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Health Select Committee

Wednesday, 9 December 2009 at 7.00 pm
Committee Rooms 1 and 2, Brent Town Hall, Forty Lane, Wembley, HA9 9HD

Membership:

Members Councillors:	**first alternates** Councillors:	**Second alternates** Councillors:
Leaman (Chair)	Castle	Hashmi
Baker	Mendoza	HB Patel
Clues	Tancred	CJ Patel
Crane (Vice-Chair)	Jones	J Moher
Mrs Fernandes	Mistry	HM Patel
Jackson	Ms Shaw	Dunn
R Moher	Mrs Bacchus	Ahmed
Moloney	Farrell	

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The press and public are welcome to attend this meeting

Issued Date Not Specified

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members

Item Page

1 Declarations of personal and prejudicial interests

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

2 Minutes of the previous meeting 1 - 12

3 Matters arising (if any)

4 Deputations (if any)

5 Brent Mental Health Service Section 75 Partnership Review 13 - 18

This report sets out the proposal to create a Section 75 partnership agreement between Brent Council and CNWL NHS Foundation Trust, expanding and replacing on the existing S31 agreement.

6 North West London Hospitals Patient Experience Improvement Programme (We Care) 19 - 32

The Health Select Committee has asked to see the details of the North West London NHS Hospitals Trust patient experience improvement programme, known as the We Care programme. The Committee was concerned by the results of the 2008 Healthcare Commission In Patient Survey which showed that NWLH was in the lowest 20% of trusts nationally in terms of patient satisfaction and opinion on the services they receive. This was despite an improvement of 5-10% on over half of the questions from the 2007 In Patient Survey.

The report provided by the Hospital Trust, attached as appendix 1, contains details on the work that has been done in each of the individual project components and the next steps for moving the programme forward.

7 Local Area Agreement Performance Review - Quarter 2, 2009/10 33 - 40

This report summarises performance against the health related Local Area Agreement targets for Quarter 2, 2009/10 and highlights key issues and solutions to them. The report is accompanied by an appendix

providing complete Local Area Agreement performance information. When Health Select Committee last looked at the LAA targets in June 2009, it was agreed that they should be considered every six months.

8 NHS Brent Commissioning Strategy Plan 41 - 78

NHS Brent has been working on a review of its commissioning strategy plan to update it following initial approval last year. Since the original strategy was approved the economic standing of the country had changed dramatically and so the plan has been reviewed to ensure its goals can be delivered in a more challenging economic environment. In addition to this, the plan needs to align with others in North West London and contribute to the strategic plan for health in the North West London sector. It also needs to reflect the eight *Healthcare for London* pathways.

A comprehensive summary of the plan is attached. The full plan will be circulated separately.

9 Acute Services Review - Public Consultation on Children's Services Update 79 - 110

The Health Select Committee is to be presented with an update on the Acute Services Review and the results of the pre-consultation campaign on the proposed changes to children's services in Brent and Harrow.

The original intention was to present the draft consultation document at the Health Select Committee meeting on 9th December so that consultation on the proposals could begin before Christmas. However, this will not be possible because the NCAT review and gateway review will not be completed until 18th December. At the last Health Select Committee it was explained to members that before public consultation could begin, NCAT and Department of Health approval was needed.

The Health Select Committee has been asked to convene a special meeting in early January 2010 to consider the draft consultation document prior to consultation starting on 11th January.

10 Health Select Committee Work Programme 111 - 122

This report sets out a list of items for inclusion in the Health Select Committee work programme in 2009/10

11 Any Other Urgent Business

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

12 Date of Next Meeting

The next meeting of the Health Select Committee is scheduled for Wednesday 17th February 2010.

*Please note that it is likely that a special meeting will be scheduled for either Tuesday 5th or Thursday 7th January 2010.

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

- The meeting room is accessible by lift and seats will be provided for members of the public.
- Toilets are available on the second floor.
- Catering facilities can be found on the first floor near the Grand Hall.
- A public telephone is located in the foyer on the ground floor, opposite the Porters' Lodge

LONDON BOROUGH OF BRENT

MINUTES OF THE HEALTH SELECT COMMITTEE
Tuesday, 20th October, 2009 at 7.00 pm

PRESENT: Councillor Leaman (Chair), Councillor Crane (Vice-Chair) and Councillors Baker, Clues and Ahmed (alternate for Councillor R Moher)

Apologies were received from: Councillors Mrs Fernandes, Jackson and R Moher

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

   None declared

2. **Minutes of the previous meeting**

   RESOLVED:-

   that the minutes of the previous meeting held on 15th July 2009 be approved as an accurate record of the meeting.

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

   None

4. **Deputations (if any)**

   None

5. **Audit Commission Review of addressing Health Inequalities in Brent**

   Cathy Tyson (Assistant Director of Policy and Regeneration) introduced a report, written by the Audit Commission, which documented the findings of the Audit Commission's review into how health inequalities were being tackled by the Council and its partners. She informed the committee that the Audit Commission project was composed of two stages. This review, she explained, had been the first stage of the project. She commented that whilst at borough level the overall health of the population was consistent with the national average, there were areas in the borough where residents were experiencing significant health inequalities.

   Cathy Tyson highlighted the key strengths that were identified in the Audit Commission's review, which included the commitment of partners to tackling health inequalities, the quality of the joint strategic needs assessment and the high level of commitment to performance managing health inequalities. She also brought to the

committee's attention the key areas of development that had been identified by the Audit Commission.

Cathy Tyson informed the committee that the second stage of the project was to carry out development work on an agreed local priority. She stated that, following discussion with the Audit Commission, partners had agreed that the local priority would be how to increase the levels of physical activity in adults. She explained that there had been a big improvement in getting young people involved in physical activity, but that more work was needed to be done to improve the participation of adults.

In the discussion which followed, it was noted that whilst there were a lot of positive aspects to the report, there were areas which needed to improve. The committee asked whether there were lessons Brent could learn from other areas in the country. In response, Neil Sands (Audit Commission) explained that as health inequalities were caused by a multitude of factors, it was difficult to find one area which was doing everything successfully. Instead, he argued that they had discovered that there were pockets of good practice and that there were many ways to be successful. He added that it was important that the Audit Commission was not too prescriptive because of the importance of local circumstances. He empathised that there was a need to ensure that a strong, sustainable and consistent approach was used to tackle health inequalities.

It was noted by the committee that one of the areas for development, identified in the review, was to ensure that the Health Select Committee maintained the effective consideration of health inequalities. It was asked, therefore, whether the committee's work programme would reflect this. In response, Cathy Tyson stated that the committee's work programme would reflect this. Neil Sands commented that it was important for scrutiny to look at key indicators to ensure that a focus on the key areas was maintained.

Following on from an enquiry as to what would happen next, Cathy Tyson explained that the next part of the project would be to look at improving the level of physical activity in adults. She stated that a meeting of the group, who would be looking at physical activity, would be convened. She stated that they would then be in a position to report back to the Health Select Committee in 3-4 months time with some proposals. She commented that it was hard to significantly improve participation in physical activity without investment and that this aspect was being looked at. A concern was raised by a member of the committee that obesity was one of the biggest health challenges that the borough faced and that more work was needed to be carried out to reduce obesity. It was noted that in order to tackle obesity, activities which did not just take place in sports centres, such as walking and cycling, needed to be promoted. In response, Cathy Tyson stated that there was a programme pilot being undertaken called MEND, which was a combined diet and exercise programme that was aimed at the whole family. She also highlighted the walk programmes which took place in the borough. Following a question about measuring the outcomes, she explained that success for the MEND programme and the walk programmes was recorded based on how many complete the programmes.

RESOLVED:-

i) that the findings of the Audit Commission's review of health inequalities in Brent and the partnership arrangements in place for tackling these issues within the borough be noted;

ii) that the committee receives a report in February 2010 on the work being done to increase physical activity carried out by adults in Brent, which forms the second part of the Audit Commission's work.

6. **GP Access Survey Results**

Mark Easton (Chief Executive NHS Brent) introduced a report which set out the results of the GP Access Survey for 2008-2009. He informed the committee that patient satisfaction with GP access in Brent had decreased compared to the 2007-2008 results. He explained that this decrease in performance was in line with both national and London averages. He informed the committee that there had been a significant decrease in Brent's response rate, but that this decrease was also in line with the national and London averages.

Mark Easton informed the committee that, as a result of NHS Brent's overall performance in the survey, an Access Improvement Transformation Programme would be undertaken. He added that the programme would be carried out internally and that a senior GP had been appointed to lead on the programme. He explained that the programme would use a best practice/shared learning methodology. He informed the committee that there were 27 practices in Brent which had scored below the Brent average and that the programme would begin with these practices, starting with the 10 lowest performing surgeries. He noted that the programme would run until the end of March 2010.

In the discussion which followed, it was asked why performance had declined in some areas. It was also asked whether premium based numbers were a national or a local problem. In response to the first enquiry, Mark Easton explained that he did not want to speculate on the reasons why public satisfaction had declined. With regards to the premium based numbers enquiry, Mark Easton explained that it was a national problem. Following an enquiry about the worst performing surgeries, Mark Easton explained that there was a significant amount of variation between surgeries. He stated that a full analysis, which showed those surgeries that performed the worst, was publically available on the internet. A concern was raised by a member of the committee that the results suggested that there were some GPs who did not care about their patients.

Mark Easton noted that there were a number of GPs who would question the methodology used for the survey as there was such a low response rate. Dr Helen Clark (Chair of Brent Local Medical Committee) explained that she was concerned by the significantly low response rate of the survey and the effect that this could have on the results of the survey. She added that she welcomed the fact that the improvement programme was to be run internally rather than by external consultants and she emphasised that steps were already being taken to improve access for patients. Mark Easton commented that the areas which scored the best tended to be those areas which had the most participants in the survey. It was

noted by the committee that it was unfortunate that the results did not reflect the success of the extended hours initiative which had helped improve access for patients.

It was asked whether the survey could also capture qualitative as well as quantitative feedback. In response, Mark Easton explained that the analysis of qualitative information would be difficult for a large sample number and that there would be a risk that the bigger picture would get lost. He also informed the committee that this survey would be taking place more regularly, on a quarterly basis from now on.

The committee agreed to look at this issue on an ongoing basis and to monitor the progress of the improvement programme.

RESOLVED:-

that the results of the GP access survey and information on the implementation of the Access Improvement Transformation Programme be noted.

7. **Smoking Cessation**

Mark Easton (Chief Executive NHS Brent) provided the committee with an update on the progress of the smoking cessation service in Brent. He explained that a briefing note had been provided to the committee which summarised the performance of the service in the first half of 2009/2010. He stated that Brent PCT had, over the last couple of years, invested a lot of money into smoking cessation and that whilst this was having some impact, it had not had the impact which had been hoped for. He explained that whilst the numbers who had stopped smoking had doubled, the numbers had been very small to begin with.

Mark Easton informed the committee that they had been running an incentive scheme whereby a financial reward was provided, to those who had delivered the stop smoking service, when the client registered with the service and once the client had quit for a certain period of time. He explained that whilst they had thought that a generous scheme would raise the number of quitters, it had not reached the numbers that they had expected it would. Mark Easton stated that the more successful PCTs had been those which had used their Smoking Cessation Teams to proactively reach out and target communities. He stated that consideration needed to be given as to whether the emphasis should be switched from individual pharmacists and GPs to this approach. He added there was currently an under-spend in the smoking cessation budget which could be used for this.

In the discussion which followed, an enquiry was made as to who had been delivering the stop smoking service. It was also asked how long it would be until Brent PCT started to consider a move away from the rewards based system. In response to the first enquiry, Mark Easton explained that it was GPs and Pharmacists who had been delivering the service. In response to the second enquiry, Mark Easton explained that it may be that they would keep using the reward based scheme but that the remaining resources would be used to commission other services to support the current approach. He added that he

would not want to dis-incentivise those GPs and pharmacists who were helping people to quit.

Cathy Tyson (Assistant Director of Policy and Regeneration), following an enquiry, explained that smoking cessation remained a local priority in the LAA but was not one of the basket of indicators which was linked to the reward grant. Mark Easton commented that smoking cessation was one of the best ways to decrease health inequalities. Cathy Tyson highlighted that there was huge variation on smoking rates in the borough, but that smoking was generally more prevalent in the borough's deprived areas.

Following a query about using dentists and opticians, Mark Easton explained that interested opticians and dentists had recently been invited to become providers of the stop smoking service. With regards to community groups, he stated that other PCTs were targeting community groups successfully and whilst it was not something Brent PCT was currently doing, it was something that the Brent PCT would want to consider as it was an untapped resource.

It was noted by a member of the committee that the figures for quarter 2 were an improvement on quarter 1. It was asked whether this would mean that the 2009/2010 target could be met. In response, Mark Easton explained that the target would not be met unless changes were made. He stated that at the current rate, only 60-65% of the target was likely to be met.

The committee agreed to monitor this issue on a quarterly basis.

RESOLVED:-

i) that the progress in meeting the smoking cessation targets for 2009/10 be noted;

ii) that it be agreed that smoking cessation updates become a standing item on the Health Select Committee agenda on a quarterly basis.

8. **Acute Services Review**

Fiona Wise (North West London NHS Hospitals Trust) provided the committee with an update on the reconfiguration of emergency surgery and paediatric services across Brent and Harrow as part of the Acute Services Review.

The committee was made aware of the letter from Mark Easton (NHS Brent) to Councillor Leaman which set out the reasons for the decision, following the independent clinical review by the National Clinical Advisory Team, to stop emergency surgery at Central Middlesex Hospital. Fiona Wise explained that the London Ambulance Service would instead be taking patients to Northwick Park Hospital or another major acute hospital if closer than Northwick Park Hospital. The cessation of emergency surgery services at Central Middlesex Hospital would result in 7-10 patients per week requiring transfer from Central Middlesex Hospital to Northwick Park Hospital. She emphasised that high risk surgical work had already been moved to Northwick Park Hospital. She commented that Central Middlesex

Hospital would remain a busy local hospital. This, she added, was all due to commence in December 2009.

Fiona Wise informed the committee of the implementation plan which was in place to ensure that the process ran smoothly. She explained that work had been carried out which looked at what was needed at Northwick Park Hospital not just to support the extra 7-10 patients per week but also how to support surgery generally. She concluded by providing the committee with some of the quality indicators that had been agreed between the PCTs. She added that this was subject to weekly reviews in the first instance.

In the discussion which followed around emergency surgery, it was asked whether the establishment of a new stroke unit at Northwick Park Hospital would have an effect on things, particularly capacity at the hospital. It was also asked what would happen with emergency surgery on children. Furthermore, an enquiry was made as to how these changes were to be communicated to people as consultation had not taken place. In response to the first question, Fiona Wise explained that the stroke unit would not affect things as there were separate plans in place for this. With regards to the second question, Fiona Wise explained that emergency surgery on children did not currently take place at Central Middlesex Hospital anyway. In response to the third issue, she explained that a draft communication plan was in place. Mark Easton added that it was important to ensure that the GP community were fully involved in the process and that they understood the new service. It was also important, he added, that people were reassured that the changes did not undermine Central Middlesex Hospital as an acute site. Fiona Wise also reiterated, following a question about the role of the ambulance service, that the ambulance service would decide where the closest place was to take a patient.

Fiona Wise then went on to update the committee about the proposed paediatric services reconfiguration. This she explained was a piece of work which was still being undertaken. She began by explaining the case for change. She noted that children and young people made up 25% of Brent's population and that Brent's birth rate was rising by 3% per annum. Furthermore, she stated, deprivation levels which impact on children and young people have increased. She added that there was currently too much dependence on hospitals and that 87% of patients at Central Middlesex Hospital were seen and had gone home the next day. She explained that the current local model of care was not aligned to Healthcare for London's recommendation that 'all local hospitals should have a paediatric assessment unit working as part of a wider network of children services across 1° and with a major acute partner.'

Fiona Wise then set out the options for change. Option one, she explained was to do nothing and retain a 24 hour inpatient facility at Central Middlesex Hospital. The other option, she stated, was to establish two consultant led paediatric assessment units, one at Central Middlesex Hospital and one at Northwick Park Hospital. She emphasised the fact that this option would mean that a unit would be set up at both Central Middlesex Hospital and Northwick Park Hospital. If option 2 was to go ahead, she noted that there would be an estimated cost saving of £0.5 million per annum. She informed the committee that the proposed paediatric configuration was expected to require a section 244 public consultation.

To conclude Fiona Wise updated the committee as to what the next steps were. She informed the committee that further deliberation would take place across Brent and Harrow and that there would be a need to secure NHS London support for the pre-consultation business case. Furthermore, she explained that the NCAT clinical review and Department of Health Gateway Review of the paediatric model would also take place before public consultation. She added that the Brent Health Select Committee was to review the formal proposals for paediatrics at the next meeting on the 9th December. She stated that the plan was for public consultation to then start pre-Christmas.

In the discussion which followed, a concern was raised that there may be a perception in the South of the borough that Central Middlesex Hospital was being undermined and that services were being centralised at Northwick Park Hospital. In response, Mark Easton explained that careful consideration would be given as to how to inform the public of proposals. He stated that the services being moved were small services and that the public needed to be informed that there was a plan to continue and develop a number of big services, such as outpatients, at Central Middlesex Hospital. Fiona Wise added that her management team were also looking at what was better placed at Central Middlesex Hospital as well as ensuring that there were viable services at both ends of the borough. She also commented that it was all part of a bigger drive to prevent people going into hospital in the first place and therefore it was also about how services can be developed elsewhere.

The committee reiterated the importance of informing the public as to how important Central Middlesex Hospital was and how it would remain so. Mark Easton commented that there was a need to publish a report on the Future of Central Middlesex Hospital. Marcia Saunders (NHS Brent) noted that it was also important to remember that Northwick Park Hospital was now a major acute facility and had greatly improved.

Dr Helen Clarke (Chair of Brent Local Medical Committee) commented that, as stated in her letter to the Chair of the Health Select Committee, she was surprised to find that the proposals, following the acute services review, had been sent to Brent and Harrow's Overview and Scrutiny Committees before the Local Medical Committee had been consulted. She stated that there were a number of areas that GPs were concerned about. She explained that things had moved forward and NHS Brent had given their commitment to consult with GPs. She commented that there was likely to be a meeting of GPs held in October to discuss the issue. She was concerned however that if the meeting was not to go ahead it would be too late to be consulted before the next Health Select Committee. In response, Mark Easton commented that he would ensure that this was followed up.

Mark Easton noted that the paediatric service model and consultation plan was due to go to the next Health Select Committee on the 9th December. However, if the project was not sufficiently developed by December for public consultation to begin, then consultation and implementation on the changes to paediatric services would be delayed until after the local government and general elections in 2010.

RESOLVED**:-**

that the presentation on the acute services review and the letters from Mark Easton and Dr Helen Clark, as appended to the report, be noted.

9. **Major Trauma and Stroke Services - Update on final report of the Joint Overview and Scrutiny Committee and decisions from Joint Committee of PCTs**

Fiona Wise (North West London NHS Hospitals Trust) updated the committee on the service reconfiguration across Brent & Harrow with regards to stroke services. She informed the committee that, following the outcome of the Joint Committee of PCT's meeting on the 20th July 2009, North West London Hospitals Trust had been designated as one of London's 8 Hyper Acute Stoke and 24 stroke units. She explained that there would be 16 hyper acute stroke unit beds and 34 stoke beds established at Northwick Park Hospital. She noted that major ward refurbishment was required and would be completed by 1st February 2010. She also stated that 10 stoke beds would be decommissioned at Central Middlesex Hospital by 31 March 2010. She provided the committee with the detailed timetable of these activities.

Fiona Wise also provided the committee with an update on the recruitment required for the service reconfiguration. This included the fact that a stoke consultant had been appointed last week and that interviews for a second post would take place in December this year. She commented that the service reconfiguration would lead to the trust being able to offer an enhanced level of service for stoke patients.

Andrew Davies (Policy and Performance Officer) updated the committee on the service reconfiguration across Brent & Harrow with regards to major trauma. He stated that, following the outcome of the Joint Committee of PCT's meeting, a major trauma centre was to be commissioned at St Mary's Hospital by April 2012. He explained that the joint Overview and Scrutiny committee would be hearing more on the proposed trauma service at its meeting on 28th October 2009.

RESOLVED**:-**

that the verbal updates on major trauma and stroke services be noted.

10. **Implementing Healthcare for London - Strategic Commissioning Plan and Primary Care Strategy Update**

Mark Easton introduced the presentation pack which provided the committee with an overview of the progress made in implementing 'Healthcare for London'. Mark Easton reminded the committee that in 2008/09 NHS Brent developed its Commissioning Strategy Plan which set out a 5 year investment programme. He noted that it was held by Healthcare for London as being one of the best strategies in London. However, he explained that due to changing circumstances, NHS Brent were having to review the plan to ensure that it was aligned with others across North West London and so that it could still support progress towards delivering the goals and outcomes in the changing economic environment. He stated that because last years plan was so good, NHS Brent was committed to retaining the same goals.

Mark Easton explained that NHS Brent was redefining the Commissioning Strategy Plan to align with the 8 'Healthcare for London' Pathways. The presentation pack, he explained, highlighted the case for change, the progress made to date and the plans for the next stage for each of the pathways. He stressed the importance of the polysystem vision and model as underpinned by the Primary and Community Services Strategy. He explained that the presentation pack showed the emerging polysystem sites and explained future plans. He stated that the overarching Polysystem Implementation Model together with the plan for consultation and implementation would be included in the revised Commissioning Strategy Plan. He stated that the signed-off Commissioning Strategy Plan had to be submitted on the 18th December and that in the meantime a series of engagement activities would be taking place.

Following a request by the committee, Mark Easton took the committee through the financial context in which the commissioning plans would be delivered, as shown from slide 40 onwards in the presentation pack. He brought to the committee's attention the three possible financial scenarios that were being looked at, which were the 'base case', the 'upside' and the 'downside' scenario. He stated that all three scenarios had been built on a 'do nothing' basis from 2010/11, which he explained meant no further investment or savings programme. He commented that all three scenarios indicated that if a do nothing approach was used, there would be a budget deficit. He then set out the level of savings or disinvestment which was required to achieve a sustainable financial position under all three scenarios.

Mark Easton informed the committee of some of the 'Healthcare for London' initiatives which could be undertaken to achieve the savings required. He then explained how the slides in the presentation pack showed how the Healthcare for London model had been applied to Brent specifically and the savings that could be made by each initiative. He concluded by explaining that if the Healthcare for London savings were achieved, in all scenarios except the downside scenario, the budget would move back into balance. He stated that additional savings would be needed in the case of the downside scenario in order to reach a sustainable position. Mark Easton stressed that the figures could be used as a basis for conversation with the clinical community about how NHS Brent could provide just as good, if not better, services by using resources more effectively.

In the discussion which followed, it was asked by the committee as to when a suitable time for the committee to look at the Commissioning Strategy Plan would be. In response, Mark Easton suggested that the committee looked at the Commissioning Strategy Plan at the 9th of December meeting before it was submitted on the 18th December. Following an enquiry over the progress of the polysystem plans and whether residents were noticing a big difference, Mark Easton explained patients would not have noticed a big difference at the moment. He added that there was now an opportunity for patients to get involved with designing their practices. He stated that there was a need to move away from incremental change to transformational. In response to a concern regarding the fact that it seemed that the East of the borough had a lack of access to a proposed polyclinic site, Mark Easton commented that the big challenge was being able to afford new buildings. He explained that the way forward was to encourage GPs from smaller practices to come together and share costs.

The committee requested an update from NHS Brent regarding the plans to close the Stag Lane Clinic in Kingsbury following the discovery of a crack in the building. Mark Easton noted that a series of discussions had taken place with the practice about moving the practice to a temporary building. At the same time he explained that NHS Brent was working with GPs to formulate a long term plan for Kingsbury. The hope, he added, was for practices in the area to come together thus reducing the number of small practices. In response to a question as to what would happen to the Stag Lane site, Mark Easton explained that one option would be to sell the site. This, he stated, could contribute to a new building but it would only cover a small fraction of the cost required. It was also asked whether temporary portable cabins would be used. Mark Easton explained that this would be one of the options but that there would be planning consent issues to consider. He reiterated that any solution at the moment would be temporary. Dr Helen Clark (Chair of Brent Local Medical Committee) commented that practices were keen to work together but that the problem was getting the funding to do so. She stated that she was concerned as to what will happen to Stag Lane if the practices did not come together. In response, Mark Easton explained that the options needed to be examined carefully and that it was too premature, at this stage, to speculate as to what would happen.

RESOLVED**:-**

i) that the update from NHS Brent on the review of the Commissioning Strategy Plan and Primary Care Strategy be noted;

ii) that the update on position with Stag Lane Clinic and primary care services in Kingsbury be noted.

11. **Health Select Committee Work Programme**

Andrew Davies (Policy and Performance Officer) updated members on the committee's work programme for 2009/10 and informed members to contact himself or the Chair if they had any items that they wanted adding to the programme. He explained that the agenda for the 9th December meeting would be altered to incorporate the issues raised at this meeting.

12. **Any Other Urgent Business**

In accordance with Standing Order 64, the Chair introduced a report which set out the proposed changes to service in the provision of shared care services for children with cancer. He explained that, as a committee, they were being asked to consider whether the proposed changes amounted to a substantial variation in service that should be subject to formal consultation. The chair explained that the report was being considered under this item because a decision was required as a matter of urgency.

Andrew Davies (Policy and Performance Officer) informed the committee of the changes being proposed. He highlighted that the number of patients affected, as shown on page 2 of the report, was small. He added that 5 out of the 8 equivalent

committees, who had already discussed the changes, had agreed that formal public consultation did not need to be carried out as there would not be a substantial variation in service. In the discussion which followed, an enquiry was made as to whether the consultation, if it was to go ahead, would be carried out on a North West London basis. In response, Andrew Davies stated that he expected it would be done on a North West London basis, but that he would need to check that this was the case.

After consideration the committee decided that as the proposals did not amount to a substantial variation in service and affected only a small number of patients, it would not be necessary to carrying out formal consultation.

RESOLVED**:-**

the committee agreed that the proposals did not amount to a substantial variation in service and therefore formal consultation was not required.

13. **Date of Next Meeting**

It was noted that the next meeting of the Health Select Committee was scheduled for Wednesday 9th December.

The meeting closed at 9.05 pm

C LEAMAN
Chair

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	Health Select Committee 9 December 2009 **Report from the Director of Housing & Community Care**
For Action	Wards Affected: ALL
BRENT MENTAL HEALTH SERVICE SECTION 75 PARTNERSHIP REVIEW	

1.0 Proposal

To create a Section 75 partnership agreement between Brent Council and CNWL NHS Foundation Trust, expanding and replacing on the existing S31 agreement.

2.0 Recommendations

2.1 To note and comment on the report

3.0 Detail

Legislative and policy framework

3.1 Section 31 of the Health Act 1999 introduced powers to enable closer and more effective working arrangements between health and local authority partners.

3.2 The Health Act was repealed and replaced by the National Health Service Act 2006: S31 flexibilities are now governed by Section 75 of this Act.

3.3 The Government White Paper 'Our Health , Our Choice, Our Say' sets out a five year plan for Health and Social Care, and reaffirms Government commitment to developing integrated Health and Social Care partnerships to support the delivery of this agenda. Mental Health Act 2009 created new arrangements and duties for the local authorities.

3.4 The plan to strengthen the existing partnership arrangement is also in line with the move of local authorities away from the traditional provider role to that of

commissioning services. "Putting People First" guidance from DH December 2007, sets the policy for personalising social care and health services. World Class Commissioning guidance from DH December 2007 set a clear agenda of strategic commissioning for PCT's based on quality and value for money.

Brent Mental Health Service [BMHS] existing partnership agreement

3.5 In 2001 a Section 31 partnership agreement was established between the London Borough of Brent and the then Central & North West London Mental Health NHS Trust (now CNWL NHS Foundation Trust), establishing arrangements for partnership working in Brent Mental Health Service. The essential components of these arrangements were:

- Establishment of a limited pooled budget
- Agreement that London Borough of Brent employees would be managed on behalf of the Local Authority by BMHS managers, themselves Trust employees. However Local Authority staff would remain employees of the LBB, and LBB procedures would continue to apply to them.

The S31 agreement was reviewed and renewed in 2004, 2007 and 2008.

Rational for the current review

3.6 Benefits of existing agreement

(i). Improved experience for mental health service users, by streamlining processes, including:

- Establishment of a single point of referral
- Shared referral criteria
- Single multi-disciplinary assessment
- Single case files
- Greater transparency for service users and continuous improvements in service delivery

(ii). Improved performance:

- Integrated multi-disciplinary workforce benefiting from joint supervision and appraisal procedures and integrated training plan, resulting in successive IIP Accreditation: in 2009 Brent Mental Health Service received the Silver IIP award.
- Pooled management posts under CNWL giving greater ownership, control and flexibility
- The majority of National Service Framework targets for mental health have been met through the Local Implementation Team
- Performed well in the key health and social care performance indicators, e.g. assessment waiting times, delayed discharges, number of adults helped to live at home

- Undergone a number of successful reviews, e.g. SP review of supported housing accommodation and management, Health Care Commission reviews of CMHTs and Inpatient services

Limitations

3.8 There are changes envisaged from the PCT lead mental review and the joint commissioning strategy for mental health, 2010 – 2014 which will be better shared through clear relationship of the Council as commissioner and CNWL as a provider partner.

3.9 Current arrangements present significant barriers to effective 'joined up' service delivery. Managers need to adhere to two sets of policies, systems and processes; while inconsistencies between the two organisations can prove both confusing and divisive to staff and service users. For example, managers have to relate to separate HR services for both organisations with different policies and process; operational budgets are managed separately through CNWL and Brent Council's financial accounting systems, requiring managers to relate to two sets of organisational budgets, payroll, accounting and finance services

3.10 Resources have to be diverted from service delivery to managing the demands of two organisations: this is neither cost effective nor conducive to positive experiences and outcomes for service users.

3.11 The professional governance, training and regulation has been met so far, but the new framework would have this on a clear formal and accountable basis that safeguards the Council's statutory duties.

Vision

3.12 Of a fully integrated service, building on the developments of the past eight years, able to deliver our shared priorities for both health and social care outcomes. This will provide an integrated mental health and social care service, which will further streamline services for service users and increase efficiency. It will successfully meet performance targets and provide value for money. There will be sound processes for financial management of a single budget, one integrated IT system, with staff managed consistently and accountable via a single management structure, whilst securing professional governance on an acceptable basis.

Scope

3.12 Our objective is to transfer in due course all Local Authority staff, functions and operational budgets within Brent Mental Health Service to the Trust.

3.13 We aim to implement this project by the end of the current financial year, and to have a Section 75 partnership agreement agreed and signed by all partners by 31 March 2010 and operational by 30 June 2010.

3.14 Stage 1 will cover the transfer of all Local Authority staff, functions and operational budgets within to the Trust. This comprises social workers, support workers and administrators.

3.15 To ensure robust arrangements for Social Care Governance, including monitoring the Approved Mental Health Practitioner function, we propose that the Lead Social Worker remain employed by the local authority, reporting to the Assistant Director of Housing and Community Care.

Progress to date

3.16 A Project Board has been appointed to steer the Project. This comprises:

- Director of Operations, CNWL NHS Foundation Trust
- Assistant Director of Housing and Community Care, LB Brent
- Service Director, BMHS
- Deputy Director of Finance, CNWL
- Assistant Director [Finance], Housing and Community Care, LB Brent
- Deputy Director of Commissioning, NHS Brent

3.17 A Project Manager has been appointed, leading a Project Team comprising senior staff from the Trust and the Council from HR, Finance, Legal and IT Departments. These senior staff lead the following work streams: Human Resources, Finance, IT, Estates and Policies.

3.18 A Project Plan has been produced scoping the tasks of the work streams.

3.19 An options appraisal outlining the options for transfer of staff has been commissioned and is close to completion. Once a preferred option has been identified a process of consultation with staff and Trades Unions will commence.

3.20 The finance work stream has commenced the process of verifying the operational budgets to be transferred.

4.0 Financial Implications

4.1 None

5.0 Legal Implications

5.1 None

6.0 Diversity Implications

6.1 None

7.0 Staffing/Accommodation Implications (if appropriate)

7.1 None

Background Papers

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	Health Select Committee 9 December 2009 **Report from the Director of Policy & Regeneration**
For Action	Wards Affected: ALL
North West London Hospitals Patient Experience Improvement Programme (We Care)	

1.0 Summary

1.1 The Health Select Committee has asked to see the details of the North West London NHS Hospitals Trust patient experience improvement programme, known as the We Care programme. The Committee was concerned by the results of the 2008 Healthcare Commission In Patient Survey which showed that NWLH was in the lowest 20% of trusts nationally in terms of patient satisfaction and opinion on the services they receive. This was despite an improvement of 5-10% on over half of the questions from the 2007 In Patient Survey.

1.2 Improving the patient experience was one of the eight key Trust objectives of 2008/2009 and resulted in a successful application for funding from NHS London, to pilot a multi professional customised patient experience programme.

1.3 The We Care programme has been designed to provide patients with a better experience of the North West London Hospitals Trust. The aim was to help to re-establish a culture of caring and compassion for patients in the busy ward environment and to equip staff with the attitudes, behaviours and competencies required to care for and build trust with the widely diverse communities that the Trust serves.

1.4 The programme consists of the following components;

- Delivering the 3Cs training – Compassionate care, Consistency & Communication
- Patient stories
- Nursing Promise
- Real time patient feedback
- Patient surveys on discharge
- PALS, Complaints and Compliments
- Bereavement care

- "Ask me 3" – increased patient involvement in their care
- Mystery shopping
- Staff satisfaction survey

1.5 The report provided by the Hospital Trust, attached at appendix 1, contains details on the work that has been done in each of the individual project components and the next steps for moving the programme forward. The Health Select Committee might wish for a further update on this before the results of the 2009 in-patients survey are published. The committee should also consider the results of that survey once they are available in order to see whether there has been an improvement on the results from 2008.

2.0 Recommendations

2.1 The Health Select Committee is recommended to:

(i). Consider the report provided by the North West London NHS Hospitals Trust on the We Care, Patient Experience Improvement Programme and question officers on the work that has been done to date.

(ii). Decide whether it wants a further update on this work before the results of the 2009 in patient survey are published.

(iii). Agree to consider the results of the 2009 in-patient survey when they are available.

3.0 Financial Implications

3.1 None

4.0 Legal Implications

4.1 None

5.0 Diversity Implications

5.1 None

6.0 Staffing/Accommodation Implications (if appropriate)

6.1 None

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North West London Hospital
Patient Experience Improvement Programme (We Care)

1. Introduction

"High Quality Care For All"; NHS Next Stage review (DOH 2008) set out a vision of an NHS that works in partnership to prevent ill health, providing care that is personal, effective and safe. This is an ambitious goal of putting quality at the heart of the NHS by making it a fundamental principle.

In order to achieve this goal, NHS Trusts need to re visit how they measure quality and focus on what really matters to their stakeholders i.e. clinical quality, patient safety and particularly patient satisfaction with services. In the past it has been suggested that the NHS has sometimes focused on delivering services to benefit the providers rather than the recipients of care. The way forward is more people centred and preventative, placing quality at the core of everything that it does.

The National Quality Board and the Care Quality Commission will provide guidance and an integrated oversight to drive forward these changes. Another piece of the quality jigsaw will be Quality Accounts, published by all NHS organisations at the same time and with the same weight as their financial accounts. At present, quality is marginally recognised in each NHS Trust's income tariff. However it is planned that a much bigger proportion will be allocated in future. This will be a big culture change for the NHS, which has traditionally been paid by volume.

The emphasis on the quality agenda demands a shift from a one size fits all service, to a more open and responsive system which focuses on the needs of the individual. The development and implementation of a patient experience improvement programme directly contributes to achieving the components of the NHS Next Stage review.

2. Background

NWLH was in the lowest 20% in the Healthcare Commission National In Patient Survey in 2008. This was despite an improvement of 5-10% on 33 out 0f 61 questions from the 2007 survey. Improving the patient experience was one of the eight key Trust objectives of 2008/2009 and resulted in a successful application for funding from NHS London, to pilot a multi professional customised patient experience programme.

The initial scoping of the project included a number of focus groups with a variety of stakeholders, to ascertain what key elements were important to them in ensuring a quality experience and give them confidence in the staff caring for them. The findings indicated that patients wanted staff to be Compassionate/caring, Consistent and better at Communicating. The findings informed the multi disciplinary training (called the 3C's) which was developed to form the basis of the "We Care" programme.

The programme was designed to provide patients with a better experience of The North West London Hospitals. The aim was to help to re establish a culture of caring and compassion for patients in the busy ward environment and to equip staff with the attitudes, behaviours and competencies required to care for and build trust with the widely diverse communities that the Trust serves.

The programme incorporates a range of initiatives, each with its own lead and action plan, aimed at providing the Trust with information which will inform how patients and their families really feel about the quality of the services. It also provides appropriate metrics that can be used to measure performance and monitor improvements.

The programme is monitored and overseen by an Executive Steering Group. A Project Implementation Group reports to the Steering Group.

3. The programme consists of the following components;

- Delivering the 3Cs training – Compassionate care, Consistency & Communication
- Patient stories
- Nursing Promise
- Real time patient feedback
- Patient surveys on discharge
- PALS, Complaints and Compliments
- Bereavement care
- "Ask me 3" – increased patient involvement in their care
- Mystery shopping
- Staff satisfaction survey

4. Delivering 3Cs –Compassionate care, Consistency & Communication training

The training was designed and facilitated by an external consultant. The aims of the training sessions were to engage senior management and front line staff and to enable them to understand the changing needs of patients and empower them to make the changes necessary to improve the patient experience and result in a re energised workforce when they saw patients more satisfied with their experience.

Staff were trained in their ward teams and this was well evaluated, as it provided a good team building opportunity and encouraged them to reflect on how they manage their individual areas and what they would like to improve and change.
To date 18 wards/departments and 679 staff have undergone training and the next group of wards are being identified for Phase 2. An E learning tool has been developed and is currently being evaluated.

Following the training, each area had a follow up meeting attended by the Ward Manager, Matron and General Manager to discuss the inputs from their team and to draw up an action plan. The plan addresses the constraints that staff feel compromise the efficiency and quality of the service. Issues raised included: information to patients, Protected Mealtimes, visiting hours, communication between members of the Multi Disciplinary Team

(MDT), delayed discharge and transfer between wards. Solutions were discussed in ward meetings and have resulted in significant changes to practice .A corporate “Coming into Hospital” patient information leaflet has been developed, protected mealtimes is being re launched and wards are using communication books to improve communication between the MDT.
Tools including Observations of Care and Patient stories are being used to monitor progress and sustainability and to give feedback to staff. These tools also demonstrate to patients and relatives that the Trust is constantly reviewing and improving its services

Next steps

- Review the content of the 3Cs training to appeal to a wider audience and improve attendance especially from medical staff
- Cascade the E learning package
- Share changes in practice and improvements from action plans with the wider team and organisation
- Explore feasibility of a Higher Education Institute facilitating the ongoing training

5. Patient stories

a) Patient Experience trackers
Patient stories are interviews with service users about their experience of receiving care. This is a powerful way of involving the person in their care and helping to find out which aspects they value and which areas need improving. The strength of the story is that the content is led by the individual involved and so reflects the issues that they feel are important.

An action plan is developed based on the themes emerging from the story and key stakeholders are informed of the major themes for improvement and sharing good practice. Themes can be included in business planning and also influence objectives for training and development.

Matrons have attended the Patient Story training and have “ Buddied” up to take stories in each other’s areas. Themes and actions are shared at the Matron’s meeting every month. Key themes emerging are: communication, information, feeling treated as an individual and dignity and respect which are pertinent to all clinical areas.

A patient story was presented to the Trust Board in August 2009 and a patient is attending the December meeting to discuss themes from his own story.

Next steps

- Patient stories are carried out by other disciplines
- .A consultant paediatrician is booked to undertake a story in November 2009
- A session is booked for pre registration medical students in December 2009
- Themes are shared with other disciplines
- Stories are a regular item on the Trust Board agenda and other key meetings

b) Mixed sex accommodation
Single sex sleeping and washing facilities are a key issue for patients. The Trust monitors this carefully at daily bed meetings to reduce the occasions that mixed gender accommodation occurs. It can be seen from the graph that generally this has been improving and we continue to focus on this key area of improving the patient experience.

6. Nursing & Midwifery Promise

A body of work has been undertaken with NWLH nurses and midwives to identify what their values are for the organisation .These have now been adopted as Trust wide values and incorporated into Our Promise to NWLH patients and reflects the NHS Constitution and the importance of delivering high quality care, the 3Cs, dignity and respect. The Promise is displayed in all wards and public areas throughout the Trust. **(Appendix 1)**

Next steps

- An audit is planned by members of the Hospital User Bank (HUB) to measure the impact of the Promise on patients and determine from staff how it relates to practice
- The Promise will be incorporated into the next Nursing and Midwifery Strategy

7. Real time patient feedback

In order to help evaluate the impact of the programme, the Trust introduced Dr Foster Patient Experience Trackers (PETS) in 12 clinical areas. The questions are based on themes from the 3Cs in particular, Caring, Compassion and Communication. Results are sent directly to the ward and the ward manager and staff devise an action plan based on the findings. This information is displayed for patients and staff to see the progress/improvements that are being made and monitored. The visibility of the actions highlights to patients that the Trust is open to feedback and keen to make improvements wherever possible.

The feedback is timely and enables the Ward Manager to pick up on issues quickly and feedback to the ward team about successes and areas of practice that need to be monitored and revise. The survey results are reported to the Trust Board monthly as part of the Quality Scorecard.

Clinical Quality- We Care	Exec Lead	RAG Status	Proxy target	YTD Target	YTD Actual	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09
Patient Experience- Dr Foster Trackers												
Staff looking after me had a caring and compassionate attitude	LR	G	80%	80%	84.4%	94.1%	83.4%	84.0%	85.1%	85.7%	84.1%	84.6%
Staff looking after me did things they said they would do	LR	G	80%	80%	82.1%	83.8%	80.2%	81.7%	83.6%	84.8%	82.6%	81.4%
I feel fully informed about what was happening with my treatment	LR	G	80%	80%	80.2%	75.0%	78.3%	80.2%	80.9%	82.7%	80.0%	80.3%
I was involved as much as I wanted to be in decisions about care	LR	R	80%	80%	79.6%	73.5%	76.5%	79.4%	81.0%	82.9%	80.2%	79.4%
Overall I was very satisfied with the care I received	LR	G	80%	80%	84.4%	88.2%	83.4%	84.3%	84.2%	86.9%	83.9%	84.6%
Enviroment												
% of patients in mixed sex accommodation	LR	G	<10%	<10%	4.5%	4.5%	4.6%	5.2%	5.3%	4.0%	3.1%	4.8%

Next steps

- Encourage staff to give the PET's to patients and relatives as often as possible to increase usage
- Sustain the actions/improvements highlighted by the PET's
- Translations of the questions to improve utilisation by all patients from non English speaking communities
- New posters and action plans to make the function and outcomes of PET's more explicit and encourage patients and families to actively ask to use the machines
- Re tendering to explore other hand held devices and roll out to all departments
- Inclusion of results in divisional clinical scorecards

8. Mystery Shoppers/ Hospital User Bank (HUB)

The NWLH Hospital User Bank (HUB) is made up of NWLH past & current patients and visitors who have volunteered to become involved in service improvement activity. The HUB data base currently stands at approx 170 members. A group of activities that the HUB are actively involved in is "Mystery Shopping". This is where HUB members observe various aspects of the Trust's services to identify what could be improved. Examples of this include:

Hand Hygiene Monitoring – Help us to combat hospital infection

Infection control equipment audit – where HUB members observe the equipment and cleanliness on the wards and various departments

Environmental audits – work is underway with the Trust domestic care contractor to adapt the hand held device that is used by supervisors to monitor cleaning. This will enable HUB members to use the same device to monitor the cleaning of public areas in the Trust.

Staff behaviours –Outpatient and reception staff are observed to ensure they welcome patients and that various other professional standards are observed.

Walking the "Northwick Park and Central Middlesex Way - members of staff and HUB members have undertaken a number of journeys from local transport and car parks to access various departments within the hospitals. Signage, WC facilities, environmental issues and disabled access issues have been noted and actioned by a working group chaired by the Director of Corporate Services.

A HUB member has been recruited to help coordinate HUB members' activities, recruitment and manage the HUB data base.
HUB members also sit on various NWLH committees including the Trust Board, Patient Information, Patient Safety, We Care implementation and Steering Groups and the Patient and Public Involvement Committee

The HUB will be used as the core of the Foundation Trust shadow membership development.

9. Patient surveys on discharge

The Trust has implemented a discharge survey which is given to all patients in ward areas that are not using the Patient Experience Trackers (PET's). Results are used to demonstrate the impact of the 3Cs training. The ward managers receive the feedback on a weekly basis and are able to feedback the results to the multi disciplinary team and take action as appropriate. **(Appendix 2)**

Next steps

- Survey revised to incorporate questions from the National InPatient Survey and Quality specification in the contract including questions to monitor compliance with single sex accommodation
- More robust system introduced to ensure efficient collection collation and feedback of data

10. PALS, Complaints and Compliments

The impact and key improvement areas of the programme are reflected in the number of PALS issues, formal complaints and compliments to staff. The Trust has also monitored the improvement in complaints in relation to nursing care since the introduction of the programme in Quarter 1.

	Q1 09/10	**Q2 09/10**
Nursing & Midwifery Complaints	42	31
Clinical care complaints involving nursing	44	34
Compliments re: Patient care	44	55

Between Q1 and Q2 for this year, the figures demonstrate a 26% reduction in nursing and midwifery complaints overall. The complaints categorised as clinical care are primarily about medical care but may also have an issue raised about nursing. Those complaints in the latter category have also reduced by 23% during this year. There is also a 25% increase in the compliments received this year to date.

Communication complaints

	Q1	**Q2**	**Total**
08/09	19	35	54
09/10	14	13	27

One of the key elements of the 'We Care" programme is to help staff to communicate more effectively with patients. The above table demonstrates that there is a 50% reduction in complaints regarding communication in the first 6 months of 2009 compared to the first 6 months of 2008/09.

Next steps

Continue to monitor and share results with a wider audience

11. Bereavement care

The Trust appointed Bereavement Co-ordinator in order to focus on the needs of patients and families. The postholder provides support and advice to bereaved families and helps them to navigate the End of Life care pathway. The service has improved communication between staff and families and also the de briefing of staff in relation to themes from complaints. It has also facilitated more effective and efficient discharge from hospital for patients who wish to die at home. Advice for bereaved relatives has been improved to include details of local bereavement services and advice on funeral arrangements A sympathy card from the Trust has been produced and is sent to bereaved relatives

Since the post has been introduced, there has been a significant decrease in bereavement themed complaints

Bereavement Complaints

	Q1	Q2	Total
08/09	**14**	**13**	**27**
09/10	**8**	**6**	**14**

It can be seen that there has been a 48% reduction in complaints received between 2008/9 and 2009/10 to date, as a result of the actions taken as part of the programme.

Next steps

- Develop the bereavement information available on the intranet
- Cascade training for dealing with bereaved families to front line staff
- Continue to work collaboratively with external support agencies such as Cruse, to improve services

12. "Ask Me 3" (Patient involvement in their own care)

Ask Me 3 is a health promotion programme originating in the USA. It identifies three questions that are fundamental to promoting health education and effective communication

- What is my main problem?
- What do I need to do?
- Why is it important for me to do this?

The questions promote patient involvement in their care. The process is currently being piloted with patients attending for. pre operative assessment . They are sent information about their role in the process and the questions to reflect on prior to their appointment

Next steps

- The process will be cascaded following review of the pilot

13. Staff survey

The relationship between low staff satisfaction and low patient satisfaction is well recognised. A recent study has identified specific links between questions from the National In Patient survey and the National staff Survey (Raleigh.V & Halit K 2008).By focusing on improving the patient experience and increasing the levels of patient involvement, a culture of staff working in partnership with patients will be created.

The Trust has developed a staff survey to demonstrate the link between staff satisfaction and the patient experience.
The questionnaire was given to all staff to complete pre and post and attendance of the 3Cs training component of the "We Care" programme.
(Appendix 3)

Next steps

- The survey will be repeated in three months to assess sustainability following the 3C training
- The Director of Human Resources and Director of Nursing are working together to monitor the impact of increased staff engagement on patient satisfaction

CONCLUSION

The implementation of the We Care programme at NWLH has had a significant impact on both patients and staff .It has given the staff the opportunity to stand back from their areas of work and view the service, attitudes and behaviours of their teams from the patient's perspective .It has also reinforced the importance of small things in the patient's journey, and how improving these issues can make a huge impact on the overall patient experience .It has also helped them to understand each other's roles and the importance of working together as a cohesive team to make the necessary changes to the service
The metrics that have been used to evaluate the impact of the programme indicate that the patients are beginning to have a more positive experience They are able to see that the Trust is endeavouring to make improvements in the environment as well as the attitudes and behaviours of the staff who are caring for them during their stay

Phase 2 of the programme will focus on sustaining the changes and improvements achieved by Phase 1 and to ensure that the 3C's Compassionate care, Consistency and Communication continue to be re-inforced and are embedded in the culture of the organisation.

Appendices

Appendix 1

Appendix 2

Discharge survey results over period from early August to end September (8 weeks)

Questions:

1. Staff looking after me had a caring and compassionate attitude
2. Staff looking me did the things they said they would do
3. As far as I am aware, staff would wash or clean their hands between touching patients
4. I felt fully informed about what was happening with my treatment
5. I was involved as much as I wanted to be in decisions about my care
6. The hospital room or ward was kept clean
7. In my opinion the hospital food was good
8. Overall, I was satisfied with the care I received

	CARING	CONSISTENCY	HAND HYGIENE	COMMUNICATION	INVOLVEMENT	CLEANLINESS
Fletcher						
Start	70%	70%	66%	75%	79%	75%
End	85%	80%	85%	75%	80%	85%
Fielding						
Start	75%	75%	75%	62%	50%	62%
End	91%	100%	91%	91%	83%	91%
Gladstone 4						
Start	87%	81%	93%	68%	68%	93%
End	84%	87%	90%	87%	81%	90%
Eliot						
Start	83%	75%	75%	83%	75%	75%
End	86%	88%	100%	97%	91%	97%
Paediatrics CMH						
Start	93%	87%	75%	87%	87%	93%
End	93%	93%	87%	93%	100%	100%

Appendix 3

	Date	No. of returns	Q1: Valued	Q2: Opinion matters	Q3: Team Spirit	Q4: Happy	Q5: Recommend family
Questions: **1**. I felt valued by the Trust **2.** My opinion matters in how the Ward Dept is run **3** I feel part of a strong team with a good team spirit					**4.** I am happy in my work **5.** If a member of my family needed hospital treatment I would recommend that they come to this Trust.		
Dickens							
Baseline	21/06/09	19	47%	60%	76%	75%	60%
Follow-up	15/10/09	17	53%	75%	86%	75%	64%
Dryden							
Baseline	15/06/09	22	36%	56%	69%	62%	47%
Follow-up	04/10/09	16	46%	64%	71%	67%	65%
Gladstone 1							
Baseline	21/06/09	19	40%	47%	65%	61%	56%
Follow-up	02/10/09	9	58%	66%	77%	83%	63%
NPH A&E							
Baseline	16/07/09	55	41%	48%	69%	61%	53%
Follow-up	15/10/09	21	50%	57%	75%	65%	66%
Gladstone 4							
Baseline	17/07/09	13	42%	61%	65%	76%	48%
Follow-up	29/09/09	8	65%	59%	96%	93%	62%

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	Health Select Committee 9 December 2009 **Report from the Director of Policy & Regeneration**
For Action	Wards Affected: ALL

Local Area Agreement Performance Review - Quarter 2, 2009/10

1. Summary

1.1 This report summarises performance against the health related Local Area Agreement targets for Quarter 2, 2009/10 and highlights key issues and solutions to them. The report is accompanied by an appendix providing complete Local Area Agreement performance information. When Health Select Committee last looked at the LAA targets in June 2009, it was agreed that they should be considered every six months.

2.0 Recommendations

2.1 Health Select Committee is recommended to consider performance against the LAA health related targets and question officers on work that is ongoing to improve performance in these key areas.

3.0 Local Area Agreement Performance Position

3.1 The Local Area Agreement for 2008-2011 was refreshed between January and March of 2008/09. The Local Area Agreement is currently made up of 29 targets, seven of which are local indicators. March 2008/09 was the final year in which the 12 stretch targets were reported. Only one stretch target relating to health has continued from LAA 2006-09, children's sport participation. This is the first Local Area Agreement report under the new Comprehensive Area Assessment regime (CAA). The CAA replaces the Comprehensive Performance Assessment that came to an end in 2008/09.

3.2 The health related targets in the Local Area Agreement are:

Priority	Indicator
12). Improving access to employment for those with mental health needs	*NI 150 Adults in contact with secondary mental health services in employment
Reducing Substance Misuse	*NI 40 Number of drug users recorded as being in effective treatment
17). Tuberculosis	Increase treatment completion rate (NHS London target)

18).Children's sport participation	The annual number of visits by young people (under 17) taking part in sport and physical activities at council owned sports centres (not part of a school club or term-time learn to swim course).
Adult Obesity	*NI 121 Mortality rate from all circulatory diseases at ages under 75 (rate per 100,000)
Improving Sexual health	*NI 112 Under 18 conception rate
26). Child Obesity	a) Proportion of pupils in year 6 with height and weight measured b)*NI 56 Obesity in primary school age children in year 6
CAMHS Service effectiveness	*NI 51 Effectiveness of child and adolescent mental health (CAMHS) services
34). Increasing self directed support	*NI 130 Social Care clients receiving Self Directed Support (per 100,000 population)
35). Brent carers	*NI 135 Carers receiving needs assessment or review and a specific carers service, or advice and information
37). Reducing delayed discharges and increasing admissions avoidance	*NI 131 Delayed Transfers of Care D41 and NI131 (Rate per 100,000)

4.0 Performance by Priority

4.1 **12). Improving access to employment for those with mental health needs** NI150 Adults in contact with secondary mental health services in employment. Performance for this indicator has shown progress by achieving target this quarter, despite the current economic climate. It is a huge challenge placing service users in the 25-49 age group into employment. Also, the lowest waged jobs are the worst affected by the recession in Brent and the majority of Jobs Seekers Allowance claimants come from this category. This could be a future barrier as anticipated service users would be placed into this category when the numbers of vacancies are shrinking. In addition, the number of general applicants has increased, increasing competition with service users. To help reduce the effects of the recession, voluntary work experience is being sought for service users to develop skills in order to compete in the job market.

4.2 **16). Reducing Substance Misuse** - NI 40 Number of drug users recorded as being in effective treatment. This indicator looks at reducing harm caused by drugs which affect the individual, their families and communities they live in. Effective treatment looks at individuals discharged from the treatment system for 12 weeks or more, those that remain in treatment 12 weeks after triage or those discharged in less than 12 weeks in a care planned approach. Performance for this indicator is reported three months in arrears and reflects performance for quarter one 1St April – 30th June 2009. This target is delivered through a number of partnership agencies. There was an under performance against target, due to one of the partnership agencies not meeting their target which had an impact on the overall performance.

4.3 **17). Tuberculosis** (Local indicator) – *Increase treatment completion rate (NHS London)* - This indicator examines the number of people accessing treatment for tuberculosis. Performance against target was achieved. Some of the success factors were joint working with community groups and improved working relationships with hospitals.

4.4 **18). Sports participation** (Local indicator) – the number of visits by young people taking part in sport and physical activity at council owned sports centres. Target has been achieved this quarter. One of the risks identified with this indicator is the closure of sports centres as there are not many other activities for young people on offer. The council is working with sports centres to ensure that facilities in the borough are well maintained.

4.5 **26). Child Obesity** CF/VS09.3 - Number of families attending the 10-week MEND programme (child obesity). There are planned measures to improve performance as this target was not achieved. These include increased awareness of MEND and its referral process. Strategic care pathways for Childhood Obesity in Brent will include MEND as a key programme. In addition to this, there will be further development of the MEND strategy to identify successful methods to maximise the current pool of recruits into the MEND programme.

4.6 **34). Increasing self-directed support** NI130 Social care clients receiving self-directed support per 100,000 population. Improved performance is reflected by a positive direction of travel although the indicator is still classed as medium risk. Recently a new financial system was implemented which may have affected performance levels slightly this quarter due to teething problems.

4.7 **35). Brent carers** NI135 Carers receiving needs assessment or review and a specific carers' service, or advice and information. Direction of travel shows that performance is worse and currently this indicator is high risk. Poor outturn on the number of assessments being undertaken and the inaccurate recording of carers assessments are contributing to poor performance.

4.8 **37). Reducing delayed discharges and increasing admission avoidance** NI131 Delayed transfers of care. Performance this quarter has improved in comparison to the previous quarter and this indicator is currently low risk. This is due to the streamlined assessment and discharge pathway and process which was recently agreed.

Background documents

Local Area Agreement 2008/11

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Performance

A Great Place: A Safe Place									
	Actual YTD	Target YTD	Alert	Distance between Actual &Target	Performance previous period	Performance this period	DOT	Annual target	Good performance is?
⊞ NI015 Serious violent crime rate	1.26	0.95	▲	0.31	0.23	0.13	✓	1.91	Smaller is Better
⊞ NI016 Serious acquisitive crime rate	13.42	15.19	★	-1.77	2.35	2.11	✓	30.40	Smaller is Better
xDNI024 Satisfaction with the way the police and local council dealt with ASB	82.00	84.00	●	-2.00	93.00	82.00	✗	84.00	Bigger is Better
LBB LAA 5.1 Number of accidental fires in residential properties	99.00	106.00	★	-7.00	55.00	44.00	✓	210.00	Smaller is Better

A Great Place: A Clean and Green Place									
	Actual YTD	Target YTD	Alert	Distance between Actual &Target	Performance previous Qtr	Performance this Qtr	DOT	Annual target	Good performance is?
NI188 Planning to adapt to Climate Change	0.00	1.00	▲	-1.00	0.00	0.00	➡	2.00	Bigger is Better
⊞ NI185 CO2 reduction from Local Authority operations	?	?	?!	?!	?	?	?	3.00	Bigger is Better
⊞ NI192 Percentage of household waste sent for reuse, recycling and composting	32.18	30.00	★	2.18	32.73	31.60	✗	30.00	Bigger is Better

A Great Place: A Lively Place									
	Actual YTD	Target YTD	Alert	Distance between Actual &Target	Performance previous Qtr	Performance this Qtr	DOT	Annual target	Good performance is?
EC SP33 No of sports visits by young people to council-owned facilities (incl courses)	71227.00	54870.00	★	16357.00	34102.00	37125.00	✓	109740.00	Bigger is Better

Please note: NI185 is an annual indicator and will not have data to report until March 2010. Figures are not available for March 2009 as data capture processes were set up only recently.

EC SP33 is a new indicator and does not have a figure quoted for March 2009. It has been set up to include physical activity courses uptake in the borough.

Performance

A Borough of Opportunity: Local Employment and Enterprise									
	Actual YTD	Target YTD	Alert	Distance between Actual and Target	Performance previous Qtr	Performance this Qtr	DOT	Annual target	Good performance is?
LBB LAA 13.1 Annual amount of additional benefit in payment as a result of advice & assistance	?	?	?!	?!	?	?	?	?	Bigger is Better

A Borough of Opportunity: Health and Wellbeing									
	Actual YTD	Target YTD	Alert	Distance between Actual and Target	Performance previous Qtr	Performance this Qtr	DOT	Annual target	Good performance is?
⊞ NI150 Adults receiving secondary mental health services in employment	9.16	8.00	★	1.16	7.19	9.16	↑	8.00	Bigger is Better
NI121 Mortality rate from all circulatory diseases at ages under 75	?	?	?!	?!	84.30	?	?	?	Smaller is Better
⊞ NI040 Number of drug users recorded as being in effective treatment	?	1037.00	?	?	?	?	?	?	Bigger is Better
LBB LAA 17.1 Tuberculosis treatment completion rate	87.00	85.00	★	2.00	87.00	87.00	➡	?	Bigger is Better

A Borough of Opportunity: Help When You Need It.									
	Actual YTD	Target YTD	Alert	Distance between Actual and Target	Performance previous Qtr	Performance this Qtr	DOT	Annual target	Good performance is?
⊞ NI130.09 Social care clients receiving Self Directed Support	12.40	11.62	●	0.78	11.20	12.40	↑	15.00	Bigger is Better
⊞ NI131 Delayed transfers of care	8.72	13.00	★	-4.28	10.38	8.72	↑	13.00	Smaller is Better
⊞ NI135 Carers receiving needs assessment or review and a specific carer's service, or advice & inf.	6.32	12.93	▲	-6.61	6.55	6.32	↓	24.60	Bigger is Better
⊞ NI141 Percentage of vulnerable people achieving independent living	?	77.00	?	?	75.58	?	?	77.00	Bigger is Better

Please note: LAA 13.1 cannot be reported until after September 2009 as the project has not yet started.

No Quarter 1 figure has been report for NI 40 (PCT). This data is normally 3 months in arrears due to different reporting deadlines between the Primary care trust and the council.

Performance

One Community: Settled homes	Actual YTD	Target YTD	Alert	Distance between Actual and Target	Performance previous Qtr	Performance this Qtr	DOT	Annual target	Good performance is?
NI154 Net additional homes provided	?	915.00	?	?	?	?	?	915.00	Bigger is Better
NI155 Number of affordable homes delivered (gross)	153.00	181.00	▲	-28.00	29.00	124.00	✓	458.00	Bigger is Better
NI156 Number of households living in Temporary Accommodation	3439.00	3615.00	●	-176.00	3549.00	3439.00	✓	3485.00	Smaller is Better

One Community: Early Excellence	Actual YTD	Target YTD	Alert	Distance between Actual and Target	Performance previous Qtr	Performance this Qtr	DOT	Annual target	Good performance is?
xNI111 First time entrants to the Youth Justice System aged 10 - 17	47.00	100.00	★	-53.00	63.00	47.00	✓	229.00	Smaller is Better
CF/VS09.3 No. of families attending the 10 week MEND programme (childhood obesity)	17.00	21.00	▲	-4.00	23.00	11.00	✗	84.00	Bigger is Better
NI051 Effectiveness of child and adolescent mental health (CAMHs) services	?	?	?!	?!	56.00	?	?	?	Bigger is Better
NI054 Services for disabled children	?	?	?!	?!	57.00	?	?	?	Bigger is Better
NI063 Stability of placements of looked after children: length of placement	66.60	78.00	▲	-11.40	65.70	67.50	✓	78.00	Bigger is Better
NI112 Under 18 conception rate	?	?	?!	?!	37.90	?	?	?	Bigger is Better
NI108 Key Stage 4 attainment for all Black and minority ethnic groups	?	?	?!	?!	?	?	?	?	Bigger is Better
NI108(a) Key Stage 4 Attainment for BME Groups (Black Caribbean Boys)	?	?	?!	?!	?	?	?	?	Bigger is Better
NI108(b) Key Stage 4 Attainment for BME groups (Somali Boys)	?	?	?!	?!	?	?	?	?	Bigger is Better

One Community: Building Our Capacity	Actual YTD	Target YTD	Alert	Distance between Actual and Target	Performance previous Qtr	Performance this Qtr	DOT	Annual target	Good performance is?
NI150 Adults receiving secondary mental health services in employment	9.16	8.00	★	1.16	7.19	9.16	✓	8.00	Bigger is Better
LBB LAA 38.1 Number of new volunteering opportunities created	279.00	270.00	★	9.00	139.00	140.00	✓	?	Bigger is Better

Please note: NI 54 has no set target as this is a baseline year.

NI 154 is an annual indicator and will not have data reported against it until March 2010.

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	Health Select Committee 9 December 2009 **Report from the Director of Policy & Regeneration**
For Action	Wards Affected: ALL
NHS Brent Commissioning Strategy Plan	

1.0 Summary

1.1 NHS Brent has been working on a review of its commissioning strategy plan to update it following initial approval last year. Since the original strategy was approved the economic standing of the country had changed dramatically and so the plan has been reviewed to ensure its goals can be delivered in a more challenging economic environment. In addition to this, the plan needs to align with others in North West London and contribute to the strategic plan for health in the North West London sector. It also needs to reflect the eight *Healthcare for London* pathways.

1.2 A comprehensive summary of the plan is included on the Health Select Committee agenda. The full plan will be circulated separately. Members will see that since this was considered at the committee meeting in October 2009, work has been done to clarify the goals, outcomes and priority areas. The goals contained in the plan are:

- Reduce premature mortality and therefore increase life expectancy by three years by 2013.
- Reduce the gap in life expectancy by 6 months by 2013
- Promote good health and prevent ill-health
- To improve the quality and safety of services, so that by 2014 health and social care providers commissioned by NHS Brent receive a Care Quality Commission Regulatory Judgment at least equivalent to the existing Good rating in the Annual Health Check for acute services, and a “Fully Compliant” Registration Status for GP and Community Services
- To improve the patient experience of services, so that by 2014 health and social care providers commissioned by NHS Brent will achieve patient experience scores at least as good as the London average

1.3 The plan also contains specific outcomes against which Health Select Committee can measure progress as the plan is implemented. The outcomes are set out below.

Health Select Committee should consider how it wishes to monitor these given the importance that this plan will have on NHS Brent's health commissioning capabilities and services provided to people in the borough.

Outcome Description	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Health inequalities in years (Males)	7.9	8.80	9.97	11.07	12.17	13.11
Health inequalities in years (Females)	1.2	1.5	1.4	1.3	1.2	1.02
Life expectancy in years (Males)	78.2	78.5	78.34	78.69	79.04	79.44
Life expectancy in years (Females)	83.4	83.8	83.61	83.91	84.22	84.55
Proportion of children completing MMR immunisation (1st & 2nd dose) by 5th Birthday	41.8%	72.7%	90.7%	94.4%	95%	95%
Smoking quitters (per 100,000)	734	911	1,059	1,059	1,059	1,059
Proportion of women aged 53-70 screened for breast cancer within the last three years	44%	49.66%	59%	71%	75%	78%
Self reported experience of patients & users	70.3%	72%	74%	76%	78%	80%
Delayed transfers of care (% of cases per 100,000 over 18)	13.6%	13%	11%	9%	7%	5%
CVD mortality (per 100,000 under 75)	85.99	86.65	82.7	78.3	73.1	67
Diabetes controlled blood sugar	56.8%	65%	68%	70%	74.3%	90%
Proportion of all deaths that occur at home	N/A	19%	20.5%	22%	23.5%	25%

1.4 The priority areas in the commissioning strategy plan are:

- Maternity & Newborn initiative
- Children & Young People initiative
- Acute Care
- Planned Care
- Mental Health
- Staying Healthy
- Long Term Conditions
- End of Life Care

2.0 Polysystem Vision

2.1 The Committee is likely to be interested in the proposals for the development of polysystems in Brent and the summary document contains information on the plans for the five localities in the borough. The principle behind the polysystem vision is to deliver transformed pathways in primary and community care through:

- Integrated multidisciplinary teams of primary, community and secondary care to improve the management of long term conditions

- Shift and redesign of pathways out of hospital into the community to provide one stop shop care including diagnostics

- Urgent care services integrated with primary care to better treat those patients who use A&E for primary care issues and to turn episodic care into planned care

- Closer working of primary care over a 50k to 80k populations to care manage the population and prevent unnecessary hospital visits and admissions

- Provide a more efficient structure for delivering care out of hospital through changes in skill mix and use of estate and overheads to support the transformational change in other parts of the health system

2.2 Currently, NHS Brent is in discussion with the Practice Based Commissioning clusters and Professional Executive Committee on the following polysystem proposals for the borough:

- Propose PBC as the locality commissioning body to commission the polysystem

- The number of localities may need to reduce in order to have fully functioning and affordable polysystems and adequate management infrastructure

- 2 Polysystems will share a polyclinic and 1 polysystem in base case will access a polyclinic in Barnet - Edgware

- 3 non PBC practices will have to be included in the plans so their population is not excluded & Polysystems will need to be more co-terminous with their locality e.g. Wembley practices having CMH as their hub

- There will have to be a programme of improving primary care that is affordable and realistic which probably means fewer spokes providing better value for money than now (including dentists and pharmacies)

- The core offering at practice level will be extended and expand the settings of care in the polysystem

- Proposed non recurrent investment in practice nursing and upskilling GPs in elective and long term conditions care

- Some investment in premises – additional consulting space in up to 50 spokes and new centres for Kingsbury, Kilburn (South Kilburn & Mapesbury) and Willesden (Dollis Hill) in base case if self financing or in the better case if has a revenue cost

2.3 The specific proposals for the PBC cluster areas are:

PBC	**Proposal polyclinics and locality centres (likely preferred options)**
Harness (76,000 population)	Polyclinic – CMH with urgent care centre & GP practice (relocate 2 existing practices) Locality centres - Monks Park and Hillside Primary Care Centres
Wembley (66,000	Polyclinic – Wembley with 8 to 8 GP led health centre with

population)	6 practices Locality centres - Monks Park (with 2 GP practices) and Sudbury Primary Care Centres (with 2 additional practices)
Kilburn (83,000 population)	Polyclinic – Willesden with 8 to 8 GP led health centre (or Queen‟s Park) Locality centre - South Kilburn locality centre (new) relocate five existing practices
Willesden (56,000 population)	Polyclinic – Willesden with 8 to 8 GP led health centre 2 practices and relocate a third GP practice
Kingsbury (62,000 population)	Polyclinic – Wembley with 8 to 8 GP led health centre or Edgware Community Hospital Locality centres - Kingsbury locality centre (new) with six practices relocated and Chalkhill Primary Care Centre

3.0 Conclusions

3.1 Assuming the Commissioning Strategy Plan is approved by the NHS Brent Board, it will be passed to NHS London for approval by the 18th December. After this time work will continue to implement the plan. Members should take the opportunity to comment on the proposals and feedback their views to NHS Brent.

3.2 This is a crucial document which will drive the commissioning intentions of NHS Brent in the coming years. The committee should consider how it wishes to monitor the impact of the proposals, perhaps by regular consideration of the outcome measures.

4.0 Recommendations

4.1 Health Select Committee is recommended to:

(i). Consider the NHS Brent Commissioning Strategy Plan and pass any comments or recommendations to the organisation for consideration before it is submitted to NHS London for approval.

(ii). Decide how it wishes to monitor the implementation of the Commissioning Strategy Plan, perhaps through regular consideration of the outcome measures contained in the summary report.

5.0 Financial Implications

5.1 None

6.0 Legal Implications

6.1 None

7.0 Diversity Implications

7.1 None

8.0 Staffing/Accommodation Implications (if appropriate)

8.1 None

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Healthcare for Brent

NHS Brent

NHS Brent Commissioning Strategy Plan

Summary of Current Draft

The material contained in these slides is based on the current draft of the CSP which is subject to further review and change and this summary has been produced to support that review process

Finance & Information Strategy Group
November 25th 2009

Vision

Making a significant improvement to the health and wellbeing of the people of Brent

NHS Brent retains its commitment to the vision and goals we set out in our CSP last year. We have amended these slightly to update them where relevant and to reflect ongoing feedback from stakeholders but the commitments we agreed with stakeholders last year are based on the same identified needs and remain fundamentally unchanged.

We recognise that achieving this vision requires us to focus on reducing the health inequalities in our borough by working with our partners, including local people, to commission high quality, accessible and value-for-money preventive and healthcare services and address deprivation – the top underlying cause of ill health in Brent. By engaging with our local community we will ensure the services available are responsive to the needs of the diverse and dynamic population we serve.

We are committed to making Healthcare for London a reality across North West London and see the significant changes that this will introduce and the renewed focus on disinvestment and decommissioning of lower priority services as opportunities to provide a greater focus on achieving our five goals.

Case for change (1)

Brent is a borough which epitomises London's opportunities and its challenges. Its structure, history and demography mean that health and healthcare remain in need of urgent change and improvement. In the current political and financial environment the NHS in Brent stands on a burning platform where the need to change the way health services are commissioned and provided becomes ever more imperative.

Reason 1 – the need to improve health in Brent

Overall the health of people in Brent is similar to the rest of the country. For example Brent's mortality rate of 570 per 100,000 is lower than the England & Wales average of 628. However, Brent's mortality rate masks a range of specific health issues requiring urgent improvement.

Reason 2 – the need to reduce health inequalities within Brent

Equity of care is a founding principle of the NHS but Brent's residents do not experience equity in their health outcomes. Brent is a borough which suffers marked health inequalities, which are both a symptom and a cause of wider variance in deprivation.

Reason 3 – the NHS in Brent is not meeting the public's expectations

Understanding and meeting public expectations and ensuring good patient experience of care are integral to NHS Brent achieving its goals. However, too often there is a mismatch between expectations and experience.

Case for change (2)

Reason 4 – the way we deliver care is not working

Healthcare policy from the Wanless review through Our health, our care, our say to Healthcare for London and the Next Stage Review has highlighted the importance of moving care from traditional acute settings to primary care and the community. In Brent whilst there has been progress there is still some distance to go in developing the requisite infrastructure, and in promoting the cultural shift for Brent residents and NHS staff that predicates success.

Reason 5 – residents should benefit from cutting edge medicine

London is in a unique position in the UK in terms of the quality and quantity of healthcare workforce on which it can draw. Innovative delivery of healthcare can be seen in the development of Healthcare for London pathways, and Academic Health Science Centres such as Imperial should promote world-class clinical innovation in north-west London.

Reason 6 – making the best use of our resources

A period of unprecedented NHS budgetary growth is at an end. In the new environment of constrained resources it is imperative that the NHS in Brent make its resources work harder and smarter to achieve our health goals for the population.

Key insights from patients, public, clinicians and local partners

There is still a need to get the basics right

Patient experience across a range of our providers remains below acceptable standards

Patients continue to experience problems accessing healthcare services and current care pathways are complex & confusing

Our local case for change is strong but change is happening too slowly

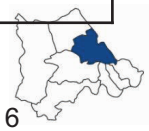
The changes required can only happen with everyone working in equal partnership, including patients & carers

Any changes to acute care need to be supported by improvements in local primary & community services

NHS Brent needs to remain financially strong: to achieve this strength will require fundamental change to the ways that services are commissioned and delivered and that doing less of the same is not an option

Existing Provider Landscape Across Brent (main providers)

Acute hospital provision	North West London Hospitals Trust (CMH and NWP)	£104m	• Approx 96% of patients are treated within 18 weeks • CQC Excellent Quality of Services • Bottom 10% nationally on self-reported patient experience • The trust is financially challenged and scored Weak for financial performance by the CQC in 2009
	Imperial College Healthcare Trust	£62m	• Approx 93% of patients are treated within 18 weeks • CQC Good Quality of Services • Bottom 25% nationally on self-reported patient experience • Scored Good for financial performance by the CQC in 2009
Community services	Brent Community Services (Emerging APO)	£39m	• Approx 98% of patients are treated within 18 weeks. • Limited ability to respond to developed services and clear specifications • BCS is the sole provider with no choice options for patients • 90% of patients are happy with the professional care they receive
Independent contractors	71 GP Practices Dentists Pharmacies	£62m	• Brent ranked 135/150 nationally on ease of seeing a GP quickly • Brent GPs scored on average 803 QOF points compared to an average of 938 across London and 954 Nationally (2008/9). • Large number of small practices with poor infrastructure • Brent ranked 149/152 nationally on patient satisfaction
Mental health	Central & North West London Mental Health Trust	£34m	• Brent is in the bottom quartile nationally with regards to the number of WTEs in crisis resolution and talking therapies • Limited choice for service users • CQC Good Quality of Services 2009 (from Excellent) • Scored Excellent for financial performance by the CQC



Goals (1)

Goal 1: Reduce premature mortality and therefore increase life expectancy by three years by 2013

Average life expectancy in Brent is close to the national target of 78.5 years for men and 83.8 years for women but many people in Brent die young and miss the opportunity to live a full life. Over the last three years on average 698 people every year died prematurely (at or below the age of 75) in Brent.

Goal 2: Reduce the gap in life expectancy by 6 months by 2013

Brent performs well in many overall measures of health but there are stark inequalities in health linked to socio-economic status, gender, ethnicity, and geography. There is an 8.8 year gap in male life expectancy between the most deprived and least deprived 10% of areas in Brent and a 1.7 year gap for females.

Goal 3: Promote good health and prevent ill-health

Smoking rates are as high as 40% in some of our most deprived wards and smoking is both the single greatest cause of preventable illness and premature death in Brent, and a major factor in health inequalities. Another cause of concern is that more than half (56%) of Brent's adult population do not participate in any sport or physical activity: one of the lowest rates in England.

Goals (2)

Goal 4: To improve the quality and safety of services, so that by 2014 health and social care providers commissioned by NHS Brent receive a Care Quality Commission Regulatory Judgment at least equivalent to the existing Good rating in the Annual Health Check for acute services, and a "Fully Compliant" Registration Status for GP and Community Services

High Quality Care for All sets out a vision of an NHS with quality of care at its heart – quality defined as clinically effective, personal and safe. NHS Brent aspires to make this vision a reality for all the care received by the residents of our borough.

Goal 5: To improve the patient experience of services, so that by 2014 health and social care providers commissioned by NHS Brent will achieve patient experience scores at least as good as the London average

For a number of reasons a significant number of providers commissioned by NHS Brent show levels of patient satisfaction below national and London benchmarks. For our main providers of acute services, we will ensure that over then next 5 years, their performance in achieving the national priority indicator "Experience of Patients" remains within or better than the national average. NHS Brent will strive to improve access to primary care services, and monitor its improvement via the relevant national priority indicator.

Outcomes

Outcome Description	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Health inequalities in years (Males)	7.9	8.80	9.97	11.07	12.17	13.11
Health inequalities in years (Females)	1.2	1.5	1.4	1.3	1.2	1.02
Life expectancy in years (Males)	78.2	78.5	78.34	78.69	79.04	79.44
Life expectancy in years (Females)	83.4	83.8	83.61	83.91	84.22	84.55
Proportion of children completing MMR immunisation (1st & 2nd dose) by 5th Birthday	41.8%	72.7%	90.7%	94.4%	95%	95%
Smoking quitters (per 100,000)	734	911	1,059	1,059	1,059	1,059
Proportion of women aged 53-70 screened for breast cancer within the last three years	44%	49.66%	59%	71%	75%	78%
Self reported experience of patients & users	70.3%	72%	74%	76%	78%	80%
Delayed transfers of care (% of cases per 100,000 over 18)	13.6%	13%	11%	9%	7%	5%
CVD mortality (per 100,000 under 75)	85.99	86.65	82.7	78.3	73.1	67
Diabetes controlled blood sugar	56.8%	65%	68%	70%	74.3%	90%
Proportion of all deaths that occur at home	N/A	19%	20.5%	22%	23.5%	25%

DRAFT

Golden thread from Needs to Outcomes

JSNA	Goals	Initiatives	WCC Outcome Measures
• Health inequalities	• Reduce the gap in life expectancy by 6 months by 2013	• Staying Healthy • Maternity and Newborn	• Reduce life expectancy gap • Reduce IMD score
• Circulatory disease and cancer are biggest killers	• Reduce premature mortality and therefore increase life expectancy by three years by 2013	• Staying Healthy • Children and young people • Long term Conditions	• Life expectancy • Reduce CVD mortality rate • Increase in smoking quitters • Increase in breast cancer screening
• Mental health as largest cause of morbidity • Smoking, diet and exercise • High diabetes, TB and HIV • Low uptake of preventive services	• Promote good health and prevent ill-health	• Mental Health • Long Term Conditions • Staying Healthy	• Increase in smoking quitters • Increase in MMR coverage
• High delayed discharges • Variation in performance across primary care	• Increase the proportion of activity commissioned from providers who perform at or above benchmarked performance standards	• Staying Healthy • Acute Care • Planned Care • End of Life Care	• Increase in MMR coverage • Reduce delayed transfers of care • Increase in diabetes controlled blood sugar • Proportion of all deaths that occur at home
• Low satisfaction with access to GPs	• Meet or exceed nationally–reported benchmarked patient satisfaction rates for all services commissioned	• Acute Care • Planned Care • End of Life Care	• Increase patient satisfaction with GP access

Maternity & Newborn initiative - Priority CSP Action Areas

1. IMPROVED PRE-CONCEPTION CARE AND ENCOURAGEMENT OF EARLY BOOKING

We will ensure that all GP practices, family planning clinics and sexual health clinics across Brent have access to the appropriate health education materials to support pro-active pre-conception care including tailored information for high-risk women.

Over the last year we have focussed considerable effort on segmenting the groups who book late for antenatal care. Whilst we will continue to work with the acute commissioning partnership to address capacity issues within local providers, we will also implement a range of initiatives aimed at increasing awareness amongst both health professionals and community groups about the importance of early booking and promote direct booking and improved community access.

2. CONTINUITY OF CARE THROUGHOUT THE MATERNITY PATHWAY

Due to workforce issues, NWLH has been unable to implement the agreed model of community midwifery. The model promotes NICE guidance with midwife-only care being provided within Children's Centres across Brent and postnatal care provided by the same team. However we recognise that this pathway is only available to women who book with NWLH and that the 49% of women who book elsewhere currently receive antenatal care from their chosen provider and postnatal care from NWLH.

In 2010/11 we will work with NWLH to implement the care pathway, including introducing joint midwife and consultant services in children's centres. In doing so we will review the amount of out block contract to ensure we are appropriately funding the care pathways as currently commissioned. In addition we will support wider work to introduce care pathways that ensure continuity of care for women booked at all of our main local providers.

Children & Young People initiative - Priority CSP Action Areas

1. THE HEALTHY CHILD

Although we have had an agreed specification for health visiting for some time, it has not been implemented due to recruitment difficulties. We will be reviewing the specification and commissioning a care pathway that fully integrates the work of health visitors with children's centres with identified elements of the healthy child programme being commissioned directly from children's centres. The care pathway will ensure that all children access the healthy child programme and that children in need of protection are offered more intensive support.

With the local authority we will be exploring new models of working with families identified as requiring additional, more intensive parenting support. We will also be developing and implementing a new specification and care pathway for school-aged children integrating more fully the work of school nurses with the extended schools programme.

2. THE UNWELL CHILD

At present, too many young children are attending acute care (both A&E and outpatients) for services that should more appropriately be provided in community settings. At the same time as we implement improvements to the infrastructure for the healthy child, we will commission a support programme for primary care in relation to self-management; management within community support and management in primary care.

We will also develop care pathways for common conditions and commission multi-disciplinary teams to work within the polysystems to provide assessment and treatment, avoiding the need for hospital referral.

3. CHILDREN WITH COMPLEX COMMUNITY NEEDS

We will review our existing pathways for children with complex community needs and establish new care pathways to support improved access to specialist care at times of acute exacerbations, both to prevent admissions and to expedite discharge; access to specialist advice in community setting and ongoing support at home and school.

Acute Care initiative - Priority CSP Action Areas

1. ACCESS TO PRIMARY CARE URGENT CARE SERVICES

Our polysystem implementation plans outline the establishment of two polyclinics providing 8-8 access to primary care urgent care consultations for both the registered and unregistered population. The third polyclinic, based on the CMH site, will provide a wider range of urgent care services and will be open 24/7. In addition, the UCC will provide the out of hours service for those GP practises across Brent who have delegated responsibility got out of hours cover to Brent.

Over time it is expected that with the planned improvements in GP availability through every GP practice in Brent (outlined in the Planned Care initiative) the demand for primary care consultations provided by other services will decrease.

2. ESTABLISHMENT OF SHORT TERM ASSESSMENT, REHABILITATION & REABLEMENT SERVICE

The STARRs service comprises a number of key elements; single point of access and brokerage; access to rapid response intensive health and social care response for people at risk of hospital admission; step-up and step-down health and social beds; rehabilitation and reablement in the community. The hub of the service will be based at CMH establishing integrated working with the UCC. The current Rapid Response service pilot is delivery early benefit with 108 referrals in October 2009, over 90% of which went on to avoid admission.

Procurement for the UCC and STARRs will commence in December 2009 and it is anticipated that both services will be in place by Spring 2010.

3. IMPLEMENTATION OF COMMUNITY-PATHWAY FOLLOWING STROKE

We are planning to use Clinicenta, in collaboration with NWLH, as the main provider of early supported discharge and stroke rehabilitation. We have agreed revised specifications for these services to ensure they meet the needs of our residents and balanced scorecard to ensure benefits realisation.

Planned Care initiative - Priority CSP Action Areas (1)

1. PRIMARY CARE CONTRACTORS

List Validation

NHS Brent currently has the highest percentage difference between registered and resident population in London. The current intensive list validation exercise is due to complete in 2010/11.

Standardised Quality of General Practice

NHS Brent has made a commitment to standardise the core offering practices provide across the Borough and only to continue to commission services from those practices that meet the agreed standard metrics. We will agree implementation plans with all practices currently not offering the core services to the required standard.

Review of Contractual Frameworks

PMS Contracts will be reviewed to ensure that they offer value for money including the targeted use of growth money to support the priorities of NHS Brent as set out in the CSP.

Performance Management

We will be reviewing with clinical commissioners our existing balanced scorecard to ensure that it meets our current and future expectations for primary care. Practices and practitioners who are not meeting the required standards will be offered support to improve practise within agreed timescales.

Succession Planning

We will be agreeing with all single handed practitioners reaching or over retirement age a succession plan. This will include the need to meet the full requirements of the core offering to the required standards.

Estates Rationalisation

NHS Brent will only support the development of new sites where the revenue implications are cost neutral. We will work closely with Kingsbury and Kilburn clusters where the needs are greatest to see how new sites can be achieved through optimal use of sites.

Improving access to primary care

NHS Brent is funding a programme of support to practises that are providing poor access focussing on the 20 practices who achieved the poorest patient experience feedback in the 2008/09 study. This scheme will continue into 2010/2011 and will be extended to support additional practices improve access.

Planned Care initiative - Priority CSP Action Areas (2)

2. CARE PATHWAYS

Through a phased programme of change we will implement an ambitious and innovative approach to the establishment of care pathways for identified specialties for elective care which supports care provided within the general practice without the need for onward referral; transforms community provision including multi-disciplinary team approach, reduces the need for onward referral to acute settings and decommissions all consultations which do not add clinical value for the patient.

Phase One (2010/11)

- Clinical prioritisation of specialities for inclusion in phase 1
- Agreement of consistent, protocol driven care pathways based upon Map of Medicine
- Agreement with clinical commissioners of Polysystem Improvement Plans with clear outcomes and expectations for practices within and across the cluster, linked to an agreed programme across all practices designed to ensure that all practices offer a high standard of quality care and advice.
- Introduction of Integrated Teams at polysystem level, comprising a designated consultant; nurse specialist and primary care specialist. Each specialty team will support the polysystem through tailored training and access to specialist advice
- Agreement of clear, measurable outcome measures including implementation of protocol-driven care, peer review and normalisation of referral rates
- Specification for community service based in polyclinics and procurement of new service to complete the primary and community transformation of elective care pathways (new services commencing 2011/12)

Phase 2

Phase 2 will commence in 2001/12 mirroring phase one with additional specialties and elective day care.

Mental Health initiative - Priority CSP Action Areas

1. RAISING PUBLIC AWARENESS, HEALTH PROMOTION & IMPROVING SERVICES IN PRIMARY CARE

NHS Brent will support the pan-London asocial marketing campaigns planned to raise public awareness and promote health. Implementation of a compliant IAPT service is planned for the summer of 2010 and will be supported by awareness raising training for primary care clinicians.

2. CO-ORDINATED COMMUNITY SPECIALIST INPUT

Concerns have been raised by both users and primary care clinicians about the number of individual teams working within the community, potentially resulting in multiple handoffs for service users and fragmentation and duplication of care. We plan to work with CNWL to rationalise the number of teams; streamline the care pathways to improve user experience and simplify communication between health and social care professionals. The new model of coordinated community specialist input will be a central component of our polysystem model of care. We plan that this work will also reduce duplication (allowing for disinvestment) and improve productivity. In addition, we intend to undertake a similar exercise in relation to Community Learning Disabilities Teams.

3. IN-PATIENT & SPECIALIST PATHWAYS

We want to commission high-quality in-patient care which is outward focussed and working towards care outside of hospital wherever possible. We anticipate that the outcome from this work (together with the community work) will be a reduction in the number of people admitted as in-patients and reductions in length of stay for those admitted. In addition, we plan to review our commissioning arrangements for those in need of specialist services to ensure that we are getting the best value for money in the most appropriate location.

4. IMPLEMENTATION OF INTEGRATED CARE PATHWAY FOR DEMENTIA

We will be developing and implementing an integrated care pathway for dementia.

Staying Healthy initiative - Priority CSP Action Areas

1. NHS HEALTH CHECKS

In 2008/09 we have undertaken detailed work to ensure successful implementation and will be commencing the phased programme from April 2010. Phasing supports the need to prioritise areas of maximum need rolling out across other polysystems across a four year period. Delivery will be commissioned from GP practices who meet the required quality specification under a Local Enhanced Scheme.

2. CHILDHOOD IMMUNISATIONS

Considerable focus in 2008/09 has been placed upon establishing the required infrastructure from which to accurately identify the current update rates and to ensure improvement both across Brent and within identified communities. Progress is now well underway to increase childhood immunisations aligned to best practice.

3. OBESITY

We will be building upon the success of our childhood obesity strategy to review our current adult obesity strategy. The launch for this work will happen in the New Year with our Physical Activity Summit with the expectation that the revised strategy, together with supporting plans for action, can be agreed by the Local Strategic Partnership in the summer of 2010.

4. SMOKING CESSATION

We are aware of the importance of smoking status to the achievement of our goals and we are disappointed that despite considerable focus the rate of improvement in our smoking cessation has not been as marked as we had planned. We will continue to work closely to identify new and more innovative ways of commissioning the service, diversifying the range of providers and incentivising providers to achieve improved outcomes.

5. BREAST, BOWEL AND CERVICAL SCREENING

We have improvement plans to ensure that we achieve trajectories for uptake for all screening programmes and across the whole of Brent.

Long Term Conditions initiative - Priority CSP Action Areas (1)

1. IMPROVED PATIENT EDUCATION AND EMPOWERMENT

Using national best practice and local community expertise we will commission a range of resources including:

- Revitalised Expert Patient Programmes and carer support
- Education programmes including continuation of DAFNE and DESMOND
- Use of Media and Accessible information (formats and language)
- Focussed work taking account of language and cultural issues
- Increased focussed use of community pharmacists particularly in relation to self-care

2. IMPROVED PRIMARY CARE MANAGEMENT (LEVEL 1 & 2 – SIMPLE & COMPLEX CARE)

In line with our Primary and Community Strategy and polysystem development plans we will implement a programme across all practices designed to ensure that all practices offer a high standard of quality care and advice. Key components of the plan will be:

- Implementation, in conjunction with other PCTs of NW London, of a risk stratification tool together with consistent care pathways for LTC
- Agreement with clinical commissioners of Polysystem Improvement Plans with clear outcomes and expectations for practises within and across the cluster, linked to development of the commissioning budget for LTC across all settings of care to polysystem commissioners.
- Development and implementation of protocol-driven access to diagnostics to address underdiagnosis across Brent, together with active review of practice registers with plans for improvement to narrow the gap between expected and reported prevalence levels at practice level
- Introduction of Integrated LTC Teams at polysystem level, comprising a designated consultant; nurse specialist and primary care specialist.
- The work is being taken forward as a shared transformation initiative between NHS Brent and London Borough of Brent, building upon the shared intermediate care strategy (level 4 – acute exacerbation) which is described under our acute care initiative and further developing joint commissioning and integrated health and social care provision for people with long term conditions across all stages of the continuum.

Long Term Conditions initiative - Priority CSP Action Areas (2)

3. IMPROVED SPECIALIST ADVICE/COORDINATION ETC (LEVEL 3 – MULTI COMPLEX CARE)

Specialist care and advice will be commissioned predominantly within polysystem settings including polyclinics. Models of commissioning will promote improved integration between GP practices and hospital specialists maximising the use of polyclinics as the appropriate setting of care and avoiding the need for attendance at acute hospitals unless specialist diagnostics or outpatient care is required.

4. IMPROVED CASE MANAGEMENT (LEVEL 3 – MULTI COMPLEX CARE)

Building upon the foundations already established through the ICCS, this workstream will mainstream care management and reablement as integral parts of LTC management within each polysystem health and social care system through;

- Early identification of people at risk using risk stratification and consistent application of the existing EARLI tool
- Integration of case management into every polysystem District Nursing Team widening the skillmix within the team to include district nurses, community matrons and social care co-ordinators, and ensuring rapid access to specialist support
- Agreed pathways/response between health and social care including enhanced reablement services supported by rehabilitation
- Appropriate use of assistive technology

The work is being taken forward as a shared transformation initiative between NHS Brent and London Borough of Brent, building upon the shared intermediate care strategy (level 4 – acute exacerbation) which is described under our acute care initiative and further developing joint commissioning and integrated health and social care provision for people with long term conditions across all stages of the continuum.

End of Life Care initiative - Priority CSP Action Areas

1. DEVELOP END OF LIFE STRATEGY

An accelerated programme of development in place with expectation that an agreed End of Life Strategy will be agreed by April 2010. The strategy will be supported by a detailed action plan and will include reference to support that carers can expect through our carers' strategy.

2. IMPLEMENTATION OF GOLD STANDARD FRAMEWORK

We will support the full implementation of the Gold Standard Framework, a systematic approach to formalising best practise so that quality end of life care becomes standard for every patient by helping clinicians identify patients in the last years of life, assess their needs, symptoms and preferences and plan care on that basis enabling patients to lice and die where they choose. In addition, we will encourage our local care homes to become accredited with the Quality Hallmark Award.

3. IMPLEMENTATION OF LIVERPOOL CARE PATHWAY

The LCP is an integrated care pathway that is used at the bedside to drive up sustained quality of the dying in the last hours and days of life. It is recommended as a best practise model, most recently, by the Department of Health in the UK. We will put in place the leadership and structures to ensure that all of our providers, including care homes, implement the 10 step implementation plan.

Polysystem Vision

Healthcare for London: Framework for Action set out polyclinics as a new model of care for transforming services across primary, community and secondary care. Polysystems are a clinically led model of care involving all partners in the network and supported by a primary care led polyclinic hub at its heart.

The polysystem will deliver transformed pathways in primary and community care through:

- Integrated multidisciplinary teams of primary, community and secondary care to improve the management of long term conditions
- Shift and redesign of pathways out of hospital into the community to provide one stop shop care including diagnostics
- Urgent care services integrated with primary care to better treat those patients who use A&E for primary care issues and to turn episodic care into planned care
- Closer working of primary care over a 50k to 80k populations to care manage the population and prevent unnecessary hospital visits and admissions
- Provide a more efficient structure for delivering care out of hospital through changes in skill mix and use of estate and overheads to support the transformational change in other parts of the health system

Polysystem proposals (in discussion with PBC and PEC)

- Propose PBC as the locality commissioning body to commission the polysystem
- The number of localities may need to reduce in order to have fully functioning and affordable polysystems and adequate management infrastructure
- 2 Polysystems will share a polyclinic and 1 polysystem in base case will access a polyclinic in Barnet - Edgware
- We will have to bring in the 3 non PBC practices so their population is not excluded & Polysystems will need to be more co-terminous with their locality e.g. Wembley practices having CMH as their hub
- We will have to have a programme of improving primary care that is affordable and realistic which probably means fewer spokes providing better value for money than now (including dentists and pharmacies)
  - Extend the core offering at practice level and expand the settings of care in the polysystem
  - Proposed non recurrent investment in practice nursing and upskilling GPs in elective and long term conditions care
  - Some investment in premises – additional consulting space in up to 50 spokes and new centres for Kingsbury, Kilburn (South Kilburn & Mapesbury) and Willesden (Dollis Hill) in base case if self financing or in the better case if has a revenue cost

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Proposed polyclinics and locality centres – likely preferred option

Harness 76,000 population

Polyclinic – CMH with urgent care centre & GP practice (relocate 2 existing practices)

Monks Park and Hillside Primary Care Centres

Kilburn 83,000 population

Polyclinic – Willesden with 8 to 8 GP led health centre (or Queen's Park)

South Kilburn locality centre (new) relocate five existing practices

Kingsbury 62,000 population

Polyclinic – Wembley with 8 to 8 GP led health centre or Edgware Community Hospital
Kingsbury locality centre (new) with six practices relocated
Chalkhill Primary Care Centre

Wembley 66,000 population

Polyclinic – Wembley with 8 to 8 GP led health centre with 6 practices

Monks Park (with 2 GP practices) and Sudbury Primary Care Centres (with 2 additional practices)

Willesden 56,000 population

Polyclinic – Willesden with 8 to 8 GP led health centre 2 practices and relocate a third GP practice

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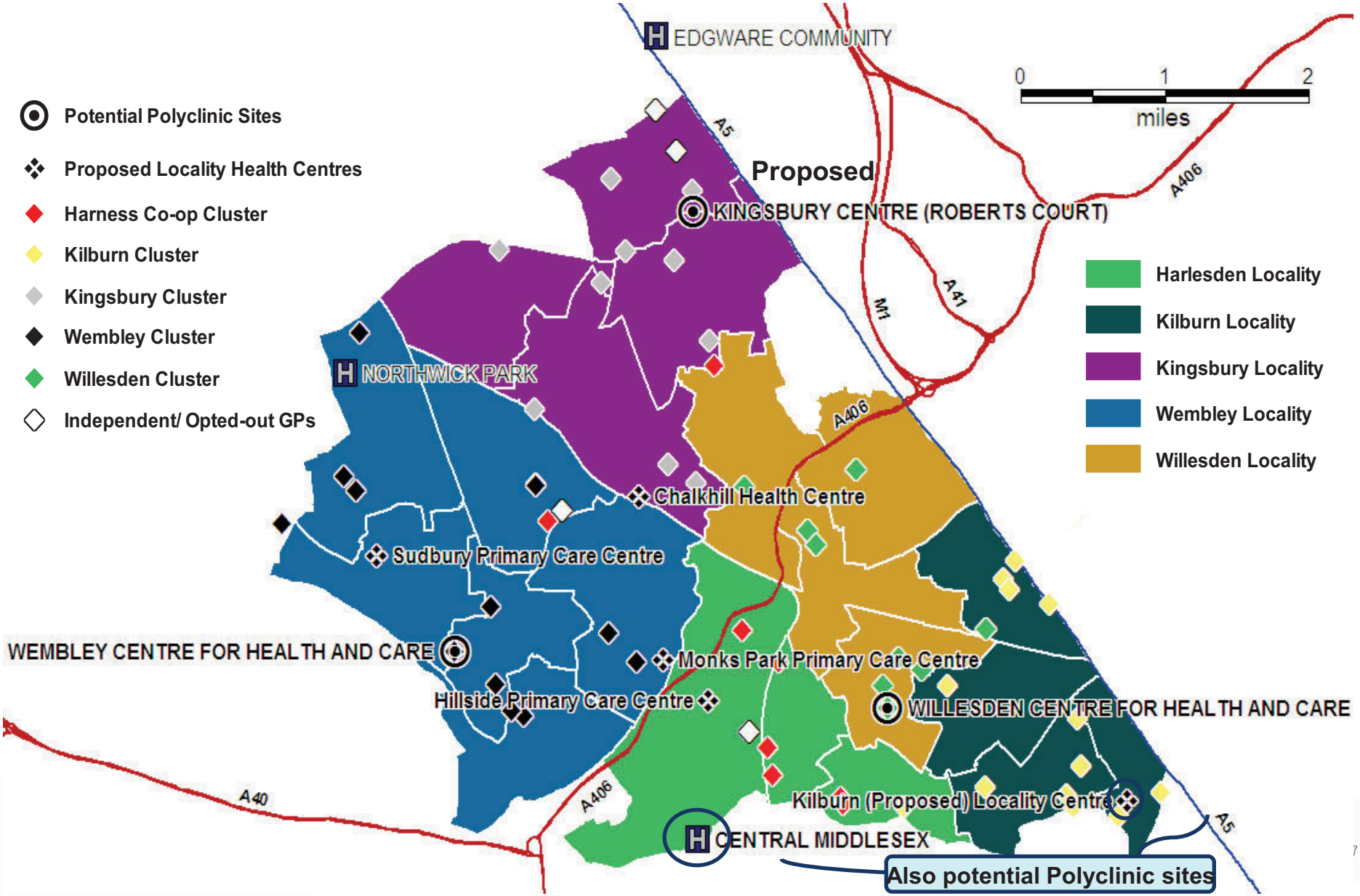
NHS Brent Polysystem Modelling

Map showing PCT Localities, PBC Clusters, possible future polyclinics and locality health centres



Market Management

The combined effect of the planned care, acute care and LTC initiatives on activity transitioning out of acute into the polysystem is summarised below. The key actions we plan to take to develop the market to introduce the transformational changes required to support these shifts are primarily associated with the introduction of the polysystems and are set out in the table.

- 242,000 outpatients move into the polysystem setting (72%)
- 4,140 current emergency admissions treated in the polysystem (20%)
- 3,300 elective procedures move into the polysystem (11%)

GPs	• Active contract management against a balanced scorecard agreed with PBC and PEC • Access transformation programme to improve access to GPs • Succession planning with practices where partners are approaching retirement. • Entry of new providers • Move towards a 'common tariff' for core GP services
Community services	• Work with BCS to determine future configuration based on the following options: Stand alone provider; Consolidation with local community provider; Merge with a foundation trust; Vertical integration with an acute trust
Acute Care	• Intermediate care – this will be contracted for the whole of Brent to achieve the required economies of scale. This service is planned to be operational from May 2010 • Urgent Care Centre – to be positioned at CMH to ensure primary care patients are treated in the appropriate setting. This service is planned to be operational from May 2010
Elective – 3 Options	1. Commission single service to provide all outpatients / elective procedures across whole of Brent (all polysystems) 2. Group similar specialities together and commission for the whole of Brent (all polysystems) 3. Group similar specialties together and commission for selective polysystems (appropriate for high volume specialties)

Past Delivery Performance

Over the course of the past year we have introduced a number of changes to improve our capability and capacity to deliver our strategic plans. We have further developed our Investment Panel process, aligning business case development and review to World Class Commissioning competencies and have also introduced a comprehensive Board performance report that monitors both the delivery of planned initiatives and their impact on key performance indicators.

We engaged an external consultancy to help implement the accelerated deployment of a best practice performance management methodology across our top 10 performance priorities. This provided a significant impetus to a number of our CSP initiatives and we have adopted this as our standard performance management methodology.

The most significant constraint to delivery over the last 12 months has been capacity. We recognise that aligning ambition to capacity is a critical success factor in delivery and we have therefore consciously focussed on delivering our Organisational Development Plan through 2009/10 to provide us with the capacity required to deliver even more ambitious plans.

Delivery and In-Year Monoitoring

It is clear that the scale and pace required to deliver this plan is significantly greater than our CSP last year and this is reflected in the scale of the improvements we are making in terms of the programme management and collaborative working arrangements that we are putting in place. We recognise that these changes will be essential in order for us to work locally and as a sector to manage the following 3 interdependent transformational changes.

- Acute sector decommissioning and disinvestment with NWL sector partners
- Development of capacity in primary and community settings
- Behavioural change across clinicians and patients

The key changes we are making to our delivery arrangements include:

- Revising our existing Investment Panel process, extending its current focus on investment appraisal to cover the full strategic planning and delivery process. EMT will meet on a monthly basis to provide full assurance of the investment portfolio including the assessment of business cases and implementation plans, monitoring of delivery against the objectives, budget, milestones and benefits contained in the business cases and plans and ongoing monitoring of the overall progress against the portfolio's investment and disinvestment plans
- Aligning our business case approval process to a formal framework for benefits realisation to ensure that the realisation of benefits set out in approved business cases is monitored effectively and corrective action taken where there is any predicted slippage in terms of benefits realisation
- Enhancing our integrated monthly monitoring processes including the Board Assurance Framework and other performance reporting to the Board, Finance and Information Strategy Group and EMT to ensure these reporting arrangements are aligned to the process changes described above
- We will establish detailed working arrangements for monitoring and coordination of plans with the sector programme team

Risk Management

Risk Description	Actions we can take to reduce the risk
Polysystem alternative to acute provision is not delivered to timescales that align to the acute sector services reconfiguration	• Regular alignment of PCT and sector implementation plans • Improve and integrate programme management arrangements within and across PCT and sector organisations
Primary care savings are not deliverable within existing GP contractual arrangements	• Tackle this as a sector to develop a coordinated approach and take advantage of cross-sector expertise
Capacity is created in polysystem settings but referrals and A&E attendances do not reduce or change sufficiently to make use of the new capacity and deliver required savings from the acute sector	• Coordinated and large-scale communications campaign in collaboration with the sector • Significant focus on involving primary care clinicians in designing and embedding pathways that assure predictable referral patterns
Quality of GP practices to develop and respond to the scale and nature of proposed changes	• Plans to develop GP practices as set out in our OD Plan
PBC does not take ownership of transfers from acute settings	• Continued focus on PBC engagement in developing pathways and associated implementation plans
PCT lacks capability to deliver the savings targets within the required timeframe	• New senior staff are joining through Q3 2009/10 and will be inducted and deployed to prioritised activities to accelerate planning and delivery
Resulting instability in established providers impacts on provider performance	• Work through the sector and locally with other providers to engage them in the development of plans and provide support for any required reconfigurations
Investment and / or disinvestment figures change significantly at full business case stage	• Revised investment and disinvestment processes will provide early warning of any changes and maintain business cases as live documents providing a composite view of impacts on investment and disinvestment so deviations can be anticipated and pre-emptive corrective action can be taken • Continue to look for further efficiency and disinvestment opportunities

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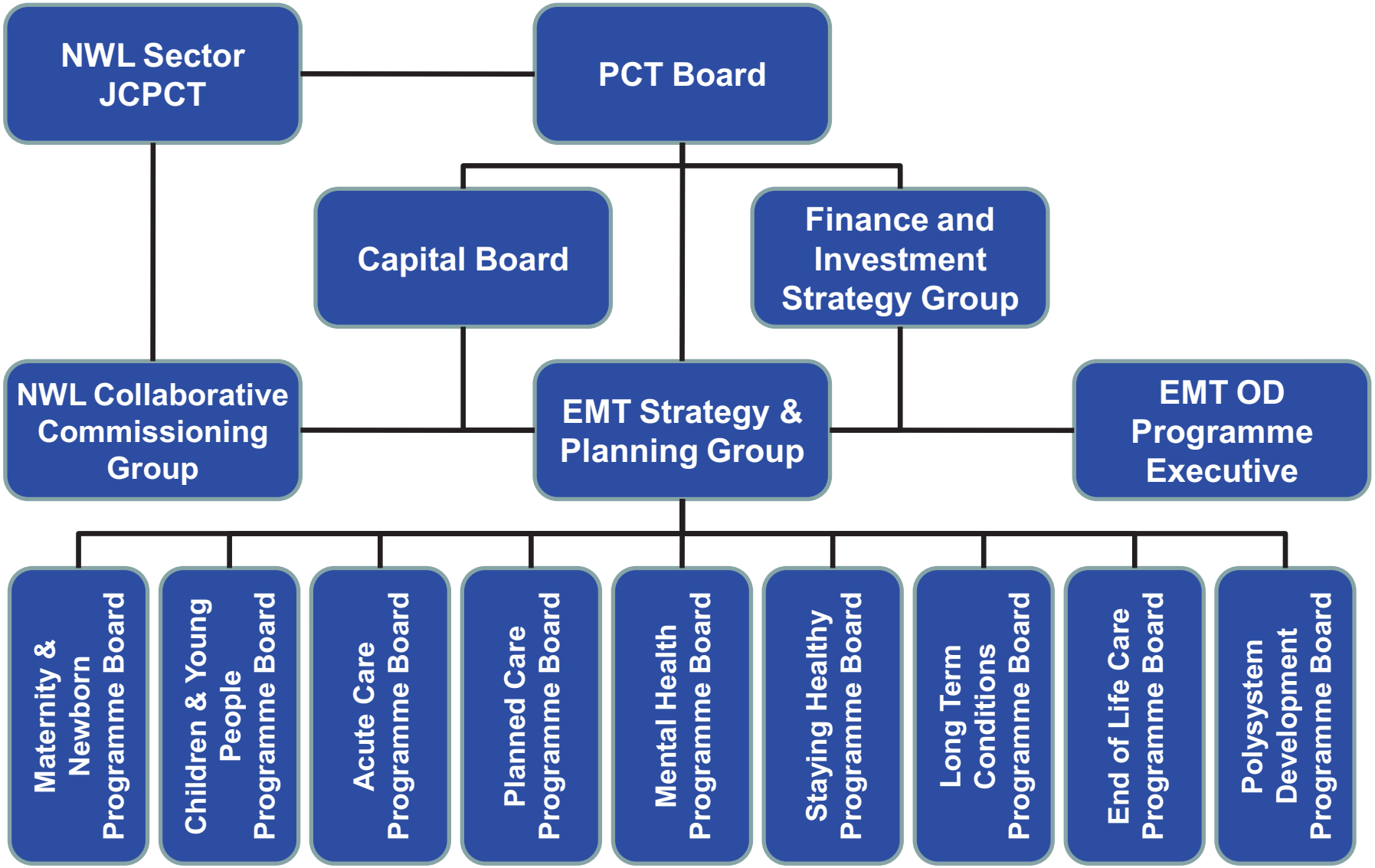
Governance



OD Plan – Overview

The Organisational Development Plan sets out NHS Brent's plan build on recent OD achievements and enable the deliver of the CSP, both in terms of our internal development as a commissioning organisation progressing towards world class commissioning status and also our role in developing the other organisations that are crucial to the successful delivery of the CSP.

We will need to work with a range of provider organisations to articulate, plan for and implement together the organisational transformations required to introduce the polysystems and thereby enable the delivery of healthcare in Brent and across North West London in the radically different ways set out in the CSP and ISP.

These other organisation include primary and community care providers as well as the acute providers whose development and reconfiguration we will seek to influence through the shared commissioning arrangements we have put in place as a sector.

OD Plan – Summary of key workstreams

Continuing our development as a commissioning organisation	• **New Ways of Working** - Developing the skills, culture, organisational systems and processes to become a more organic, adaptable, outward looking and responsive organisation. • **Partnership and engagement** - Strengthening our commissioning arrangements, developing productive partnerships including PBC, and increased active engagement with the public and other stakeholder groups • **Information and Analytics** – Advanced analytical skills and insights to support strategic commissioning decisions and drive performance.
Pathways into Polysystems	Supporting the creation of new service and organisational model including design, skills analysis, capability development and models of staffing and covering: • **Governance and structure** – reviewing and introducing appropriate governance and structure arrangements to support the design, development and delivery of the polysystems model including the roles of PBC and PEC and collaborative working arrangement with the sector • **Primary care development** – Developing PBC, general practice and other primary care providers to ensure they are ready to take on the roles required of them and have the required capability and capacity to respond to and absorb the planned shifts and changes • **Market management –** focussing on the procurement and workforce development requirements • **Benefits realisation** – ensuring that the implementation and monitoring plans are in place to assure the realisation of benefits

Completing and aligning the plans

The final submission date for our WCC strategic plans is December 18th . The key activities for completing, aligning, reviewing and approving the plans in each of the remaining 4 weeks are summarised below,.

Week ending 27/11	• Alignment of financial plan to CSP • FISG review of draft summary of CSP • PBC Review of draft summary of CSP • Submission of draft CSP to NWL Sector team to support alignment to sector ISP • Alignment of OD Plan to CSP
Week ending 4/12	• PBC Workshop • Submission of final drafts of CSP and OD Plan to Board for provisional approval
Week ending 11/12	• Health Select Committee review of CSP Draft • Pathways to Polysystems stakeholder event • Board reviews and approves final drafts of CSP and OD Plan subject to further identified changes
Week ending 18/12	• FISG approve self-assessment scores and any final significant changes to CSP and OD Plan • Complete final draft incorporating feedback from Board • Final submission of plans to NHS London as part of WCC assurance process

	Health Select Committee 9 December 2009 **Report from the Director of Policy & Regeneration**
For Action	Wards Affected: ALL

Acute Services Review – Public Consultation on Children's Services Update

1.0 Summary

1.1 The Health Select Committee is to be presented with an update on the Acute Services Review and the results of the pre-consultation campaign on the proposed changes to children's services in Brent and Harrow. As members will recall, the local NHS would like to establish two Paediatric Assessment Units (PAUs), one at Northwick Park Hospital (NPH) and another at Central Middlesex Hospital (CMH) and centralise the inpatient service at NPH. It is anticipated that this will reduce unnecessary admissions and improve the links with community child health services.

1.2 Since the last Health Select Committee meeting the pre consultation business case for paediatric services has been reviewed with NHS London which has asked the National Clinical Advisory Team (NCAT) to review the proposed clinical model. The Department of Health has also scheduled a three day gateway review which requires interviews with local stakeholders including patient representatives and members of Brent and Harrow's respective health scrutiny functions. Councillor Chris Leaman will be interviewed as part of this gateway review.

1.3 The original intention was to present the draft consultation document at the Health Select Committee meeting on 9th December so that consultation on the proposals could begin before Christmas. However, this will not be possible because the NCAT review and gateway review will not be completed until 18th December. At the last Health Select Committee it was explained to members that before public consultation could begin, NCAT and Department of Health approval was needed.

1.4 Health Select Committee has been asked to convene a special meeting in early January 2010 to consider the draft consultation document prior to consultation starting on 11th January. If this was left until the next scheduled Health Select Committee after the 9th December (which is on 17th February) there would not be enough time to consult on these proposals prior to the local elections in May 2010.

The chair of the committee has agreed to the request for a special meeting, which will be held on either the 5th or 7th January 2010.

1.5 The local NHS is eager to reconfigure children's' services in advance of the wider North West London sector review scheduled in later summer 2010. If public consultation is deferred until after the elections then the changes will be considered as part of the wider sector review. The Acute Services Review Project Board is concerned that this would delay the benefits to local people and ties our process into a complex sector arrangement.

1.6 The Health Select Committee should consider the update on the project included on the agenda and the results of the pre-consultation campaign and question officers from NWL Hospitals and NHS Brent on progress. The Committee should also confirm the date it wishes to hold the special meeting in January 2010.

2.0 Recommendations

2.1 Health Select Committee is recommended to:

(i). Note the update on the acute services review and the results of the pre-consultation campaign and question officers on the progress of the project.

(ii). Confirm the date that the special meeting will take place to consider the public consultation proposal in early January 2010 – the 5th or 7th January have been suggested as options for this meeting.

3.0 Financial Implications

3.1 None

4.0 Legal Implications

4.1 None

5.0 Diversity Implications

5.1 None

6.0 Staffing/Accommodation Implications (if appropriate)

6.1 None

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Report to:	**Brent Health Select Committee**
Report from:	**NHS Brent, NHS Harrow and North West London Hospitals NHS Trust**
Date of Meeting:	**9 December 2009**
RE:	**Public consultation on children's services**

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1. Purpose of report

To update the Health Select Committee (HSC) on the proposed reconfiguration of paediatric services across Harrow and Brent as part of the local Acute Services Review (ASR).

The local NHS has also asked the HSC to establish an additional meeting in early January 2010 to consider the proposed public consultation on the reconfiguration of paediatric services across Harrow and Brent.

The meeting would need to be held before 8th January 2010 to enable a full 12 week public consultation to be completed before an anticipated seven - eight week *purdah* is issued in advance of the general and local government elections.

2. Background

As discussed at the previous meeting the local NHS would like to establish two Paediatric Assessment Units (PAUs) at both Northwick Park Hospital (NPH) and Central Middlesex Hospital (CMH) and centralise the inpatient service at NPH. It is anticipated that this will reduce unnecessary admissions and improve the links with community child health services.

As Fiona Wise explained at the meeting on 20th October, the CMH PAU will be consultant led and will run from 10am to 10pm, 7 days per week. It is anticipated that the PAU at CMH will be able to treat 87% of paediatric presentations, with the remaining 13% requiring transfer to an inpatient unit (which will either be at NPH or St Mary's Hospital). The 13% equates to approximately three patients per day who would need to be transferred by ambulance to an inpatient unit. Both Imperial Healthcare (which runs St Mary's) and Ealing Hospital have confirmed that they are supportive of our plans.

3. Progress since the NHS' last report (20 October 2009)

Following two lively deliberative events held in Brent and Harrow on the 22nd and 24th September, the local health economy has also completed a detailed pre consultation campaign with the local community and voluntary sector; the local NHS and other groups including the Brent Youth Parliament and the Brent Area Consultative Forum. Full details are included in the separate report included with HSC papers.

In the meantime, the pre consultation business case for paediatrics has been reviewed with NHS London which has asked the National Clinical Advisory Team[1] (NCAT) to review the proposed clinical model. The Department of Health has also scheduled a three day gateway review which requires interviews with local stakeholders including patient representatives and members of Brent and Harrow's respective health scrutiny functions.

4. Why is the extraordinary meeting required?

The ASR Project Board had planned to present the draft consultation document at this evening's meeting however this has not been possible because, as a result of capacity constraints, the NCAT and DH reviews will not now be completed until 18 December.

As explained at the previous HSC[2] and in a subsequent letter[3] to the chair the local NHS' ability to commence public consultation prior to Christmas was dependent upon securing both NCAT and Department of Health (DH) approval in advance of the Brent Health Select Committee on 9 December.

The next Harrow OSC is due on 28 January and the Brent Health Select Committee does not meet until 17 February which does not allow sufficient time to consult prior to the May elections.

The local NHS is therefore requesting that both scrutiny functions schedule two extraordinary meetings prior to 8 January to consider the public consultation proposal.

At their meeting of 24 November, Harrow OSC has requested that they send its two scrutiny health leads (as observers) to the proposed Brent HSC in January rather than establish their own meeting.

It is important to emphasise that the meeting is not required if NCAT does not approve the clinical model.

5. Why can't the public consultation wait until after the national and local elections?

HSC members will recall (from the presentation on 20 October) that the local NHS is eager to reconfigure children's' services in advance of the wider North West London sector review scheduled in later summer 2010. If public consultation is deferred until after the elections then the changes will have to be considered as part of the wider sector review. The ASR Project Board is concerned that this would delay the benefits to local people and tie our process into a complex sector arrangement.

As discussed earlier, HSC members have been sent a draft report on the pre-consultation process which has included 325 local parents and carers. 91% of the public agreed or strongly agreed with the case for change and 98% agreed with the local NHS' proposal.

HSC members will recall that under the proposed model of care, consultant paediatricians will be available to give children an expert assessment until 10 pm during the week, at both

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[1] All reconfiguration proposals that require public consultation are subject to initial clinical assurance provided by NCAT members.

[2] 20th October 2009

[3] 11th November 2009

hospitals with increased cover at weekends. This is an increase of over 100% in access to a paediatrician.

As a result, fewer children will be admitted to hospital with conditions like asthma and gastroenteritis which don't need to be treated in hospital; parents will receive the reassurance they require and resources will be saved to invest in alternative services and facilities closer to home.

4. Recommendations

Brent HSC members are asked to:

i) Note the progress made to date;
ii) Establish an additional meeting before 8 January 2009 to consider the proposed public consultation on the reconfiguration of paediatric services across Brent and Harrow. The two Harrow scrutiny leads for health would be invited to this meeting as observers. It is not anticipated that they will have speaking rights but would be able to ask questions through the chair.

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The North West London Hospitals NHS

NHS Trust

NHS Harrow

NHS Brent

PRE CONSULTATION REPORT

Acute Services Review:
Paediatric Services in Brent and Harrow

November 2009

Faraz Yousufzai

Report on the Pre Consultation Campaign for the Acute Services Review of Children's Services in Brent and Harrow
November 2009

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Report on the Pre Consultation Campaign for the Acute Services Review of Children's Services in Brent and Harrow

November 2009

EXECUTIVE SUMMARY

Context:

The Acute Services Review conducted an 18 day pre-consultation campaign across Brent and Harrow to discuss a single proposal to reconfigure children's acute services within the wider context of community based services.

Activity Delivered:

Number of BRENT meetings/events	**12**
Number of HARROW meetings/events	**8**
Total number of face to face participants	**325**
Total number of days of Pre Consultation	**18**
Average number of people engaged per day	**18.1**

Stakeholders Engaged:

5 key stakeholder groups were identified: *NHS staff; Community and Voluntary Sector; Frequent Users; Young People; and the General Public*. The purpose of the campaign was to build on the deliberative events held in September and take the reconfiguration proposal to a wider and more diverse audience. This was done through 20 face to face activities including meetings, workshops and events that ensured over 325 Brent and Harrow residents were directly engaged with an opportunity to 'have their say'.

Key Outcomes:

- **9 out of 10 people agreed with the case for change and the proposal presented** - out of the test cohort representing key stakeholder groups: frequent users, young people, voluntary organisations and the general public
- **75% of events (15 out of 20) were in overall favour of the proposal presented** – There were 3 exceptions: *Brent Youth Parliament, Brent sickle cell youth group ('Broken Silence') and Brent Area Consultative Forum (over 50"s).*

Top 5 themes:

1. **What will be done to 'enhance community based services' and provide more care closer to home?** What will be done to make the following services more accessible in the community: Occupational Therapy, Physiotherapy, Speech/Language Therapy, Community nursing and GP access?
2. **'I fully support the proposals because…** giving parents more options, reducing the burden on A+E and centralising emergency surgery and overnight care at NWP means that children and young people get the best care possible.'
3. **Why is the system not child friendly for the ones that use/need it most**. Children with learning difficulties and long term conditions cannot continue to wait 3 hours be it for scheduled appointments or emergency help at A+E, the PAU or the UCC.
4. **Will the long term care of Sickle Cell sufferers become fragmented between CMH and NWP?** There are an estimated 2,000 'sicklers' in Brent and Harrow that make up over 3% of all annual hospital admissions in the region.
5. **If a young person presents at A+E with a psychotic incident**, will the PAU or UCC be equipped with the expertise to manage the situation appropriately and effectively?

RECOMMENDATIONS

ACUTE SECTOR

1. **All subsequent consultations on this reconfiguration of acute services should present a single proposal to the public as a means to the meet the challenges that the case for change presents.** Further options should only be included if they are as practically and economically viable and there is a real choice to be made between them. This would require all options to receive equal treatment in any materials produced as opposed to inclusion without due consideration. This campaign opted to present a single proposal with a clear and strong presentation of the 'ase for change' which engendered clarity, resulting in overwhelming support.

2. **To utilise frequent users of services and in particular 'parent carers' that have volunteered to act as good will ambassadors** at ASR consultation events and meetings. This will strengthen the case for change and add further credibility to the proposed reconfiguration.

3. **A full statutory consultation will do more to continually engage frequent users** including stakeholders that suffer from or represent the interests of people with *mental health, sickle cell and other physical disabilities* to ensure reconfiguration meets their emergency needs as well.

4. **It is crucial that 'Enhanced Community Services' is seen as an intrinsic part of any proposal for reconfiguration of services** as this was the unanimous consensus from all stakeholders. It must therefore appear in strength within the consultation document as well as in the feedback questions to stakeholders.

5. **NWP should plan and execute a mid to long term integrated and multi channel communication and media strategy to engage Brent residents and positively shift attitudes towards NWP**. The feedback clearly indicated that NWP enjoys an extremely low brand image in the eyes of Brent residents and to a lesser extent, Harrow residents. It is clear that much of this is based on perception as opposed to actual reality. Perceptions are based either on pre 2007 experiences or on the continual re-telling of out dated 'horror stories'. A comprehensive crisis media strategy also needs to be in place to limit the ability of an unforeseeable crisis to undermine public trust in the institution as a whole.

6. **The following question should be included in the final consultation document:** *'Should these proposals come into effect, which hospital would you choose to go to in an emergency during the night?'*

PRIMARY CARE

1. **Provider Services need to urgently revise their communication strategy for information distribution**. This review should be done immediately and in partnership with an advisory 'community panel'.

2. **Joint Commissioners to seriously consider more commissioning of VCS** organisations to provide a micro engagement function into local communities.

3. **New mothers lists to be shared with Children Centres** (DPA issues to be resolved) so they can follow up with services.

Report on the Pre Consultation Campaign for the Acute Services Review of Children's Services in Brent and Harrow

November 2009

1. CONTEXT

The Acute Services Review Board as part of their commitment to continuous stakeholder engagement has recently completed a 3 week pre consultation campaign on proposals to improve children's health services across Brent and Harrow.

Running from 19 October to 11 November 2009, this pre-consultation campaign lasted 18 days and sought views on the proposed reconfiguration of acute paediatric services within the wider context of community based services.

This included capturing stakeholder experience of existing children's health services and discussions about how primary care trusts might extend significantly the range and scale of services to be delivered closer to home and so protect young patients from unnecessary hospital visits.

It is important to emphasise that this campaign was an informal pre-consultation and forms part of a continuous stakeholder engagement campaign that began in October 2008.

The terms and scope of this pre consultation have been directly informed by the two deliberative events held in Brent and Harrow in September 2009. Based upon the findings of these events, the key terms for this campaign were identified as:

1. To present a single proposal for change, rather than a complex set of options that require significant and detailed explanation.

2. To engage a more diverse group of stakeholders that represent the varied and specialist interests across the two Boroughs

3. To strengthen the understanding of the 'case for change'

4. To determine the level of consensus on the proposed new model across a more localised and diverse audience including 'seldom heard voices'.

5. To place acute services within the wider context of primary care community based provision through exploring stakeholder experiences and seeking their views on what 'enhanced community services' means to them.

The campaign has been timed to present its findings to the ASR Board in November 09 and the Health Select Committees and Overview and Scrutiny Committees for both Brent and Harrow in late November and early December. This will ensure readiness for the launch of a full 12 week statutory consultation in December 09 / January 10, should it become necessary.

2. METHODOLOGY

To achieve optimum and meaningful engagement in the time allocated for this stage of the Acute Services Review, activity has focussed exclusively on creating as many face to face engagement opportunities as possible through events, workshops and meetings. This has ensured that the majority of feedback has been informed and immediate.

Though this represents a slight departure from the original engagement plan, in that information has been disseminated in a targeted way (i.e. only presented face to face), it has not had any negative impact upon the delivery of an effective pre-consultation.

Due to the nature of the engagement activity taking place (i.e. often within time constrained existing meetings) it is important to note that this report is primarily qualitative in nature and presents the substantive issues arising from the feedback of participants.

A 'test cohort' representing a cross section of stake holders was targeted via 4 ASR initiated and organised events. This made it possible to capture and present a set of 'hard' quantitative data, allowing us to quantify the level of support for both the case for change and the reconfiguration proposal. The test cohort targeted young people, community and voluntary organisations, frequent users and the general public (under 50's).

3. ENGAGEMENT ACTIVITY

Stakeholder communications were targeted at special interest groups such as NHS staff, community organisations, frequent user groups, young people and parents through posters and event invites. They emphasised our open door policy and encouraged stakeholders to be pro-active in contacting us directly to arrange face to face meetings or attend scheduled events.

The importance assigned to this pre-consultation campaign is demonstrated by the fact that it represented the major area of effort for the communications and engagement staff within the partner organisations throughout the engagement period and was also supported by significant involvement of staff at the most senior levels of both NHS Brent, NHS Harrow and NWLHT, from chief executives and Board Directors to Heads of services downwards.

Engagement consisted of 3 types of face to face activities:

1. 'Mini - deliberative style events' are specifically organised with targeted stakeholders to raise awareness, knowledge and create an open space for more in depth discussion and feedback. (up to 3 hours long)

2. 'Presentations' take place as tabled items on an existing agenda and often permit only a limited opportunity for immediate discussion and feedback. (15mins)

3. 'Workshops' offer a mix between these two approaches. (up to 60mins)

The most productive engagement method was via workshops and mini deliberative style events which offered the greatest time and flexibility to discuss the issues. Where joining an existing meeting, only verbal presentations were permitted. These were no longer than 15 – 20 minute agenda items. See Table 1 on page 8 for a summary of the engagement activity.

It is therefore the view of this report that relative to the stage of development, targeted stakeholders were given significant opportunity to comment on the proposals and that a more than adequate response was generated within the prescribed time period.

It should be noted that any process of public engagement is not intended to be a popular referendum on the proposals being considered. In seeking to identify the best way forward, NHS organisations are required to take full account not only of public views, but also of the professional judgement of clinicians and the financial affordability of services.

Clearly, the ideal is for these three perspectives to coincide, but where they do not, it is the task of NHS Boards, which always have a majority of independent non-executive members, to weigh the different arguments and take the final decision.

Please note that Appendix 1, at the end of this report, contains a selection of the materials used at the events. This includes power point slides, proposal summary and participant questionnaires. All of these are modelled off previously agreed materials utilised during the September deliberative events.

Report on the Pre Consultation Campaign for the Acute Services Review of Children's Services in Brent and Harrow
November 2009

TABLE 1: Summary of Engagement Activity

Organisation		Date	Number of Participants
NHS			**51**
1	BRENT CSP - Clinical Stakeholder Engagement Event	26-Oct-09	-
2	HARROW School Nursing Team Presentation	03-Nov-09	15
3	BRENT Children's Services (Leads) Presentation	05-Nov-09	11
4	HARROW Wide PBC exec Presentation	05-Nov-09	10
5	BRENT GP Paediatrics Event	11-Nov-09	15
COMMUNITY AND VOLUNTARY SECTOR			**102**
6	HARROW Patient Forum meeting Presentation	10-Oct-09	10
7	BRENT Daniels Den – Mum/toddler group Presentation	22-Oct-09	38
8	BRENT multi faith Forum Presentation	04-Nov-09	10
9	HARROW Association of Somali Voluntary Organisations	06-Nov-09	15
10	HARROW VCS Engagement Event	09-Nov-09	3
11	BRENT VCS orgs Engagement Event	10-Nov-09	12
12	BRENT Parent Forum Workshop	11-Nov-09	13
13	HARROW Parent Partnership interview	10-Nov-09	1
FREQUENT USERS			**36**
14	BRENT Somali Parent Carers Event	13-Oct-09	18
15	BRENT Sickle Cell Youth Workshop: 'Broken Silence'	20-Oct-09	9
16	BRENT Parent Carers Event	05-Nov-09	9
YOUNG PEOPLE			**62**
17	BRENT YOUTH PARLIAMENT Workshop	24-Oct-09	42
18	HARROW YOUTH PARLIAMENT Event	11-Nov-09	20
GENERAL PUBLIC			**74**
19	BRENT Area Consultative Forum (over 40's) Presentation	03-Nov-09	65
20	HARROW St Georges Centre engagement road show	31-Oct-09	9
			325

4. STAKEHOLDER FEEDBACK – Headline statistics

'Hard' Quantitative feedback – Test Cohort
As stated, though the scope and nature of this engagement campaign primarily produced qualitative data on the substantive issues raised, a test cohort representing 4 of the priority stakeholders provided hard quantitative data via the 4 organised events (See activities 10, 11, 16 and 18 in table 1 above). This cohort represents a cross section of age, interest and geography. The participants included ***frequent users***, ***young people***, ***voluntary / community organisations*** and the ***general public***. The following 2 core questions were asked of participants as part of their feedback questionnaire with the following responses:

1. To what extent would you agree or disagree that changes are needed to the way hospital services are provided for children in Brent and Harrow?

	Brent Parent Carers Event	Brent Community and Voluntary Event	Harrow Youth Parliament Workshop	Harrow Community and Voluntary Event	Totals	%
strongly disagree						
disagree						
neither			4		4	
agree	**3**	**10**	**4**	**2**		
strongly agree	**6**	**2**	**12**	**1**	**40**	**91%**

2. Do you agree with the proposal for change?

					Totals	%
Agree with Proposal	**9**	**12**	**19**	**3**	**43**	**98%**
Disagree with Proposal	0		1		1	

In addition to this, the qualitative feedback (see proceeding section) indicates an overwhelming consensus of agreement for both the case for change and the proposed reconfiguration of acute services.

'Soft' Quantitative feedback

The following two tables (table 2 and table 3 below) represent a quantification of the level of overall support for the reconfiguration proposal during each of the 20 engagement activities listed in Table 1. This is based entirely on the verbal and written feedback that was captured.

This is useful because it begins to indicate the levels of support to be expected from stakeholder groups as well as the groups that may require more targeted support during any subsequent consultation campaign and whose concerns need to be fully understood.

Please also note that where possible, these conclusions have been tested with a cross section of the participants to ensure accurate and objective representation.

TABLE 2: Overall Support by Event

	SUPPORT	OPPOSE	N/A
	Harrow School Nursing Team		
	Harrow Wide Executive		
	Brent GP Paediatrics Event		
	Harrow patient forum		
	Brent Daniels Den playgroup		
	Harrow Association of Somali Organisations		
	Harrow VCS Engagement Event		
	Brent VCS Engagement Event		
	Brent Parent Forum		
	Harrow Parent Partnership		
	Brent Somali parent carers		
	Brent parent carers event	Brent Youth Parliament	
	Harrow Youth Parliament	Brent Area Consultative Forum	Brent CSP Workshop
	Harrow St Georges Centre Road show	Brent sickle cell youth group	Brent Multi Faith Forum
% of events	**75% (15 groups)**	**15% (3 groups)**	10% (2 groups)
% of people this represents	**61%**	**36%**	**3%**

COMMENTARY ON TABLE 2:

- **Table 2 clearly illustrates that 75% of the face to face engagements resulted in an overall majority in favour** of the reconfiguration proposal.
- **3 key groups, notably all situated in Brent, had strong concerns** that outweighed their support. Two of them involved young people; one of them involved over 50's:
- **The young people focused their concerns on 2 key issues**: Transferring patients in the night from CMH to NWP and, particularly from the Sickle cell group, a fear of poor quality of care and patient experience at NWP.
- **The over 50's expressed concerns, but** it is likely that insufficient time to present and discuss the issues contributed to this outcome (only 15mins at ACF meeting).

TABLE 3: Overall Support by Stakeholder Group

NHS STAFF	VOLUNTARY COMMUNITY	FREQUENT USERS	YOUNG PEOPLE	GENERAL PUBLIC
Harrow School Nursing Team	Harrow patient forum	Brent Somali parent carers	Harrow Youth Parliament	Harrow St George Shopping
Harrow Wide Executive	Brent Daniels Den playgroup	Brent parent carers event		
Brent Children Service Leads	Harrow Association of Somali Orgs			
Brent GP Paediatrics Event	Harrow VCS Engagement Event			
	Brent VCS Engagement Event			
	Brent Parent Forum			
	Harrow Parent Partnership			

COMMENTARY ON TABLE 3:

- **100% of NHS and Voluntary Community Sector** events expressed an overall majority in support of the reconfiguration proposals.
- **There is a clear correlation between those events that had 60 minutes+ face to face time and those events that resulted in overall majority support.** Where less than 60mins is spent presenting and discussing, participants are left with too many unresolved concerns.

The next section highlights the most frequent comments, concerns and questions raised within each stakeholder group.

5. STAKEHOLDER FEEDBACK – The Substantive Issues

In this section, the key issues raised by each stakeholder group have been selected. Where applicable, issues that were given limited treatment in the deliberative events report, and were raised during this campaign, have been prioritised to reduce unnecessary repetition and to offer the ASR board a greater diversity of insights.

A full and unabridged transcript of all captured feedback at each of the 20 meetings and events listed in Table 1 is being compiled as a separate appendix to this document.

Summarised feedback by stakeholder group is as follows:

5.1 NHS FEEDBACK

GPs

- **Support form Brent and Harrow GPs** who attended the Paediatrics event on 10th September and the 11th November and/or the Harrow Wide Executive meeting, were overwhelmingly in favour of centralising emergency surgery and overnight care at Northwick Park Hospital with the establishment of PAU's and UCC's on both sites.

- **Effective and direct communication / consultation with GP's is imperative** – Clinical leads and GPs have advised that it is imperative that any proposals are effectively communicated to all GP's and that they are given a reasonable time in which to comment and respond.

HARROW SCHOOL NURSING TEAM
A team of 15 staff including 12 qualified school nurses to varying degrees.

- '**Nothing New'; 'Sounds like more Duplication' –** Reference was made to the 8 bed PACU unit at NWP that was opened in 1998 and closed in 2007 even though there was considerable independent research that found that the PACU model was 'perceived to be an effective alternative to standard A&E services for the assessment and early management of acutely ill children and their families attending a hospital'.

- **Would like to see more services delivered in the community.** Specifically: Diabetics, Epilepsy, TB and bed wetting clinics delivered closer to home. There was a suggestion that currently, an individual can visit their GP, be sent to NWP and then directed to the school nursing team. This is a poor use of resources leading to poor patient experience and care.

BRENT CHILDREN SERVICES LEADS
This was a team of clinical and non clinical mangers, paediatricians and nurses led by Assistant Director at Brent PCT, Janet Matthews.

- **Broad acceptance of the changes but further ongoing engagement is required**. Community Nursing in particular expressed a degree of scepticism and sense of 'being ignored' during the ASR process – This may be due in part to the limited time available to present and discuss the proposal in sufficient detail.

- **Joint Commissioners must seriously consider our bids to expand community services –** for example: children admitted for hydration and who do not require an intravenous solution, their care could be delivered by a Community Children's Nurse in a community setting, if they have had the correct training.

- **Parents demand more OT, speech therapists and Physiotherapists –** A paediatric therapy manager noted that Brent has enough staff to meet the demand but parents and carers are not carrying out rehabilitation programmes with their children. Special schools do not work in partnership as they are unwilling to employ sufficient staff to support children with complex needs. Parents need to be supported and trained. This could be done by Health Visitors. Delivery must take place in a community setting – not at NWP or CMH where possible.

5.2 COMMUNITY AND VOLUNTARY SECTOR FEEDBACK

BRENT AND HARROW MOTHER AND TODDLER GROUPS
These were a mix of informal play groups and parent forums made up almost entirely of mothers from diverse ethnic groups including immigrant Indian, Polish, Italian, Pakistani, Bengali and Sri Lankan. Average age range was 30 – 43. There were some parent carers in the groups as well.

- **'When we get into Hospital, everything more or less falls into place** so what you are proposing sounds brilliant'
- **'The system does not work for children.** Children with long term conditions, particularly those with Learning Difficulties, cannot wait! They physically cannot wait. Its hell for us and them'.
- **Can Children's dentists be based in new Polyclinics** so we don't have to go to the high street?
- **Repeated experiences of GP's not recognising symptoms of major conditions** such as pneumonia and patients having to go to A+E just to be seen. No trust in GPs.
- **Are there Children specific clinicians?** GPs, nurses and receptionists need training in how to deal with people and children under 5.
- **Consistently poor experiences of A+E,** enduring long waits of up to 12 hours. Hence, the PAU and UCC are welcomed if it means children will be seen quicker.
- **Why has there been a reduction in baby clinics over the years?** Will more services be provided at children's centres and large centres like Wembley? Will they provide blood tests for under 12's? Or will I be sent to NWP?
- **Multi-lingual workers** would be helpful for the immigrant communities.
- **Are we really able to deliver** enhanced community services?

HARROW SOMALI COMMUNITY
15 all female Harrow residents between the ages of 33 and 60

- **'If these proposals make sure that my child gets what he/she needs, when she needs it, then I support you!'**
- **GP services are completely unresponsive** to us. Forced to travel to Finland to get appropriate medical attention.
- Several experiences of being left in Hospital corridors without pain relief or support
- **Sense of being treated differently** because they are immigrants

(Community and Voluntary Sector Feedback Continued)

HARROW SOMALI COMMUNITY

- **Although they can speak English, sometimes they need language support** to be able to express complex symptoms and feelings. GP doesn't listen when a patient finds it hard to express themselves and it is often used as a means to not deal with the patients needs.
- **Waiting times are too high** and Hospital doctors do not keep their scheduled appointments.
- **Positive recent experience as an in-patient at NWP** for 2 weeks.

BRENT COMMUNITY AND VOLUNTARY SECTOR
12 participants predominantly from the south of the Borough attended. Participants included young mothers, Children Centre workers, an Afro-Caribbean voluntary group, Brent Social services and Brent LINK. Ethnic mix of Indian, African, Black British and English. Ages 30 – 60+

- **Overwhelming support for the proposals** as it will improve delivery of services BUT: need to explain more about how you will 'enhance community services'.
- **There is an absence of Voluntary and Community sector organisations** in the proposed plans - Will the third sector be built into the commissioning process
- **'Better use of Hospital staff and resources** as well as division of emergency care and A+E may reduce waiting times'
- **Can NWP cope with the changes?** Can the NHS really deliver better services?
- **Communications must be effective** – It is irrelevant that leaflets are produced by the pct if they are not getting to the people that need them.
- **Poor maternity experiences from 18months ago create fear** and anxiety about other services at NWP.
- **Deep concern expressed for young people with mental health issues.** They need early intervention but are not getting the support that they need, when they need it.
- **Poor experience of customer services at GPs.**
- **Fantastic experience of long term care at NWP.**

(Community and Voluntary Sector Feedback Continued)

HARROW COMMUNITY AND VOLUNTARY SECTOR
3 participants attended. An executive member of Harrow Link, a retired Doctor and a junior officer from the Harrow Overview and Scrutiny Committee.

- **'Proposals make sense' BUT -** need to elaborate much more on what is meant by Community based services.
- **Communications must target older young people –** they need easy and relevant access to information on eating disorders, self esteem and substance abuse.
- **Poor access to children's health services –** is a common finding from Harrow Link surveys and informal intelligence gathering.
- **Poor Access to specialist Paediatric Mental Health care** – lack of information for young people
- **Children still regularly translate for migrant parents –** this is not appropriate at all. Harrow needs to be able to provide this service today and then communicate that effectively to the relevant audiences so they know about it

5.3 FREQUENT USERS FEEDBACK

BRENT SICKLE CELL PATIENTS
These participants were between 18 and 24 and described their ethnicity as Black British.

- **Acceptance that change is needed -** and that the proposal may address some of the challenges. Many concerns expressed including:

- **Transition wards needed for 18 year olds –** it is very distressing for a young sickle cell sufferer who is in crisis to be left on an adult ward after years of care in a children's ward. Participants talked about suddenly being around elderly people who were dying and the anxiety and fear that creates.

- **'Sickle cell patients hate NWP!' –** Several participants expressed grave concern and fear of the perceived poor hygiene at NWP and how that might particularly affect a 'sicklers' compromised immune system. One participant cried to the ambulance driver not to take her to NWP while in crisis.

- **Overwhelmingly negative experience and perception of NWP –** This includes being transferred from CMH to NWP on a weekend. Contrasted with one positive experience of good nursing care in the Children's ward.

- **Transfer of Histories -** Concern over split care between CMH and NWP. Fear of loss of long term care relationships and lost histories.

- **Prejudice prevents care –** there is a growing sense that the reason for the perceived low levels of awareness and provision of community services for sickle cell suffered is tied up with race as the vast majority of sufferers come from an African or Caribbean heritage background.

BRENT PARENT CARERS
A small group of parent carers between the ages of 30 and 48 from diverse ethnic backgrounds including black, Asian, white and mixed heritage. They represented children with varying degrees of autism, learning difficulties and special needs. 2 of the participants were parents of children who attended Grove Park and Hay Lane Special schools.

- **'No problem with the proposal' –** There was almost unanimous agreement that the proposals will provide better care for their children because 'centralising staff and services means our children can get whatever help they might need'.

- **'Travelling is not a problem' –** We are used to going to wherever we have to, to get the best care for our child'.

- **Often need simple help at night –** 'It sounds like the UCC will deal with my child's breathing difficulties and I agree A+E is not the place to go, if there is an alternative'.

- **The UCC and PAU give us more options – '**which means we will go to A+E less'.

(Frequent Users Feedback continued)

- **Looks like a great model but will it reduce 'waiting' –** Waiting times are critical to children with Autism as they are physically and emotionally incapable of waiting.
- **Proposal needs more information on 'enhanced community services' –** what does that mean?
- **Poor experience of diagnosis and care of Autism** – There needs to be more awareness about the special needs of children with disabilities. Issues concerning waiting times and sign posting to services need to be addressed.
- **Struggle to access community based care** – 'there is no support for parents with autistic children unless you are prepared to shout and scream for it'. 'It took me 10 years to secure Speech therapy for my son'.
- **What services are provided and where**? There is a profound sense of lack of co-ordination and of not being listened to or supported.
- **Involve parents more in care –** Self management is crucial to bringing care closer to home. Are there training sessions available? What about the Expert Patient Programme?

5.4 YOUNG PEOPLE FEEDBACK

BRENT YOUTH PARLIAMENT
40 young people attended this Parliament session from all over Brent. The group was split into 3 groups: 10-11 yrs; 12-15 yrs; and 16+. The predominantly focussed on 2 issues: the transferring of children at night and the cost/resource effectiveness of the proposal.

16+ GROUP:

- **What will happen if a child is too sick to be moved?** Is this not dangerous? Children may find this very unpleasant and cause them unnecessary anxiety.
- **Will an ambulance take children from CMH to NWP?** If so, how will you fund this? Is there not a shortage of ambulances?
- **General sense that we don't need A+E, PAU and UCC** – lack of clarity as to their function and how they all work together to provide the best care possible.
- **PAU sounds like a good idea** – as its open when it is needed most.
- **Would it be better to centralise and designate NWP as the Children's Hospital?** Therefore you would not need to set up PAU's and UCC at CMH. Might it be better to have total concentration of resources, funds and effort?
- **Have there been PAUs before?** Do we know how effective they will be?
- **Does this make good financial sense?**
- How would more rooms help if there is a shortage of doctors?

10-11 GROUP:

- Leave the beds – NWP is too far for some people
- Do not move children over night as their condition might get worse.
- Have an even split of beds at both Hospitals

12-15 GROUP:

- Will NWP be more crowded and mean more illnesses?
- If this saves the NHS money, could you use the money to set up 'urgent care units' in between the two hospitals, so children don't have to travel too far?
- How will they staff 2 new PAU's and a new UCC, if there is shortage of staff?

(Young people feedback continued)

HARROW YOUTH PARLIAMENT
20 young people attended this session. In complete contrast to the Brent group, there was much more support for the proposal and acceptance of the case for change.

- **Primary experience of health services is characterised by 'waiting'** – whether it be at GP's, A+E or scheduled out patient's appointment.
- **The vast majority believed that the proposal will meet the challenges** that we face, and provide quicker and more efficient services.
- **Are PAU's necessary?** Expanding the urgent care centre will be more efficient and less expensive OR…
- **Invest in better community services and the NHS will save through 'prevention'** rather than cure. Community settings are more accessible and more comfortable for children and families.
- **Concern – will people be sufficiently educated** about these new services?

5.5 GENERAL PUBLIC

BRENT AREA CONSULTATIVE FORUM (over 50's)
HARROW ST GEORGES SHOPPING CENTRE ROAD SHOW (under 50's)

Interestingly, the over 50's had stronger views against both the case for change and the proposal itself. This stands in stark contrast against the other stakeholder groups, but particularly against parent carers and frequent users of children's services, who voiced overall support both in verbal and written form.

Over 50's – Brent ACF

- **Fear that CMH will close down –** CMH is just a shell of what it used to be and NWP is a 'horrible concrete jungle!'
- **Strong feelings against NWP –** 'Blood on the floor!'
- **Are you taking away 'choice'?** Concern that patients will be taken to NWP regardless of patients wishes. Though this was explicitly refuted, it was the source of many questions.
- **Alternative Solution to the case for change: 'limit the birth rate' –** via more aggressive family planning provision.
- **Reference to allegedly unused NHS buildings -** 'We want more community based services!'
- **Is this really affordable?** It is hard to see how it will save the NHS money.

Under 50's – St Georges Centre Road Show

- **'The proposal makes sense but what does enhanced community services mean and can NWP really cope with the increased demand?'**
- **Parents relayed positive experiences of NWP but confessed to fears based on stories they have heard** – 'My child received excellent care at NWP when he had an operation on his knee.'

6. CONCLUSIONS

The analysis of the comments made during the engagement campaign revealed a widespread consensus for the 'case for change' and a thorough understanding and acceptance of the challenges that we face.

There is also broad consensus in support of the proposals though there is an observable difference in reaction between those that use the services and those that don't. Those that do are much quicker to voice their support for the reconfiguration of acute services and that support is more likely to be strong.

There is however a unanimous agreement on one issue: That more services should be provided closer to home in a community setting. And that this will do more for improving the everyday experience of health care services for children, young people and their carers than anything else.

Taking the responses as a whole, the messages that come across are fairly clear:

KEY MESSAGES:

- People want to be sure they will receive/deliver the best possible care. This means being able to access services easily, patient access to care when and where its needed, better coordination across different providers, better post hospital care, being treated with dignity and more support closer to home.
- The views and wellbeing of parents, carers and frequent users of services need to be better considered and taken into account
- People are concerned about whether the changes can be implemented by NHS BRENT, NHS HARROW and NWLHT within the staffing and funding available and still meet patient demand.

The message from the pre-consultation campaign could therefore be summed up by the phrase:

'The proposal is good. It rightly proposes excellent specialist care in one hospital; it offers real alternatives to A+E and aspires to create services that are closer to home and easier to access. But can you deliver?'

APPENDIX 1: Summary of Proposals

This was distributed at events to aid group discussions.

NEW AND IMPROVED HEALTH CARE SERVICES FOR CHILDREN IN BRENT AND HARROW

This table shows you how children's health services would look if our proposals were accepted. The boxes highlighted in yellow indicate 'new' services or 'changes' to old services. You can see that both hospitals would have **new Consultant led Paediatric Assessment Units** and a **new Urgent Care centre** would be set up at Central Middlesex. Both Brent and Harrow would also look to **increase the services they provide in the community.** And finally we can **centralise the expertise and equipment for longer term care and emergency surgery** at Northwick Park so children and young people are always receiving the best care available.

	Northwick Park Hospital	Central Middlesex Hospital
24/7 Accident and Emergency Services	☑	☑
24/7 Children's Ward 'Rainbow Ward' and 'Jacks Place'	☑	**12hrs/day**
Day care Appointments, minor operations + observation beds	☑	☑
Night Care	☑	
Emergency Surgery	☑	
Children transferred to NWP per day for all overnight stays		**3 children**
Consultant led Paediatric Assessment Unit PAU open 12hrs/day	☑	☑
24/7 Urgent Care Centre for non life threatening emergencies	☑	☑
Specialist Sickle Cell Day service		☑
Enhanced community based services (via GP, nurses and home visits etc)	☑	☑

BENEFITS TO CHILDREN AND YOUNG PEOPLE:

2. **Better use of Hospital staff** – which means consultants and nurses are where they are needed, when they are needed.
2. **NWP becomes a dedicated centre for mums and their babies, children and young people** – which means that specialist equipment and staff are all together in one place
2. **Central Middlesex will have a new PAU and UCC** for doctor appointments and day operations – which means that they can still fix a child's broken arm.
2. **More services closer to home** will be provided in GP surgeries, polyclinics and at home by community nursing teams – which means fewer hospital visits.

APPENDIX 2: Participant Questionnaire page 1/3

This was completed and returned to the event lead at the end of each of the 4 events.

Improving Health Services for Children
PRE CONSULTATION WORKSHOP

IMPROVING HOSPITAL SERVICES FOR CHILDREN

Participant Questionnaire

Please complete the questionnaire before leaving and hand it in when you sign out.

All your answers will be kept anonymous. The information you provide will only be used by the NHS and authorised third parties for the purposes of this review of hospital services. It should take no more than five minutes to complete.

The North West London Hospitals NHS NHS Trust NHS Harrow NHS Brent

APPENDIX 2: Participant Questionnaire page 2/3

Q1 Of the following statements which one best describes how much you know about planned changes in hospital services for children, in Brent and Harrow?
PLEASE TICK ONE ONLY.

		☑
1	I know nothing	

Q3 Do you agree with the proposal for change? ☐

Q4 Tell us why

Write in...

Q5 And overall, how do you think people rate the quality of service provided by Central Middlesex Hospital?
(On a scale of 1 to 10, where 1 is very poor and 10 is excellent)
PLEASE TICK ONE ONLY.

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q6 And overall, how do you think people rate the quality of service provided by Northwick Park Hospital?
(On a scale of 1 to 10, where 1 is very poor and 10 is excellent)
PLEASE TICK ONE ONLY.

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

APPENDIX 2: Participant Questionnaire page 3/3

Q7 To what extent do you agree or disagree with the following statements.
(Where 1 is strongly disagree and 10 is strongly agree.)

Q8 And also how good or bad do you think we have been at the following?
(Where 1 is very bad and 10 is excellent.)

1	The care and attention taken when inviting you to attend the event									
Please tick one only	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐	10☐
2	Making you feel welcome									
Please tick one only	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐	10☐
3	Running a good discussion at the event									
Please tick one only	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐	10☐
4	Explaining things so that people could have their say									
Please tick one only	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐	10☐

APPENDIX 3: Power Point Slides

(On request as file size greater than 12MB)

Health Select Committee Work Programme – 2009/10

Health Select Committee – 9th June 2009				
Pre Meeting Planning		**Post Meeting Actions**		
Subject and Witness	**Issue**	**Outcomes and Actions Arising**	**Responsible Officer**	**Deadline and Status**
Swine Flu Update	NHS Brent will update the committee on the steps it's taking to prepare for a possible swine flu pandemic in the UK. The Committee should take this opportunity to question officers on the preparations and make recommendations if they have concerns.	The committee agreed to consider this issue again later in the year if the situation deteriorated and a flu pandemic was declared.	Andrew Davies to liaise with PCT staff as necessary.	To be confirmed, depending on events in coming months.
Local Area Agreement Targets – Six month reporting	The Committee has asked to consider progress against the health related Local Area Agreement targets on a 6 monthly basis. The next scheduled time to do this is in June 2009.	Agreed to bring back a further report in six months time. The committee also want to keep looking at smoking cessation data and information on adults participating in sport even though these are no longer LAA targets.	Rebecca Fogarty / Jim Connelly	9th December 2009
Improving access to GPs in Brent	This item has been placed on the work programme so that the committee can follow up the access to GPs issues, previously considered in October 2008. NHS Brent has produced an action plan that is being implemented across the borough. The committee should follow up progress on this work.	The committee has asked to see the results of the annual patient satisfaction survey in October 2009.	Jo Ohlson	20th October 2009
North West London	The Committee has been concerned about	Report noted. Will follow up later in	Fiona Wise	To be

Hospital NHS Trust Financial Position	the financial standing of the North West London NHS Hospitals Trust financial position. There have been two issues of concern – the ability of the trust to break even and plans to make savings requirements in 2009/10. Members have asked to receive regular updates from the trust in order to monitor this and consider the impact of the financial difficulties on services and patients.	the year. This issue will also be central when the committee is discussing the acute services review and the options for change.		confirmed.
JOSC Update	Update on the final outcome of the Stroke and Trauma Joint Overview and Scrutiny Committee.	Report noted. Final JOSC report to be circulated to all members of the committee. Feedback from JCPCT will be provided in October.	Andrew Davies	20th October 2009.
Children's Surgical Services	Update members on the commissioning of specialist children's surgical services and position regarding formal consultation.	The committee agreed that formal consultation on these proposals was not required.	Andrew Davies to inform NWL Collaborative Commissioning Group	Done – 10th June 2009.
Health Select Committee Work Programme	The Health Select Committee needs to select its work programme for 2009/10 and will be presented with a report setting out items that could be included in the programme.	Work programme agreed, but will be on each Health Select Committee agenda for members to add or remove items.	Andrew Davies	To be included on each committee agenda.
Acute Services Review	Update paper from NHS Brent. Health Select is being asked to consider how it wishes to sign off the review by the end of June 2009.	A fuller discussion on options is to take place in July 2009. A meeting will be held beforehand to agree what information is required at the 15th July committee meeting.	Andrew Davies	15th July 2009

Health Select Committee – 15th July 2009				
Pre Meeting Planning		**Post Meeting Actions**		
Subject and Witness	**Issue**	**Outcomes and Actions Arising**	**Responsible Officer**	**Deadline and Status**
North West London Acute Services Provider Review	The North West London Joint Committee of PCTs has set up a review of acute provider services in the sector. The local acute services review will feed into this wider review. The sector wide review will consider: • The implementation of Healthcare for London - where proposals for major trauma and stroke have been launched, but with other changes to follow. • The plans PCTs have to base more care outside hospital by strengthening primary and community care provision. • The need for hospitals to have a secure financial, performance and strategic base, so that they can achieve Foundation Trust status. • Specific proposals on services at Central Middlesex and Northwick Park Hospital. A discussion paper is to be released in July 2009, which the Health Select Committee should consider.	Update report considered. Outcome of acute services review to be reported to Health Select Committee members at Harrow Overview and Scrutiny Committee meeting on 28th July 2009. It was agreed by members that if necessary the chair and vice chair of the committee could sign off the consultation process for the review before next committee meeting on 20th October 2009.	Mark Easton, NHS Brent. Andrew Davies to co-ordinate with PCT and Hospital Trust.	October 2009
North West London Sector Acute	A collaborative commissioning group has been set up by PCTs in North West London	Report noted.		

Commissioning Vehicle	to commission some acute services. The Health Select Committee will be presented with a report outlining the role and remit of this group and information on the services it is to commission in the sector. Complex surgical services for children is an example of a service that is being commissioned by the sector acute commissioning vehicle.			
North West London NHS Hospitals Trust – In Patient Survey Results	Results of the Care Quality Commission annual patients' survey have been released and will be presented to the Health Select Committee for information and comment.	The committee has asked the hospital trust to present details and results of the "We Care" programme to a future meeting. The programme is being run to address some of the issues highlighted in the survey, such as treating patients with dignity and respect and trust and confidence in doctors. This has been scheduled for December 2009.	Fiona Wise, NWL Hospitals.	
Local Involvement Network Annual Report	It is a statutory requirement for the Brent LINk to present its annual report to an overview and scrutiny committee. This will be presented to the Health Select Committee at its meeting in July 2009.	Report noted.		
District Nurses Parking	The committee has referred the issue of district nurses parking to the portfolio holder for highways and transportation and the Highways Committee and asked for a report back setting out how the issue might be resolved. This should be considered at the June meeting of the Health Select Committee.	Not considered – still to go to the Highways Committee.	Andrew Davies to chase.	

Health Select Committee – 20th October 2009				
Pre Meeting Planning		**Post Meeting Actions**		
Subject and Witness	**Issue**	**Outcomes and Actions Arising**	**Responsible Officer**	**Deadline and Status**
World Class Commissioning Strategy Plan Refresh	NHS Brent will be reviewing its World Class Commissioning strategy plan in the light of revised funding projections from the Department of Health. The PCT is following a three stage process for this review: • Submitting a case for change to the Department for Health by Sept 2009 • Looking at the implications for services of three possible funding settlements for NHS Brent • Submit final Commissioning Strategy Plan by December 2009 The Committee will be updated on this work, including the impact of the different options the primary care trust is working on.	Agreed to consider the plan again in December 2009 prior to its submission to NHS London.	Thirza Sawtell, NHS Brent	December 2009
Primary Care Strategy – Follow up from challenge session	There were three specific issues relating to the Primary Care Strategy that members wanted to follow up following their challenge session in April 2009 – i). The five cluster plans for Brent to see	Noted.		

	how services will change to implement the strategy in each area of the borough. ii). The Investment Plan for the strategy. This should be in place by October 2009. iii). The plans for the polyclinic in Willesden. NHS Brent intends to tender for this service by October 2009. These issues will be picked up in the Commissioning Strategy Plan item.			
GP Access Survey Results	Results of the annual GP access survey will be presented to the committee to give members an indication of how satisfied members of the public are with GP access in the borough. The committee has taken a keen interest in GP access previously and so this will be a useful report which goes some way to seeing whether patients are satisfied with NHS Brent initiatives, such as extended hours which is now available in most practices.	The committee has asked to consider the results of the quarterly GP access surveys to assess the progress of the NHS Brent action plan to improve customer satisfaction in this area.	Thirza Sawtell, NHS Brent	February 2010
Smoking Cessation	This is a serious issue in Brent, given that PCT services were withdrawn during turnaround. Services have now been reinstated, but performance has been off target. The chair of the Health Select Committee has asked for smoking cessation information to be included on the agenda after seeing the provisional results for the 1st quarter of 2008/09: 4 week quit – 105	To be considered quarterly. The committee will next look at this in February 2010.	Jim Connelly, NHS Brent	February 2010

	13 week quit - 0			
Acute Services Review	Details on the consultation proposals, plus options for consultation to presented to the committee. Consultation to be on inpatient paediatric services.	Full details on the paediatric service proposals, plus consultation to be presented to the committee in December 2009.	Mark Easton / Fiona Wise	December 2009
Health Inequalities	The Audit Commission has completed a report into Brent's Health Inequalities. This will be presented to the Health Select Committee for comments.	Report noted. The committee will include health inequalities issues on its agendas. The next stage of this project, to increase adult participation in sport will be reported in early 2010.	Cathy Tyson	March 2010.
Major Trauma and Stroke Services – Update on final report of the Joint Overview and Scrutiny Committee and decisions from Joint Committee of PCTs	The major trauma and stroke services consultation will be completed in May 2009 and the final decisions on the location and number of services will be taken by the Joint Committee of PCTs in July 2009. Health Select Committee considered the consultation in March 2009 and will be updated on the results of this work, including the number and location of Major Trauma Centres and Hyper Acute Stroke Units in August / September 2009.	Update on final JOSC in December 2009.	Andrew Davies	December 2009.

Health Select Committee – 9th December 2009				
Pre Meeting Planning		**Post Meeting Actions**		
Subject and Witness	**Issue**	**Outcomes and Actions Arising**	**Responsible Officer**	**Deadline and Status**
Section 75 Arrangements for the delivery of mental health services in Brent	The Committee has asked to be consulted on the proposals to extend the Section 75 agreements for the provision of mental health services in Brent. This is likely to come forward towards the end of 2009 and has been pencilled in for the December meeting of the committee.			
Local Area Agreement Targets	The committee agreed in June 2009 to continue to monitor the LAA targets on a six monthly basis. The committee will only consider indicators that have an impact on health and well being.			
Results of the "We Care" programme at North West London Hospitals Trust	As a result of issues raised by the 2008 Hospital Trust Inpatient Survey, NWL Hospitals has commissioned a piece of work called "We Care", which is aimed at giving patients views to hospital staff, through video interviews with members of the public and use of real time patient feedback. The Committee has asked to see the results of this work and learn about the impact that it has had on the staff who work at the trust.			
NHS Brent Strategic Commissioning Strategy Plan	This follows on from the discussion had by the committee in October 2009 on the strategic commissioning intentions of NHS			

	Brent. The committee will be given an opportunity to consider the plan prior to submission to NHS London.			
Acute Services Review – Paediatric Service Proposals	The committee will be presented with the consultation proposals and preferred service options for paediatric services, provided in Brent at Central Middlesex and Northwick Park Hospitals. The committee needs to agree the consultation proposal and consider how it will scrutinise and comment on the specific issues affecting services in the borough.			
JOSC Update	Update from the final JOSC meeting, considering the future of stroke and trauma services in London.			

Health Select Committee – 17th February 2010				
Pre Meeting Planning		**Post Meeting Actions**		
Subject and Witness	**Issue**	**Outcomes and Actions Arising**	**Responsible Officer**	**Deadline and Status**
Sports Participation / Audit Commission Review of Health Inequalities	The committee is keen to monitor participation in sport data even though the indicator is no longer included in the Local Area Agreement. Performance had been below target when the committee looked at this in June 2009. Members are interested to know what the council is able to do to			

	encourage people to take three, 30 minute periods of exercise each week. Increasing participation in sport is also the project that is following on from the Audit Commission's review of health inequalities.			
Childhood Obesity	This issue came out of discussions on the local area agreement in June 2009. Members are concerned about the levels of childhood obesity in the borough. Thought needs to be given about how they want to approach this issue to make best use of committee time.			
Immunisation Task Group	Childhood immunisation has been selected as the next Health Select Committee task group. The task group findings and report will be presented to the committee in October 2009.			
GP Access – quarterly survey results	The committee has asked to see regular access satisfaction results because of the decline in performance shown in the latest annual access survey. These will be presented on a quarterly basis.			
Smoking Cessation Performance Monitoring	The committee has requested that performance information on smoking cessation in Brent is presented each quarter because of concerns about this service, and whether targets for the year will be met.			
Public Health Annual Report	NHS Brent will present details of the Annual Public Health Report for the committee to consider and comment on.			
Access to Health Sites Task Group –	The committee should follow up the access to health sites task group later this year in			

12 month follow up	line with good practice on the completion of task groups.			

Health Select Committee – 24th March 2010				
Pre Meeting Planning		**Post Meeting Actions**		
Subject and Witness	**Issue**	**Outcomes and Actions Arising**	**Responsible Officer**	**Deadline and Status**
Standards for Better Health Declarations	Each year the committee puts together its comments on the work of the three health trusts in Brent for the Care Quality Commission Standards for Better Health Declarations. The Committee will consider the trust's self assessments before finalising its comments.			
Health Inequalities Audit Commission Review Follow Up				

Items to be timetabled

The following items are included in the Health Select Committee Work Programme, but are still to be allocated a meeting for consideration.

Proposed Item	Issue for Health Select Committee
Primary Care Strategy – Implementation of Strategy – consultations as and when they arise	NHS Brent will confirm its Primary Care Strategy in spring/summer 2009. Implementation of the strategy will follow on from this and could result in service changes that will be of interest to members, not least the polyclinic development at Willesden Centre for Health and Care. Issues arising from the implementation of the strategy will be brought to the Health Select Committee as and when they arise.
Services for people with learning disabilities	Following a report by the Local Government Ombudsman and the Parliamentary Health Service Ombudsman into health and social care services for people with learning disabilities, it has been recommended that all health and social care organisations review the systems they have in place to they have in place to plan to meet the full range of needs of people with learning disabilities in their area. It was also recommended that they review the capacity and capability of the services they provide and/or commission for their local populations to meet the additional and often complex needs of people with learning disabilities. Organisations were asked to report their findings within 12 months. Health Select Committee may want to follow up this issue with local health organisations to ensure the needs of people with learning disabilities are being met.
Consent for health services involving patients with learning disabilities	Issue raised by Cllr Ruth Moher - could the issue of how the trusts deal with patients with a learning disability be considered by the Health Select Committee. Carers have expressed concern that when their adult children have refused treatment that was needed, such as an injection, then the treatment was not given. Could the committee look at the issue of consent for people with learning disabilities? This is very closely linked to the issue above and could be considered in a broader look at services for people with learning disabilities.
North West London Acute Provider Landscape	The North West London Collaborative Programme office has contacted the council with a view to consulting members on the acute services provider landscape in 2009. More detail will be included in the work programme when it is sent to the council.
Health Inequalities	The Health Select Committee may want to revisit health inequality data to see how progress is being made in reducing our well established inequalities. A “stock take” has been suggested.
Swine Flu Update	This was considered by the Health Select Committee at its meeting on 9th June. Members agreed to keep this issue in the work programme and to consider it again at a future meeting if the need arose. This can be added to a meeting agenda if necessary, in due course.