NOTES

BRENT tPCT TURNAROUND PLAN TASK GROUP
Tuesday, 9th January 2007 at 7.00 pm

PRESENT: Councillor Farrell (Vice-Chair in the Chair) and Councillor Matthews (alternate for Councillor Clues).

Apologies for absence were received from Councillors Clues and Detre.

Also present were:

Jean Gaffin (Chair, Brent tPCT)
Nigel Webb (Interim Chief Executive, Brent tPCT)
Phil Church (Turnaround Director, Brent tPCT)
Clare Murdoch (Chief Executive, Central and North West London Mental Health Trust)
Dr Peter Carter (Independent Witness)
David Dunkley (Head of Community Care, Brent Mental Health Service)
Mary Wells (Chief Executive, North West London Hospitals Trust)
Judith Stanton (Director of Public Health, Brent tPCT)
Martin Cheeseman (Director of Housing and Community Care, LB Brent Council)

12 members of the public were present, including PCT and CAMHS employees, Brent residents and a member of the press.

Introduction from the Chair

The Chair welcomed everyone to the first meeting of the tPCT Task Group, which had been established to scrutinise the impact of the proposed Brent Teaching Primary Care Trust (Brent tPCT) Turnaround Plan. She also noted the apologies of both Councillors Clues and Detre who were unfortunately unable to attend the current meeting due to unforeseen reasons.

Background – Why was the task group established?

The Chair commented that due to the scale of the Brent tPCT Turnaround Plan, and the fact that it would have major implications for both local people and the tPCT's health partners, it was felt that in depth analysis, discussion and examination was required on this issue. Thus, the Council's Health Select Committee had agreed to take the matter forward through the formation of a task group, which would call witnesses and take evidence as part of the formal scrutiny process.

Copies of the Task Group meeting schedule and an outline of the aims and remit of the group were circulated to those present. Phil Newby (Director of Policy and Regeneration) outlined the proposed work programme, commenting that the issues involved should be examined through a series of

meetings. He advised that the meetings would follow the four 'Chapters' adopted by the tPCT in the Plan:

1. **Commissioning**
2. **Demand management**
3. **Provider services**
4. **Brent tPCT internal/back office issues.**

It was suggested that witnesses would not be called to the final Task Group meeting on 8th February 2007. Instead, members would meet in closed session to examine the evidence collated throughout the process. The conclusions of the Task Group would then be presented to the Health Select Committee and, subsequently, Full Council.

The Chair also emphasised that whilst the Council would use the specific powers it possessed in relation to health under the Local Government Act 2000 to call witnesses and take evidence, it was hoped that everyone involved would proceed in the spirit of partnership and co-operation. At this point, representatives from the Brent tPCT were asked to make representations to the Task Group, following which those present from other health authorities would be given the opportunity to contribute.

Brent tPCT Representations

Nigel Webb (Interim Chief Executive, Brent tPCT) reminded those present of the scope of the Turnaround Plan. As it would not be possible to cover all the work streams involved, he felt that some indication of the areas on which the Task Group wished to focus their enquiry would be useful. "*Partnership is essentia*l", "*The final target and deadline are absolutely clear- we need to minimise the impact if we can*". "*We don't like it either; we are professional and efficient managers*", "*Other surprises are possible, there are no assurances and no absolute guarantees*". Whilst acknowledging these points, the Chair noted that the most recent copy of the tPCT Turnaround Plan (dated 16th November 2006) had only been made available four days before the meeting, and it was felt that at present the tPCT priorities were currently unclear. Thus, it was suggested that at present the scope of the Task Group should remain broad, although any further indication of tPCT priorities would be welcomed. "*I am confident that the board was aware of the clinical impacts in the decision they made*".

Jean Gaffin OBE (Chair, Brent tPCT) outlined the background to the current tPCT financial situation. "*Budget was raided by the SHA in February, then there were further technical issues, more top slicing, and then financial management issues*". It was pointed out that the initial problems had been brought about by a £11.3 million 'top slice' payment that had been imposed by the London SHA, which had led to the first savings plan. However, further financial issues had subsequently been uncovered and, at the request of the SHA, the tPCT had entered into the turnaround process, including the appointment on a Turnaround Director. It was stressed that the current

document was part of an ongoing process and, therefore, it needed to be recognised that it would be subject to change.

Attention was also drawn to the fact that the position of the Trust meant that the implementation of the Plan itself was not negotiable. Mr Webb advised that the first priority had to be achieving financial balance by March 2008. Thus, whilst there might be flexibility around some of the savings proposals, if some were removed others would have to be identified in order to achieve the required savings.

Questions

In response to queries regarding the SHA 'top slice' payment, it was confirmed that the figure of £11.3 million had not been based on the fact that the tPCT had at the time been in balance. Instead, all London PCTs had been asked to make contributions to the SHA totalling 3.6 percent. It was also confirmed that further 'top slice' payments might be required from the SHA in order for it to balance its own finances.

The Chair requested assurances that appropriate financial structures and processes had been put in place to prevent similar problems occurring in the future. In response, it was noted that the newly appointed Interim Finance Director was aware of the need to ensure that such structures were in place and that the Trust had reached a clear picture of its financial position. It was hoped that this work would be completed by the end of January and, whilst it was not possible to provide an absolute guarantee that further financial issues would not be uncovered during the turnaround process, this was not anticipated.

Following a question raised, it was confirmed that the tPCT had made representations to the SHA regarding the current situation and, consequently, had been given two years to achieve financial balance, in contrast to a number of other local authorities who had only been granted a year.

At this point, the Chair registered the concern of the Task Group that the tPCT had not been forthcoming in discussing their proposals with partner agencies, and representatives from the Central and North West London Mental Health Trust (CNWL MHT) and North West London Hospitals Trust were invited to comment on the tPCT Turnaround Plan from their perspectives.

Central and North West London Mental Health Trust (CNWL MHT)

The Task Group were advised that **Clare Murdoch (CNWL MHT Chief Executive)** had only been in post for a number of days. Therefore, it was agreed that as **Dr Peter Carter (Independent Witness)** had only left this post the previous week, it would be more appropriate for him to lead for the organisation.

It was emphasised that a very positive meeting had recently taken place between the two organisations, at which proposals to minimise the impact of the Turnaround Plan on mental health service provision were discussed. Members heard that approximately £30 million was spent by the tPCT on commissioning services with the CNWL MHT, with a further £12 million spent elsewhere on mental health services provision. Following discussions, the tPCT had agreed to review options for reallocating this £12 million services in order to safeguard core mental health service provision.

Dr Carter: "*Sympathetic to the fact that a government edict demanded a balancing of the books*". Whilst sympathy with the current tPCT situation was noted, it was pointed out that CNWL MHT had a similar statutory duty to balance finances, and had done so for the past 12 years. Furthermore, Dr Carter stressed that despite relatively high levels of deprivation and socio-economic problems, Brent still had one of the lowest levels of mental health funding in London. Furthermore, it was commented that the proposed 10 percent cuts to substance misuse services should be viewed within a context of high drug and alcohol problems within the borough. "*Horrified that substance misuse would see reduction of this scale and far from saving money it would cost more in the long-term*" "*We need an explanation of what went wrong mid-term*?"

Asserting that some of the proposed savings options might have detrimental cost implications for the future, Dr Carter reminded the Task Group that the coercive nature of many mental health services meant that cuts could not reduce demand. It was advised that currently all of the Brent Mental Health Services were working to capacity and therefore any reduction in beds would simply result in patients being transferred to private beds, which would prove costly. It was also felt that the Brent Learning Disability Partnership provided a good service and withdrawing funding would be counterproductive, and lead to the loss of high quality carers.

In conclusion, Dr Carter noted that as the tPCT had previously been expected to achieve balance, questions needed to be asked about how the organisation had reached its current financial position. "*The 5th January 2007 was the first in-depth meeting and it was hard to get answers previously*".

North West London Hospitals NHS Trust

Mary Wells (Chief Executive, North West London Hospitals NHS Trust) emphasised the close working relationship that existed between the North West London Hospitals NHS Trust (NWL HT) and the Brent tPCT. She advised that the Trust held monthly meetings with both Brent and Harrow PCTs, which had proved useful in the current situation.

"*We have turned one of our corners*". Whilst Ms Wells was pleased to note that the NWL HT had achieved an in-year financial balance, it was nevertheless pointed out that a future reduction in work passed from the tPCT to the Trust could lead to future problems. Up to a point the Trust could deal with this issue by reducing capacity. "*Previous PCT proposals included radical*

suggestions that haven't come to fruition". However, it was pointed out that large quantities of elective work being transferred to external providers could have a destabilising effect. She further added that in the event of the tPCT issuing a list of preferred providers, it was hoped that the NWL HT would be included in this list. "*If large amounts of elective work goes to a private provider this could destabilise our organisation*". Late hospital discharges were also highlighted as an area of concern, and some frustration was expressed about the lack of progress being made by the Council and tPCT on this issue.

London Borough of Brent Council

Martin Cheeseman (Director of Housing and Community Care, LB Brent) noted that the Council was currently in a difficult position in terms of its position within the local health economy. Stressing the need for savings options to take into account the link between health and social care, he argued that if sufficient account was not taken of the impact that the savings proposals would have on the Council, the Turnaround Plan would inevitably fail. "*The local authority has been conveniently forgotten*","Health and social care are interlinked and we need to ensure a whole systems approach". "*The turnaround plan will fail if it puts considerable additional cost on local authority budgets*".

"*We too have a statutory duty to balance our books and to limit the level of increase on the Council tax*". Given that the local authority also had a duty to balance its accounts, it was noted that difficult financial decisions would have to be taken if the estimated £9 to £10 million costs were passed across from the tPCT. Using the example of social care to illustrate the point, it was further asserted that such measures could have further negative implications. For example, one possible consequence of raising the eligibility criteria for social care, might be a subsequent increase in hospital admissions. "*There are not enough resources to provide the sustaining level of services that the people of Brent deserve*".

Mr Cheeseman also commented that other options needed to be examined regarding the Turnaround Plan, such as the phasing of some long-term savings. As there was already insufficient funding within health and social care to provide effective levels of care for the people of Brent, it was noted that the Turnaround Plan timescales represented an issue of concern, and the department would be approaching central government regarding this matter.

General Discussion and Questions

In her capacity as **Director of Public Health, Judith Stanton (Director of Public Health, Brent tPCT)** was asked to comment on what impact she thought that the tPCT cuts would have on public health. She responded by stressing that the Trust would endeavour make the cuts in such a way that they would not lead to greater problems for the future, and that this aim had

influenced the development of some of the 'pods' within the Turnaround Plan. "*Presented with a pressured timetable for turnaround*".

The Chair expressed concern that a formal health impact assessment (HIA) had not been carried out before the Turnaround Plan had been taken to the tPCT Board for consideration. Following discussion, it was confirmed that a HIA had not been conducted on each of the proposals, as this was not deemed necessary. Instead, the proposals had gone to the Board following extensive clinical input on each of the four clusters, and individual savings options were now being examined. Dr Stanton pointed out that HIAs would be carried out on areas identified as potentially having a disproportionate effect on the population, and health visitors and school nurses were cited as two examples. It was hoped that this work would be complete by the end of January 2007 and, stressing that discussions were ongoing, those present were informed that the tPCT would welcome further input from partners on this process. **Phil Church, tPCT Turnaround Director**, "*Financial expedients have over taken the need to consider issues in full*". However, "*Impact assessment is an implicit watermark running through the turnaround plan*".

Mary Wells (Chief Executive, NWL HT) added that HIAs would be required before the Trust could enter into agreement with the tPCT on areas of work for next year. She reassured that Task Group that the two organisations would continue to work together on this issue.

Given that HIAs were soon to be carried out on some areas, a question was raised as to whether any of the lines within the Turnaround Plan might change. In response, it was advised that the tPCT Board had requested that further work be carried out on three lines within the Plan involving school nursing services, health visiting services and cuts in the Brent Carers grant. Whilst these lines might change further, Dr Stanton confirmed that the others would remain the same, although the detail within them might be subject to change. The Chair commented that as the Task Group worked through the four clusters, health impact issues would be central. Therefore, partner agencies would be asked to attend a future meeting to feedback on health impact assessments and comment on issues around health inequalities. The Chair also commented on the importance of openness and transparency, throughout the current process, urging all four organisations present (the tPCT, Council, NWL HT and CNWL MHT) to work in cooperation on the issue of HIAs, and how the current proposals would affect the people of Brent.

The Chair noted with concern the lack of documentation that had been made available from the tPCT regarding the Turnaround Plan, particularly how the tPCT Board had been advised about health impact issues. Insufficient information on weighting of savings proposals was also noted as an area of concern. Those present exchanged views as to whether the information before the Task Group was adequate, with the tPCT asserting that the issue highlighted the cultural differences between the Council and tPCT, as NHS organisations were not required to document decisions in the same manner as local authorities. It was, however, claimed that health impact issues had been appropriately considered. Referring to page 14 of the copy of the

Turnaround Plan before the Task Group, it was argued that such issues were covered in the document but, due to differences in terminology, they were referred to as risks rather than health impacts. It was noted by representatives from CNWL MHT that they had not received a copy of this document.

During discussion, some concern was raised that the tPCT had failed to take fully into account the impact of particular issues relating to individual partner organisation e.g. the coercive nature of some mental health services and associated problems with making cuts in such areas, and this assertion was disputed by Nigel Webb (Interim Chief Executive, tPCT). It was also confirmed by Dr Stanton that, as an area of identified risk, mental health services were an area that would be subject to HIA. Dr Carter raised concerns about the autism service which was set up two years ago and is working well and is now a proposed saving- It is unclear why.

Dr Carter (Independent Witness) drew the item to a close on a positive note by stressing that he was confident that if the suggested proposals from the meeting he had had with the tPCT were implemented, core mental health services for the people of Brent could be safeguarded. The Chair reminded everyone that this was an example of the constructive working required to take matters forward.

Future meetings of the Task Group

Phil Newby (Director of Policy and Regeneration) drew attention to the fact that 39 percent of the current savings had been direct result of SHA 'top slice' payments. Therefore, the need for the SHA to respond to questions on this issue was emphasised, and the Chair confirmed that efforts would be made to request SHA representation at a future meeting of the task group.

Nigel Webb advised that representatives from the tPCT would not be available to attend the meeting scheduled for 25th January 2007.

It was noted that the next meeting of the Task Group would take place on **Tuesday, 17th January 2007**.

The Chair concluded by thanking all those present for attending the meeting. On behalf of the Task Group she also extended her best wishes to Dr Peter Carter in his new role, and to Jean Gaffin, who was shortly leaving her position in the tPCT.

The meeting ended at 8.50 pm

Cllr M Farrell
Acting Chair

NOTES

BRENT tPCT TURNAROUND PLAN TASK GROUP
Wednesday, 17th January 2007 at 7.10 pm

PRESENT: Councillor Clues (Chair), Councillor Farrell (Vice Chair) and Councillor Detre

Also present were:

Nigel Webb (Interim Chief Executive, Brent tPCT)
Phil Church (Turnaround Director, Brent tPCT)
Andrew Parker (Director of Strategic Commissioning and Performance, Brent tPCT)
Judith Stanton (Director of Public Health, Brent tPCT)
Amanda Craig (Chair of Professional Executive Committee (PEC), Brent tPCT)
Patricia Atkinson (Director of Nursing, Quality and Clinical Governance, Brent tPCT)
Samih Kalakeche, (Head of Joint Commissioning, Brent tPCT)
Christabel Shawcross (Assistant Director of Community Care, LB Brent Council)
David Dunkley (Head of Community Care, Brent Mental Health Service)
Mary Wells (Chief Executive, North West London Hospitals Trust)
Ann O'Neill (Executive Director, Brent Mencap)

Apologies for absence were received from Clare Murdoch (Chief Executive, Central and North West London Mental Health Trust).

Introduction from the Chair

The Chair introduced the meeting by thanking Councillor Farrell for chairing the previous meeting, which he had unfortunately been unable to attend due to unforeseen circumstances.

A copy of the note of the previous meeting was circulated, and it was agreed that any comments would be relayed to James Sandy (Policy and Performance Officer, LB Brent) following the meeting.

Brent tPCT Representations

Nigel Webb (Interim Chief Executive, Brent tPCT) explained that the full Turnaround Plan was lengthy and, consequently, it had been necessary to produce a shorter, more accessible document for review with key staff. Copies of this paper, the *"Brent tPCT Turnaround Programme Summary"*, were distributed to those present. It was also stressed that this was a working document and would therefore be subject to change.

Members were reminded that despite the identified savings, the tPCT would still have a financial gap at the end of the year. Thus, the current process would have to be repeated if the organisation were to achieve financial balance by March 2008. In response to a question from the Chair, it was confirmed that the exact level of the budget gap would be identified in the report due to be received by the tPCT Board on 25th January 2007. Whilst the estimated overspend for the current financial year was £17.5 million, members heard that considerable savings would be required in order to reach this figure.

At this point, tPCT representatives were invited to comment on each of the individual strands within *Commissioning* and *Demand Management*, two of the four clusters covered by the Turnaround Plan. Some strands were relatively straightforward and, therefore, the note below only covers those areas on which substantive discussion took place.

1A) Contract Control

Andrew Parker (Director of Strategic Commissioning and Performance, Brent tPCT) explained that the tPCT planned to transfer Harrow PCT Sub Acute beds from Northwick Park Hospital **(A30)** to its own hospital at Willesden. Given the existing plans to reduce bed numbers at Willesden, one member questioned the rationale behind this strategy. In response, it was emphasised that a new clinical model made it possible to achieve the same level of care with fewer beds.

A further question was raised about the potential for 'bed blocking' at the North West London NHS Hospitals Trust (NWL HT). Mr Parker responded that the issue was complicated and required further work from all partner agencies. **Mary Wells (Chief Executive, NWL HT)** reminded those present of the concerns of the NWL HT about lack of progress made by the Council and tPCT regarding excess delays in late discharges. She further noted that a session would take place in February, at which this issue would be further explored. **Christabel Shawcross (Assistant Director of Community Care, LB Brent)** drew attention to the fact that an external auditor had previously commented on a good working relationship between the three health partners on this issue. Whilst stressing that the Council had invested funds to tackle the problem, it was asserted that issues such as patient choice and varying patient needs had to be taken into account.

There was an exchange of views about the situation regarding bed shortages prior to Christmas, which had resulted in a request for the tPCT to temporarily reopen beds at Willesden Hospital. Members heard differing views about why the option to temporarily reopen the Willesden beds had failed. It was noted that the proposals by the NWL HT to run the beds had been rejected by the tPCT on economic grounds.

Those present were informed of plans to manage waiting lists through targeted reductions **(A51, B7)**. Thus, whilst national targets would still be met, some patients would be booked in for operations in the next financial year. There followed a discussion about this issue, specifically in relation to the areas of smoking and obesity **(A51)**. The Chair expressed concern that such measures might lead to a delay in operations. In response, **Amanda Craig (Chair of Professional Executive Committee (PEC), Brent tPCT)** clarified that patients would be encouraged to give up smoking or lose weight prior to having an operation, which would also have the advantage of making the procedure safer. If the patient failed to undertake this course of action, it was confirmed that they would then be placed on a waiting list and the clinical safety of the operation would be reviewed.

Councillor Farrell questioned whether these outcomes would be achievable, given the alterations to smoking cessation work and dietetics outlined in the Turnaround Plan. She was informed that whilst there was to be a reduction in dietetics services, evidence pointed to the fact that the issue of obesity was dealt with more effectively at GP level, through practice nurses and healthcare assistants. Members were also advised of plans to discontinue a £200k scheme used to prescribe nicotine patches through pharmacists. Nigel Webb stressed that work was still being carried out on this issue both at local and national level. However, a decision had been taken that smoking cessation targets could still be met without the scheme. Following a question about whether a health impact assessment (HIA) had been carried out, it was asserted that disproportionate health impacts had been considered. Members were further reminded that those eligible for free prescriptions would still be able to obtain patches through their GP without charge, and that there were now many smoking cessation advisors working with GPs to tackle the problem.

A question was raised about whether the current proposals would lead to increased waiting lists. Whilst acknowledging that some targets might be transferred to the start of the next financial year, it was stressed that the Trust was currently ahead of its national targets and therefore could expect to meet those set for this year. Additionally, it was pointed out that where patients had already been booked-in for operations, they would have their date honoured.

1B) GP Activity

Amanda Craig (Chair of Professional Executive Committee (PEC), Brent tPCT) commented on the work that had been undertaken to develop a cluster-based referral management system **(B9)**. It was explained that regular meetings took place between practices to review referral rates, and so far the scheme had been popular. One member expressed concern that by setting targets, the scheme did not take into account differing health needs across the borough and might lead to GPs failing to make necessary referrals. Ms Craig responded that the system was based on peer review and, whilst GPs would be encouraged to review whether referrals were necessary and meet targets, the emphasis was still on making referrals based on clinical judgment and best practice.

2) Continuing Care/Joint Commissioning

Members heard that service level agreements (SLA) had been terminated with some voluntary organisations and, further to a query from the Chair, it was asserted that there was no evidence that this strategy had resulted in negative impacts from a health point of view. Some concern was registered by Christabel Shawcross about the decision to remove funding for a bathing service previously funded jointly by the local authority and tPCT. **Samih Kalakeche, (Head of Joint Commissioning, Brent tPCT)** responded that the tPCT had been unable to justify continued funding given the small number of people using the service. He disputed the suggestion that this might be seen as an example of the tPCT withdrawing from partnership working, arguing instead that issues such as client needs and economies of scale had to be factored into the situation.

Concerns were raised about the proposals to close a specialist learning disability CAMHS service **(A22)**. Although reassurances were given that those affected would still have access to general CAMHS services, it was pointed out that the decommissioning of a new specialist service might lead to capacity problems elsewhere within the organisation. **Ann O'Neil (Executive Director, Brent Mencap)** also highlighted that people with learning disabilities and mental health needs did not access community health services and, thus, reductions in the specialist service could result in future problems.

In response, it was stressed that the tPCT was confident that the same level of service would be continued following the proposed restructuring. It was explained that savings could be achieved by decommissioning the service and reconfiguring it at lower unit costs. Furthermore, in response to comments about lack of consultation, **Judith Stanton (Director of Public Health, Brent tPCT)** asserted that within the limitations imposed by the timescales of the turnaround process, the Trust had examined issues around disproportionate health needs and impacts.

The task group were advised that £0.5 savings had already been delivered by transferring costly out of borough placements to CNWL MHT placements **(A26)**. Since this initiative had fallen within the terms of the current SLA, there had been no additional cost to the tPCT. **David Dunkley (Head of Community Care, Brent Mental Health Service)** added that this was a positive example of achieving efficiency savings rather than cutting core services. Members also requested that the Chief Executive of the CNWL MHT attend a future meeting of the task group to comment on the proposals from the perspective of this organisation.

There followed a discussion regarding the issue of continuing care **(A23, 40 and 61).** Members were informed that 11,000 patients were supported through continuing care, at a cost to the tPCT of approximately £28 million. Furthermore, once the costs of Section 28 patients and pre-2003 placements were included, the overall costs to the PCT totalled £31.5 million. The breakdown of these patients was given as follows:

1) generic continuing care patients;
2) long stay patients (Section 28);
3) pre-2003 patients.

Mr Parker noted that the local authority had in 2005 been informed that patient reviews would be carried out on patients falling within these categories. Patient review panels had been set up to ensure that the process met the continuing care criteria. Between 10 and 15 percent of patients had so far been assessed, and it was hoped that all 11,000 reviews would have taken place by July 2007. Following a request for clarification, it was confirmed that the majority of patients already assessed had not met the continuing care criteria and would now be passed to the local authority for social care assessment.

Christabel Shawcross reminded those present that whereas patients who met the continuing care criteria for healthcare did not have to pay for their treatment, this was not a simple matter. Those assessed by the local authority for social care were also financially assessed, and therefore might be required to pay. It was further emphasised that local authorities had previously been criticised for making people pay for their care who should have been assessed for free continuing health care.

Samih Kalakeche stated that the local authority had withdrawn from the tPCT's Continuing Care Review Panel. Christabel Shawcross responded that this was incorrect. Following legal advice, taken after the Grogan judgement where the decision made by a PCT had been criticised, the local authority attended panels with 'observer status'. She further welcomed the comments made that the tPCT would offer to fund a social worker to assist with the assessment work that the local authority would now be required to undertake. Those present heard that the Council was only assessing those cases where it was felt that due process had been followed, and others were referred back to the tPCT. It was asserted that there had been a previous agreement to draw a line under pre-2003 cases, and that further discussions with the tPCT were required regarding Section 28 patients.

Following a suggestion that costs were unfairly being passed to the local authority, Mr Webb emphasised the view that tPCT was currently paying for patients for which it was not responsible and, therefore, the review process was required in order to rectify this situation. It was further stressed that over the past few years the local authority had enjoyed a considerable subsidy for services.

Members were advised that the review process had not been instigated because of the Turnaround Plan, though rate of assessments had been accelerated as a result of the current situation. It was argued that it was not possible to determine whether any Brent patients had been assessed as ineligible for both continuing care and social care until the local authority assessments had been completed. Ms Shawcross interjected to highlight that there were multiple reasons for the lengthy nature of the local authority assessment process, including the unreasonable number of referrals passed

on at any one time, and the fact that agencies such as the Department of Work and Pensions were involved. She also stressed that cases might not be Brent's responsibility. It was confirmed that of the 12 patients passed to the local authority, only 3 cases had been agreed.

The Chair questioned whether the review programme had been accelerated to a level where it would not be possible for the Council to keep pace with the patients being passed across for assessment. Whilst acknowledging that from April 2006 the level of review work had increased, it was stressed that this meant that all 11,000 patients would be assessed within 8 rather than 10 months. Ms Shawcross stated that the current speed of the process presented problems for the Council, and was unreasonable. Nevertheless, she sought to stress to members that the department was continuing to meet its statutory obligations and was currently examining the best way forward.

tPCT representatives were questioned about whether they had made representations to the SHA regarding the current situation. Mr Church responded that the Trust had been in negotiations with the SHA about concessions, the result of which had been a move from one to two year period in which to achieve financial balance. However, it was felt that the SHA would not move on the overall amounts involved. Further to concerns expressed about the Council's ability to absorb the additional costs, Mr Webb accepted that further discussions might be required to find a way to resolve this issue. However, he was clear on the point that the Trust was currently funding patients for whom they should not be responsible. The Chair then concluded the discussion on this item by noting the concern of health partners that they were not being fully included in the current process.

Members heard that **A48** related to the adjustment of a service level agreement with the CNWL Drug and Alcohol Action Team (DAAT). Despite an underspend for the detox unit at CNWL, targets had been met and therefore a decision had been taken to reduce funding. It was stressed that instead £45k had been invested on rehabilitation services elsewhere. Further to questions raised, Mr Kalakeche advised that he did not believe that there would be any negative impact from this move, and that the police would have been informed of discussions that had taken place with the DAAT.

Phil Newby (Director of Policy and Regeneration, LB Brent) reminded those present that Local Area Agreement (LAA) funding was based on targets, and was informed that the tPCT was confident that LAA targets would be met.

The Chair sought confirmation that HIAs would be broader than just looking at clinical impact. Councillor Farrell reaffirmed this would be health in its widest sense. Judith Stanton confirmed that a date had been set for those HIAs that would be carried out, and partners including the local authority invited.

3) Cessation of Funding

A number of questions were raised about the planned expenditure reduction in tuberculosis (TB) training and education **(A5)**. Given that Brent had one of the highest TB rates in London, Councillor Farrell expressed concern about this strategy. She also questioned whether the measures would have an impact on TB rates in the borough. Whist acknowledging this point, Judith Stanton emphasised that TB remained high on the agenda, and the current plans were aimed at mainstreaming this issue. She added that the Trust had also incorporated the work of a previous Brent Council task group on this issue. Following a query about whether a HIA had been carried out, it was clarified that A5 related to a post which had been allocated funding in the tPCT budget. However, the post had not subsequently been filled.

The task group asked a number of questions about proposed savings in the area of sexual health. One member was concerned about proposals to reconfigure contraceptive services and delay recruitment to a sexual education post, given that both STD and teenage pregnancy rates were rising. It was further noted that young people did not wish to use GPs for sexual health services, and instead preferred to use dedicated services, such as the one provided at Chalkhill. This point was acknowledged, and it was explained that the current proposals were going out to tender so that ways of providing the best possible sexual health service could be explored. It was further stressed that the tPCT would be spending over £2 million with the voluntary sector on sexual health services.

A member suggested that the word tender be replaced with consultation throughout the documentation.

4) New Initiatives

It was noted that the use of the Wembley Walk-In Centre was currently being assessed, with public consultation soon to commence. Those present were advised on plans instead for the establishment of an A&E front of house facility, which would provide a service to walk-in patients who currently attended A&E. It was hoped that this in turn would reduce unnecessary hospital admissions.

5) Others

Phil Church (Turnaround Director, Brent tPCT) noted that those strands under the 'Others' heading had only been included for members' information, as they were not in the current draft of Turnaround Plan. It was further clarified that some of these strands had been removed permanently, whereas others had been taken out until further work had been carried out.

With regard to **A50**, 'ISTC Independent Sector – opportunity to engage independent sector', **Mary Wells (Chief Executive, NWL HT)** drew attention to the potentially destabilising effect to the NWL HT if it lost significant amounts of elective work. She added that further work was required on the review of emergency provisions.

Other representations & General Questions

At this point, the Chair invited representatives from the voluntary sector to comment on the tPCT proposals.

Brent Mencap

Ann O'Neil (Executive Director, Brent Mencap) was invited to comment on the tPCT proposals from a voluntary sector perspective. Noting that the proposals would have a significant impact on a high number of Brent Mencap service users, she felt that there had been very little consultation with the voluntary sector in the borough. It was argued that the current situation raised questions about management within the tPCT and had significantly damaged the reputation of the organisation both within the voluntary sector and beyond. She further noted that the current proposals failed to take into account the recommendations of the recent Disability Rights Commission report on health inequalities, *"Closing the Gap".*

The Chair invited any final comments from the local authority.

LB Brent Council

Rik Boxer (Assistant Director, Achievement and Inclusion, LB Brent) added that both the Council and tPCT had signed up to implement the Brent Children and Young People's Plan and therefore it was important that both organisations now found a way forward to implement these joint set of commitments.

Christabel Shawcross drew attention to the impact that the proposals would have on the people of Brent and also the very short timescales in which the cuts would be made. She commented on the previously good working relationship between the Council and tPCT, and added that she would welcome any comment from the tPCT as to how they could negotiate a way through the current problems and safeguard patient care.

David Dunkley highlighted that mental health services were under funded within Brent. Thus, he felt that further work would need to be carried out in order to ensure that core services were protected.

One member asked Mr Webb to comment on the estimated financial impact on the Council's budget. He confirmed that it was thought that the costs would be between £2.5 million and £4 million for the 2006/07 and £6 million to £10 million for 2007/08.

The Chair thanked those present for attending, and further noted that the contributions had been very useful for members to gain a better understanding of the turnaround process. On behalf of the task group he did, however, wish to comment on the following:

1) that further information was required on what constituted core health responsibilities;

2) that the tPCTs relationship with the local authority and other partner agencies was currently in a fragile state;

3) that the impact of the current proposals on the people of Brent remained the main concern of the task group.

Additionally, the Chair noted that that the task group was particularly concerned about the issue of health impacts, and urged those present to remain mindful of the human cost of the savings programme.

Phil Newby (Director of Policy and Regeneration) concluded by noting the general agreement amongst those present regarding insufficient funding within the health and social care economy. Therefore, both DoH and SHA representatives would be asked to attend a future meeting of the task group.

The meeting ended at 10.22 pm

There was a break between 9.10 pm and 9.25 pm.

Councillor D Clues
Chair

NOTES

BRENT tPCT TURNAROUND PLAN TASK GROUP
Wednesday, 31st January 2007 at 1.30 pm

PRESENT: Councillor Clues (Chair) and Councillor Moloney (alternate for Farrell)

Also present were:

Nigel Webb (Interim Chief Executive, Brent tPCT)
Bashir Arif (Director of Integrated Health Services, Brent tPCT)
Phil Church (Turnaround Director, Brent tPCT)

Christabel Shawcross (Assistant Director of Community Care, LB Brent Council)
Martin Cheeseman (Director of Housing and Community Care, LB Brent)
John Christie (Director of Children & Families, LB Brent)
Jo Gilbert (Head Teacher, Manor School)
Shirley Bickers (Brent Carers Centre)
Helen Cylwik (Elders Voice)
Ann O'Neil (Brent Mencap)
Richard Downes (Brent Advocacy Concerns)

Apologies for absence were received from Councillor Farrell.

Nigel Webb (Interim Chief Executive, Brent tPCT) queried whether the meeting was quorate, given that only two of the three members were present. It was clarified that the task group had delegated authority from the Health Select Committee. Therefore, the viability of the meeting rather than its quoracy was the issue at hand, and it could proceed on the basis of two thirds of the task group being present.

Introduction from the Chair

The Chair introduced the meeting by stressing the importance of dialogue and engagement between all those present. The notes of the last meeting of the task group were circulated, and it was agreed that any comments would be relayed to officers following the current meeting.

At the previous meeting it had been advised that the final Turnaround Plan savings figure would be made available at the tPCT Board meeting on 25th January 2007, and the Chair requested confirmation on this amount. Whilst reminding that it was not possible to achieve a precise figure, **Mr Webb (Interim Chief Executive, Brent tPCT)** advised that the anticipated overspend for the current year was £20.3 million, requiring a savings target of £9 million. It was stated that if it was not possible to renegotiate the loan from

the Strategic Health Authority (SHA) the tPCT would need to find approximately £40 million to cover these costs.

Brent tPCT Representations

tPCT representatives were invited to comment on each of the individual strands within the *Provider Services* Cluster (Cluster C). Due to a prior engagement, tPCT representatives were only available to attend until 3.30 pm. Thus, in order to ensure that voluntary sector representatives were given the opportunity to make representations, it was not possible to cover all of the strands within Cluster C during the course of the meeting. Instead, the discussion below related to those areas discussed, and it was agreed that the rest would be taken at the next meeting on 8th February 2007.

Cluster C – Provider Services

Bashir Arif (Director of Integrated Health Services, Brent tPCT) outlined those strands covered by the *Provider Services* cluster, explaining that the current situation had provided an opportunity for the tPCT to review the range of services it provided. It was also noted that the efficiency of some of these areas had not been examined in a number of years.

Those present heard that proposals within integrated community nursing **(C1 and C32)** involved a review of health visitor and district nursing services, with a view to bringing them together on a cluster basis. It was explained that whilst traditionally health visitors had worked in isolation on individual cases, the current strategy involved moving towards more corporate case loads. This meant that a team headed by a health visitor, but also including other health care professionals such as nurses, nursery nurses and health visiting assistants, would be responsible for a range of cases. Whereas the average workload was currently approximately 300 families per health visitor, it was anticipated that each team would look after 600 to 650 families. Whilst acknowledging that the number of health visitors would be reduced, it was stressed that 9 new nursery nurse posts and one staff nurse position would be created. At this point, **Jo Gilbert (Head Teacher, Manor School)** added that concerns had been raised by those working in Children's Centres about the possibility of losing health visitor provision.

Mr Arif advised on the proposed changes within the district nursing team. The plans involved the deletion of two district nursing posts and 9 staff nursing posts. However, instead a new post of Community Matron had been created, and three would be employed throughout the borough. It was emphasised that overall the changes would lead to a better skills mix within the team, meaning that more highly qualified staff could focus on assessments rather than routine tasks. It was also asserted that this strategy would result in improvements in the quality of care.

Using the case of an individual Elders Voice service user to illustrate her point, **Helen Cylwik (Elders Voice)** interjected to express concern that in

reality the changes would simply result in a reduced numbers of district nurses to the detriment of those who relied on them. Whilst reiterating his previous point about the need for a better skills mix within the team, Mr Arif responded that he would be willing to speak to Ms Cylwick about this individual case following the meeting.
Members heard that a review was being conducted regarding children's services (C6), and that the current contract the tPCT had with the local authority was over budget. John Christie (Director of Children and Families) responded that the proposals represented a reduction in services. He further added that if the tPCT reduced funding for statemented children, the local authority was required to provide such services, and the funding gap had to be met through the Schools Budget.

There followed a discussion about the strands relating to the closure of 20 acute beds at Willesden Hospital **(C7 and C8)**. Mr Arif outlined that changes to the model of care for rehabilitation had resulted in a reduction in patient lengths of stay and, therefore, the number of beds required. Further to the concerns raised by Councillor Moloney on this issue, attention was drawn to the fact that the number of patients at Willesden waiting for social care places was now significantly improved. Further to a question raised, it was explained that most patients leaving Central Middlesex Hospital would instead go into a placement, receive community care or go home, depending on the circumstances involved. **Phil Church (tPCT Turnaround Director)** pointed out that following the closure of these beds in November 2006, the tPCT had not subsequently seen an increased number of patients being transferred from Central Middlesex to elsewhere within the Brent tPCT. Instead, evidence pointed to the fact that Central Middlesex was managing well under the new system, which it was asserted was operating as well as the previous arrangements.

At the request of the Chair, **Christabel Shawcross (Assistant Director, Housing and Community Care)** noted that whilst the issue of acute beds at Willesden had been previously discussed, further work was required to ensure a smooth pathway for patients. She also pointed out that further discussions were being conducted to find a way forward regarding funding issues. Adding that the Willesden beds had provided the local authority with some degree of flexibility within the system, **Martin Cheeseman (Director of Housing and Community Care)** pointed to the fact that some delays within the system were unavoidable, for example where a patient required alterations to their property before they could leave hospital. Whilst acknowledging this point, Mr Arif nevertheless sought to highlight the view that those 11 patients were currently being inappropriately placed, with a resulting cost to the tPCT.

Following a question from the Chair, it was confirmed that the tPCT were currently exploring alternative options for the future use of the empty wards. In the short term, there were plans to temporarily reopen beds to assist the North West London NHS Hospitals Trust. Further to a request for assurances, it was confirmed there were no plans to close the hospital. Members were also reminded that the bedded service represented only a

small proportion of health care provision at the hospital, and outpatient services were continuing as previously.

Mr Arif continued by informing those present of the plans to review current continence services **(C13)**, with a view to withdrawing some areas of provision, including nursing homes. The Chair questioned whether this might lead to other long term problems, and heard that the strategy would be kept under review. Noting that further work would also be carried out with tPCT staff on promoting continence, it was also stressed that only a very small proportion of people had been so far affected by the strategy, most of whom were patients with minor health problems. **Ann O'Neil (Brent Mencap)** refuted the claim that certain groups, such as people with learning disabilities, would remain a priority, noting that she had received correspondence from a concerned individual for whom the service had been removed. Concern was also registered about the fact that special schools would have the service removed.

The task group was advised that the provision of dietetic services was to be centralised **(C19)**, as the current services had a low attendance rate, which had proved costly in terms of service provision. Given the high level of diabetes in Brent, the Chair questioned whether access to such services would continue to be maintained for all communities within the borough. Mr Arif responded in the affirmative, noting that whilst routine care for diabetics was dealt with at GP level, further support could be accessed by referring a patient to the care pathway. It was also emphasised that a great deal of support was available for diabetics, given that it represented an important healthcare issue within Brent.

Helen Cylwik reminded those present that the centralisation of services could disproportionately affect older people, who might have difficulty travelling to services. She further noted that the diabetes project run by Elders Care had been terminated following the cessation of tPCT funding in April 2006. Mr Arif responded that, in total, the range of services would increase, and further clarified that whilst services would be centralised, they would still be provided at a number of sites across the borough.

It was advised that work was being undertaken to integrate the various teams operating within Children's Services **(C21)**. J**ohn Christie (Director of Children and Families, LB Brent)** noted concerns that this would result in a reduction of services. In response, he was advised that most of the savings identified in this area would be the result of the reduced number of individual service managers required following the merging of teams.

Mr Christie also commented on the fact that uncertainty about future funding of occupational therapy and physiotherapy was concerning for both the local authority and schools. In reply, it was noted that a Children's Centre Community Strategy had been drafted, and further steps had been taken towards providing services that were more child focused. With regard to specific concerns about occupational therapy provision within special schools, it was agreed that the matter would be taken forward following the meeting.

Those present heard that options were being considered for a reduction of some posts within the community team for people with learning disabilities, and that the tPCT would be consulting on the model of care at Neasden Resource Centre with a view to implementing changes. Following questions, it was noted that some of the posts deleted had already been vacant. One voluntary sector representative was concerned at the proposals to reduce agency staff post, as she felt that those currently employed by the Trust provided a good level of care. One member also asked whether consultation had been carried out with the local authority on the proposals, and it was confirmed that the tPCT would liaise with the Director of Housing and Community Care on this issue.

Other representations & General Questions

At this point, the Chair invited representatives from the voluntary sector to comment on the tPCT proposals.

Voluntary Sector & Community Representatives

Jo Gilbert (Head Teacher, Manor School) spoke on behalf of Brent Heads of Special and Primary Schools. She outlined a number of concerns felt by those working in this area, including the impact of reduced occupational therapy, physiotherapy and speech and language therapy and loss of funding for school nurses. Overall, she sought to emphasise that the existing provision of services, such as occupational therapy and CAMHS, had never been sufficient in terms of meeting children's needs and, therefore, the current reductions were even more worrying. Particular attention was drawn to the fact that the number of children with complex needs in Brent Primary Schools was increasing. Ms Gilbert commented that it was felt that some costs had been unfairly passed from the tPCT to schools, and this in turn would affect the most vulnerable children in the borough.

The Chair reminded that those present appreciated that the tPCT was currently in a difficult situation and needed to achieve financial balance. However, given their demand led nature, there was a need for multi-agency partnership working to ensure that funds were secured for such services.

Following this, **Richard Downes (Brent Advocacy Concerns)** provided a presentation, copies of which were circulated to members. Using the words of individual service users to illustrate his point, he highlighted the impact of the tPCT proposals on people with learning disabilities. It was stressed that people with learning disabilities were already discriminated against under the current health care system, and that this problem would be further exacerbated by the cuts. The Chair noted that the presentation was very useful in drawing attention to the significant impact that the tPCT savings, and the need for further partnership working as a result.

Helen Cylwik (Elders Voice) noted concerns about lack of consultation on the tPCT Turnaround Plan and felt that it had put strain on partnership working within the health and social care economy. She further reminded that the closure of local walk-in centres would have a disproportionate affect on older people for whom even a small increase in travel to another centre might prove difficult. It was stressed that Elders Voice had already received cases involving people who were experiencing such problems. The Chair added that the voluntary sector was a major contributor to healthcare in the community. He further noted the concern of the task group that consultation was essential in order to ensure that the issue of health impacts was appropriately addressed.

Shirley Bickers (Brent Carers Centre) advised those present that the Brent Carers Centre would still be funded. However, whilst accepting that there was a need to review some aspects of service provision, she was concerned that within the current context of savings, the changes would not be carried out appropriately. She also raised concerns about lack of consultation and pointed out that reduced support for carers could have long term consequences if they required additional healthcare in the future as a result. In conclusion, she stressed the need to look flexibly at individual cases, when implementing changes. The Chair further added that Brent Carers were amongst the most invaluable contributor to the local health care economy.

Ann O'Neil (Brent Mencap) noted that the cuts targeted the most vulnerable adults and children within the borough. She, nevertheless, noted that she looked forward to working in consultation and partnership with the tPCT again in the future.

The Chair then invited representatives from the local authority to comment on the tPCT proposals.

LB Brent Council

Martin Cheeseman (Director of Housing and Community Care, LB Brent) briefly outlined the position of the local authority. Whilst acknowledging that it was essential for the tPCT to strive towards achieving greater efficiencies, he noted that they should all the same be questioned on their proposals. Where there were areas of debate as to whether an item was the responsibility of the local authority or tPCT, he pointed out that this did not detract from the fact some services would still need to continue regardless. Therefore, there was a need for both organisations to approach central government to press for further resources.

Nigel Webb concurred with this point, emphasising that the tPCT did not want to be in the current situation, and that service cuts were very much a last resort. Whilst reminding those present that the organisation was in a difficult situation as there were no "easy" savings options left, he confirmed the commitment of the tPCT to working in cooperation. Following a request from

the Chair, he agreed that information on the outcomes of the health impact assessments due to be carried out would be brought to the next meeting.

The Chair concluded by thanking those present for their contributions to the meeting. He stated that hundreds of cases had been presented from people within Brent who were affected by the tPCT proposals, noting that the task group would have to agree on an appropriate means of including these representations.

The meeting ended at 3.30 pm

Councillor D Clues
Chair

NOTES

BRENT tPCT TURNAROUND PLAN TASK GROUP
Thursday, 8th February 2007 at 7.30 pm

PRESENT: Councillor Clues (Chair) and Councillor Farrell

Also present were:

Nigel Webb (Interim Chief Executive, Brent tPCT)
Bashir Arif (Director of Integrated Health Services, Brent tPCT)
Patricia Atkinson (Director of Nursing, Quality and Clinical Governance, Brent tPCT)
Phil Church (Turnaround Director, Brent tPCT)

Christabel Shawcross (Assistant Director of Community Care, LB Brent Council)
Martin Cheeseman (Director of Housing and Community Care, LB Brent)
Clare Murdoch (Chief Executive, Central and North West London Mental Health Trust)
Councillor Lorber (Leader of the Council, LB Brent)

Introduction from the Chair

The Chair introduced the meeting, noting that discussion would focus on strands of the tPCT Turnaround Plan within Cluster C, *Provider Services,* and Cluster D, *Internal* tPCT issues.

Brent tPCT Representations

Cluster C – Provider Services

Bashir Arif (Director of Integrated Health Services, Brent tPCT) commented on those strands within the *Provider Services* cluster that had not been covered at the previous meeting.

The task group raised a number of questions regarding proposed changes to the provision of smoking cessation services **(C31)**. Members were advised that nicotine replacement therapy would in future only be provided free of charge to those who were exempt from prescription payments. Councillor Farrell questioned the rationale behind this strategy, given that the forthcoming ban on smoking in public places would inevitably result in an increased number of people trying to quit smoking. In response, it was pointed out that that as a high number of Brent residents were eligible for free prescriptions, only approximately 20 percent of people in the borough would be affected, and they would still have access to professional support through their GP. Following a request for assurances, **Nigel Webb (Interim Chief Executive, Brent tPCT)** clearly stated that in his opinion the rationalisation of

smoking cessation services would not have an impact on the ability of people in Brent to give up smoking.

Members were then informed about planned alterations to school nursing provision **(C24 and C27)**, which would result in the establishment of a single service rather than the 6 separate teams currently in operation throughout the borough. It was explained that these changes would see a reduction of 9 school nurses, 2 junior nurses and 4 administrative posts. Mr Arif also acknowledged that the reconfigured service would only focus on the health component of school nursing, but not the educational element that had been previously included in this area of work. Consequently, school areas would no longer participate in areas of curriculum engagement, such as support for health promotional activities and training for teachers. The Chair registered concern that teachers would not be qualified to deal with health care issues, pointing to the danger of cumulative impact if issues such as sexual health, smoking and drug and alcohol misuse went unaddressed following the service alterations. Highlighting as an example an existing project carried out in schools on sexual health issues, **Patricia Atkinson (Director of Nursing, Quality and Clinical Governance, Brent tPCT)** sought to reassure members that work on these areas would continue.

In response to a question from the Chair, Mr Arif stressed that the proposals around school nursing had been subject to significant internal scrutiny, with child protection issue fully taken into account. Further to a question raised, it was clarified that whilst school nurses did carry out a degree of opportunistic immunisation, this service was primarily carried out at GP level. Therefore, it was not anticipated that changes to school nursing would result in any drop in immunisation figures within the borough.

Phil Church (Turnaround Director, Brent, tPCT) reminded the task group that the proposals around school nursing had not been agreed at the last meeting of the tPCT Board. Instead, the strand had been subject to further review and revision, and would now be considered at the meeting of the tPCT Board in March. Therefore, he felt that it was important to note that the proposals covered in **C24** and **C27** did not currently form part of the Turnaround Plan. Attention was also drawn to the fact that following review, a decision had been taken to reduce by half the amount of savings identified from this strand. Whilst acknowledging that the work stream was currently on hold, the Chair nevertheless felt that the questions raised regarding the school nursing proposals were still valid, given that the intention was to reintroduce the strand following consideration by the tPCT Board.

Cluster D – Internal

Patricia Atkinson (Director of Nursing, Quality and Clinical Governance, Brent tPCT) advised members that Cluster D primarily related to internal tPCT issues aimed at achieving greater efficiencies.

Reminding those present that the tPCT estate rationalisation strategy had previously been brought before the Council's Health Select Committee, she outlined plans to close some estates that were not fit for purpose, and replace them with new build properties **(D5A)**. It was pointed out that the programme had not been initiated because of the Turnaround Plan, although the clinic closure rate had been accelerated as a result. Councillor Farrell questioned whether healthcare pathways could be appropriately delivered, given that some centres would close without a permanent replacement centre already in place. She also felt that transferring to a new centre might have a disproportionate impact on those, such as the elderly, who might have problems travelling even slightly further to a healthcare facility.

Neil O'Farrell (Premises and Estates Manager, Brent tPCT) responded that the new sites would continue add to healthcare pathways, and also stressed the view that it was possible to deliver on pathways in temporary accommodation. Furthermore, where temporary facilities were being provided until a new centre opened, it was asserted they were generally of a better standard than those being closed. Additionally, he argued that closing sites did not offer the same range of services that would be provided at the new sites and, in some instances, did not provide adequate disability access. Further to a question raised, it was explained that the Trust has examined demographic hotspots before agreeing on key areas of primary care need in which services should be located.

The Chair expressed concern about insufficient transport links between one closing centre, Helena Road, and the Willesden Centre for Health and Care to which patients would be transferred. Mr Arif accepted this point, commenting that the tPCT had lobbied the bus companies for better services in the area. However, overall he emphasised that the facilities provided at Willesden and all other new sites would be far superior to those available at the closing sites. Whilst acknowledging that people might have to travel slightly further to reach services, it was emphasised that all new sites were no more than a mile to a mile and a half from the current service.

Martin Cheeseman (Director of Housing and Community Care, LB Brent) highlighted that one strand involving a PFI refinancing initiative **(D4)** had been withdrawn because a change of Department of Health (DoH) policy. He noted that both the local authority and tPCT could agree that this development was regrettable, given that it could have achieved £2 million worth of savings without any reduction of service.

Other representations & General Questions

At this point, the Chair invited **Clare Murdoch (Chief Executive, Central and North West London Mental Health Trust)** to provide an update on the impact of the tPCT Turnaround Plan from a CNWL Mental Health Trust perspective. She advised that encouraging progress had made over the past month, with both organisations working jointly to examine possible savings options from within the total mental health spend in the borough. It was noted

that discussions were ongoing, with another meeting taking place the following week.

However, Ms Murdoch expressed considerable concern about a recent announcement by the tPCT to decommission the CNWL Assertive Outreach Team (AO Team). Whilst discussions had previously taken place between CNWL MHT and the tPCT about reconfiguring this service to achieve £400k of savings, she emphasised that the loss of the team had not been anticipated, and would have far reaching implications. Members heard that AO Teams formed part of the wider mental health national framework. It was then explained that the CNWL AO Team was designed to meet the needs of patients with severe and often complex mental health needs, who were typically disengaged from statutory services. Thus, there were concerns that the loss of AO Team intervention would lead to increased hospital admissions and lengths of stay, which in turn would put pressure on the Trust's in-patient capacity. Further to a question raised, Ms Murdoch stressed that there was a great deal of evidence to support the view that AO Teams reduced hospital admissions. She also pointed out that the loss of the service would also have equalities implications, given that 85 percent of AO service users came from BME groups.

It was noted that the proposal to decommission the AO Teams had not been covered in the Turnaround Plan. In response, **Phil Church (Turnaround Director, Brent tPCT)** advised that this decision had originally been taken in October 2006 as part of a routine service review, and consequently was not covered in the Plan. In addition, Mr Webb stressed the difficulties of discussing the specific details of one strand within the Plan without prior notice that members wished to consider this matter in depth. The Chair thanked Clare Murdoch for her presentation, noting that this was an issue that the Council's Health Select Committee would need to revisit at a future date.

Noting that at one issue raised at the previous meeting had involved partnership working, the Chair asked **Martin Cheeseman (Director of Housing and Community Care, LB Brent)** to comment the "whole systems approach" to partnership working. He outlined that the term referred to all contributors to community wellbeing, and thus encapsulated those operating in areas such as housing and transport, as well as the traditional health providers. It was further noted that whilst the recent government White Paper *"Our Health, Our Care, Our Say"* had placed emphasis to working towards this approach, a number of strands within the Turnaround Plan ran contrary to this aim.

He further drew attention to the need to incorporate flexibility into the Turnaround Plan, reminding that issues such as future demographic changes and the cumulative impact of the proposals should be taken into consideration. Finally, he stressed that using a whole systems approach to health impact assessment (HIA) would achieve very different answers to adopting a purely clinical approach.

The Chair asked for clarification as to how the HIAs conducted by the tPCT had related to a whole systems approach. He was advised that a process had been followed, through which the wider implications of actions had been taken into consideration. The Chair expressed concern about the lack of acknowledgment of the cumulative impact of the Turnaround Plan in the document, given that some people would be affected by a number of strands. Nigel Webb (Interim Chief Executive) also stressed whilst the current situation clearly led to a clash of national priorities regarding healthcare, central government was clear on the point that it was absolutely necessary that the tPCT return to financial balance. Those present were reminded that current lobbying efforts had not proved successful in campaigning against the level of savings required. He also added that failure to achieve financial balance would also put the health of the people of Brent at risk.

It was acknowledged that Brent tPCT's standing with the Strategic Health Authority (SHA) had suffered due to the current situation. Nevertheless, it was stressed that this had only been the case recently, and Nigel Webb emphasised the commitment of the organisation to rebuilding its reputation over time.

Councillor Farrell noted that the decommissioning of the CNWL AO Team represented a significant concern for the task group. She was advised that the tPCT would continue to engage with the Trust on this issue and would be willing to bring this matter before health scrutiny again at a future date. The Chair concluded the meeting by thanking those present for their contributions to discussion. Noting that this was the last meeting of the task group, he advised that an interim report would now be produced, drawing together the group's findings and recommendations.

The meeting ended at 8.45 pm

Councillor D Clues
Chair