Ormond Street
- Community paediatric services from London North West Healthcare NHS Trust
- Child and adolescent mental health services from Central North West London NHS Trust

The providers are responsible for the facilities from which they deliver the services that Brent CCG commissions. The quality assurance concerning provider facilities lies within the remit of the Care Quality Commission. The contracts which Brent CCG holds with the providers include service conditions and quality standards that ensure appropriate facilities management.

2.1 Acute paediatric services an Northwick Park and Ealing Hospitals

LNWHT provides the following acute paediatric services across the NPH and Ealing Hospital sites:

- **2 General Paediatric departments** at NPH and Ealing Hospital:
    - 16 in-patient beds at Ealing Hospital;
    - 21-24 in-patient beds at NPH (number of beds flexes in line with acuity).
- **1 neonatal department** at NPH – Ealing Hospital neonatal service will close in July 2015 as part of the Shaping a Healthier Future (SaHF) reconfiguration programme
- **Specialist Care Baby Unit (SCBU)** There is a Level 2 Unit at NPH commissioned by NHS England (NHSE). The Level 1 SCBU at Ealing Hospital will close in July 2015 as part of the Shaping a Healthier Future reconfiguration programme
- **Tertiary Haemoglobinopathies Service** NHSE commissioned
- **Paediatric Oncology Shared Care Unit (POSCU) Service** NHSE commissioned

Apart from the transfer of neonatal and SCBU services at Ealing Hospital in July 2015, no other changes are planned until June 2016 when in-patient paediatric services will transfer from Ealing Hospital.

The table below sets out the total annual cost of acute paediatric services commissioned from LNWHT:

	NPH	Ealing Hospital	Overall Expenditure
Total Annual Planned Cost	£5,651,434	£3,186,145	**£8,837,579**
Actual Cost	£5,154,664	£3,258,324	**£8,412,988**
Variance Cost	£496,770	-£72,179	**£424,591**

2.2 Paediatric activity and finance at Northwick Park Hospital

The table below sets out 2014/5 paediatric activity at Northwick Park Hospital. Significant increases in activity are highlighted in red and include:

- Urology
- Audiological medicine
- Clinical Immunology and Allergy
- Dermatology
- Diabetes

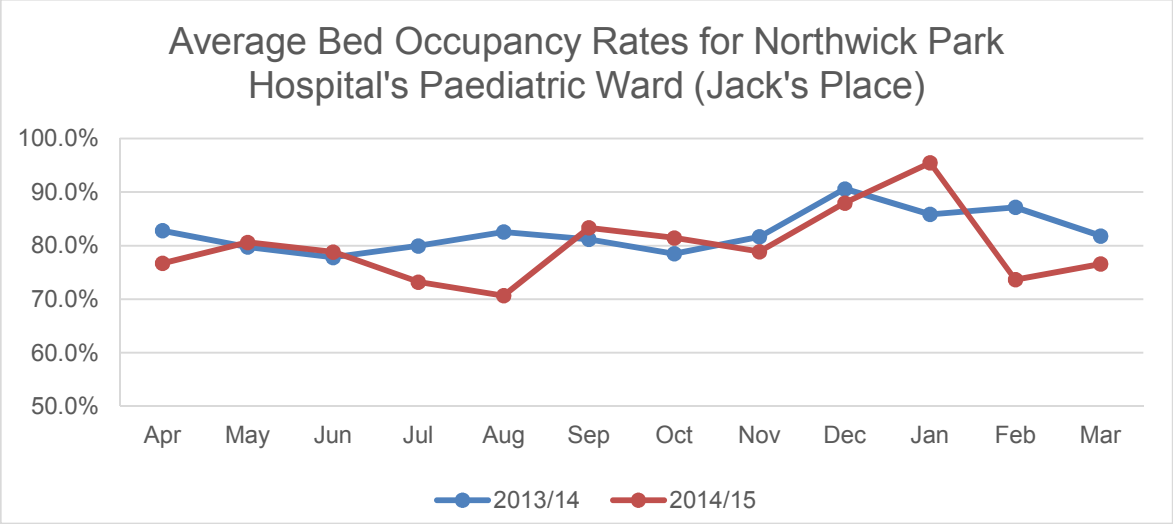
Despite increased activity in some areas there is an estimated underspend of £496,770 against annual cost at NPH.

Northwick Park Hospital - 2014/15 M12 - Paediatric Treatment Functions
Plan vs Actuals - Activity and Cost

Treatment Function Name	Annual Activity	YTD Actual Activity	YTD Variance Activity	Annual Cost	YTD Actual Cost	YTD Variance Cost
Paediatric surgery	68	54	14	£12,806	£8,479	£4,327
Paediatric urology	82	141	-59	£27,979	£55,269	-£27,290
Paediatric gastrointestinal surgery	0	3	-3	£0	£3,700	-£3,700
Paediatric trauma and orthopaedics	163	113	50	£310,232	£268,797	£41,435
Paediatric ear, nose and throat	1,044	756	288	£323,079	£276,670	£46,409
Paediatric opthalmology	677	621	56	£104,013	£91,951	£12,062
Paediatric gastrolenterology	7	13	-6	£6,921	£10,853	-£3,932
Paediatric endocrinology	118	107	11	£32,492	£29,803	£2,689
Paediatric audiological medicine	628	683	-55	£87,188	£66,405	£20,783
Paediatric clinical immunology and allergy service	192	226	-34	£32,017	£36,957	-£4,940
Paediatric infectious diseases	623	284	339	£73,665	£41,810	£31,855
Paediatric dermatology	0	110	-110	£0	£14,991	-£14,991
Paediatric respiratory medicine	108	92	16	£31,295	£26,048	£5,247
Paediatric nephrology	56	63	-7	£9,793	£7,327	£2,466
Paediatric medical oncology	54	14	40	£160,145	£34,732	£125,413
Paediatric rheumatology	76	84	-8	£26,249	£31,907	-£5,658
Paediatric diabetic medicine	214	249	-35	£32,800	£34,147	-£1,347
Community Paediatric	36	12	24	£37,561	£28,539	£9,022
Paediatric neuro-disability	106	93	13	£50,241	£34,630	£15,611
Paediatric cardiology	2	0	2	£1,331	£0	£1,331
Paediatric	7,988	7,967	21	£4,282,510	£4,039,771	£242,739
Paediatric neurology	107	115	-8	£9,117	£11,879	-£2,762
TOTAL	12,349	11,800	549	£5,651,434	£5,154,664	£496,770

2.2.1 Paediatric in-patient bed occupancy at Northwick Park Hospital (Jack's Place) for 2013-14 and 2014-15

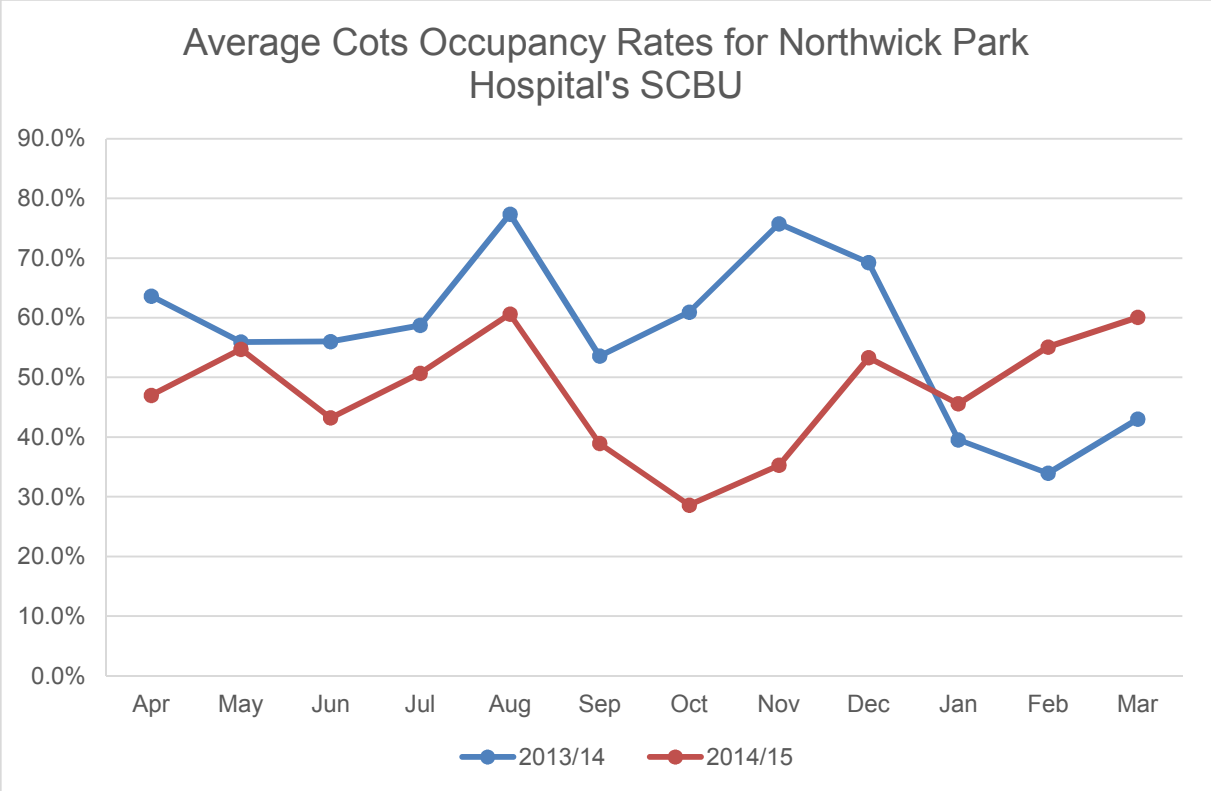
Month	2013/14			2014/15		
	Average Occupied Beds	Total Beds	Average Bed Occupancy Rate	Average Occupied Beds	Total Beds	Average Bed Occupancy Rate
Apr	17.4	21	82.8%	16.1	21	76.7%
May	16.7	21	79.7%	16.9	21	80.6%
Jun	16.3	21	77.8%	16.5	21	78.8%
Jul	16.8	21	80.0%	15.4	21	73.2%
Aug	17.3	21	82.6%	14.8	21	70.7%
Sep	17.0	21	81.2%	17.5	21	83.3%
Oct	16.5	21	78.5%	17.1	21	81.4%
Nov	17.1	21	81.7%	16.6	21	78.9%
Dec	19.0	21	90.6%	18.5	21	88.0%
Jan	18.0	21	85.9%	20.0	21	95.5%
Feb	18.3	21	87.2%	16.9	23	73.7%
Mar	17.2	21	81.8%	17.6	23	76.6%



Overall, there has been a slight decrease in average bed occupancy rate on a monthly basis in 2014/15 from 2013/14 apart from an increase in October 2014 and near full capacity in January 2015.

2.2.2 SCBU occupancy at Northwick Park Hospital for 2013-14 and 2014-15

Month	2013/14			2014/15		
	Average Occupied Cots	Total Cots	Average Cots Occupancy Rate	Average Occupied Cots	Total Cots	Average Cots Occupancy Rate
Apr	12.7	20	63.6%	9.4	20	47.0%
May	11.2	20	55.9%	10.9	20	54.7%
Jun	11.2	20	56.0%	8.6	20	43.2%
Jul	11.7	20	58.7%	10.1	20	50.7%
Aug	15.5	20	77.4%	12.1	20	60.6%
Sep	10.7	20	53.6%	7.8	20	38.9%
Oct	12.2	20	60.9%	5.7	20	28.6%
Nov	15.2	20	75.8%	7.1	20	35.3%
Dec	13.8	20	69.2%	10.7	20	53.3%
Jan	7.9	20	39.5%	9.1	20	45.6%
Feb	6.8	20	33.9%	11.0	20	55.1%
Mar	8.6	20	43.0%	12.0	20	60.1%



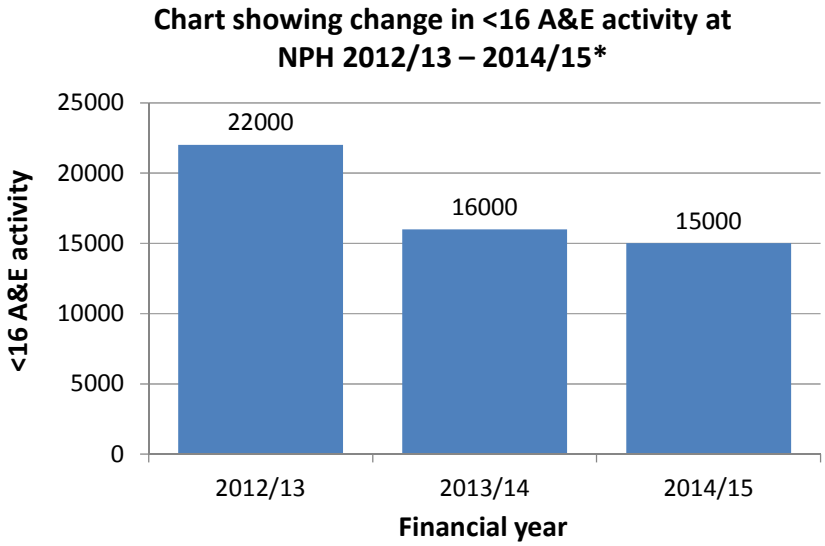
Overall, there has been a marked decrease in average bed occupancy rate from April – November 2014 on a monthly basis compared to 2013/14. However, there was then a significant continual increase from December 2014 to March 2015. However, the highest occupancy rate was only ever 60.6% at its peak.

2.2.3 Transfers due to lack of beds/cots

Occupancy rates as shown in the above graphs demonstrate that NPH currently has sufficient numbers of paediatric beds/cots to manage demand. An additional three paediatric in-patient beds will be in place prior to the planned transition in June 2016.

2.2.4 <16 years old A&E activity at Northwick Park Hospital

Paediatric activity at NPH A&E has fallen by 30% since 2012/13. Patients who self-present at NPH A&E are streamed through the Urgent Care Centre. The Urgent Care Centre is able to see and treat more patients as a proportion of the activity in the emergency department which is a factor in reducing levels of paediatric A&E activity at NPH.



*Assumptions: NWL commissioned activity from SUS used – assumption that NWL commissioned activity accounts for 78% of total activity. 2012/13 activity extrapolated from 3 months of data.

2.3 Paediatric activity and finance at Ealing Hospital

The table below sets out 2014/15 paediatric activity at Ealing Hospital. The way in which activity is recorded by Ealing Hospital is not as detailed as at Northwick Park Hospital. All their activity is recorded collectively and not under the different headings (though their services will cover the same conditions). In-patient Quality Innovation Productivity and Prevention (QIPP) relates to quality improvements that have achieved improved productivity. These gains act as a surplus figure. Significant increases in activity are highlighted in red.

There is an estimated overspend of £72,179 against annual cost at Ealing Hospital.

Ealing Hospital 2014/15 M12 - Paediatric Treatment Functions
Plan vs Actuals - Activity and Cost

Treatment Function Name	Annual Activity	YTD Actual Activity	YTD Variance Activity	Annual Cost	YTD Actual Cost	YTD Variance Cost
Paediatric Inpatients	2330	2403	-73	£2,185,323	£2,222,828	-£37,505
Paediatric Inpatients QIPP	-24	0	-24	-£18,355	£0	-£18,355
Paediatric Inpatient XBD	182	233	-51	£63,317	£82,837	-£19,520
Paediatric Out Patients	5144	4808	336	£974,324	£916,120	£58,204
Paediatric Out Patients QIPP	-296	0	-296	-£58,977	£0	-£58,977
Paediatric OP Procs	228	209	19	£39,865	£36,539	£3,326
Paediatric Tele	24	0	24	£648	£0	£648
TOTAL	**7589**	**7653**	**-64**	**£3,186,145**	**£3,258,324**	**-£72,179**

3 Planned improvements to paediatric services for children in Brent

- **New community based services –** As part of a wider programme of community service re-design, community-based paediatric asthma and paediatric phlebotomy services will be improved. Brent CCG is also participating in a pan-North West London programme to review the provision of community-based paediatric services.
- **Child and Adolescent Mental Health Services (CAMHS) -** Brent CCG in partnership with the North West London Collaboration of CCGs, has recognised the need to improve out-of-hours CAMHS provision and has invested an additional £140k as part of a £1.1m pilot which is aimed at improving the urgent care response to children and young people with a mental health crisis. The pilot will be undertaken during a comprehensive review of CAMHS in 2015/16 to inform the future service developments required.
- **New Paediatric Epilepsy service** to reduce need for travel to tertiary centres
- **Opening of specialist feeding investigations service** to reduce travel to Great Ormond Street Hospital to provide care closer to home.
- **NHSE/CCG co-commissioning of Paediatric High Dependency Unit (HDU)** to critical care level 2 to reduce impact of un-commissioned HDU activity in Jack's Place.
- **Completion of Jack's Place refurbishment by Winter 2016** – all CQC actions included plus SaHF reconfiguration requirements.
- **Development of Paediatric Assessment Unit** in the NPH Paediatric Emergency Department Observation area (SaHF reconfiguration requirement) to facilitate 12 hour discharge.

4 Care Quality Commission review of paediatric services at Northwick Park Hospital

The August 2014 Care Quality Commission inspection report identified a number of areas where the Trust must make improvements, specifically related to children in Jack's Place were:

- The environment is suitable and that appropriate equipment is available, safe and suitable in paediatric services at Northwick Park Hospital.

Recommendation / Finding	Action taken
Jack's Place: The design of the ward meant that many areas were not observable from the nurses' station, or the reception desk, which posed a safety risk when children were playing in the ward. *Regulation 15 (1) (a)*	Review of ward configuration undertaken with options scoped and costed. Refurbishment starts in July 2015 and will be completed by October 2015
	All compliance actions complete and ongoing monitoring across services both at NPH and Central Middlesex Hospital
Neonatal unit A fridge in the neonatal unit was iced up and there were gaps in the temperature recording. *Regulation 16 (1) (a)*	• Fridge defrosted • Out of date samples disposed off • HCA to add to rota of temperature recordings

5 Impact of Shaping a Healthier Future reconfiguration on Northwick Park Hospital paediatric services

5.1 Shaping a Healthier Future (SaHF) overview

The 'Shaping a Healthier Future (SaHF) programme, led by local clinicians, proposed changes to services in North West London (NW London) that would safeguard high quality care and services for the local population. The principles behind this are: putting the patient at the centre of the NHS; providing more accessible care; and establishing centres of excellence so that more expertise is available more of the time.

Under SaHF proposals, maternity, neonatal and paediatric in-patient services will be consolidated at fewer sites, resulting in the closure of some services at Ealing Hospital.

These changes have the unanimous support from all medical directors in NW London, who have written to the Health Secretary setting out that 'there is a very high level of clinical support for this programme across NW London' and that these changes will 'save many lives each year and significantly improve patients' care and experience of the NHS.'

SaHF proposed the consolidation of paediatric in-patient services from six sites to five sites to incorporate paediatric emergency care, in-patients and short stay facilities. The five sites are aligned to the five major Trusts to allow a full array of support services including diagnostics and surgery:

- Chelsea and Westminster Hospital
- St Mary's Hospital (part of Imperial College Healthcare Trust)
- Hillingdon Hospital

- West Middlesex Hospital
- Northwick Park Hospital

Consolidating paediatric services at fewer sites will enable Trusts to improve levels of consultant cover. Consistent presence of senior clinicians will:

- Enable NW London to provide consistent 7 day services
- Reduce paediatric Serious Untoward Incidents (SUIs)
- Reduce paediatric emergency admissions
- Reduce mortality rates
- Increase patient satisfaction
- Expose trainees to a wider range of complex cases
- Provide a platform for Out of Hospital services

On 20th May 2015 Ealing CCG Governing Body agreed that:

- Maternity and neonatal services should close at Ealing Hospital on 1st July 2015, with activity re-distributed in NWL.
- Paediatric inpatient services should close at Ealing Hospital on 30th June 2016, 12 months after the maternity transition.

Over the next 12 months, detailed implementation planning work will be undertaken in preparation for the paediatric changes. Regular checkpoints have been built into the process to enable commissioners to monitor progress and intervene as necessary.

5.2 Anticipated impact on paediatric services at NPH

The changes at Ealing Hospital will have implications for hospital sites elsewhere in North West London. Detailed activity modelling has been undertaken to establish the likely flow of patients to alternative sites. This modelling is based on a 'highest case' scenario, resulting in the re-provision of current Ealing paediatric activity with a contingency of 27% above current activity, ie 127%. The 'highest case' scenario approach ensures that sufficient contingency is built into the system to account for unexpected increases in demand. The activity model will be refreshed in the coming months using the latest available data. Paediatric activity is currently falling at Ealing Hospital, so it is likely that the amount of additional capacity built into the system will exceed the 27% already planned and accounted for.

It is anticipated that Northwick Park Hospital will receive an additional 500 paediatric inpatient admissions per year as a result of the changes at Ealing Hospital. This includes significant contingency (additional 27% system-wide over-provision referenced above) and translates into a need for 3 additional paediatric inpatient beds at Northwick Park Hospital. London North West Healthcare Trust (LNWHT) have secured funding from the Shaping a Healthier Future programme to create 3 additional inpatient beds via an expansion of Jack's Place. Work has already commenced and it is anticipated that the new physical capacity will be in place by winter 2015.

The workforce implications of the changes are being worked through as part of the implementation planning process. It is anticipated that the majority of Ealing staff will be redeployed to receiving sites in line with activity. The Shaping a Healthier Future programme is also working with Health Education North West London (HENWL) to increase the number of paediatric doctors available in North West London overall.

The closure of paediatric in-patient services at Ealing Hospital on 30th June 2016 will mean that in some cases, Ealing A&E will be required to stabilise, assess and transfer paediatric

patients as paediatric specialist input will no longer be available on-site. To ensure that sufficient contingency exists across the system, activity modelling does not take into account Ealing A&E's retained ability to manage children, or the benefits of new services (such as the Paediatric Rapid Access Clinic and improved Urgent Care Centre). Again, patient flow assumptions are based on a scenario in which activity is significantly higher than current activity levels (plus 27%). In practice, the true volume of transfers will be lower. Under this 'highest case' scenario, Northwick Park Hospital plan to receive an additional 4-5 A&E attendances (for under 16 year olds) per day from June 2016. LNWHT has confirmed that they have the physical space within the new Northwick Park Hospital A&E to absorb this additional activity with the additional three in patient beds.

5.3 Preparing patients and the public about these changes and the Assurance Process

The SaHF reconfiguration programme underwent a full statutory public consultation process. In February 2013 the Joint Committee of Primary Care Trusts agreed to proceed with the SaHF proposals. This included the consolidation of maternity units in North West London from 7 to 6 (the remaining 6 maternity units will be Chelsea and Westminster Hospital, St Mary's Hospital (part of Imperial College Healthcare Trust), Hillingdon Hospital, West Middlesex Hospital, Northwick Park Hospital, Queen Charlotte's and Chelsea Hospital (part of Imperial College Healthcare Trust) leading to the closure of Ealing Hospital Maternity Unit.

In October 2013, the Secretary of State endorsed these plans, although no decision was made on the timing of the transition of maternity services.

In late 2013 Ealing Hospital raised concerns to the Medical Director of NHS England (London region) regarding the issue of a reduction in deliveries for the Trust and the risk this posed to the quality of care. In response to the concerns raised by Ealing Hospital, on 19th March 2014 Ealing CCG Governing Body made a decision to invest in contingency plans for the transition of maternity and neonatal services from Ealing Hospital by 2015.

Ealing CCG Governing Body met again to discuss the issue in October 2014 and agreed to plan for the implementation and assurance of these changes. The Governing Body considered the initial outputs of the first phase of assurance at its meeting in March 2015 and agreed that further work was required.

Ealing CCG Governing Body met on 20th May 2015 to consider the outputs of this assurance work and decided that a date could now be set for the transition. The Governing Body considered a range of documents and heard from clinical leaders regarding this change.

All of the papers for this meeting are available to view on the Ealing CCG website at: www.ealingccg.nhs.uk

- The case for change (maternity & paediatrics)
- An overview of the new North West London (NWL) model of care for maternity
- Feedback from a review undertaken by the London Clinical Senate
- The modelling of activity following the transition (maternity and paediatrics)
- Readiness for the proposed changes
- Outputs of the assurance processes undertaken by CCGs in North West London, NHS England and the Trust Development Authority (TDA)

- An implementation plan for the changes which would be enacted following the CCG decision on timing

- An overview of the communications, engagement and equalities work planned

The Ealing Governing Body took questions from the public before its decision on whether to set a date for this change.

6 Conclusion/Summary

In summary and as approved by Ealing CCG Governing Body, maternity and neonatal services are planned to close at Ealing Hospital on 1st July 2015, with activity re-distributed in NWL. Paediatric in-patient services should close at Ealing Hospital on 30th June 2016, 12 months after the maternity transition.

Brent OSC is asked to note the planned changes to services, the approach to preparing patients affected and the public about these changes and the assurances being undertaken by Ealing CCG (on behalf of the 8 NWL CCGs including for Brent) to ensure a safe and smooth transition.

Brent CCG and LNWHT will provide further updates on progress.

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Brent	**Scrutiny Committee** 16 June 2015 **Report from Scrutiny Task Group**
For Information	Wards Affected: ALL

Access to Extended GP Services and Primary Care in Brent - Interim Report

1.0. Summary

1.1. This report provides interim feedback on the work of the Scrutiny Task Group focused on Access to Extended GP Services and Primary Care in Brent. The report outlines the task group scope and methodology and provides an overview of emerging findings and recommendations.

1.2. Brent Clinical Commisisoning Group (CCG) and London North West Healthcare NHS Trust are changing the way healthcare is provided in Brent. The Scrutiny Task Group was established to review the primary care element of Brent CCG's transformation programme and assess the extent of the changes and investment made in the Brent GP networks and primary care services for the effective implementation of the changes to the acute sector set out within Shaping a Healthier Future (SaHF).

1.3. Access to the right care, in the right place, at the right time, is a common theme throughout transformation plans. The intention is for hospitals to concentrate on providing specialist services. Other services will be provided in a community setting, which will require additional capacity in primary care and a greater link between health and social care in ensuring patients receive a more integrated and coordinated service. This should prevent the need for more acute interventions.

1.4. The review was primarily concerned with the capacity within the Brent GP network, access to out of hours care and the delivery of out-of-hospital services to provide enhanced extended primary care to meet the needs of local residents. The work of the task group included identifying areas that are working well, as well as any barriers, weaknesses or risks associated with the transformation of primary care in Brent.

2.0. Recommendation

2.1. Members of the Scrutiny Committee are recommended to note the progress that the task group has made to date.

3.0. Detail

Scope of the Review

3.1. The aim of the Scrutiny Task Group was to assess the extent of the changes and investment made in the Brent GP networks and primary care services necessary for the effective implementation of the changes to the acute sector set out within SaHF.

3.2. The review focused on the following key questions:

1. What are the needs of Brent residents, including vulnerable groups, in relation to accessing GP care?
2. Is there sufficient capacity within the Brent GP network to provide enhanced extended primary care to meet the objectives set out within the SaHF proposals?
3. Are there any barriers, weaknesses or risks associated with the transformation of primary care?
4. What actions are required to ensure effective primary care services are available in Brent?
5. What actions are needed to ensure fair and equitable access to GP services is available to all Brent residents?

Task Group Membership

3.3. The task group included:
Councillor Reg Colwill (Chair)
Councillor Amer Agha
Councillor Rita Conneely
Councillor Mary Daly
Councillor Claudia Hector
Councillor Wilhelmina Mitchell Murray

Review Methodology

3.4. In carrying out the review the task group invited a range of partners to contribute through face-to-face meetings and discussion groups. A range of visits and observations were also carried out between January and March 2015.

3.5. Information, advice and views were gathered from a number of people and sources, including:

- Reviewing a range of documents relating to the national, regional and local picture on primary care;
- Gathering information on Brent CCG's primary care transformation programme;

- Reviewing health needs, demographic data and statistical information;
- Meetings with key officers from Brent CCG, Brent Council, NHS England, London Ambulance Service and the Local Medical Committee;
- Meetings with GPs;
- Seeking the views of patient groups, including Patient Participation Groups and Healthwatch Brent;
- Attending Multi-Disciplinary Group meetings;
- Carrying out a range of visits, including visiting a GP Access Centre, Brent Urgent Care Centre and observing a Health and Social Care Coordinator Action Learning Set;
- Gathering information on examples of best practice in neighbouring boroughs, including a visit to a GP practice in Westminster.

A full list of participants will be detailed in the final report.

3.6. During the review, the task group had the opportunity to speak with a range of partners who shared their opinions and experiences of services. The task group recognises that people have different experiences of primary care and, through the analysis of information gathered, has tried to present a balanced view of the opinions given.

Emerging Findings

Demand for Primary Care

3.7. There is growing demand for primary care due to an ageing population, increased long-term conditions and changing expectations. Brent's population increased by 1.7% from 311,215 in 2011 to 320,190 in 2013[1]. Brent's population will continue to grow, rising by 10,456 over the next five years, from 320,781 in 2015 reaching 331,237 in 2020, an increase of 3.3%[2].

3.8. Brent is an ethnically diverse borough. In Brent, the black, Asian and minority ethnic (BAME) groups make up 65.0% of the population, compared to 41.8% in London[1]. This has increased since 2011, where BAME groups made up 63.7% of the population. About one third (36.0%) of the population are Asian; 35.0% white and 21.1% black[1].

3.9. The number of older people is increasing. Between 2011 and 2013, the largest increase was in people aged 80 and over; this population grew by 10.8% from 8,048 in 2011 to 8,917 in 2013[1]. This places increased pressure on both health and social care services.

3.10. Population growth, widening health inequalities and complexity are driving up demand on general practice nationally. General practice undertakes 90% of NHS activity for 7.5% of the cost, seeing more than 320 million patients per

[1] Brent JSNA – People and Place (2014)
[2] GLA SHLAA based population projections, 2013 rnd

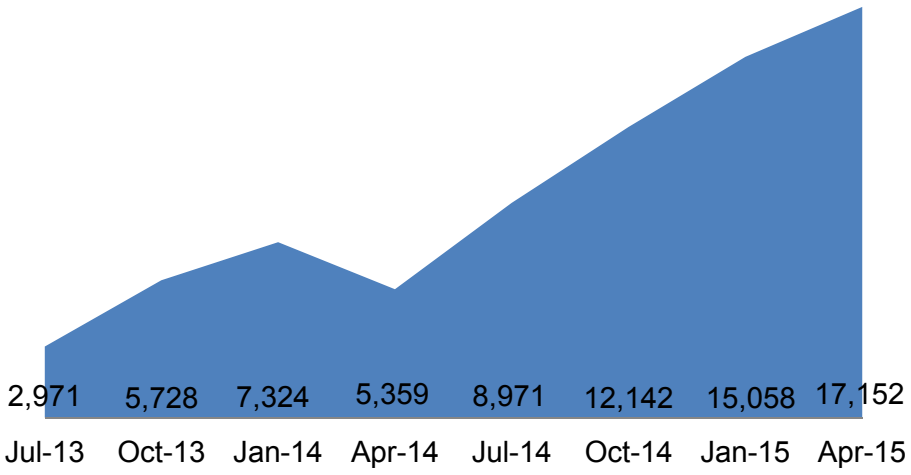
year[3]. Changes in patients' health needs and expectations, an expected increase in long term health conditions (now taking up 70% of hospital and primary care budgets in England[4]), as well as ongoing budget pressures, present real problems for health services.

Access to Primary Care

3.11. The review found that there is an overall feeling that public confidence in individual GPs is good. The biggest concern is access. In 2012 there were 69 GP practices in Brent and 339,381 registered patients. In April 2015 there are 67 GP practices in Brent, with 365,165 registered patients[5].

3.12. The number of registered patients across the 67 practices has risen since 2012 and is continuing to rise. The number of registered patients increased from 360,155 to 363,071 between October 2014 and January 2015[5]. This is an increase of nearly 3,000 patients in a relatively short time. Figures published by the HSCIC in April 2015 showed a further rise in the number of registered patients within the borough to 365,165[5]. A patient doesn't have to live in Brent to register with a Brent GP.

Figure 1: New patients registered since April 2013



3.13. Population projections for Brent, outlined in paragraph 3.7., suggest an ongoing increase in resident numbers, which will place increasing pressure on GP services, already under strain. In addition to the projected increase in resident numbers, projections show changes in the age profile of residents with an increase in the number of older residents placing additional pressures on both health and social care services[1].

[3] NHS England –Transforming primary care in London (2013)
[4] NHS England
[5] HSCIC – Number of Patients Registered at a GP Practice

3.14. Brent CCG has lower patient satisfaction results compared to the national average with regards to accessing primary care. Opening times and access to appointments outside of working hours vary across practices. Out of the 67 Brent GP practices, 37 open after 6pm, including 15 that open until after 7pm. 37 practices open at 8.30am or before. Of these, three open at 7.30am and ten at 8am[6]. Brent ranks 191st out of 211 CCGs with respect to patient satisfaction on opening hours and, for overall satisfaction, Brent ranks 204th out of 211. Whilst 71% of people would recommend their practice to someone moving to the area, this is the 200th best result of 211 with 112 CCGs scoring above 80%[7]. The CCG's plans to extend access to primary care aim to improve access and increase patient satisfaction rates.

3.15. Through discussions held, access by telephone was identified as an issue for practices, with a need to invest resources. Concerns with GP premises were also highlighted through the review and the constraint these place on delivering services.

Extended GP Services

3.16. The development of GP Hubs in Brent was seen as a way of freeing up capacity, managing demand differently and providing access to care out of hours in delivering a seven day service. It is dependent on practices working together in networks in order to provide extended access to GP appointments. The extended GP hub model was also driven by an opportunity to offer choice to the patient in obtaining an appointment rather than having to wait to see their GP. Patients can still go to their GP but it remains hard to get an appointment with certain GPs.

3.17. A hub is a GP practice that offers evening and weekend appointments for patients registered with other practices in the area, providing access to primary care out of normal GP practice opening times. The hubs are not walk-in centres. The pilot scheme of GP Access Hubs provided a hub in each clinical network across Brent CCG at the following locations:

- Harness Locality: Wembley Centre for Health and Care and Harness Harlesden Practice
- Kilburn Locality: Staverton Surgery and Kilburn Park Medical Centre
- Kingsbury Locality: Chalkhill Family Practice
- Willesden Locality: Willesden Centre for Health and Care
- Wembley Locality: Integrated Health CIC and Sudbury Primary Care Centre

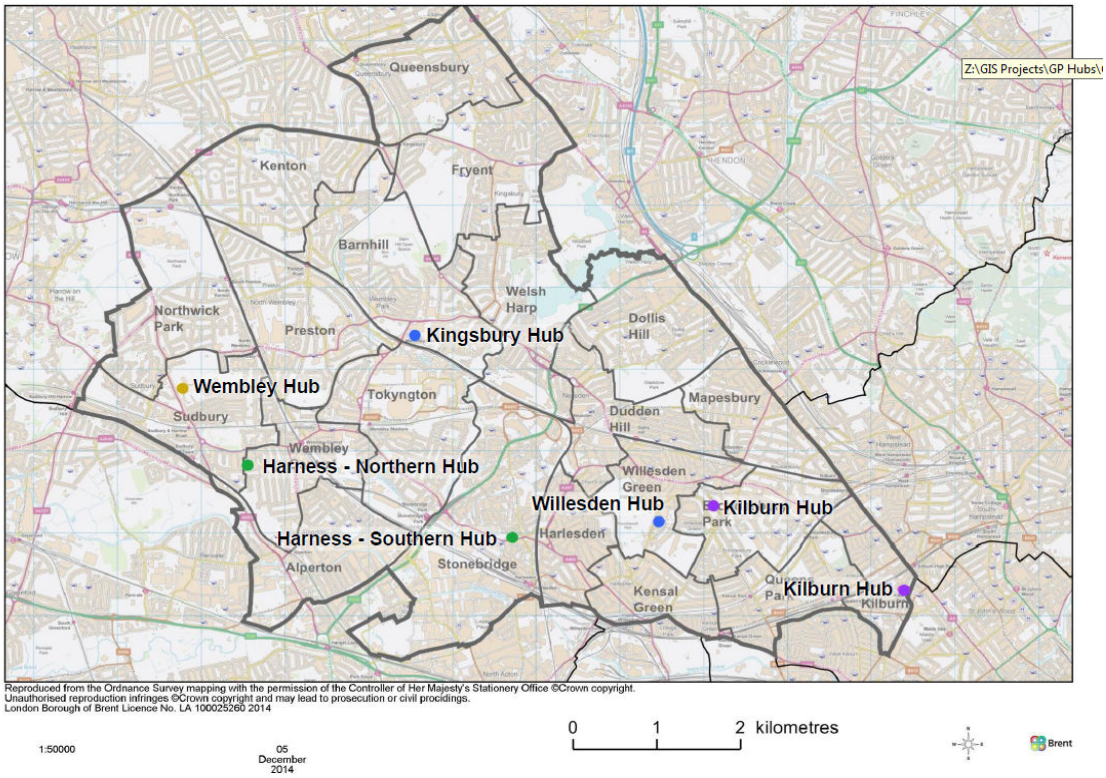
3.18. Following a review of the pilots, the CCG carried out a procurement exercise for a longer-term service in 2014, with the implementation of a three year contract from April 2015. The model is also being rolled out to additional sites. This was based on a revised service specification for the future service, which details both national and local defined outcomes for the service. The

[6] NHS Choices: GP opening times, downloaded 05/02/2015 *one practice did not have opening times recorded

[7] Brent CCG – Service Specification for Primary Care Access Hubs

main changes include removing week-day afternoon appointments at hubs due to NHS England requirements that the service should not overlap with core GP hours and changes to Saturday and Sunday appointments (revised hours of 9am to 3pm on Saturday and Sundays and to include bank holidays).

Figure 2: Map of GP Hubs Pilot



3.19. The sessions on a Saturday afternoon have been reduced as appointments were not being taken up in the pilot arrangements. However, the changes in operating hours have removed some of the additional capacity in managing demand as the availability of the afternoon appointments, offered as part of the initial pilots, could alleviate some of the pressure on practices in providing additional appointments during week days. This will not be offered going forward.

3.20. In March 2015, the hubs had delivered an additional 70,000 GP and nurse appointments in primary care[8]. The task group has requested a breakdown of recent utilisation of GP hub appointments to gain a better picture of the impact of the hub model in delivering extended access. There is also further information required in analysing the implications for local residents resulting from additional travel requirements in attending GP hub appointments.

3.21. Evidence received during the review highlighted that awareness of the GP hubs during the pilot phase had been relatively low across the borough. A survey carried out by Healthwatch Brent during November and December 2014, found that the majority of respondents did not know what a hub was and that 15% of people surveyed had used a hub appointment[8]. Lower take-up of

[8] Brent CCG

weekend appointments also raises questions as to whether appointments are being offered at times that meet local residents' needs.

Out of Hospital Strategy

3.22. The development plans for Brent's out-of-hospital services were outlined in March 2012 and endorsed by the Brent CCG Governing Body in May 2012. The strategy sets out five main areas of action, including:

- Easy access to high quality, responsive primary care making out-of-hospital care first point of call for people
- Clear and planned care pathways
- Rapid response to urgent needs – if a patient has an urgent need, a clinical response will be provided within four hours
- Social care and health providers working together
- Patients spending an appropriate time in hospital, supported by early discharge

Initiatives to deliver the actions set out in the out-of-hospital strategy are being rolled out.

3.23. The Brent Short Term Assessment Rehabilitation and Reablement Service (STARRS) is reported to be delivering year on year improvements in preventing hospital admissions and was set to exceed its target to prevent 2,300 admissions in 2014/15 (figures provided in March 2015 showed 2,796 preventions[9]).

3.24. Services to deliver more outpatient services in the community and develop community health care facilities are in the early stages. This includes Community Ophthalmology Service (implemented October 2014), Brent Integrated Diabetes Service (launched October 2014) and Sickle Cell Service (commenced March 2015).

3.25. Concerns regarding district nursing, providing support to patients who are housebound or find it difficult to access regular healthcare, were raised during the review. The District Nurses work closely with GP surgeries and in partnership with other health and social care professionals in providing healthcare needs assessments, care planning and nursing care within the home. Issues regarding recruitment and retention were raised during the review. This requires further investigation but feedback received included a need to develop a programme to support district nursing, to ensure an effective, motivated and responsive service is in place.

3.26. If, as outlined in the transformation plans, hospitals will focus on the provision of specialist services, other services need to be fully established in a community setting. With services in the early phases of implementation and no robust data available, it is too early to evaluate the impact.

[9] Brent CCG

Integrated Care Programme

3.27. The Integrated Care Programme (ICP) was introduced in 2012 with the aim of improving care for people with a long term condition such as diabetes, coronary heart disease, respiratory problems and those over the age of 75. The programme has received good feedback from patient surveys carried out.

3.28. As part of the programme, multi-disciplinary groups meet in each locality on a monthly basis to discuss patients referred to them. The aim of the multi-disciplinary approach is to care for patients within the community wherever possible and avoid unnecessary hospital admissions. The multi-disciplinary groups observed were well attended and provided a good opportunity for discussion and support. Figures provided by Brent CCG in March 2015 show that in excess of 8,500 care plans have been completed to date, 142 multi-disciplinary group meetings held with 477 patients discussed.

3.29. A new role of Health and Social Care Coordinators (HSCCs) has been developed, with appointments made in 2014. HSCCs act as the first point of contact for patients in relation to their care and provide support for the delivery of care plans, signposting patients to services and resources within the community where appropriate. The task group had the opportunity to attend an Action Learning Set and discuss case studies, which highlighted good outcomes in individual cases in terms of delivering interventions to reduce dependency on GP services and avoid unnecessary hospital admissions.

3.30. The value of the role of HSCCs is acknowledged. The HSCC role has been introduced as part of a pilot programme. The task group identified areas for consideration in reviewing the pilot and planning future arrangements for the role. For example, the team are currently being supported through a bespoke training programme but it is unclear how they will be supported going forward or how future arrangements will be funded. Details of the reach of the role were also unclear and there appear to be differing viewpoints as to the key focus (clinical or support services). There is also further clarity required regarding the level of responsibility and breadth of the role, in identifying any potential areas of overlap with other roles and services.

3.31. Brent CCG carried out evaluation of the ICP through 600 patient surveys, which provides positive feedback on the programme. The findings show that the care plan has enabled 72% of people surveyed to be more confident to manage their health. 75% of care planned patients said their family or carer was involved in decisions about their health as much as they wanted them to be. The outcomes delivered through the programme also included a reduction of 398 non-elective (emergency) admissions according to analysis provided by the CCG in March 2015.

3.32. The task group wish to carry out further analysis of the full results of the patient survey in gaining a clearer picture of the impact of the ICP.

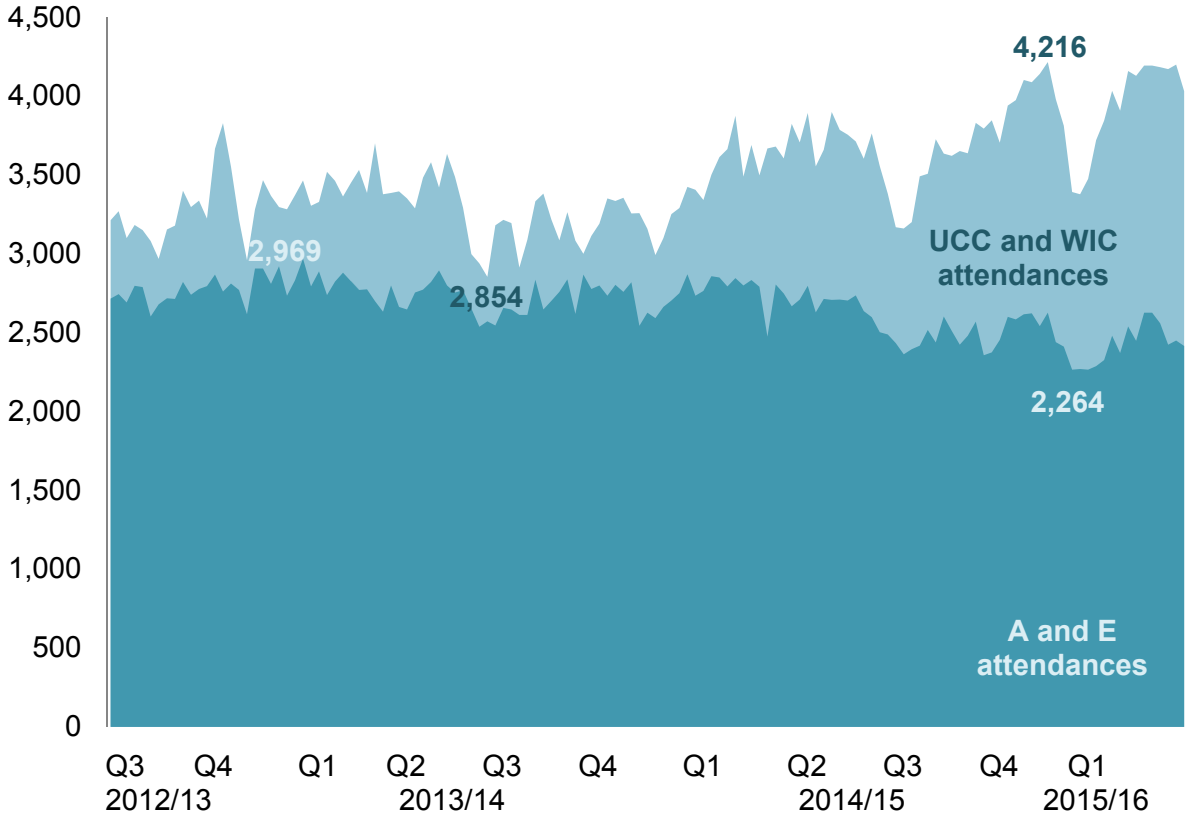
Emergency and Urgent Care

3.33. Brent CCG commissions the Urgent Care Centre (UCC) at Central Middlesex Hospital, delivered by Care UK. The UCC offers medical care 24 hours a day, seven days a week, to treat minor illness and injuries that require urgent and immediate attention. The task group visited the UCC at Central Middlesex Hospital as part of the review. Prior to the visit, the task group were concerned with access, facilities, waiting times, patient experience and utilisation of the centre.

3.34. During the task group visit, members were informed that steps had been taken to ensure that the UCC could respond to needs following the closure of the A&E department at Central Middlesex Hospital. Additional facilities and services have been commissioned including a holding bay to manage any transfer requirements and private ambulance service to support non-emergency transfers. Waiting times are reported to vary dependent on medical priorities but it was felt that patients are realistic about waiting.

3.35. UCCs are required to offer a breadth of expertise, seeing high risk patients, especially now the A&E facility has closed. It is recognised that access to the service will vary, as what is deemed urgent may differ between individuals and clinicians.

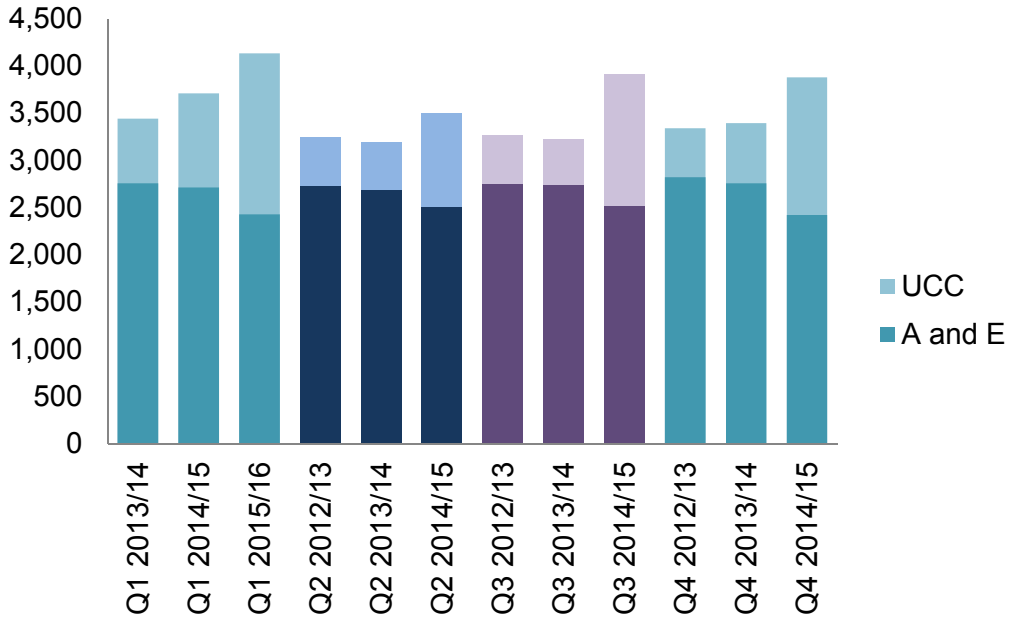
Figure 3: A&E and UCC Weekly Attendances[10]



[10] NHSE. Up to Q2 2014/15 – dataset for Ealing Hospital and NWL Hospital Trust. From Q3 2014/15 – dataset for London North West Healthcare Trust.

3.36. Figures three and four show an increase in trend in UCC and walk-in centre (WIC) attendances, which may be a result of difficulty in accessing GP appointments. However, recent coverage of the UCC at Central Middlesex Hospital reported a decrease in UCC attendance in February 2015[11]. This could have been following one of the clear dips or might be that patients are unaware of the service and facilities or treatment provided at Central Middlesex Hospital; this requires further investigation. There are questions regarding residents' awareness of the service, as well as the success of the communication strategy to publicise the UCC. Barriers to accessing the facility were experienced during the task group visit, including poor signage and the cost of parking for the UCC.

Figure 4: A&E and UCC Attendances by Quarter[12]



3.37. The additional ambulance service has been commissioned to manage non-emergency transfers. There are currently concerns regarding the performance of London Ambulance Service (LAS). National standards for responding to a life threatening or urgent case is eight minutes 75% of the time. Figures provided in January 2015, showed that the LAS were achieving the standard in under 11 minutes (reaching 75% of the most seriously ill and injured patients in under 11 minutes). Brent is the fourth busiest borough in London for category A emergency calls. Of these calls, 56% were responded to in eight minutes and 92% in 19 minutes.[13]

[11] http://www.kilburntimes.co.uk/news/health/brent_urgent_care_centre_sees_decrease_in_patients_as_a_e_demands_rise_1_3971026

[12] NHSE

[13] LAS (January 2015)

3.38. The LAS staffing levels continue to be below where they need to be. London has the highest utilised staff in the country (utilised for 90% of the day – from job to job – compared to other parts of the country which are around 60%).[13] There is a national shortage of paramedics and the recruitment and retention of staff is key to service performance. At the end of November 2014, LAS had 411 frontline vacancies. In January 2015, Brent had 55 vacancies.[13] Frontline shortages are being addressed through a range of measures, including working with universities to roll out training programmes and a national and international campaign to recruit staff, with a targeted campaign in Australia. However, it appears that there was a delay in addressing staffing issues within the LAS and the task group has some concerns regarding how staff retention will be addressed, with factors such as the cost of living likely to have an impact on staff turnover in London.

Managing Expectations

3.39. The task group spoke with a range of people who were able to share their opinion and experience of services. A recurring theme within discussions was communication. An area raised was the need for further support to educate and support people in managing their own health care at home where appropriate. During the review, there were a number of examples shared in which patients attend appointments unnecessarily and educating members of the public on how to access GP or other primary care services would free up time currently used to address non-medical issues. However, this needs to be carefully managed in ensuring those who do need medical care seek advice. Links with both schools and workplaces were viewed as important in educating people in making informed decisions in accessing GP services. A booklet has been produced to help improve access to primary care in Brent.

3.40. Practices receive a lot of requests for admin. A number of areas which create additional workload were highlighted during the review; this is time which could be used to address medical issues. For example, GPs receive requests from schools to provide letters, requests from employers for sick notes (with regular requests for sick notes after just three days absence) and regular requests from housing departments, social workers and occupational therapists. This places additional pressure on GP practices.

Emerging Recommendations

3.41. Full recommendations are still being finalised and will be informed by the additional evidence required in presenting a full picture of access to extended GP services and primary care in Brent. Key insight and lessons learned through the range of discussions and visits held, as well as an analysis of the findings to date, have highlighted some areas for consideration.

The following emerging recommendations have been identified:

- The development of a clear, borough-wide, publicity campaign to provide information on GP Access Hubs.

- To carry out a detailed review of utilisation of GP Access Hubs following the initial six months and first full year of operation against the new service specification, providing a detailed evaluation on the level of take up, impact on patient satisfaction regarding access and impact on A&E attendances.

- The development of a clear communication strategy for ensuring the public are aware of and informed of the Urgent Care Centre and the services provided.

- Introduction of clearer road and access signs for the Urgent Care Centre and a review of the cost of parking at the centre.

- The development of a communication strategy, including targeted activities with schools and workplaces across the borough, in promoting the right access to services, raising awareness of the range of services available and support to manage care at home where appropriate.

Next Steps

3.42. There is further evidence required to support the task group in drawing conclusions and finalising recommendations. A final report will be presented to the Scrutiny Committee in the Autumn.

4.0 Financial Implications

4.1 There are no direct financial implications arising from this report.

5.0 Legal Implications

5.1 There are no legal implications arising directly from this report.

6.0 Diversity Implications

6.1 There are no diversity implications arising directly from this report.

Cllr Colwill
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Brent	**Scrutiny Committee** 16 June 2015 **Report from the Director of Public Health**
For Information	Wards Affected: ALL
Public Health - Priorities and Progress	

1.0 Summary

1.1 As a result of the Health and Social Care Act 2012, local authorities have new responsibilities for public health. This report outlines these responsibilities and how the Council is discharging these.

1.2 The public health roles of Public Health England and NHS England are also summarised as well as areas where the Council is working with PHE and NHSE on matters of public health importance.

1.3 The report outlines the significant public health commissioning undertaken by the Council, including areas of collaboration with other Councils.

1.4 Drawing upon the 2014 Annual Report of the Director of Public Health, the report outlines public health priorities for Brent and how these are being addressed.

2.0 Recommendation

2.1 Members of the Scrutiny Committee are recommended to note the progress that is being made with respect to the Council's public health responsibilities.

3.0 Detail

Changes to public health responsibilities as a result of the Health and Social Care Act 2012

3.1 The Health and Social Care Act 2012 conferred new public health responsibilities onto local authorities in three domains:

- Health improvement
- Health protection
- Health services public health.

3.2 As a result of the Act, responsibility for a range of services previously commissioned by the NHS transferred to the Council. The Council now commissions:

- Substance misuse prevention, treatment and recovery services
- Sexual health services
- School nursing
- NHS health checks
- Services to support positive behavioural change, e.g. smoking cessation.

3.3 Not all the NHS responsibilities for public health transferred to Councils. The Health and Social Care Act created Public Health England (PHE) and NHS England (NHSE) who both have significant roles in public health.

The role of PHE

3.4 PHE is an executive agency, sponsored by the Department of Health with over 5000 staff. It is responsible for:

- making the public healthier by encouraging discussions, advising government and supporting action by local government, the NHS and other people and organisations
- supporting the public so they an protect and improve their own health
- protecting the nation's health through the national health protection service, and preparing for public health emergencies
- sharing information and expertise with local authorities, industry and the NHS, to help them make improvements in the public's health
- researching, collecting and analysing data to improve understanding of health and come up with answers to public health problems
- reporting on improvements in the public's health so everyone can understand the challenge and the next steps
- helping local authorities and the NHS to develop the public health system and its specialist workforce.

The public health role of NHS England

3.5 NHSE has wide ranging responsibilities. These include commissioning, on behalf of PHE, a number of public health services, with an annual budget of £2.2 billion. These services are:

- National immunisation programmes
- National screening programmes
- Public health services for offenders in custody
- Sexual assault referral centres
- Public health services for children aged 0-5 years (including health visiting, family nurse partnerships and much of the healthy child programme).
- Child health information systems

3.6 Responsibility for commissioning public health services for children aged 0-5 years will transfer from NHSE to local authorities in October 2015. This is a change in responsibility for commissioning, the employment of the 0-5 public health workforce (mainly health visitors) will not change.

Health protection

3.7 PHE and NHSE work together closely on health protection, planning and preparing and responding to health emergencies such as the recent Ebola situation. Directors of Public Health (DsPH) have a duty to ensure that NHSE and PHE have the appropriate plans in place. In London that assurance is provided through the London Health Resilience Partnership. In addition health protection arrangements are a standing item on the Brent Borough Resilience Forum's agenda.

Health services public health

3.8 'Health services public health' refers to the requirement for local authority public health teams to provide public health advice to their local CCG. This includes needs assessment, evidence reviews, advice on evaluation and advocacy for prevention and health promotion. The DPH is a non voting member of the CCG Governing Body.

Mandated local authority functions

3.9 While local authorities have a range of public health responsibilities, only a subset of these are "mandated" or "prescribed". While local authorities have more autonomy than the NHS had on how to discharge their public health responsibilities, the following services must be provided:

- Sexual health services - testing and treatment for sexually transmitted infections
- Sexual health services – contraception

- NHS Health Check programme[1]
- Local authority role in health protection
- Public health advice to CCGs
- National Child Measurement Programme[2]

The public health grant

3.10 Brent Council receives a ring fenced public health grant which is currently £18.848 million. The original two years of ring-fencing was extended by DH to cover 2015/16. From 2016 onwards it is anticipated that the grant will no longer be ring fenced.

3.11 Local authorities will receive an additional allocation when they take on responsibility for health visiting. Brent Council have challenged the allocation proposed by DH due to concerns that it may be insufficient. Discussions are underway with NHS England to attempt to resolve this.

3.12 The Chief Executive or Section 151 Officer and the DPH are required to provide to PHE annual statements of assurance that the grant has been applied (or, where amounts are held in the authority's public health reserve, is planned to be applied) to discharge the public health functions set out in Section 73B (2) of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) in accordance with the grant conditions set out in the 'Ring-fenced Public Health Grant Determination 2014/15: No 31/2241'. This has been done for 13/14 and 14/15.

3.13 The Council is required to account for its use of the grant according to defined categories. These are listed in appendix 1.

Staffing

3.14 As a result of the transfer of responsibilities from the NHS to the Council, a number of staff transferred from the PCT to the Council under TUPE creating a public health establishment of 25 posts.

[1] The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or have certain risk factors, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes. In Brent the Council commissions general practices to provide NHS Health Checks.

[2] The National Child Measurement Programme (NCMP) measures the weight and height of children in reception class and year 6 to assess the numbers of overweight and obese children annually

3.15 Brent has a 'dispersed' model of public health staffing with a core team of 9 reporting to the DPH and 16 dispersed staff whose line management is within other teams and departments but with a professional accountability to the DPH. This dispersed structure will be reviewed in 15/16.

Public health contracts which transferred from the NHS to the Council

3.16 The public health grant which the Council receives is based upon the historic spend of the PCT on public health. The majority of this spend was on commissioned services and the Council inherited NHS contracts for substance misuse, sexual health, school nursing and behaviour change interventions at a value of approximately £12.742 million. In addition a range of public health "local enhanced services" were commissioned from GPs and Community Pharmacies in Brent at a historic cost of approximately £1 million. Costs are approximate as a number of the public heath contracts are activity driven

3.17 During 2013/14 the Executive agreed to replace the inherited NHS arrangements for "local enhanced services" with the establishment of an approved providers' list to which Brent GPs and community pharmacies were admitted subject to the satisfaction of certain clinical requirements, for example the requisite training. Following an application process, 42 practices were accepted to the list to provide IUCD fitting, 63 to undertake chlamydia screening, 67 to provide smoking cessation services and 67 to undertake health checks. Fifty nine community pharmacies are approved to offer smoking cessation and 49 to provide emergency hormonal contraception.

3.18 During 2014/15 all inherited NHS contracts were re-commissioned, with the exception of GUM services (see 3.19 – 3.20). In December 2014, Cabinet agreed the award of eleven contracts for an initial period of two years with a total value of £ 15.556 million. The procurement exercise secured two year savings of £997,000. These contracts cover:

- Substance misuse services
- A young people's sexual health and substance misuse service
- Contraceptive services
- Chlamydia screening (for young people)
- Local HIV prevention services
- School nursing
- A post health check service for those found to be a high risk at their health check

3.19 Councils have a statutory duty to ensure the provision of services to test and treat sexually transmitted infections – GUM (genitourinary medicine) services. There is also a statutory requirement that these services are open access which means Brent residents may access services anywhere without referral and the Council is liable for the cost of this activity. Many Brent residents do

access services at our local provider (London North West Healthcare Trust) but others use clinics elsewhere, notably in Central London.

3.20 In recognition of the significant patient flows across Council boundaries, the Council has joined with a number of other authorities to collaboratively negotiate contracts with a range of GUM providers across north and central London. This collaboration has secured advantageous prices relative to those paid by non participating boroughs (equating to £253,000 or 6% of contract value of avoided cost in 2014/15). This collaborative has now expanded into the London Sexual Health Services Transformation Project (see 3.27 – 3.29).

Council action to address Brent public health priorities

3.21 The 2014 Annual Report of the Director of Public Health for Brent[3] provides a summary of health and wellbeing and health related behaviour in Brent. Life expectancy in Brent is better than the England average, at almost 80 years for men and 86 years for women. The premature mortality rate[4] is also better than the national average, at 334 deaths per 100,000 population. However, this still means there are on average 650 premature deaths per year in the Borough. The main causes of premature mortality in Brent are cancer (36% of deaths before 75), heart disease and stroke (26%) and respiratory disease (8%).

3.22 Many premature deaths are potentially avoidable. NHSE commissions cancer screening and PHE runs the periodic "be clear on cancer" campaigns which have been shown to be associated with people seeking help earlier for symptoms which could be caused by cancer. Earlier diagnosis of cancer is associated with improved survival.

3.23 NHS health checks aim to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. In 2014/15, 16,824 people were invited by their GP to attend a health check, 56% (9,414) of whom took up the offer. Age, gender and ethnicity affect cardiac risk and the uptake of health checks is monitored by these factors. The ethnicity of those receiving a health check closely reflects the ethnicity of the eligible population. However women and younger age groups are more likely to take up the offer of a health check and improving uptake for men and those aged 65 to 74 are priorities. In 2014/15, as a result of NHS health checks in Brent, 330 people were found to have high blood pressure, 194 were diagnosed with diabetes and 1320 were found to have pre-diabetes.

3.24 A health check will only be worthwhile if any identified risk is addressed. In addition to potential clinical interventions by GPs, the Council has recently commissioned an intensive post health check intervention to which GPs can refer. The programme offers tailored nutritional and physical activity advice and support. The service commenced in April 2015 so performance data is not

[3] Annual report of the Director of Public Heath for Brent 2014
[4] Premature mortality is defined as death before the age of 75

yet available. The eligibility criteria for the programme have been adjusted to reflect the higher diabetic and cardiovascular risk in the Asian population.

3.25 Smoking is the primary cause of preventable morbidity and mortality accounting for over one third of respiratory deaths, over a quarter of cancer deaths and about on seventh of deaths from heart disease and stroke. There are an estimated 241 deaths related to smoking each year in Brent. Smoking cessation support services are provided by Council staff as well as by GPs and community pharmacies in Brent. In 2014/15, 893 people were supported by these services to quit smoking. Cigarettes are not the only form of tobacco used in Brent with chewing or smokeless tobacco and shisha being widely used. A stop chewing service is offered in Brent alongside the stop smoking service. However, uptake has been disappointing and the Brent Tobacco Control Alliance has been working with a local oral surgeon to raise awareness of the dangers of paan chewing.

3.26 Rates of diabetes are high in Brent and expected to rise. Over 23,000 people are recorded as having a diagnosis of diabetes on GP registers. The commissioning of treatment services, including patient education, is the responsibility of the NHS and Brent CCG has made significant investments in this area. In addition to commissioning health checks and the post health check intervention, which is designed to reduce participants' risk of diabetes, the Council has worked with Diabetes UK to recruit and train local people to act as volunteer Diabetes Champions. The Champions work with communities to raise awareness of the risk of diabetes and how people can reduce this.

3.27 Rates of sexually transmitted infections (STIs) are high in Brent with the borough ranked the 21st highest for diagnosed STIs, with particularly high rates of gonorrhoea, syphilis and genital warts. High and rising rates of STIs are seen across much of London and are one reason for our participation in the London Sexual Health Transformation Programme (LSHTP).

3.28 In 2014/15, the LSHTP developed a case for change for GUM services in London:

- London has the highest rates of STIs in England.
- Significant numbers of residents from every London borough are assessing services in central London.
- There is a significant imbalance in the commissioner/provider relationship. Service development has typically been provider-led. No single Council has sufficient leverage to deliver significant system-level change
- The systems for clinical governance need improvement. Patient flows and the lack of a 'helicopter view' of what is taking place within individual services make it difficult for councils to have sufficient assurance over quality and safety.
- Growth in demand for these services and costs of healthcare are likely to significantly outpace growth in the Public Health Grant. In

addition the open access nature of the services means that it is difficult to control or predict demand.

The case for change led to 2 key conclusions:

- Significant change is required to the traditional models of service delivery
- Collaboration on a wide scale across councils is needed to deliver the level of change required and to commission these services more effectively

3.29 The LSHTP currently involves 22 councils across London and is now developing the proposed new service model with key stakeholders such as clinicians, patients and the third sector. Alongside this an appropriate procurement strategy and approach is being developed. It is anticipated that this work will entail new contracts starting to come into place from April 2017.

3.30 There are over 800 people diagnosed with HIV living in Brent. Commissioning of HIV treatment services is the responsibility of NHSE. However an important, albeit non-mandated, component of the Council's sexual health commissioning is HIV prevention. Brent is a partner in the Pan London HIV Prevention Programme which has let contracts for condom distribution and outreach with men who have sex with men, a review of targeted condom distribution for Black African communities and a communication and media campaign with the slogan "Do it London" promoting HIV testing and condom use. In addition to this pan London work, since April 2015 the Terence Higgins Trust has been commissioned to deliver local HIV prevention in Brent including work with faith communities.

3.31 Childhood obesity rates are worryingly high in Brent and show no sign of improvement. The most recent figures from the National Child Measurement Programme (NCMP) show 11 percent of children in Brent reception classes are obese as are 24 percent of children in year 6, both higher than the England average. The Council has recently commissioned a child weight management programme which will be available to children and their families who are found to be overweight or obese in the NCMP

3.32 There are a number of common risk factors for obesity and poor oral health and childhood oral health is also poor in Brent. On starting school, forty six percent of children have at least one decayed missing of filled tooth.

3.33 Reflecting the importance of the first years of life on later health and wellbeing, the Council runs a Healthy Early Years (HEY) scheme. The HEY scheme is an accreditation and award scheme for nurseries, child-minders and Children's Centres. The scheme has been very positively evaluated by a parental survey which showed evidence of behaviour change: for example, an increase in children registered with a dentist of almost a quarter at nurseries and children's centres and of a third at child minders.

3.34 Dental services are commissioned by NHSE who receive dental public health advices from PHE. Healthy Smiles Brent in a joint initiative between the Council, NHSE and PHE. Dentists are visiting ten Brent primary schools to promote oral health and tooth brushing and to offer free fluoride varnish treatment. The pilot is currently being evaluated.

3.35 Brent has a high proportion of people born aboard, including in countries with high rates of tuberculosis (TB). Brent has the second highest rates of TB in the UK with around 300 cases diagnosed each year. Following the recent publication by PHE and NHSE of their Collaborative Tuberculosis Strategy for England, the Council's public health team is bringing together the CCG, NHSE and PHE to explore the feasibility of introducing screening for latent TB in primary care.

3.36 Levels of severe and enduring mental illness, such as schizophrenia and bipolar disorder, are higher in Brent than the England average: just over one percent of the population in Brent is living with a severe and enduring mental health illness. Around 16,000 people are on a GP register for depression. Social care work closely with the CCG to ensure effective and appropriate services are in place for people with mental illness. A recent Health and Wellbeing Board considered the wider issues of how mental wellbeing could be promoted and mental health and wellbeing strategies are under development for both adults and for children and young people.

3.37 It is estimated that over 1,800 people in Brent are using opiates and / or crack cocaine. Alcohol use in Brent is polarised. The proportion of residents who abstain from alcohol is, at 31 percent, almost twice the national average. However, the proportion of the population estimated to be high risk drinkers is at 7 percent higher than the national average. The Council commissions a range of treatment and recovery services including work with the criminal justice system and outreach services. Historically performance in this sector has been assessed by successful completions of treatment. Services in Brent have a strong track record of delivery. However changes to national performance measurement systems run by PHE have interrupted the flow of performance data

3.38 The Council commission a service user led organisation, B3, to provide services to support recovery from drugs and alcohol. B3 deliver the Brent Recovery Champions programme which provides opportunities for those completing their recovery and aftercare programmes to improve their skills and knowledge in such areas as peer support, service monitoring, volunteering and advocacy. Graduates of the programme act as peer mentors, undertake mystery shopping and deliver BSAFE a weekend service providing support to service users and their families. B3 were closely involved in the recent procurement of substance misuse services from helping to shape the specifications to evaluating tender submissions.

3.39 Public Health England estimates that only 37 percent of people in Brent achieve their five a day portions of fruit and vegetables. The Council's public health team undertook a survey of secondary school students. With nearly 2,500 students responding, the survey showed that students attending schools less than 400m from a takeaway ate more takeaways at lunch, on the journey home from school and at home for their evening meal. These results have informed the inclusion of an exclusion zone for new takeaways near schools in planned Development Management Policies. To address existing takeaways, the Council is about to launch the Healthy Catering Commitment. This is a voluntary award scheme where catering businesses commit to providing healthier options and adopting healthier cooking techniques.

3.40 Average levels of physical activity in Brent are well below recommendations and are less than for England and for London. The Council has invested in a number of outdoor gyms. Evaluation by the Council's public health team showed the gyms had increased physical activity levels amongst people who were previously inactive. Based upon this research a further six gyms will be installed in Brent parks in 2015/16. The public health grant is also being used to fund free swimming lessons and to commission a programme of targeted activities for people with disabilities

4.0 Financial Implications

4.1 These are covered in the body of the report

5.0 Legal Implications

5.1 These are covered in the body of the report

6.0 Diversity Implications

6.1 These are covered in the body of the report

7.0 Staffing/Accommodation Implications (if appropriate)

7.1 These are covered in the body of the report

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Appendix 1

Categories for reporting local authority public health spend

Prescribed functions:		
		Total spend 000's
1	Sexual health services - STI testing and treatment	**3, 651**
2	Sexual health services – Contraception	**1,850**
3	NHS Health Check programme	**236**
4	Local authority role in health protection	**51**
5	Public health advice	**78**
6	National Child Measurement Programme	**341**
Non-prescribed functions:		
7	Sexual health services - Advice, prevention and promotion	**542**
8	Obesity – adults	**170**
9	Obesity - children	**64**
10	Physical activity – adults	**727**
11	Physical activity - children	**684**
12	Drug misuse - adults	**4,314**
13	Alcohol misuse - adults	**1,100**
14	Substance misuse (drugs and alcohol) - youth services	**472**
15	Stop smoking services and interventions	**775**
16	Wider tobacco control	**114**
17	Children 5-19 public health programmes	**1,375**
18	Miscellaneous, which includes:	**171**

	• Non-mandatory elements of the NHS Health Check programme • Nutrition initiatives • Health at work • Programmes to prevent accidents • Public mental health • General prevention activities • Community safety, violence prevention & social exclusion • Dental public health • Fluoridation • Local authority role in surveillance and control of infectious disease • Information & Intelligence • Any public health spend on environmental hazards protection • Local initiatives to reduce excess deaths from seasonal mortality • Population level interventions to reduce and prevent birth defects (supporting role) • Wider determinants	

Brent	**Scrutiny Committee** 16 June 2015 **Report from the Strategic Director, Children and Young People**
Access to affordable childcare	

1.0 Summary

This report aims to look at the challenge of providing access to affordable, quality childcare. This is not only a Brent issue, but also a national issue and one that is receiving much attention following the Queen's Speech. Childcare initiatives have over recent years focussed on child development and the associated benefits to children in narrowing the gap in attainment between the most disadvantaged children and children from better-off families. Increasingly the focus has also turned to the financial benefits of using childcare, particularly in enabling parents to return to work, thereby offering a way out poverty. In order for all of the above objectives to be met, childcare must not only be high quality, but flexible and affordable enough for parents at all levels of society to be able to access and use according to the demands of their employment.

Similarly different factors determine the affordability of childcare for parents and for providers. Parental access to information about the support to which they may be entitled, the costs of the childcare, and parental circumstances (preferences, including cultural preferences, income levels and type of provision) all play a key part for parents. For providers factors such as their overheads, for example premises and staffing, determine their pricing structure and inform their business model. The private, voluntary and independent (PVI) sector has stated that the allocation of funding by the Government for the free entitlement is insufficient and does not cover the cost of delivery of high quality places.

Ensuring that high quality childcare is affordable for all parents requires the Government nationally and the Council at a local level to consider a range of factors in order to address this challenge. This is a particular issue for the Council which has a statutory responsibility to ensure sufficiency of childcare in the borough, but is not given funding to help develop or shape the market in any way.

2.0 National context

Parents currently have access to help with childcare through 15 hours of free early education for 38 weeks of the year for all three and four year-olds. The government has now made a commitment to extending this free entitlement to 30 hours a week. A timeline has yet to be confirmed but indications have been given already that this will be expedited and implemented as soon as possible. 40% most disadvantaged two year-olds can also access 15 hours of free early education; through the childcare element of Working Tax Credits, soon to be replaced by Universal Credit; and through employer-supported childcare vouchers, soon to be replaced by the tax-free

childcare scheme. The childcare is accessed both through the maintained sector, in nursery classes in schools and in nursery schools and through childcare providers in the private, voluntary and independent (PVI) sector, including childminders.

Research suggests that staff qualification levels have a significant impact on the quality of childcare offered. Schools have traditionally had higher levels of qualification compared with the private and voluntary sector. In the PVI sector there is now an increase in the numbers of staff qualified to Level 3 and above, but this has significant cost implications for providers and so remains variable. This in turn means that overall numbers of childcare places available do not necessarily indicate sufficiency of high quality places.

Clearly adequate funding is a factor in enabling quality, so are adequate training and support in order to ensure that the quality of provision is raised in weaker settings, whether these are schools or in the PVI sector, and quality is maintained where settings are already Ofsted Good or Outstanding. This is in the context of reduced funding and therefore targeting of resources at areas of highest need such as weaker settings and pooling of existent funding streams through partnerships to maximise value and return, particularly between schools and the PVI sector, will be the way to achieve the best results under constrained circumstances.

3.0 Brent context

3.1 Numbers of children

Brent has a high and increasing birth rate relative to the London and national averages, suggesting Brent will experience high population growth. Wembley is the locality with the largest projected population increase based on actual numbers. According to 2011 census data the London Borough of Brent has seen large increases in the child population between 2001 and 2011. The 0-4 age group experienced a 38% increase, the 5-9s experienced a 16% increase, the 10-14s a 9% increase and the 15-19s a 12% increase[1]. The table below sets out the 0 – 4 population in Brent as of January 2014 (Brent NHS data):

Table 1 – numbers of children aged 0 - 4 in Brent:

Locality	Under 1	Age 1	Age 2	Age 3	Age 4	Grand Total
Harlesden	802	905	850	809	849	4215
Kilburn	853	890	831	726	585	3885
Kingsbury	801	759	704	639	441	3344
Wembley	1483	1463	1395	1166	855	6362
Willesden	869	839	794	818	582	3902
rand Total	**4808**	**4856**	**4574**	**4158**	**3312**	**21708**

3.2 Childcare provision

The borough currently has 119 PVI providers, 197 childminders, 4 nursery schools and nursery classes in 53 primary schools through which families can access childcare, either 15 hours a week that are free or a combination of free hours and fee paying hours. Tables 2 and 3 set out the numbers and Ofsted gradings of PVI providers and childminders respectively:
Table 2 – PVI providers

Locality	Ofsted Outstanding	Ofsted Good	Requires Improvement / Satisfactory	Inadequate	Settings with no Ofsted result*	Total Number of PVIs
Wembley	7	19	6	0	3	**35**
Kingsbury	1	19	2	1	4	**27**
Harlesden	2	19	2	0	2	**25**
Willesden	1	7	3	0	0	**11**
Kilburn	5	13	1	1	1	**21**
Total	**16**	**77**	**14**	**2**	**10**	**119**

Table 3 - Childminders

Locality	Ofsted Outstan-ding	Ofsted Good	Requires Improvement / Satisfactory	Inade-quate	Met**	Not Met***	Settings with no Ofsted result*	Total Number
Wembley	2	26	7	1	3	3	9	**51**
Kingsbury	2	12	6	0	2	1	3	**26**
Harlesden	1	23	6	0	7	3	6	**46**
Willesden	4	18	5	1	4	3	10	**45**
Kilburn	1	15	3	2	0	1	7	**29**
Total	**10**	**94**	**27**	**4**	**16**	**11**	**35**	**197**

Table 4 - Nursery classes in maintained schools

Locality	Ofsted Outstanding	Ofsted Good	Requires Improvement / Satisfactory	Inadequate	Settings with no Ofsted result*	Total Number
Wembley	5	10	0	0	0	**15**
Kingsbury	2	8	0	0	0	**10**
Harlesden	1	10	2	0	0	**13**
Willesden	4	5	0	1	1	**11**
Kilburn	0	6	4	1	1	**12**
Total	**12**	**39**	**6**	**2**	**2**	**61**

Table 5 – Nursery schools

Locality	Ofsted Outstanding	Ofsted Good	Requires Improvement / Satisfactory	Inadequate	Settings with no Ofsted result*	Total Number
Wembley	0	0	0	0	0	**0**
Kingsbury	0	0	0	0	0	**0**
Harlesden	0	2	0	0	0	**2**
Willesden	0	0	0	0	0	**0**
Kilburn	1	0	1	0	0	**2**
Total	**1**	**2**	**1**	**0**	**0**	**4**

*Settings with no Ofsted result – New providers/schools waiting for their first Ofsted inspection
**Met – No children on roll at time of inspection but conditions of registration met
***Not met – No children on roll at time of inspection and conditions of registration not met

In the last few years, we have seen a steady increase in the number of both childminders and PVI providers in the borough being graded Good or Outstanding by Ofsted. This is due to a combination of higher levels of qualifications in the sector, more targeted support at different levels of need from Brent Council's Early Years Quality Improvement Team and other support from the Central Early Years team in terms of business support, early years public health and training and workshops.

In Brent, 3 and 4 year olds are accessing their free entitlement almost equally across the maintained and PVI sectors. Two year olds are accessing their funded places primarily in the PVI sector at the moment, however some schools are now beginning to express an interest in delivering places and this picture may change.

Full-time funded nursery places (25 hours a week) are being offered in some maintained schools and nursery schools for children meeting eligibility criteria set out below:

Section	Criteria	Verification document
Step 1: Applicants must meet requirements in Sections A and B		
A	The parent's post code must be within Brent: i.e. HA0,HA3,HA8,HA9,NW2,NW6,NW9 and NW10	Recent evidence with parents name and address. For example: a. Utilities bill b. Bank statement c. Telecoms bill d. Council tax bill
B	One parent must be in receipt of one of the benefits listed below: 1. Income Support 2. Income based Job Seekers Allowance 3. An income related employment and support allowance 4. Support under part IV of the Immigration and Asylum Act 1999 5. Child Tax Credit (providing you are not entitled to working tax credit) and have an annual income that does not exceed £16,190 6. Guarantee element of State Pension Credit	1. Letter from Department of Work and Pensions (DWP). Letter must be dated within the last [four] weeks and clearly shows that the benefit is still being paid to parent/carer. 2. As for 1 3. As for 1 4. Letter the National Asylum Support Service (NASS) confirming the granting of asylum status 5. Most recent Tax Credit Award notice (Form TC602) issued to parent/carer by Her Majesty's Revenue and Customs 6. Pension Credit M1000 Award notice to confirm Guaranteed Element of State Pension Credit issued by The Pension Service.
Step 2: If there are still more eligible applicants than available places those applicants meeting Section C take preference		
C	One of the following criteria must be met: 1. Newly arrived or asylum seeker 2. Evidence from an appropriate professional to demonstrate that home circumstances could significantly affect a child's wellbeing	1. Home Office letter 2. Letter from professional
Step 3: Following Step 2, if there are still more eligible applicants than available places the following criteria will be applied:		
Sibling in the school		
Step 4: Following Step 3, if there are still more eligible applicants than available places the following criteria will be applied		
Distance from school		

This will be of great help to those low-income families who are able to access this, but as not all schools are offering 25 hours places, an element of postcode lottery and in-equity exists. Furthermore, there are no funded full time places in the PVI sector, and families can only access a maximum of 15 hours a week of funded early education in this sector.

Table 6 – Take up of the free entitlement for 2, 3 and 4 year olds (Nursery Education Grant (NEG) 2 and NEG 3 and 4)

Spring 2015	NEG 2 in PVI settings/ childminders	NEG 3 and 4 in PVI settings/ childminders	3 and 4 year olds in school nurseries
Harlesden	384	481	479
Kilburn	140	411	493
Kingsbury	208	570	532
Wembley	337	975	605
Willesden	99	178	521
Total take up	1168	2615	2630

3.3 Cost of childcare

Table 7 – Average hourly childcare costs in Brent

Average hourly fees

	Average rate for under 2s	Average rate for over 2s
PVIs	£5.45 (from 47 respondents)	£5.25 (from 58 respondents)
Childminder	Average hourly rate £6.02	

The average cost of childcare in the PVI sector is set out in the table above and the range for PVI settings is from £5 an hour to £15 an hour. The picture of affordability is variable. Whilst parents frequently cite the cost as the reason for not using childcare, a parental survey carried out for Brent's Childcare Sufficiency Assessment in 2014 to which we had 1400 responses, revealed that affordability as a barrier had reduced from 51% not finding it affordable in 2011 to 36% in 2014.

Notwithstanding this, affordability is likely to remain a key issue for many parents in Brent. Brent is one of 15% most deprived local authorities in the country and residents have lower incomes and experience significantly higher levels of deprivation and poverty than the national or London averages. Over a third of children live in poverty within Brent. This is also higher than both the London and national averages. For some parents therefore, even with help with childcare costs through the free entitlements and Tax Credits, childcare could still be unaffordable.

A further contributing factor to the take up of childcare in Brent has been cultural perceptions and traditions. There are communities who historically are more reluctant to use formal childcare as they prefer to use relatives or indeed feel that children are too young and would be better off at home. For these families, the high cost of childcare is an added reason to justify their children not being in formal childcare. We now have community champions who are promoting the benefits of childcare, but it is likely to take time for the message to be accepted and mindsets changed.

3.4 Provision for children with special educational needs or a disability (SEND) and Children in Need (CIN)

Table 8 – Children with SEND in Brent* (September 2014)

Locality	Under 1	Age 1	Age 2	Age 3	Age 4	Total
Harlesden	1	4	15	30	26	76
Kilburn	4	2	9	16	25	56
Kingsbury	1	2	9	14	32	58
Wembley	1	2	20	43	66	132
Willesden	1	6	11	30	32	80
Total	**8**	**16**	**64**	**133**	**181**	**402**

*Numbers are based on statutory notifications, received from community paediatricians, on pre-school children who are likely to have additional needs at school

Due to the level of the support they often require, affordable childcare can be a particular challenge for families who have children with SEND. Some families have reported that they are charged increased fees by PVI providers in order to offer an increased ratio or other support. This increased cost often places affordable childcare out of reach of these families and results in one or more of the parents having to stay at home in order to look after their child.

Brent has a multi agency panel that provides the funding equivalent to an additional 15 hours childcare to nurseries in order to meet the additional costs. This covers costs such as increased staffing, specific training so that staff can meet their needs or specialist resources that enable the child to access the learning opportunities within the nursery. As of April 2015 there are 96 children being supported through this funding, making childcare for children with SEND more affordable.

A potential additional cost for families with a child with SEND is the cost of transport to the 4 specialist settings within Brent which have highly trained staff and the specialist equipment that is needed by these children. In many cases, parents may have to meet the additional cost of transport where the children have high levels of equipment or have restricted mobility which means that they can't travel by public transport. In some circumstances the panel will provide Brent transport to the specialist nurseries if families meet the criteria

4.0. The role of the Local Authority

Under the Childcare Act 2006, local authorities have a statutory duty to secure sufficient childcare for the needs of working parents/carers in their area for children up to 1 September after they turn 14 years, or until they reach the age of 18 in the case of children with a disability. This has provided the overarching framework, including setting out the roles and responsibilities of local authorities in recent years. However, recent guidance has set a different direction, which will have a significant impact on the local authority role, as set out in Brent's Early Years Childcare Strategy 2013-2016:

- The emphasis of the local authority role will shift slightly away from its traditional role in promoting high quality provision; and instead the local authority should act as a champion for children and their families, particularly those at risk of poorer outcomes.
- The local authority will continue to need to ensure there is sufficient childcare available, including early education places for all 3 and 4 year olds; and relevant 2-year olds, which also should be flexible in order to enable parents to work or study.

- Ofsted must be the sole arbiter of quality of provision - the local authority will no longer have a quality assurance role. The local authority will be expected to target its support to providers who receive poorer Ofsted inspection judgements.

The above work is carried out by staff within Brent Council's Central Early Years team and the Early Years Quality Improvement team. Innovative approaches and partnerships with schools and other partners are needed in order to be able to achieve our objectives of meeting the childcare needs of families with young children in Brent within constrained resources. It is also important for partnerships within the council between teams such as Early years and family support, Social Care, Employment and Enterprise and Housing who are all working with many of the same families, in order to ensure that we maximise the support that we offer to our most vulnerable families.

In the past year, the Early Years and Family Support Service has developed and implemented two key initiatives to support access to flexible and affordable childcare in the borough. One, which subsequently went on to win the Innovation Award at the LGC Awards this year, was the creation of the country's first flexible childminding pool with Ofsted registered childminders offering short notice, out of hours, overnight and weekend care. This was in response to feedback from the Council's employment team, from Jobcentre Plus and from families that a lack of flexible childcare was preventing parents from returning to work or even attending interviews.

Early Years and Family Support Services officers have also worked with colleagues in the Housing Department to develop a local childcare subsidy funded from the DHP for families in receipt of Housing Benefit. This is in addition to any other help that they could access through national schemes and the objective was to support those who were taking up or returning to employment, or in work-based training programmes during the first six months.

5.0 Brent's Child Poverty Strategy – Childcare

The Brent Child Poverty Strategy 2011 - 2021 was produced in partnership with key stakeholders and informed by a Child Poverty Needs Assessment. The strategy set out a vision:

For no children or young people to be disadvantaged by poverty in 2021 by breaking the cycle of deprivation and mitigating poor children becoming poor adults. Over the next decade we will ensure that each child has the best possible start in life and not be disadvantaged by family circumstance or background.

The baseline needs assessment provided a sound evidence base for shaping and influencing the development of the strategy and its priorities. It highlighted key factors contributing to child poverty including parents on low income, financial capability and debt, troubled families, unemployment and barriers to employment. The availability and affordability of childcare was highlighted as one of the biggest barriers to employment.

The Child Poverty Strategy was developed as a long term document (2011-2021), recognising that the intergenerational factors influencing poverty are longstanding and vulnerable to the performance of the national economy. The strategy sets out six key priorities to reduce and mitigate the levels of poverty in Brent:

1. Reduce the poverty levels of children living in low income households;
2. Supporting troubled families;
3. Reduction in the not in education, employment or training (NEET) group;
4. Improve the financial capacity of parents;
5. Support looked after children and children on the edge of care; and

6. Improve the health and wellbeing of children with a focus on reducing obesity, tooth decay and poor mental health.

The Brent Child Poverty Strategy is currently being refreshed in response to the Government's Child Poverty Strategy published in 2014. This is also an opportunity to review progress against priorities and reflect changes within the borough.

Brent has received both formal and informal recognition for steps taken in tackling child poverty across the borough. For example, the Child Poverty Action Group have provided informal feedback on our 2011 strategy and formal recognition has been received from the Greater London Authority for Brent's flexible childcare policy.

6.0 Conclusions

Affordable, accessible and flexible childcare has a key part to play in supporting families and ensuring that each child has the best possible start in life. This is a diverse borough, a one size fits all solution will not work and neither can it be the responsibility of any one agency, a whole Council approach and effort will be required.. Innovative new approaches, underpinned by an understanding of the needs of both the childcare sector and diverse groups of parents, must be adopted alongside a thorough review of effectiveness and impact of existing systems, to see what is working and what must be changed.

For some people, particularly those on very low incomes, childcare will never be affordable and local and national efforts and resources should be targeted at these groups. Much work has happened already in the borough resulting in a steady increase, both in the quality of the childcare providers in the borough and in take-up of the free entitlements in the last five years. This effort needs to be continuous to maintain what has already been achieved and to plug gaps that have been and are being identified. The following actions are being pursued:

- Promotion of childcare and its benefits must be ongoing. The Early Years and Family Support Service works in partnership with other teams and external partners to promote childcare through outreach, marketing campaigns and the council webpages. This must now be accompanied by targeted promotion to groups historically less likely to use childcare, highlighting in particular the benefits of childcare to all parents and the importance of quality to ensure their child is supported to make progress
- Emphasising the importance of the home learning environment so that parents are aware of the key role that they can play in supporting their child's learning. The interactions that take place in the home environment have more influence on a child's future achievement than innate ability, material circumstances or the quality of early years or school provision. Quality improvement work within the borough has incorporated a focus on how practitioners engage and work with parents to improve outcomes for children. Settings will be encouraged to utilise their Early Years Pupil Premium funding to sustain and further develop parental involvement
- Raising awareness of entitlements and any help available with the costs of childcare. Ensure that information on these is accurate and up to date. As mentioned in this report, the cost of childcare remains a barrier to many and information on help with the costs of childcare is invaluable. This is already available online but we need to ensure that it continues to be available in different formats for those families who need this
- Accepting that families who need childcare may be accessing a range of council services, even if not the Early Years Service, and ensuring that within the Council, all frontline teams and external partners too have enough knowledge of services available in order to signpost effectively / deliver basic information
- Encouraging parents not to give up until they have explored all options for childcare and help with childcare costs in order to find a solution or a combination of these that works for them

- Continuing close working with Brent CVS and further developing the existing volunteer programme in children's centres and Brent's Parent Champions project, involving community members (volunteers and parents) as advocates for childcare, particularly in communities which traditionally have shown preferences for informal childcare through family and friends
- Continue to offer business support to providers to help them develop sustainable business models
- Continue to raise the quality of childcare providers in the borough, targeting the weakest in particular with intensive support.

7.0 Legal Implications

The free entitlement is a statutory duty to be delivered by local authorities in accordance with the DfE's statutory guidance. Childcare providers have to sign a provider agreement with the local authority in order to be able to offer funded places and one of the key criteria has always been that funded places must be offered free at the point of delivery.

Some providers have stated that the rates that they are being paid to offer funded places are too low, thereby making it unaffordable for them. In some cases, they have resorted to imposing additional charges on parents as a condition of being able to access a free place and this has led to breaches in their agreement with the local authority. This is a national issue and the government will now be reviewing their funding of this scheme in light of their plans to extend the entitlement to 30 hours a week.

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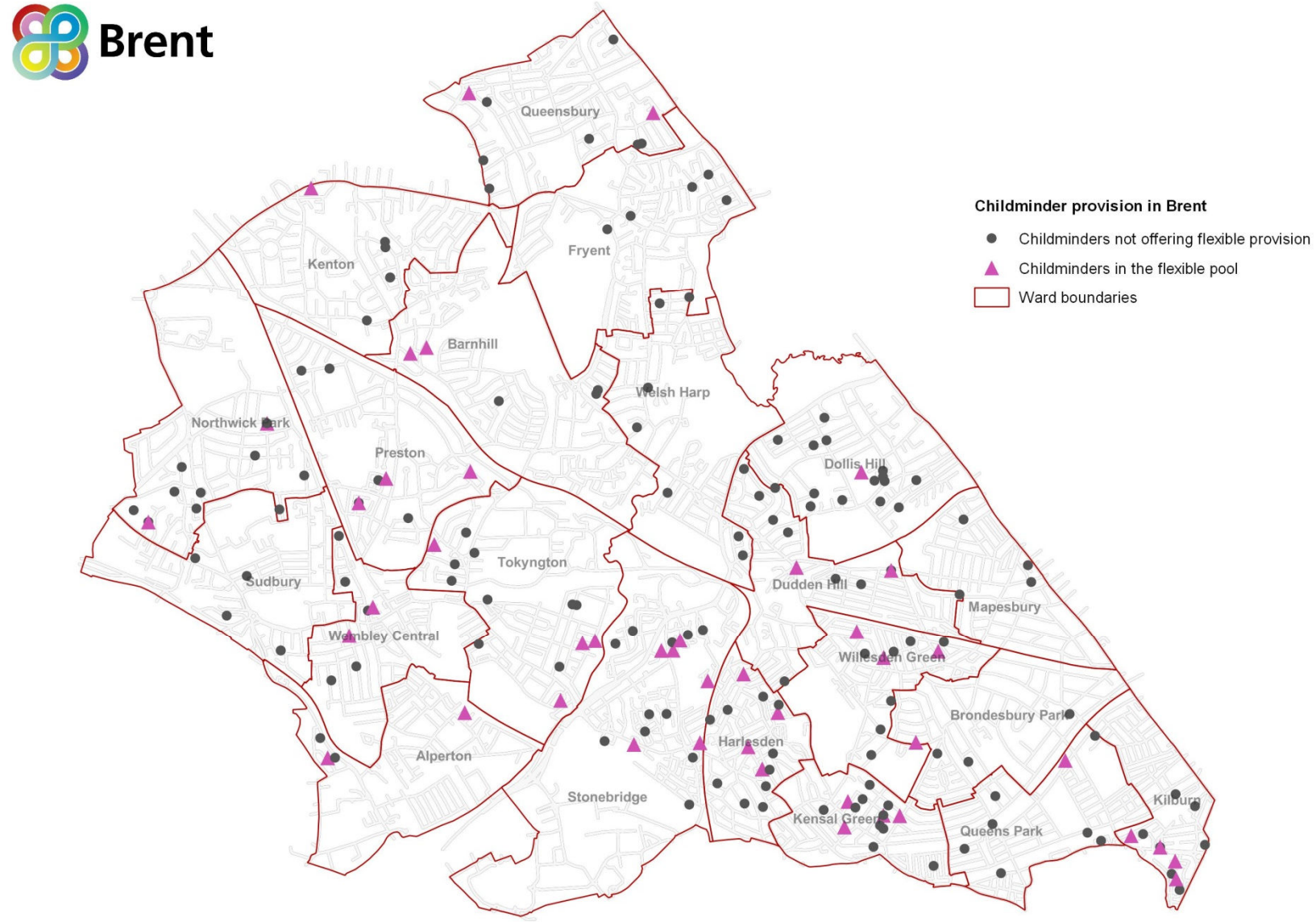
Appendix 1: Childminder provision in Brent



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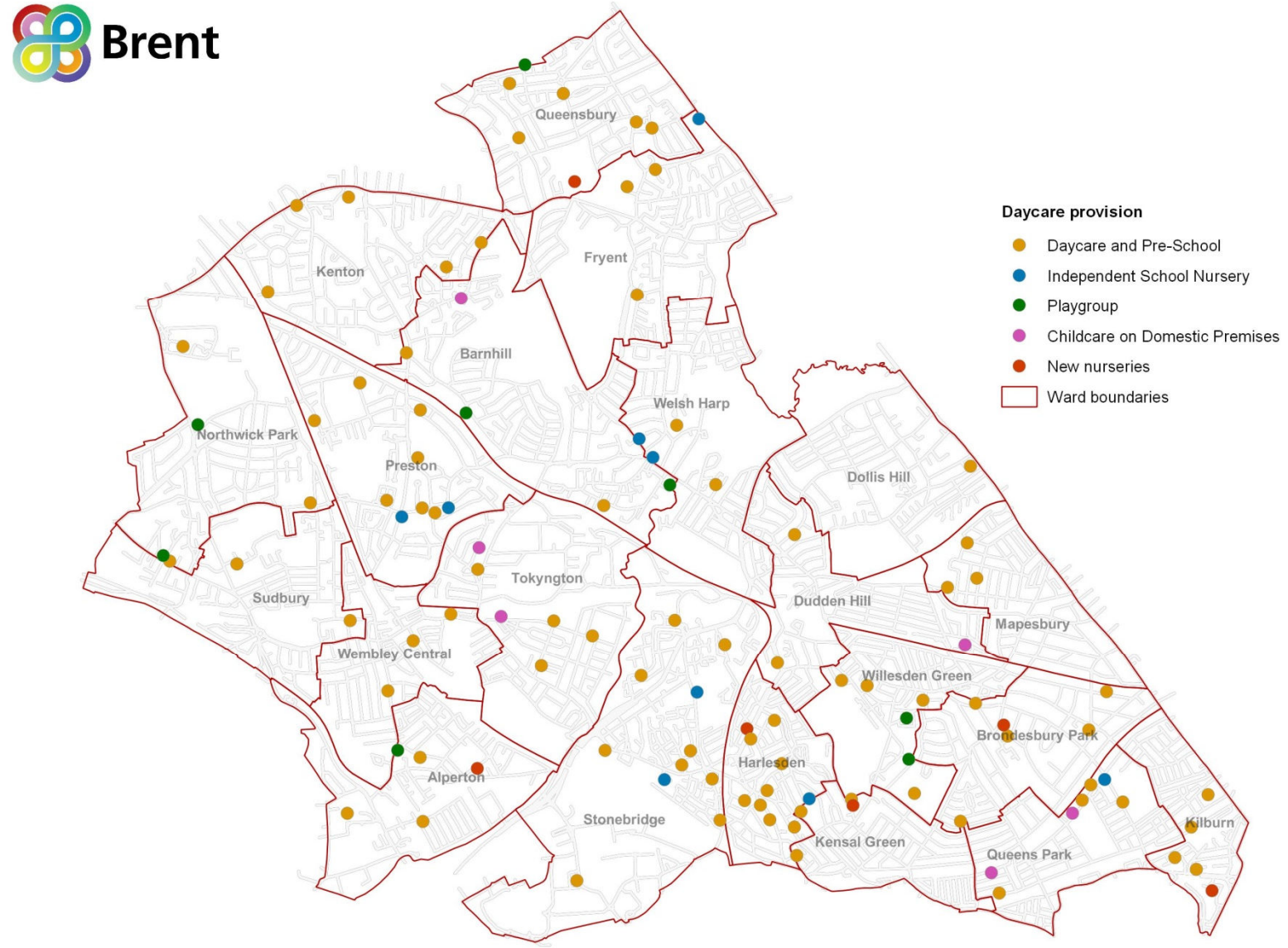
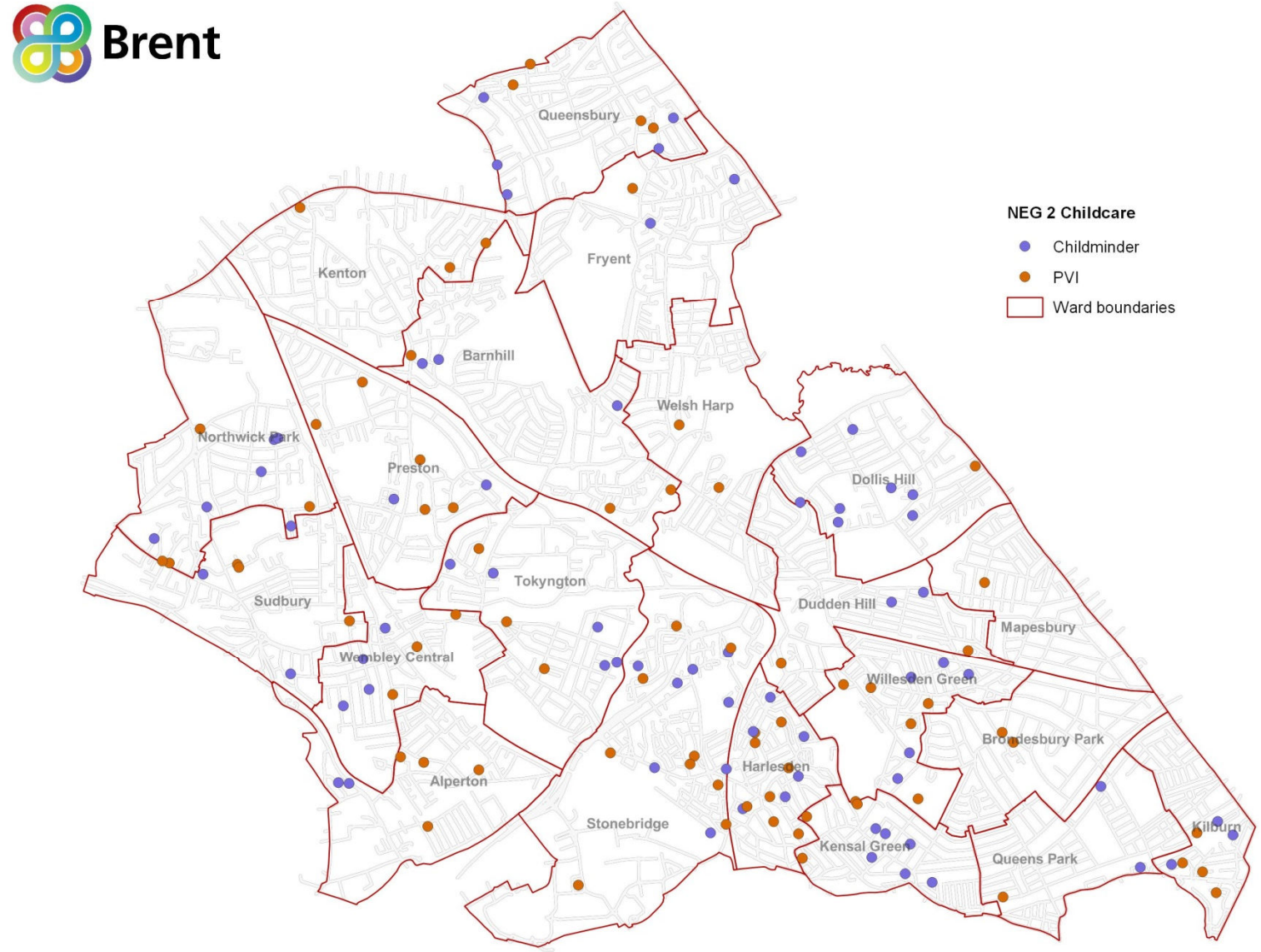
Appendix 2: Daycare provision in Brent



Appendix 3: NEG2 childcare provision in Brent



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Scrutiny Committee
Forward Plan 2015/16

Date of Committee	Agenda items	Responsible officers
Tuesday 16 June 2015	• Access to affordable childcare. • Paediatric Services in Brent. • Public Health – priorities and progress. • Report from the Access to GP services task group	Sara Williams, Operational Director Early Help and Education. Northwest London Hospitals Trust, Brent Clinical Commissioning Group. Melanie Smith, Director of Public Health Chair of Task Group
Wednesday 8 July 2015	• Licencing procedures including licenced premises and betting shops. • Local Government ombudsman complaints and corporate complaints. • Up-date on performance of Brent Housing Partnership	Andy Donald, Strategic Director Regeneration and Growth Cathy Tyson, Head of Policy and Scrutiny Tom Bremner, Managing Director Brent Housing Partnership. Andy Donald, Strategic Director Regeneration and Growth

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