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Brent

Scrutiny Committee

Wednesday 9 September 2015 at 7.00 pm
Board Room 7&8 - Brent Civic Centre, Engineers Way, Wembley HA9 0FJ

Membership:

Members Councillors:	**Substitute Members** Councillors:
Filson (Chair) Colwill (Vice-Chair) Daly Farah Kelcher Miller Stopp Tatler	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
Vacancy

Observers
Ms J Cooper
Ms C Jolinon
Mrs L Gouldbourne
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 disclosable pecuniary, personal or prejudicial interests in the items on this agenda.	
2	**Deputations (if any)**	
3	**Minutes of the previous meeting**	1 - 6
4	**Matters arising (if any)**	
5	**Central and North West London NHS Foundation Trust - Care Quality Commission report and action plan** The Care Quality Commission (CQC) has published a report on the quality of services provided by Central North West London NHS Foundation Trust and an action plan has been developed by the Trust to respond to the findings of the inspection.	7 - 78
6	**Scrutiny task group on Access to extended GP services and primary care in Brent** 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).	79 - 162
7	**Terms of reference for task groups on Fly Tipping and CCTV** These reports set out the proposed scope for the Scrutiny task group on Fly Tipping in Brent on Close Circuit Television (CCTV) in Brent.	163 - 186

8	**Scrutiny forward plan and key comments, recommendations and actions**	187 - 204

9 Any other urgent business

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

Date of the next meeting: Thursday 8 October 2015

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

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

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Brent

MINUTES OF THE SCRUTINY COMMITTEE
Wednesday 12 August 2015 at 7.00 pm

PRESENT: Councillor Filson (Chair) and Councillors Daly, Farah, Kelcher, Stopp, Miller and Tatler, together with co-opted members Mr Alloysius Frederick, Dr J Levison and Mr Payam Tamiz

Also Present: Councillors Choudhary, Mahmood and Pavey

Apologies were received from: Councillor Colwill, co-opted Member Ms Christine Cargill and appointed observer Lesley Gouldbourne

1. **Declarations of interests**

None declared.

2. **Deputations**

None.

3. **Minutes of the previous meeting**

The minutes were tabled at the meeting. Members agreed to approve them as an accurate record but asked to be allowed to raise any matters arising at the next meeting.

RESOLVED:-

that the minutes of the previous meeting held on 14 July 2015 be approved as an accurate record of the meeting.

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

See above.

5. **Council's future Transport Strategy**

Members considered the report on the Council's future transport strategy. The Chair welcomed Councillor Southwood (Lead Member for Environment) and Tony Kennedy (Head of Transportation) to the meeting. Councillor Southwood explained that the strategy presented a long term framework and needed to be seen in conjunction with supporting strategies that provided more detail such as the cycling strategy. In future years a walking strategy and a freight strategy would be developed.

The Committee heard from Councillor Choudhary and two members of the public: Mr Dilwyn Chambers and Mr David Kaye. The comments put forward included the view that there were gaps in the strategy because there was a lack of reference to the potential for developing rail links with specific reference being made to the Dudden Hill rail line. The committee heard criticism that the strategy did not mention global warming or air quality; did not pick up on the uses that could be made of the canals and did not address the transport difficulties caused by Wembley Stadium on event days. There was criticism of London TravelWatch which it was suggested appeared to have achieved little in the way of improvements to transport in the borough. It was pointed out that Kilburn High Road served one of only two town centres in the borough and yet was not mentioned in the strategy. This was also an example of where the Council had to work with a neighbouring borough and the issue of inter-borough conflict at the borough's boundaries was not picked up in the strategy.

The Committee expressed concern that the strategy was too brief and lacked ambition. Members felt that it lacked evidence in places whilst making certain assertions and was rooted in the possibilities as they related to Transport for London (TfL) and the availability of funding rather than going beyond this into areas where the Council needed to send out strong messages and councillors needed to lobby to address some of the major transport concerns in the borough.

Members of the Committee in considering the strategy raised the following points:

- the strategy appeared to have been overly influenced by the feedback to the consultation and restricted itself to those areas listed in paragraph 6.1 of the covering report,

- there was a lack of information on the budgets available for improvements to transport,

- reference to the Council's Disabled Transport Fleet and working with other Council departments to improve accessibility was missing,

- the strategy did not articulate or reflect the needs of the borough in order to support future Local Implementation Plan (LIP) annual spending submissions,

- evidence, including demographic data was not included to show the effect car clubs had in different areas of the borough,

- the objective to reduce the number of car journeys by changing behaviour to avoid unnecessary trips was not included, along with more information on the level of car ownership and trends in the borough,

- whilst recognising that the cycle strategy provided more information, it was felt that reference should be included on the barriers to cycling and the different types of traffic calming measures employed,

- the target for agreeing travel plans with schools needed to be more ambitious than the stated 10% increase,

- the strategy should address the implications of the introduction of the night time tube service,

- there was a lack of evidence of what the most effective ways to reduce car speeds were and there was concern about the level of enforcement within 20mph zones,

- given the continued uncertainty over the expansion of Heathrow, concern was expressed that aspects of the strategy were dependent on this and it was not clear what the Council's current position on Heathrow was,

- the strategy should incorporate the major health provision reconfigurations within the borough and the implications this had for transport to hospitals, other health facilities and hospital parking,

- it was felt that the strategy should address not just equality of access for those with disabilities but the disparity between different areas of the borough,

- whilst supporting the air quality targets, mention was made of the importance of monitoring and the need to address the health issues around the use of diesel fuel,

- in making many of the points referred to, the Committee felt the strategy needed to incorporate more of the cross cutting work being undertaken within the Council.

Given the extent of the comments made by members of the Committee, it was felt that the document was not ready to be submitted to Cabinet for approval.

Councillor Southwood and the Head of Transportation accepted that some of the targets contained in the strategy could be increased and that the overall level of ambition demonstrated in the document could be strengthened. However, it was pointed out that this was an overarching strategy with other sub-strategies supporting it and it was open to review every 5 years as the situation and challenges facing the borough changed.

RESOLVED:

that Cabinet be informed that:

(a) Scrutiny Committee recommends that Cabinet defer taking a decision on approving the Long Term Transport Strategy for Brent so that fuller consideration can be given to the points raised on it by the Committee;

(b) Scrutiny Committee requests that Cabinet note the comments made by the Committee and agrees to the recommendations below being more fully addressed in the finally agreed strategy:

(i) the strategy needs to be more ambitious and incorporate reference to schemes on which the Council might need to lobby in order to see them progress,

(ii) the strategy should not be restricted to only those schemes and improvements that might be supported by TfL and included in LIP submissions, especially bearing in mind the forthcoming London Mayoral election when a new Mayor will be elected who might have different priorities; there was a need for the serious public transport issues and road usage problems to be addressed,

(iii) reference should be included of the Dudden Hill rail line and its potential,

(iv) the possibility of a conflict of approach with neighbouring boroughs and the need to develop shared visions with other boroughs on those transport issues at the borough boundary should be articulated,

(v) greater focus should be given on equality of access from the different geographical areas of the borough (North/South – East/West),

(vi) a review of the document should be undertaken to remove some of the assertions made or support them with more evidence based statements and give a clearer focus to the strategy, bearing in mind that many of the 'daughter' strategy papers have yet to be written,.

(vii) the strategy should include demographic evidence and have a greater focus on access to primary locations such as hospitals, schools, leisure centres etc.,

(viii) greater prominence should be given to the work being undertaken with schools to improve safety and congestion around schools,

(ix) a stronger message should be included on the health effects of diesel and the implications of this around the movement of freight.

6. **Food Standards Audit**

Members considered the report on last year's Food Standards audit of the Council's discharge of its Food Standards Act 1990 duties. The Chair welcomed Councillor Denselow (Lead Member for Stronger Communities) and David Thrale (Head of Regulatory Services) to the meeting. Councillor Denselow stated that he recognised the concern about the capacity to carry out the over due inspections but pointed out that the Council was being expected to provide the same level of service as it had done in past years when the Council was better funded. At the same time the borough had a rising population and more premises to inspect. The number of outstanding inspections now stood at 192 and he assured the Committee that these would be dealt with by the end of the year by utilising additional resources from elsewhere in the service. In the meantime Regulatory Services was undergoing a review which would need to establish the basis for being able to sustain the service in the future. The Food Standards Authority would be visiting the Council during the following week and Councillor Denselow undertook to ensure Scrutiny Committee was informed of the outcome to this.

The Head of Regulatory Services explained the staffing structure and the challenges facing the team. In response to questions, he explained the rationale behind not prioritising the higher category inspections. It was the smaller businesses that often created more work in bringing them into compliance.

Councillor Denselow emphasised the financial pressures by explaining that resources had been re-allocated in order to eliminate the outstanding inspections and this in turn put pressure on other parts of the service. The Committee was informed that although there were resources available to recruit additional staff this would still not be sufficient to meet the level of inspection and enforcement demanded by the Food Standards Authority. This was a position faced by many other councils. In answer to a question from the committee, the Head of Regulatory Services confirmed that consideration was being given to different models of service delivery.

Councillor Denselow acknowledged that there was a need to get a message across to local residents in response to press headlines, that the number of outstanding inspections did not mean the borough was full of dangerous premises.

The question of how the present situation impacted on the health of local residents was raised. In response it was admitted that it was hard to measure this and no precise data existed to help identify the potential health impacts.

The Chair referred to the action plan attached as appendix A to the report and asked if there were any concerns arising from it. It was explained that where the 'Action taken to date' column was in red it tended to indicate that decisions had yet to be taken to deal with the required improvement target, rather than to any underlying issue so progress was being made on all the targets included in the plan.

RESOLVED:

that the findings of the Food Standards audit carried out in July 2014, the issues arising, response to date and the planned actions be noted.

7. **Any other urgent business**

None.

Items for information.
The Chair informed the meeting that Mr Iram Yaqub, a governor at Oliver Goldsmith primary school was to be appointed to the committee at the next Council meeting as a new co-opted member representing primary school governors.

The Chair informed the meeting that a system for logging key requests for information made at meetings of the committee would be brought to the next meeting.

8. **Date of next meeting**

Noted as 9 September 2015.

The meeting closed at 9.35 pm

D FILSON
Chair

Brent	**Scrutiny Committee** 9th September 2015 **Report from the Chief Operating Officer**
For Action	Wards Affected: ALL

Central North West London NHS Foundation Trust Care Quality Commission Quality Report and Improvement Action Plan

1.0 Summary

1.1 This covering report accompanies the report published by the Care Quality Commission (CQC) on the quality of services provided by Central North West London NHS Foundation Trust and the action plan developed to respond to the findings of the inspection.

1.2 The report was published by the CQC on 19th June 2015 following an announced inspection conducted during May 2015. The CQC conducted the inspection as part of their annual programme of work.

1.3 The findings of the CQC inspection highlight a number of areas where the services provided by CNWL Trust were found to be 'requiring improvement.' This judgement was particularly influenced by the findings in relation to three of the core mental heath services. These are:-

- The acute wards for adults of working age, including the centre at Park Royal.
- Wards for older people with mental health problems
- Community based mental health services for adults of working age.

1.4 The area of most concern related to safety issue on the acute wards for working age adults which was rated as inadequate. A number of the recommendations arising relate specifically to improvements required at the Park Royal Mental Healthcare Centre. These are detailed in the accompanying action plan from CNWL and include steps to reduce the number of patients who are absent from the facility without authorised leave.

1.5 The inspection report identified ongoing pressures on the demand for acute mental health beds affecting inner London boroughs, while community based services were found to be experiencing difficulties in recruiting staff. The CQC also noted that the inspection was conducted during a period when the trust was required to deliver reductions in their expenditure and was in the process of implementing a number of change programmes.

2.0 Recommendations

2.1 The committee is recommended to question representatives of the CNWL Trust regarding their response to the findings to the CQC inspection and the timescale for implementing improvement set out in the accompanying action plan.

3.0 Detail

3.1 Central and North West London NHS Foundation Trust (CNWL) provides integrated health and social care services to a population of around three million people living in the South-East of England including London, Milton Keynes and Buckinghamshire. The trust has an annual income of £439 million, employs just under 6500 staff who provide about 300 services from more than100 locations. The mental health services provided by the trust are located mainly in the five London boroughs of Westminster, Kensington & Chelsea, Brent, Harrow and Hillingdon. The findings in the inspection report from the CQC cover all the areas of the trusts Mental Health Service activities in London. However the action plan and improvement priorities, provided by CNW, relates specifically to Mental Health services in Brent.

3.2 While the CQC inspection finding was ‘requires improvement’ for the Trust as a whole they also highlighted a number of positive strengths. The CQC particularly commented on the caring and compassionate attitude of staff which was rated as ‘outstanding’. They also rated the quality of the strategic planning and leadership of the Trust as ‘good’.

Contact Officers

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Central and North West London NHS Foundation Trust

Quality Report

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Stephenson House
75 Hampstead Road
London NW1 2PL
Tel: 020 3214 5700
Website: www.cnwl.nhs.uk

Date of inspection visit: 23 - 27 February 2015
Date of publication: 19/06/2015

Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Campbell Centre Hillingdon Hospital Mental Health Centre Northwick Park Mental Health Centre Park Royal Centre for Mental Health St Charles Mental Health Centre The Gordon Hospital	 RV3Y1 RV383 RV312 RV320 RV346
Long stay rehabilitation mental health wards for working age adults	Fairlight Avenue Hillingdon Hospital Mental Health Centre (Colham Green Road) Horton Haven Kingswood Centre Roxbourne Complex	 RV314 RV3AN RV351 RV3CA RV355
Forensic inpatient wards	Park Royal Centre for Mental Health	RV312
Child and adolescent mental health wards	Collingham Child and Family Centre	RV3CX
Wards for older people with mental health problems	Beatrice Place Hillingdon Hospital Mental Health Centre Northwick Park Mental Health Centre	RV329 RV3AN RV383 RV320

Summary of findings

	St Charles Mental Health Centre TOPAS Waterhall Care Centre The Butterworth Centre	RV3Y2 RV391
Wards for people with learning disabilities	Kingswood Centre Seacole Centre	RV3CA RV3CV
Community based mental health services for adults of working age	Stephenson House	RV3EE
Mental health crisis services and health based places of safety	Campbell Centre Hillingdon Hospital Mental Health Centre Northwick Park Mental Health Centre Park Royal Centre for Mental Health St Charles Mental Health Centre The Gordon Hospital Stephenson House	RV3Y1 RV3AN RV383 RV312 RV320 RV346 RV3EE
Specialist community mental health services for children and young people	Stephenson House	RV3EE
Community based mental health services for older people	Stephenson House	RV3EE
Community mental health services for people with learning disabilities	Stephenson House	RV3EE
Community substance misuse services	Stephenson House	RV3EE
Community health inpatient services	Windsor Intermediate Care Unit Hillingdon Hospital Mental Health Centre (Hawthorne Unit) South Wing St Pancras Hospital	RV3X8 RV3AN RV3X1
Community health services for children, young people and families	Stephenson House	RV3EE
Community health services for adults	Stephenson House	RV3EE
Community end of life care	Stephenson House	RV3EE
Community dental services	Stephenson House	RV3EE
Community sexual health services	Stephenson House	RV3EE

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for services at this Provider	Requires improvement 
Are Mental Health Services safe?	**Requires improvement** 
Are Mental Health Services effective?	**Good** 
Are Mental Health Services caring?	**Outstanding** 
Are Mental Health Services responsive?	**Requires improvement** 
Are Mental Health Services well-led?	**Good** 

Mental Health Act responsibilities and Mental Capacity Act/Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however, we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

Contents

Summary of findings

Overall summary

We found that Central North West London NHS Foundation Trust was performing at a level which led to a judgement of **requires improvement**.

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

The inspection of the trust was one of great contrast. The community health services were rated as good with the sexual health services rated as outstanding. The overall rating for caring was outstanding reflecting the individualised care provided in the community dental and sexual health services. The mental health services had three core services that required improvement. These were the acute wards for adults of working age, wards for older people with mental health problems and the community based mental health services for adults of working age.

The area of greatest concern related to safety and responsiveness on the acute wards for adults of working age which were rated as inadequate. There were however significant challenges being faced by the trust at the time of the inspection with pressures across the mental health acute care pathway.

We also found geographical differences, especially in London between the inner and outer London boroughs. The inner London boroughs were facing the greatest bed pressures for people needing acute mental health services. The outer London boroughs were facing challenges of demands for community services and difficulties in staff recruitment resulting in waiting lists. This was particularly notable in the London Borough of Hillingdon for mental health and community services.

There was much for the trust to be proud of. Most notably we found staff were very positive about the work of the trust and in most places care was delivered by hard working, caring and compassionate staff.

Two areas stood out as being very positive. The first were the opportunities given to staff for their personal development through strong support and access to training. We heard of many examples where staff had been able to extend their skills and develop their career within the trust and as a result provide better care to patients. Secondly we heard many examples of where the trust embraced innovation and change. Staff told us how new ideas were welcomed and we saw many examples of service improvements taking place.

We found the trust was well led. There was a strong leadership team who had developed an open culture where the vision and values were known and were being put into practice. At the time of the inspection the trust was implementing a new divisional structure with a greater focus on local contact. Running through this will be a new accountability structure to ensure effective communication and learning. This will hopefully lead to more robust governance processes and to staff working at ward and team level receiving the information they need to know.

We will be working with the trust to agree an action plan to assist them in improving the standards of care and treatment.

Summary of findings

The five questions we ask about the services and what we found

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated safe as **requires improvement** for the following reasons.

In the acute wards for adults of working age we found that:

- Some of the ward environments at the St Charles MHC, Park Royal MHC and the Gordon Hospital did not have clear lines of sight. There was a lack of planning of how risks in the environment would be managed on a daily basis.
- The failure to increase staffing to support increased numbers of patients on some wards put patients at risk of not having their needs met appropriately.
- The training of staff in new restraint techniques had not yet been fully implemented. This meant that staff working together on wards were not all trained in the same techniques and in line with current best practice on the use of prone restraint. At the end of the last quarter there were about 75 incidents of prone restraint a month across the trust. Until this training is complete staff were using out of date interventions that could present a risk of injury to staff and patients.
- Although the trust had a plan to reduce the number of ligature points on the wards, the work would take some time to complete. Until this was done, patients on the ward who were at high risk of suicide would be at increased risk. In response to this wards had prepared local management plans. When we looked at these documents and spoke to staff working on the acute wards they were still not able to clearly articulate how they would manage the ligature risks on the wards in terms of the support given to individual patients who were at high risk of suicide to keep them safe. In addition the privacy and dignity of patients was not always promoted as a result of measures to manage ligature risks that resulted in blanket restrictions.
- In the event of the use of rapid tranquilisation, monitoring of physical vital signs was not always maintained until the patient was alert.
- The records relating to the seclusion of patients at St Charles MHC did not provide a clear record of medical and nursing reviews, to ensure that these kept people safe and were carried out in accordance with the code of practice.
- There were a significant number of detained patients absconding from acute wards especially from St Charles, Park Royal and the Gordon Hospital. In the 6 months prior to the inspection 82 detained patients absconded whilst receiving

inpatient treatment and not when taking leave. In response to a serious incident, steps had been taken to address this at one hospital. Further review and actions were needed to reduce the risk of harm for patients using these services.

In the community based mental health services for working age adults we found that:

- Not all services had properly maintained automated external defibrillators (AED) machines to be used in the event a person had a cardiac arrest.
- The standard of some risk assessments was poor. They were out of date and lacked detail. Important information was not included.
- There were insufficient staff available in the Brent, Hillingdon and Harrow community recovery teams to work as care co-coordinators which meant that duty workers in some services were responsible for supporting a number of patients. This meant the safety and welfare of patients was potentially at risk.

On the wards for older people with mental health problems we found that:

- Oak Tree ward and TOPAS did not comply with the guidance on same sex accommodation.
- On Redwood ward the medication trolley was not locked when left at the nurse's station. We saw medication had been left where it could have been picked up by patients which meant that they may not have been protected from avoidable harm.
- On Redwood ward the drugs to be used for emergency resuscitation were not stored together which could make them harder to locate in an emergency.
- At the TOPAS centre there was no record so staff knew about current safeguarding alerts and any actions that needed to take place to keep people safe.

However across the trust staff knew how to report incidents and the trust was implementing a range of measures to share the learning from incidents. Whilst most staff teams knew about incidents that had happened in their services, there were teams that had not benefitted from learning across divisions.

The trust had worked to reduce some areas of risk highlighted in serious incidents such as reducing the numbers of pressure ulcers acquired in services and reducing the risk of falls.

Safeguarding was understood by staff and the trust was actively involved in local multi-agency safeguarding work.

Summary of findings

In most services the trust recognised the importance of maintaining safe staffing levels and had a recruitment strategy in place that was addressing staffing shortfalls.

Medication was managed well across most of the trust and any safety issues were promptly identified and addressed.

Are services effective?

Good

We rated effective as **good** for the following reasons:

Most patients had a comprehensive assessment in place including where needed a physical health assessment. Whilst there was still further work to do, the quality of care planning had improved and the trust was monitoring and improving on the numbers of people being given a copy of their care plan.

The trust had a wide range of measures in place agreed with commissioners, stakeholders, other professional bodies and set internally to monitor and improve the outcomes of people who use their services.

The training provided by the trust was varied and welcomed by staff who felt they had opportunities to develop their knowledge and skills. Inaddition to an induction and mandatory training staff also attended a wide range of other training both internal and external to the trust. Staff felt well supported through supervisions and appraisals.

There were many positive examples of multi-disciplinary and multi-agency working.

The trust was making good progress in the training of staff and appropaite use of the Mental Capacity Act.

There were however a few areas for improvement as follows:

- In community based mental health services the provider must ensure that patients using community services are referred for regular physical health checks.
- In wards for older people with mental health problems the provider must ensure on Redwood ward that patients physical health checks take place regularly to ensure their health is monitored.

Are services caring?

Outstanding

We rated caring as **outstanding** for the following reasons:

The staff we spoke to across the trust were enthusiastic, passionate and demonstrated a clear commitment to their work. Care was delivered by hard working, caring and compassionate staff. In many

services we saw great attention being given to providing care that was meeting the individual needs of each patient. This was particularly notable in the community dental and sexual health services where staff were going the extra mile. The trust was aware of a few areas where the attitude of staff had distressed some patients and was taking steps to address this constructively.

The trust undertook regular surveys to obtain feedback from people who used the services to promote the improvement of the care provided. We found many examples of carers being actively involved but the trust has also recognised that there is further work needed in some areas. The trust was working well with advocacy services.

There were however a few areas for improvement as follows in services for older people with mental health problems:

- On Redwood ward at St Charles we saw that a number of the female patients attend the mealtime in their nightwear with no dressing gown and this did not preserve their dignity.
- Patients were not always involved in their care planning nor did they have a copy of their care plans where appropriate.
- On several wards patients did not have access to a lockable space in their rooms and were not able to lock their own bedroom doors.
- People could not close their observation panel from inside their room to have privacy.

Are services responsive to people's needs?

Requires improvement

We rated responsive as **requires improvement** for the following reasons.

In the acute wards for adults of working age and the PICU we found that:

- Despite work to mitigate this, the pressure on acute beds meant that wards were often over-occupied. There was not always a bed for patients and they slept on sofas or a temporary bed was used. Patients returning from leave did not always have an identified bed and a bed was not always available in the PICU.
- Patients were often transferred to different wards to sleep and returned to the ward during the day. This disrupted the continuity of their care and patients felt it affected their well-being.

- Privacy and dignity of patients was not always promoted. Patients were not able to make calls in private. At the Campbell Centre patients in shared rooms were not able to attend to their personal care needs with an adequate level of privacy and dignity.
- Information on how to make a complaint was not always available in the PICUs and verbal complaints were not always being recognised and addressed with access to the complaints process.

In the mental health crisis services and health based places of safety we found that:

- People who were in a place of safety and were assessed as requiring inpatient beds experienced long delays before being admitted. The delays in accessing inpatient beds meant that some people received care that did not meet their needs.
- The places of safety at the Gordon hospital and Park Royal had no separate access.This meant that people had their privacy compromised as they arrived at the places of safety.
- In the North Kensington home treatment team based at St Charles the interview rooms were divided by a door with a glass panel covered by a small curtain. Private conversations could easily be overheard in either room. This meant their privacy and dignity was not maintained.

On the wards for older people with mental health problems we found that:

- Redwood ward reported that they took patients from the adult wards in order to alleviate pressure on adult wards. Some of these patients were not clinically appropriate for the ward environment.
- Most wards admitted patients into the beds of patients who were on leave. This meant that patients who were on leave, but not yet officially discharged, might not be able to return if they needed to.

On the long stay rehabilitation mental health wards we found that:

- In some areas information on how to complain was not clearly displayed and sometimes verbal complaints were not addressed using the complaints process where the patient would have liked to access this procedure.

Whilst for patients needing an acute mental health service the service was not responsive at the time of the inspection, we did find that in other services patient access and discharge arrangements were working well and in line with local targets. We did however

note that there were a number of services with long waiting lists in the London Borough of Hillingdon. The services were very aware of the need to offer appointments that met the needs of the patients and the importance of being reliable and punctual.

Most of the care was delivered in facilties that promoted recovery, comfort, dignity and confidentiality. Where this has not been achieved this will need to be addressed.

The trust served a very diverse population across each of the areas it covered. The trust demonstrated a real commitment in terms of meeting people's equality, diversity and human rights.

In some areas information on how to complain was not available. We also heard from patients who said they would have preferred their verbal complaint to be addressed in a more formal manner. The trust is introducing a centralised patient support service which will aim to make it easier for patients to provide feedback and raise concerns. It also aims to improve how they acknowledge and respond to concerns received about their services.

Are services well-led?

Good

We rated well led as **good** for the following reasons:

The trust had a clearly developed vision with values and strategic objectives. The staff knew what these were and felt part of the organisation.

The trust was led by a stable board and executive team. There was a programme of visits to services and leaders were felt to be visible and accessible. The trust were following through the recommendations from a governance review undertaken by Deloitte last year which should further develop their leadership.

The trust had undertaken work to meet the 'fit and proper persons requirement' which ensures that directors of health service bodies are fit and proper persons to carry out the role. This included undertaking a number of checks and this process needed to be completed.

The trust used a range of indicators and other measures such as surveys to monitor the performance of services. In many cases this accurately reflected when improvements needed to take place. Managers in teams and wards were using this information to varying degrees to highlight when work was needed. The trust did acknowledge that there were still too many variations in standards between services. The new divisions with a new accountability framework appears to offer an opportunity to improve information and reduce variations.

Summary of findings

The inspection took place at a time when the trust was being asked to save nearly 20% of its income over 3 years resulting in the consolidation and redesign of a number of services. All the savings plans included senior clinical input and feedback from people who use the services. However some staff felt they could be better informed and involved in the changes.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Bruce Calderwood, recently retired Director of Mental Health and Disability, Department of Health

Team Leader: Jane Ray, Head of inspection for Mental Health, Learning Disabilities and Substance Misuse, Care Quality Commission

The team of 118 people included:

Ten allied health professionals

Four analysts

One dentist

Thirteen experts by experience who have personal experience of using or caring for someone who uses the type of services we were inspecting

Twenty nine inspectors

Five junior doctors

Ten Mental Health Act Reviewers

Twenty two nurses from a wide range of professional backgrounds

Two planners

Two pharmacists

Seven senior doctors

Four social workers

Nine people from a range of other backgrounds such as governance, safeguarding, policy, communications etc.

Why we carried out this inspection

We inspected this core service as part of our on going comprehensive mental health inspection programme.

How we carried out this inspection

To get to the heart of the experience of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit the inspection team:

- Requested information from the trust and reviewed the information we received
- Asked a range of other organisations for information including Monitor, NHS England, clinical commissioning groups, Healthwatch, overview and scrutiny committees, Health Education England, Royal College of Psychiatrists, other professional bodies and user and carer groups
- Sought feedback from patients and carers through attending fourteen focus groups and meetings
- Received information from patients, carers and other groups through our website
- Carried out two short notice inspections in Epsom and Milton Keynes
- Visited the main sites for the community services with the Divisional Leads

During the announced inspection visit from the 23 – 27 February 2015 the inspection team:

- Visited 137 wards, teams and clinics
- Spoke with 285 patients and their relatives and carers who were using the service
- Spoke with the managers or acting managers for each of the wards and teams
- Spoke with 913 other staff members; including doctors, nurses and social workers

Summary of findings

- Attended and observed 87 hand-over meetings and multi-disciplinary meetings
- Joined care professionals for 31 home visits
- Attended 22 focus groups attended by around 200 staff
- Interviewed 9 senior executive and board members

We also:

- Collected feedback from 177 patients using comment cards
- Looked at 413 treatment records of patients
- Carried out a specific check of the medication management on 10 wards
- Looked at a range of policies, procedures and other documents relating to the running of the service
- Requested and analysed further information from the trust to clarify what was found during the site visits

After the main inspection week the inspection team:

- Carried out eight more short term announced or unannounced inspections of wards and teams including community based mental health services, community CAMHS teams, community learning disability teams and wards for older people.

The team inspecting the mental health services at the trust inspected the following services:

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay rehabilitation wards
- Forensic inpatient wards
- Wards for older people with mental health problems
- Wards for people with learning disabilities
- Wards for children and adolescents with mental health problems
- Community based mental health services for adults of working age
- Mental health crisis services and health based places of safety
- Community based mental health services for older people
- Community mental health services for people with learning disabilities
- Specialist community mental health services for children and young people

The community based substance misuse services provided by the trust were also inspected but not rated.

The team inspecting the community services at the trust inspected the following services:

- Community health services for adults
- Community health services for children, young people and families
- Community inpatient services
- Community end of life care
- Community dental services
- Community sexual health services

The team would like to thank all those who met and spoke with inspectors during the inspection and were open and balanced when sharing their experiences and perceptions of the quality of care and treatment at the trust.

Information about the provider

Central and North West London NHS Foundation Trust (CNWL) provides integrated health and social care services to a population of around three million people living in the South-East of England including London, Milton Keynes and Buckinghamshire. The trust has an annual income of £439 million, employs just under 6500 staff who provide about 300 services from more than100 locations.

Sixty per cent of the trusts services are provided in the community, in people's homes, clinics and schools. The trust also has specialist inpatient services for people needing intensive treatment. Services are provided to children and young people, adults of working age and to older people.

CNWL was formed in 2002, following the merger of three mental health trusts. It became a foundation trust in 2007. Over the years additional contracts were awarded to the trust so it now provides mental health and community health services.

The mental health services provided by the trust are located mainly in the five London boroughs of Westminster, Kensington & Chelsea, Brent, Harrow and

Summary of findings

Hillingdon as well as Milton Keynes. The community services provided by the trust are located mainly in Camden, Hillingdon and Milton Keynes. Other services are provided outside these areas. In addition the trust also provides health services in 17 prisons, young offenders institutions and immigration removal centres. These services were not inspected during this inspection but will be inspected jointly with HMI of prisons. The trust works in a complex commissioning environment, with services commissioned on a local and national level.

The trust has 28 locations registered with CQC. CNWL locations have been inspected on 33 occassions at 18 of the locations. Four locations were non-compliant at the time of this inspection as follows:

- Beatrice Place – Regulation 9 care and welfare of people who use services
- The Campbell Centre – Regulation 20 records
- HMP Woodhill – Regulation 19 complaints
- St Charles Mental Health Centre – Regulation 18 consent to care and treatment, Regulation 9 care and welfare of people who use services and Regulation 10 assessing and monitoring the quality of service provision

With the exception of HMP Woodhill this non-compliance was followed up as part of the inspection.

What people who use the provider's services say

Before the inspection took place we met with 13 different groups of patients, carers and other user representative groups as follows:

- Loud and clear advocacy service (Brent, Harrow and Hillingdon)
- Mind in Harrow
- Older adult user group (Kensington & Chelsea and Westminster)
- Westminster Mind
- Rethink (Milton Keynes)
- Westminster carers network
- Milton Keynes carers network
- Mortimer Market user group
- Wheelchair user group – Hillingdon
- Brent user group
- Healthwatch user group (Hammersmith & Fulham, Kensington& Chelsea and Westminster)
- Meeting with representatives from Healthwatch (Camden, Milton Keynes, Kensington & Chelsea and Hillingdon)
- Different Voices advocacy group – at St Charles

During the inspection the teams spoke to 465 people using services or their relatives and carers, either in person or by phone. We received 177 completed comment cards. We also received 32 individual comments from people through our website.

Much of the feedback we received was very positive as follows:

- Most staff were kind, supportive, tried to meet peoples needs, professional and helpful. This was particularly positive when people had named individuals who were involved in their care.
- The trust promoted user engagement through user groups.
- The trust offered opportunities for user involvement for example in staff recruitment, policy development, patient forums etc.
- The trust was promoting and making increased use of advocacy services.
- Some services received particular mention such as the memory clinics.

Some of the challenges that we were told about were as follows:

- The greatest number of concerns were from people who told us their experiences of accessing acute mental health services and included – length of time waiting in A&E for a bed, patients sleeping on couches in wards as a bed was not available, patients moving between wards and sites and carers not always told.
- Carers not always feeling well informed, listened too or involved such as attending ward rounds. Carers also expressed particular concerns about staff not responding when they reported that the person they were supporting was experiencing a deterioration in their health.
- Some negative comments about staff attitudes – especially at the Gordon Hospital

Summary of findings

- Access to psychological therapies in a timely manner from staff with the correct skills and experience.
- People not having access to their care plan.
- People not having access to lockable space when they were an inpatient.
- Difficulties in using the complaints process.
- Reductions in services, especially day centres in areas such as Brent.
- Whilst receiving a new wheelchair went well, getting the wheelchair repaired in a timely manner was hard, especially in Hillingdon.
- Whilst the trust welcomed user involvement, it did not always provide feedback when issues were raised.

Good practice

Trust wide:

- The positive attitude of staff was very evident throughout the inspection. This was reflected in their pride in working for the trust and their service and in their wish to provide the highest standards of care to people using the service.
- The pharmacy team not only ensured that the arrangements for the supply of medicines was good, but also provided considerable guidance and support to staff and patients throughout the services.
- Patients carers and staff all valued the courses provided by the recovery college and the opportunities for personal development. The recovery college was very well organised and responsive to local need.
- The trust serves very diverse communities and throughout the inspection we saw many examples of how the trust is supporting people who use the services, their families and carers in terms of their individual needs.

Acute wards for adults of working age and psychiatric intensive care units:

- In 2014 the acute care services introduced daily 'whiteboard' meetings on each ward. These were attended by a range of disciplines including the consultant psychiatrist, matron, staff nurse, psychologist, pharmacist, occupational therapist and medical trainees. The meeting provided a daily update on each patient and opportunity for professions to have daily oversight of what was happening with each patient.
- On some of the wards they had recruited 'peer support workers' (PSW) who worked on a full or part-time basis. These were people who had experience of using mental health services. They worked as part of the team and were able to provide additional insight into what is was like to be a user of services. The PSW's spoke of their role as being a 'bridge' to facilitating better working between patients and staff.
- The occupational therapy (OT) team at the Riverside Centre in Hillingdon were involved in ongoing research with a local university. This was a four year project and involved previous and current patients in research around their experience of using OT and how this had an impact on their lives.
- At the Gordon Hospital there was a Homelessness Prevention Initiative (HPI) that supported patients admitted to a Westminster acute mental health bed that were homeless or at risk of homelessness. This project assessed and supported people to help facilitate discharge planning and reduce readmission, with the aid of peer support workers.
- Eastlake and Ferneley wards had created a therapeutic environment using a mix of service user and professional artwork, areas of colour and enhanced lighting for areas with no natural light. A psychologist employed by the trust has advised on the décor.

Community based mental health services for working age adults:

- A consultant pharmacist attended the North Kensington and Chelsea community recovery team every week. Patients could book appointments with them to discuss their medicines.
- The North Westminster assessment and brief treatment and community recovery teams provided

very good care. They were particularly sensitive to the cultural background of patients. Patients received care and treatment specifically tailored to their own diverse needs.

- Almost all services had employed peer support workers, people who had used or were using mental health services, who were a positive addition to the teams.
- Several community services involved patients in interviewing prospective new staff members as part of the recruitment process.
- Most teams held regular forums for patients and carers to give feedback about the service.

Rehabilitation wards for working age adults

- Staff across the services had a very good understanding of the Mental Capacity Act and were able to demonstrate good documentary evidence of using the Act in practice.

Inpatient wards for people with a learning disability

- A wide variety of information had been made available in accessible formats for people using the service.

Children and adolescent inpatient wards

- Each child was offered an individualised programme of assessment and treatment. Upon admission a range of assessments were completed including psychiatric and psychological assessments. The team worked together to formulate detailed care plans.
- Collingham was a member of the Royal College of Psychiatrists' Quality Network for Inpatient CAMHS (QNIC) accreditation network. The service was recently accredited 'as excellent'.
- NICE guidance was followed when prescribing medication.Trust guidelines for unlicensed medicines were followed.
- Behavioural therapy and systemic family therapy were amongst the NICE recommended treatments available for children at Collingham.
- The service's last routine outcome measurement report completed from the Royal College of Psychiatrists' Quality Network for Inpatient CAMHS (QNIC) for the period of April 2013 – 2014 showed positive results. Outcome measures were used in the service to monitor a person's progress in a systematic way.
- Children's feedback was sought and used to inform service development.
- Children had participated in the interview process for a new member of staff and for student placements by developing interview questions for the panel on areas that were important to them.

Specialist community mental health services for children and young people

- The Brent CAMHS service ran the targeted mental health in schools (TaMHS) programme. They worked to support school staff to recognise young people with emotional wellbeing and mental health needs. They provided access to advice and consultation from a professional in mental health.
- Young people had been used on interview panels for new staff in the trust and had been involved in developing questions for candidates.

Wards for older people with mental health problems

- At Beatrice Place the team was pioneering a new sensory activity programme designed for adults in the advanced stages of dementia called Namaste. This evidence based programme focused on meeting the physical and emotional needs pf patients through meaningful activity which in turn decreases distress and resulting behavioural problems. The activity used music, fragrance, plants, sensory stimulation, massage and food treats to improve the comfort and pleasure of the patient's experience. It had just started running but Beatrice Place was the first NHS service to pilot the programme. Staff reported that a couple of their higher risk patients had improved communication and demonstrated less agitation and distress since they started attending the programme.

Community based mental health services for older people

- Brent and Kensington & Chelsea and Westminster memory clinics are accredited by the Royal College of Psychiatrists as 'excellent' as part of their memory service national accreditation programme.

Summary of findings

- The Brent memory service have introduced five primary care dementia nurses (PCDN). The PCDN was developed from the Admiral Nurse model which is patient and carer focused and described as having 'one foot in the memory service and one foot in GP surgeries'.The role is intended to support GPs to better manage patient care and reduce referrals to the service as well as enabling people who use the service to stay in their own home with support for longer.

Community dental services

- The commitment of staff to provide the best care they could. Staff spoke with passion about their work, felt proud and understood the values of the organisation.
- The positive feedback received from patients regarding the quality of care they received. The care provided was person centred, individualised and based on evidence based guidelines.

Community health inpatient services

- South Wing St Pancras had introduced weekly observations of staff practice. Ward managers visited and observed the practice of staff on other wards. The ward managers relayed their findings to the clinical lead at the St Pancras community in patient weekly clinical indicator team meetings.

Sexual health services

- The sexual health services participated in a wide range of research and innovation both nationally and internationally. This means that the patients who use these services had access to some of the latest approaches to meet their individual needs.

Community health services adult teams

- Good partnership working between Hillingdon hospital and the community rehabilitation team had highlighted to commissioners bed days could be reduced by providing intensive seven day a week therapy through evidenced based practice. As a result commissioners had invested significantly in the rehabilitation team.
- Camden respiratory and neuro-therapy teams had a range of positive initiatives to ensure vulnerable people had access to good quality and effective care. For example taxis were provided for the patient and carer to attend the pulmonary rehabilitation class. The class included group and individual exercises, education sessions and a question and answer session with the consultant. Sessions with nurse, clinical psychologist, dietitian, occupational and physiotherapists were available. British Lung Foundation packs were given to patients and leaflets were available in different languages with access to interpreters if required. Patient feedback had informed the timing of sessions.
- The district nurse bag in Milton Keynes had been designed to ensure all the necessary equipment was available to use during each appointment.

Community health end of life care

- In response to concerns from a group of people with a learning disability the Islington ELiPSe team and the Camden palliative care team worked with the group giving them advice, information and support about the decisions they could make regarding their care at end of life.
- The Hillingdon palliative care team worked closely with nursing homes to improve the end of life care for people in the home which had resulted in an increase in people dying in the homes rather than in hospitals.
- The 'transform end of life project' will run for five years to educate, mentor and train clinical and medical staff in end of life care. New documentation was being piloted which incorporated five key tools to improve communication between patients, families and clinical staff that will also roll out across the community Camden, Islington ELiPSe palliative care services.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve the acute wards for adults of working age

- The trust must address the blind spots in the ward environment of St Charles MHC, Park Royal MHC and the Gordon Hospital to enable clearer lines of sight and reduced risks to patients and staff.
- Staff working on the wards must be able to articulate how they are assessing and managing the potential risks from ligature points for the patients using this service. The use of blanket restrictions must be reviewed and risks from ligatures managed to reflect the needs of the patients on the ward.
- The provider must ensure that staffing levels are adjusted to reflect the actual numbers of patients on the wards. This number must include those patients spending the day on the ward even if they are sleeping on another ward or at another hospital overnight.
- The trust must implement the training of all staff in new restraint techniques to ensure that staff working together on wards are all trained in the same techniques and in line with current best practice on the use of prone restraint, to prevent injury to staff and patients.
- Staff must always monitor and record physical vital signs in the event of the use of rapid tranquilisation until the patient is alert. They must improve medical reviews of patients receiving rapid tranquilisation to ensure patients are not at risk.
- The trust must ensure that records relating to the seclusion of patients provide a clear record of medical and nursing reviews, to ensure that these are carried out in accordance with the code of practice.
- The trust must take further steps at the Gordon Hospital and other sites where acute inpatient services are provided to ensure that risks to detained patients from being absent without authorised leave are minimised.
- The trust must ensure that, on admission to a ward, patients have a designated bed that is within the ward occupancy levels.
- Patients returning from leave must have a bed available on their return to the ward.
- The trust must take steps to reduce the number of times that patients are moved to other wards to sleep for non-clinical reasons. Where it is unavoidable, staff must ensure that a thorough handover takes place to promote continuity of care. Patients must only be moved at reasonable times so that they are not adversely affected.
- The trust must promote the privacy and dignity of patients. Patients must be able to make calls in private. At the Campbell Centre patients in shared rooms must be able to attend to their personal care needs with an adequate level of privacy and dignity.
- The trust must ensure the acute wards for adults of working age are well led by having contingency plans in place for when the numbers of patients needing a bed increases above the beds available.

Action the provider MUST take to improve the psychiatric intensive care unit

- The trust must ensure information is available to inform patients how to make a complaint. They must ensure verbal complaints are addressed and, if needed, patients and carers have access to the formal complaints process.

Action the provider MUST take to improve mental health crisis services and health based places of safety:

- The trust must ensure that when a person is assessed as requiring an inpatient bed that they are able to access a bed promptly.
- The trust must ensure that the access to the trusts places of safety promotes the patients dignity and privacy by the provision of a separate entrance.
- The trust must ensure people's private conversations cannot be overheard in adjoining interview rooms at St Charles hospital.

Action the provider MUST take to improve community based mental health services for adults of working age

- The provider must ensure that where automated external defibrillators (AEDs) are provided because there is a clinical need for this equipment, for example at Hillingdon community recovery team (Pembroke Centre) that they are maintained on a regular basis, accessible and available for use. The provider must ensure that other teams also have resuscitation equipment if needed.
- The provider must ensure that all patient risk assessments in Harrow community recovery team are comprehensive, detailed and thorough. They must be reviewed regularly and updated after incidents. There must be a personalised crisis plan in place for each patient.
- The trust must ensure there are sufficient staff available to work as care co-ordinators so that duty workers in some services are not holding large numbers of patients which could potentially create a risk for the safety and welfare of patients.
- The provider must ensure that patients using community services are referred for regular physical health checks.

Action the provider MUST take to improve the long stay / rehabilitation mental health wards for working age adults

- The trust must ensure in all the rehabilitation services that information is available to inform patients how to make a complaint. They must ensure verbal complaints are addressed and if needed have access to the formal complaints process and that learning also includes verbal as well as written complaints.

Action the provider MUST take to improve the wards for older people with mental health problems

- Oak Tree ward and TOPAS must comply with same sex accommodation guidelines to promote peoples safety, privacy and dignity.
- On Redwood ward at St Charles medication must not be left unsupervised in reach of patients.
- On Redwood ward at St Charles medication used for emergency resuscitation must be kept in one place so it is easily accessible in an emergency.
- At the TOPAS centre in Milton Keynes staff must have access to a record of safeguarding alerts so they can know what action to take to keep people safe and learn from previous events.
- On Redwood ward peoples physical healthcare checks must take place as regularly as each person needs to ensure their health is monitored.
- On Redwood ward primarily but also on other wards for older people, patients must be supported to be dressed in a manner that preserves their dignity, have access to a lockable space to protect their possessions preferably their bedroom, have night time checks that are the least intrusive as possible, be able to close their observation panels in their door from inside their room and participate in the preparation of their care plan and have a copy where appropriate.
- Redwood ward must not provide beds for working age adults who are not clinically appropriate for a service for older people.
- A bed must be available for patients who are on leave incase they need to return to the ward.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve trust wide services

- The trust should complete its work to fully embed the work on the fit and proper person requirement.
- The trust should fully implement the new accountability framework to ensure there is effective ward to board sharing of information and learning.
- The trust should complete it's work on complaints to ensure they are addressed in a more consistently high standard.

Action the provider SHOULD take to improve the acute wards for adults of working age

- The trust should provide individual lockable space for patients to keep their possessions safe.
- The trust should ensure that maintenance issues at Park Royal MHC are resolved in a timely manner.
- The trust should ensure that patients are not confined to bedrooms and that seclusion is implemented in accordance with the code of practice: Mental Health Act 1983.

Summary of findings

- Staff at the Gordon Hospital should ensure copies of consent to treatment forms are attached to medication charts.
- The trust should address the sound of the alarms at St Charles MHC so that they are as least disruptive to patients as possible, and do not affect their well-being.
- The trust should improve the new multi-disciplinary care planning system to ensure that all disciplines record directly onto this. Nurses informed us that they make entries for other professionals following reviews of care. The expectation for nurses to do this is not in the spirit of the system and could lead to inaccurate professional judgements being recorded.
- Male staff were reluctant to interact with female patients on Pond ward following a safeguarding investigation. Further support should be provided to staff to enable patients to approach any member of staff for support.
- Staff should encourage all patients to get involved in planning their care and treatment. This involvement should be clearly recorded.
- Discharge planning should be incorporated into the care planning for patients so that care and treatment is recovery focussed.
- The trust should monitor the impact of bed management pressures and the ability of staff to facilitate patients' entitlement to take Section 17 leave off the ward.
- The trust should promote any staff and patient feedback processes so that all people have an opportunity to be involved in the trust.

Action the provider SHOULD take to improve mental health crisis services and health based places of safety:

- The trust should ensure the building work to make the Gordon Hospital places of safety is completed.
- The trust should ensure people's risk assessments are updated on the trust's electronic records system to accurately reflect their changing risk.
- Arrangements for lone working should be reviewed to ensure that all teams have robust systems in place.
- Where appropriate, staff should record when they have assessed a person's capacity to make a decision within the written records.
- The teams should consider ways to ensure they collect regular feedback from people who have used their services.

Action the provider SHOULD take to improve community based mental health services for adults of working age

- The trust should ensure that people using the service have crisis plans that reflect their individual circumstances.
- The staff should be supported to learn about incidents from services in other parts of the trust so they can apply the lessons learnt to their work.
- Where people using the service are being supported by a lead professional clinician their care care plans should aim to be more person centred.
- The trust should focus recruitment to fill posts where the vacancies mean that a team does not have internal input from a particular care professional.
- The provider should ensure that all staff in all services fully understand the Mental Capacity Act and code of practice.
- The provider should address with staff at the Harrow Community Recovery Team how they approach and support patients with a personality disorder.
- The provider should ensure that the areas used by patients at Mead House (Hillingdon CRT) are refurbished so that it is a pleasant environment for patients to use.
- The provider should ensure that risk registers in Harrow and Hillingdon Community Recovery Teams reflect all risks. Risk registers should be detailed, thorough and risk rated.

Action the provider SHOULD take to improve forensic wards

- The trust should consider how learning from incidents across different divisions is embedded in practice

especially where there are wards with similaries either in geography or function such as other wards on the Park Royal site and other rehabilitation wards in the trust.

- The trust should consider if a seclusion room can be provided on the same floor as the wards.
- The trust should ensure areas for work identified in infection control audits are carried through.
- The trust should provide ongoing training and support to ensure all staff had a good understanding of the Mental Capacity Act and how this would be used in practice with the patients using these services.
- The trust should ensure that repairs to equipment in the wards are reported and fixed in a timely manner.

Action the provider SHOULD take to improve community mental health services for people with learning disabilities:

- Accurate records should be available of the training staff have completed to ensure staff complete the necessary training.
- Vacant occupational therapy and speech and language therapy posts should be filled as soon as possible to ensure people who use the service have access to that professional input where needed.

Action the provider SHOULD take to improve the long stay / rehabilitation mental health wards for working age adults:

- The trust should ensure that maintenance issues are addressed across the London services in a timely manner.
- The trust should review the layout of Fairlight and Colham Green to try and achieve the greatest level of gender separation to promote people's safety and dignity.
- The services should keep blanket restrictions under review such as levels of observation, access to hot drinks and the impact of the front door at Colham Green being opened only by an electronic lock controlled from within the staff office to ensure the least restrictive measures are in place that reflect peoples' individual needs.
- The trust should ensure that staff at Fairlight had consistent access to information necessary to provide support and care for people through the electronic patient record system.
- The London services should ensure that staff have an understanding of the role of independent mental health advocates and general advocates within the services so that patients can be supported to access the most appropriate service.
- The trust should ensure that where investigations are needed as part of incident enquiries that these take place in a timely manner especially where staff are suspended.
- The trust should look at the arrangements for patients to have or replace keys for their rooms to ensure they could lock their rooms without having to rely on staff doing this for them.
- The trust should support staff to have an improved knowledge of incidents across the trust from other divisions so the learning can be put into practice.

Action the provider SHOULD take to improve the wards for people with learning disabilities:

- Recruitment of staff to work in the services both nursing and other allied professions should continue to be a priority for the trust until posts are filled.
- The care planning process should be more individualised. Care plans should be in a format that is meaningful to that person, there should be a strong recovery focus and the care plans should be put into practice for each person.
- The service should have accurate training records so that people's training needs can be identified and addressed.
- The service should work with commissioners to make arrangements for a replacement independent mental health advocacy service at the Kingswood Centre and staff should know who to contact then this service is needed.
- Activities on people's programmes should happen in practice.
- Patients should receive the support they need to practice their faith if they wish to do so.

Summary of findings

Action the provider SHOULD take to improve children and adolescent inpatient wards

- The service should consider the broader implications of the search policy in the service. There was a risk that children could bring in dangerous items that could go undetected.
- The service should ensure that all families understand when restraint may be used on their child and why.

Action the provider SHOULD take to improve specialist community mental health services for children and young people

- The trust should ensure that the lone working policy and use of panic alarms are embedded across the service. There was a difference in how the panic alarm system and lone working system was operating across the teams. This meant that if there was an incident other staff in the team would not be alerted to this, and be able to offer effective support or take steps to ensure staff safety in a timely manner.
- The trust should ensure that all staff know how to report incidents and understand the duty of candour regulation.
- The trust should ensure that staff are appropriately supported about changes that affect them during the ongoing reconfiguration of the CAMHS community services.
- The trust should ensure young people and their families are clear on who to contact in a crisis out of hours.

Action the provider SHOULD take to improve the wards for older people with mental health problems

- The trust should ensure staff working on wards for older people can clearly articulate how they are supporting patients to keep safe in terms of the ligature risks on the ward.
- At St Charles chairs with split covers should be repaired or replaced and enough chairs should be available so people can eat together.
- Here actions are needed following environmental risk assessments, these should be followed through.
- The trust should review the layout at Beatrice Place to try and provide gender separation in terms of bathroom facilities.
- On Redwood ward risk assessments should be updated following incidents.
- The trust should ensure staff have opportunities to discuss and learn from incidents across the trust and not just their site.
- The trust should ensure that Mental Health Act documentation is completed correctly for patients on TOPAS, Redwood ward and the Butterworth Centre to ensure people are being supported to understand their rights, their medication is authorized and their leave is approved.
- The trust should ensure that staff have been supported to have the training needed to support patients with their physical healthcare in line with the training provided at Beatrice Place.
- The trust should ensure that where patients are subject to a deprivation of liberty safeguard that the authorisations are kept under review and updated as needed.

Action the provider SHOULD take to improve the community-based mental health services for older people

- The care plans should include a full physical healthcare management plan where physical health issues noted on initial assessments.
- The teams should explore if care plans can be provided in a more accessible format.
- The services should ensure all staff have access to regular formal supervision
- The services should collate informal verbal complaints so that lessons can be learnt from these.

Action the provider SHOULD take to improve community substance misuse services

- The provider should ensure that each person receiving treatment has potential risks associated with the treatment assessed, and that where potential risks are identified an appropriate plan to manage or mitigate these risks is put in place. This work had been identified by the trust and needs to be completed.
- The provider should ensure that a robust system to monitor and dispose of medical equipment that has passed its expiry date is in place at each site.

Summary of findings

- The provider should ensure that staff record information relating to physical health checks in a standardised format to ensure that this information is readily accessible to all staff who may need to access it.
- The provider should ensure that all patients with identified health risks, such as at QT prolongation, are referred at regular intervals for electrocardiograms (ECG), in line with trust policy and procedure.
- The provider should ensure that recovery care plans across all sites are holistic and contain all information relating to care and treatment including the views of the patient.
- The provider should ensure that a clear policy and procedure is available at all sites that provides guidance on the frequency with which patients prescribed controlled medicines should be reviewed by the prescribing doctor.
- The provider should ensure that premises promote the dignity of people needing to access facilities at each geographical site.

Action the provider SHOULD take to improve community dental services

- The trust should continue to work closely with commissioners to ensure that patients in Hillingdon PDS can access care and treatment needed within a reasonable timescale.

Action the provider SHOULD take to improve community health inpatient services

- The trust should provide facilities for patients to store their medication where they are able to self-administer.
- The staff at the Windsor unit in Milton Keynes should receive regular supervision.
- The trust should ensure that patient records at the Windsor unit in Milton Keynes are well organised.
- The trust should ensure the manager post at the Windsor unit in Milton Keynes is filled.
- The trust should ensure good practice is shared across the community inpatient services.

Action the provider SHOULD take to improve in community health adult teams

- The district nursing staff in Hillingdon should all have with them the essential equipment needed to do their job.
- Where teams are using electronic and paper patient notes the recording should be more consistent. Assessments and the review of assessments should be completed in line with the agreed procedures for the team.

The district nursing teams in Hillingdon should all maintain high standards of infection control practice.

Central and North West London NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

The trust's systems supported the appropriate implementation of the Mental Health Act and its Code of Practice. Administrative support and legal advice was available from the Mental Health Act lead in a centralised team within the trust, as well as Mental Health Act law managers and Mental Health Act administrators based at each hospital site.

The staff carried out regular audits to ensure the Mental Health Act was being implemented correctly and produce a quarterly Mental Health Act Performance Report. A Mental Health Law group met every two months to review Mental Health Act performance and trends and provided a governance structure.

Training was provided to staff centrally and within local teams. Role specific training was given where required. Overall staff appeared to have a good understanding of the Mental Health Act and code of practice.

Detention paperwork was generally filled in correctly, was up to date and was stored appropriately.

There was a good adherence to consent to treatment and capacity requirements and copies of consent to treatment forms were mostly attached to medication charts where applicable.

People had their rights explained to them on admission to hospital. Where people did not understand their rights, the Trust had a policy that a discussion of rights would be repeated daily for the first 14 days following detention and weekly thereafter. We found however that discussions of rights were not always regularly repeated following unsuccessful attempts.

Within all of the wards visited apart from the learning disability services we found that people had access to Independent Mental Health Advocacy (IMHA) services and information on IMHA services was provided to patients. Patients and staff appeared clear on how to access IMHA services appropriately.

Where there are some individual areas for improvement these are identified in the core service reports.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust provides a statutory mental health law training course all staff working in clinical settings. This includes training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards.

Requires improvement

Are services safe?

The trust has an up to date policy on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

We found variations in the use of the MCA in terms of the completion of MCA assessments and recording this appropriately and the use of best interest meetings. The long stay rehabilitation mental health wards for working age adults showed good practice in terms of the Mental Capacity Act. Where there are some individual areas for improvement these are identified in the core service reports including the forensic inpatient wards and learning disability wards.

There is a trust wide MCA lead and also leads in different services to support staff as needed.

Between the 1 May 2014 and the 31 October 2014 there had been 102 DoLS applications. Some were still waiting to be assessed and several had not been authorized. In the wards for older people with mental health problems we found some DoLs where the authorisations had expired and new applications needed to be made. This reflects the on-going learning process that trusts are experiencing about this process.

Adherence to the MCA is monitored through the Mental Health Law group which provided a governance process. This looked at the results of audits and considered new methodology.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

We rated safe as **requires improvement** for the following reasons.

In the acute wards for adults of working age we found that:

- Some of the ward environments at the St Charles MHC, Park Royal MHC and the Gordon Hospital did not have clear lines of sight. There was a lack of planning of how risks in the environment would be managed on a daily basis.
- The failure to increase staffing to support increased numbers of patients on some wards put patients at risk of not having their needs met appropriately.
- The training of staff in new restraint techniques had not yet been fully implemented. This meant that staff working together on wards were not all trained in the same techniques and in line with current best practice on the use of prone restraint. At the end of the last quarter there were about 75 incidents of prone restraint a month across the trust. Until this training is complete staff were using out of date interventions that could present a risk of injury to staff and patients.
- Although the trust had a plan to reduce the number of ligature points on the wards, the work would take some time to complete. Until this was done, patients on the ward who were at high risk of suicide would be at increased risk. In response to this wards had prepared local management plans. When we looked at these documents and spoke to staff working on the acute wards they were still not able to clearly articulate how they would manage the ligature risks on the wards in terms of the support given to individual patients who were at high risk of suicide to

Requires improvement

Are services safe?

keep them safe. In addition the privacy and dignity of patients was not always promoted as a result of measures to manage ligature risks that resulted in blanket restrictions.
- In the event of the use of rapid tranquilisation, monitoring of physical vital signs was not always maintained until the patient was alert.
- The records relating to the seclusion of patients at St Charles MHC did not provide a clear record of medical and nursing reviews, to ensure that these kept people safe and were carried out in accordance with the code of practice.
- There were a significant number of detained patients absconding from acute wards especially from St Charles, Park Royal and the Gordon Hospital. In the 6 months prior to the inspection 82 detained patients absconded whilst receiving inpatient treatment and not when taking leave. In response to a serious incident, steps had been taken to address this at one hospital. Further review and actions were needed to reduce the risk of harm for patients using these services.

In the community based mental health services for working age adults we found that:

- Not all services had properly maintained automated external defibrillators (AED) machines to be used in the event a person had a cardiac arrest.
- The standard of some risk assessments was poor. They were out of date and lacked detail. Important information was not included.
- There were insufficient staff available in the Brent, Hillingdon and Harrow community recovery teams to work as care co-coordinators which meant that duty workers in some services were responsible for supporting a number of patients. This meant the safety and welfare of patients was potentially at risk.

On the wards for older people with mental health problems we found that:

- Oak Tree ward and TOPAS did not comply with the guidance on same sex accommodation.
- On Redwood ward the medication trolley was not locked when left at the nurse's station. We saw medication had been left where it could have been picked up by patients which meant that they may not have been protected from avoidable harm.
- On Redwood ward the drugs to be used for emergency resuscitation were not stored together which could make them harder to locate in an emergency.
- At the TOPAS centre there was no record so staff knew about current safeguarding alerts and any actions that needed to take place to keep people safe.

However across the trust staff knew how to report incidents and the trust was implementing a range of measures to share the learning from incidents. Whilst most staff teams knew about incidents that had happened in their services, there were teams that had not benefitted from learning across divisions.

The trust had worked to reduce some areas of risk highlighted in serious incidents such as reducing the numbers of pressure ulcers acquired in services and reducing the risk of falls.

Safeguarding was understood by staff and the trust was actively involved in local multi-agency safeguarding work.

In most services the trust recognised the importance of maintaining safe staffing levels and had a recruitment strategy in place that was addressing staffing shortfalls.

Medication was managed well across most of the trust and any safety issues were promptly identified and addressed.

Our findings

Track record on safety

- The CQC Intelligent Monitoring system was used to give an indication of potential risks for the trust in preparation for the comprehensive inspection. There was a risk identified in relation to an indicator which

measures the number of deaths of patients detained under the Mental Health Act. This showed that there were two deaths from December 2012 till November 2013.

- NHS Trusts are required to submit notifications of incidents to the National Reporting and Learning System (NRLS). In total 7680 incidents were reported to NRLS between the 1 December 2013 and 30 November 2014. These figures showed that two-thirds of the incidents reported occurred in a mental health setting. Of these 80% were classified as "no harm" incidents.
- For the purposes of the inspection there was a focus on never events and serious incidents. Between the 1 December 2013 and 30 November 2014 there were 0 never events, 144 serious incidents and 39 deaths.
- Most of the serious incidents related to community services and were grade 3 or 4 pressure ulcers. Most of these occurred in the patients' own home. It was not possible to tell from the data if the pressure ulcers were found by community staff when they started providing a service, or if they occurred during the course of providing a service.
- The trust provided a more detailed breakdown of the serious incidents between September 2013 and January 2015. For mental health services there had been three inpatient deaths during this time two in the Milton Keynes services and one in Hillingdon. There had also been 14 suicides of patients receiving services from the trust, 2 in Brent, 6 in Milton Keynes and 6 in Hillingdon. There had also been one homicide in Hillingdon. Just prior to the inspection there was another suicide in Westminster. An independent review is taking place of the cluster of suicides in Hillingdon.
- From the 2 September 2013 till 30 September 2014 there were 3 admissions of patients under 18 to an adult ward, although they were offered support to meet their needs until an appropriate placement was identified. This is reported as a serious incident due to the potential risks for the young person of being in an adult environment.
- The NHS Safety Thermometer measures a monthly snapshot of four areas of harm including falls. From November 2013 for the next 13 months the numbers of pressure ulcers had continued to fluctuate. This is largely outside of the trusts' control as they report pressure ulcers for community patients when they start to provide them with a service. The number of patient falls resulting in harm had reduced in the second six months to 96 cases.
- The trust provided a more detailed breakdown of the serious incidents between September 2013 and January 2015. This showed that for community patients receiving an inpatient service 7 had developed pressure ulcers, 4 at the Windsor unit in Milton Keynes, 2 at the Hawthorne unit in Hillingdon and 1 at St Pancras in Camden. Also at the Windsor unit in Milton Keynes 4 patients had experienced fractures as a result of falls. Last years quality account had made reducing avoidable pressure ulcers a target in the Milton Keynes services and this was achieved. Training is mandatory on reducing falls and pressure ulcers for all staff working in services for older people.
- Every six months the Ministry of Justice publishes a summary of schedule 5 recommendations which have been made by coroners with the intention of learning lessons from the causes of deaths. In the most recent report (October 12 – March 2013) there were two recommendations about patients being cared for by the trust. Only one of these was directly related to the trust's services and was about the use of medications for patients with a bi-polar disorder and the need to provide contact details for when further psychiatric care is needed on discharge letters sent to GPs.

Learning from incidents

- The feedback from external stakeholders was that the trust was open and transparent and shared information on incidents and the action taken. This meant it was fulfilling its duty of candour.
- The trust monitored whether it was completing the investigation of serious incidents within the expected timescales. Between the 1 December 2013 and 30 November 2014 there had been 144 serious incidents. At the time this information was collected 26 had exceeded the expected timescales for completing the investigation and one had been open for over 10 months. We were told by staff that delays in investigations can be very difficult for staff especially where they are suspended from duty.
- The five Central and West London clinical commissioning groups fed back that in 2013 / 2014 there were concerns raised about the quality of serious

incident report root cause analyses being received in relation to suicides. This led to the trust developing a team to ensure this work was completed to an appropriate standard and this has led to an improvement in the quality of this work in line with the national serious incident framework for reporting. Four root cause analyses were randomly chosen by the inspection team and these had been completed comprehensively.

- In the 2013 NHS Staff Survey the trust performed better than the national average for staff witnessing and reporting potentially harmful incidents and near-misses. This reflected our inspection findings that staff were confident in the use of the incident recording system and the application of the incidents and serious incidents policy.
- The trust monitored the numbers of incidents reported as part of its monthly service line dashboard. The trust had an incident group that reviewed recent incidents, identified themes and scope for organisational learning.
- The trust had a number of means of sharing learning from incidents and complaints. This included an email bulletin called 'Listen. Learn. Act' . There were also learning events, for example the assessment and brief treatment teams had quarterly learning from incident events. There were also lots of meetings across the trust, peer reviews and some opportunities for reflective practice.
- The trust also produced an annual organisational learning report looking at themes coming out of incidents and complaints. This had highlighted four main areas for work for 2014-15. These were communication and information sharing during clinical handover, discharge or transfers of care. The second area was risk assessments, risk management and mitigation through care planning. There was also a theme about understanding and managing expectations. The final area was workforce and leadership issues which included areas such as adequate staffing and staff behaviour and attitude.
- At the time of the inspection the trust had just implemented a new divisional structure in December 2014 strengthening its links with local geographical areas. Alongside this was the introduction of a new accountability framework which included the executive board reviewing the incidents in each division. There is also an exception reporting process to ensure significant incidents were escalated quickly to the Chief Operating Officer.
- As part of the new divisional structure there were defined governance structures through divisional management boards and divisional quality boards. They will take responsibility for ensuring the learning from incidents reaches individual services through monthly service level team meetings.
- The inspection of the trust took place at a time when these changes were relatively new and still being embedded. This meant that whilst staff generally knew about incidents and the associated learning that had taken place within their immediate teams, there was less knowledge and learning across different geographical areas or between divisions. This was particularly noted in the community based mental health services for adults of working age, forensic wards, rehabilitation services and wards for older people with mental health problems.
- Staff were positive about the process of de-briefing after a serious incident. This ensured that support was provided to the patient and the staff involved in the incident. Where needed staff were supported to seek medical assistance, have input from occupational health and counselling services. It also provided an opportunity for the team to reflect on learning from the incident.

Safeguarding

- The trust had systems in place to safeguard people from abuse. Most staff we spoke to understood the importance of safeguarding vulnerable adults and children.
- Due to the size of the trust, services had safeguarding leads who could support staff with raising an alert and knew the detailed arrangements in the geographical area in which the service was located. Staff in most services said that they felt able to raise issues of potential abuse and seek advice from local safeguarding teams on whether an alert was appropriate.
- Local authorities fed back that the trust was actively engaged in local multi-agency safeguarding boards and associated work.
- The trust had a central safeguarding committee that reviewed recent safeguarding cases, identified themes

and organisational learning. Overall the numbers of alerts was increasing reflecting increased staff awareness. In addition services kept a record of local safeguarding issues so that they could ensure that where follow up action or learning was needed that this could place. At the TOPAS centre in Milton Keynes we found this information was not available and staff were not clear on the actions they needed to take.

- Safeguarding training was delivered at three levels for vulnerable adults and children. Staff attended the appropriate level of training based on their role. The trust monitored the completion of this mandatory training and in most areas of the trust over 90% of staff had completed the required training.
- The trust carried out an internal audit of its safeguarding work in 2014. This found the need for safeguarding information on the intranet to be improved, to ensure safeguarding is discussed at supervisions and to look at opportunities for shared learning.

Assessing and monitoring safety and risk

- The trust was aware that work was needed to improve assessing and managing risk to patients. There was a target in place for the mental health services that risk assessments should be completed and reflected in care plans in 95% of patient records. At the end of the last quarter at the end of December 2014 an internal audit showed this had only been achieved in 80% of records.
- The inspection looked at the availability and content of risk assessments across the core services and found a very mixed picture. In some services the risk assessments had improved such as the psychiatric intensive care units. In others the picture was very mixed. For example in some of the teams providing community based mental health services for adults the risk assessments were excellent. But in the Harrow team there were risk assessments that needed to be reviewed or where current potential risks were not reflected in the risk assessment.

Potential risks

Safe staffing

- The trust had carried out a review of staffing levels across the services and agreed the levels that should be in place although it was reviewing the skill mix of staff in inpatient settings. The trust had an e-roistering system in place which enabled them to monitor staffing levels.
- At the end of the last quarter December 2014 the trust had 721 vacant posts out of 6542 budgeted posts. At the time of the inspection there were staff vacancies of around 10% which had reduced from 16% a year ago. There were particular hotspots for vacancies including offender care and band 5 nurses in community services in Milton Keynes and Hillingdon and band 5/6 mental health nurses in Milton Keynes, Brent and Harrow. There were higher vacancies in outer London boroughs, for example 23% vacancies in Brent. Nurse recruitment was the greatest challenge. The executive team received a monthly update on recruitment and the specific challenges were noted on risk registers where appropriate.
- The trust had an active recruitment and retention strategy. This included improving how it attracted potential staff through targeted recruitment schemes. Ideas being put into practice were working with the universities to attract nursing students, engaging with local communities to attract staff and national & international recruitment. They also attracted staff through offering opportunities for learning and development. The courses provided through the recovery college were attractive to staff. There was a career pathway for health care assistants and they supported unqualified staff who wanted to do nurse training. Work was on-going to reduce the time taken to recruit staff and to address hotspots with targeted recruitment.
- There was a strong commitment to only recruiting staff with the appropriate skills through the use of assessment centres. Less than 40% of prospective nurses received a job offer following verbal and numerical skills testing. Staff commented on the improved quality of new staff who were being recruited.
- The trust was trying to increase the number of bank staff they can call on and reduce the use of agency staff. Bank staff received the same training as substantive staff in terms of statutory and mandatory training.
- The NHS staff survey results in 2014 reflected some of these challenges as one of the bottom five ranked

scores was the percentage of staff working extra hours. Staff experience had improved in the percentage of staff pressure in the last 3 months to attend work when feeling unwell but had deteriorated in terms of the percentage of staff suffering work related stress.

- Levels of staff sickness were generally within reasonable levels at 3.5%. Higher levels of staff sickness were noted in the Milton Keynes services at 5.7% and acute mental health services at 4.5%. Staff turnover was running at 18.2%.
- We did find that whilst staffing was very challenging in a number of areas, that the trust was working to keep staffing safe. The main area of concern was on the acute wards for adults of working age where there due to bed pressures there were extra patients spending the day on a few wards and where day time staffing levels had not been adjusted to reflect these increased numbers.
- The week of the inspection we found the number of people using the community based mental health services who were waiting to be allocated a care co-ordinator varied between the community recovery teams. In Kensington & Chelsea and Westminster there were 2 or 3 people. Whereas in Harrow there were 16, Brent 35 and Hillingdon 40. Whilst these people were reviewed weekly and there were plans to allocate them to senior staff, and help being received from other teams, their lack of a named care co-ordinator could impact on their care as they had complex needs and needed close support.
- Where patients needed higher levels of observation and support managers were able to increase the staffing levels. Also we heard of arrangements that had been made to meet the needs of patients with specific needs. For example in the community team for people with a learning disabilities in Brent and Harrow the speech and language therapy post was vacant and so the trust had made an arrangement with another provider to ensure patients with swallowing difficulties could receive timely treatment while the post was being filled. We also found many examples of teams working together to prioritise work and ensuring that patients needs were met.

Safe and clean ward environments and community care

- The trust provided services from a very variable range of physical environments. The trusts estate comprised of 124 buildings within 100 separate sites. Some buildings were new and purpose built such as the mental health unit at Northwick Park Hospital and the Hawthorne intermediate care unit in Hillingdon. Others such as the Gordon Hospital in Westminster were older and provided very challenging environments for the delivery of care.
- During the inspection we heard from staff that there could be challenges in the timely completion of building repairs that were impacting on the quality of the service available to the patients. This was raised in particular by staff working in some of the London mental health rehabilitation services and the Park Royal mental health unit. From the 1 April 2014 the estate maintenance services were provided by single outsourced service provider.
- We did found that facilities were generally clean. Infection control and health & safety is monitored across the trust through audits and this is overseen by trust wide committees. The inpatient services had patient led assessments of the care environment (PLACE). Overall the PLACE assessments gave high cleanliness scores with St Pancras having the lowest score at 95.4%. Staff working in community services had a good understanding of infection control.
- Standards of infection control were generally high across the trust although it was noted that some district nurses in Hillingdon were not removing outer clothing before carrying out patient care.
- The health and safety group is supported by an estates led fire safety group. In November 2014 the London Fire Brigade served an enforcement notice in respect of Pall Mall a community mental health site. The trust confirmed that the improvements required in terms of information available on site, staff training and work on fire doors had taken place and the enforcement notice had been lifted.
- The trust had undertaken risk assessments of ligature risks in the mental health inpatient areas during the last year. These were prioritising where physical changes to the environment to reduce ligature points would take place first. The previous inspection at St Charles had identified that ligature risk needed to be managed more effectively and this was an area of non-compliance. In response to this wards had prepared local management plans. When we looked at these documents and spoke to staff working on the acute wards they were still not able to clearly articulate how they would manage the ligature risks on the wards in terms of the support given

to individual patients who were at high risk of suicide to keep them safe. In addition the privacy and dignity of patients was not always promoted as a result of measures to manage ligature risks that resulted in blanket restrictions. For example all the bathroom doors had been removed and replaced with curtains in the bathrooms used by the shared bays at the Campbell Centre in Milton Keynes.

- At the Gordon Hospital the two place of safety rooms both contained ligature points. The toilet for use of people was also not ligature free. Although staff could manage risk through observation, the environment meant people could not be supported safely without compromising their privacy. The trust had agreed to the refurbishment of the place of safety and work was starting in April 2015.
- We looked at whether patients using mixed gender inpatient services were provided with 'same sex accommodation' to promote their privacy and dignity. We found that in most wards this separation was provided with male and female patients having separate bedrooms and bathroom areas. However at Oak Tree ward in Hillingdon and TOPAS in Milton Keynes these arrangements were not completely in place which compromised peoples safety, privacy and dignity. In a couple of community rehabilitation services (Fairlight and Colham Green) and one continuing care service for older people (Beatrice Place) bathrooms were used by people of both genders or involved people passing the bedrooms of other patients to reach the bathrooms. These were smaller community based services and the staffing and risk assessments in place meant that these arrangements did not compromise the privacy and dignity of people currently using the services, however where possible providing separate bathrooms for people of each gender should be promoted.

Physical interventions

- The trust had a policy on the prevention and therapeutic management of violence and aggression. This had been updated in 2014 after the publication of the Department of Health guidance "Positive and Pro-active Care".
- Between 1 May 2014 and 31 Oct 2014 restraint was used on 773 occasions. Restraint was being used mostly on the mental health psychiatric intensive care units, acute and forensic inpatient wards. In 284 (36.7%) of these 773 incidents, patients were restrained in the prone position. In 319 (41.3%) of the 773 incidents of restraint rapid tranquilisation was administered. The number of prone restraints was being closely monitored by the trust through a restrictive interventions group. However at the end of the last quarter (December 2014) the numbers of prone restraints remained at around 75 a month which is a high figure. The trust had a strategic action plan on restrictive interventions and had set a target to reduce the use of all forms of restraint by 50% in 18 months. Physical intervention training was delivered by an in-house tutor team and the model used was the general services association . The training focused on verbal de-escalation techniques but also teaches techniques to safely restrain patients. Since October 2014, all staff attending this training had been taught in a new technique to safely restrain patients in the supine position. At the time of the inspection over 200 staff had been trained in the new technique however these were staff from across the wards. They were not able to always use this revised training as they could be working with people who had not had been taught the new technique. Immediately after the inspection the trust said they had developed a plan to accelerate the delivery of restraint in the supine position to the remaining staff that required this update. The trust had secured an external training venue and had brought in additional trainers to deliver this. This additional training would be commencing in April 2015 and was scheduled for completion in June 2015. Whilst this new technique is expected to support a reduction in prone restraint wider work was also being undertaken via the trust's strategic action plan to support a reduction in all restrictive interventions. Areas know to be high users of all forms of restrictive practices would be prioritised with a particular emphasis on de-escalation and alternatives to physical interventions and enforced medication. The trust said that as part of this training package, all staff will receive an introduction to positive behaviour support planning and advanced directives.
- There were in total 276 incidents of use of seclusion across 14 wards at the trust (1 May- 31 Oct 2014). Eighty (29.9%) of incidents recorded were in Caspian Ward (Park Royal), this was followed by Shore Ward with sixty (21.7%) incidents. There were no incidents of long term segregation recorded. The trust was aware of variations in the use of seclusion across the sites and the Restrictive Interventions group were monitoring the

seclusion incidents. The seclusion rooms across the trust were generally in a reasonable state. One seclusion room at Park Royal Mental Health Centre had a 'blind spot', where staff could not safely view the patient at all times. At Northwick Park the seclusion room had no clock. There had previously been a clock but it was removed as the fixture it hung from was considered a ligature risk. The clock was reinstalled and was ligature risk free by the end of our visit. The medical and nursing reviews were checked for people in seclusion and at St Charles these were not clear or contemporaneous. This meant that patients were at risk of not having their needs reviewed in a timely manner whilst in seclusion.

- Between the 1 September 2014 and the 28 February 2015 there were 247 incidents of patients detained under the Mental Health Act who were absent without leave. These were mostly from acute inpatient wards and the numbers were St Charles 57, Hillingdon 43, Park Royal 40 and the Gordon Hospital 30. Thirty three percent (82) of these incidents were patients who had absconded whilst residing on the ward. The three sites with the most incidents of patients absconding from the ward were St Charles 21, Gordon Hospital 17 and Park Royal 12 incidents. The trust was monitoring numbers of patients absconding and this was reported on the trust performance dashboard. In addition at the Gordon Hospital additional staff had been deployed to observe the entrances to the wards following a serious incident that took place just prior to the inspection.
- A few examples of blanket restrictions were identified in the rehabilitation mental health wards. This included set levels of observation for everyone in one service, restricting access to making hot drinks and one service where the front door could only be unlocked from within the staff office. These needed review to ensure the least restrictive measures were in place that reflected peoples individual needs.

Safe equipment

- Medical devices across the trust were mostly regularly maintained and checked regularly to ensure they were fit for purpose. They were also appropriately located to ensure they could be accessed when needed. The exception to this was at the Pembroke Centre in Hillingdon where the equipment needed a maintenance check. Also on Redwood ward at St Charles the medication used for emergency resuscitation had been separated into two storage places which could make it hard to locate in an emergency.

Medication management

- There were safe and effective arrangements in place for medicines. The trust was actively and continuously seeking ways to improve medicines management, medicines optimisation and patient safety related to medicines.
- Medicines governance arrangements were good. The trust held regular medicines management meetings and safe medication practice group meetings. We looked at the minutes of these meetings and saw that action was taken promptly when any issues were identified. Medicines errors and incidents were reported quarterly. There was a good culture of reporting of medicines incidents to encourage learning, and we saw that there were local learning events following on from any medicines incidents. We saw that there had been only 5 service user incidents related to medicines in 2014, none of which had resulted in serious harm.
- The trust carried out a wide range of medicines related audits to assess how they were performing, and to identify areas for improvement, such as audits of controlled drugs, missed doses, medicines reconciliation, safe and secure handling of medicines, medicines dispensing times, antibiotic prescribing and rapid tranquilisation. The audits for 2014 demonstrated that the trust was performing well. Where improvements were needed, we saw that action was taken promptly. For example, although medicines were stored securely in all of the areas we inspected, the trust's own safe and secure handling of medicines audit 2014, carried out in 226 areas where medicines were handled, had identified that some improvements were needed, such as disposal of pharmaceutical waste and medicines refrigerator monitoring. The trust already had an action plan in place to address this.
- The trusts medicines reconciliation audit 2014 showed that 98% of patients admitted to the trust had a medicines reconciliation completed during their stay, 86% within 24 hours of admission. The purpose of a medicines reconciliation is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission and therefore minimising medication errors. The trust's audit showed

that further work was needed to meet the standards set in the trusts medicines reconciliation procedure, such as the number of sources used to identify prescribed medicines and completing of the medicines reconciliation within the agreed timeframe. The trust already had an action plan in place to address this.

- Arrangements for the supply of medicines were good. There was one trust pharmacy department at St Charles Hospital, which supplied medicines to six of the trust sites. There were service level agreements in place with other NHS trusts for the supply of medicines to the other trust sites. There were also arrangements in place for medicines supplies and advice out of hours. Patients and staff in all of the locations we inspected told us that they did not experience any delays in receiving their medicines, both on the wards and on discharge from the trust. Therefore there was good access to medicines and medicines advice.
- Dispensing time audits from 2014 showed that 88% of all out patient prescriptions were dispensed within 60 minutes. The trust's dispensing turnaround times for medicines for discharge showed that 18.8 % took longer than 4 hours to dispense and check, however the chief pharmacist told us that more accurate data is going to be collected for the next audit, as medicines for discharge were ordered in advance, so the long turnaround time did not necessarily mean that this had caused any delays in discharging people from the trust.
- The trust took part in the Prescribing Observatory for Mental Health (POMH-UK), a national audit-based quality improvement programme to improve prescribing practice in mental health. We saw from these audits that some areas for improvement had been identified, such as medicines reviews for people prescribed anti-psychotic medicines, prescribing thiamine for people undergoing alcohol detoxification in substance misuse services and improvements needed to the monitoring for people prescribed lithium therapy. The trust was already taking action to make these improvements.
- When we checked a sample of prescription charts in each of the areas of the trust we inspected, we saw that these were completed fully, providing evidence that people were receiving their medicines safely and as prescribed. When people were detained under the Mental Heath Act, the appropriate legal authorities were in place for medicines to be administered. There was evidence in all of the areas we inspected, apart from at Milton Keynes, of good clinical input by the pharmacy team, providing advice to staff and patients, and making clinical interventions with medicines to improve patient safety. The issues with medicines management at Milton Keynes had already been identified by the trust prior to our inspection. The chief pharmacist told us that there was a lack of senior pharmacy leadership on this site, which had an impact on how medicines were managed; however there was already agreement to recruit a pharmacist in 2015 to oversee medicines management at Milton Keynes.
- We did find on Redwood ward at St Charles that patient safety was compromised with medication being left unattended within the reach of patients.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

We rated effective as **good** for the following reasons:

Most patients had a comprehensive assessment in place including where needed a physical health assessment. Whilst there was still further work to do, the quality of care planning had improved and the trust was monitoring and improving on the numbers of people being given a copy of their care plan.

The trust had a wide range of measures in place agreed with commissioners, stakeholders, other professional bodies and set internally to monitor and improve the outcomes of people who use their services.

The training provided by the trust was varied and welcomed by staff who felt they had opportunities to develop their knowledge and skills. In addition to an induction and mandatory training staff also attended a wide range of other training both internal and external to the trust. Staff felt well supported through supervisions and appraisals.

There were many positive examples of multi-disciplinary and multi-agency working.

The trust was making good progress in the training of staff and appropriate use of the Mental Capacity Act.

There were however a few areas for improvement as follows:

- In community based mental health services the provider must ensure that patients using community services are referred for regular physical health checks.
- In wards for older people with mental health problems the provider must ensure on Redwood ward that patients physical health checks take place regularly to ensure their health is monitored.

Our findings

Assessment and delivery of care and treatment

- The trust used several electronic patient record systems across its various locations. Most of the areas we visited completed comprehensive assessments of the people they were supporting. The assessments varied dependent on the needs of the individuals. For example older people admitted to inpatient services would be assessed for the risk of falls and tissue viability.
- The trust had set a target that all patients would have a recorded medical physical health assessment after admission. In the last quarter this was achieved for 97% of patients. The trust also had a target of all mental health inpatients having a nursing physical assessment after admission. In the last quarter this was achieved for 94% of patients (just below the target of 95%). The inspectors found that these assessments had been completed.
- The National Audit of Schizophrenia found in 2014 that the trust was well below what should be provided in terms of monitoring physical health for patients with this diagnosis. We looked at whether patients were having their physical health monitored and appropriate support with physical health care conditions. The arrangements for this varied throughout the trust. However in most areas this was taking place. On Redwood ward at St Charles, a ward for older people not everyone was having regular physical health checks despite having complex physical health care needs. In the community based mental health services we found that in Hillingdon and Harrow there were patients who had been identified as needing an annual physical health check that had not been referred to the GP.
- The trust acknowledged that the quality of care planning is variable across the trust. This is not aided by the different patient record systems. We found that there was a lot of work taking place to improve care planning and in many of the areas we visited the quality of care planning had improved and they were more personalized. In some teams the care planning was very good such as in the community mental health services

for children and young people. In the specialist dental services the clinical records were well constructed and including treatment plans that showed that different options had been considered.

- The trust knows there is more work to do to ensure patients are offered a copy of their care plan. For community patients the trust had a target of 80% having been offered or received a copy of their care plan. At the end of the last quarter 74% of patients said they had been offered or received a copy of their care plan. We found that patients being offered a care plan varied between services. In the community health services for adults, most people had a copy of their care plan in their home. In the community based mental health services a significant number of patients would just have a copy of a letter from a lead professional clinician to their GP which said that the letter constituted a care plan. These were sometimes written in technical language that the patient would find hard to understand. In the learning disability services most patients had a care plan but more thought was needed to ensure these were accessible and meaningful to the individual.

Outcomes for people using services

- The trust has a wide range of measures in place agreed with commissioners, other stakeholders such as Monitor and in partnerships with social care with the aim of improving the outcomes of people who use their services.
- The Commissioning for Quality and Innovation (CQUIN) framework for 2014/15 has incentivised the trust to deliver improvement. We heard about some of the areas they are working on such as expanding the use of the friends and family test, further reductions in the prevalence of pressure ulcers and developing shared patient records.
- The trust ensured it maintained the care it provided and the associated procedures in line with the latest NICE guidance. A trust wide group oversees this process and shared the work with divisional teams.
- The trust in 2013-14 had participated in all of the national clinical audits that it was eligible to participate in. Those relating to its mental health services included the National Audit of Schizophrenia and the Prescribing Observatory for Mental Health (POHM-UK). They had also participated in national clinical audits relating to its community services including the Sentinel Stroke National Audit Programme, National Audit of Intermediate Care, the Falls and Fragility Fractures Audit Programme, the National Parkinsons Audit and the Epilepsy 12 Audit (in Milton Keynes).The actions that were taking place from these audits were reported in the trusts annual Quality Account.
- In October 2014 the trust identified that there were 106 internal and local clinical audit projects taking place. These had been agreed by the trust or division or service as a priority as part of their quality improvement processes. Examples of trust wide internal audits included infection control hand hygiene audits and a safeguarding adults audit. Local clinical audits covered a wide range of areas including assessments, risk assessments, discharge information, capacity assessments. Some were very specific to the service such as the use of sub-dermal implants in sexual health services or the management of children with asthma in school for the school nursing service in Hillingdon. These audits led to change for example the audit on the management of children with asthma in school had led to more training for teachers and other school staff.
- In terms of measuring outcomes for individuals the trust was using the Health of the Nation Outcome Scales to measure the health and social functioning of people with a severe mental illness and over time the patient outcomes. Services also used a range of other outcome measures to see how patients were progressing. Some specific examples of this were found at the Collingwood child and family centre where the progress of the young people was carefully monitored. In the end of life care services the outcome of care approaches was monitored to see if they supported patients to die in their own homes rather than in hospital. In community health services for children, young people and families the progress of children who were participating in programmes to reduce obesity was monitored.

Staff skill

- The trust provided a corporate induction for all staff. All staff had to attend within one month of starting their employment. We heard that this training was very helpful and also enabled staff to meet colleagues who will work across the trust.
- In addition staff received a local induction that supported them to understand their specific role in the services. For example the learning disability service provided a five day training course providing staff with specific skills.

Good

Are services effective?

- The trust had core mandatory training requirements with attendance defined for qualified and unqualified staff working in different parts of the trust. This included fire safety, moving and handling, health and safety, infection control, safeguarding adults and children, conflict resolution, equality and diversity, information governance and resuscitation & anaphylaxis. At the time of the inspection 86% of staff had completed the mandatory training, although the trust was struggling to ensure this data was collected accurately.
- In addition there were other statutory and essential to role training courses. For example staff working in services for older people received training on falls and pressure ulcers. School nurses and district nurses received training on vaccinations. Some training was specifically provided for managers such as investigations & root cause analysis.
- Staff talked positively about the training opportunities they received. For example the trust is piloting the Care Certificate for healthcare assistants. Starting this year they were going to put all HCAs though the course. Staff also talked about accessing training through the recovery college.
- The trust worked in partnership with a number of higher education institutions and local education training boards. It provided apprenticeships, undergraduate and post-graduate vocational training programmes especially in mental and sexual health, medicine and nursing. They had the quality of some of this work closely monitored by Health Education England. An example of this work was in post-graduate medical education where the trust had developed a programme which had won awards in faculty development and leadership.
- The trust expected all staff to have completed an annual appraisal and at the time of the inspection 85% had this in place and the target in the trust was 95%. This was close to the national average of 86% and had been identified as an area for improvement in the staff survey 2014. The trust said that they were moving their focus from staff completing an appraisal to ensuring this was completed well.
- The trust had an expectation that staff will have access to monthly clinical and managerial supervisions. Most staff we talked to said they were receiving clinical and managerial supervision although the frequency was variable between services. Staff at the Windsor unit in Milton Keynes said their supervision was not happening regularly as there was interim management arrangements in place while a permanent manager was recruited.
- The trust expected staff to have access to regular team meetings and we found that these were usually taking place and in some cases there were also meetings providing opportunities for reflective practice which was well received.
- We found examples of where managers were working to address staff performance issues. Staff said this can sometimes take far too long and the trust acknowledged that the process needed to be streamlined and this work was underway.
- The trust aimed to celebrate the success of staff who lived the trust's values. They had an 'employee of the month' award and an 'annual gem ceremony ' to celebrate exceptional staff contributions.

Multi-disciplinary working and inter-agency work

- Staff spoke favourably about internal multi-disciplinary work. We observed 87 multi-disciplinary meetings and staff handovers. This reflected some good practice and we saw staff working well together in a respectful manner making the most of each others skills and experience.
- We also saw many examples of how different teams in the trust worked together to support patients as they moved between services. This was particularly evident for patients who were moving from inpatient services to receiving support from community teams. We heard about how information was shared and staff from community teams attended meetings on the ward.
- We heard from stakeholders that the trust faced on-going challenges in working with GPs and sending them timely information.
- We found some examples of good inter-agency work and also some challenges. We heard from a number of local authorities about the successful integrated partnerships working across health and social care through section 75 agreements. For example in Harrow and Westminster there were pooled budget arrangements in place. We heard about a number of successful initiatives such as the work with the police and the establishment of the street triage team in Milton Keynes which has seen a reduction in the number of people being taken to a police cell as a place of safety. Another initiative was the trust's work with the homeless

project with housing colleagues in the Royal Borough of Kensington and Chelsea where trust staff were supporting people with their mental health so that housing colleagues could have greater success with addressing their housing needs. We were told by local authorities that they welcomed the change in the trust's structure with its local borough focus and felt that this would make communication with the trust work better. They also valued the trust having a head of social work and a partnerships development manager who work closely with the borough lead social workers through the local partnership boards.

- NHS England commented that the trust actively contributed to both national and regional clinical advisory structures in areas such as HIV, eating disorders and CAMHS. The Trust also contributed to London wide groups for mental health services such as the perinatal network, CAMHS group and eating disorders groups. These groups have reviewed pathways in London services, contributed to quality incentive schemes and implemented national processes as required.

Information and Records Systems

- Staff told the inspection team repeatedly about the difficulties of working with the different patient record systems found throughout the trust.
- This has been acknowledged by the trust and there is an information technology strategy in place. An external IT firm had been appointed to build and deliver a new IT infrastructure. This will include opportunities for mobile technology so staff that can access information when working in the community and patients have access to their information and opportunities to be more involved in planning their care for example through the use of social media. It is hoped this work will improve the trust information and record systems.

Consent to care and treatment

- The trust provided a statuatory mental health law training course for all staff working in clinical settings. This includes training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. In some areas CNWL staff can access local multi-agency training such as in Milton Keynes.
- The trust had an up to date policy on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).
- We found variations in the use of the MCA in terms of the completion of MCA assessments and recording this appropriately and the use of best interest meetings. The long stay rehabilitation mental health wards for working age adults showed good practice in terms of the Mental Capacity Act. Where there are some individual areas for improvement these are identified in the core service reports including the forensic inpatient wards and learning disability wards.
- There is a trust wide MCA lead and also leads in different services to support staff as needed.
- Between the 1 May 2014 and the 31 October 2014 there had been 102 DoLS applications. Some were still waiting to be assessed and several had not been authorized. In the wards for older people with mental health problems we found some DoLs where the authorisations had expired and new applications needed to be made. This reflected the ongoing learning process that trusts are experiencing about this process.
- Adherance to the MCA is monitored through the Mental Health Law group which provided a governance process. This looked at the results of audits and considered new methodology.

Assessment and treatment in line with Mental Health Act

- The trust's systems supported the appropriate implementation of the Mental Health Act and its Code of Practice. Administrative support and legal advice was available from the Mental Health Act lead in a centralised team within the trust, as well as Mental Health Act law managers and Mental Health Act administrators based at each hospital site.
- The staff carried out regular audits to ensure the Mental Health Act was being implemented correctly and produce a quarterly Mental Health Act Performance Report. A bi-monthly Mental Health Law group met to review Mental Health Act performance and trends and provided a governance structure.
- Training was provided to staff centrally and within local teams. Role specific training was given where required. Overall staff appeared to have a good understanding of the Mental Health Act and code of practice.
- For the most part detention paperwork was filled in correctly, was up to date and was stored appropriately.

Good

Are services effective?

- There was a good adherence to consent to treatment and capacity requirements and copies of consent to treatment forms were attached to medication charts where applicable.
- People had their rights explained to them on admission to hospital. Where people did not understand their rights, the Trust had a policy that a discussion of rights would be repeated daily for the first 14 days following detention and weekly thereafter. We found however that discussions of rights were not always regularly repeated following unsuccessful attempts.
- Within all of the wards visited apart from the learning disability services we found that people had access to independent mental health advocacy (IMHA) services and information on IMHA services was provided to patients. Patients and staff appeared clear on how to access IMHA services appropriately.
- Where there are some individual areas for improvement these are identified in the core service reports.

Outstanding ☆

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of findings

We rated caring as **outstanding** for the following reasons:

The staff we spoke to across the trust were enthusiastic, passionate and demonstrated a clear commitment to their work. Care was delivered by hard working, caring and compassionate staff. In many services we saw great attention being given to providing care that was meeting the individual needs of each patient. This was particularly notable in the community dental and sexual health services where staff were going the extra mile. The trust was aware of a few areas where the attitude of staff had distressed some patients and was taking steps to address this constructively.

The trust undertook regular surveys to obtain feedback from people who used the services to promote the improvement of the care provided. We found many examples of carers being actively involved but the trust has also recognised that there is further work needed in some areas. The trust was working well with advocacy services.

There were however a few areas for improvement as follows in services for older people with mental health problems:

- On Redwood ward at St Charles we saw that a number of the female patients attend the mealtime in their nightwear with no dressing gown and this did not preserve their dignity.
- Patients were not always involved in their care planning nor did they have a copy of their care plans where appropriate.
- On several wards patients did not have access to a lockable space in their rooms and were not able to lock their own bedroom doors.
- People could not close their observation panel from inside their room to have privacy.

Our findings

Dignity, respect and compassion

- The staff we spoke to across the trust were enthusiastic, passionate and demonstrated a clear commitment to their work. Care was delivered by hard working, caring and compassionate staff.
- We observed many examples of positive interactions between staff and patients throughout the inspection visit. For example when we inspected the Brent home treatment team we found the consultant and was making links with the GP's of the patients so that he could meet with the GP and patient to discuss any matters about the patients care and discharge arrangements. In the community sexual health services patients told us about how staff really paid attention to the details of their care and recognised their emotional needs. In the specialist dental services we saw staff taking the time to fully explain the treatment and providing the reassurance and empathy during complex treatments. In the end of life services we heard about the support that was provided to the whole family.
- There were a few places where there were a cluster of negative comments about the attitude of staff from people who have used the services. This was particularly noted for the Gordon Hospital and St Charles. It was also noted that an analysis of complaints completed by the trust had also highlighted staff attitude as a recurring theme. We could see that this was being addressed in a variety of ways including through supervision and the use of training to promote positive behaviours. Where needed the trust was also investigating individual concerns.
- We did also find on some of the wards for older people with mental health problems that further steps could be taken to promote people's dignity and privacy. For example on Redwood ward at St Charles female patients were attending mealtimes wearing a nightdress but no dressing gown. In wards for older people with mental health problems we found that some observation panels in bedroom doors could not be closed on the inside by the patient.

Outstanding ☆

Are services caring?

- The trust carried out a number of internal surveys to measure patient satisfaction in the care they were receiving. In quarter three ending December 2014 these surveys showed that 98% (of 2618) reported they were treated with dignity and respect, 91% (out of 104) felt safe during their most recent mental health inpatient stay and 91% (out of 623) thought their care co-ordinator had organised the care that they needed well.

Involvement of people using services

- We found that in most wards there were regular community meetings taking place which enabled patients to have some involvement in the services they were receiving.
- There were eight different advocacy services operating across the geographical areas covered by the trust. People who used the services told us that had information available about the advocacy services and could access these as needed.
- The trust did a survey in quarter 3 ending in December 2014 which received feedback from 2601 patients. The results were that 81% of people using services reported that they were 'definitely' involved as much as they wanted to be in their care and treatment. We did find though, when looking at patient records that there was mixed recording to show that patients, carers or an advocate acting on their behalf had definitely participated in discussions about their care and treatment. This was evident in wards for older people with mental health problems.
- We also heard about local surveys that took place within some services. For example in the community sexual health services quick feedback cards had been devised with tear off tabs and were placed in clinical waiting areas. In some clinics up to 94% of the patients completed the surveys and the cards were read daily to ensure urgent matters were addressed in a timely manner.
- The trust had a target that for mental health patients who have a carer identified that their details are in the person's notes. The target was for this to be in place for 70% of patients and at the end of the last quarter 76% of patients' had this information in place.
- From feedback from carers and from an analysis of the complaints there was still a recurring theme of some carers not feeling involved, not being invited to meetings or being listened to. The trust had recognised the need for further work on this and had an improving involving project. This included a commitment to carers to provide them with better information on who to contact in a crisis, how to complain, medication, recovery college courses amongst others. This is an area for on-going work as not involving carers who know the people receiving a service can lead to risks of that person not having their needs met.
- Most of the inpatient areas we visited had arrangements in place to introduce patients arriving on the ward in a thoughtful manner that enabled them to be shown around. We saw different examples of information being given to patients and their relatives and carers to introduce them to the service.

Requires improvement

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary of findings

We rated responsive as **requires improvement** for the following reasons.

In the acute wards for adults of working age and the PICU we found that:

- Despite work to mitigate this, the pressure on acute beds meant that wards were often over-occupied. There was not always a bed for patients and they slept on sofas or a temporary bed was used. Patients returning from leave did not always have an identified bed and a bed was not always available in the PICU.
- Patients were often transferred to different wards to sleep and returned to the ward during the day. This disrupted the continuity of their care and patients felt it affected their well-being.
- Privacy and dignity of patients was not always promoted. Patients were not able to make calls in private. At the Campbell Centre patients in shared rooms were not able to attend to their personal care needs with an adequate level of privacy and dignity.
- Information on how to make a complaint was not always available in the PICUs and verbal complaints were not always being recognised and addressed with access to the complaints process.

In the mental health crisis services and health based places of safety we found that:

- People who were in a place of safety and were assessed as requiring inpatient beds experienced long delays before being admitted. The delays in accessing inpatient beds meant that some people received care that did not meet their needs.
- The places of safety at the Gordon hospital and Park Royal had no separate access.This meant that people had their privacy compromised as they arrived at the places of safety.
- In the North Kensington home treatment team based at St Charles the interview rooms were divided by a door with a glass panel covered by a small curtain. Private conversations could easily be overheard in either room. This meant their privacy and dignity was not maintained.

On the wards for older people with mental health problems we found that:

- Redwood ward reported that they took patients from the adult wards in order to alleviate pressure on adult wards. Some of these patients were not clinically appropriate for the ward environment.
- Most wards admitted patients into the beds of patients who were on leave. This meant that patients who were on leave, but not yet officially discharged, might not be able to return if they needed to.

On the long stay rehabilitation mental health wards we found that:

- In some areas information on how to complain was not clearly displayed and sometimes verbal complaints were not addressed using the complaints process where the patient would have liked to access this procedure.

Whilst for patients needing an acute mental health service the service was not responsive at the time of the inspection, we did find that in other services patient access and discharge arrangements were working well and in line with local targets. We did however note that there were a number of services with long waiting lists in the London Borough of Hillingdon. The services were very aware of the need to offer appointments that met the needs of the patients and the importance of being reliable and punctual.

Most of the care was delivered in facilties that promoted recovery, comfort, dignity and confidentiality. Where this has not been achieved this will need to be addressed.

The trust served a very diverse population across each of the areas it covered. The trust demonstrated a real commitment in terms of meeting people's equality, diversity and human rights.

Requires improvement

Are services responsive to people's needs?

In some areas information on how to complain was not available. We also heard from patients who said they would have preferred their verbal complaint to be addressed in a more formal manner. The trust is introducing a centralised patient support service which will aim to make it easier for patients to provide feedback and raise concerns. It also aims to improve how they acknowledge and respond to concerns received about their services.

Our findings

Right care at the right time

The trust worked closely with commissioners, local authorities, people who use services, GPs and other local providers to understand the needs of the people it serves and to plan and design services to meet their needs. This meant that across the trust there were a number of different service configurations in place across the mental health and community services.

Mental health acute care pathway:

- The most significant area of concern from the inspection related to acute care pathway for mental health services. In the six months between the 1 April 2014 and 1 September 2014 the average mean bed occupancy for the acute beds on each site was as follows: St Charles 108%, the Gordon Hospital 103%, Park Royal 113%, Northwich Park 106% and the Riverside Centre in Hillingdon 108%. In December 2014 the trust closed one further acute mental health ward, Mulberry South ward at the South Kensington and Chelsea Mental Health Centre. The trust said they had delayed this closure for several months in response to bed pressures.
- The trust told us that due to these exceptional pressures they were now placing a few patients in the independent sector and buying beds from another trust. This arrangement had started shortly prior to the inspection. The trust also had a very committed bed management team who worked hard to manage the whole process of ensuring people who needed admission had a bed.
- All the acute wards for working age adults we visited were full and the majority of patients on the wards were detained under the Mental Health Act 1983. With the exception of one ward, the wards were operating with over-occupancy. On Thames ward there were 21 patients allocated to the 17 beds. Crane ward had 27 patients (four patients on leave) allocated to 18 beds, plus one extra patient accommodated in a quiet lounge. Frays ward had 23 patients allocated to 18 beds. An extra bedroom had been created on Amazon, Ganges and Crane wards, by converting a quiet lounge into a bedroom. In some cases these were a long way from toilet/ bathroom facilities, which patients had to ask to use, due to these being kept locked.
- As a result of the over-occupancy of wards, beds were not always available for patients on their return from leave. For the first two months of 2015 there were 68 occasions across the acute and PICU wards when a bed was not available to patients in need of these, or there were delays to a patient receiving a bed. The highest number of these occurred on Thames ward, where there were 18 occasions, and on Danube ward there were 10 occasions when a bed was not available.
- Overall, between November 2014 and January 2015 there were a total of 57 occasions where patients did not have a bed to sleep in and slept on the sofa or in the quiet room on a temporary bed. Some incident reports showed that a patient was kept in the 'Place of Safety' (136 suite) for two nights. One person had also spent 32 hours in the assessment area at St Charles MHC when no bed was available on Danube ward.
- There were frequent moves between wards for some people for non-clinical reasons. Between November 2014 and January 2015 there were 85 occasions across the acute wards where patients slept on a ward other that the one they were admitted onto. The highest number of these occurred at St Charles MHC where during this period there were 38 occasions when patients slept on another ward. Other data submitted by the trust showed that for the month of February 2015, there were 167 occasions when patients slept out on another ward.
- Some patients were transferred during the night and went to wards where they did not know, or were not known by, the multidisciplinary team. We were informed they were always escorted by a qualified nurse. Patients told us that sometimes they were moved very late at night, for example at around midnight, and had to return to the ward by 6:30am the following morning.

This was confirmed to us by staff, although they said they attempted to move patients after they had received their evening medicines, between 9:00pm and 10:00pm. Patients told us that when they refused to move they were accommodated on sofas on the wards.

- The wards that patients transferred to was a substance misuse ward, older people's ward or rehabilitation facility. However, a patient from Frays ward slept overnight in a psychiatric intensive care unit (PICU) despite there being no clinical need requiring this. This meant there would not always be a bed available in the PICU when a person required more intensive care. The moving of patients between wards impacted on the continuity of care they received and patients reported this as being disruptive to their care and well-being.
- On Danube ward a patient had spent eight consecutive nights on a different ward, followed by a further thirteen on another ward. The patient had spent the majority of their admission sleeping on a different ward from that to which they were admitted. Another patient had spent ten consecutive nights on a different ward, whilst another had spent five consecutive nights away from the ward. On Thames ward a patient admitted on 31 January 2015 had spent every night of their admission on another ward, which was 24 consecutive nights.
- Linked to the pressures on the acute care pathway we found that some people were kept in the places of safety for a long time. From December 2014 till the end of January 2015 the places of safety were used 157 times. Of these, the length of stay was 6-10 hours in 31 cases and over 10 hours in 18 cases. Most of these (26) occurred at the Westminster place of safety. Staff told us that due to pressure in finding a bed within an inpatient ward, some people had to wait a long time prior to admission. We looked at the incident reports relating to the places of safety for January 2015. These showed that people were often having to wait a long time before being admitted. For example, one person had to wait 18 hours before getting a bed, another spent two nights waiting for a bed and a third left the unit to sleep on an older people's ward at 23:10 before returning early in the morning. The delays in accessing inpatient beds meant that some people received care for extended periods of time in an environment that did not meet their needs.
- In Milton Keynes the trust had developed a pilot street triage service to try and reduce the usage of section 136. In this scheme, which had been in operation since beginning of January, a nurse was based with the police for four nights a week, Thursday to Sunday. Initial results have shown a reduction in admissions to the health based place of safety. For the first three weeks of January there were 20 contacts, only one of these lead to usage of the place of safety.
- The psychiatric liaison teams worked 24 hours a day in accident and emergency departments. In Harrow the team provide staff for a 'transit' lounge. This room had armchairs and tea making facilities. It was designed to provide a quieter area for people to be assessed and supported in rather than the A&E. Staff we spoke with told us they found this facility useful as it enabled them to support people in a comfortable environment with more confidentiality. The trust opened a second 'transit' lounge in Hillingdon during the week of the inspection.
- At the time of the inspection the trust was trying to mitigate the pressures for patients needing to access acute services. We saw very active bed managers across all the sites trying to support discharge arrangements and access beds within the trust. The trust had also just agreed arrangements to place some patients in services provided by another London NHS Trust and some beds in the independent sector.

Other mental health inpatient services:

- Some patients were experiencing a delay in their discharge. For example in the long stay rehabilitation mental health wards there were patients waiting for discharge. Despite the support of bed managers and the pro-active work of staff the delays were usually caused by the difficulties of finding alternative suitable placements to meet peoples needs. This was also the case for some patients using the learning disability services.

Community mental health services:

- The home treatment teams had a target that all urgent referrals were assessed within an hour. This was generally achieved. Most of the teams were not 24 hour. During the hours the teams worked they would receive referrals directly. Out of hours, people would be referred to the psychiatric liaison teams. The home treatment

teams were responsible for 'gatekeeping' all admissions to inpatient beds. Most teams were achieving, or close to achieving, 100% for this indictor that all referrals that may need admission to hospital were seen by the team.

- The trust had an urgent advice line that is available out of hours. This provided advice, support and signposting to other services. Some people raised concerns with us that this was called a crisis line, as the team could only signpost and support, rather than provide full crisis team support.
- For the assessment and brief treatment teams and the assessment and short term intervention team in Milton Keynes people were usually seen and assessed within locally agreed target times.
- For the community recovery teams whilst most referrals were accepted the Brent and Hillingdon teams had waiting lists for patients who needed a care co-ordinator.
- We did hear about the challenges of discharging some patients due to a lack of shared care arrangements with GPs about the administration of antipsychotic medication.
- For the substance misuse teams there were no waiting lists operating in any service and patients referred to the services would be assessed and receive treatment within 3 weeks. In Hillingdon we did hear that due to high demand they were thinking that they may need to introduce a waiting list. The Ealing and North Westminster services offered a 'one stop shop' where patients could access support with social issues which was really valued by the patients.
- The community mental health teams for older people had a 10 days working target from referral to assessment, for non-urgent cases. This target was being met except in Hillingdon where the waiting time was 15-20 working days.
- The memory clinics had a target waiting time of 30 days from referral to assessment. In Hillingdon this target was being missed and people were waiting 90 days. A temporary doctor had been employed to help with the backlog of referrals.
- The learning disability teams did have a waiting list for speech and language therapy whilst posts were being filled. The trust had arranged input with another provider for patients with swallowing difficulties so their urgent needs could be addressed. The Harrow team did have a waiting list of 56 people for psychology input but they were being reviewed to see if they still needed a service.
- Across the CAMHS teams we were told that they tried assess young people within agreed timeframes. Emergency admissions to A&E were seen by staff on the same day, urgent referrals within 24 hours and routine referrals within four weeks. Referrals were usually screened by senior clinicians and sent on to the appropriate pathway. Waiting times for young people varied depending on the pathway they were allocated to. There were a high number of referrals in Brent and Hillingdon teams and these continued to increase. The number of referrals accepted into teams had outstripped capacity which had had an impact on waiting lists and times for treatment. In Hillingdon there had been an increase in deliberate self-harm cases presenting to A&E who were not previously known to CAMHS or previously identified by other agencies. At the time of the Hillingdon inspection there were over 100 people on the treatment waiting list and some had been waiting for 12 months or more for treatment. A clinically driven protocol was in place to manage and reduce the waiting list. This was done through a multi-disciplinary process overseen by a consultant and team manager. A clinical nurse specialist had been brought in to help reduce the waiting list and following the inspection we were informed that further funding had been awarded to the Hillingdon team by the local commissioning group for a further two, fixed term, posts to help reduce the waiting list further. However, a longer tem sustainable plan was not in place. In Brent waiting lists were discussed in team meetings. Risk was monitored and urgent cases were prioritised. For instance if people self-harmed or exhibited psychotic behaviours. The biggest waiting lists were for people with attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD).

Community health services:

- Sexual health services operated a direct referral system across all clinics with appointments normally available within 48 hours. Drop in sessions were also available. Clinic hours had extended to make them more accessible for people outside office working hours.

Requires improvement

Are services responsive to people's needs?

- Community health inpatient services had clear care pathways from admission to discharge. Discharge planning started as soon as patients were admitted to the wards.
- For community dental services there was an assessment process to ensure patients met the referral criteria. In the Hillingdon services there had been a sharp increase in referrals into the service for patients who met the criteria. This had heavily impacted on the waiting times for specialist treatment such as endodontic and periodontal treatment. The average waiting times were currently 26 weeks for endodontics (longest wait 39 weeks), 15 weeks for periodontics and 19 weeks for paediatric dental care. In the meantime, Hillingdon dental services had put initiatives in place to try and reduce the waiting lists where possible. This included varying and utilising the skill mix of clinical staff to increase clinic hours and therefore numbers of patients seen.
- For community health services for children, young people and families there were different arrangements in place across different geographical areas and teams in terms of referral, transfer and discharge arrangements. At the time of the inspection some teams or specialisms were experiencing waiting lists. For example the referrals for speech and language therapy in Milton Keynes had increased and there was a 17 week waiting list for an assessment. The Mosaic Centre in Camden single point of referral system experienced a backlog of referrals at the end of 2014. This was mainly due to the increase in referrals and the lack of sufficient staff to carry out the assessment. This was addressed once the backlog was found and a new process was now in place to manage the number of referrals. At Hillingdon there were good processes for the handling of referrals through a single point of access and multi-disciplinary triage. For example a child being referred to the Woodlands centre would be assessed and if they were identified as having a social communications disorder the child would be passed on to the rapid autistic spectrum disorder assessment team. In Hillingdon the service had set up a local parents forum called 'transition' which was a meeting for older children with complex needs and their parents to discuss how they would be transferred as their child got older.
- The community end of life services could be accessed through self-referral and from professionals. New referrals were allocated on a daily basis. Urgent referrals were followed up in 24 hours and non-urgent referrals in 48 hours. These targets were being met. Patients also had access to advice out of hours although the detailed provision depended on local arrangements.
- The community health services for adults had different arrangements in each borough. For example in Milton Keynes there was a rapid assessment and intervention team who triaged referrals to ensure the service provision was prioritised. In Camden referrals including self-referrals went to a central access point where they were triaged and the allocated to the appropriate team.

Accessibility of appointments:

- Generally we found that services were aware of the need to follow up patients who missed appointments especially where they might find it difficult to engage.
- Most services tried to offer flexible appointments and were aware of the need not to cancel urgent appointments and to be on time for appointments.

The facilties promote recovery, comfort, dignity and confidentiality

- Most of the services where care was provided were clean, well decorated and comfortable. Most inpatient services had access to quiet lounges, rooms for therapeutic activities and outside space.
- Some services, where people were staying for a longer period of time encouraged people to bring with some personal possessions and personalise their rooms. An example of this was at the Butterworth centre which was a service for older people with mental health problems.
- On the acute mental health wards we found that patients could not always make phone calls in private, some quiet lounges were being used as bedrooms. At the Gordon Hospital there was a lack of outside space and at the Campbell Centre at Milton Keynes bathroom doors off shared bedrooms had been replaced by curtains due to ligature concerns which compromised the privacy of patients.

Requires improvement

Are services responsive to people's needs?

- On some acute wards and wards for older people with mental health problems we heard that patients were not able to lock their rooms and store possessions without them being put in a ward safe. This meant that items had gone missing which caused distress.
- The feedback about meals in inpatient services was mixed. At the Riverside centre in Hillingdon patients were positive about food but at St Charles people were less positive which corresponded with recent findings from surveys. Most services used a system of chilled meals being heated up although others cooked meals on the site. Access to snacks and drinks was generally good although patients being able to make their own drinks varied without there always being a clear reason.
- Access to therapeutic activities were generally very good for people using inpatient services. In the community people spoke positively about the courses available at the recovery college. In some services we did hear there were not enough activities in the evening and in the learning disability services we found that the activities that took place were sometimes less than the ones on their individual activity plan.
- In the Hillingdon community recovery team (Mead House) some areas that patients used were neglected with paint flaking off walls and chairs that appeared dirty as they were worn.
- At the North Kensington home treatment team based at St Charles the interview rooms were divided by a door with a glass panel covered by a small curtain. Private conversations could easily be overheard in either room. This meant their privacy and dignity was not maintained.
- The places of safety at the Gordon hospital and Park Royal had no separate access. Park Royal had its place of safety unit on the first floor and the toilet was reached by going through the nurses' office. The Gordon hospital place of safety was accessed through the front door for the hospital. This meant that people had their privacy compromised as they arrived at the places of safety. The trust had plans to redevelop both of these places of safety.The other places of safety had their own entrances and privacy could be maintained within the suites.
- The building where Westminster CAMHS was based was not considered fit for purpose. Options were being considered in the trust for a new base. Similarly the building where Brent CAMHS was based was considered not fit for purpose. The estates team within the trust had been tasked with finding appropriate premises.
- The clinic environment for sexual health services were very pleasant and these had been designed with input from patients and staff working with the architects.

Meeting the needs of all people who use the services

- The trust served a very diverse population across each of the areas it covered. The trust demonstrated a real commitment in terms of meeting people's equality, diversity and human rights.
- The trust was part of the Stonewall Diversity Champions programme. For the past two years the trust had made it into the Stonewall top 100 employers at numbers 23 and 70. In 2014 they came top of the Stonewall healthcare equality index receiving particular praise for training on LGBT equality and the Mortimer Street outreach services within the sexual health services.
- The trust had five equality objectives 2012-16 which included: increasing diversity awareness raising opportunities available to staff, developing community engagement events with minority communities relevant to each service, improving recording rates for sexual orientation, disability staus and religion of patients on the patient administration systems, reducing the proportion of staff members reporting discrimination and harassment from patients, carers and the public and improving the proportion of staff who thinks the organisation acts fairly with regard to career progression regardless of ethnic background, religion, sexual orientation or age.
- Equality and diversity training was mandatory and 81% of staff were up to date with this training.
- The trust's excellent Equality Act compliance report 2014 gave examples of some of the work done by the trust. This included a strengthened equality and diversity leads network, an extended faith visitor programme, a trust faith and spirituality conference, an in house interpreting service providing over 9500 face to face interpreting sessions in the past year, a quarterly newsletter 'inclusion news', community development workers, expanded numbers of peer recovery trainers in

the recovery college and peer support workers in clinical settings. We saw many examples of this work in our visits to services where people were being provided with support that reflected their individual needs.

- There were several networks for staff including BME network. These were led by staff. The BME network looked at policies and was working with managers on diversity issues. There was a leadership programme for BME staff and a women in management course.
- The trust was using values to drive culture and encourage constructive challenge of poor behaviours eg not speaking in a foreign language in front of other staff and patients.
- The trust was aware of areas where staff do not reflect the diversity of the client group and there had been some targeted recruitment to try to address this.
- The focus this year was on staff with disabilities. This has not been given the same level of focus as other minority groups.

Learning from concerns and complaints

- Information on how to complain was provided in most inpatient wards and in community services. In the rehabilitation services at Horton and in the psychiatric intensive care units the information was not available. Staff tried to resolve concerns at the time they were raised and these were recorded in patients notes. Several patients told us that they would have preferred their concerns to be dealt with more formally as they did not feel they had been thoroughly addressed.
- Some information had been developed in individual services to gain feedback and support people using services to raise concerns. For example, an easy read and pictorial complaints leaflet was available for patients and relatives at the Kingswood Centre. Sexual health service staff had all been trained to ask for feedback about the service and had developed tear offer comments cards for people using the service to record complaints and feedback. The trust website also had information on how to make a complaint but senior managers acknowledged this was not easy to follow. It was hoped that a new system for managing concerns and complaints, that was being introduced, would address this and make it easier for people to make a complaint.
- Approximately 72% of complaints received by the trust between October and December 2014 related to a mental health service. Complainants were offered an opportunity to meet with staff and discuss and resolve their complaints locally. They could bring an advocate or relative or friend with them to the meeting for support.
- The trust responded to most complaints promptly. However, they were not meeting their own target of responding to 95% of complaints within 25 days. The trust had responded to 84% of complaints within the specified time in the third quarter of 2014-15 and to 79% of complaints in the first half of quarter four. Fourteen complaints had been open for more than six months. Several of these were awaiting the conclusion of investigations or were where the complainant had changed their mind about making a complaint and the complaint had been reopened. Five responses had been delayed because investigating staff had left or changed or the reasons for delay were unclear.
- The trust looked at variations in response times between teams and services and followed up with local directors where teams were failing to reach the agreed trust target times.
- We reviewed 13 complaint files and responses provided to complainants by the trust. There were no statements from staff or investigation notes in any of the files. As a result it was difficult to see how the conclusions in the responses had been reached by the investigator.
- The final response letters were not structured consistently and were not signed by the chief executive, or in her absence, by a director.
- The quality of responses varied. For example, one final response failed to explain how the complaint could be escalated to the Parliamentary and Health Service Ombudsman. Another final response letter breached confidentiality as the letter provided employee identifiable data about actions taken against them by the trust. The responses were often very long and detailed but were difficult to understand and not always written in plain English. Most letters failed to identify any learning points arising from the complaint However, one response letter from the psychotherapy service told the complainant there has been a change in the operational policy of the service as a result of their complaint.

Requires improvement

Are services responsive to people's needs?

- The quality of complaint responses was not routinely checked by the associate director for quality or director of nursing, who had overall responsibility for complaints, before letters were sent to complainants. Specific standards had not been set in terms of the quality of responses expected. Senior managers sometimes carried out spot checks on responses to ensure they were of good quality. However, senior managers acknowledged there was a need to provide training to staff in order to set standards and improve the quality and consistency of responses.
- The trust had carried out two complainant satisfaction surveys between September 2013 and May 2014. The number of respondents to the surveys was small but complainants who took part were generally happy with the response to their complaint although several people remained dissatisfied with the process and outcome.
- Reports about complaints and issues taken up with the patient advice and liaison service (PALS) were provided to the trust board every quarter. The report to the board in January showed that specific learning from complaints had been identified. A newsletter had been developed to inform staff about learning from complaints. This was called 'Listen.Learn.Act'. The first newsletter had been sent to staff in December 2014. It highlighted themes from complaints including staff attitude, communication, risk assessment and the importance of following up patients who did not attend appointments.
- The trust did not systematically look at complaints in terms of the ethnicity or other personal characteristics of complainants in order to see whether there were more or less complaints from any particular group of people using the services. In addition the trust did not specifically look at whether complainants were reflective of the population using trust services. A senior manager told us this had been done in the past and that service commissioners had recently requested a breakdown of complainants to include an analysis of ethnicity. However, there was no overall strategy in place to ensure that all patients and people using services were well informed about the trust complaints procedure, could access the system or were confident to raise concerns.
- The trust board had agreed a new centralised patient support service which would incorporate the management of complaints about trust services. The new complaints management process was due to start on 1 April 2015 alongside the implementation of a new incident reporting system.
- This new process aimed to ensure that patients would find it easier to provide feedback about their experiences and that concerns including those raised verbally would be dealt with promptly by local services. Where concerns progressed to being formal complaints about services, the individual service would ensure it was dealt with appropriately and within agreed timescales. Under the new system divisional directors would be responsible for the quality of the complaint responses and sign off all responses for their division. Training was planned for staff including a workshop for senior managers and divisional directors. This was due to commence in May 2015.

Good

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

We rated well led as **good** for the following reasons:

The trust had a clearly developed vision with values and strategic objectives. The staff knew what these were and felt part of the organisation.

The trust was led by a stable board and executive team. There was a programme of visits to services and leaders were felt to be visible and accessible. The trust were following through the recommendations from a governance review undertaken by Deloitte last year which should further develop their leadership.

The trust had undertaken work to meet the 'fit and proper persons requirement' which ensures that directors of health service bodies are fit and proper persons to carry out the role. This included undertaking a number of checks and this process needed to be completed.

The trust used a range of indicators and other measures such as surveys to monitor the performance of services. In many cases this accurately reflected when improvements needed to take place. Managers in teams and wards were using this information to varying degrees to highlight when work was needed. The trust did acknowledge that there were still too many variations in standards between services. The new divisions with a new accountability framework appears to offer an opportunity to improve information and reduce variations.

The inspection took place at a time when the trust was being asked to save nearly 20% of its income over 3 years resulting in the consolidation and redesign of a number of services. All the savings plans included senior clinical input and feedback from people who use the services. However some staff felt they could be better informed and involved in the changes.

Our findings

Vision values and strategy

- The trust had developed its own vision and values in consultation with people who use services, staff, carers and other stakeholders. These were displayed across the trust and people we spoke with were familiar with the four values of compassion, respect, empowerment and partnership.
- The trust had two plans that set out how it would provide high quality and safe care. The first was the trust's strategic plan 2014–19. This highlighted six strategic priorities. These were to put patients first, providing high quality care and best outcomes. The next was a partnership for change looking at system wide transformational change. The others were developing a workforce for the future, achieving financial stability, information technology for the future and having consolidation and growth.
- The second was the trust's operational plan 2014–16 which looked at immediate challenges. The operational plan identified five main challenges. These were to maintain quality and innovation, affordability, working with commissioners to review contacts, improve the use of technologies especially IT and managing increased demand from population increases and an aging population. There were priority programmes refreshed on an annual basis to meet these challenges which included redesigning services, addressing key staffing challenges such as recruitment, modernising information technology systems, maintaining financial control, estate management, opportunities for growth and strengthening the current portfolio of services. The operational plan also set quality priorities for 2015-16 which were to involve patients in decisions about their care, support carers and to have a competent and compassionate workforce.
- The trust appeared to clearly understand the key internal and external challenges and these recognised the financial situation. They had involved internal and external stakeholders in the development of the priorities. These programmes had executive led work

streams. An internal programme management office supported this work through helping staff to implement change programmes to respond to the challenge of achieving savings targets and where possible improving the quality of services. It also worked with senior managers to ensure the progress of projects were monitored.

Governance

- At the start of the inspection, there was a presentation from the trust to the inspection team. This highlighted a major challenge as being variations in standards, practice and environments between services. The inspection found these variations existed and meant that some patients did not always receive services of an acceptable standard.
- The trust did use a range of indicators and other measures such as surveys to monitor the performance of services. It was positive to note that these indicators did reflect areas for improvement. These included ensuring community patients had a copy of their care plan and ensuring mental health patients had a completed risk assessment and that progress was being monitored. The trust also collected information to monitor other priorities such as staff data, complaints data and incident data. The inspectors found that at a ward or team level the use of this information to monitor the service or make improvements was very variable. For example team managers used information about which staff had completed mandatory training to ensure those that needed the training had the time to attend.
- In addition to the use of information the monitoring of the performance of services was achieved through line management arrangements. The chief executive and executive directors met every week and discussed significant concerns. It was apparent from interviews that despite the size and complexity of the trust this team had a very good knowledge of the services provided by the trust, especially the chief operating officer. The executive directors and non-executive directors all talked about how they regularly visited services as a way of finding out what was happening. We heard from wards and teams about these visits and how much they were valued.
- At the time of the inspection a new divisional structure was being implemented to be operational from the 1 April 2015. Alongside this was a new accountability framework. This clearly set out corporate, divisional and service level responsibilities. This also included standardized agendas to be used at monthly meetings to ensure information was shared at all levels of the organisation. It clearly specified the information that the divisions needed to provide to the board and committees to ensure a structured sharing of information and assurance. In addition the executive board will be reviewing the progress of each division on a quarterly basis. Whilst previous divisional structures and monitoring had been in place these new arrangements should result in a more consistent and robust approach. Whilst in an organisation the size of CNWL there will always be some variations in services a measure of success will be if the variations that are having a detrimental impact on patient care are identified and addressed in a timely manner.
- The trust has clear risk management processes in place with risks discussed at different levels of the organisation. Risk registers were collated at a divisional and trust wide level. The most significant risk identified during the inspection, the care of patients needing access to an acute inpatient mental health service, was identified as a high risk on the risk registers for January 2015. The Deloitte final report published in February 2015 had identified that risk registers were in place but some needed to be updated. This had been completed by the trust. We did find in the Harrow and Hillingdon community recovery teams that the risk registers did not reflect the risks being managed by the team. The trust accountability framework going forward linked to the new divisional structures made the consideration of risk management an area of work for all levels of the organisation.
- Commissioners, local authorities and other partners were largely very positive about their working relationships with the trust. Where there were problems they often related to difficulties in addressing local issues with local managers although when the issues were escalated to executive directors they were then resolved promptly. The London clinical commissioning groups also talked about the lack of consistency in terms of the quality of care at a borough level and outcomes being often determined by individual

borough culture. The feedback was that they all felt very positive about the new divisional structure and the improvements this would bring to local knowledge, working relationships, management and decision making.

Leadership and culture

- The executive board consisted of eight executive directors who were the most senior managers responsible for the day to day running of the trust. Most of the executive directors had been with the trust for many years. The chief executive had been in this post since 2007 and prior to this was director of nursing and quality. The chief operating officer joined the trust in 1988 and was appointed to the current role in 2013. The medical director was appointed in 2003 and the executive director of nursing in 2010. The stability and organisational knowledge which came from this consistency was recognised by the inspection team. The Deloitte report recommended the trust to consider succession planning, which seemed very sensible and this had gone to the trust nominations committee for formal consideration.
- The trust also had a very stable group of non-executive directors. The chair had been a non-executive director since 2000 and became trust chair in January 2014. A board development programme was in place and regular away days took place. At the time of the inspection there was no board member with a clinical background which the inspectors felt was needed. The chair recognised the need to have someone with these skills and said that they intended to recruit a clinician later this year when two non-executive positions become available.
- The council of governors consisted of appointed governors representing organisations including local authorities and voluntary services, elected governors representing people who use the services, staff, carers and members of the public. They undertook roles such as appointing the chair and non-executive directors, consulted on service changes and represented the views of members. In addition to quarterly meetings where a range of items relating to the operation of the trust were discussed, there were also sub-groups looking at specific topics and governor breakfasts / teas with the chair where the governors set the agenda. Governors found the chair accessible and felt that the trust listened to their feedback. Individually governors played roles on committees and for example they had significantly influenced the strategic objectives. They also had over-ruled the board on the choice of a non-executive director. From speaking to governors there was clearly a variation in how individuals recognised the need to support and also challenge the board. The Deloitte report recommended a review of the size of the council of governors which was being considered, but there should also be consideration given to whether the governors can further develop their role of constructive challenge.
- The executive directors, non-executive directors and governors had a programme of visits to services and staff were able to tell us about when visits had taken place. Leaders were felt to be visible and accessible especially the chief executive and chief operating officer. Staff also said that they felt they did have opportunities within their services, divisions and trust wide to be involved in the discussions around changes and the development of their services.
- The trust recognised that there was still more work to do to create a healthy culture in the organisation that promoted the safety and well being of staff. Very positively the NHS staff survey 2014 had in the five top ranking scores (and better than the national average) the fact that staff reported good communication between senior management and staff and staff recommended the trust as a place to work or receive treatment. However their bottom five ranking scores included the percentage of staff working extra hours, the percentage of staff experiencing discrimination at work and the percentage of staff experiencing bullying, harassment or abuse from other staff.
- The inspection team did hear many examples of how people felt well led at a team or divisional level and about their positive experiences of team working. Many people described how they felt there was an open door policy and that managers were approachable, supportive and visible.
- The acute wards for working age adults were not well managed overall. There were bed managers in place and staff were working very hard to manage daily bed pressures safely. Contingency measures had not been in place to prevent the impact on patients from the high bed occupancy. Whilst the trust had taken steps just

prior to the inspection to access beds outside the trust, this response had been planned after the problems had developed and patients' safety and dignity had been compromised.

- The trust had a variety of leadership development opportunities in place. A number of staff were undertaking NHS leadership academy courses. Consultant medical staff had access to 'management fundamentals' a bespoke programme co-designed with Imperial College providing 8 training days over a 4 month period. In Camden there was a 'management essentials' training course. In Hillingdon there have been several leadership courses for band 6 and 7 staff. There was also an in-house management development programme for London staff working in the mental health services accredited with the Chartered Management Institute. In Milton Keynes there was a clinical leadership programme for bands 6/7 staff. Staff also had access to a wide range of external courses.
- The trust recognised the pressure placed on staff from working in changing services. There was a programme in place to manage staff sickness and support staff to return to work. There was also a wellbeing strategy developed by the occupational health team and this had extended the employee support scheme to incorporate physiotherapy as well as additional counselling support.
- Most staff we spoke to said they would feel able to raise any concerns with their line manager or other senior staff in the trust. Staff raised eight whistle-blowing concerns from July 2014 – January 2015. Four of these had been referred on by the Care Quality Commission. The trust had publicized the whistle-blowing process and most staff knew that this was available. The whistle-blowing policy was also in the process of being reviewed and the results were being considered at the March 2015 Audit Committee.
- As part of the inspection we looked at whether the trust was fulfilling the regulation relating to the duty of candour. This means they operate with openness, transparency and candour which means that if a patient is harmed they are informed of the fact and an appropriate remedy offered. We heard from a number of patients, staff and external stakeholders that the trust was open and transparent in sharing details of safety incidents. We also saw the trust was taking steps to ensure incidents, complaints and other concerns were fully investigated. Most people felt satisfied with how this is happening, but a few remained unhappy with how their individual concerns had been addressed. The Care Quality Commission will continue to look at the duty of candour as part of future inspections.

Fit and Proper Person Requirement

- The trust was prepared to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of health service bodies are fit and proper persons to carry out the role.
- A new fit and proper persons policy was approved by the trust board on 4 March 2015, the week after our inspection. The policy outlined the checks required for directors on appointment and on-going annual checks of fitness. These included checks of criminal record, insolvency and bankruptcy, identity, right to work, employment history, professional registration and qualifications. The policy required the chair to confirm annually to the council of governors that all directors fulfilled the FPPR.
- The new fit and proper persons policy stated that "DBS checks (criminal record checks) are undertaken only for those posts which fall within the definition of a "regulated activity" or which are otherwise eligible for such a check to be undertaken." However, without a DBS check for all directors, the trust will not fully comply with Schedule 4 part 2 of the Regulation to ensure appointees are of good character.
- The policy described the action to be taken if a director was found to be in breach of the FPPR, which included advising the relevant professional regulator if the individual was a registered health or social care professional.
- A number of actions had been taken in the period between the regulation coming into force in November 2014 and the trust board agreeing the new policy March 2015. For example, the trust had carried out checks of the insolvency register and register of disqualified directors for each director.
- The trust was in the process of applying for a disclosure and barring service (DBS) check for all executive and

non-executive directors. At the time of the inspection disclosures had been received for ten directors. Results were awaited for three people and three applications had yet to be completed.

- All the contracts of current directors had been amended to reflect the requirement for them to be compliant with the FPPR. Directors were required to make an annual declaration of their fitness in respect of the regulation. The trust's constitution had been amended to include a requirement for all directors to fulfil the FPPR. Assessment of the continued fitness of directors was to be undertaken each year as part of the annual appraisal process. All directors had received an appraisal in 2014. The Chair was undergoing an annual appraisal which involved receiving feedback from all directors and governors of the trust.
- We reviewed the personnel files of six directors on the trust board. Three of these were executive directors and three were non-executive directors. All had been appointed prior to the FPPR coming into force in November 2014. There had been no new appointments to the board since then. Most of the checks on current directors required by the policy had already been carried out or were in process. However, one director's file had only one employment reference rather than the required two and in another file there was no evidence that the director's professional qualification had been checked and verified. DBS checks had not yet been completed for two of the six directors we checked.

Engagement with people and staff

- The trust worked with patients and carers in a number of ways to improve the quality of their services. Examples of this included patients helping with telephone surveys to get patient feedback on services (over 2500 calls made a quarter), patients and carers helping with staff recruitment and training, patients and carers involved in setting the annual quality standards, helping on steering groups responding to feedback from surveys and helping to update information materials or reviewing policies. Also patients attended board meetings to share their story. The trust had a carers council that included carers and staff representatives. Carers groups had been established in some services.
- Throughout the geographical area covered by the trust there were a wide network of user and carers groups. Some of these were directly supported by the trust and others are more independent. The feedback from these groups was that whilst the trust was very supportive of the groups and welcomed their feedback, there was also a concern that this did not translate into changes or that they were not aware of the changes that had taken place.
- The new friends and family test was rolled out by the trust in October 2014 and was available online on the trusts website. This included campaigns to encourage patients and staff to complete the test. The test was available in different formats for people with dementia, children and people with a learning disability. It was translated into the organisations top10 languages and was available in a large font.
- The trust had a number of peer support workers employed throughout their services offering practical assistance to help people regain control over their lives and support their recovery. We found that this had enhanced the quality of engagement across the services concerned.
- In June 2014 a staff engagement strategy was launched. The five keys areas of work were as follows: safe staffing (review staffing levels, recruitment, use of e-roistering), personal development for staff (ensure training and appraisals done well), promote staff health and well-being (focus on stress management including a new policy), hand-washing (ensure the facilities are available), reduce staff experiencing discrimination (raise the profile of the equality and diversity network, monitoring themes and addressing issues)
- Staff engagement occurred through a number of other means including a weekly newsletter, use of social media, staff magazine, holding focus groups with staff called "the conversation" and a programme of listening events.
- Staff felt generally very involved in their services and able to raise issues and discuss areas for improvement. The staff working in Milton Keynes and the dental services in Buckinghamshire recognised that they were still adjusting to being part of the trust. In services that were going through a process of change staff did not always feel listened to or sufficiently involved. This was raised by staff in the sexual health services, the Westminster CAMHS service and the home treatment teams in Kensington & Chelsea and Westminster.

Quality improvement, innovation and sustainability

Good

Are services well-led?

- We heard about many areas of innovation across the trust. One of these was the work the trust was doing with GPs to strengthen primary care. This is known as primary care plus and aimed to help people stay well and reduce their need to access secondary services. We were told that in terms of long term development the focus was very much on patients being able to access their physical and mental health services together through fully integrated services.
- The trust also participated in external peer review and service accreditation. This included the Quality Network for Perinatal Mental Health Services at Coombe Wood, the Psychiatric Liaison Accreditation Network where the service at the Chelsea and Westminster Hospital was accredited as excellent and the Quality Network for Inpatient CAMHS where the service at the Collingham Child and Family Centre was also accredited as excellent. Other accreditations included the Quality Network for Inpatient Learning Disability Units, the Memory Services National Accreditation Programme where the Brent, Kensington & Chelsea and Westminster services were accredited as excellent and the Electroconvulsive Therapy Accreditation Service where the St Charles service was accredited as excellent.
- The trust has a clinical ethics committee. It is made up of clinicians, managers, a lay member, a service user as well as a philosopher and an ethics and law lecturer. This committee has been running for 10 years and had reviewed over 95 cases.
- At the time of the inspection CNWL was having to save £84m over the next 3 years, £32.7m in 2014-15, £23m in 2015-16 and £28m in 2016-17. This represented nearly 20% of its income. Monitor expressed concerns about whether these savings would be achieved. A number of people we spoke to throughout the organisation shared this concern. In order to achieve this the trust was consolidating and redesigning services. A number of services that were inspected had taken part in the DRIVE programme (delivering realistic improvements, value and efficiencies). The aim with the support of an external partner was to try and streamline processes such as referrals and documentation and create more time for clinical care as well as saving money. The trust had a programme management office to oversee all the projects. All the savings plans had a quality impact assessment. They always included senior clinical input and where relevant input from people who use the service, carers and wider stakeholders. We looked at the quality impact assessments and found evidence of clinical involvement.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision People were not being protected against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to identify, assess and manage risks to people. Although numerous ligature risks had been identified on the acute and PICU wards staff were not able to articulate the measures being taken to manage these risks for the patients using the service. There were a number of blind spots in the wards that did not have a clear line of sight. Measures were not always in place to reduce risks to patients and staff. Significant numbers of detained patients were absconding whilst receiving inpatient care. This needed to be reviewed so that measures could be put into place to reduce the risk to patients. This is a breach of Regulation 10 (1)(b)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse Patients were not being protected against the risks of unsuitable control or restraint.

This section is primarily information for the provider

Requirement notices

The training of staff in current best practice in terms of prone restraint had not been completed across whole staff teams to ensure that staff had the necessary skills to restrain people safely where this intervention was needed.

This is a breach of Regulation 11(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

The trust had not ensured that patients were appropriately assessed and that the welfare and safety of patients was maintained.

The reasons for the administration of rapid tranquilisation, and the reviews of patients' physical health, including vital signs, following rapid tranquilisation were not always demonstrated to ensure patients were not at risk.

This is a breach of Regulation 9(1)(a)(b)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

Patients were not being protected against the risks of unsafe or unsuitable care.

The records relating to the seclusion of patients did not provide a clear record of medical and nursing reviews, to demonstrate that these were carried out in accordance with the code of practice: Mental Health Act 1983.

This section is primarily information for the provider

Requirement notices

This is a breach of Regulation 20(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The trust did not take appropriate steps to ensure there were sufficient numbers of staff. The failure to increase staffing numbers in response to increased numbers of patients on the acute admission wards put patients at risk of not having their needs met appropriately. There were insufficient staff available to work as care co-ordinators which meant that duty workers in the Brent, Hillingdon and Harrow CRT's were responsible for supporting a number of patients. This meant the safety and welfare of patients was potentially at risk. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The trust had not taken proper steps to ensure that each person using the service was protected against the risks of receiving care or treatment that was inappropriate or unsafe. The wards were over-occupied. On admission to the ward, patients did not have a designated bed and often slept on other wards. Patients returning from leave did not have a bed on their return to the ward.

This section is primarily information for the provider

Requirement notices

Some people in the acute wards experienced several moves between wards for non-clinical reasons during one admission. Of these, some people were transferred during the night or went to wards where they did not know, or were not known by, the multidisciplinary team.

At the Harrow community recovery team patients' risk assessments were not thorough or detailed. They were not updated after risk incidents.

The planning and delivery of care did not always protect the welfare and safety of patients. Several patients using Harrow and Hillingdon CRTs had not been referred for regular physical health checks.

On Redwood ward patients were not having ongoing physical health checks.

On Redwood ward female patients were wearing clothing that did not preserve their dignity.

Patients from adult wards were receiving care and treatment on the older people's wards when this was not always clinically appropriate.

Patients were admitted to the beds of patients on wards for older people with mental health problems who were on leave but not discharged. This meant they may not be able to return to the ward if they needed to.

People were not being protected against the risks of receiving care or treatment that is inappropriate or unsafe. Delays in accessing inpatient beds when required meant that people had to be supported in health based places of safety and bed management lounges for extended periods of time.

This is a breach of Regulation 9(1)(b)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulations 9,10 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services
Diagnostic and screening procedures	
Treatment of disease, disorder or injury	

This section is primarily information for the provider

Requirement notices

The trust did not have suitable arrangements to ensure the dignity and privacy of people.

Patients were not able to make telephone calls in private.

At the Campbell Centre patients in shared rooms were not able to attend to their personal care needs with an adequate level of privacy and dignity.

People using the place of safety at the Gordon Hospital and Park Royal had to pass through other parts of the hospital rather than accessing the service through a separate entrance which could compromise their privacy and dignity.

This is a breach of Regulation 17(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment

The provider had not protected service users from the risk of the use of unsafe equipment by ensuring the equipment is properly maintained and suitable for purpose.

At the Hillingdon community recovery team (Pembroke Centre), the automated external defibrillator (AED) had not been properly maintained. As a result there was a risk to people from the use of unsafe equipment in an emergency situation.

This is a breach of regulation 16(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures Treatment of disease, disorder or injury	The trust did not have an effective system to inform people of how to make a complaint. There was a lack of information in some rehabilitation services and the PICU's to inform people how to make a complaint. There was not a central register of verbal complaints and it was possible that where patients wanted a formal response to their complaint this was not happening. This is a breach of Regulation 19(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The provider had not ensured that patients were protected from the risks associated with unsafe or unsuitable premises by means of suitable design and layout. Oak Tree ward and TOPAS did not comply with guidance on same sex accommodation and compromised patients safety, privacy and dignity. On several wards patients did not have access to a lockable space to safely store their personal possessions which should ideally have been provided through a key to their bedroom door. Patients could not close their observation panel from inside their room to have privacy. Interview rooms at St Charles hospital did not maintain the confidentiality of people using the service. This was in breach of regulation 15(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulations 10 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The provider did not protect patients against the risks assosciated with the unsafe handling of medicines. On Redwood ward medication was left in an unlocked medication trolley where patients could have picked it up. On Redwood ward the drugs used for emergency resuscitation were not stored together which could make them harder to locate in an emergency. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The provider had not made suitable arrangements to ensure that patients are safeguarded from the risk of abuse by responding appropriately to an allegation of abuse. At the TOPAS centre there was no record so that staff would know about current safeguarding alerts and any actions that needed to take place to keep people safe. This was a breach of regulation 11(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision

This section is primarily information for the provider

Requirement notices

The trust did not have suitable arrangements in place to protect patients against the risk of inappropriate or unsafe care and treatment by means of the effective operation of systems to reflect information that it is reasonable to expect the trust to be aware and make changes to the care provided.

The trust management had not anticipated increases in the demand for acute inpatient beds and put contingency plans in place that preserved the safety and dignity of patients.

This was a breach of regulation 10(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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Brent

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Services provided and their rating:

Service	Type	Overall Trust Rating	Local Brent Provision
Acute wards for adults of working age	Mental health	Inadequate	Pond Ward, Pine Ward, Shore Ward
Mental Health Psychiatric Intensive Care Units	Mental health	Inadequate	Caspian Ward
Mental Health Crisis Services and Health Based Places of Safety	Mental health	Good	Park Royal Mental Health Centre
Mental Health Services	Long stay rehabilitation mental health wards for working age adults	Good	Fairlight
Community Based Mental Health Services for Older People including Memory Services	Mental health	Good	Fairfields House, Central Middlesex Hospital,
Community Based Mental Health Services for Adults of Working Age	Mental health	Requires improvement	Brondesbury Road, Park Royal Mental Health Centre, Roundwood Centre, Central Middlesex Hospital
Specialist community mental health services for children and young people	Mental Health Services	Good	Bell House, Warranty House,
Learning Disability Services	Mental health	Inspected but not rated	Brent and Harrow Community Team (Learning Disabilities)

Trust wide areas of good practice

The CQC noted that the positive attitude of staff was very evident throughout the inspection. This was reflected in their pride in working for the trust and their service and in their wish to provide the highest standards of care to people using the service.

The pharmacy team not only ensured that the arrangements for the supply of medicines was good, but also provided considerable guidance and support to staff and patients throughout the services.

Patients, carers and staff all valued the courses provided by the recovery college and the opportunities for personal development. The recovery college was very well organised and responsive to local need.

Please note that 'must do's' identified by the CQC are made for core services areas, and therefore not all will be applicable to the borough's services.

Acute Wards for Adults of Working Age

Areas of good practice:

- The wards all had access to information to monitor and audit quality through data extracted from the electronic record system.
- Generally the CQC found that patients spoke very positively about the support they received from the staff. They said staff were helpful, caring, listened to them and gave them encouragement and support with their needs. Most of the patients spoke of being involved in their care and support planning
- CQC observed positive, kind and caring interactions between staff and the patients, including under challenging circumstances.
- Acute services were effective. Clinical staff made assessment of patients' needs including physical care on admission to wards. Where needs were identified, the care plans reflected those needs.
- Multidisciplinary teams worked effectively together in caring for and supporting patients.
- The staff in acute services were kind and respectful to patients and had a good understanding of individual needs. During MDT meetings, CQC observed that patients and their relatives were encouraged to express their views.
- In 2014 the acute care services introduced daily 'whiteboard' meetings on each ward. These were attended by a range of disciplines including the consultant psychiatrist, matron, staff nurse, psychologist, pharmacist, occupational therapist and medical trainees. The meeting provided a daily update on each patient and opportunity for professions to have daily oversight of what was happening with each patient.

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Areas for improvement:

12 x 'must do's'

1. The Trust must address the blind spots in the ward environment of Park Royal MHC to enable clearer lines of sight and reduced risks to patients and staff.
2. Staff working on the wards must be able to articulate how they are assessing and managing the potential risks from ligature points for the patients using this service. The use of blanket restrictions must be reviewed and risks from ligatures managed to reflect the needs of the patients on the ward.
3. The provider must ensure that staffing levels are adjusted to reflect the actual numbers of patients on the wards. This number must include those patients spending the day on the ward even if they are sleeping on another ward or at another hospital overnight.
4. The Trust must implement the training of all staff in new restraint techniques to ensure that staff working together on wards are all trained in the same techniques and in line with current best practice on the use of prone restraint, to prevent injury to staff and patients.

   Staff must always monitor and record physical vital signs in the event of the use of rapid tranquilisation until the patient is alert. They must improve medical reviews of patients receiving rapid tranquilisation to ensure patients are not at risk.
6. The Trust must take further steps at the Park Royal MHC and other sites where acute inpatient services are provided to ensure that risks to detained patients from being absent without authorised leave are minimised.
7. The Trust must ensure that, on admission to a ward, patients have a designated bed that is within the ward occupancy levels.
8. Patients returning from leave must have a bed available on their return to the ward.
9. The Trust must take steps to reduce the number of times that patients are moved to other wards to sleep for non-clinical reasons. Where it is unavoidable, staff must ensure that a thorough handover takes place to promote continuity of care. Patients must only be moved at reasonable times so that they are not adversely affected.
10. The Trust must promote the privacy and dignity of patients. Patients must be able to make calls in private.
11. The Trust must ensure the acute wards for adults of working age are well led by having contingency plans in place for when the numbers of patients needing a bed increases above the beds available.

Mental Health Crisis Services and Health Based Places of Safety

Areas for improvement:

2 x 'must do's'. 4 x 'should do's'

Must do's

- The Trust must ensure that when a person is assessed as requiring an inpatient bed that they are able to access a bed promptly.
- The Trust must ensure that the access to the Trust's places of safety promotes the patient's dignity and privacy by the provision of a separate entrance.

Should do's

- Risk Assessments should be updated on the Trust's electronic record system to reflect changing risk.
- Lone Working should be reviewed to ensure all teams have a robust system.
- A patient's capacity to make a decision should be recorded in the written records.
- Team to consider ways of collecting regular feedback from service users.

Mental Health Psychiatric Intensive Care Units

Areas for improvement:

1 x 'must do'. No 'should do's'

- The Trust must ensure information is available to inform patients on how to make a complaint. They must ensure verbal complaints are addressed and, if needed, patients and carers have access to the formal complaints process.

Community Based Mental Health Services for Adults of Working Age

Areas of good practice

- Almost all services had employed peer support workers, people who had used or were using mental health services, who were a positive addition to the teams.
- Several community services involved patients in interviewing prospective new staff members as part of the recruitment process.
- Most teams held regular forums for patients and carers to give feedback about the service.

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Areas for improvement:

3 x 'must do's'. 4 x 'should do's'

Must do's

- The provider must ensure that where automated external defibrillators (AEDs) are provided because there is a clinical need for this equipment, for example at Hillingdon community recovery team (Pembroke Centre) that they are maintained on a regular basis, accessible and available for use. The provider must ensure that other teams also have resuscitation equipment if needed.
- The Trust must ensure there are sufficient staff available to work as care co-ordinators so that duty workers in some services are not holding large numbers of patients which could potentially create a risk for the safety and welfare of patients
- The provider must ensure that patients using community services are referred for regular physical health checks.

Community Based Mental Health Services for Older People including Memory Services

Areas of good practice

- Services are thoughtful, considered & respectful, working closely with relatives.
- Staff have access to training to support them in their job role.
- There are clear processes for reporting and learning from incidents.
- Very good use of the Mental Capacity Act to support decision making.
- Staff used NICE guidance to deliver service.
- There are strong triage systems in place to ensure people are seen in a timely manner.
- There are good processes in place to follow up DNAs and cases are closed on an individual, considered basis.

Areas for improvement:

0 x 'must do's'. 4 x 'should do's'

- Care Plans should include a full physical healthcare management plan where physical health care issues are noted on initial assessment.
- The teams should explore if care plans can be provided in a more accessible format.
- The services should ensure all staff have access to regular supervision.
- The services should collate informal verbal complaints so that lessons can be learnt from these.

CAMHS

Areas of good practice:

- The Brent CAMHS service ran the targeted mental health in schools (TaMHS) programme. They worked to support school staff to recognise young people with emotional wellbeing and mental health needs. They provided access to advice and consultation from a professional in mental health.
- Incident reporting and learning from incidents was apparent across teams. Staff had been trained and knew how to make safeguarding alerts. Staff managed medicines well.
- Young people referred to teams were seen by a service that enabled the delivery of effective, accessible and holistic evidence-based care.
- Staff demonstrated their commitment to ensuring young people received robust care by being proactive and committed to people using the service, despite the challenges with limited resources.
- There was strong leadership at a local level and service level across most of CAMHS that promoted a positive culture within teams.
- There was a commitment to continual improvement across the services.
- Young people were used on interview panels and had been involved in developing interview questions.

Areas for improvement:

0 x 'must do's'. 0 x 'should do's'

This section contains actions that are being taken, or are already in progress, in response to the findings presented in the CQC reports. Our conversations with you will help shape these actions and deliver a robust action plan back to the CQC.

The following actions are underway to address the 'Must do's' and 'Should do's':

Safe environment and safe care:

- The Team reviews Care Plans and Risk Assessments weekly at the Clinical Review Meeting.
- Monthly audits completed by Team Doctor and staff members.
- Where blind spots/lines of sight is an issue, works to place mirrors and address blind spots has been completed.
- Ligature risks have been identified in each ward and documented in risk registers held in each of these clinical areas. Ligature risk competency framework and training programme has been developed. Staff have been assessed against the framework and forms part of their clinical supervision.

- There is a Trust Wide Ligature removal programme led by one of the corporate Estates Officers, who oversees this programme. The programme is then reviewed at regular estates meeting.
- The ligature risk audit is completed on an annual basis and this is led by the Trust Health and Safety Department and the Estates Team. The above programme is monitored by the service manager.
- Datix incident reports are monitored by the Matrons and service manager and all episodes of self-harm are responded to with the individual team (including Consultant Psychiatrist) providing assurance on care and treatment plans.
- The Trust Risk Assessment policy includes a review of suicide and self-harm risk and individual patients presenting with ligature tying risks, or general risk of suicide or self-harm are identified and these issues are managed across the Multi-Disciplinary Teams on an ongoing basis.
- The observation and engagement policy provides the practice framework for managing self-harm risk via therapeutic engagement and enhanced one to one observation for patients identified as presenting significant self-harm risks
- Statistics on the use of close observation are monitored via the daily Trust wide bed capacity reports.
- Since May 2015, fortnightly audits are being carried out by the Divisional Governance Team to monitor the completion of vital signs monitoring following rapid tranquilisation, and the reason is specified. The results, by clinical team, are fed back to ward managers and the lead clinician for immediate follow up action, and are discussed at team meetings, handovers, and during staff supervision. Results are monitored by the Divisional Director of Nursing.
- The Trust has undertaken a Security Review of all acute in-patient wards: the report from this was agreed by the Operations Board, chaired by the Chief Operating Officer on 23rd April 2015.
- As a result, the actions we are implementing have been designed to support a reduction in the number of people absconding from the wards and has set a target to reduce this by 50% by 1 April 2016.
- The Trust has designed an e-learning package that will be essential to role for all staff, to be completed prior to working with the inpatient environment. This training package will now be delivered and fully implemented by 19 October 2015. The delay in delivery is due to technical issues with the training platform. The training will be delivered to all existing staff over a 8 weeks and new staff will complete this as part of their local induction. Where agency staff are employed, hardcopy versions will be delivered by ward managers. The Trust has put in place interim Security and Safety Guidance; this has been distributed to all staff working at acute inpatient sites until the e-learning package is fully implemented.
- A Security Review has been completed; this identified that 'tailgating' (i.e. closely following a visitor or staff member through an exit) is a primary cause of absconsion.
- Work has been completed to remove all door release buttons, located in nursing offices, to assist in the prevention of tailgating and guidance on relational security is included in the Interim Security and Safety Guidance, to ensure that a member of staff is by the ward entrance door to greet visitors or authorise guests.
- A review of the physical security infrastructure has been conducted and works at those sites identified by the CQC have been prioritised. There are plans for additional doors to increase the 'layered approach' to security (i.e. the additional doors will combine with existing security controls to further minimise the risk of absconsion) where necessary.This work will be completed by 5th December 2015. The remote door release has been removed from all the doors, this means that only staff with a swipe card reader can enter or exit the ward. All other individuals will need to be let on or off the ward.
- Work is ongoing with inpatient staff (multi-disciplinary teams) to ensure that where risk of absconsion for a patient is identified as a result of a risk assessment that the risk management plan is reflected in the patient's care plan. This is being addressed through local Quality Governance Groups and Team Meetings. Care plans are regularly audited by Ward Managers and Clinical Team Leaders.
- The AED Standard Operating Protocol clarifies that staff are to keep a record of daily checks on the AED including that:

  i - it is in place and serviceable with a green light displayed on the AED

  ii - the attached pads are in date

  iii - a razor and shears are immediately available with the AED

  iv - There is immediate access to spare pads and battery or an alternative AED
- Team Managers will monitor that these checks are being recorded and sign the completed forms each month. The AED Standard Operating Procedure has been circulated to all adult community mental health teams, which includes the explanation around AED maintenance and that an annual maintenance check is expected from BCAS and that this will be reflected on the sticker on the AED.
- Audits are completed to ensure each risk has an associated care plan results are fed back to care coordinators and where risks are found without a care plan remedial action is taken.
- All service users have their physical health care needs assessed on initial assessment and then every 6 – 12 months.

Brent

Dignity and privacy:

- Private patient telephone calls: Access to private phone calls is available for all patients. This is via cordless telephones, telephone booths or the ability to make mobile phone calls from patient bedrooms.

Staffing:

- There is a local Lone Working Policy for Brent HTT. This is under review currently to incorporate an alert system. The local policy will be in line with the new Trust wide Lone Working Policy.
- Staffing levels are adjusted reflecting the changing clinical risks and patient number of a ward to ensure patient safety and comfort. This is monitored and reviewed on a daily basis.
- All team members have access to regular clinical supervision and this is being monitored by matrons.

Safeguarding service users from abuse and patients not being protected against the risk of unsuitable control or restraint:

- The Trust is now training all relevant staff who may be required to use physical intervention in the delivery of an alternative technique to the prone restraint position.
- As of 28 August, 98% of staff have been trained in the alternative supine position
- Where wards have seclusion rooms a seclusion log is in place, which is completed on every episode of seclusion.

Care and welfare of people who use services:

- There is an HTT service user questionnaire to collect feedback from service users. The feedback is evaluated and fed back on a monthly basis.
- The Trust will explore other relevant formats for care plans to be provided in a more accessible format to meet the accessibility requirement of patients.

Bed Management:

- Bed availability is reviewed at weekly bed management meetings and through the scrutiny of daily out of hours senior manager on call reports with a process of escalation to address any delays.
- **Local ownership:** bed occupancy is discussed at least twice daily with Borough and Clinical Directors
- New Place of Safety Project underway and led by Estates. A separate entrance will be provided in the new suite.
- The number of patients who have slept out or been moved has reduced to a minimal level.
- The overall aim of the Trust's bed management process is to reduce the bed occupancy rate to 95% by 1 June 2016.
- Immediate Actions we have taken:
  - **Stopped admission** of adults to older adult wards
  - **Greater central oversight:** set up centrally-led 3 x weekly bed management meetings, chaired by the Chief Operating Officer, at which we discuss/review:
    - all 4, 8, 12, 24 and >24 hour breaches;
    - monitor the number and reasons for patients staying over 60 and 100 days;
    - community and home treatment team engagement in preventing unnecessary admissions, and
    - community team provision of support in progressing delayed discharges and work together to resolve unnecessary delays.
  - **Escalation process** both in and out of hours to manage patient flow put in place.
  - **Improved information flow:** twice daily (morning and evening) bed state disseminated across the Trust
  - **Use of ECR beds:** we are using ECR beds as and when necessary with the support of funding from commissioners - these conversations are ongoing.
  - **Engagement of stakeholders:** Borough Directors are currently working closely with our local authority and commissioner colleagues in managing delayed discharges. This is on-going.

Quality of service provision:

- Care plans have been reviewed ensuring crisis plans are in place.
- Quarterly Peer Audits of Crisis Plans commenced July 2015.

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Complaints:

- New complaints posters and leaflets have been designed and displayed in patient/public areas.
- Spot checks by service managers/matrons to ensure these posters are up and leaflets available to patients, special confirmation to be received from the Ward managers for PICU's.
- Our new DatixWeb system is used to capture all patient feedback, including concerns and complaints, verbal and written. DatixWeb allows regular reports to check verbal concerns and complaints are being logged and acted on.

Staff have been briefed of this requirement via the Trust's weekly news, and a series of communication and this is supported by the new Patient Feedback Policy.

The revised Patient Feedback Policy and procedure has been launched and includes the requirement to record verbal feedback.

- Informal complaints are discussed as they come in will be discussed at the monthly community quality and management team meeting.

Respecting and involving service users:

- Patient capacity to make a decision is audited fortnightly using a proforma.

CAMHS:

- Triage system is in place; process in place reiterated to staff which is beginning to address the high demand on the service.
- The service has reissued and discussed the Lone Working Policy and procedures and managers have been asked to review alarm systems.
- Care and Crisis Plan - all staff reminded to discuss this with service users and record that this has been done. Service users to be given a crisis card.

Discussions from the Quality Summit to be taken forward in partnership with commissioners and other stakeholders.

- Urgent Pathway Business Case: Pathway into services - objective to provide 24/7 home treatment. Need to think about **how different pathways link up** when we set services up. HTT add something but is a beginning, **need to develop good strong interfaces**.
- Large organisation need a standardisation of process but commissioners want something local - this is the challenge. Not about just co-producing with CCG and GP's in primary care. Relationships developed between primary and secondary care - what to do in crisis. Need to do a level of comms and engagement - this is the way you access things in practice.
- CCG - Referral optimisation: soft ware to standardise the way GP's refer into services.
- Redesign trying to standardise case loads and outcomes.
- Emergency duty teams: not going to be big enough to do all the social care, need to think more broadly than that. Large proportion is children. **A lot of crisis is social care. Business case was too health / medically orientated**.
- From day one **planning for discharge** from community teams. Communicating expectations to the patient to start off with.
- Learning Disabilities: Services feel very unable to respond to crisis - **building LD into crisis care and urgent care services**.
- **Housing:** sharing programme developed in Brent; maximising nominations rights; specific post focusing on this with clear targets in relation to housing. Monitoring how people are maintaining tenancy; Incentive payments; discussion re placing people who are on housing benefit. Inpatient housing surgery at Park Royal.
- **Acute redesign** addressing length of stay and safer discharge. Care plan should outline what you would do in a crisis; contingency. Well being planning. Problem - share cared pathway - GP also without capacity
  - o **Action:** Clinical Workshop with local GP's to see how the GP and secondary care can work together to discharge to primary care.
  - o **Action:** Inviting key GP's who have had a lot of mental health experience. CCG happy to facilitate clinical discussions and have some targeted sessions.

Brent	**Scrutiny Committee** 9th September 2015 **Report from the Chief Operating Officer**
For Action	Wards Affected: ALL

Covering Report for Scrutiny Task Group on Access to extended GP services and primary care in Brent

1.0 Summary

1.1. 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).

1.2. 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. As part of this work the task group also reviewed information relating to the local health profile, primary care workforce and delivery of preventative services.

1.3. 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 in making recommendations.

2.0 Recommendations

2.1. The Scrutiny Committee consider the contents of the report.

2.2. The Scrutiny Committee approve the 14 recommendations made by the task group and support the development of an action plan across partner organisations to take these forward.

2.3. The Scrutiny Committee agree to receive a progress report against the recommendations in six months time.

3.0 Detail

3.1. The task group set out to understand the needs of Brent residents in relation to accessing primary care and how local services are meeting these needs. In doing so, the task group reviewed the capacity within the GP network to provide enhanced extended primary care and any actions required in ensuring effective primary care services and fair and equitable access for all. Key areas of focus were agreed during the work of the task group, these included:

- Demand for primary care;
- Access to primary care in Brent;
- Delivering the out-of-hospital strategy;
- Developing an integrated care approach;
- Investing in the primary care workforce;
- Responsive urgent and emergency care; and
- Focusing on health and wellbeing.

3.2. In reviewing the areas outlined above, 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 carried out between January and March 2015. This was supported by the analysis of data relating to the local health profile and services.

Demand for primary care

3.3. Evidence presented to the task group highlighted the pressure that GPs are under in meeting increasing demand for services. In Brent, a growing population and the projected increase in the number of older people provide additional challenges. The total number of registered patients appears to be growing faster than the resident population. A high population churn and the high number of migrant patient registrations with GP practices also place additional pressure on services.

Access to primary care in Brent

3.4. Access to GP services appears to vary across the borough, with a range of GP to patient ratios and surgery opening times at practices. The most recent patient survey indicates lower patient satisfaction rates in Brent compared to the national average in relation to accessing primary care and low levels of awareness of services out of hours. The task group feels new opportunities to extend the roll-out of alternative models of access, including Skype and FaceTime consultations, email appointments and e-prescriptions, would be of benefit to Brent's residents.

3.5. Recent investment in extended GP services to deliver evening and weekend appointments has supported the development of GP Access Hubs across the

borough. In March 2015, the hubs had offered over 70,000 additional appointments[1]. Following the pilot phase, a new contract came into effect in April 2015. Performance data has shown an improvement in the take-up of appointments in comparison to the pilot scheme but utilisation is still below target levels of 85%. This raises questions regarding the awareness of the hub model and the extent to which the model is fully meeting the needs of the local population.

Delivering the out-of-hospital strategy

3.6. Brent CCG outlined their out-of-hospital strategy in 2012. The strategy set out five main areas of action including easy access to primary care, clear and planned pathways, rapid response to urgent needs, joint working across health and social care and supported discharge from hospitals.

3.7. The impact of Brent Short Term Assessment Rehabilitation and Reablement Service (STARRS), with targets for preventing hospital admissions being exceeded, was highlighted as an area of success in evidence provided to the task group. However, other community based services, including the Community Ophthalmology Service, Brent Integrated Diabetes Service and Sickle Cell Service are in the early stages of implementation and the impact of these services has not yet been assessed.

Developing an integrated care approach

3.8. The benefits of a multi-disciplinary approach in supporting the delivery of primary care in Brent was acknowledged by the task group. This includes a clear need for a coordinated role across health, social care and the voluntary sector in supporting people with long-term conditions. A key concern for the task group is ensuring that the patients' needs are central to this role.

Investing in the primary care workforce

3.9. A national programme is in place to expand the primary care workforce. In Brent, there has been a reduction in the number of full time equivalent (FTE) GPs between 2013 and 2014, from 208fte to 200fte[2], and there is a higher proportion of GPs in older age groups (65 and over) compared to London and England. This raises concerns regarding any potential shortfall in capacity in the future and the further strain it would place on services already under pressure.

Responsive urgent and emergency care

3.10. There has been a general increasing trend in Urgent Care Centre (UCC) and walk-in centre attendances, however, it is felt that there is still further work required in raising awareness of services across the borough. These services are required to offer a breadth of expertise. During a visit to the UCC at

[1] Brent CCG
[2] HSCIC

Central Middlesex Hospital, the task group were able to see the additional facilities commissioned in providing healthcare.

Focusing on health and wellbeing

3.11. During the review, there were a number of examples shared in which patients attend appointments unnecessarily and where 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. It is recognised that 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.

3.12. It was highlighted that there are a number of areas which create additional workload; 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.

Recommendations

3.13. In light of the findings of this review, the task group make the following recommendations.

1. NHS England, Brent CCG and local GP networks carry out a review of current GP opening hours across the borough and consider additional ways of accessing GP services, including the roll-out of Skype and FaceTime consultations, telephone consultation and email consultations where appropriate and within Information Governance principles. Online appointment bookings and e-prescription ordering have been enabled in all Brent GP practices and patients should be encouraged to take up these services.

2. NHS England and Brent CCG produce an action plan including opportunities for sharing of good practice across networks in improving patient experience when making appointments and contacting the surgery by phone, with a view of improving patient satisfaction rates in the next GP patient survey.

3. Brent CCG and NHS England clarify the out of hours element of the GP contract for people in Brent and publicise out of hours services across the borough given the lack of information and awareness by local residents highlighted in the most recent GP patient survey.

4. Brent CCG develops a written protocol between GP practices and GP Access Hubs for the receipt of hub attendance reports to ensure continuity of care and minimise the risk of fragmentation of primary care health services.

5. Brent CCG carries out a detailed review 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 and UCC attendances.

6. That the review, outlined in recommendation five, includes public engagement to assess the extent to which the model reaches and benefits all residents in any part of the borough, including vulnerable groups, and to determine public support for the model.

7. Brent CCG carries out a rolling programme of evaluation of the impact of the out-of-hospital strategy against individual contractual arrangements for services.

8. Brent CCG outlines its plans to commission any additional community services to support primary care to meet the needs of Brent residents in the community following its support for changes to hospital care.

9. Brent CCG in partnership with Brent Council's Adult Social Care Department review the job description of care coordinators, including the breadth, key requirements and core competencies of the role currently being piloted to ensure these can be fulfilled.

10. Brent CCG in partnership with LNWHT Community Services investigate the extent of the gap in recruitment and retention of district nursing in Brent and consider the need for a programme to support district nursing, focused on ensuring an effective, motivated, independent and responsive service is in place.

11. Healthwatch Brent to work with providers to develop a clear communication strategy for ensuring the public are aware of and informed of the Urgent Care Centres available to the residents of Brent, as well as the services provided at Central Middlesex Hospital.

12. Care UK and London North West Healthcare NHS Trust review access to the Urgent Care Centre at Central Middlesex Hospital, including the introduction of clearer road and access signs for the Urgent Care Centre and a review of the cost of parking at the centre.

13. Brent Council, Brent CCG and Healthwatch Brent develop a communication strategy with targeted activities across the borough, including establishing links with schools, workplaces and local faith groups, in promoting the right access to services, raising awareness of the range of services available and promoting self care. This should include using a range of communication methods across our diverse communities.

14. Brent Council's Public Health Department continues work with NHS England and Brent CCG to improve the take up of preventative services, including health checks.

3.14. The task group recognises that these recommendations will need to be implemented in partnership across agencies and with the support of patients and the public. It is proposed that this is managed through a joint action plan.

4.0 Financial Implications

4.1 None

5.0 Legal Implications

5.1 None

6.0 Diversity Implications

6.1 The recommendations outlined in the report will have positive impacts on Brent's communities and aim to improve access to primary care and promote self care.

7.0 Staffing/Accommodation Implications (if appropriate)

7.1 There may be implications for key organisations in implementing the recommendations set out in the report, including Brent Council, Brent Clinical Commissioning Group, NHS England and local service providers. Any staffing or accommodation implications would need to be identified during the development of the action plan in taking the recommendations forward, with a proposal that these are reviewed by the relevant lead organisation.

Background Papers

Access to Extended GP Services and Primary Care in Brent - Interim Report (June 2015)

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Access to extended GP services and primary care in Brent

A Scrutiny Task Group Report

September 2015

Membership

Councillor Reg Colwill (Chair)
Councillor Amer Agha
Councillor Rita Conneely
Councillor Mary Daly
Councillor Claudia Hector
Councillor Wilhelmina Mitchell Murray

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GLOSSARY OF TERMS

A&E	Accident & Emergency
BCF	Better Care Fund
CCG	Clinical Commissioning Group
GP	General Practitioner
HSCC	Health and Social Care Coordinators
HSCIC	Health and Social Care Information Centre
GP Access Hub	GP practice offering 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.
LAS	London Ambulance Service
LLMC	Londonwide Local Medical Committees *An overarching organisation providing strategic leadership, support, administrative, secretarial, communications and educational services to 27 of London's 32 LMCs.*
LMC	Local Medical Committee *A borough-based elected representative statutory body.*
LNWHT	London North West Healthcare NHS Trust
MDG	Multi Disciplinary Group
NHSE	NHS England
NWL	North West London
SaHF	Shaping a Healthier Future
STARRS	Short-term Assessment, Rehabilitation and Reablement Service

CHAIR'S FOREWORD

The Scrutiny task group was established to review the implementation of the primary care element of Brent Clinical Commissioning Group's transformation programme and examine access to primary care services in the London Borough of Brent.

The task group was concerned with the capacity in Brent and the ability of local services to meet demand and ensure fair and equitable access to primary care services.

Brent's population is rising and we recognise the significant pressures on general practice as well as the central role it plays in the local healthcare system. The growing demand for primary care is impacted by an ageing population, an increase in long-term conditions and changing patient expectations. To address concerns with access to services we need ongoing investment in general practice and innovative ways of meeting demand for primary care. We also need to continue to promote health and wellbeing and encourage our local residents to support themselves wherever possible.

Our ambition is for Brent to be a borough in which people live well, with access to high quality healthcare when they need it. Recent initiatives have been established to increase capacity and deliver improved access to primary care, including the development of GP Access Hubs across the borough. The task group supports the development of extended primary care services where these offer local residents improved access and a choice of services to best meet their needs but we feel that access still remains a concern in Brent. The report outlines key recommendations from the task group findings and we urge the Council, Brent Clinical Commissioning Group, NHS England and partner organisations to implement the recommendations of the task group in full.

I would like to thank everyone who participated in our work, including patient group representatives, officers, local commissioners and service providers. In particular I wish to thank local GPs, Health and Social Care Co-ordinators and Multi Disciplinary Groups for taking the time to meet with the task group. Thanks also to staff from the Urgent Care Centre at the Central Middlesex Hospital and representatives from Brent Clinical Commissioning Group, Central London Clinical Commissioning Group, NHS England, the Londonwide Local Medical Committees, Local Medical Committee, London Ambulance Service, Brent Patient Participation Groups and Healthwatch Brent for their participation in this review. I would also like to acknowledge the contribution from officers in Brent Council's Policy Team and Research and Intelligence Team in supporting the work of the task group and helping prepare this report.

A final thank you to my task group colleagues for their time and valuable contributions to this review – Cllr Agha, Cllr Conneely, Cllr Daly, Cllr Hector and Cllr Mitchell-Murray.

Cllr Reg Colwill
Chair, Access to Extended GP Services and Primary Care in Brent

EXECUTIVE SUMMARY

Good access to primary care services across the London Borough of Brent is central in ensuring local residents receive the right care, in the right setting, at the right time. Demand for primary care is growing and population projections for Brent suggest an ongoing increase in resident numbers, placing increasing pressure on GP services already under strain. The projections also show changes in the age profile of residents with an increase in the number of older residents resulting in additional challenges for both health and social care services.

The purpose of the task group was to review access to extended GP services and primary care in Brent. The review was concerned with the capacity in Brent, out of hours care and the delivery of out-of-hospital services to provide enhanced and extended care to meet the needs of local residents as acute hospital care is reduced as proposed by Shaping a Healthier Future (SaHF). 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.

Key areas of focus were agreed during the work of the task group and are outlined within the report. For each key area, the task group has reviewed the views of participants and evidence gathered in drawing conclusions and making recommendations. These key areas include:

- Demand for primary care;
- Access to primary care in Brent;
- Delivering the out-of-hospital strategy;
- Developing an integrated care approach;
- Investing in the primary care workforce;
- Responsive urgent and emergency care; and
- Focusing on health and wellbeing.

Evidence presented to the task group highlighted the pressure that GP services are under in meeting increasing demand for services. These pressures will not go away with other factors impacting on healthcare services both now and in the future. As mentioned above, a growing population and the projected increase in the number of older people provide additional challenges, as well as the deprivation level in the borough and high population churn. Brent has a high number of migrant patient registrations with GP practices. The total number of registered patients at GP practices also appear to be growing faster than the resident population.

Brent Clinical Commissioning Group are carrying out a programme to transform how primary care is delivered in Brent, focusing on delivering more health care in the community and improving access to GP services. This has included the development of a new hub model to deliver extended GP services in Brent. The model is offering additional capacity in the evenings and at weekends but, with take up below target levels, it needs to be assessed to measure the extent to which it is meeting the needs of all residents. Addressing increasing demand will require ongoing work to look at flexible ways in which people can access primary care, including GP opening hours, e-prescriptions, Skype and FaceTime consultations, as well as out-of-hours and extended access. The task group believes the ability to deliver primary care services that meet the needs of local people, improve patient experience and reduce dependency on urgent and emergency care requires involvement of residents in the design of new solutions.

RECOMMENDATIONS

In light of the findings of this review, the task group make the following recommendations. The task group recognises that these recommendations will need to be implemented in partnership across agencies and with the support of patients and the public.

Recommendations are categorised under the following key areas.

Access to primary care in Brent

1. NHS England, Brent CCG and local GP networks carry out a review of current GP opening hours across the borough and consider additional ways of accessing GP services, including the roll-out of Skype and FaceTime consultations, telephone consultation and email consultations where appropriate and within Information Governance principles. Online appointment bookings and e-prescription ordering have been enabled in all Brent GP practices and patients should be encouraged to take up these services.

2. NHS England and Brent CCG produce an action plan including opportunities for sharing of good practice across networks in improving patient experience when making appointments and contacting the surgery by phone, with a view of improving patient satisfaction rates in the next GP patient survey.

3. Brent CCG and NHS England clarify the out of hours element of the GP contract for people in Brent and publicise out of hours services across the borough given the lack of information and awareness by local residents highlighted in the most recent GP patient survey.

4. Brent CCG develops a written protocol between GP practices and GP Access Hubs for the receipt of hub attendance reports to ensure continuity of care and minimise the risk of fragmentation of primary care health services.

5. Brent CCG carries out a detailed review 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 and UCC attendances.

6. That the review, outlined in recommendation five, includes public engagement to assess the extent to which the model reaches and benefits all residents in any part of the borough, including vulnerable groups, and to determine public support for the model.

Delivering the out-of-hospital strategy

7. Brent CCG carries out a rolling programme of evaluation of the impact of the out-of-hospital strategy against individual contractual arrangements for services.

8. Brent CCG outlines its plans to commission any additional community services to support primary care to meet the needs of Brent residents in the community following its support for changes to hospital care.

Developing an integrated care approach

9. Brent CCG in partnership with Brent Council's Adult Social Care Department review the job description of care coordinators, including the breadth, key requirements and core competencies of the role currently being piloted to ensure these can be fulfilled.

Supporting the primary care workforce

10. Brent CCG in partnership with LNWHT Community Services investigate the extent of the gap in recruitment and retention of district nursing in Brent and consider the need for a programme to support district nursing, focused on ensuring an effective, motivated, independent and responsive service is in place.

Responsive urgent and emergency care

11. Healthwatch Brent to work with providers to develop a clear communication strategy for ensuring the public are aware of and informed of the Urgent Care Centres available to the residents of Brent, as well as the services provided at Central Middlesex Hospital.

12. Care UK and London North West Healthcare NHS Trust review access to the Urgent Care Centre at Central Middlesex Hospital, including the introduction of clearer road and access signs for the Urgent Care Centre and a review of the cost of parking at the centre.

Focusing on health and wellbeing

13. Brent Council, Brent CCG and Healthwatch Brent develop a communication strategy with targeted activities across the borough, including establishing links with schools, workplaces and local faith groups, in promoting the right access to services, raising awareness of the range of services available and promoting self care. This should include using a range of communication methods across our diverse communities.

14. Brent Council's Public Health Department continues work with NHS England and Brent CCG to improve the take up of preventative services, including health checks.

We recognise the work required in implementing these recommendations in full. It is hoped that these can be delivered through active collaboration with Council colleagues and support from the Brent Health and Wellbeing Board.

1. INTRODUCTION

The Scrutiny Task Group was established to review the implementation of the primary care element of the the transformation programme and examine access to primary care services in light of Shaping a Healthier Future (SaHF). The review was concerned with the capacity in the London Borough of Brent, access to out of hours care and the delivery of out-of-hospital services to provide enhanced and extended care to meet the needs of local residents as acute hospital care is reduced as proposed by SaHF. 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.

Brent Clinical Commisisoning Group (CCG) and London North West Healthcare NHS Trust are changing the way healthcare is provided in Brent. These plans are reflected in the CCG's draft five year strategic plan (2014) and is a direct response to the proposals contained within the SaHF document for North West London.

There are three major transformational programmes:

- Shaping a Healthier Future – the 'reconfiguration' of hospital services, including a reduction in the number of available hospital beds;

- Primary Care Transformation – focusing on the provision of health care in the community and more primary care services, including initiatives to deliver better access to GP services; and

- Whole Systems Integrated Care – joining together health and social care to provide more integrated health services to patients.

The plans set out major changes for the way in which healthcare is delivered, reducing dependance on acute hospital services and reinvesting in primary and community care. The three programmes have many interdependencies. The intention is for hospitals to concentrate on providing specialist services. Other services will be provided in a community setting, which will require the expansion of capacity in primary care, and a greater link between health and social care to ensure patients receive a more integrated and coordinated service, meeting both health and social needs and preventing more acute interventions.

The North West London draft five year strategic plan outlines that the scale of change required in primary care to achieve quality, patient experience and financial objectives is significant. To ensure that the changes to hospital services are implemented successfully, there is an increased need for effective and accessible primary care to deliver out of hospital care, deliver improved access and meet rising patient expectations. This includes new models for primary care, including access to extended GP services through locality networks and where appropriate across all Brent practices by networks working jointly.

2. TASK GROUP MEMBERSHIP

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

3. METHODOLOGY

The aim of the Scrutiny task group was to assess the progress of primary care transformation in Brent, including investment in Brent GP networks and primary care services, in order for this to address the reduction in the acute services as proposed by SaHF.

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?

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.

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 the Brent CCG 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, Londonwide Local Medical Committees 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 (MDG) 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 can be found in section seven of this report.

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.

4. BACKGROUND AND POLICY CONTEXT

4.1 The local picture

Brent is an outer borough in North West London. It has a long history of ethnic and cultural diversity, which has created a place that is truly unique and valued by those who live and work in the borough. Brent has a young, dynamic and growing population.

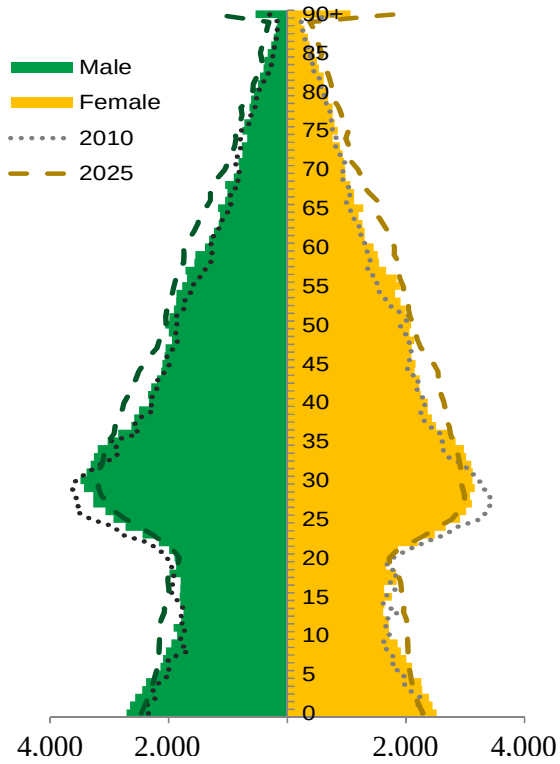
Brent's population

Brent's population increased by 1.7% from 311,215 in 2011 to 320,190 in 2013[1]. Population projections for Brent show a continued increase, with the population rising by 10,456 over the next five years, from 320,781 in 2015 reaching 331,237 in 2020, an increase of 3.3%[1].

➢ **Age**

Brent has a large proportion of people aged under ten and between 25 and 35 years of age. Currently the under tens make up 14.1% of the population; this is projected to decrease to 12.8% in 2025. Those aged between 25 and 34 make up 19.7% of the population; this is also expected to decrease over the next ten years to 17.5%. The older population has increased since 2010 and is projected to increase further. The number of people aged 65 and over has increased from 32,593 in 2010 to 36,045 in 2015. This cohort is projected to increase by 9,081 to 45,127 in 2025, a percentage increase of 25.2%. Looking more closely at the older population, those aged between 85 and 89 are projected to increase by 48.5% from 2,905 in 2015 to 4,313 in 2025 and those aged 90 and over, by 90.3%, from 1,607 to 3,057.[1]

Figure 1: Population by age and gender 2015[1]

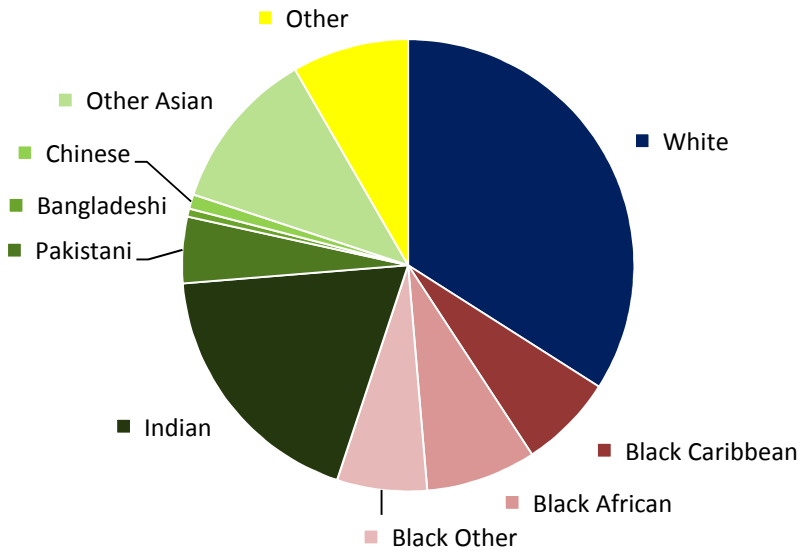


[1] GLA SHLAA based population projections 2013 rnd

➢ Ethnicity

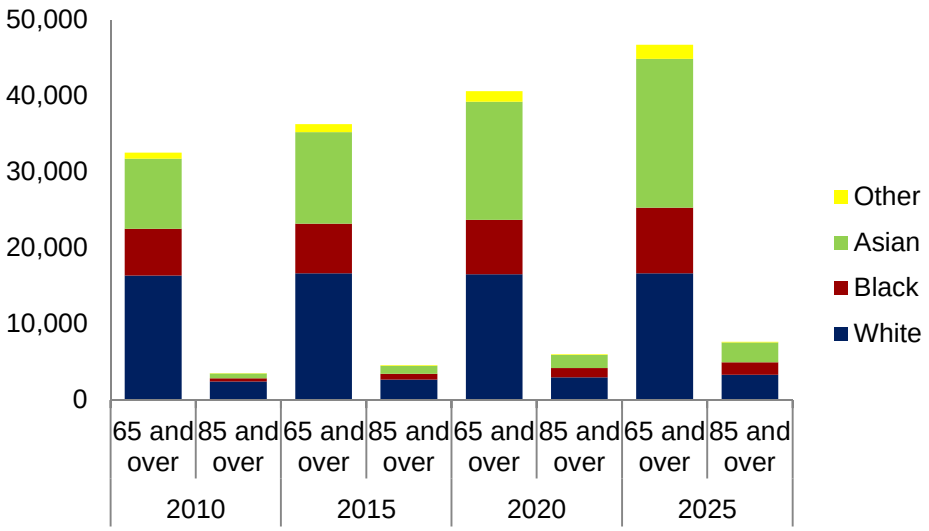
Brent is an ethnically diverse borough. In Brent, the black, Asian and minority ethnic (BAME) groups make up 65.0% of the population, compared to 41.8% in London[1]. About one third (37.0%) of the population are Asian; 34.0% white and 21.1% black[1].

Figure 2: Ethnicity profile 2015[1]



Currently the population aged 65 and over is predominantly white (45.9%). Although the numbers of white people aged 65 and over remains at around 16,000, the proportion is projected to decline to 35.7% in 2025[1]. The numbers and proportion of Asian people aged 65 and over will increase from 33.1% in 2015 to 41.8% in 2025[1]. The population aged 85 and over has a bigger change, with the number of white people increasing, but the proportion of white people decreasing from 59.2% of the population in 2015 to 43.2% in 2025. Conversely, the proportion of Asian and black people will increase from 22.4% and 16.6% to 33.8% and 21.7% respectively[1].

Figure 3: Change in ethnicity of people aged 65 and over and 85 and over from 2010 to 2025[1]



➢ Migration

Brent has the highest number and population share of non-UK born residents out of all the London Boroughs, 55% of residents were born outside of the UK and 26% of residents have arrived in the borough since 2000[2].

Brent residents who left the borough moved to the East of England and South East, as well as Harrow. More residents came to Brent from Camden and Kensington and Chelsea than migrate there. Results from the Resident's Attitude Survey (September – November 2014) revealed that 30% moved to Brent because the housing was affordable and 25% because friends and relatives were already here.

➢ Length of residence in the UK

In Brent, 44.9% of residents were born in the UK, compared to 63.3% of London residents. Over a quarter (25.7%) of Brent's residents have been resident in the UK for less than ten years.[3]

Table 1: Length of residence in the UK of Brent residents[3]

	Brent		London	
Length of residence in the UK	n	%	n	%
Born in the UK	139,788	44.9	5,175,677	63.3
Less than 2 years	19,332	6.2	368,529	4.5
2 years or more but less than 5 years	26,822	8.6	458,019	5.6
5 years or more but less than 10 years	33,997	10.9	620,600	7.6
10 years or more	91,276	29.3	1,551,116	19.0

➢ Languages

There are 149 languages spoken in Brent, 63% speak English as their main language, 8% Gujarati, 3% Polish, 3% Arabic, 2% Tamil, 2% Portuguese, 2% Somali, 2% Romanian, 2% Urdu and 13% other. In one in five households nobody speaks English as their main language and in Alperton one in 40 households cannot speak English[3].

➢ Deprivation

Brent is ranked amongst the top 15% most-deprived areas of the country[4]. This deprivation is characterised by high levels of long-term unemployment and low average incomes. Children and young people are particularly affected with a third of children in Brent living in low income households and a fifth in single-adult households. The proportion of young people living in acute deprivation is rising. In 2013, Brent had the fourteenth highest rate of child poverty (after housing costs) in the UK, tenth highest in London[5]. In 2014, 30% of Brent households had an annual income of £20,000 or less.[6]

[2] www.ONS.gov.uk Population - migration
[3] 2011 Census
[4] Indices of Multiple Deprivation (IMD) 2010
[5] End child poverty 2013: http://www.endchildpoverty.org.uk/why-end-child-poverty/poverty-in-your-area
[6] CACI 2014

In Brent there are 218,100 working age people. Of these, 159,800, (73.3%) are economically active. Since 2004 the working age population has increased by 37,000 to 218,100. The rate of economically active people in Brent is lower than the rate for London (76.7%) and for the UK (77.4%).[7]

What is the impact for healthcare in Brent?

In order to provide an analysis of the demand and level of need for primary care services in Brent, it is important to gain an understanding of the landscape in which services operate. There are key challenges that will impact on healthcare services both now and in the future, including a growing population, the deprivation level in the borough, the number of children and young people living in low income households, a projected increase in the number of older people and high population churn.

A more detailed analysis of the health profile of the borough is outlined in section 5.1. However, it is important to highlight the impact of these key challenges including an increased demand on local primary care services as a result of a growing population.

Population projections indicate that the number of older people in Brent is increasing. Figures outlined above show that between 2011 and 2013, the largest increase was in people aged 85 and over. This places increased pressure on both health and social care services.

Transformational programmes to improve healthcare in Brent

Brent CCG and North West London plan to 'transform' the way health care is provided in Brent. There are three major transformational programmes being carried out in Brent. These include SaHF, Primary Care Transformation and Whole Systems Integrated Care.

The SaHF Programme, officially launched in 2012, set out a vision for the future of how services are delivered across North West London. The programme was established to address inconsistencies and variations with current systems, as well as meeting changing demands of the local population. The programme envisages a shift from hospital and secondary care to primary and community care.

In 2012 NHS NWL CCGs outlined their commitment to changing healthcare in the NHS NWL Case for Change (February 2012). The transformation of care across the eight NWL boroughs (Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster) included the reconfiguration of services with an emphasis on investing in primary care services and providing more services in the community. This involves changing the way services are provided across hospitals, GP practices and other community care sites, focusing on integrated care delivered through a partnership between health and social care, and more investment in GP services and other local healthcare. Self management is also viewed as playing a central role in the transformation of services. A focus of the service redesign is on people taking care of themselves and accessing treatment in the community and managing their own conditions.

[7] Brent Diversity Profile – Labour Market. Work patterns in Brent 2015

Table 2: Transformation programmes

Programme	Details	Proposed outcome	What does this mean for Brent?
Shaping a Healthier Future	The reconfiguration of hospital services	Centralised services to support specialist and improved outcomes. More health services available out of hospital, in settings closer to patients' homes seven days a week	Changes for Northwick Park Hospital and Central Middlesex Hospital, including the reduction of acute beds
Primary Care Transformation	Making it easier to see a GP and making more treatments available in a community setting	Patients have access to General Practice services at times, locations, via channels that suit them seven days a week	More services delivered on a network basis New IT capability to offer electronic prescriptions, electronic bookings and online consultations GP Access Hubs offering appointments evenings and weekends
Whole Systems Integrated Care	Joining together health and social care to provide more integrated health services to patients	Patients with complex needs receive high quality multi-disciplinary care close to home, with a named GP acting as a care-coordinator	A care plan for people with a long-term condition, with support from Health and Social Care Coordinators

In a report to the Overview and Scrutiny Committee in August 2014, Brent CCG outlined their ambition to increase the effectiveness and capacity of primary care in the borough. The CCG stated that this will provide all patients with:

> *Coordinated care* – 'providing patient-centred, coordinated care and GP-patient continuity'
>
> *Accessible care* – 'providing a responsive, timely and accessible service that responds to different patient preferences and access needs'
>
> *Proactive care* – 'supporting the health and wellness of the population and keeping people healthy'
>
> *Convenient care* – 'provided at a range of centres, including some local GP centres and community settings'[8]

The report also highlighted constraints on practices, including a lack of staff and space, placing an emphasis on moving towards delivering primary care in networks to maximise potential for delivering extended services.

[8] Brent CCG's Transformational Programme for Health Services in Brent. Report to the Overview and Scrutiny Committee (August 2014).

It is acknowledged that operational models for delivering out-of-hospital strategies will differ between CCGs but the delivery of out-of-hospital care should be based on a set of agreed principles, outlined in the NWL CCG draft five year strategic plan:

Urgent

- Patients with urgent care needs provided with a timed appointment within four hours;
- Patients with non-urgent needs offered the choice of an appointment within 24 hours, or at their own practice within 48 hours;
- Telephone advice and triage available 24 hours a day, 7 days a week through the NHS 111 service.

Continuity

- All individuals who would benefit from a care plan will have one;
- Everyone who has a care plan will have a named 'care co-ordinator';
- GPs will work in multi-disciplinary networks;
- Longer GP appointments for those who need them.

Convenience

- Access to General Practice 8am to 8pm (Monday to Friday) and 6 hours per day during the weekend;
- Access to GP consultation in a time and manner convenient to the patient;
- Online appointment booking and e-prescriptions available at all practices;
- Patients given online access to their own records;
- Online self-management advice, support and service signposting.

In April 2014, 20 GP pilots were announced nationally; this included all eight CCGs in North West London who were awarded £5 million from the Prime Minister's Challenge Fund to support schemes to make it easier for patients to see their GP. The aim of this funding was to provide capacity for networks to focus on planning and IT capability, and to support practices working together in order to provide extended opening hours, weekend opening and better use of technology. Brent received a total of £958,000, allocated to the four networks of Harness, Kilburn, Kingsbury & Willesden and Wembley for their development.

Continued support for the GP networks is outlined within Brent CCG commissioning intentions 2015 – 2016; this includes support in developing enhanced services in primary care and continuing to develop out-of-hospital services. The continued provision of extended opening hours is also outlined in the commissioning intentions.

Potential impact for residents

It is important to understand the impact of these changes on the local population. Local residents will also need to be informed of how changes to services may affect them. Between 2012 and 2014 consultation and evaluation was carried out on proposals. This included a strategic review of the equalities impacts of proposals under SaHF, commissioned by NHS North West London in 2012.

The equalities impact assessment was carried out at a strategic level and was based on the population across North West London. The findings of the review carried out by Mott MacDonald (2012) highlighted that clinical evidence showed a proportionally higher rate of demand for some or all services under review among children (under 16), young people (16

to 25), older people (65 and over), disabled people, particularly those with learning disabilities and mental health conditions, and gender reassignment[9].

Through the evaluation of the overall impact of SaHF proposals potential negative impacts were identified. These included loss of hospital familiarity and meeting the specific needs of equality groups, the period of transition which could create some confusion amongst the population, patient – clinician relationships and longer journey times to access emergency care.

As a result of the proposed changes to acute provision, the review highlighted that the impact of longer journeys is more likely to affect people with disabilities and older people for who travel can be more challenging. The assessment identified that women are also more likely to travel by bus, foot, community transport or taxi than men. BAME residents are also more at risk in terms of longer journey times as they are less likely to live in a household with a car. Deprived communities are less likely to have their own private transport. However, the review identified that this is more likely to impact visitors than patients, with patient journeys more likely to take place by ambulance. Mitigation and opportunities to address the potential negative impacts were outlined in the review.

If objectives set out in SaHF are realised a number of potential positive impacts were identified, including improved health outcomes for complex and acute patients and care delivered closer to home and within the community.

4.2 The national picture

The NHS Five Year Forward View was published in October 2014 setting out a vision for the future of the NHS. The Five Year Forward View outlines the need for new partnerships between health, local communities, local authorities and employers in delivering outcomes. It also acknowledges the importance of prevention and public health in avoiding illness. This includes action on obesity, smoking, alcohol and other major health risks. Patient control, integration of health and social care and a role for voluntary organisations and local communities also feature in the plan.

The NHS set out in its vision future models of care continuing to move away from traditional boundaries between services – primary care, community services and hospitals – with services integrated around the patient and an increased emphasis on strengthening and expanding primary care and out-of-hospital care. A key focus is stabilising general practice with a range of initiatives as outlined below in the new deal for primary care from the NHS England Five Year Forward Plan (2014):

A new deal for primary care (NHSE, 2014)

General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS, but it is under severe strain. Even as demand is rising, the number of people choosing to become a GP is not keeping pace with the growth in funded training posts - in part because primary care services have been under-resourced compared to hospitals. So over the next five years we will invest more in primary care.
Steps we will take include:

- Stabilise core funding for general practice nationally over the next two years while an

[9] NHS North West London (2012). Equalities Impacts – Strategic Review. Shaping a Healthier Future.

independent review is undertaken of how resources are fairly made available to primary care in different areas.

- Give GP-led Clinical Commissioning Groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services.
- Provide new funding through schemes such as the Challenge Fund to support new ways of working and improved access to services.
- Expand as fast as possible the number of GPs in training while training more community nurses and other primary care staff. Increase investment in new roles and in returner and retention schemes and ensure that current rules are not inflexibly putting off potential returners.
- Expand funding to upgrade primary care infrastructure and scope of services.
- Work with CCGs and others to design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities.
- Build the public's understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or A&E visit.

A paper published by the King's Fund (2015), in response to the NHS five year forward view, outlined the changes required in developing new health policy and supporting local leaders in implementing the new care models and transformational changes outlined in the plan. It recognises the importance of systems leadership and the requirement for organisations to work together in local systems of care and take forward initiatives. This includes implementing new forms of commissioning and contracting.

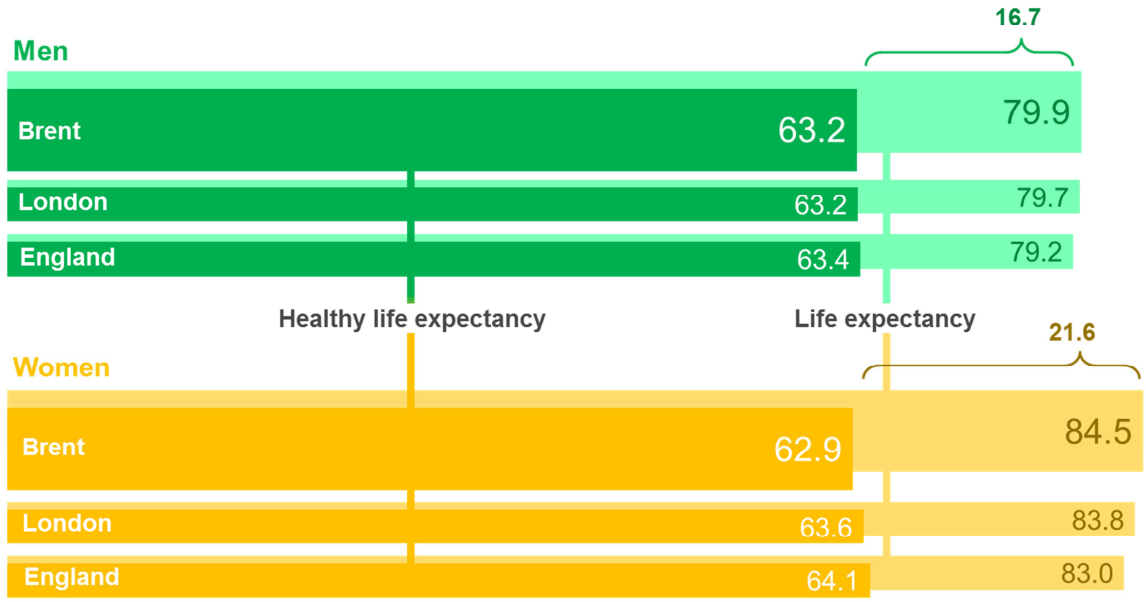
5. KEY FINDINGS

5.1 Demand for primary care

Local Health profile

There is a growing demand for primary care due to an ageing population, long-term health conditions and changing expectations. In Brent life expectancy is increasing steadily; for women born between 2010 and 2012 life expectancy is higher (84.5) than London (83.8) and England and Wales (83.0). Men born between 2010 and 2012 have similar life expectancy (79.9) to London (79.7) and England and Wales (79.2). Although life expectancy is long in Brent, healthy life expectancy is similar to the average for London (63.2 for men and 63.6 for women) and England (63.4 for men and 64.1 for women) for both men (63.2) and women (62.9), meaning that women in Brent are likely to live longer in bad health.[10] However, within the borough, there is inequality in health with a life expectancy gap for men of 9.2 years, ranging from 74.2 years in Stonebridge to 83.4 years in parts of Preston[11]. Women have a longer life expectancy than men, ranging from 80.6 years to 90.5 years, a gap of 9.9 years[11].

Figure 4: Life expectancy and healthy life expectancy, 2010-2012[10]



The main causes of premature mortality[12] in Brent include cancer (724 deaths of people aged under 75 between 2011 and 2013) and heart disease and stroke (521 deaths of people aged under 75 between 2011 and 2013)[13]. Brent has a high rate of people dying prematurely from heart disease or stroke (93.5 per 100,000 population) and ranks 110th out of 150 local authorities.[14] The rate of premature death from heart disease or stroke is 80.1 per 100,000 population in London and 78.2 per 100,000 population in England. Although

[10] Brent JSNA
[11] ONS: life expectancy at birth 2008 to 2012
[12] Dying before the age of 75
[13] Public Health outcomes framework
[14] http://healthierlives.phe.org.uk/topic/mortality/area-details#are/E09000005/par/E92000001/ati/102/pat/

cancer has caused more premature mortality, Brent has a good record for cancer and ranks 20th out of 150 local authorities.[14]

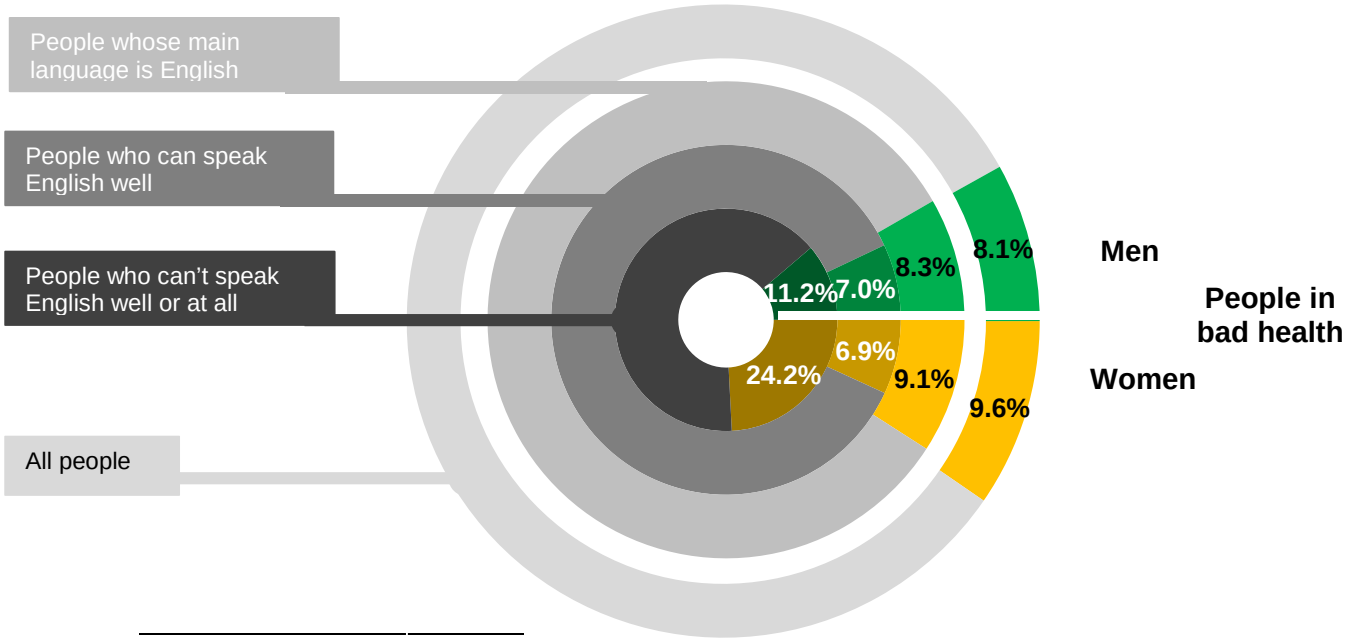
For self reported health in Brent, 82.9% reported their health as good or very good[15]. At ward level, Kilburn had the highest number of residents who assessed their health as "very good" (8,448 residents), while Kenton had the lowest number of residents (5,502 residents) in "very good" health. Harlesden had the highest number of residents with both "good" health (5,815 residents) and those reporting "very bad" health (313 residents).[16] In Brent, 85.6% of people felt their day-to-day activities were not limited at all by a long term health problem or disability. This is similar to the London average of 85.8% and slightly better than the England average of 82.4%.[15]

In 2012/13, 3.4% of adult patients registered with NHS Brent CCG were on a GP register for depression, this is lower than the national average of 5.8%. Take up of talking therapies is lower in Brent (53%) compared to England (60%) in relation to the number of referrals who enter treatment. Estimates show that 19.5% of Brent residents surveyed consider themselves to have high levels of daily anxiety compared to the England average of 21%.[16] In Brent, 2,369 people aged 65 and over are currently predicted to have dementia. This is estimated to increase to 3,857 by 2030.[16]

In 2012/13 there were over 23,000 people in Brent recorded as having a diagnosis of diabetes on GP registers. This equates to 8% of the GP registered population, which is above the England average of 6%.[16]

There has been a dip in births in Brent and the under five population is expected to remain fairly static over the next five years. Children in Brent have worse than average levels of childhood obesity. This will impact on future health needs within the borough if these children stay in Brent. The most common cause for planned admission to hospital is dental extraction. In 2011/12, 46% of five year olds had one or more decay filled or missing teeth. Immunisations rates are below 95%.[16]

Figure 5: Health by proficiency in English[15]



[15] 2011 Census
[16] Brent JSNA

In Brent there are additional challenges. Although 20% of households do not have English as their main language, only 8% of people are unable to speak English well or at all. People that are unable to speak English well or at all are more likely to be in bad health, with 35.4% in bad health (24.2% of which are women) compared to the average of 17.7%.[15] This presents additional challenges for ensuring individuals can access the care and support they require.

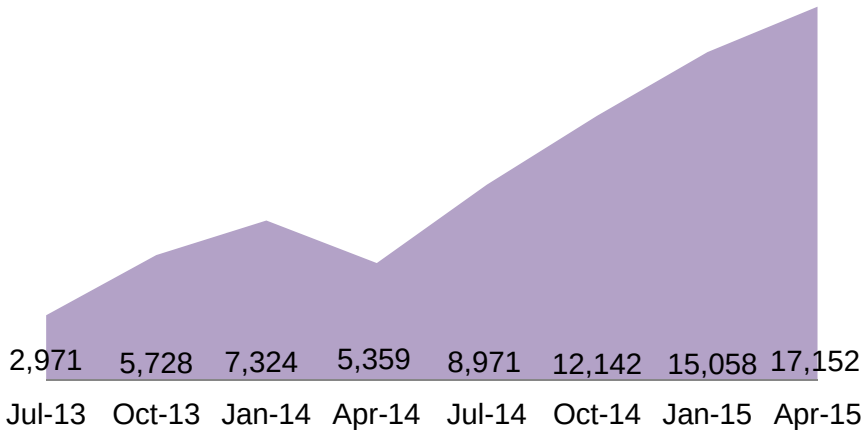
Registered patients

In 2012 there were 69 GP practices in Brent and 339,381 registered patients. In April 2015 there were 67 GP practices in Brent, with 365,165 registered patients.[17] The number of registered patients across the 67 practices has risen since 2012 and is continuing to rise. Between April 2014 and April 2015, the number of registered patients increased by 11,793 from 353,372 to 365,165, which on average is nearly 3,000 patients per quarter.[17]

Figure 6 shows the overall increase in patients between July 2013 and April 2015. It is important to note that a patient doesn't have to live in Brent to register with a Brent GP.

Population projections for Brent, outlined in section four, 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.

Figure 6: New patients registered since April 2013[17]



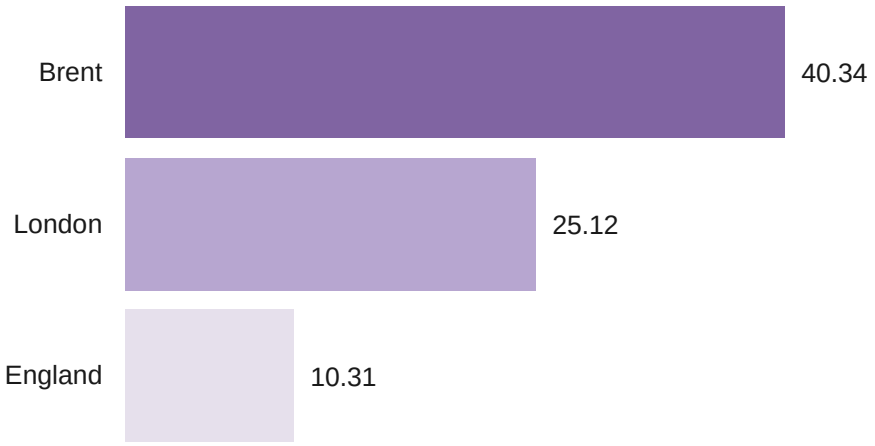
Migrant patient GP registrations

Brent has a high number of migrant patient registrations with GP practices. The estimated migrant patient GP registration rate for Brent is around 40.3 per thousand population, compared to 25.1 for London and 10.3 for England. The figures are slightly lower (35.8) when the total patient estimates are used instead of population estimates, although the trend

[17] HSCIC – Number of Patients Registered at a GP Practice

is similar.[18] The smaller proportion of migrant registrations is due to a higher number of registered patients in the borough, compared to the population estimate.

Figure 7: New migrant patient GP registrations per thousand population[18]



Of the 374 local authorities for which the migrant patient registration rate is available, Brent had the sixth highest. Rates range from 0.9 per thousand (Caerphilly) to 57.4 per thousand (Cambridge).

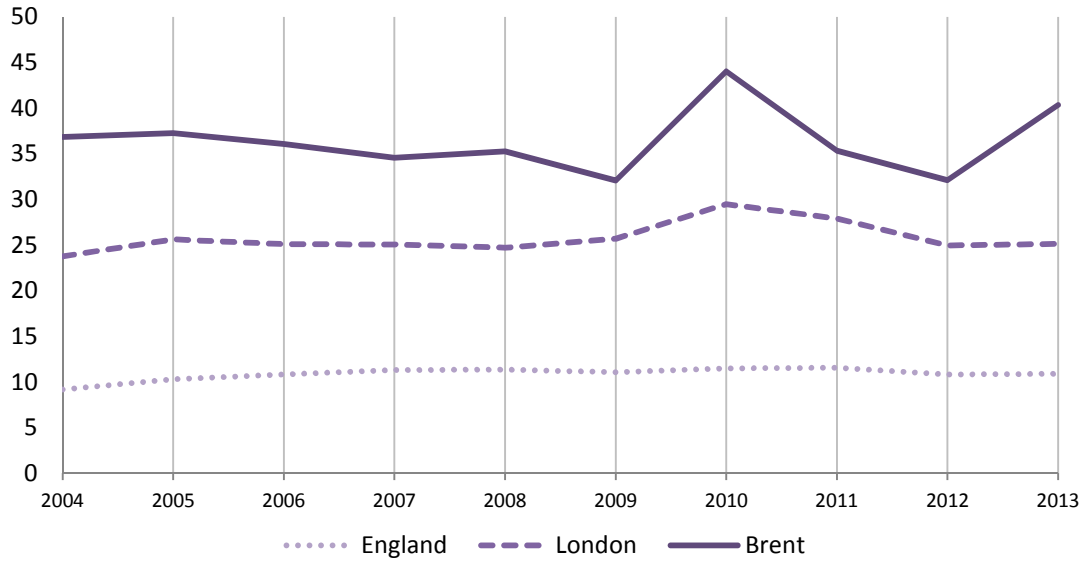
Table 3: Top ten migrant patient GP registrations (2013)[18]

	Local Authority	Migrant GP registrations per thousand resident population
1	Cambridge	57.4
2	Oxford	52.3
3	Newham	48.4
4	Tower Hamlets	42.8
5	Westminster	41.1
6	Brent	40.3
7	Kensington and Chelsea	35.9
8	Camden	35.8
9	Hammersmith and Fulham	35.2
10	Haringey	35.2

Examining migrant GP registration rates over a ten year period, 2004 to 2013, shows Brent's rates have remained at a high rate compared to London and England, although mostly following the same trajectory as London, peaking at a rate of 44 per thousand population[18] (as illustrated in Figure 8).

[18] ONS international migration http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Local+Area+Migration+Indicators#tab-data-tables

Figure 8: New migrant GP registrations 2004-2013[18]



Patient growth analysis

The two previous sections illustrate the growth in patient population. Looking at this in more detail and comparing patient growth with the local resident population growth, we are able to identify whether there are any unexpected changes in patient groups. In January 2015 there were 363,071 patients registered in Brent while the projected population for mid-year 2015 was 325,226.[19] In the period from January 2014 to January 2015 the patient registrations increased by 2.2% while in the comparison period (June 2014 to June 2015) the population of the London Borough of Brent increased by 1.1%.[19]

It is important to note, the area of residence of the registered practice population and ward boundaries do not correlate. However, as a guide to the changes in each, it is possible to compare the median and quartile ranges of the GP practices in Brent CCG with the wards of Brent. One practice had a decrease in patient population of 12.4%. During the same period another practice had an increase in patient population of 41.4%. These are the extremes in population change, for example the second greatest increase was 19.7%. The average (median) population growth for practices (January 2014 to January 2015) was 1.6%. This compares to an average (median) population growth for wards of 0.6%. The population growth of the middle 50% of practices varied between a decrease of 0.9% and an increase of 5.1%, this compares to an increase in the middle 50% of wards from 0.4% to 1.1%.[19] A full breakdown of patient growth rates by practice is detailed in appendix 1.

Both practices and wards are experiencing a range of growths in the registered patient population and in some cases shrinkages but despite the practices showing some more extreme movements the changes would appear to be largely in step. A comparison by gender, shows that there is no significant difference in the increase of the female population but indicated that the male population is increasing faster than the borough's wards, with an

[19] Comparing the number of patients registered to Brent CCG GP surgeries on January 1st 2014 and January 1st 2015 with the mid-year population projections for Brent for 2014 and 2015 from the GLA (using the Ward SHLAA capped AHS short term 2014 Round projections).

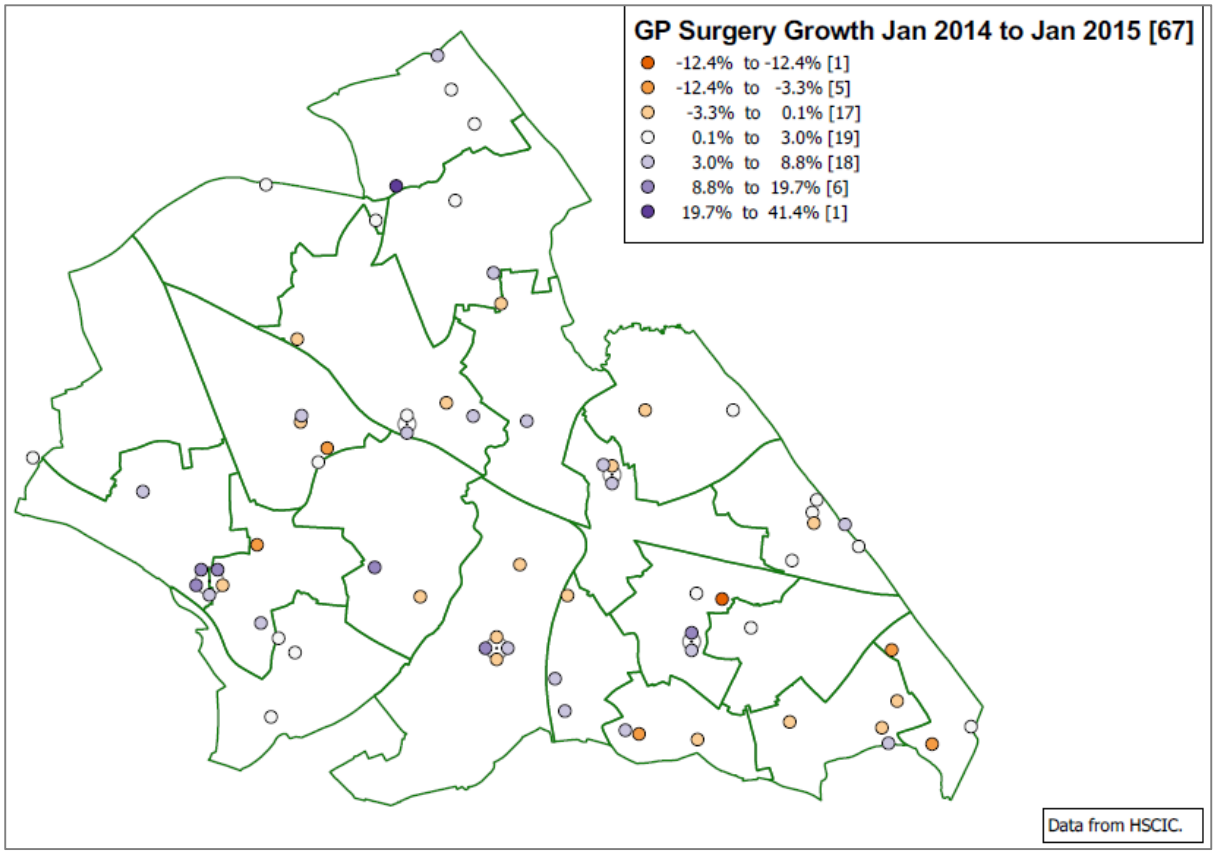
average (median) population growth of 2.9% compared to the ward population growth of 0.8%. More specifically, this is men between the ages of 20 and 54.[1918]

Table 4: Population growth in Brent CCG practice and Brent wards[19]

Total population	Brent CCG practices	Brent wards
Minimum	-12.4	-0.4
1st quartile	-0.9	0.4
Median (average)	1.6	0.6
3rd quartile	5.1	1.1
Maximum	41.4	5.9

The patient registers of Brent GP practices appear to be growing faster than the population projections. The task group recognise that continuing regeneration across the borough and surrounding areas could impact this further. Looking at the GP practice growth across Brent there is a fairly even spread of growth in the centre of the borough. This is not true for the whole borough, as all practices in Alperton and Queensbury had an increase in registered patients between January 2014 and January 2015. During the same period, the majority of practices within the wards of Kilburn, Queens Park and Kensal Green had a decrease in registered patients as illustrated in figure 9. In terms of pressure, while there are particular wards with a higher rate of growth in patient numbers, an analysis of capacity at individual practice level would be required to determine whether a practice is able to manage this increase in demand.

Figure 9: GP practice growth January 2014 to January 2015[20]



[20] HSCIC

5.2 Access to primary care in Brent

Commissioning arrangements

NHS England commissions all primary care, including medical, pharmacy and optometry, dental and secondary care dental services. Most medical practices operate as independent contractors in a partnership model but the contract also allows for Foundation Trusts and limited companies to be providers (i.e. walk-in centres). GPs generally have responsibility for running their business and managing their premises in addition to providing medical care for their registered population. NHS England funds core GP services based on the number and type of patients on the practice registered list via a national contract. Other payments to practices include additional services, Quality Outcome Framework (reward and incentive programme), enhanced services and funding for premises (e.g. rent reimbursement, rates, capital grants). Enhanced services are primary medical services provided by GPs, over and above the core services to patients, to address the populations healthcare needs.

GP practices are contracted to provide care for patients between 8am and 6.30pm Monday to Friday. Many practices also provide additional services, including extended opening. Brent CCG currently commissions extended primary care outside of core hours through a hub model. Brent CCG is also responsible for commissioning a range of community based services including NHS walk-in centres, Urgent Care Centres, Community Ophthalmology Services, Brent Short Term Assessment Rehabilitation and Reablement Service (STARRS), Brent Integrated Diabetes Services (BIDS), Sickle Cell, CAMHS, health services for Looked After Children, primary care dementia nurses, and community nurses.

The above services are only part of the range of services commissioned by the CCG. Brent CCG also commissions services from GPs and networks to support the Out of Hospital Strategy. This includes cardiology (ECG and 24 hour BP monitoring), insulin initiation, phlebotomy, End of Life, IAPT and cancer injection administration.

Access to general practice and patient experience

There are 67 GP practices in Brent, with practice list sizes ranging from 1,672 patients to 14,518[21] (a full list of practices sizes is attached in appendix 2). Figure 10 shows the location of practices in the borough and population density. In some cases there is more than one GP practice in the same building. There appears to be a good geographical spread of practices across the borough with the exception of Northwick Park, Kenton and north Preston. However, patients may choose to access practices located outside of the borough.

National figures show that the average number of appointments per patient in general practice rose from 3.9 to 5.5 between 1995 and 2008[22]. As at 30 September 2014, there were 1,784 registered patients per full time equivalent GP (based on 200.2 FTE) in Brent, which means that the GPs across Brent are delivering approximately 1.9 million consultations a year based on an average of 5.5 appointments per patient per annum. This places huge pressures on practices but will also vary across practices, as illustrated by the number of patients per GP varying considerably in the borough, from 410.8 to 6,256.5.[23] Looking at the number of patients per GP in neighbouring boroughs, Brent is the fourth highest of the eight North West London CCGs (as outlined in Table 5).

[21] HSCIC – Number of Patients Registered at a GP Practice (April 2015)
[22] HSCIC (2008). Trends in Consultation Rates in General Practice 1995 to 2008

Figure 10: Map of GP practices and population density

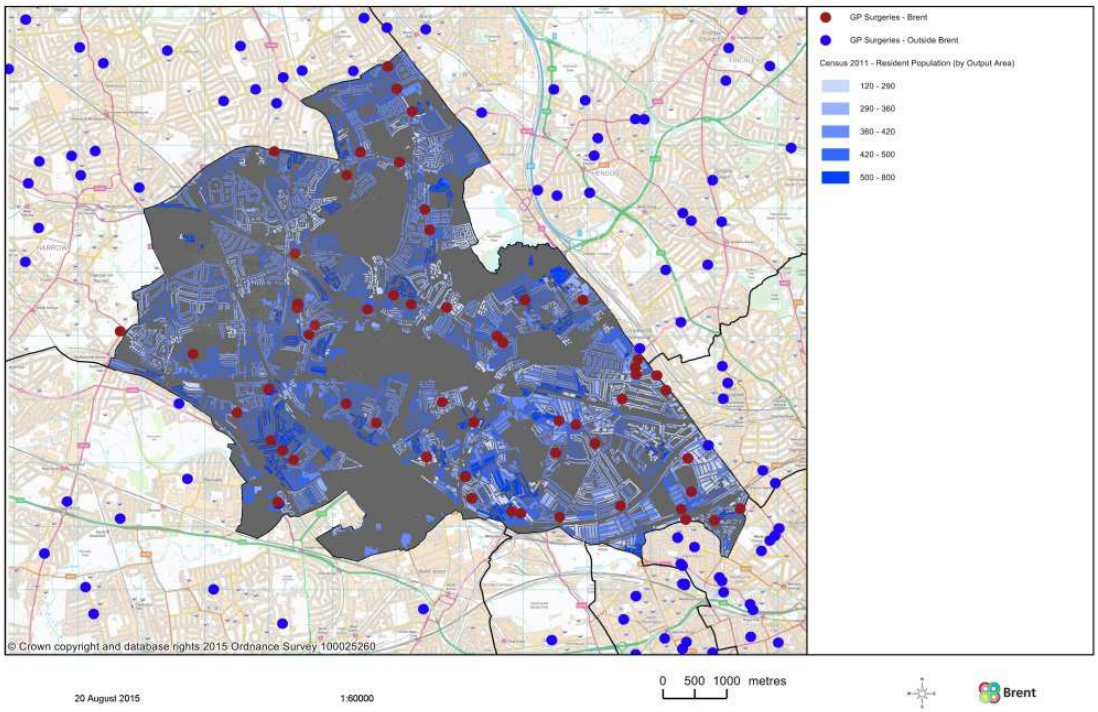


Table 5: GP FTE and patient numbers 30 September 2014 [23]

CCG	Total Patients	Total GPs (FTE)	Patients per GP	Total number of practices	Population (2011 Census)
NHS BRENT CCG	357,173	200.20	1,784.08	67	311,215
NHS HARROW CCG	252,174	145.64	1,731.51	36	239,056
NHS EALING CCG	413,640	211.11	1,959.35	80	338,449
NHS HOUNSLOW CCG	291,038	142.40	2,043.88	53	253,957
NHS HAMMERSMITH AND FULHAM CCG	201,766	125.25	1,610.96	31	182,493
NHS HILLINGDON CCG	295,072	159.10	1,854.59	48	273,936
NHS CENTRAL LONDON (WESTMINSTER) CCG	199,409	117.48	1,697.43	40	219,396
NHS WEST LONDON (K&C) CCG	234,882	149.05	1,575.83	53	158,649

Brent CCG has lower patient satisfaction results compared to the national average with regards to accessing primary care. 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.[24]

[23] HSCIC General and Personal Medical Services, England – 2004-2014 as at 30 September 2014
[24] Brent CCG – Service Specification for Primary Care Access Hubs

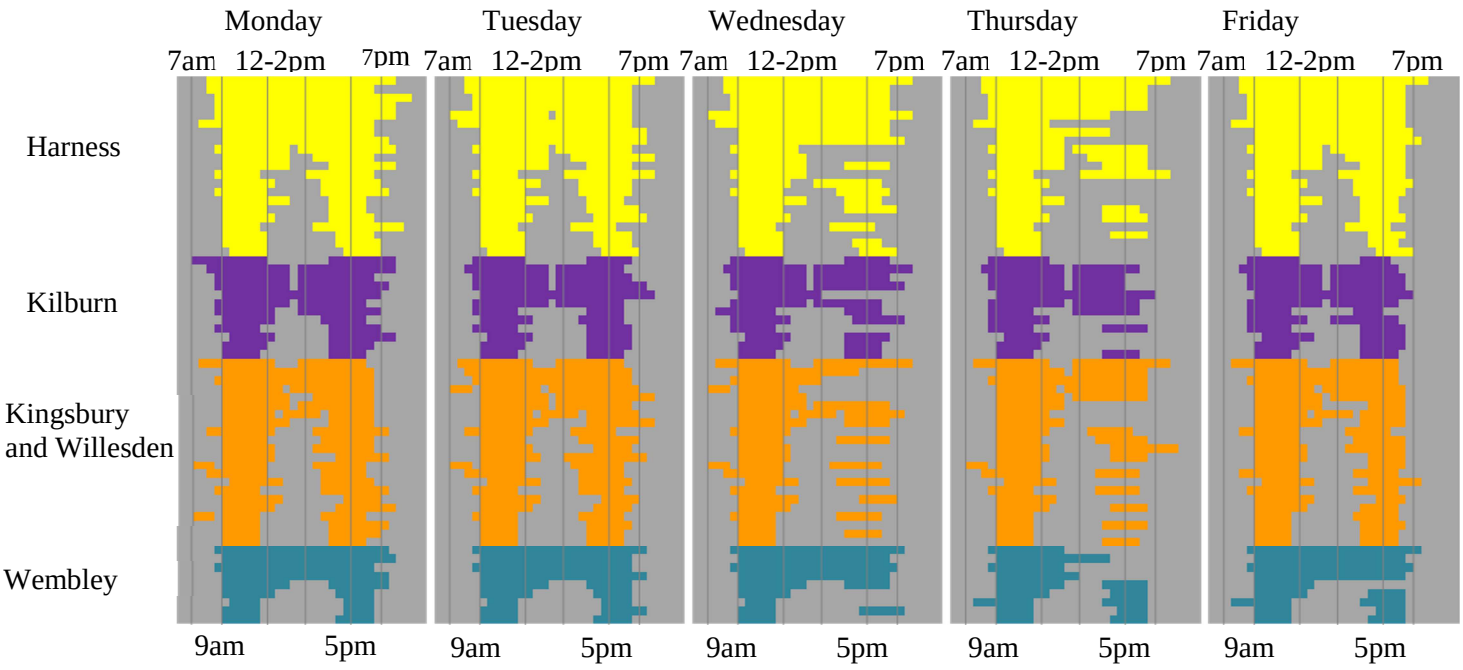
An analysis of the 2013/14 GP patient survey shows that 71.0% of patients would recommend their practice, compared to the national average of 78.7%. Four practices report a significantly better recommendation rate than the average for England, while three have a significantly lower rate. These three practices report a rate below 50%. Statistically, the remaining 60 practices are similar to the England average.[25]

Table 6: GP patient survey 2013/14 [25]

Measure	Brent CCG Average	England Average
Would recommend practice	71.0%	78.7%
Satisfied with phone access	70.4%	75.5%
Satisfied with opening times	73.2%	76.9%
Saw / spoke to nurse or GP same or next day	47.4%	50.7%
Good overall experience of making appointment	68.6%	74.6%
Know how to contact an out of hours GP service	44.2%	55.8%

Satisfaction with phone access is also lower than the national average (70.4% in Brent compared to the England average of 75.5%). Out of the 67 practices in Brent, 17 report a significantly better rate of satisfaction with phone access than the average for England, while eight have a significantly lower rate; five of these report a rate lower than 50%. Telephone access was also raised in the feedback received from participants. During the task groups visits, access by telephone was raised as an issue for practices and a need to invest resources was identified.

Figure 11: Surgery opening times in Brent[26]



[25] https://gp-patient.co.uk/surveys-and-reports#july-2015

In Brent, 73.2% of patients are satisfied with opening hours, compared to 76.9% in England. Six practices report a significantly better rate of satisfaction than the average for England, while three are significantly lower (two of which report a rate below 50%).[25] Figure 11 shows the surgery opening hours of practices across GP networks in Brent. Practices may be open for longer but the chart shows when GP appointments are available.

All practices offer morning appointments Monday to Friday, with the majority of practices offering afternoon appointments. There are a number of practices which do not offer appointments between 12pm and 2pm. It is acknowledged that some surgeries are sole practitioners and other activities may also take place during these times, for example home visits. Access to appointments outside normal working hours vary across practices. Out of the 67 Brent GP practices, 37 open after 6pm, including 15 that open until after 7pm, and 37 practices open at 8.30am or before. Of these, six open at 7am at least one day a week and ten at 8am.[26] Concerns with GP premises were also highlighted through the review and the constraint these may be placing on delivering services.

Results from the 2013/14 patient survey showed that less than 50% of respondents saw or spoke with a nurse or GP the same or next day in Brent, compared to 51% in England. In Brent, 10 practices report a significantly higher proportion of patients able to see or speak to a nurse or GP the same or next day compared to the average for England, while seven are significantly lower. In Brent, 42 practices have a rate below 50% (just under two thirds of Brent GP practices). The majority of respondents (68.6%) reported a good overall experience of making an appointment, compared to 74.6% for England, with ten practices reporting a significantly higher proportion of patients with a good experience of making an appointment than the England average, while four have a significantly lower proportion (two of which have a proportion smaller than 50%). The poorest result related to knowledge of how to contact an out of hours GP service (an average response of 44.2% in Brent), with 54 out of 67 practices having a proportion below 50%.[25] This raises concerns regarding how out of hours services are publicised across the borough and any additional information the public may require. The task group feel this is an area which needs urgently addressing.

Waiting times for GP appointments in Brent vary. Based on data from patient survey results, 43.0% of patients wait more than 15 minutes to see a GP, higher than the England average of 27.1%. In terms of perception, 50.6% of Brent patients who expressed a view considered they had to wait too long (*a bit* or *a lot*), compared to an England average of 34.5%.[25]

It is acknowledged that good access to GP services will mean different things to different people. The service people receive when contacting their local surgery and the ability to make timely appointments will be key to overall levels of satisfaction. In March 2015 Healthwatch Brent commissioned a piece of research into GP services in Brent. The research looked at the process for booking appointments and waiting times. Of those surveyed 31 out of 85 respondents (36.5%) received an appointment on the same day. Of the 31 patients who saw their GP on the same day, 15 said it was easy, while six said that it was not easy.[27] The majority of people interviewed make appointments to see their GP by telephone. Patients also go directly to their surgery to make an appointment or wait in a queue. Online booking is being tried by more people but has not always been successful. The research highlighted that the current systems for emergency booking, which rely on early morning contact, may disadvantage certain groups, such as those on particular types of medicine and those who rely on carers. It was also suggested that queuing and online booking disadvantaged older people and those with poor access to IT.

[26] NHS Choices: GP opening times, downloaded August 2015
[27] Healthwatch Brent

Figure 12: Waiting time at surgery[28]

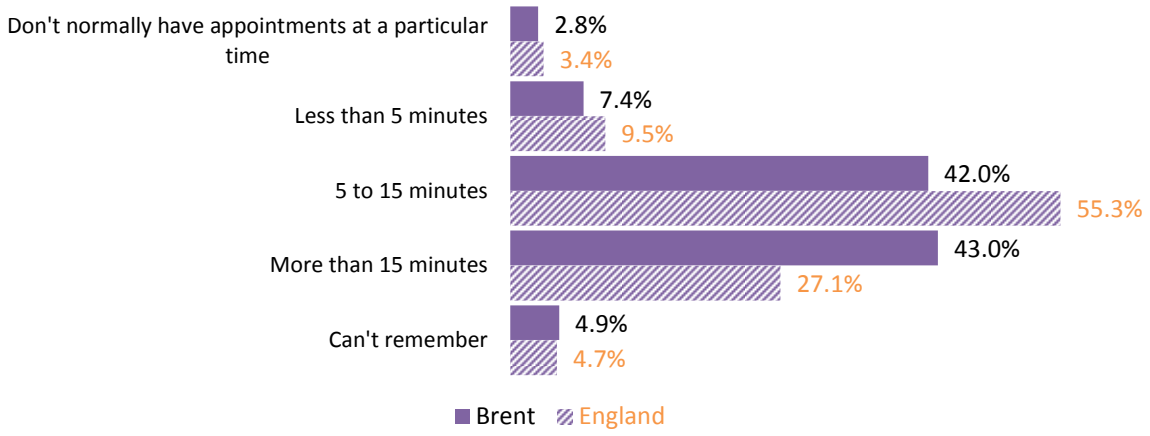
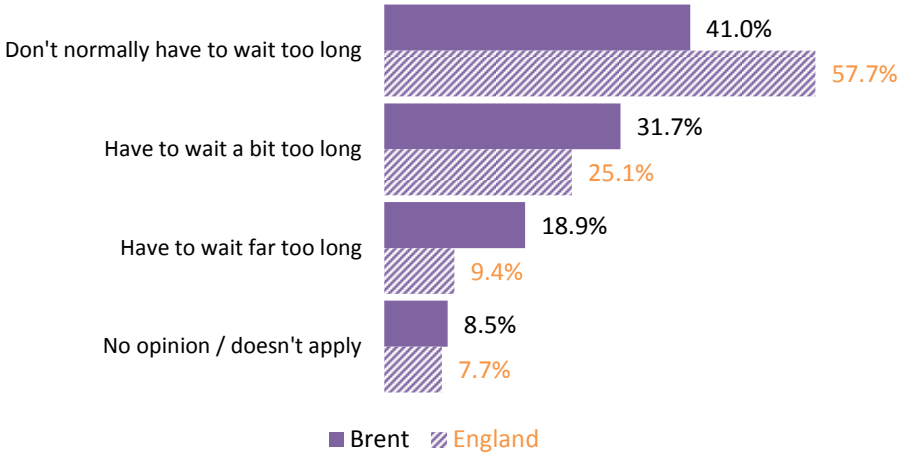


Figure 13: Impression of waiting time at surgery[28]



The research found that most patients felt that the overall service they receive from their GP practice is good or okay. The response to individual GPs is good, with 94.2% of respondents rating their relationship with their GP as good or okay. The survey also found patients to be loyal to their surgeries, with recognition and appreciation for the good work that is being done.

Ensuring that local people can continue to receive an improved level of service from primary care provision is outlined in Brent CCG commissioning intentions. This includes enabling practices to develop improvement plans to address their performance needs and improve the overall patient experience. Local plans to introduce extended hours in primary care aim to improve access and increase patient satisfaction rates.

[28] This is based on aggregated, weighted, data collected from Jul-Sept 2014 and Jan-Mar 2015 by NHS England. Number of respondents giving each answer as a percentage of the number of people who responded to the question

Key Learning and Insight

The task group found that access to GP services continues to be a key concern for Brent residents. There is significant pressure on GPs with capacity stretched, a result of a growing population and increasing demand for primary care. GP services need to find ways to expand or change to meet ongoing demand, including other means of communication.

Residents' experience of access to GP services appears to vary. A number of contributing factors were highlighted, including the variance in the GP to patient ratio and a range of opening times for practices across the borough. Many practices have limited opening hours between 7am and 7pm. There are particular gaps during 12pm and 2pm and on Wednesday and Thursday afternoons. This highlights the need for an urgent review of GP opening hours across primary care centres. It is also acknowledged that GP premises may be placing additional constraints on services.

Patient satisfaction rates in Brent are below the national average, with areas that need addressing including patient experience of making appointments and phone access to surgeries. Awareness of out of hours GP services is also a key concern.

Recommendation 1
NHS England, Brent CCG and local GP networks carry out a review of current GP opening hours across the borough and consider additional ways of accessing GP services, including the roll-out of Skype and FaceTime consultations, telephone consultation and email consultations where appropriate and within Information Governance principles. Online appointment bookings and e-prescription ordering have been enabled in all Brent GP practices and patients should be encouraged to take up these services.

Recommendation 2
The patient survey shows varying levels of patient satisfaction across practices. NHS England and Brent CCG produce an action plan including opportunities for sharing of good practice across networks in improving patient experience when making appointments and contacting the surgery by phone, with a view of improving patient satisfaction rates in the next GP patient survey.

Recommendation 3
Brent CCG and NHS England clarify the out of hours element of the GP contract for people in Brent and publicise out of hours services across the borough given the lack of information and awareness by local residents highlighted in the most recent GP patient survey.

Extended GP services

The development of GP access hubs was seen as a way of freeing up capacity, managing demand differently and providing access to out of hours care through the delivery of seven day care provision. It is dependent on practices working together in networks in order to provide extended access to GP appointments.

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 pilot scheme of GP access hubs provided a hub in each clinical network across Brent CCG at the following locations (a full list of hubs can be found in appendix 3):

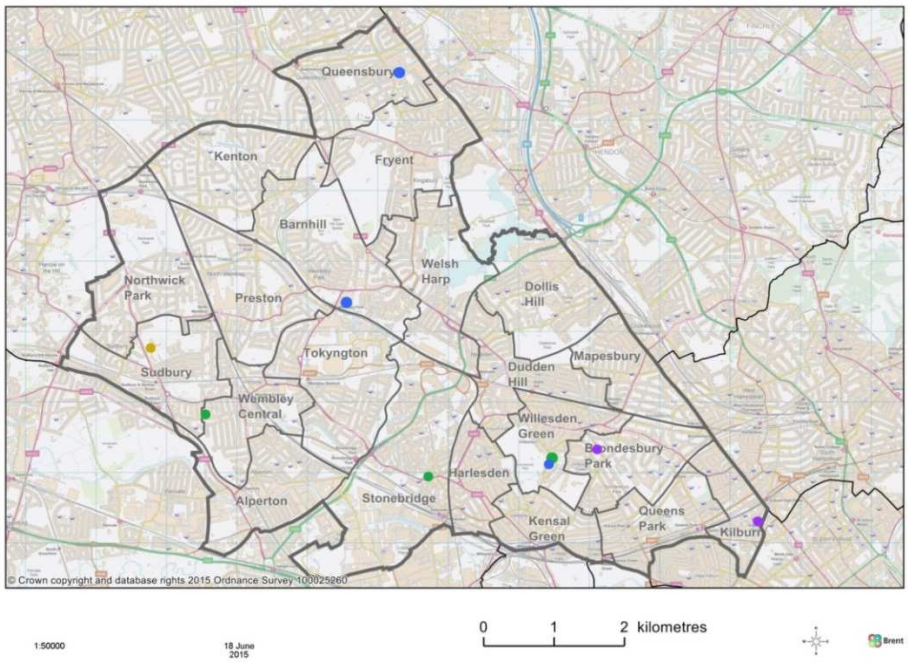
- Harness Locality: Harness Harlesden Practice and Wembley Centre for Health and Care

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

An evaluation of the pilots was undertaken in January 2014 and the Applied Research Unit at Brent CCG analysed 900 patient satisfaction questionnaires. Patient feedback from the pilots was positive with patients reporting that they like being able to see a GP or a nurse in the evenings and at weekends. Patients also said that they would recommend the service to family and friends. Over 75% of users stated that they would go to A&E or the Urgent Care Centre if the service was not available to them[29]. An analysis of the demographic data showed that most users are aged between 20 and 50 (65%), with the largest number aged 30 to 39 (27%). The majority of users were female (64%) and about 55% of users were unmarried.[29] Figures provided by Brent CCG show that the highest usage in the pilot sites was between 3pm and 6pm. The areas for improvement highlighted during the evaluation of pilots in January 2014, including poor levels of utilisation, a need to increase publicity and marketing, and establish patient pathways to refer patients from other services such as A&E, UCC, LAS and 111, are being addressed by Brent CCG.

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. GP hubs and access to extended opening hours are outlined in Brent CCG's commissioning priorities for 2015/16 and the model has been rolled out to additional sites. The location of GP hub sites is detailed in figure 14. This was based on a revised service specification, which details both national and local defined outcomes for the service. The main changes include removing week day afternoon appointments at hubs due to NHS England requirements that the service should not overlap core GP hours and changes to weekend appointments (revised hours of 9am to 3pm on Saturday and Sundays and to include bank holidays).

Figure 14: Map of GP access hubs



[29] Brent CCG – Hub Access Service Review of Pilot Sites (September – December 2013)

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 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 as GP practices are funded to provide core hours.

The total investment in extended GP hubs is £1.9 million, funded by Brent CCG.[30] In March 2015, the hubs had delivered an additional 70,000 GP and nurse appointments in primary care[30]. Utilisation figures for pilot sites outlined in the Hub Access Service Review (September – December 2013) showed a total GP utilisation of 42% and utilisation of nurse appointments at 25%.[29] As part of the new service specification, providers are required to complete and return monthly utilisation reports and the specification sets out key performance indicators including a reduction in A&E and Urgent Care Centre attendances. The target is for 85% capacity utilisation, 90% of patients seen within waiting times of no more than 20 minutes and delivering 90% patient satisfaction.

Under the new arrangements, there are 1,234 GP and nurse appointments offered per week. Figures provided for April 2015, showed utilisation of 59.9% for GP appointments and 32.1% for nurse appointments across all sites. As outlined in the figures in Table 7, the utilisation in April 2015 varied across localities from 83.3% of appointments booked in Harness to 38.6% in Wembley. This is an improvement on the pilot scheme and the overall percentage of GP appointments booked had increased further in June 2015 to 67.7% across all sites. A total of 7,064 patients were seen by a GP at a hub between April and June 2015 (from 8,036 appointments booked). Utilisation of nurse appointments also increased between April 2015 (32.1%) and June 2015 (43.3%). However, figures are still significantly below the target of 85% utilisation, which raises some questions about the best use of the nursing role. There are also a number of do not shows, averaging 12.8% for GP and nurse appointments across all sites in April 2015, 10.2% in May 2015 and 11.3% in June 2015.[30]

Table 7: GP access hubs utilisation April – June 2015[30]

Network	Apr-15			May-15			Jun-15		
	GP appts offered	No. booked appts	Percentage of booked appts	GP appts offered	No. booked appts	Percentage of booked appts	GP appts offered	No. booked appts	Percentage of booked appts
Harness	1,110	925	83.3%	1,272	1,026	80.7%	1,206	990	82.1%
Kingsbury & Willesden	1,351	750	55.5%	1,375	849	61.7%	1,451	1,051	72.4%
Kilburn	1,012	550	54.3%	1,130	586	51.9%	931	593	63.7%
Wembley	684	264	38.6%	726	197	27.1%	681	255	37.4%
TOTAL	4,157	2,489	59.9%	4,503	2,658	59.0%	4,269	2,889	67.7%

During November and December 2014, Healthwatch Brent carried out a survey asking residents about GP hubs. This was carried out via a questionnaire sent to members and contacts. A total of 41 responses were received. This is a relatively small sample of residents and some respondents lived in the London Borough of Harrow (information on the registered practice was not collected). The results of the questionnaire showed that the majority of respondents did not know what a GP hub appointment was and 15% of people surveyed had used a hub appointment, highlighting a possible problem with communication about the model. The results showed that almost everyone had a positive view of their GP practice, and most people were prepared to wait for an appointment. In response to the

[30] Brent CCG

general experience of their own practice, the majority of respondents felt making a GP appointment is OK, quite good, good or very good. A copy of the report can be found in appendix 4.

A key area of concern for the task group was that access to additional appointments, without having to wait, may come at the cost of continuity. Continuity of care allows an individual to build up a relationship with their GP. There was also concern about access to patient records and the process for following up on patients seen at a hub site. There are agreed procedures in place to manage this. Patient records are sent via secure email from the registered practice to the hub where the appointment will be held. This is sent either the day before or on the day of the appointment. The hub updates the patient record and sends it back to the registered GP practice to ensure any issues or concerns are followed up. A summary report of the hub attendance is received by the registered practice the next working day. Performance indicators have been built into the contract to monitor this process. The task group feel there is an additional need for the patient to receive their hub attendance report so they understand any required follow up. This will also help promote patient engagement and support ownership of their individual care. An agreed written procedure for receiving and acting on recommendations from the hub visit would support this.

The relationship between GP practices and the GP access hub model is unclear. Performance monitoring indicates that the full capacity of the service is not currently being utilised. Improving the utilisation of extended GP services would require increased publicity across the borough, including clarity over the purpose and range of services offered in the hubs, particularly in relation to nursing. Given the importance of self care in the SaHF model, details of health promotion built into the model would be of benefit. With an emphasis on meeting targets and delivering services seven days a week, contracts are based on seven day access but, feedback received indicates that some patients do not want to visit a GP at the weekend, as weekend appointments are not being filled. There is also further information required in analysing any equality impacts of the model of extended primary care.

Key Learning and Insight

Over 70,000 additional appointments have been offered to date through the GP access hub model. Data shows a recent increase in the take up of GP access hub appointments but utilisation still remains below the target level for the service.

It appears that awareness of the roll out of GP access hubs and access to the hubs has been varied across the borough, which is having an impact on utilisation of the service. There is still some confusion over the range of services offered in hubs and how local residents access them in fully utilising resources.

The evaluation of the pilot phase indicated that the majority of people using the service were young women, which raises further questions as to whether the range of services on offer are meeting the needs of users. Additional appointments are not being offered at times that suit patient preferences as these fall within the GP core hours (the highest usage in the pilot was between 3pm and 6pm) and may not alleviate pressures on GP practices, UCCs and A&E.

Recommendation 4

Brent CCG develops a written protocol between GP practices and GP Access Hubs for the receipt of hub attendance reports to ensure continuity of care and minimise the risk of fragmentation of primary care health services.

Recommendation 5

Brent CCG carries out a detailed review 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 and UCC attendances.

Recommendation 6

That the review, outlined in recommendation five, includes public engagement to assess the extent to which the model reaches and benefits all residents in any part of the borough, including vulnerable groups, and to determine public support for the model.

5.3 Delivering the out-of-hospital strategy

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.

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 2014/15 target to prevent 2,300 admissions.[31]

Services aimed at delivering 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).

If, as outlined in the transformation plans, hospitals focus on the provision of specialist services, other services need to be fully established in a community setting. Despite the investment in out-of-hospital services there appears to be little progress, with many services still in the early phases of implementation. Without robust data available, it is too early to evaluate the impact at this stage.

Key Learning and Insight

The task group acknowledge the success and impact of STARRS in preventing hospital admissions. However, the roll out of other areas outlined in the out-of-hospital strategy have been delayed, with a number of services starting in late 2014. It is too early to measure the impact of these services in evaluating the investment of both time and resources in commissioning out-of-hospital community based services and the benefits these are

[31] Brent CCG - figures provided in March 2015 showed 2,796 preventions

delivering for local residents.

Recommendation 7
Brent CCG carries out a rolling programme of evaluation of the impact of the out-of-hospital strategy against individual contractual arrangements for services.

Recommendation 8
Brent CCG outlines its plans to commission any additional community services to support primary care to meet the needs of Brent residents in the community following its support for changes to hospital care.

5.4 Developing an integrated care approach

Integrated Care Programme

The Integrated Care Programme (ICP) was introduced in 2012 to improve care for people with long term conditions such as diabetes, coronary heart disease, respiratory problems and those over the age of 75. The ICP is focused on delivering person-centred integrated health and social care across the boroughs of Brent, Ealing, Harrow and Hillingdon. The ICP works with a range of partner organisations and stakeholders, including acute trusts, mental health trusts, local authorities, community services and primary care, as well as voluntary sector organisations.

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.

The current NHSE guidance recommends that GPs carry out a care plan for the top 2% most vulnerable patients identified using an appropriate risk stratification tool. This equates to approximately 7,200 people based on the current population in Brent. Integrated care is predominantly aimed at people with long-term conditions. Figures provided by Brent CCG in July 2015 estimated that there are around 57,528 people in Brent living with a long-term condition[32], out of a total GP registered population of 363,071[33]. However, not all of these people are likely to need a care plan as many of them will be stable and not at high risk of admission. A joint decision between the patient and their GP as to whether they feel they would benefit would form part of the process. Figures provided by Brent CCG in March 2015 show that in excess of 8,500 care plans had been completed, 142 multi-disciplinary group meetings held with 477 patients discussed. The number of care plans completed since the start of the ICP in 2012 had increased to 11,000 in July 2015, with just under 6,000 having been carried out in 2014/15.[3232]

A quality review audit of the care planning process was carried out in January 2015. The purpose of the audit was to review the quality of care plans, to improve learning through sharing good practice and to improve quality of plans. Brent CCG evaluated the ICP through 600 patient surveys; these provided 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, and 75% of patients with a care plan said their family or carer was

[32] Brent CCG
[33] HSCIC

involved in decisions about their health as much as they wanted them to be. Figures provided by the CCG in March 2015, showed that the outcomes delivered through the ICP had also included a reduction of 398 non-elective (emergency) admissions.[32]

Health and Social Care Coordinators

The HSCC role has been introduced as part of a 12 month pilot programme funded by Brent CCG through the ICP. The team are currently being supported through a bespoke training programme. There are economic drivers for this model, including a reduction in A&E attendance and a reduction in hospital admissions, as well as outcomes of improved patient experience.

Appointments were 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. The individual case studies highlighted good outcomes in terms of delivering interventions to reduce dependency on GP services and avoid unnecessary hospital admissions.

HSCCs are viewed as playing a key role at the heart of multi-disciplinary groups, acting as the first point of contact for vulnerable people in relation to their care. There are currently 13 HSCCs representing 180 practices across three boroughs. There are five HSCCs in Brent, covering 67 practices across the borough. The HSCCs support joint working across agencies, working with both the local authority and voluntary sector to identify those who might not have been identified via a GP route. They also receive referrals from Adult Social Care. The HSCCs provide support as part of the hospital discharge process and work alongside STARRS, making referrals to and picking up cases from STARRS as appropriate.

During the observation of the HSCC Action Learning Set, the task group were presented with several case studies from HSCC Teams across the three boroughs. There appeared to be common circumstances for the individuals supported by the HSCCs and similar information provided in terms of inventions detailed in the case studies. Support was offered to patients who were frequent users of A&E and had high numbers of GP calls. The HSCCs deliver a range of interventions coordinated through the care plan, including regular contact with the patient, family and carer. The HSCCs are also able to raise cases with GPs and at practice meetings, organise home and hospital visits and facilitate multi-disciplinary meetings where necessary. There appear to be good outcomes delivered through these interventions including securing temporary step-down care for patients, and finding workable solutions in avoiding dependence on GP services (for example, support from carers within the home, links with befriending services and access to pharmacies). They were also able to share good outcomes, including an overall reduction in hospital admissions contributing to a reduction in non-elective (emergency) admissions. The work of the HSCCs relies on information sharing and good local knowledge in facilitating access to the right support within the community. They also have a role in sharing information with patients and introducing use of other agencies where appropriate. Some challenges were raised, in terms of information sharing, including system flow issues from hospital to GP practice.

Case studies provided by the HSCCs highlighted some good outcomes in individual cases presented to the task group. The task group identified areas for consideration in reviewing the pilot and planning future arrangements for the role. 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. An added complication raised through discussions is that there is no single agency employer bringing together one joint management framework.

Key Learning and Insight

The task group acknowledge the positive outcomes of a multi-disciplinary approach and the opportunity for professionals to meet through multi-disciplinary forums in sharing resources, knowledge, skills and expertise.

There is a clear need for a coordinated role across health, social care and the voluntary sector. This role should have at its core ensuring that the patients' needs are paramount. It is felt that with the coordinators are currently constrained by the number of patients they have to see. The core competencies, level of responsibility and breadth of this role need to be reviewed in considering future arrangements. It is also evident that this role can only function effectively if the services are available to meet the needs of the vulnerable patients in the community.

Recommendation 9
Brent CCG in partnership with Brent Council's Adult Social Care Department review the job description of care coordinators, including the breadth, key requirements and core competencies of the role currently being piloted to ensure these can be fulfilled.

Recommendation 10
Brent CCG outlines its plans to commission any additional community services to support primary care to meet the needs of Brent residents in the community following its support for changes to hospital care.

5.5 Investing in the primary care workforce

General Practitioners

A national shortfall in GPs has received much attention. In 2013, the Royal College of General Practitioners (RGCP) released information indicating that a lack of funding could lead to a shortfall of 16,000 GPs in England by 2021.[34] A survey of 458 GPs carried out by Pulse in April 2015, found that 9% of Full Time Equivalent (FTE) GP positions are currently unfilled, compared with a 6% vacancy rate in 2014.[35] More recently, the RCGP said the pressure of more consultations, complex cases and increased bureaucracy was causing fatigue and burnout.[34] Figures for GP vacancies in Brent were requested as part of the review but were not available at the time of writing.

In September 2014 there were 254 GPs working in Brent both full and part-time equivalent (200.2 FTE)[36]. In 2012 and 2013 there were 208 FTE GPs in Brent, showing a reduction of 7.8FTE.[36] The headcounts and FTEs for other types of practice staff are shown in table 8.

[34] Royal College of General Practitioners
[35] http://www.pulsetoday.co.uk/your-practice/practice-topics/employment/gp-vacancy-rate-at-highest-ever-with-50-rise-in-empty-posts/20009835.article#.VberH_7bKJA

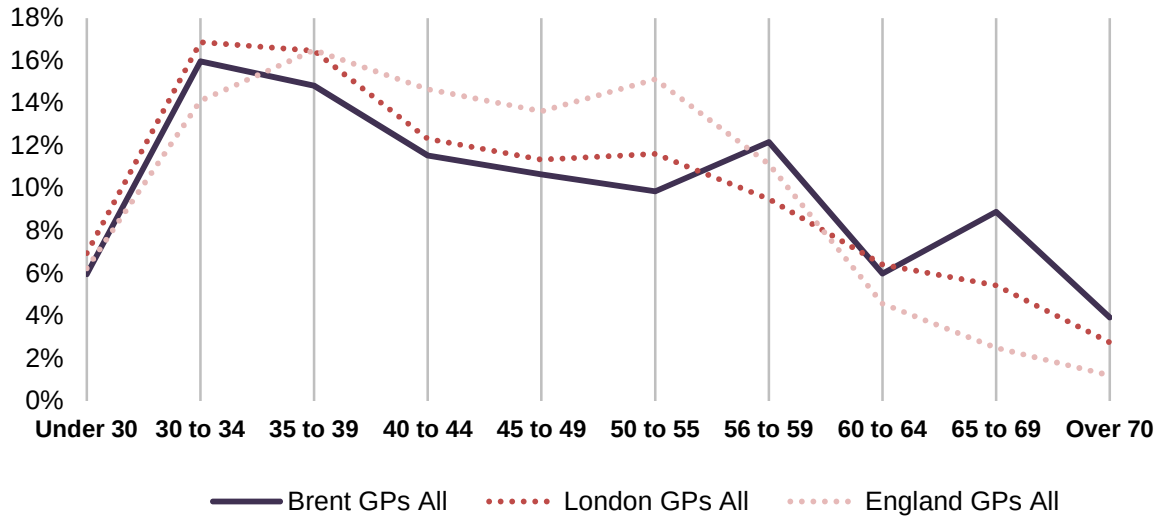
[36] HSCIC

Table 8: GP headcount and full-time equivalent (as at 30 September 2014)[36]

Role	Headcount	Full-time equivalent
GPs	254	200.20
GP Provider	158	133.23
GP Registrar	25	22.20
GP Retainer	3	1.33
GP Other	68	43.44
Practice Staff	744	460.81
Direct Patient Care staff	97	45.88
Admin staff	499	352.68
Other staff	43	9.60
Nurses	105	52.65
Advanced Nurses	13	8.65
Extended nurses	12	3.37
Practice Nurses	80	40.63

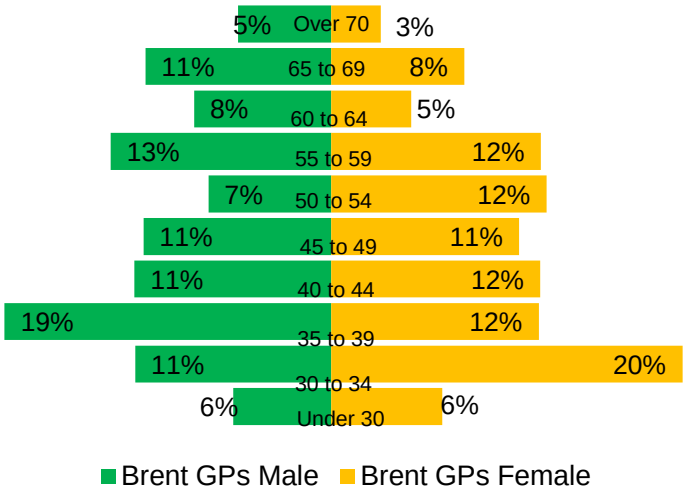
In Brent 16.0% of GPs are aged between 30 and 34, in line with National and London averages. Brent CCG has a lower proportion of younger GPs (under 50) than England, and slightly below that of London (CCGs within the London Commissioning Region) and a higher proportion of GPs in older age groups (65 and over) than London or England.

Figure 15: FTE GPs by age groups[36]



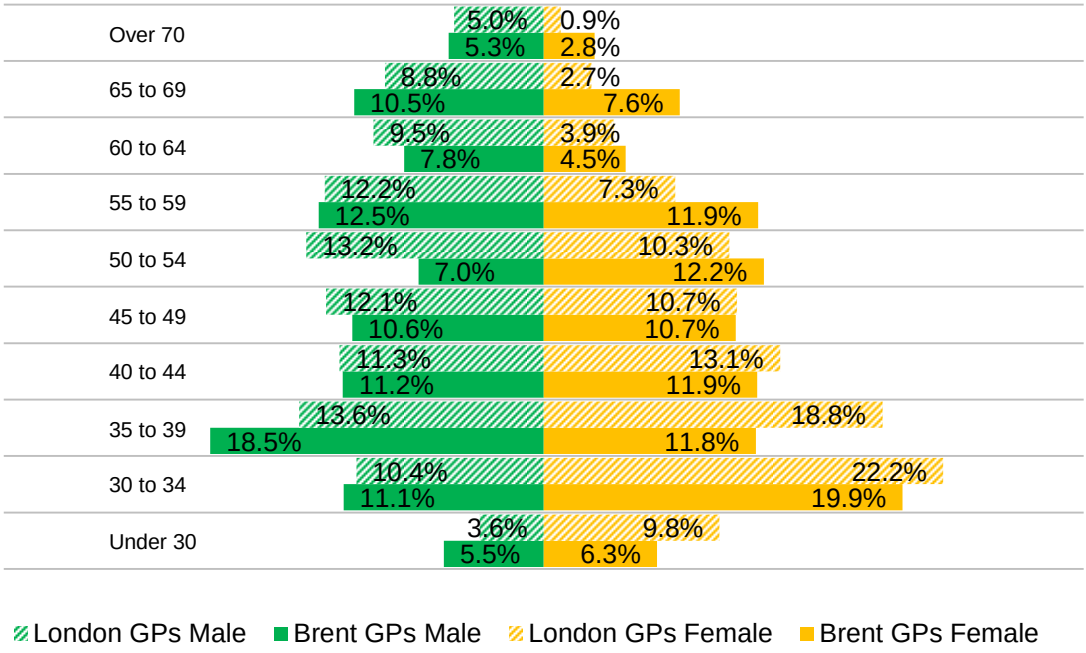
There are more female GPs in Brent than male GPs, with 110.0 female GPs compared to 90.2 male GPs (FTE). When the headcount is considered, there is a more marked difference, with 149 female and 105 male GPs. This suggests that men are generally working more hours than their female colleagues. Figure 16 shows the number of male GPs within each age group as a percentage of all male GPs and the number of female GPs in each age group as a percentage of all female GPs.

Figure 16: GPs in Brent[36]



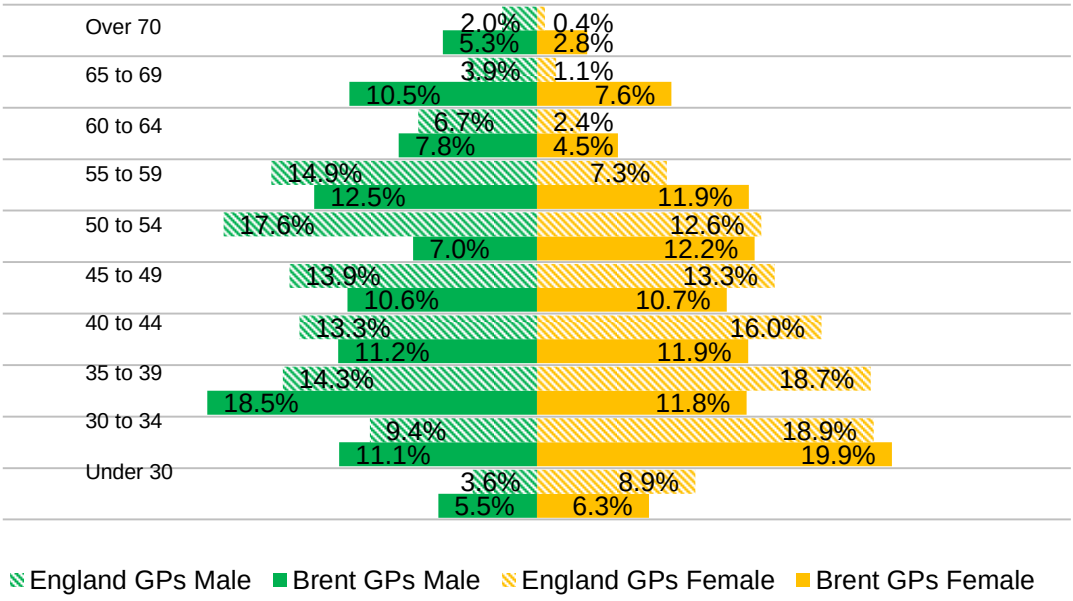
There is a noticeable discrepancy between male and female GPs in their 30s, with a greater proportion of women aged between 30 and 34 and a greater proportion of men between 35 and 39. Comparing this pattern with London and England averages, the higher proportions of female GPs aged 30 to 34 seems typical, while the higher proportion of male GPs aged 35 to 39 is more unusual.

Figure 17: Brent GP age and gender profile compared to London[36]



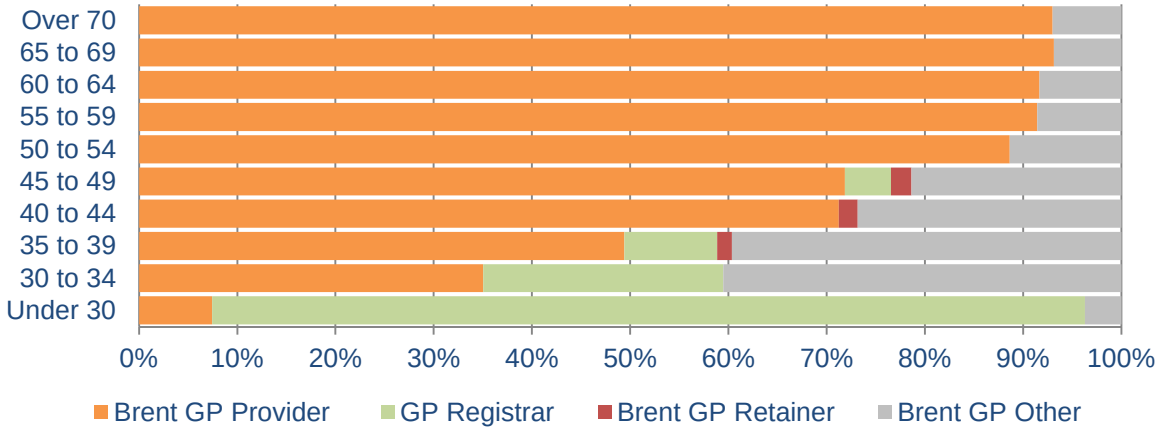
There are slightly more men in older age groups in Brent, with 43.1% of male GPs and 39.0% of female GPs are over 50. Comparing Brent with London and England, the tendency for male GPs to appear in older age groups is much more marked. Across London and England, almost half of male GPs are over 50 compared to around a quarter of female GPs. However, as outlined above, there is a higher proportion of GPs in Brent aged 65 and over compared to London and England.

Figure 18: Brent GP age and gender profile compared to England[36]



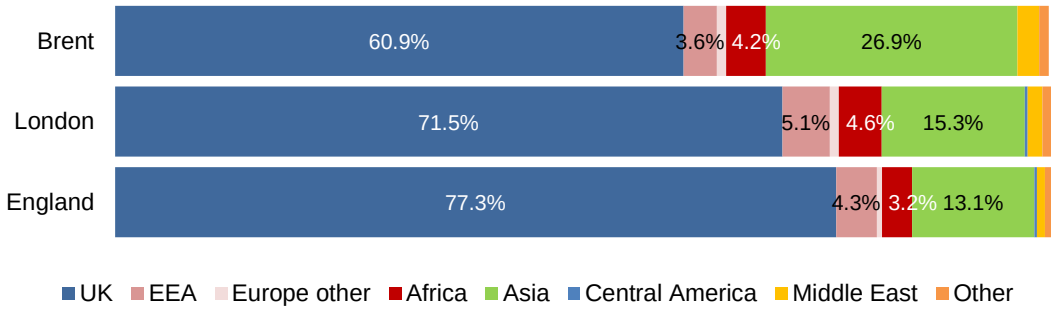
Of the types of GP classified, GP Registrars (those being trained for general practice) are generally the youngest. In Brent, around 90% of GPs under 30 and a quarter of GPs aged between 30 and 34 are GP Registrars with fewer than 10% in the older categories. Brent's distribution of GP types to age groups is in line with London and England.

Figure 19: Brent GP type and age[36]



Around 60% of GPs in Brent qualified in the UK, about 10% lower than London and 17% lower than England. A further breakdown of county of qualification is included in the primary care workforce profile in appendix 5.

Figure 20: Country of qualification[36]



District nursing

District nurses are commissioned by the CCG and provided as part of LNWHT Community Services. The service cares for patients in the community and has a close working relationship with primary care. District nurses provide individual healthcare needs assessment, care planning and provide nursing care within the home. Issues regarding recruitment and retention were raised during the review. This requires further investigation in looking at plans to increase the workforce in Brent. Feedback received during the review included a need to develop a programme to support district nursing, to ensure an effective, motivated and responsive service is in place. This service is key to the delivery of the out-of-hospital strategy. The task group have some concerns regarding the issue of recruitment and retention and the impact this may be having on residents and GPs ability to access the service. The task group felt that clearer commissioning commitments to an extended and enhanced district nurse workforce were needed.

Investing in the workforce

In January 2015 a £10 million investment to expand the general practice workforce was announced by NHS England. Building the Workforce – the New Deal for General Practice (NHS England 2015) sets out a ten point action plan and outlined NHS England's commitments to tackle workforce issues. NHS England has developed a range of initiatives in collaboration with Health Education England (HEE), the Royal College of General Practitioners (RCGP) and the British Medical Association (BMA) to increase the number of GPs and develop the role of other primary care staff such as nurses and pharmacists. This includes a marketing campaign to promote general practice and recruit newly trained doctors into general practice in areas that are struggling to recruit. It would ensure that GPs are retained through offering part-time work opportunities for individuals considering a career break or retirement and encourage doctors to return to general practice through the introduction of a new induction and returner scheme. There will be targeted investment to encourage GPs to return to work in areas of greatest need.

The investment and initiatives outlined above have been developed to tackle workforce issues. It will be a while before the outcomes are fully realised which will not address current issues in balancing capacity and demand. At the same time as pressures on capacity, the expectation and demands for what GPs are being asked to deliver in terms of quality and quantity has increased. The Local Medical Committees (LMC) outlined that the ambition is for 20 minute patient consultations, where required, in their discussion with the task group. At present this is constrained by both GP numbers and premises, with investment in doctors surgeries required.

Key Learning and Insight

The task group acknowledge and welcome the initial investment in the recruitment and retention of GPs but realise the impact of new initiatives to address the national shortage in GPs will take time to be realised. It was also felt, with a growing role of primary care, further investment will be required to fully address pressures on the service and ensure the workforce is resourced to support the move to community based care outlined in transformation programmes.

There has been a reduction in the number of GPs in Brent between 2013 and 2014 and figures show a higher proportion of GPs in older age groups (65 and over) compared to London and England. Any additional shortfall in capacity will place further strain on services already under pressure. There are also additional concerns regarding support for district nursing.

Recommendation 10

Brent CCG in partnership with LNWHT Community Services investigate the extent of the gap in recruitment and retention of district nursing in Brent and consider the need for a programme to support district nursing, focused on ensuring an effective, motivated, independent and responsive service is in place.

5.6 Responsive urgent and emergency care

Brent's residents have a number of routes to access urgent and emergency care, including A&E at Northwick Park Hospital, Urgent Care at Central Middlesex Hospital, Northwick Park Hospital, St Mary's Hospital or St Charles Hospital, Walk-in Centres in Wembley, Edgware or Cricklewood and out of hours cover at General Practice. Results of the patient survey 2013/14, as outlined in section 5.2. show that only 44.2% of patients know how to access out of hours care.

Urgent Care Centre

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 UCC is a GP led service with an interdisciplinary team of GPs, nurse practitioners and Health Care Assistants. The Centre receives patients through the NHS 111 service, the London Ambulance Service and walk-in patients. 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.

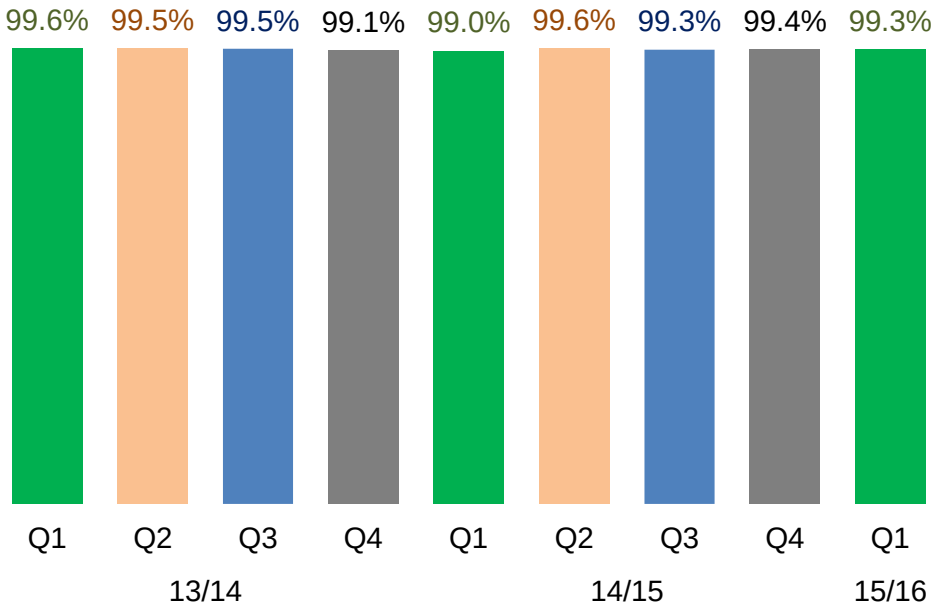
During the task group visit, members were informed that steps had been taken to ensure that the UCC could respond to needs following the closure of the A&E department at Central Middlesex Hospital. Additional facilities and services have been commissioned including a holding bay to manage any transfer requirements and private ambulance service to support non-emergency transfers. Waiting times are reported to vary dependent on medical priorities. Over 99% of patients are seen at Urgent Care Centres and Walk-in Centres within four hours, as illustrated in figure 21.

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.

Figures 23 shows an increasing trend in UCC and walk-in centre (WIC) attendances, which may be a result of difficulty in accessing GP appointments. However, coverage of the UCC at Central Middlesex Hospital reported a decrease in UCC attendance in February 2015[37]. This could have been following one of the clear dips (illustrated in figure 22) 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 still 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.

Figure 21: Percentage of patients seen at WIC and UCC within four hours 2013/14 to Q1 2015/16[38]



37
http://www.kilburntimes.co.uk/news/health/brent_urgent_care_centre_sees_decrease_in_patients_as_a_e_demands_rise_1_3971026

38 Source: NHS England: A and E attendances and emergency admissions (http://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/)
Information for London North West Healthcare NHS Trust from Q3 2014/15 onwards; 2013/14 and Q1and 2 2014/15 information for North West London Hospitals NHS Trust and Ealing Hospital

Figure 22: A&E and UCC weekly attendances[39]

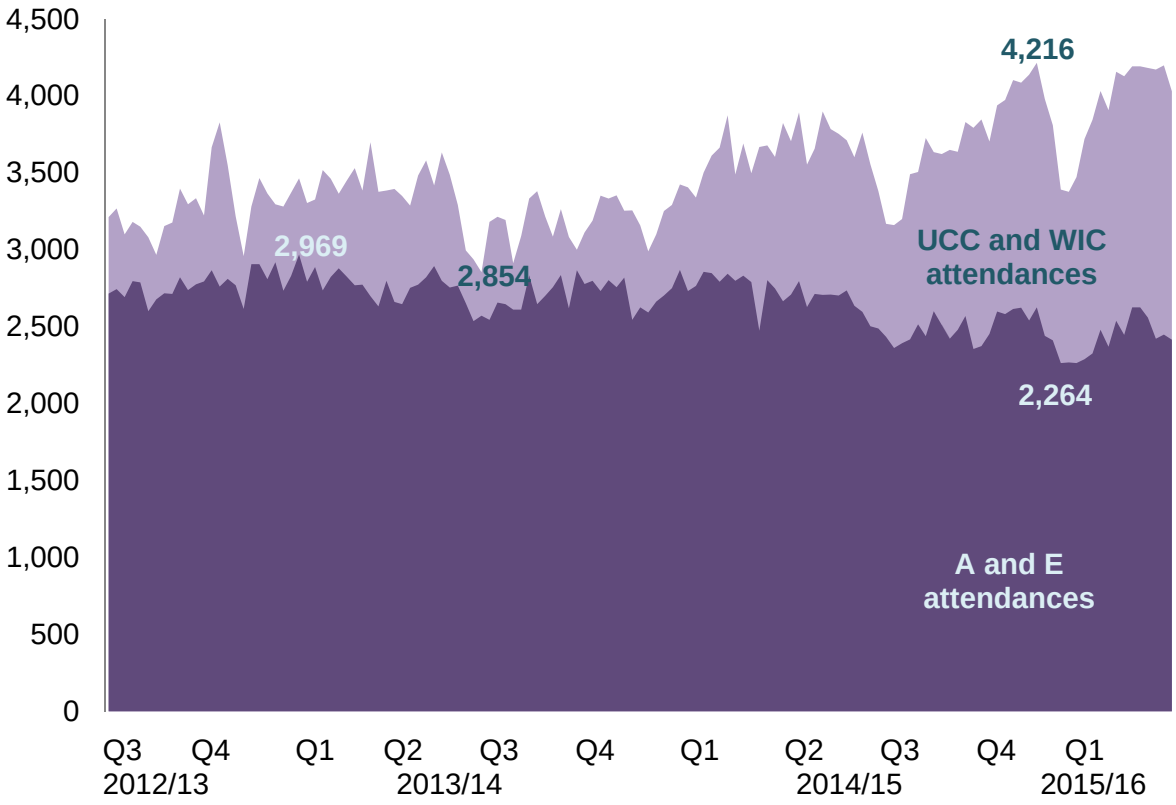
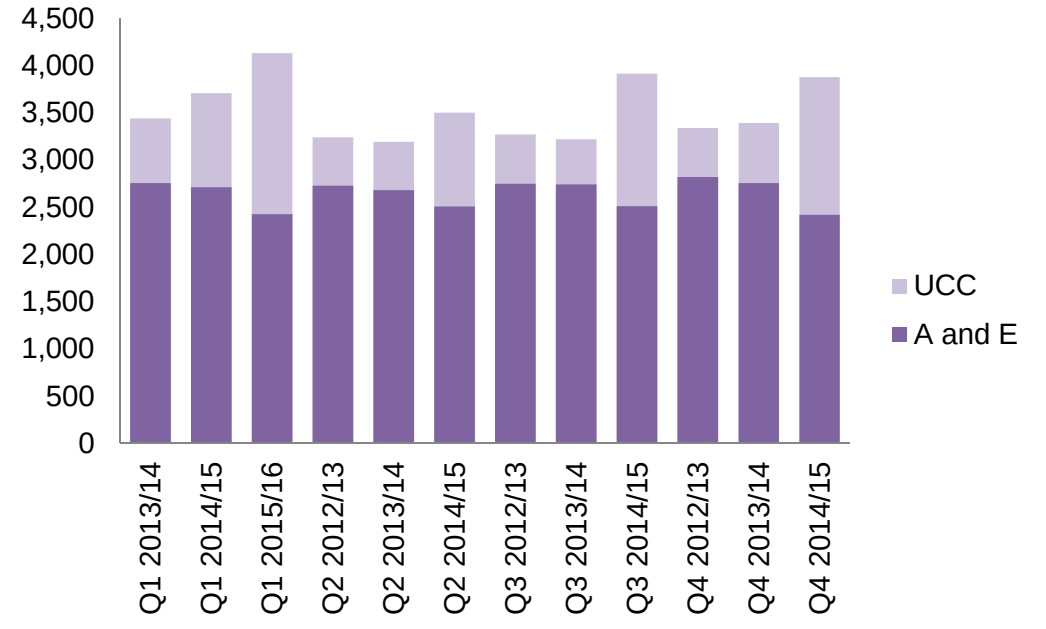


Figure 23: A&E and UCC attendances by quarter[40]



[39] 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.
[40] NHSE

London Ambulance Service

There are currently concerns regarding the performance of the 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 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 within eight minutes and 92% within 19 minutes.[41]

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%).[41] 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.[41] 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.

Key Learning and Insight

There is a general increase in UCC and walk-in centre attendances. The services are required to offer a breadth of expertise and It is acknowledged that additional facilities have been commissioned for the UCC at Central Middlesex Hospital to provide care for patients. There still remain concerns regarding residents' awareness of these services in supporting individuals in accessing the right service at the right time.

Recommendation 11
Healthwatch Brent work with providers to develop a clear communication strategy for ensuring the public are aware of and informed of the Urgent Care Centres available to the residents of Brent, as well as the services provided at Central Middlesex Hospital.

Recommendation 12
Care UK and London North West Healthcare NHS Trust review access to the Urgent Care Centre at Central Middlesex Hospital, including the introduction of clearer road and access signs for the Urgent Care Centre and a review of the cost of parking at the centre.

5.7 Focusing on health and wellbeing

Managing expectations

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

[41] LAS (January 2015)

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 to make informed decisions in accessing GP services. A booklet has been produced to help improve access to primary care in Brent. The task group feel that publicity materials need to be distributed more widely in accessible ways across the borough.

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. All of which place additional pressure on GP practices.

Preventative services

NHS health checks are vital to early detection of chronic disease such as diabetes. The programme also offers economic benefits due to ill health prevention. Free NHS health checks are offered to people aged between 40 and 74 who are not on a related disease register (cardiovascular, diabetes, hypertension). Local authorities are responsible for offering a check to those who are eligible once every five years, inviting 20% of their eligible population each year.

22.3% (16,824) of the eligible population in Brent were offered a health check in 2014/15 of which 56% (9,424) received one. The invitation rate was higher than the England average of 19.7% but lower than the London average (23.7%). The uptake rate is higher than the London and England average of 48.8%. Since 2011, 71,650 have received an invitation to attend a NHS Health Check in Brent (93% of those eligible) of which 40,381 Brent have received a health check (53%)[42].

The Brent Health and Wellbeing Strategy outlines a number of key challenges in Brent. These include poor oral health amongst children, rising obesity levels, low levels of physical activity, alcohol-related hospital admissions, mental health, high levels of many long-term chronic conditions and rising levels of dementia amongst older adults.[43] As outlined in section 5.1., heart disease, strokes and cancers are the biggest killers in Brent. In addressing these issues, the Health and Wellbeing Strategy, outlined the need to increase access to and expand preventative and screening programmes.

Preventative services are commissioned by both Public Health and the NHS. There are a range of preventative services across the borough, a number of examples of which were shared with the task group during the review, including diabetes champions.

Diabetes is one of Brent's biggest health challenges with 7.8% of Brent's population having type 2 diabetes. The risks of type 2 diabetes can be reduced by changes in lifestyle and early diagnosis. Good diabetes management is important to staying healthy. To address this issue, Brent Council is working with Diabetes UK to recruit and train diabetes community champions. The aim of the project is to help raise awareness of diabetes and enable people to spot the signs. Since being recruited, the diabetes champions have carried out 31 events at various locations in the borough, with over 2,000 people attending.[44] Success will continue be monitored against a list of key outcomes.

[42] NHS Health Checks Annual Performance Report 2014/15

[43] Brent Health and Wellbeing Strategy 2014-2017

[44] Brent Public Health

Brent Council has invested in outdoor gyms across the borough to help address the low levels of physical activity and to over come identified barriers to exercise, including cost and lack of access. Evaluation of the outdoor gym project was carried out in 2014. Findings showed an increase in the use of outdoor gyms between 2013 and 2014. Further actions have been identified to increase the take up of facilities including more targeted promotion.[45]

Supporting access to services

Through discussions held it was recognised that GPs are often viewed as a route to accessing support. GPs can be a key service for linking with individuals who may be socially isolated. Care plans are an opportunity to screen for unmet needs and can be used as a reference point for clinicians and patients; this includes social isolation and loneliness. With changes to the traditional day services model and access to community activities, social isolation and loneliness was perceived to be an issue within the borough. Areas mentioned included difficulty in accessing day services and a waiting list for befriending service. HSCCs have a key role to play here and are currently supporting individuals at risk of social isolation. A new project, the Social Isolation in Brent Initiative, has also been established and will help address some of these concerns.

It is also recognised that there are a number of people who do not register with a GP. This includes the homeless, hard to reach communities and residents new to the borough who take time to register and may only do so when they require the service. This highlights the need for a flexible model to meet different levels of need for primary care services across the borough.

Key Learning and Insight

There is recognition that to provide good general practice to meet both current and future needs, new models of care are required. Some of the challenges are around access to appointments but there is a need to for this to be balanced with managing expectations and the promotion of self-care.

The need to improve access to and extend preventative services across the borough has been recognised. The task group feel that this work needs to continue to actively promote take up of preventative services and screening.

Recommendation 13

Brent Council, Brent CCG and Healthwatch Brent develop a communication strategy with targeted activities across the borough, including establishing links with schools, workplaces and local faith groups, in promoting the right access to services, raising awareness of the range of services available and promoting self care. This should include using a range of communication methods across our diverse communities.

Recommendation 14

Brent Council's Public Health Department continues work with NHS England and Brent CCG to improve the take up of preventative services, including health checks.

[45] Brent outdoor gym evaluation (2014)

6. CONCLUSION

The review focused on understanding what is working well and where improvements are required in delivering extended GP services and primary care in Brent. The task group has reviewed data gathered and feedback from a range of partners who commission, deliver or access local services in drawing conclusions and making recommendations. The aim of these recommendations is to help improve access to primary care for the residents of Brent.

It is recognised that people will have different views and experiences of primary care. It is also acknowledged that good access to GP services will mean different things to different people. However, access to GP services appears to be of concern and through this review a common issue raised has been the recognition of current pressures placed on primary care services, and in particular local GP practices.

Changes in patients' health needs and expectations, an expected increase in long term health conditions, as well as ongoing budget pressures, continue to present real problems for both health and social care services. In expanding primary care services there is a commitment to offer access to primary care 24 hours per day, seven days a week. To respond to these changes and meet this commitment, it is recognised that investment in capacity as well as new models are required. The task group feel that these models and any changes to services need to be informed by Brent's residents in ensuring that services meet the needs of local people, improve patient experience and reduce dependency on emergency care. This should also be supported by further promotion of self-care across the borough in managing current and future demand.

7. LIST OF PARTICIPANTS, REFERENCES AND APPENDICES

7.1 List of Participants

Brent Clinical Commissioning Groups	Assistant Director – Primary Care Deputy Chief Operating Officer Director of Finance for Harness Care Cooperation Ltd Local GP representatives
Brent Council	Director of Public Health Strategic Director – Adult Social Services Team Leader – Research and Intelligence
Central London Clinical Commissioning Group	Chair
Central Middlesex Urgent Care Centre	Medical Lead GPs Service Manager
Healthwatch Brent	Coordinator Director
Local Medical Committee (LMC)	Chair – Brent LMC Medical Director, Londonwide LMCs
London Ambulance Service	LAS Operational Manager
Multi Disciplinary Group (MDG)	Willesden and Kingsbury MDG Harness MDG
NHS England	Head of Primary Care
Patient Participation Groups	Chair

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1.	Growth rates by Brent GP Practice January 2014 to January 2015
2.	Numbers of Patients Registered at a GP Practice (April 2015)
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4.	Healthwatch Brent – Report for Scrutiny Task Group 07/01/15
5.	Primary care workforce profile

Growth rates by Brent GP Practice January 2014 to January 2015

Growth rates of patients registered to Brent CCG GP surgeries on January 1st 2014 and January 1st 2015

GP Practice Code	GP Practice Name	Actual Growth	Percentage Growth
E83654	CRICKLEWOOD BROADWAY SURGERY	200	8.8
E84002	FORTY WILLOWS SURGERY	-120	-1.8
E84003	PREMIER MEDICAL CENTRE	371	7.6
E84006	THE LAW MEDICAL GROUP PRACTICE	-52	-0.4
E84007	UXENDON CRESCENT SURGERY	-57	-1.1
E84011	ST ANDREWS MEDICAL CENTRE	-527	-12.4
E84012	THE WINDMILL MEDICAL PRACTICE	133	1.9
E84013	CHURCH END MEDICAL CENTRE	10	0.1
E84015	WILLOW TREE FAMILY DOCTORS	145	1.3
E84017	SUDBURY & ALPERTON MEDICAL CENTRE	130	1.6
E84020	THE STAG - HOLLYROOD PRACTICE	107	4.1
E84021	THE WILLESDEN MEDICAL CENTRE	99	0.9
E84023	PARK HOUSE MEDICAL CENTRE	-96	-1.8
E84025	THE LONSDALE MEDICAL CENTRE	-199	-1.4
E84026	BUCKINGHAM RD SURGERY	332	6.4
E84028	THE STONEBRIDGE PRACTICE	-98	-2.1
E84029	HARNESS HARLESDEN PRACTICE	155	6.7
E84030	AKSYR MEDICAL PRACTICE	-122	-2.0
E84031	BRENTFIELD MEDICAL CENTRE	-165	-1.8
E84032	ELLIS PRACTICE	628	8.1
E84033	CHALKHILL FAMILY PRACTICE	33	0.7
E84036	GLADSTONE MEDICAL CENTRE	371	4.3
E84042	KILBURN PARK MEDICAL CENTRE	113	1.5
E84048	THE FRYENT WAY SURGERY	262	2.9
E84049	BRAMPTON HEALTH CENTRE	559	41.4
E84051	STANLEY CORNER MEDICAL CENTRE	172	3.0
E84056	THE CLARENCE MEDICAL CENTRE	-60	-3.3
E84063	LANCELOT MEDICAL CENTRE	-270	-4.3
E84066	HAZELDENE MEDICAL CENTRE	-22	-0.7
E84067	CHURCH LANE SURGERY	-31	-0.4
E84074	FREUCHEN MEDICAL CENTRE	-333	-5.2
E84076	OXGATE GARDENS SURGERY	78	1.2
E84077	THE SHELDON PRACTICE	42	1.8
E84078	STAG LANE MEDICAL CENTRE	86	2.6
E84080	STAVERTON SURGERY	120	1.6
E84083	LANFRANC MEDICAL CENTRE	82	1.3
E84084	THE BEECHCROFT MEDICAL CENTRE	-241	-5.2

E84086	WALM LANE SURGERY	75	1.0
E84620	PRESTON ROAD SURGERY	231	4.2
E84624	PARK ROAD SURGERY	110	5.4
E84626	THE SUNFLOWER MEDICAL CENTRE	-5	-0.2
E84635	THE SURGERY	553	14.2
E84637	HILLTOP MEDICAL PRACTICE	303	12.3
E84638	ALPERTON MEDICAL CENTRE	132	2.3
E84645	ACTON LANE SURGERY	235	7.1
E84656	ROUNDWOOD PARK MEDICAL CENTRE	163	4.9
E84661	PRIMARY CARE MEDICAL CENTRE	34	1.1
E84665	NEASDEN MEDICAL CENTRE	277	3.8
E84667	BLESSING MEDICAL CENTRE	115	5.3
E84669	THE EAGLE EYE	169	7.5
E84674	CHICHELE ROAD SURGERY	113	1.8
E84678	PRESTON MEDICAL CENTRE	-61	-1.7
E84684	THE TUDOR HOUSE MEDICAL CENTRE	113	4.1
E84685	INTERGRATED HEALTH CIC	289	3.7
E84690	CREST MEDICAL CENTRE	-61	-1.4
E84696	PEEL PRECINCT SURGERY	-98	-5.5
E84699	KINGS EDGE MEDICAL CENTRE	25	0.6
E84701	PEARL MEDICAL PRACTICE	409	11.8
E84702	WILLESDEN GREEN SURGERY	-39	-1.3
E84704	ST.GEORGES MEDICAL CENTRE	-50	-2.1
E84705	CHAMBERLAYNE RD SURGERY	-2	-0.1
E84706	FRYENT MEDICAL CENTRE	103	4.9
E84708	THE VILLAGE MEDICAL CENTRE	125	6.1
E84709	WEMBLEY PARK DRIVE MEDICAL CENTRE	191	1.9
Y00206	BURNLEY PRACTICE	707	18.1
Y01090	SMS MEDICAL PRACTICE	383	14.0
Y02692	BRENT GP ACCESS UNIT HARNESS-WEMBLEY	1360	19.7

Source: HSCIC - http://www.hscic.gov.uk/article/2021/Website-Search?q=Numbers+of+Patients+Registered+at+a+GP+Practice&go=Go&area=both

Numbers of Patients Registered at a GP Practice - April 2015

Practice code	Practice name	All Patients	Male patients	Female patients
E84696	Peel Precinct Surgery	1,672	926	746
E84056	The Clarence Medical Centre	1,757	1,103	654
E84049	Brampton Health Centre	2,061	1,017	1,044
E84624	Park Road Surgery	2,170	1,105	1,065
E84708	The Village Medical Centre	2,178	1,157	1,021
E84706	Fryent Medical Centre	2,203	1,173	1,030
E84704	St. Georges Medical Centre	2,272	1,060	1,212
E84667	Blessing Medical Centre	2,357	1,135	1,222
E84077	The Sheldon Practice	2,429	1,343	1,086
E84669	The Eagle Eye	2,461	1,273	1,188
E84029	Harness Harlesden Practice	2,498	1,264	1,234
E83654	Cricklewood Broadway Surgery	2,499	1,362	1,137
E84705	Chamberlayne Road Surgery	2,523	1,292	1,231
E84626	The Sunflower Medical Centre	2,674	1,376	1,298
E84020	The Stag - Holyrood Practice	2,742	1,393	1,349
E84637	Hilltop Medical Practice	2,810	1,478	1,332
E84702	Willesden Green Surgery	2,840	1,573	1,267
E84684	The Tudor House Medical Centre	2,888	1,465	1,423
E84066	Hazeldene Medical Centre	3,104	1,719	1,385
E84661	Primary Care Medical Centre	3,160	1,577	1,583
Y01090	SMS Medical Practice	3,210	1,807	1,403
E84078	Stag Lane Medical Centre	3,413	1,755	1,658
E84656	Roundwood Park Medical Centre	3,546	1,720	1,826
E84678	Preston Medical Centre	3,588	1,963	1,625
E84011	St Andrews Medical Centre	3,596	2,013	1,583
E84645	Acton Lane Surgery	3,601	2,006	1,595
E84701	Pearl Medical Practice	3,951	1,953	1,998
E84690	Crest Medical Centre	4,293	2,232	2,061
E84084	The Beechcroft Medical Centre	4,386	2,219	2,167
E84635	Harrow Road Surgery	4,455	2,445	2,010
E84699	Kings Edge Medical Centre	4,484	2,390	2,094
E84028	The Stonebridge Practice	4,682	2,348	2,334
E84033	Chalkhill Family Practice	4,697	2,324	2,373
Y00206	Burnley Practice	4,739	2,448	2,291
E84023	Park House Medical Centre	5,208	2,483	2,725
E84003	Premier Medical Centre	5,348	2,604	2,744
E84007	Uxendon Crescent Surgery	5,367	2,644	2,723
E84026	Buckingham Rd Surgery	5,530	2,821	2,709
E84638	Alperton Medical Centre	5,771	3,134	2,637
E84620	Preston Road Surgery	5,836	3,071	2,765
E84030	Aksyr Medical Practice	5,981	2,980	3,001
E84051	Stanley Corner Medical Centre	5,995	3,244	2,751
E84063	Lancelot Medical Centre	6,000	4,008	1,992
E84074	Freuchen Medical Centre	6,024	3,254	2,770
E84083	Lanfranc Medical Centre	6,318	3,280	3,038

E84076	Oxgate Gardens Surgery	6,339	3,092	3,247
E84674	Chichele Road Surgery	6,387	3,628	2,759
E84002	Forty Willows Surgery	6,637	3,325	3,312
E84012	The Windmill Medical Practice	7,119	3,690	3,429
E84086	Walm Lane Surgery	7,640	3,671	3,969
E84042	Kilburn Park Medical Centre	7,693	3,909	3,784
E84665	Neasden Medical Centre	7,786	4,179	3,607
E84080	Staverton Surgery	7,862	3,791	4,071
E84013	Church End Medical Centre	7,893	3,904	3,989
E84067	Church Lane Surgery	8,126	4,544	3,582
E84017	Sudbury & Alperton Medical Centre	8,175	4,182	3,993
E84685	Integrated Health CiC	8,252	4,141	4,111
E84032	Ellis Practice	8,491	4,164	4,327
Y02692	Brent GP Access Unit Harness-Wembley	8,608	5,105	3,503
E84031	Brentfield Medical Centre	8,978	4,493	4,485
E84048	The Fryent Way Surgery	9,132	4,721	4,411
E84036	Gladstone Medical Centre	9,178	4,703	4,475
E84709	Wembley Park Drive Medical Centre	10,204	5,301	4,903
E84021	The Willesden Medical Centre	10,992	5,709	5,283
E84015	Willow Tree Family Doctors	11,672	5,764	5,908
E84025	The Lonsdale Medical Centre	14,166	6,646	7,520
E84006	The Law Medical Group Practice	14,518	7,204	7,314

Source: http://www.hscic.gov.uk/article/2021/Website-Search?productid=17788&q=Numbers+of+Patients+Registered+at+a+GP+Practice&sort=Relevance&size=10&page=1&area=both#top

Location of services in Brent

GP Access Hubs

Harness - Northern Hub
Wembley Health Centre
116 Chaplin Road
Wembley
Middlesex
HA0 4UZ
Mon to Fri 6pm - 9pm
Sun 9am – 3pm

Harness - Southern Hub
Harness Harlesden Practice
Hilltop Primary Care Centre
150 Hilltop Avenue
Harlesden
NW10 8RY
Mon to Fri 6pm -9pm
Sat 9am – 3pm

Kilburn Hub
Kilburn Park Medical Centre
12 Cambridge Gardens
London NW6 5AY
Mon to Wed 6pm -9pm

Kilburn Hub
Staverton Surgery
51 Staverton Road
London NW2 5HA
Thurs & Fri 6pm -9pm
Sat 9am – 3pm
Sun 9am – 3pm

Willesden Hub
Burnley Practice
Willesden Centre for Health & Care
Robson Avenue
London
NW10 3RY
Mon to Fri 6pm -9pm
Sat 9am – 3pm
Sun 9am – 3pm

Kingsbury Hub
kingsbury.hub@nhs.net
The Welford Centre
113 Chalkhill Road
Wembley Park
HA9 9FX
Mon to Fri 6pm -9pm
Sat 9am – 3pm
Sun 9am – 3pm

Wembley Hub
Sudbury Primary Care Centre
Vale Farm
Watford Road
Wembley Middlesex
HA0 3HG
Mon to Fri 6pm -9pm
Sat 9am – 3pm
Sun 9am – 3pm

NHS
Brent
Clinical Commissioning Group

1

Healthwatch Brent

Summary of views on GP Hubs

For Brent Scrutiny Task group 07/01/15

Context – Healthwatch Brent received this information in May 2013.

Are these figures the same at the start of 2015?

- 164 Principle GPs, 66 Salaried GPs and 168 Doctors on the supplementary list
- 1.85million appointments a year in general practice
- Integrated Care Organisation (ICO run by Ealing Hospital) 360 staff no details of people seen
- Northwest London Hospitals Trust About 4800 employees see **451251 people/cases a year**
- **Adult Social Care**
- **11435** contacts, **5272** receive a service (telecare to residential), **4288** receive a service paid for by Brent in 2012-2013
- **473** individuals got direct payments in 2012/3
- **4809** assessments in 2012-2013
- **3960** reviews each year (2012-2013)

Healthwatch Brent gathered **general views** from patients between April and November 2014, in which the main service areas commented on were -

GP Services	34%
Hospital	20%
Mental health	7%
Children & young people's health services	5%
Dentist	5%
A&E	4%

A fuller breakdown is attached as appendix 2.

In November and December 2014, Healthwatch Brent asked residents about **GP Hubs** via a questionnaire sent to members and contacts.

This group excluded groups who do not have access to the internet, including people with learning disabilities, older people and people with visual impairments.

We received 41 responses.

The full survey is attached as appendix 1.

Some of the most notable responses were –

Knowledge of GP Hubs appointments -

No knowledge	26
Yes	8
Vague understanding	6
Inaccurate inderstanding	2

6 people had used a Hub appointment. All 6 said this was satisfactory. 2 of those were people who said they did not know about GP Hubs.

Additionally, at Northwick Park Hospital A&E in December 2014 –

3 of 10 Brent residents we spoke to said they knew of GP Hubs

and 3 of 21 Harrow residents –please note, Harrow do not have GP Hubs.

General experience of making a GP appointment?

Ok / Quite good / good / very good	18
Poor / Bad / very bad	6
Got poor lately	3
Emergency appts ok	6
General appts take weeks	5
General appts take days	5
Long wait To see own GP	4
Phone issues	4

Most people reported that making an emergency appointment is quick.

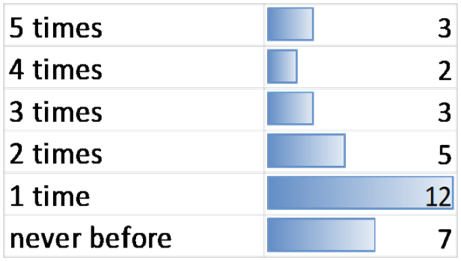
4 people said they would go to A&E for an emergency appointment.

2 people said they would phone 111.

Almost everyone had a positive view of there GP practice, and most people were prepared to wait for an appointment.

Additionally, 6 of the 10 Brent residents at NPH A&E said they did not know about the Urgent Care Centre at CMH.

Of the 35 people spoken to at NPH A&E the following numbers had used A&E in the past 12 months -



A more in depth HWB GP survey report is due to be published in Feb 2015. Whilst this will pick up the known concerns about appointment waiting times, the main focus will be on secondary concerns around communication, including referrals to secondary health services.

Appendix 1

Healthwatch Brent

Summary of views on GP Hubs

For Brent Scrutiny Task group 07/01/15

Do you know about GP hubs in Brent?

Healthwatch Brent surveyed members of the public in November/December 2014.

We asked the following groups – Contacts by email, HWB members via bulletin, Public at health centres and stalls, Elders Voice group, Health Focus Group

Our question	What people said	Numbers of responses
Do you know what a GP hub appointment is? If so, please say what you think it is.	**Total number of people who responded** No Yes Vaguely Inaccurately	**41** **26** **8** **6** **2**
How did you find out about it?	NHS 'Your Healthcare Services in Brent' booklet delivered to my home – each of these had a vague understanding GP National press Healthwatch Brent Radio 4 Health Focus Group Internet	**4** **4** **3** **2** **1** **1**

Have you ever been offered an appointment at another local surgery? Did you go, and how was it?	No Yes – including 2 patients who said no to the first question and 1 advised to go to NHS drop-in All 6 said this went well / ok / helpful	**36** **6**
What is your experience of making a GP appointment, generally?	Yes and vague group had slightly more positive comments Ok / Quite good / good / very good Poor / Bad / very bad Got poor lately Emergency appts ok General appts - - Weeks - Days Long wait To see own GP Phone issues **Additional comments** If urgent you can go between 8:30 and 11am and wait to see GP Have to phone on the day – can't get advance appt Emergency appt in the morning, but I can't attend then Have to call at 9 on the dot or all appts are gone GP happy to do home visit Not good, but then found out I could get appt more quickly	**18** **6** **3** **6** **5** **5** **4** **4** **1** **2** **1** **1** **1** **1**
What do you do if you can't get an appointment quickly enough?	Wait This hasn't happened Can sit and wait to be seen Go to A&E x4 Emergency appts Dial 111 Ask for phone consultation Ask for a Hub appt Go to pharmacy Suffer Pray	**10** **9** **5** **4** **2** **2** **1** **1** **1** **1** **1**

	Don't know No comment	**1** **3**
Is there anything else you want to tell us about your GP practice – good or bad?	Great / very good / good practice Just the appointments system is bad Hardly ever need to go Good and bad Can be rude sometimes	**17** **1** **2** **2** **1**

If you want to know what GP hub appointments are, please visit: http://www.brentccg.nhs.uk/en/news/113-more-gp-appointments-for-brent-residents

For information about what Healthwatch Brent does, or to get involved, please visit: www.healthwatchbrent.co.uk

Appendix 2

Healthwatch Brent

Summary of views gathered by HWB

For Brent Scrutiny Task group 07/01/15

- **Views gathered by Healthwatch Brent**

We gathered 180 views:

93% came from members of the public
2% came from organisations
2% came from members of Healthwatch Brent

64% came from meeting people at health and social care services
21% through the enquiries email and telephone
15% by our reply mailers that we leave at health and social care services

- **Most people commented on -**

GP Services	34%
Hospital	20%
Mental health	7%
Children & young people's health services	5%
Dentist	5%
A&E	4%
A wide range of other services (1% per service)	25%

- **Type of comments**

Complaint	45%
Concern	20%
Compliment	18%
Comment	11%
Questions	6%

Views gathered on GP services – Healthwatch Brent – Nov 2014

Nature of comment	Number	%
People giving views	59	34% of all views gathered by HWB
Total number of comments	64	100%
Negative comments	46	72%
Too long to get an appointment	19	30%
Unhappy with diagnosis or referral	11	17%
Not enough time with GP	6	9%
Poor physical environment	5	8%
Not seeing the same GP	4	6%
Rude receptionist	3	5%
Poor communication with people with learning disabilities	2	3%
Long waiting time in reception	2	3%
Individual concerns	3	5%
Positive comments	15	23%
Good / helpful service	9	14%
Easy to get appointments	5	8%
Physical environment	1	1%
Neutral comments	3	5%
Some staff good, others not good	3	5%

- **Quotes**

GP – “My concern is that it is difficult to get an appointment. I'm told to book on line. I've to wait along time to get an appointment."
“I'm happy with the service at Tanfield Ave Medical Centre. I can usually get an appointment within 2-3 days.”
"I'm pleased with the service given. [My GP at] Kilburn Park Medical Centre is very good so there is usually a waiting list to see him."

HWB response –
The CCG is trialling GP Hub appointments to make it easier to get an appointment. We sent out a survey about this to all of our individual contacts including over 200 local organisations. In December we will let Brent Council’s Scrutiny Committee know what people said.
We are carrying out surveys and producing a report to further explore GP services.

Hospital - "There are communication problems, mostly with admin staff [at CMH]. They need to be more efficient. I ran up to make an appointment, I gave my name and address and I was told that I had been discharged because the records shows that I had died"

HWB response -
We wrote to the relevant manager of 4 services to raise concerns and made direct contact possible for patients and their families to get a response, including Willesden Centre for Health and Care and Park Royal Centre for Mental Health.

Children – "It is good to have someone to talk to [at CAMHS]. However, to be better it would be good to have more things like Brent User Network."

HWB response -
We will undertake a fuller survey of young people to hear about their mental health services. We will produce a report on this early in 2015.

Dentist – Concern was raised by a number of people about a lack of dental treatment in Brent for people with learning disabilities. This related to a lack of communication about changes to services and that people now need to travel out of the borough for most treatment.

HWB response –
This has been constantly raised at the old Primary Care Trust, the Learning Disability Partnership Board and Brent CCG, without any improvement.

A&E - I was kept in A&E for 10hrs, without a diagnosis. I felt dreadful. I later found out that I have an over active thyroid - I don't have any faith in the medical service".

HWB response -
We will be visiting A&E at Northwick Park in December to get the views of patients. We will give this information to Brent Council's Health and Wellbeing Board.

- **What else we did in response to your views**

We signposted people to the correct complaints procedure, and to Voiceability if they needed support.
We met with CQC to start exploring how we share information about the concerns raised by people in Brent.
We trained 8 volunteers to make Enter and View visits to services that we have received concerns about.

We offered small grants to small organisations to gather views from their communities, so that we hear from as wide a range of people in Brent.

Additional views regarding referrals from GP to outpatients

I had to wait for 9 weeks for a referral had to chase up a referral left at the surgery which had not been sent to the hospital. I then had to wait 8 months to see a counsellor

I'm disappointed to get paracetamol as a treatment after visiting the GP. It does not help. It's difficult to get a referral. Some GP are better than others, they give referrals and prescriptions for children, so it can be done."

Had problems accessing records from GP surgery - not co-operative at all. Had problems being referred to hospital, took several visits and another GP in the surgery eventually did the referral. When I tried to talk to GP about my concern, Dr. rang me and was very rude.

I've been getting a run around from my GP surgery and CMH. I had my annual eye check and was given new glasses. There was I problem with one eye and the Optician gave me a letter to give to my GP. I needed to have my eyes examined at Central Middlesex hospital. I have been waiting a very long time to get the appointment. When I checked at my GP surgery the receptionist said that the referral letter was faxed to the hospital. I went to CMH but they said that they had not received the referral. The GP receptionist claimed that CMH had lost the referral and they would fax it again.

GP taking time to get results back for urine test and blood test. Referred to hospital and had to repeat tests.

GPs do not give enough time or make referral in time for proper care.

Healthwatch Brent involvement with Whole Systems Integrated Care -

Healthwatch Brent have been invited to play a full role in the development of the Engagement Enabler as part of the Better Care Fund. The Better Care Fund is a reallocation of resources from Health to the Local Authority with the express purpose of finding ways in working together.

Brent was a successful pioneer site for the Better Care Fund with their proposal being accepted by NHS England in September 2014. There are four workstreams under the Better Care Fund as follows :-

Scheme 1: Keeping the most vulnerable well in the community (this includes a project called Integrated Care Pathway (ICP) headed by Sheikh Aladin and Whole Systems Integration Scheme headed by Sarah McDonnell) - supported by Healthwatch Brent by Tessa Awe

Scheme 2: Avoiding unnecessary hospital admissions headed by Isha Coombes - supported by Healthwatch Brent by Daksha Chauhan-Keys

Scheme 3: Efficient multi-agency hospital discharge headed by Yolanda Dennehy - supported by Healthwatch Brent by Miranda Wixon

Scheme 4: Improving urgent Mental Health care headed by Duncan Ambrose - supported by Healthwatch Brent by Anne-Marie Morris

The Healthwatch Brent representatives were selected from within the original task group that was put together when writing the proposal for the BCF and it is the hope that this task group which also includes Keritha Ollivierre and a representative from the Council will work to develop a toolkit that will form a basis for future engagement within the Council and the CCG to ensure that a wide range of people are communicated with and in particular those people from protected groups.

The purpose of this work is to develop better services to people living in their own communities in a joined up way so that professionals are working around the person and not the person having to navigate a complex web of health and social care systems.

Have your say either by contacting Healthwatch Brent giving them your views on what is happening now and the plans for the future.

(I will ask Philip Vining if he has a diagrammatic model of governance for the BCF which may be useful for us to include in the bulletin.)

The Healthwatch Brent working group has suggested that we could have an event in the New Year to get a broad range of views on engagement to develop the toolkit.

Item 2: GP Hubs - that is all on the report but in a nutshell

Healthwatch Brent were asked to moderate the submissions made by the four GP localities about how they were going to respond to the Prime Ministers Challenge on longer GP opening hours. All four localities put forward comprehensive proposals and suggested that they would be engaging with the patient participation groups and CVS Brent to ensure that this is patient focussed. Healthwatch Brent is delighted that there was a strong proposal of engagement in all four proposals that will now be worked up to a business case to make sure that they have the appropriate resources to deliver their promises.

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Primary Care Workforce Profile (Brent)

14 July 2015

Total number of GP practices in Brent: 67 (note: two of these practices actually fall within the boundaries of neighbouring boroughs; Camden and Harrow, however they are classified as GPs from within Brent CCG).

Totals and Full-time equivalents

There are 254 GPs working in Brent of any working hours (full or part-time). The Full-time-Equivalent (FTE) for these GPs is 200.2.

The headcounts and FTEs for other types of practice staff is shown below.

	Headcount	Full-time equivalent
GPs	254	200.20
GP Provider	158	133.23
GP Registrar	25	22.20
GP Retainer	3	1.33
GP Other	68	43.44
Practice Staff	744	460.81
Direct Patient Care staff	97	45.88
Admin staff	499	352.68
Other staff	43	9.60
Nurses	105	52.65
Advanced Nurses	13	8.65
Extended nurses	12	3.37
Practice Nurses	80	40.63

FTE figures rather than headcounts have been used to calculate the following workforce profile.

GP Providers are practitioners who have entered into a contract to provide services to patients.

GP Retainers are practitioners who provide service sessions in general practice. They are employed by the partnership to undertake set sessions, being allowed to work a maximum of four sessions per week.

GP Registrars are fully registered physicians who are being trained for general practice under an arrangement approved by the Secretary of State.

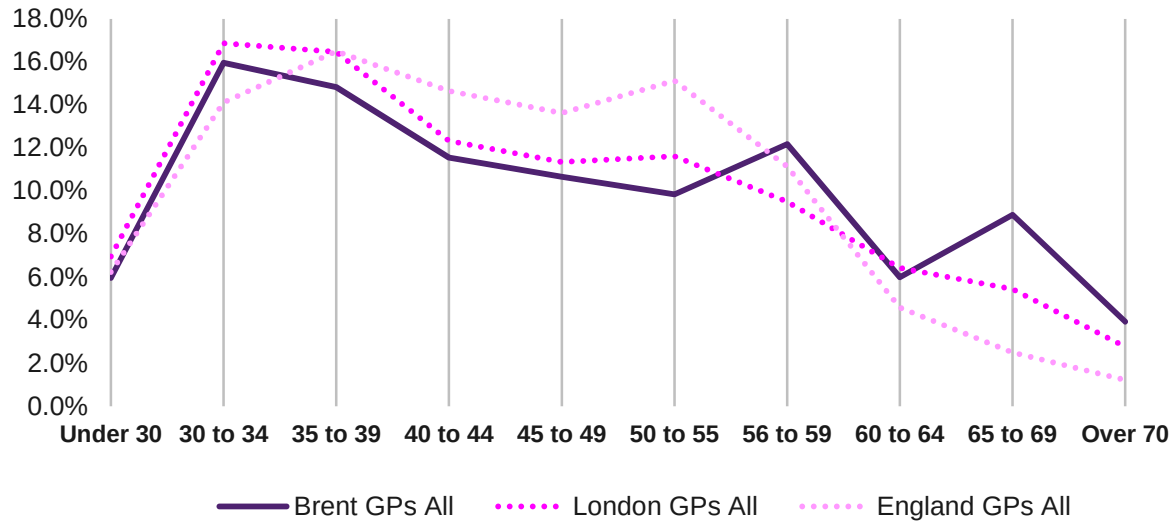
http://www.hscic.gov.uk/catalogue/PUB13849/nhs-staf-2003-2013-gene-prac-rep.pdf

Age profile

The biggest age group for Brent GPs is 30 to 34, which is in line with both the National and London average.

Brent CCG has a lower proportion of younger GPs (under 50) than England, and slightly below that of London (CCGs within the London Commissioning Region). Brent has a higher proportion of GPs in older age groups than London or England.

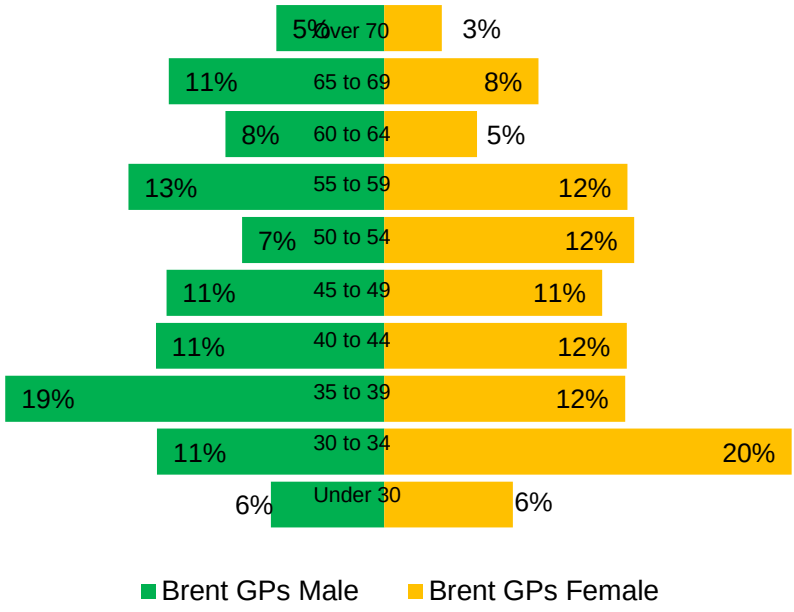
FTE GPs by age groups



Age and gender profile

There are more female than male GPs in Brent, with 109.99 female GPs compared to 90.21 male GPs (FTE). When the the headcount (staff with any working pattern) is considered, there is a more marked difference, with 149 female and 105 male GPs. This suggests that men are generally working more hours than their female colleagues.

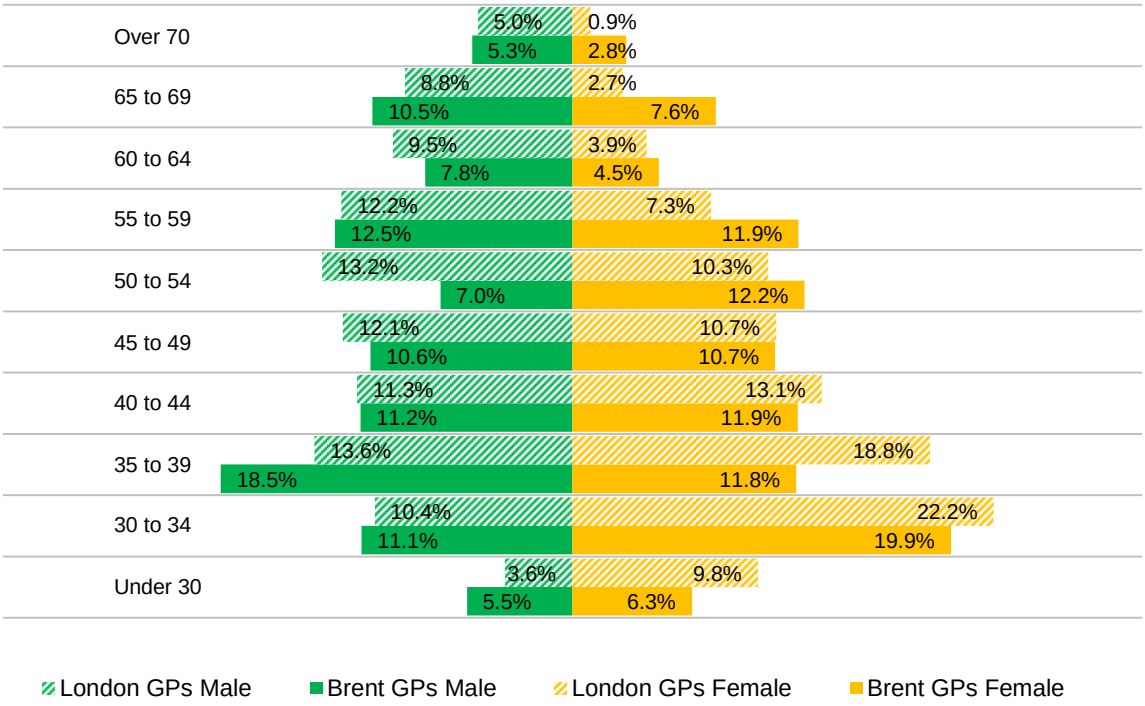
The following chart shows the number of male GPs within each age group as a percentage of all male GPs and the number of female GPs in each age group as a percentage of all female GPs.



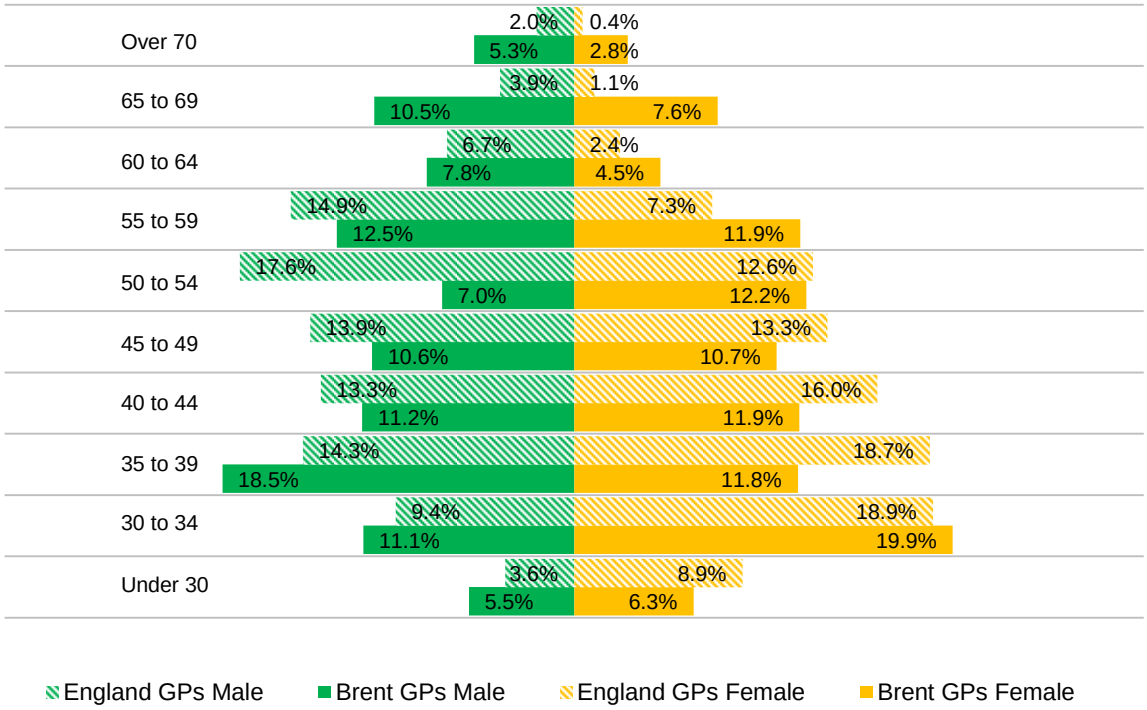
There is a noticeable discrepancy between male and female GPs in their 30s, with a greater proportion of females aged 30 to 34 and a greater proportion of male GPs aged 35 to 39. Comparing this pattern with London and England averages, the higher proportions of female GPs aged 30 to 34 seems typical, while the higher proportion of male GPs aged 35 to 39 is more unusual.

There are slightly more males in older age groups in Brent. Forty-three per cent of male GPs and 39% of female GPs are over 50. However, comparing Brent with London and England, the tendency for male GPs to appear in older age groups is much more marked. Across London and England, almost 50% of male GPs are over 50 compared to around 25% of female GPs.

Brent GP age and gender profile compared to London



Brent GP age and gender profile compared to England

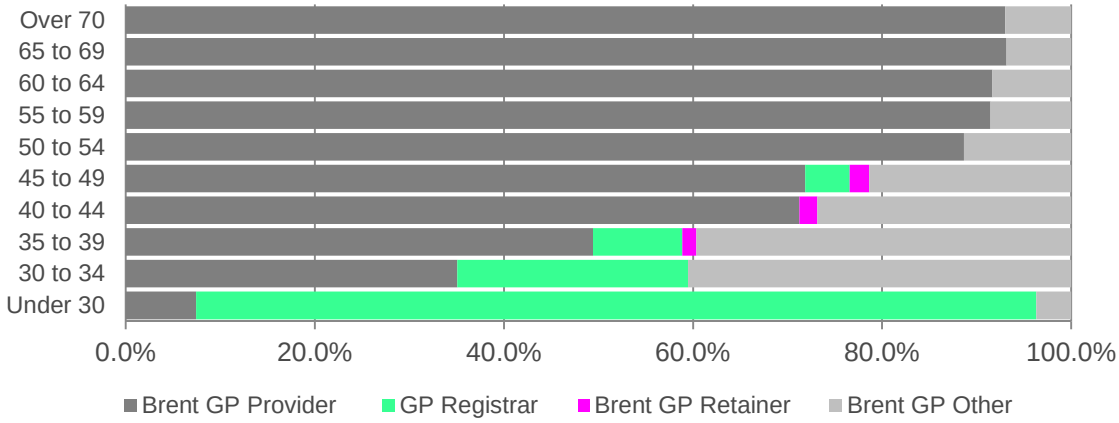


Types of GP and age

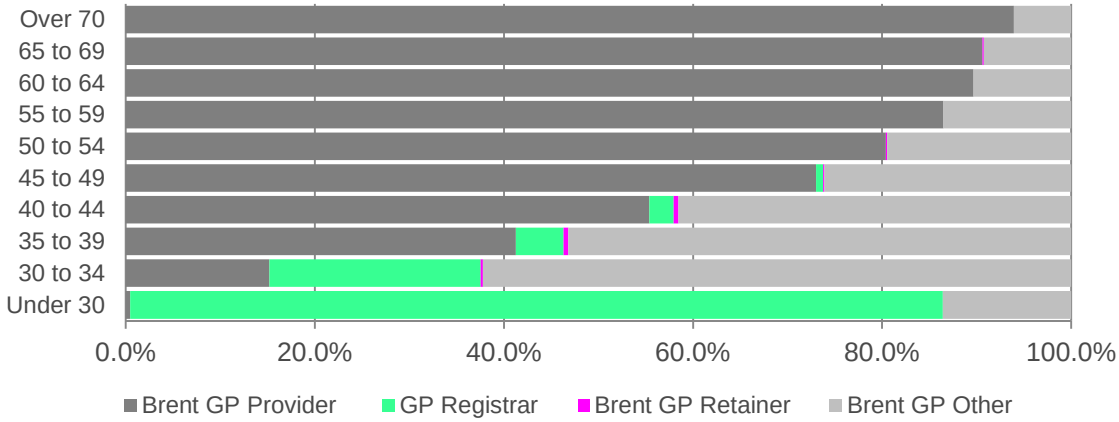
Of the types of GP classified, GP Registrars (those being trained for general practice) are generally the youngest. In Brent, around 90 percent of GPs who are under 30 and a quarter of GPs aged 30-34 are GP Registrars with less than 10% in the older categories.

Brent's distribution of GP types to age groups is in line with London and England.

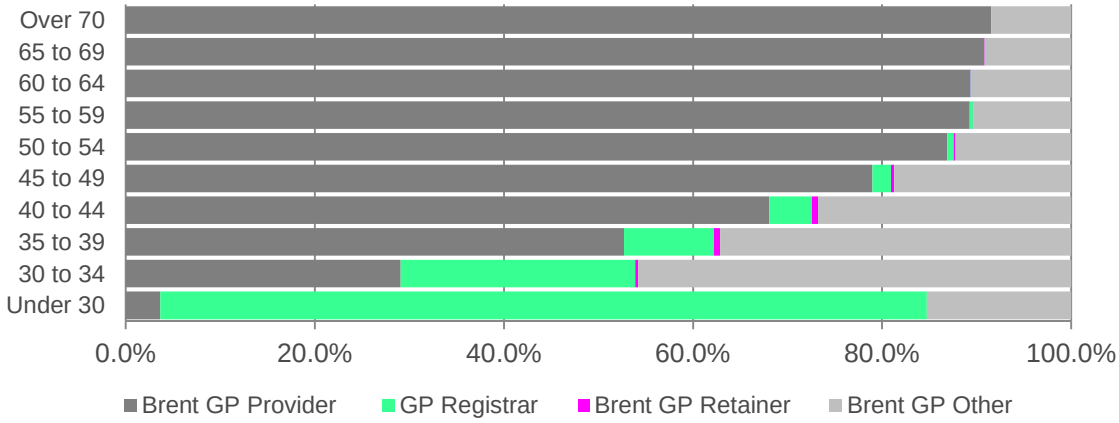
Brent GP type and age



London GP type and age

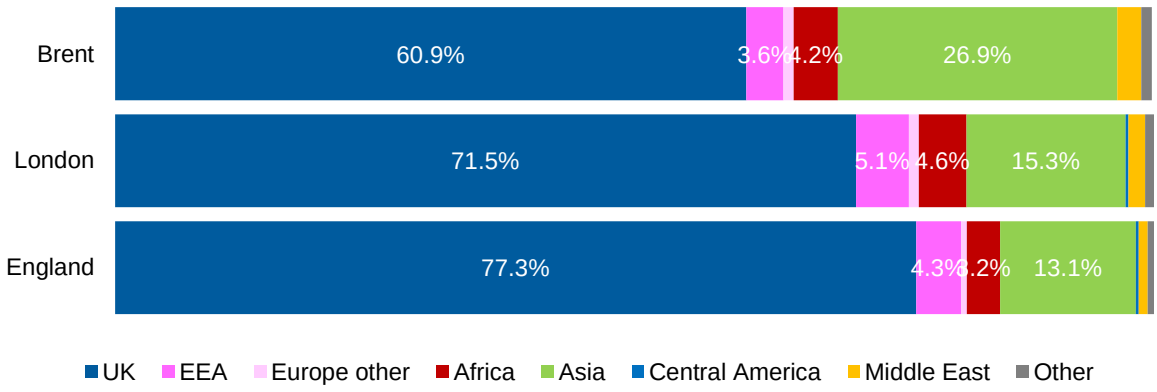


England GP type and age



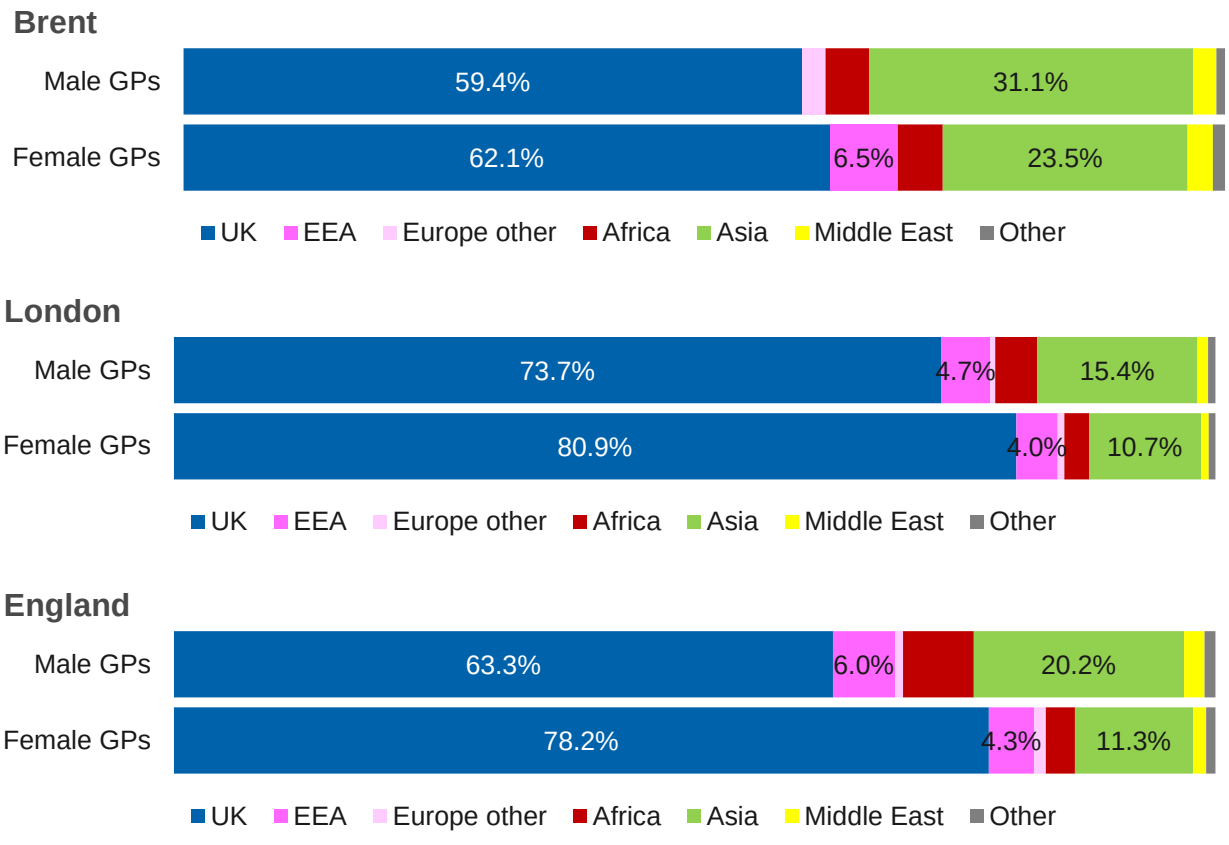
Country of Qualification

Around 60% of GPs in Brent qualified in the UK, a figure around 10% lower than that for London and around 17% lower than that for England. Of those GPs who qualified elsewhere, the majority of these came from Asia. This is the case across London and England, but not to such a great extent as for Brent.



Country of Qualification and gender

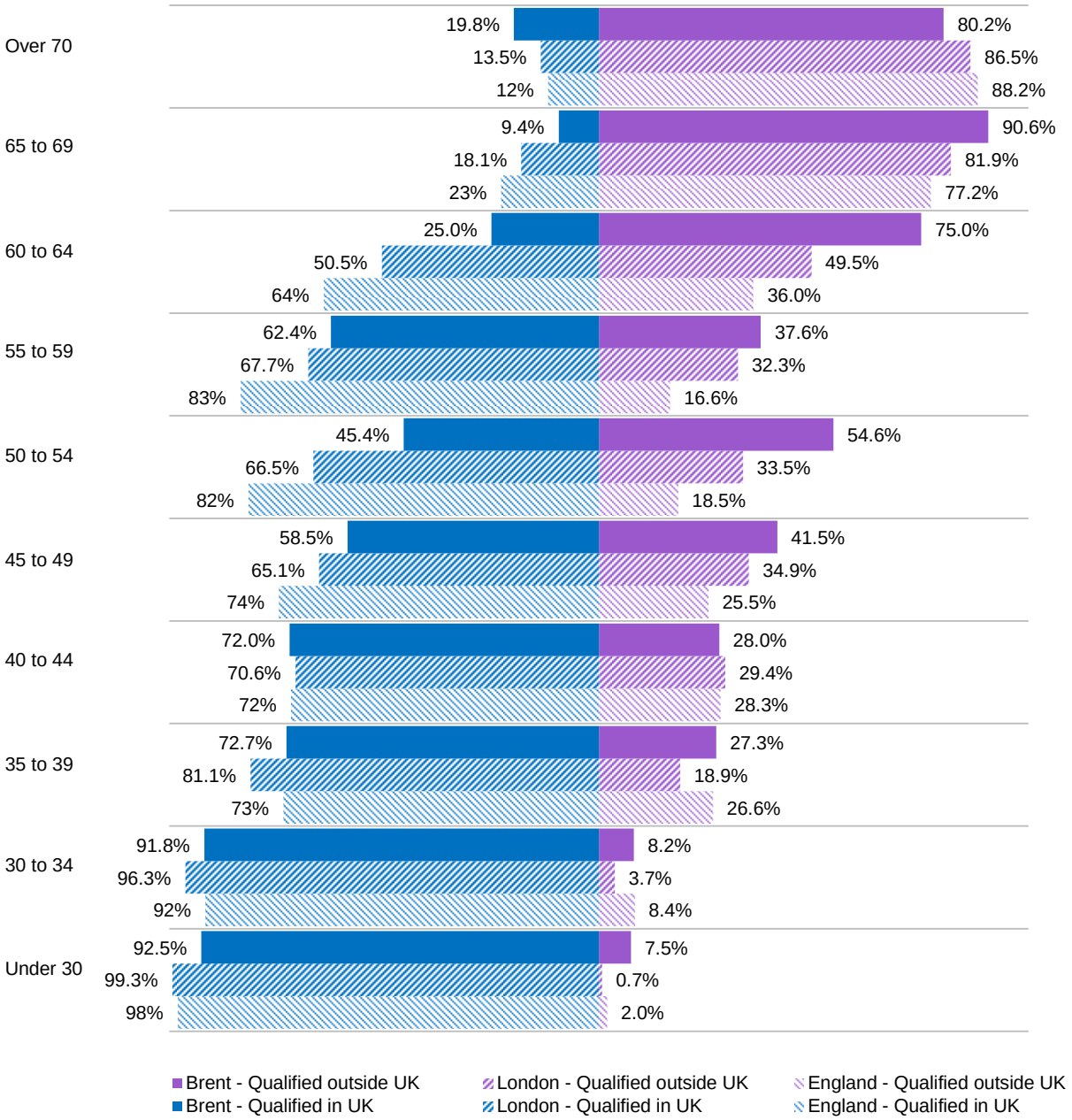
The proportion of male GPs qualifying outside the UK is generally higher than that of females, with more male GPs coming from Asia. This is in line with the trends seen in London and England, although Brent generally has a greater proportion of non-UK qualifying GPs.



Country of qualification and age group

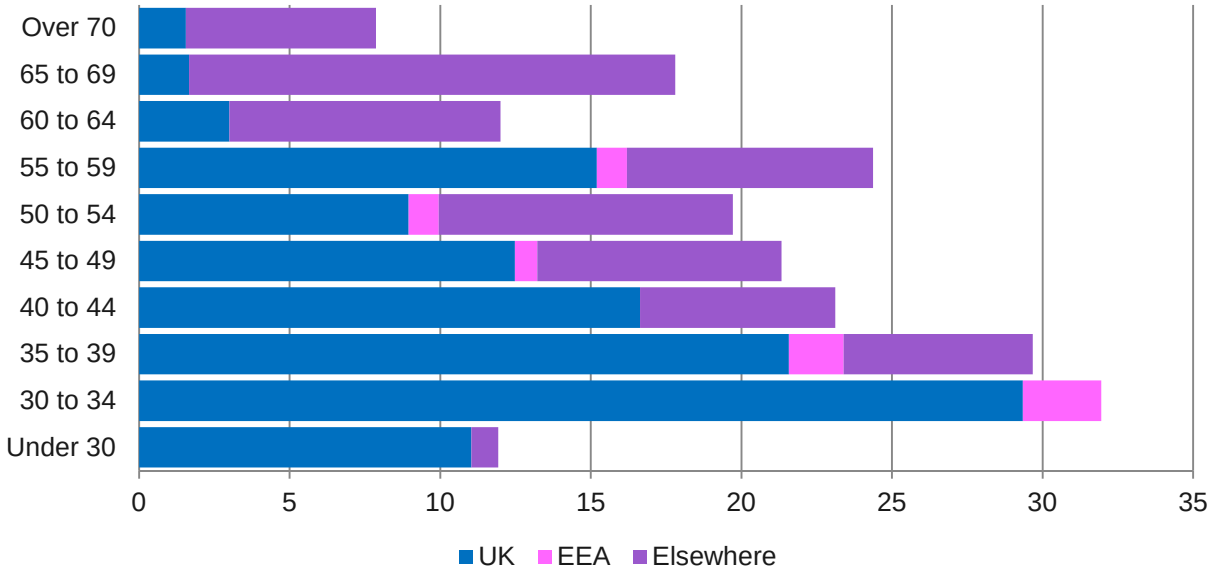
The chart below shows the number of GPs who qualified in the UK and non-UK countries in each age group as a percentage of the total number of GPs in that age group, compared to the equivalent figures for London as a whole and England.

There is a clear trend toward younger GPs becoming qualified in the UK whilst older GPs qualified elsewhere. This is the case throughout London and England, but at most ages Brent generally has a greater proportion of GPs qualifying outside the UK.



GPs qualifying in the UK / European Economic Area (EEA) and Elsewhere

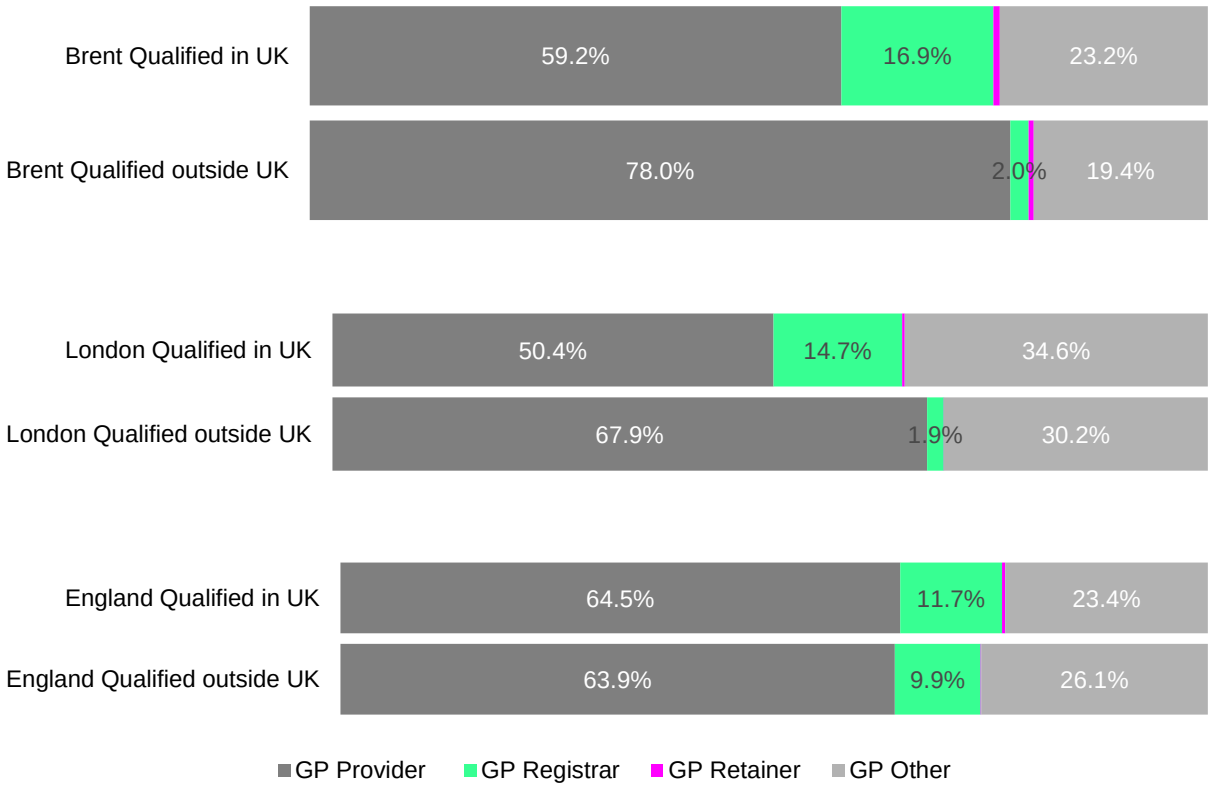
As well as the trend for younger GPs qualifying within the UK rather than elsewhere, there is also a greater proportion of GPs in younger age groups qualifying within the EEA. This is in line with trends across London and England.



Country of qualification and types of GP

Breaking down GPs into those qualified within the UK and elsewhere, it is apparent that a much higher proportion of GPs qualified within the UK are registrars rather than providers.

Brent has a similar proportion of GP Registrars to London qualified with and outside the UK, but it has a greater proportion of Registrars qualified in the UK than in England as a whole.



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Brent	**Scrutiny Committee** 9th September 2015 **Report from the Chief Operating Officer Department**
For Information	

Proposed Scope for Scrutiny Task Group on Fly Tipping in Brent

1.0 Summary

1.1 This report sets out the proposed scope for the Scrutiny task group on Fly Tipping in Brent. This task group has been requested by the Scrutiny Members in response to communicated concerns from Brent residents'.

1.2 The purpose of the task group will be to focus on analysing five key areas:

1. Knowledge
   - Behavioural and sociological research /information from other authorities on successful strategies
   - Brent fly tipping levels, why we have the levels we do?
   - Increasing trends

2. Education
   - Public communication
   - Education (at schools and through community / cultural groups)

3. Enforcement
   - Current systems (to what extent is this proving effective?)
   - Success of enforcements
   - Deterrents (e.g. CCTV)
   - Trade waste and dumping

4. Impact
   - Impact of new 'Green Bin Tax'
   - Impact of Landlord Licensing in reducing the issue

5. Publicity
   - Success / failure of previous and current publicity campaigns
   - Analysis of how much public awareness there is

1.3 The task group will review the local policies and processes of the council and its partners, national research and guidelines and the views and opinions from local residents groups and businesses. The task group will also consult with experts in this field and other London boroughs which have been identified as being innovative and leaders in reducing fly tipping.

The task group will review a number of concerns in regards to fly tipping; which we will seek to look at in the context of Brent, these are:

- The estimated costs every year to investigate and clear up. This cost falls on taxpayers and private landowners.
- Fly-tipping poses a threat to humans and wildlife, damages our environment, and spoils our enjoyment of our towns and countryside.
- Fly-tipping undermines legitimate waste businesses where illegal operators undercut those operating within the law. At the same time, the reputation of legal operators is undermined by rogue traders.
- As with other things that affect local environment quality, areas subject to repeated fly-tipping may suffer declining property prices and local businesses may suffer as people stay away.
- Fly-tipping harms Brent's image as an attractive place to live and work. Brent was recently ranked 3rd in a national survey of the worst boroughs in which to live.

1.4 Making sure that Brent is an attractive place to live, with a pleasant environment, clean streets; well-cared for parks and green spaces is an objective within the Council's Borough Plan. Ensuring that fly tipping is reduced and in the long term eradicated is a widely backed element within the context of our "Better Place" priorities.

2.0 Recommendations

2.1 Members of the Scrutiny Committee are recommended to agree the scope, terms of reference and time scale for the task group on fly tipping in Brent, attached as Appendix A and B.

3.0 Detail

3.1 With member consensus on keeping our borough clean and reducing fly tipping, Members of the Scrutiny Committee requested a time-limited task group undertake a focused piece of work on potential actions to change behaviours through education and reduce fly tipping in Brent. The proposed scope and terms of reference for this work is attached as Appendix A and B.

Contact officers:
Cathy Tyson,
Head of Policy and Scrutiny
cathy.tyson@brent.gov.uk
0208 937 1045

Peter Gadsdon
Operational Director Strategic Commissioning

Appendix A

Fly Tipping
Proposed scope for Scrutiny Task Group
August 2015

Task Group Chair: Cllr Sam Stopp
Task Group Members: Colin George, Chirag Gir, Cllr Bernard Collier, Cllr Krupa Sheth, Cllr Aisha Eniola.

Time frame: Provide report to the Scrutiny Committee meeting on Thursday 5th November 2015

1. What are we looking at?

Fly tipping is the illegal deposit of waste on land contrary to Section 33(1)(a) of the Environmental Protection Act 1990. The types of waste fly tipped range from 'black bag' waste to large deposits of materials such as industrial waste, tyres, construction material and liquid waste. Fly tipping is a significant blight on local environments; a source of pollution; a potential danger to public health and hazard to wildlife. It also undermines legitimate waste businesses where unscrupulous operators undercut those operating within the law.

Local authorities and the Environment Agency (EA) both have a responsibility in respect of illegally deposited waste. Local Authorities have a duty to clear fly-tipping from public land in their areas and consequently they deal with most cases of fly-tipping on public land, investigating these and carrying out a range of enforcement actions. The Environment Agency investigates and enforces against the larger, more serious and organised illegal waste crimes. Both Local Authorities and the Environment Agency are required to collect data on their activity and report this to the Flycapture database. Responsibility for dealing with fly-tipping on private land rests with private landowners and is not subject to mandatory data reporting.

2. Why are we looking at this area?

There is significant public concern in Brent about a perceived increase in illegal dumping over the last few years. It is suggested in some quarters that cuts to Brent's budget, handed down by central government, have adversely affected our ability to keep the streets clean. What's more, it is possible that the apparent increase in fly-tipping is a symptom of declining community spirit and cohesion.

Uncontrolled waste disposal can be hazardous to the public, especially when the waste consists of drums of toxic material, asbestos sheeting, syringes or used drugs. There could be a high risk of damage to watercourses and underlying soil quality from the dumped waste. Fly-tipping looks unsightly and this can harm investment in an area. Cleaning up fly-tipping costs taxpayers' money.

According to the Department for Environment, Food and Rural Affairs Flycapture Database, the most common types of fly-tipped waste are (starting with the greatest quantity): general household waste; white goods (fridges, freezers and washing machines); construction rubbish (demolition and home improvement rubbish); garden rubbish; and rubbish from businesses.

Local Context

Fly tipping is not a just a Brent problem, it is a problem experienced by all areas of the county, urban or rural.

Fly-tipping incidents reported by local authorities in 2013-14

LA_Name	Total Incidents	Total Incidents Clearance Cos
Newham LB [a]	67930	£3,026,234.00
Enfield LB	31692	£1,348,880.00
Haringey LB	31045	£1,491,507.00
Southwark LB	26638	£1,108,692.00
Westminster City Council	17121	£699,653.00
Hounslow LB	15864	£564,135.00
Croydon LB	15113	£1,366,642.00
Greenwich LB	12765	£715,829.00
Camden LB	10950	£229,852.00
Lewisham LB	9152	£293,672.00
Hammersmith and Fulham LB	9011	£529,042.00
Redbridge LB	8939	£390,390.00
Harrow LB	8429	£740,504.00
Hackney LB	7635	£1,210,485.00
Brent LB	**7001**	**£425,399.00**
Chelsea	6934	£273,482.00
Ealing LB	5765	£243,201.45
Tower Hamlets LB	5201	£241,176.00
Waltham Forest LB	4723	£184,419.00
Havering LB	3620	£157,650.00
Merton LB	3064	£172,574.00
Richmond upon Thames LB	2871	£61,393.00
Bromley LB	2809	£190,587.93
Islington LB	2634	£101,706.00
Hillingdon LB	1995	£90,405.00
Barnet LB	1779	£51,836.00
Barking and Dagenham LB	1282	£119,278.00
Sutton LB	1264	£89,049.00
Lambeth LB	1206	£98,523.00
Wandsworth LB	1105	£78,083.00
Bexley LB	1078	£45,111.00
London Corporation	530	£15,331.00
Kingston-upon-Thames LB	339	£14,466.00

It is worth noting that the methods used to capture and record data by local authorities are not consistent and why there is a vast difference in the figures above.

High incident areas within Brent:

- Harlesden
- Mapesbury
- Willesden Green
- Kensal Green
- Queens Park
- Wembley Central

Brent Waste Enforcement

Brent urges residents to take an active role and responsibility in keeping their communities clean. Brent encourages residents to be alert and forward on any evidence of fly-tipping to the council. The Cleaner Brent app makes it easy to report litter, fly-tipping, and other problems in streets, parks and cemeteries to us using your smartphone.

The app allows residents to provide information such as:

- registration of vehicle
- time of incident
- location and description of waste
- description of people dumping the waste
- Pictures, if possible, but strongly warns against confront suspects.

Brent will then arrange for it to be removed and trace the origin of the waste to identify who fly-tipped it and when the waste was dumped. Legal action will then be taken when the offender is identified. It is essential that any evidence passed on to Brent is treated as highly confidential and protected from entering the public domain and witnesses who provide it must be seen to be neutral and unbiased.

A review of the overall reporting system will need to be undertaken. There appears to be a public perception that, regardless of any incremental improvements delivered by the Cleaner Brent app, it takes too long for the enforcement team to respond to complaints. It is also suggested that enforcements are not actively followed up.

How enforcement links in with the new Landlord Licensing scheme must also be assessed, as it is hoped that this will be a key part of reducing the issue of fly-tipping in the most overcrowded parts of the borough.

Whilst Cllr Kelcher's own review will look at the effectiveness of CCTV provision in Brent, it would be worth touching upon this also in relation to fly-tipping. Is CCTV an effective detterent?

National Context

Local Authorities dealt with a total of 852 thousand incidents of fly-tipping in 2013/14, an increase of 20 per cent since 2012/13 with nearly two thirds of fly-tips involving household

waste.

This increase follows more recent year on year declines in the number of incidents. A number of local authorities have reported an increase in the number of fly-tipping incidents. Some local authorities have introduced new technologies; such as on-line reporting and electronic applications as well increased training for staff and have explained this as a factor in the increase in the number of incidents reported.

Local Authorities carried out nearly 500 thousand enforcement actions at an estimated cost of £17.3 million, which was over a £2.0 million increase on the previous year. This equated to an increase of 18 per cent on enforcement actions in the same period.

- The most common place for fly-tipping to occur was on highways, 47 per cent of total incidents in 2013/14.
- Incidents of fly-tipping on footpaths, bridleways and back alleyways increased 15 per cent in England in 2013/14. Together these now account for 29 per cent of fly tipping incidents.
- Approximately a third of all incidents consisted of a small van load of material or less.
- The estimated cost of clearance of fly-tipping to Local Authorities in England in 2013/14 was £45.2 million, a 24 per cent increase on 2012/13.

3. Legislation and Government Policy

Section 33(1)(a) of the Environmental Protection Act 1990; Fly-tipping is rubbish that is illegally dumped on land without permission from landowners or without a licence. It is an arrestable offence with a £50,000 maximum fine or five years imprisonment and any vehicles used in offences can be seized.

What are the main issues?

- It costs an estimated £86m-£186 million every year to investigate and clear up. This cost falls on taxpayers and private landowners.
- Fly-tipping poses a threat to humans and wildlife, damages our environment, and spoils our enjoyment of our towns and countryside.
- Fly-tipping undermines legitimate waste businesses where illegal operators undercut those operating within the law. At the same time, the reputation of legal operators is undermined by rogue traders.
- As with other things that affect local environment quality, areas subject to repeated fly-tipping may suffer declining property prices and local businesses may suffer as people stay away.
- Fly-tipping harms Brent's image as an attractive place to live and work. Brent was recently ranked 3rd in a national survey of the worst boroughs in which to live.

4. What should the review cover?

The review will address the following key areas:

- Knowledge

    - Behavioural and sociological research /information from other authorities on successful strategies
        - LB Brent
        - LB Hackney
        - LB Lambeth
        - LB Haringey
    - Brent fly tipping levels, why we have the levels we do?
    - Increasing trends

- Education
    - Public communication
    - Education (at schools and through community / cultural groups)

- Enforcement
    - Current systems (to what extent is this proving effective?)
    - Success of enforcements
    - Deterrents (e.g. CCTV)
    - Trade waste and dumping

- Impact

    - Impact of new 'Green Bin Tax'
    - Impact of Landlord Licensing in reducing the issue

- Publicity

    - Success / failure of previous and current publicity campaigns
    - Analysis of how much public awareness there is

5. How do we engage with the community and our internal and external partners?

As part of this review the task group will invite relevant partners to get involved; though workshops, discussion groups and one-to-one interviews.

Partners: Group 1

- Relevant Council Departments (Waste Enforcement)
- Brent partners such as the Police and Clinical Commissioning Group (CCG)
- Environment Agency
- Keep Britain Tidy

Partners: Group 2

- Contact Partners & Local Groups:
- Brent & Harrow CCG
- Harlesden Town Team
- Reach Team – Kensal Green
- Willesden Green Town Team
- Harlesden Town Team
- The Cricklewood Town Team
- Alperton Riverside Town Team
- Keep Wembley Tidy

6. What could the review achieve?

The review is expected to deliver a number of outcomes as listed below:

- Better understanding of residents waste disposal behaviour in Brent.
- Clearer understanding of the Council's role and the work it undertakes regarding fly tipping.
- Reduction in the levels of fly tipping in Brent.
- Cleaner and safer environments for all Brent residents.
- Reduction in clean-up and enforcement costs.
- Opportunities for increase revenue.
- More community involvement and stronger residents an council relationships.
- Better community spirit and cohesion.
- Efficiency savings such as officer time.

Appendix B

FLY TIPPING
MEMBERS TASK GROUP

TERMS OF REFERENCE

A. CONTEXT

Fly tipping is the illegal deposit of waste on land contrary to Section 33(1)(a) of the Environmental Protection Act 1990. The types of waste fly tipped range from 'black bag' waste to large deposits of materials such as industrial waste, tyres, construction material and liquid waste. Fly tipping is a significant blight on local environments; a source of pollution; a potential danger to public health and hazard to wildlife. It also undermines legitimate waste businesses where unscrupulous operators undercut those operating within the law.

Local authorities and the Environment Agency (EA) both have a responsibility in respect of illegally deposited waste. Local Authorities have a duty to clear fly-tipping from public land in their areas and consequently they deal with most cases of fly-tipping on public land, investigating these and carrying out a range of enforcement actions. The Environment Agency investigates and enforces against the larger, more serious and organised illegal waste crimes. Both Local Authorities and the Environment Agency are required to collect data on their activity and report this to the Flycapture database. Responsibility for dealing with fly-tipping on private land rests with private landowners and is not subject to mandatory data reporting.

Uncontrolled waste disposal can be hazardous to the public, especially when the waste consists of drums of toxic material, asbestos sheeting, syringes or used drugs. There could be a high risk of damage to watercourses and underlying soil quality from the dumped waste. Fly-tipping looks unsightly and this can harm investment in an area. Cleaning up fly-tipping costs taxpayers' money.

B. PURPOSE OF GROUP

A Council Members' task group chaired by an elected member and coordinated by a council Scrutiny officer was set up in August 2015. Sponsored by the Scrutiny Committee, the aim of task group is to collate, review and evaluate evidence gathered from various sources; which include; residents, local groups and a number of best practicing local authorities. Evidence will also be sought from guest speakers from a number of related government departments and non government organisations (NGO).

The objectives at the time were:

1. Liaise with stakeholders to gather evidence.

2. Use reviewed evidence to inform findings and recommendations for reduced levels of fly tipping in Brent.

C. AIM & OBJECTIVES

Aim of the Task Group is to gather and review evidence; once the evidence is reviewed the task group will produce a paper with their finding and recommendations. Areas that the review will cover:

- **Aims;** The review will address the following key areas:

    - Knowledge
        - Behavioural and sociological research /information from other authorities on successful strategies
            - LB Hackney
            - LB Lambeth
            - LB Haringey
        - Brent fly tipping levels, why we have the levels we do?
        - Increasing trends

    - Education
        - Public communication
        - Education (at schools and through community / cultural groups)

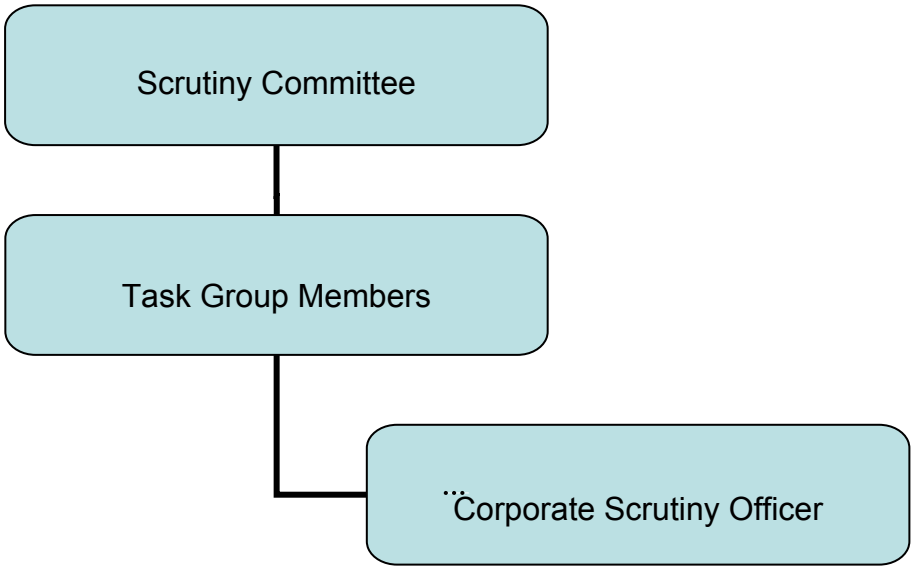
    - Enforcement
        - Success of enforcements
        - Deterrents
        - Trade waste and dumping

    - Impact
        - Impact of new 'Green Bin Tax'
        - Impact of Landlord Licensing in reducing the issue

- **Objectives;** The review is expected to deliver a number of outcomes as listed below:

    - Better understanding of residents behaviour in Brent
    - Reduction in the levels of fly tipping in Brent
    - Cleaner and safer environments
    - Reduction in clean-up and enforcement costs
    - Opportunities for increase revenue
    - Better community spirit and cohesion
    - Efficiency savings/Officer time

D. GOVERNANCE & ACCOUNTABILITY



E. MEMBERSHIP

1. Cllr Sam Stopp (Chair)
2. Cllr Aisha Eniola
3. Cllr Krupa Sheth
4. Cllr Bernard Collier
5. Colin George
6. Chirag Gir

Kisi Smith-Charlemagne – Scrutiny Officer

Other key stakeholders would be invited as appropriate.

F. QUORUM & FREQUENCY OF MEETINGS

There should be at least 2 members present at each meeting. A minimum would be the Chair, and another member of the task group. The task group will meet twice per month or approximately every two weeks with sub meetings held between the chair and the Scrutiny Officer ass required.

G. DATE OF REVIEW

Start: August 2015
End: Scheduled for presentation to the Scrutiny Committee on 5 November 2015

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Brent	**Scrutiny Committee** 9th September 2015 **Report from the Chief Operating Officer Department**
For Information	

Proposed Scope for Scrutiny Task Group on Close Circuit Television (CCTV) in Brent

1.0 Summary

1.1 This report sets out the proposed scope for the Scrutiny task group on Close Circuit Television (CCTV) in Brent. This task group has been requested by the Scrutiny Members in response to Brent residents' requests for increased levels of CCTV in the borough.

1.2 The purpose of the task group will be to focus on analysing four key areas:

1. Public perceptions of CCTV:

- Why do so many residents groups campaign for CCTV?
- What impact do residents think CCTV on their street will have?
- Does CCTV make people feel safer?

2. The effectiveness of CCTV:

- Is CCTV an effective deterrent, what actual impact does it have?
- How many offenders are caught and prosecuted through CCTV footage?
- How can CCTV be benchmarked?
- What is the best cost/benefit analysis of CCTV available (e.g. cost of installing, monitoring, maintaining and upgrading versus cost of crimes)?

3. The current systems in Brent:

- What are the current council processes in place for installing (and removing) cameras and monitoring their footage, how can this be improved?
- Does the Council have the right policies in place to work with partner organisations such as the police?
- Which other local authorities have excellent practice and how do we compare?

4. Working innovatively, involving the community and securing alternative funding sources:

- Are the community integrated into our CCTV policies and systems as much as they should be and how could this be improved?
- How can the Council support community initiatives around "Citizens CCTV" and what is the current legislation in place concerning such schemes?
- What sources of alternative funding are in place for CCTV, and is the Council accessing these as fully as it should be?

1.3 The task group will review the local arrangements of the council and its partners, national research and guidelines and the views and opinions from local residents and businesses. The task group will also consult with experts in this field and other London boroughs which have been awarded and identified as leaders in CCTV. The task group will review a number of concerns in the use of CCTV; which we will seek to look at in the context of Brent, these are:

- Effectiveness of CCTV in Brent and how can we evidence this?
- Impact is CCTV making in reducing anti social behaviour crime
- CCTV camera placement within Brent and how do we decide this
- Crime deterrents for Brent communities
- Current resources available
- Residents attitudes toward CCTV (in support or against)

1.4 Making sure that we continue to reduce crime, especially violent crime, and making people feel safer is an objective within the Council's Borough Plan. Improving the use of CCTV in the borough is one element within the context of our "Better Place" priority.

2.0 Recommendation

2.1 Members of the Scrutiny Committee are recommended to agree the scope, terms of reference and time scale for the task group on CCTV in Brent, attached as Appendix A and B.

3.0 Detail

3.1 With member consensus on crime reduction and community safety, Members of the Scrutiny Committee requested a time-limited task group undertake a focused piece of work on potential actions to improve the use of CCTV in Brent. The proposed scope and terms of reference for this work is attached as Appendix A and B.

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Head of Policy and Scrutiny
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0208 937 1045

Peter Gadsdon
Operational Director Strategic Commissioning

Appendix A

Close Circuit Television (CCTV) in Brent
Proposed scope for Scrutiny Task Group
August 2015

Task Group Chair: Cllr Matt Kelcher
Task Group Members: Cllr Liz Dixon, Cllr Janice Long, Cllr Lloyd McLeish, Mike Wilson and Sandria Terrelonge
Time frame: Provide report to the Scrutiny Committee meeting on Thursday 5th November 2015

1. What are we looking at?

Close Circuit Television (CCTV)

Across the developed countries of the world today surveillance is part of everyday life and this has led to the acknowledgement that the UK is part of a surveillance society. The UK has experienced a massive growth in Close Circuit Television (CCTV) since the 1980s and this was initially based on the assumption that CCTV was a solution for crime and disorder. The earliest usage of Closed Circuit Television (CCTV) actually dates back to 1942 when it was first used by the military in Germany. The military used remote cameras with black and white monitors to observe the launch of V2 rockets. In the years since that time CCTV has become very common in non government and military sites. In the 1970's and 1980's CCTV was commonly used as an added security measure in banks. Many other retailers also began to use these CCTV's in their shops as a method to both prevent and record any possible crime. There is no proof that CCTV's decreased crime rates, but they have been very successful in helping to apprehend criminals who were recorded in the act.

CCTV's also became very useful in monitoring traffic. Britain first started using them for this purpose and thousands of cameras were placed all over the city to monitor traffic and to see if there were accidents. Since that time they have been placed in vehicles such as taxis, buses and trains. They have also been placed in private areas such as parking lots to attempt to decrease instances of vandalism.

Today CCTV's are very common in the home. Many homes with security systems have these installed as an added security feature to prevent break-ins or unwelcome intruders. They are also used in many public areas including schools and airports to record any suspicious activity.

2. Why are we looking at this area?

After a number of Brent residents requested CCTV cameras to be installed in their communities, scrutiny members feel that is was the right time to conduct a review into the effectiveness of CCTV in Brent. The review will focusing on the prevention of anti social behavioural crimes, apprehending offenders, costs and alternative funding and the levels of reassurance given to residents.

The use of closed circuit television cameras for the purposes of tackling crime has greatly increased over the last decade. There is no official figure for how many cameras are in use, although a figure of 4.2 million, based on academic research, is often cited. Although the rationale for CCTV use is that it "prevents crime", a number of studies have questioned the assumptions underlying this claim and drawn attention to a complex range of factors that should be taken into account when assessing CCTV's effectiveness. A 2007 report by the Campbell Collaboration claimed that CCTV has a "modest but significant desirable effect on crime" but that its use should be "more narrowly targeted" than at present.

Overall, the impact of CCTV has been variable, it is important to remember that the characteristics of areas and the crime problems generated in them varies considerably, and the suitability of CCTV will depend, at the very least, on the nature of those problems, the presence of other measures, and the commitment and skills of management and staff to making CCTV work. The belief that CCTV alone can counter complex social problems is unrealistic in the extreme. At best CCTV can work alongside other measures to generate some changes, but it is no easy panacea, and there is a lot still to be learnt about how to use it to best effect.

- The total UK cost of installing, operating and maintaining CCTV cameras between 2007 and 2011 was £515 million.
- Britain's crime rate is not significantly lower than comparable countries that do not have such vast surveillance.
- Cost of CCTV versus extra police officer on our streets

Local Context

In Brent we use CCTV to assist with efforts to combat crime and disorder, enforce bus lane offences, moving traffic contraventions and manage events around Wembley Stadium. We keep an eye on dangerous situations, locate suspects of crime and provide valuable support to the police, emergency services and other organisations because our CCTV recordings may be used as evidence for court cases.

We have 183 cameras in key locations throughout Brent with the majority in the following locations:

- 19 Neasden
- 21 Harlesden
- 43 Kilburn
- 69 Wembley

Brent cameras are monitored 24 hours a day by staff in our CCTV control room. There is an agreement with Transport for London to allow Brent access their cameras during emergencies. Brent is not responsible for private CCTV cameras.

Brent's CCTV team will:

- report incidents to the emergency services
- provide evidence for criminal or civil proceedings
- help detect crime by working in partnership with the Police and other law enforcement agencies

- keep traffic moving in lanes through effective monitoring
- work with the Police to disrupt potential incidents

In early 2015 a Brent CCTV operative received a Certificate of Appreciation at the first Metropolitan Police CCTV Awards ceremony. He was nominated for his excellent work in spotting two crimes on CCTV at the end of last year.

National Context

The origins of CCTV provision for public space in this country lie in the early 1980s. Since then the use of CCTV systems has expanded gradually but significantly. The earliest systems were funded in a small number of cases by the police or local businesses, but in the majority of cases by local authorities through what were then known as City Challenge or Safer Cities Initiatives. Subsequent Government funding took the form of the CCTV Challenge Competition between 1994 and 1999, under which £38.5 million was made available for some 585 schemes nationwide.

In turn, between 1999 and 2003, major investment was made in public space CCTV through the Home Office-funded Crime Reduction Programme (CRP). A total of £170 million of capital funding was made available to local authorities following a bidding process. As a result of this funding, more than 680 CCTV schemes were installed in town centres and other public spaces. The end of the Crime Reduction Programme signalled the end of a dedicated central funding regime for public space CCTV. However, local areas continued to have access to Home Office grant monies in the form of general funding for crime reduction.

Most public space CCTV is now owned, monitored and managed by local authorities, many of whom have procured different systems at different times and with a range of different specifications, leading to a mix of schemes across the country. Although the Government has invested heavily in public space CCTV schemes, so too have local authorities and local partnerships. Local authorities also continue to carry much of the burden for the ongoing costs of running and maintaining their schemes.

3. Legislation and Government Policy

The Information Commissioner's Office (ICO) issued its first code of practice under the Data Protection Act 1998 (DPA) covering the use of CCTV in 2000. The code was developed to explain the legal requirements operators of surveillance cameras were required to meet under the Act and promote best practice. The code also addressed the inconsistent standards adopted across different sectors at that time and the growing public concern caused by the increasing use of CCTV and other types of surveillance cameras.

The unwarranted use of CCTV and other forms of surveillance cameras has led to a strengthening of the regulatory landscape through the passing of the Protection of Freedoms Act 2012 (POFA). The POFA has seen the introduction of a new surveillance camera code, which focuses on the 12 guiding principles of surveillance issued by the Secretary of State since June 2013 and the appointment of a Surveillance Camera Commissioner to promote the code and review its operation and impact. The ICO has contributed to this tougher regulatory landscape by taking enforcement action to restrict the

unwarranted and excessive use of increasingly powerful and affordable surveillance technologies.

Surveillance Commissioner
The Surveillance Camera Commissioner, (the commissioner), is a statutory appointment made by the Home Secretary under Section 34 of the 2012 Act. The commissioner's statutory functions are:

- Encouraging compliance with this code;
- Reviewing the operation of this code; and
- Providing advice about this code (including changes to it or breaches of it).

4. What are the main issues?

- Effectiveness of CCTV in Brent and how can we evidence this?
- Impact is CCTV making in reducing anti social behaviour crime
- CCTV camera placement within Brent and how do we decide this
- Crime deterrents for Brent communities
- Current resources available
- Residents attitudes toward CCTV (in support or against)

5. What should the review cover?

The review will address the following key areas:

Public perceptions of CCTV

- Why do so many residents groups campaign for CCTV?
- What impact do residents think CCTV on their street will have?
- Does CCTV make people feel safer?

The effectiveness of CCTV

- Is CCTV an effective deterrent, what actual impact does it have?
- How many offenders are caught and prosecuted through CCTV footage?
- How can CCTV be benchmarked?
- What is the best cost/benefit analysis of CCTV available (e.g. cost of installing, monitoring, maintaining and upgrading versus cost of crimes)?

The current systems in Brent

- What are the current council processes in place for installing (and removing) cameras and monitoring their footage, how can this be improved?
- Does the Council have the right policies in place to work with partner organisations such as the police?
- Which other local authorities have excellent practice and how do we compare?

Working innovatively, involving the community and securing alternative funding sources

- Are the community integrated into our CCTV policies and systems as much as they should be and how could this be improved?
- How can the Council support community initiatives around “Citizens CCTV” and what is the current legislation in place concerning such schemes?
- What sources of alternative funding are in place for CCTV, and is the Council accessing these as fully as it should be?

6. How do we engage with the community and our internal and external partners?

As part of this review the task group will invite relevant partners to get involved; though workshops, public group discussions and one-to-one interviews.

Partners: Group 1

- Relevant Council Departments:
  - Crime and Community Safety Team
  - CCTV Team
- Police
- Brent partners:
  - Brent Housing Partnership (BHP)
  - Wembley Stadium
  - Wembley Arena
  - Transport for London
- Local Groups:
  - Brent Neighbourhood Watch Association
  - Local Joint Action Group
  - The Junction Residents Association
  - Mapesbury Residents Association (MAPRA)
  - NorthWestTWO Residents' Association
  - Queens Park Residents Association
  - St Raphael’s Residents Association
  - Sudbury Town Residents' Association

Partners: Group 2

- Home Office
- The Surveillance Camera Commissioner
- Best Practice Local Authorities:
  - LB Enfield
  - LB Islington
  - LB Hammersmith & Fulham
  - LB Hackney

7. What could the review achieve?

The review is expected to deliver a number of outcomes as listed below:

- A more focused use of current CCTV resources
- Better understanding of the CCTV needs for Brent
- More deterrent evidence linked to CCTV operations
- Stronger partnership working, with partner such as the Police and TFL

- Residents feeling safer in Brent communities

Appendix B

Close Circuit Television (CCTV)
MEMBERS TASK GROUP
TERMS OF REFERENCE

A. CONTEXT

The origins of Close Circuit Television (CCTV) provision for public space in this country lie in the early 1980s. Since then the use of CCTV systems has expanded gradually but significantly. The earliest systems were funded in a small number of cases by the police or local businesses, but in the majority of cases by local authorities through what were then known as City Challenge or Safer Cities Initiatives. Subsequent Government funding took the form of the CCTV Challenge Competition between 1994 and 1999, under which £38.5 million was made available for some 585 schemes nationwide.

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Most public space CCTV is now owned, monitored and managed by local authorities, many of whom have procured different systems at different times and with a range of different specifications, leading to a mix of schemes across the country. Although the Government has invested heavily in public space CCTV schemes, so too have local authorities and local partnerships. Local authorities also continue to carry much of the burden for the ongoing costs of running and maintaining their schemes.

B. PURPOSE OF GROUP

A Council Members' task group chaired by an elected member and coordinated by a council Scrutiny officer was set up in August 2015. Sponsored by the Scrutiny Committee, the aim of task group is to collate, review and evaluate evidence gathered from various sources; which include Brent's Crime and Community Safety and CCTV Teams, Local groups, Brent Police and partners such as Registered Social Landlords (RSL's), Transport for London and Wembley Stadium and Arena. The task group will also engage with central government organisations which include the Home office and the Surveillance Camera Commissioner.

The objectives at the time were:

1. Liaise with stakeholders to gather evidence.

2. Use reviewed evidence to inform findings and recommendations for fully utilising current resources to improve the use of CCTV in Brent.

C. AIM & OBJECTIVES

Aim of the task group is to gather and review evidence; once the evidence is reviewed the task group will produce a paper with their finding and recommendations. Areas that the review will cover:

- **Aims**

  The aims of the task group form four main themes

  - Public perceptions of CCTV

    - Why do so many residents groups campaign for CCTV?
    - What impact do residents think CCTV on their street will have?
    - Does CCTV make people feel safer?

  - The effectiveness of CCTV

    - Is CCTV an effective deterrent, what actual impact does it have?
    - How many offenders are caught and prosecuted through CCTV footage?
    - How can CCTV be benchmarked?
    - What is the best cost/benefit analysis of CCTV available (e.g. cost of installing, monitoring, maintaining and upgrading versus cost of crimes)?

  - The current systems in Brent

    - What are the current council processes in place for installing (and removing) cameras and monitoring their footage, how can this be improved?
    - Does the Council have the right policies in place to work with partner organisations such as the police?
    - Which other local authorities have excellent practice and how do we compare?

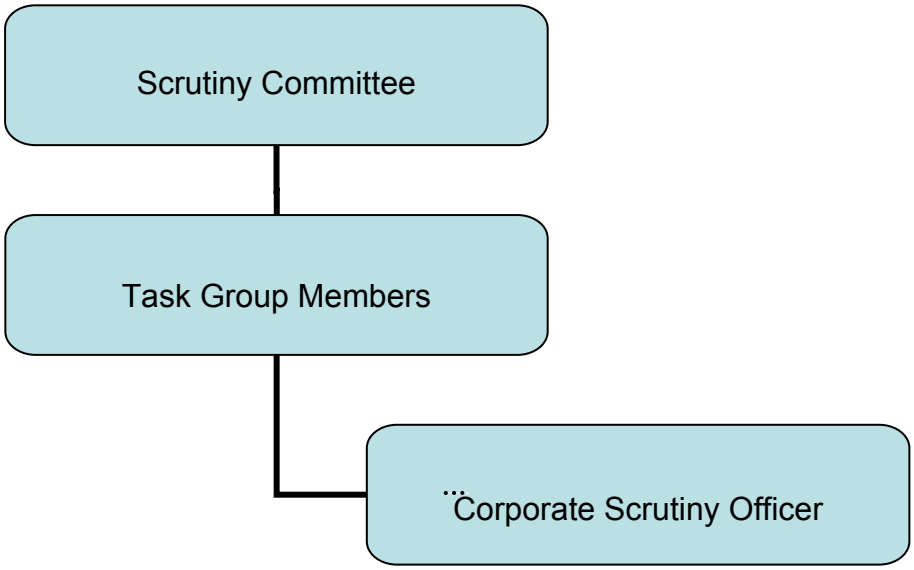
  - Working innovatively, involving the community and securing alternative funding sources

    - Are the community integrated into our CCTV policies and systems as much as they should be and how could this be improved?
    - How can the Council support community initiatives around “Citizens CCTV” and what is the current legislation in place concerning such schemes?
    - What sources of alternative funding are in place for CCTV, and is the Council accessing these as fully as it should be?

- **Objectives**

  - A more focused use of current CCTV resources
  - Better understanding of the CCTV needs for Brent and its residents
  - More deterrent evidence linked to CCTV operations
  - Stronger partnership working, with partners such as the Police and TFL, Brent Housing Partnership (BHP), and other Registered Social Landlords (RSL’s)
  - Residents feeling safer in Brent communities

D. GOVERNANCE & ACCOUNTABILITY



E. MEMBERSHIP

1. Cllr Matt Kelcher (Chair)
2. Cllr Liz Dixon
3. Cllr Janice Long
4. Cllr Lloyd McLeish
5. Mike Wilson (Co-opted Member)
6. Sandria Terrelonge (Co-opted Member)

Kisi Smith-Charlemagne – Scrutiny Officer

Other key stakeholders would be invited as appropriate.

F. QUORUM & FREQUENCY OF MEETINGS

There should be at least 2 members present at each meeting. A minimum would be the Chair, and another member of the task group. The task group will meet twice per month or approximately every two weeks with sub meetings held between the chair and the Scrutiny Officer as required.

G. DATES OF REVIEW

Start: August 2015
End: Scheduled for presentation to the Scrutiny Committee on 5 November 2015

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Scrutiny Committee
Forward Plan 2015/16
September 2015

Date of Committee	Agenda items	Responsible officers
Wednesday 9 September 2015	• Report from the Access to GP services task group • Central and North West London NHS Foundation Trust. CQC Report and Action Plan • Terms of reference for task groups on Fly-tipping, CCTV.	Chair of the task group CNWL Trust Cathy Tyson, Head of Policy and Scrutiny
Thursday 8 October 2015	• Annual report on Ombudsman and corporate complaints • Parking Strategy (cabinet report)	Cathy Tyson, Head of Policy and Scrutiny Lorraine Langham, Chief Operating Officer

Thursday 5 November 2015	• CCTV task group report • Fly-tipping task group report • Local Safeguarding Children's board Annual Report	Chair of task group Chair of task group Independent Chair of Children's Safeguarding Board.
Wednesday 2 December 2015	• South Kilburn Regeneration	Andy Donald, Strategic Director of Regeneration and Growth.
Wednesday 6 January 2016	• Budget Scrutiny Report • Update on the impact of the charging for Green waste collection. • Safer Brent Partnership – update on progress.	Chair of Scrutiny Lorraine Langham, Chief Operating Officer Chair of Safer Brent Partnership
Tuesday 9 February 2016		
Wednesday 24 February 2016	• School Achievement Report	Gail Tolley, Strategic Director Children and Young People
Tuesday 5 April 2016		
Tuesday 26 April 2016	• Annual Report of Scrutiny Committee	Cathy Tyson, Head of Policy and Scrutiny
Tuesday 21 June 2016		
Wednesday 13 July 2016		

2014-15 Scrutiny Committee Meetings – Key Comments, Recommendations and Actions

Meeting Date	Item	Comments and Recommendation	Action
6th August 2014	Central Middlesex Hospital Closure Assurance Transforming Healthcare in Brent	That an update be provided on the Central Middlesex Hospital A&E closure assurance at a future meeting of the committee. That a further report updating the committee on the progress made in relation to transforming healthcare in Brent be submitted to a future meeting of the committee.	Clearer understanding of the action plan proposed. Further transparency of plans between the CCG and Brent Council.
	Call In - Changes to Recycling and Green Waste Collections	An outline of the suggested course of action of the Scrutiny Committee is to: • Seek a report responding to the concerns outlined. • Question lead member and senior officers and the leader. • If necessary, set up a very brief task finish group to examine these issues in more depth. (i) that the decisions made by the Cabinet on 21 July 2014 regarding changes to recycling and green waste collections be noted; (ii) that a review be held following a period of 9 months; (iii) that efforts should be made to ensure the removal of the green waste bins be as close as possible to 1 March 2015 to minimise inconvenience to residents.	More consideration given to the impact of residents. Ensure that longer consultation is considered for such matter in the future.
	Scope for Promoting Electoral Engagement Task Group	The scope and timeline for the task group on Promoting Electoral Engagement as set out in Appendix A to the report was agreed.	
	Budget Scrutiny Panel - Terms of Reference	The terms of reference for the Budget Scrutiny Panel as set out in Appendix A to the report was agreed.	
9th September 2014	Closure of A&E at Central Middlesex Hospital	That an update on performance at Northwick Park Hospital Accident and Emergency Department to be provided to the committee in six months time.	Further information on the progress and performance of NPH and A&E services. Holding these services to account on improved performance for residents.
	Parking Services Update	That Cabinet be requested to reappraise the existing arrangements for visitor parking permits, taking into account the serious concerns expressed by the Scrutiny Committee	Equality impact assessments to be reconsidered

		and members of the public.	
	Proposed Scope for Scrutiny Task Group on the Pupil Premium	It was proposed that the task group also examine qualitative data regarding the activities undertaken by schools. He advised that holistic activities which aimed to meet emotional as well as academic needs were also very important for a child's development and attainment. It was emphasised that some enrichment activities did not deliver immediately observable results and that this should be considered when looking at the period of study. It was further suggested that the task group engage with parents and children to discuss their experiences. The scope and time scale for the task group on the use of the Pupil Premium, attached as Appendix A to the report was approved with the condition that the recommendations be incorporated.	Recommendations made were incorporated in the tasks group's scope of work.
1st October 2014	North West London Hospitals Trust Care Quality Commission inspection compliance action plan	• Members asked for further information on plans in respect of major emergencies and emphasised the importance of ensuring key roads were open as is this had been an issue, for example, during the 7 July 2005 London bombing incidents. • Members also asked whether the planned additional beds at NPH had happened and if so how many. The committee sort views with regard to the progress made since the CQC inspection and how confident was the Trust that the action plan would achieve the objectives and within the timescales set. The Chair requested that a report be presented to the committee in about two months' time updating them on progress with the action plan, including whether the measures listed were on target to be achieved within deadlines set. In addition, any members who had questions requiring specific details were to submit these to Cathy Tyson (Head of Policy and Scrutiny, Assistant Chief	

		Executive Service) who coordinate responses from NWLHT.	
	Local Safeguarding Children Board annual report	The Chair stated that a briefing note updating the work of the task group on the Pupil Premium would be provided to members. He emphasised the importance of safeguarding children and welcomed the report.	Gaps in the report which the committee raised have been considered and will be included in the next annual report
	Draft school places strategy	• Whilst members appreciated the opportunity the presentation gave for pre-scrutiny prior to a report going to Cabinet, enquired whether officers were confident that primary schools could maintain educational standards as they got larger. • Members also asked whether placing Special Educational Needs (SEN) pupils was relatively trouble free. A question was raised as to whether schools in the north of the borough were taking more pupils than those in the south and where could details be found of pupil numbers throughout the borough. Another member asked whether school expansion posed risks in terms of whether there was sufficient infrastructure in place. The Chair concluded discussion by acknowledging the large interest from members and other councillors on this item and in noting the improvement in placing pupils in the last two years. However, he emphasised the need to sustain progress and requested that school places be considered at a Scrutiny Committee meeting in around two months' time.	
	Children's centres	• Member suggested that the children centres were concentrated in a particular area and neglected the north of the borough. Members sought advice on what members should be focusing on in view of the fact that the report had already been approved by Cabinet. • A member sought clarity that the children's centres provided for those children up to and including four years of age. In noting that children were entitled to nursery places between two to three years of age, she sought further reasons for how children's centres were being	

		used. • In respect of the Barham Park building, it was noted that there were proposals for a nursery to be included; however sought clarity on this matter as Barham Park Trust had stipulated that the building was for community use only and the lack of consultation on this proposal had also angered residents. The Chair commented that the long term future of the children's centres would be clearer in around four months time and he requested that an update be provided to the committee at around that time.	
3rd November 2014	Employment, Skills and Enterprise Strategy consultation	The Chair acknowledged the substantial work that had been undertaken in developing the strategy and the progress made so far. He requested that a progress report on the strategy be presented to the committee in two to three months' time.	
	Overall impact of the Benefit Cap in Brent after one year of implementation	• Member asked if any lessons had been learnt since the OBC had been introduced and had there been any surprising developments. • Members also asked if there were any strategic issues that needed consideration in the future. In respect of resource issues, comments were sought about how significant these were and what were the expectations in the medium term. A question was raised as to where customers who moved out of the borough were moving to. • A member asked if the council was able to assist Brent CAB in dealing with the increased demand that they were struggling to cope with and was there any help for single under 35 year olds on Benefits. The Chair explained that this item had been requested shortly before the meeting and this is why a presentation had been given. The importance of continuing to engage with residents about welfare reforms was emphasised and it	

		was requested that the committee receive regular updates on this issue.	
26th November 2014	Care Quality Commission Quality Compliance and Quality Improvement Action Plan	• Members sought an update was sought on Delayed Transfers of Care, responding to the committee's queries NWLHT advised that the CQC had commented on the open and frank culture amongst staff. That an update on the progress made in addressing the recommendations of the CQC be presented to a future meeting of the committee.	
	Local Impact resulting from Changes to maternity, neonatal, paediatric and gynaecology services at Ealing Hospital	The committee questioned what contingency plans were in place if it was found that the proposals were not feasible or appropriate. It was questioned whether similar modelling had been undertaken regarding the anticipated dispersal of service pressures for A&E units following the closure of the unit at Central Middlesex Hospital (CMH). That the committee be provided with an update on the implementation of the proposed changes to maternity, neonatal, paediatric and gynaecology services at Ealing Hospital at a future meeting.	
	Developing Central Middlesex Hospital	• The committee sought further information regarding the provision of in-patient mental health service at the Park Royal site. Queries were raised regarding the consultation activities undertaken, including the number held and how they were advertised. • Further details were sought regarding the services available in the North of the borough and the procedures in place to deal with large scale health emergencies. A view was put that consultation on changes to primary care had been poor. Councillor Daly requested that details of the number of beds to be removed across North West London under SaHF be provided to her in writing. (i) That the update report be noted	

		(ii) That further information regarding the proposals for Central Middlesex Hospital be provided to the committee in writing and include a breakdown of the financial implications of the proposals.	
	Promoting Electoral Engagement - Scrutiny Task Group report	That the recommendations of the 'Promoting Electoral Registration' task group as detailed in the report be endorsed.	Since the report was agreed by service areas, the Programme Management Office has been tasked with developing a project to support the implementation of the recommendations. The Project started in January 2015 with an advertising campaign. The team have completed promotional activities and are now focusing on outreach and community engagement activities. Since the beginning of the project voter registration has increased by 2768.
6th January 2015	Safer Brent Partnership Annual Report 2013 - 2014	The Chair welcomed the SBP report and stressed the need to continue dialogue between the partners in the SBP and the community. He requested that the committee receive an update on the work of the SBP in around six months' time.	Refocus on VAWAG stats, number may be going up, but this is due to more confidence in reporting and better recording of incidents.
	Interim feedback from the Budget Scrutiny Task group	Members suggested that the Investments and Pensions Manager be invited to the next Budget Scrutiny Task Group meeting. The Chair concluded by stating that there was still much work to do before the final task group report and the recommendations it would make.	The Cabinet responded positively to the concerns raised and the debates held by the Budget Panel Task Group of the Scrutiny Committee. . The Budget Panel's report and recommendations were included as part of the Final Budget Report which was agreed by the meeting of Full Council in March 2015.
10th February 2015	Current Status of Systems Resilience Group and Winter Pressure Update	• The committee commented that they had been told at previous meetings that transferring staff from the closed A&E at CMH to NPH would lead to improvements in staffing levels and clarification was sought as to whether this had been demonstrated. • An explanation of the difference between bank and agency staff was requested and members asked what the	

		ring fenced grant in respect of delayed transfers of care was specifically for and what was the size of the grant. • Members added that he had a positive personal experience when he had needed to visit the A and E at NPH around Christmas time and the service he received was efficient. The Chair added that in some reports, the information was provided was not always as clear as it could be and was difficult to explain to residents and he asked that this be taken into account in future reports. He asked that an update on the SRG be provided at a future meeting.	
	Brent Education Commission - six month update on the implementation of the Action Plan	(i) that the contents of the report be noted and that a further update be received in the autumn of 2015; (ii) that the introduction of a proportionate approach to school improvement and the more robust challenge offered to schools at risk of underperforming be welcomed; and (iii) that the local authority's role in progressing a shared approach to supporting schools with its key educational partners, including Brent Schools Partnership and the two Teaching School Alliances be welcomed.	
	Annual report academic year 2013-14: Standards and achievement in Brent schools	The Chair requested that an update on this item be presented to the committee at a meeting in the autumn of 2015. (i) that the priorities proposed for 2014-15 intended to accelerate improvement be noted; and (ii) that the progress made in the overall performance of Brent's primary schools in 2013-14 be welcomed.	
11th March 2015	Update on Customer Access Strategy	• Members asked whether the testing would be undertaken borough wide and it was commented that the triage system had worked well to date and asked whether there was training for staff in dealing with particularly complex issues. • Members also asked what would be ideal way in which residents would describe the service they had	

		experienced as far as the council was concerned. • Members sought further information on what service areas had been underperforming and how was misdirecting of calls by the switchboard being monitored or picked up. In terms of calls reported as misdirected, it was asked if this was formally recorded. • Comments were made regarding a danger of making the council too remote from the community by shifting access via IT and telephony channels and removing opportunities for direct contact with residents The Chair requested an update on this item for the December 2015 Scrutiny Committee meeting. That the progress being made in implementing the aims of the new Community Access Strategy be noted	
	Housing pressures in Brent	• Member stated that issue of extensions in rear gardens needed to be investigated more. • Another member queried whether information held on landlords was confidential and • Member commented that it was regretful that the large housing stock the council had in the 1980s had been eroded by selling a significant proportion to housing associations at lower cost over the past few decades. It was added that he felt that the council's Pension Fund should invest more in housing. The Chair requested an update on this item in six months' time, including details of the number of people who were leaving the borough. That the report on housing pressures in Brent be noted.	
	Unemployment and Work Programme providers	The Chair emphasised the importance of the non disclosure agreement being reached between the Work Programme providers and the council. He added that it would be useful	The issue of cooperation with work programme providers has been highlighted and a greater urgency to

		if there could be more information on how the council could assist Work Programme providers and their clients and that there needed to be a more joined up approach. He requested that the committee receive updates on unemployment levels and Work Programme providers on a quarterly basis. That the report on unemployment levels in Brent and the Work Programme be noted.	resolve some of the minor partnership issue is now at the forefront to the committee's agenda. Non disclosure agreements are being completed.
30th April 2015	Environmental Sustainability Agenda	• 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	Highlight to the committee the work undertaken across key service areas to address the issue of sustainability. Focusing on five key areas: transport and travel; air quality; in-house carbon management; street lighting and parking; public realm and waste; and parks and biodiversity.

		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. That an update on the Environmental Sustainability Agenda be to the committee in six months time.	
	Future Commissioning intentions of Brent Clinical Commissioning	• 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. • Members queried what action was being taken to raise awareness of dementia amongst different communities, including the provision of materials in a variety of languages. • Members 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. • Members further queried the 2014/15 spending on enhanced GP services and the work undertaken to evaluate their success. That an update be provided to a future meeting of the committee	
	Use of Pupil Premium Grant Scrutiny Task group	(i) that the recommendations of the task group be endorsed (ii) that subject to Cabinet agreement of the recs, an update on the implementation of the task group's recommendations be provided to a future meeting of the Scrutiny Committee The recommendations of the Pupil Premium Task Group be endorsed, subject to Cabinet approval. The committee	To date, the work done by the task group has raised the profile of the Pupil Premium. It has also encouraged further partnership working by the council, schools, Children Centres, parents, children and all educational providers. The task group has opened up the

		receive an update on the implementation of the Task Group's recommendations at a future meeting of the committee.	discussions for innovative use of the PPG in Brent.
	Scrutiny Annual Report 2014/15	Committee members were invited to submit feedback on the draft report which would be finalised for the end of May 2015. The draft Annual Scrutiny Report 2014/15 was noted.	The Annual report highlights the work that the scrutiny committee has undertaken this year. Focussing on the part that the committee has played in key council decisions which have lead to improved outcomes and services for residents.
	Equalities and HR Policies and Practices Review and draft Action Plan	• 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. • 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, members queried how the council compared to other boroughs and whether there was an opportunity to learn from the practices of other local authorities. 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.	
16th June 2015	Paediatric Services - CCG	• Members requested a copy of the data modelling which was used by Shaping a Healthier Future to assure the CCG of the projections of demand to underpin the case for	Joint report produced on behalf of Brent Clinical Commissioning Group (CCG) and London North West Healthcare NHS Trust

		transfers of services from Ealing to Northwick Park and the future bed capacity required in the paediatric services at NWP. They also requested the data that will be used to inform reassurance decisions next March. • Members request that the Accountable Officer – CCG, provide further details of the financial costs set out in the table at para 2.2 regarding how the same level of paediatric service would be achieved within reduced costs. The committee requested that they receive a further update from the CCG on the information used to reach assurance on the safe and smooth transfer of services at their meeting in February 2016. CCG /NWLHT agreed to this request.	(LNWHT). Provide insight into the Paediatric Services and current provision provided to Brent residents. Highlight the potential impact on Northwick Park Hospital with regards to the impending changes to paediatric services at Ealing Hospital taking place on 30 June 2016.
	Access to GP services Interim Task Group Report	The committee requested that the final report on the access to GP services should include further information on:- • Details of the location of GP hubs, public awareness of the GP hub mechanism and any evidence of the public's confidence in their GP. • How the future publicity campaign for GP hubs will be delivered. • Members requested information on how many GP's were sited in single GP practices or in practices with more than one GP. The also requested information on the numbers of GP's who are approaching retirement age. • Information was requested on how many GP practices were experiencing difficulties in recruit trained staff and if this was related to housing costs. Any information on how GP's are addressing recruitment problems. • Information on the numbers of people registered with a GP, number of people not registered and those who may still be registered with a GP in Brent but have moved away. Members requested that the additional information	Interim feedback on the work of the Scrutiny Task Group focused on Access to Extended GP Services and Primary Care in Brent. Provided an outline of the task group scope, methodology and an overview of emerging findings and recommendations.

		requested is included within the final report of the task group on GP services which will be considered at the July meeting of the Committee.	
	Brent Public Health Update	• Members requests that the financial return for Public Health expenditure made to the Department of Health is also circulated to scrutiny. • Members asked for a detailed breakdown of the numbers of people offered and accepting a health check update by GP practice • It was requested that a breakdown of the drugs and alcohol budget with numbers of patients in treatment by type of treatment is provided to the committee. This should include the indicative figures for the range of spend per patient for different types of treatment packages. • The number of people who have been helped to stop smoking by GP practice. • There was also a request for some future work to be undertaken on the school nurse service. This has only recently come under the councils contracting responsibilities and further work is being undertaken on the future contractual priorities. Members commented that the report while outlining the expenditure and priorities for improving public health did not provide a picture of the impact made in tackling health inequalities. Would like further information on the actual change in prevalence of preventable health conditions.	Highlight new local authority Public Health responsibilities and how the Council is discharging this responsibility as a result of the Health and Social Care Act 2012.
	Access to affordable childcare	• Members requested further information on the use of discretionary housing payments to support childcare costs for people moving into employment who have been affected by changes in welfare benefit payments. • It was asked if any work has been undertaken to assess the impact of support given to parents to access employment.	Focused look at the challenge of providing access to affordable and quality Childcare.

		Members asked to receive an update on the implementation of the overall Child Poverty strategy in 2016.	
14th July 2015	Brent Housing Partnership - Performance	• Questions were asked on the cost of BHP modernising its computer systems, income from leaseholder charges and details of where the charges had been defended against legal action. • Members of the committee questioned the delays in job completions. • Members also asked how cases of anti social behaviour and illegal sub-letting were handled. • Members requested further information from BHP on Void times, complaints, communication with residents, seeking possession and illegal sub-letting.	An overview of BHP 2014/15 performance, providing a demonstration of how it works to deliver objectives set out by the council.
	Developing Scrutiny Work Programme 2015/16	It was confirmed that the Budget scrutiny panel would be reconvened to consider the budget for 2016/17. • The committee asked that a briefing paper be provided on how the protection of pubs had been incorporated into the Development Management Plan. • That a briefing paper be provided on the admissions policies adopted by different types of schools. • That the chair, education co-opted members and a senior officer from the Children and Young People's department meet to discuss the education related topics. (i) That the arrangements and principles for the effective operation of the Scrutiny Committee, as set out in paragraphs 3.1 – 3.6 of the report submitted, be noted; (ii) That the proposed process for defining the annual work programme for scrutiny detailed at paragraphs 3.10-3.14.	Arrangements of the future operation of the Scrutiny Committee and the process for developing a robust work programme.
12th August 2015	The Councils future Transport Strategy	The Committee expressed concern that the strategy was too brief and lacked ambition. Members felt that it lacked evidence in places whilst making certain assertions and was rooted in the possibilities as they related to Transport for	An opportunity for the Scrutiny Committee to review and comment on the councils draft Long Term Transport Strategy (LTTS) before it is submitted to Cabinet.

		London (TfL) and the availability of funding rather than going beyond this into areas where the Council needed to send out strong messages and councillors needed to lobby to address some of the major transport concerns in the borough. • Scrutiny Committee recommends that Cabinet defer taking a decision on approving the Long Term Transport Strategy for Brent so that fuller consideration can be given to the points raised on it by the Committee; • Scrutiny Committee requests that Cabinet note the comments made by the Committee and agrees to the recommendations below being more fully addressed in the finally agreed strategy: i. The strategy needs to be more ambitious and incorporate reference to schemes on which the Council might need to lobby in order to see them progress. ii. The strategy should not be restricted to only those schemes and improvements that might be supported by TfL and included in LIP submissions, especially bearing in mind the forthcoming London Mayoral Election when a new Mayor will be elected who might have different priorities. There is a need for the serious public transport issues and road usage problems to be addressed. iii. Reference should be included of the Dudden Hill rail line and it's potential. iv. The possibility of a conflict of approach with neighbouring boroughs and the need to develop shared visions with other boroughs on those transport issues at the borough boundary should be articulated. v. Greater focus should be given on equality of access from the different geographical areas of the borough (North/South – East/West).	The LTTS has been developed to provide strategic direction to the transport investment throughout the borough over the next 20 years (2015-2035)

		vi. A review of the document should be undertaken to remove some of the assertions made or support them with more evidence based statements and give a clearer focus to the strategy, bearing in mind that many of the 'daughter' strategy papers have yet to be written. vii. The strategy should include demographic evidence and have a greater focus on access to primary locations such as hospitals, schools, leisure centres etc. viii. Greater prominence should be given to the work being undertaken with schools to improve safety and congestion around schools. ix. A stronger message should be included on the health effects of diesel and the implications of this around the movement of freight.	
	Food Standards Audit	• Members of the committee questioned Officers and the lead member on structure and staffing of the team. Members made inquire about the numbers and the profile of Brent businesses, with emphases on the risk categories. Members were keen to know what penalties the council could face if improvements are not made. • Members wanted to know how the budget for the services was currently being spent and how this related to the improvements required. • One Member questioned how the present situation impacted on the health of local residents. The findings of the Food Standards audit carried out in July 2014, the issues arising, response to date and the planned actions were noted.	A detailed look into the July 2014 Food Standards Authority audit of the Councils discharge of its Food Safety Act 1990 duties. The report further highlighted the audit reports findings and the Councils responses including the action plan the Council is using to monitor progress.