Overview & Scrutiny

Brent tPCT Turnaround Plan Task Group

Final Report
March 2007

Chair's Foreword

In establishing a cross-party task group, the Health Select Committee set out to get a picture of the real impact that Brent tPCT's turnaround plan would have on the lives of local people and on the community as a whole. Whilst scrutiny has specific powers in relation to health we approached this investigation in the spirit of partnership and co-operation, calling witnesses and taking evidence to explore the issues positively.

We have been particularly disappointed and had our work impeded because the London Strategic Health Authority has consistently ignored our requests to attend and explain the rationale driving the tPCT's turnaround plan. As a consequence, it will be necessary to seek further evidence and clarification from them and the Department of Health.

As this report illustrates, Brent tPCT has begun to implement a turnaround plan that runs contrary to the context of national policy. Consistently we have heard evidence that suggests its proposals undermine the agenda set out within the "o*ur health, our care, our say*" white paper. The tPCT are caught between two opposing dynamics. It is a cause for concern that the need to achieve financial balance has been placed above the needs of local people, and that risk assessments have been more fiscal than human.

Members and partners alike have all acknowledged that there are not enough resources in the health and social care economy to meet the demands being faced. Whilst this has been recognised at a local level, we are concerned that it continues to be ignored regionally and nationally.

Our recommendations provide a framework for a greater public debate on the impact of these proposals, as well as build our evidence base further through real-life case studies. We are conscious that in the short space of time that the task group has met we have not been able to hear every issue in full. The creation of a task group panel, therefore, will allow for on-going scrutiny into local NHS finances. Furthermore, we have called upon colleagues in other overview and scrutiny committees to help us explore specific areas of concern.

I would like to thank those officers from the tPCT and the Council who gave evidence and co-operated with this review, given the very public and contentious nature of some of the issues. I would also like to express my thanks to those from the voluntary and community sector whose constructive engagement and candour has helped us to form a fuller picture of the real impact of the proposed savings.

Cllr Rev. David Clues
Chair, Brent tPCT Turnaround Plan Task Group

Role/Powers

The Health Select Committee has delegated authority from the Council's Overview & Scrutiny Committee to investigate, scrutinise, and develop policy with regards to public health and "well-being" in Brent[1].

The Committee has taken a pro-active approach to reviewing and monitoring the performance and provision of services by partners within the borough, from a community perspective.

At its meeting of the 4th October the Health Select Committee elected to establish a time-limited, cross-party task group, to examine the impact of the Turnaround Plan forwarded by Brent teaching Primary Care Trust (tPCT).

Members

The Task group comprised of the following members:

- **Cllr Rev. David Clues (Chair, Health Select Committee)**
- **Cllr Mary Farrell (Vice-Chair, Health Select Committee)**
- **Cllr John Detre (Member, Health Select Committee)**

Officer Support

The work of the task group was supported by:

Phil Newby, Director of Policy & Regeneration (Lead Officer for Overview & Scrutiny)

James Sandy, Policy & Performance Officer (Support Officer for Health Select Committee)

Siobhán O'Shea, Democratic Services Officer, Legal & Democratic Services

Further advice and evidence was taken from Senior Officers within the Council (listed in on page 28).

[1] The constitutional and statutory powers of this committee are detailed in Appendix (A).

Executive Summary

Purpose

On 23rd November 2006 the board of Brent tPCT agreed savings proposals and efficiencies within its "Turnaround Plan". The Council's Health Select Committee elected to establish a cross-party task group to examine the plan in full, given the gravity of the proposed savings, the lack of detailed information and public documentation.

Investigation and approach

The Task Group gathered evidence from independent witnesses and experts. The impact of the proposed savings were considered from the point of view of the local community, with emphasis placed on those vulnerable people most at risk from cuts to services.

Themes and findings

The task group structured its work programme around the key objectives highlighted in the Brent tPCT Turnaround Plan, adopting the following themes: Local Health Economy, Commissioning & Demand Management, Provider Services, and Internal. The task group's findings are detailed within each themed section of this report.

Recommendations[2]

1. That a public hearing on the Turnaround Plan proposals is convened to allow concerned parties to contribute to an open scrutiny of issues and to respond directly to the findings of the task group.

2. That the Health Select Committee resolves to establish a task group panel on NHS finances.

3. That the Executive endorse an independent review of the Turnaround Plan's Health Impact Assessment.

4. That specific elements of the Brent tPCT Turnaround Plan are referred to the other Overview & Scrutiny Committees of the Council to allow for more in-depth investigation.

5. That the Executive continue to lobby Government on behalf of the Borough for a recognition and acknowledgement of a lack of resources in the local health economy.

[2] A full set of recommendations can be found on page 32 of this report.

Introduction

In February 2006, NHS London, the Strategic Heath Authority (SHA), resolved to create a contingency fund for trusts facing financial difficultly by applying a uniform top-slice of 3% to each PCT budget within the London region. Locally constituting £11.3M, Brent tPCT developed an initial savings plan, which also sought to address other technical and financial management issues as part of its review. The review gradually uncovered wider financial concerns and resulted in the SHA and Brent tPCT agreeing to enter into a "turnaround" process. A turnaround team from KPMG were appointed in September 2006. An interim Chief Executive was appointed in parallel to the Turnaround Director to deliver the process and address the estimated £31M deficit of the trust.

On 23rd November 2006 the board of Brent tPCT agreed those savings proposals and efficiencies within the resulting "Turnaround Plan". It was apparent to those members present at the meeting that the documents available to the Board and to the public were distinct. In light of the gravity of the proposed savings, the lack of detailed information and public documentation, the Council's Health Select Committee elected to establish a cross-party task group to examine the plan in full[3]. Its focus was:

- The failure of Brent tPCT to provide full details of proposed savings amounting to £14M in this financial year and a total of £31M in the next, and to adequately inform either the Council or the Health Select Committee on the nature and scale of its proposed savings, prior to their release.

- The extent of health impacts assessments used to provide a picture of the full implications of savings proposals for the local community.

- The creation and release of separate documents relating to the Turnaround Plan for the tPCT Board, the public, and local Councillors (at its meeting on the 23rd November 2006).

The committee drew attention to its specific concerns relating to the presentation document released at the meeting on the 23rd November. These included:

[3] At its meeting of the 6th December 2006.

- The absence of detail relating to the scale of the predicted deficit for 2006/7.
- The imposition of a turnaround deadline of March 2007.
- The absence of adequate benchmarking information and the comparative data upon which it is based.
- A lack of detail relating to those working groups generating savings plans, the process of challenge they employed, and examples of best practice cited within this exercise.
- An absence of "*…appropriate communications and consultations* (*will need to be*) *undertaken with relevant stakeholders*[4]".
- No full explanations as to those "further downward pressures" mentioned in the document, but not spelt out as part of the overall plan.
- A failure to map out a credible timetable for implementation.
- The summary of commissioning, demand management, provider services, and internal initiatives not adequately providing the level of detail required to determine the true impact of this plan.

Aims and scope of investigation

The Task Group agreed that a process of intensive investigation would be necessary to scrutinise the turnaround plan before the implementation of its proposals. Meetings were conducted in open session, calling on evidence in a "panel" setting[5].

The Task Group agreed to gather evidence from independent witnesses and experts to provide a qualified perspective to its proceedings. The impact of the proposed savings were considered from the point of view of the local community, with emphasis placed on those vulnerable people most at risk from cuts to services.

Further emphasis was placed on the need for partnership and collaboration, so that the findings of the task group could provide information and insight to the Council, its Executive, the Local Strategic Partnership (LSP) regarding the issues the borough faces, impact on local people, and ways forward.

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[4] Primary care trusts (PCTs), Enhancing performance, Department of Health, P4, December 2006.

[5] A copy of the agreed scope of investigation and schedule of meetings constitutes Appendix (B)

The task group's priority was to determine the direct effect of the savings on local people. As well as assessing those proposals that will have a direct impact on services provided by the Council, the task group considered their indirect impact on organisations within the voluntary and community sector. The London Strategic Health Authority was also invited to provide evidence and explanation with regards to the current "turnaround" approach of the tPCT, along with neighbouring NHS Trusts.

The task group structured its work programme around the key objectives highlighted in the Brent tPCT Turnaround Plan, with each strand forming the theme of a task group meeting:

- **Commissioning and Demand Management**
  Examining Changes to purchasing arrangements, spending reductions, contractual management and monitoring, value for money criteria and the quality of services.
  The prioritisation of health needs in relation to the budgetary framework, the implication of "cost effective" services and practices on local people and service users. The implications of a "reduction in accident & emergency (A&E) attendance" and the processes through which this would be achieved.

- **Provider Services**
  Seeking detailed evidence in relation to "core health service priorities" and the impact of a "value for money" model on voluntary and community sector commissioned to provide services, and those vulnerable people reliant on such services. Exploring the rationale and impact of a "right sizing" of the tPCT's core team. A detailed review of changes to criteria and compliance monitoring.

- **Internal**
  Proposed changes to the management structure and the impact on strategic overview, the planning of preventative care, and the capacity of the organisation to promote the preventative care agenda. Changes to support services and the impact on local contractors procured to provide services. A detailed breakdown of property portfolio changes and proposed sales, in relation to service prioritisation and "cost effectiveness".

The task group conducted its investigation using the Department of Health's White Paper "*Our health, Our care, Our say: a new direction for community services*[6]" as a reference point, allowing members to assess the extent to which the turnaround plan was compatible with the direction of national policy.

The white paper includes the following aims:

- Health and social care services will provide **better prevention services with earlier intervention**.

- People give a high priority to convenient access to social and primary care that they can choose and influence. We will give people **more choice and a louder voice**.

- We need to **do more on tackling inequalities and improving access to community services**. We will ensure that local health and social care commissioners work together to understand and address local inequalities.

These clear objectives are demonstrated by the Secretary of State;

> *"Our strategy is to put people more in control, to make services more responsive, to focus on those with complex needs and to shift care closer to home*[7]*"*.

Furthermore, the House of Commons Select Committee published its first report of its investigations into NHS deficits in December 2006, which helped to provide members with an overview of the financial and structural changes of recent months, significantly it has found that;

> "Between 2002 and 2006, NHS spending has increased more than at any other time since the NHS's foundation. In 2002/03, the start of the 5-year period covered by the NHS Plan, its spending was £57.2 billion; by the end it will be around £96.2 billion. It will have risen from approximately 7% to 9% of GDP"[8].

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[6] "Our health, our care, our say: a new direction for community services", department of Health, January 2006.

[7] Ibid, P20.

[8] "NHS Deficits; First Report of Session 2006-07, Volume 1", House of Commons Health

And that

> "In the last 2 years the NHS has been in overall deficit and there has been an increase in the number of NHS organisations with a deficit. These deficits are not new. There have been hidden underlying deficits for many years, but they were revealed by policy changes which increased transparency, in particular the switch in accounting procedures…[9]".

In parallel to the work of this task group, the Council's Executive has been engaged in lobbying activity through regional organisations. Significantly in a reply letter to the Chair of London Councils[10], addressing a perceived "cost shunting" experienced in some Boroughs, the Secretary of State responded;

> "With regard to your suggestion that NHS organisations are seeking to withdraw from continuing care obligations and that additional costs are being borne by local authority partners, I would like to reassure you that this is simply no the case[11]".

Therefore, the task group sought to examine further the potential shift of resources and the implications for the Council. However, the impact of the proposals on residents and services users and its long-term effect on the health and well being of the borough was the overriding priority.

Select Committee, 7th December 2006, P3.

[9] Ibid, P7.

[10] Cllr Merrick Cockell, Royal Borough of Kensington & Chelsea Council.

[11] Letter from Patricia Hewitt MP to Cllr Cockell, Leader, London Councils, 29th January 2007

Task Group Themes:

(1) Local Health Economy

At its first meeting on the 9th January 2007, the task group received a broad overview of the likely impact of the tPCT Turnaround Plan proposals on the local health economy from the perspective of the local NHS Trusts and the Council.

A lack of consultation and the delayed release of key documents limited the time the task group had to target key work streams. Members of the Task group received the most recent copy of the Brent tPCT Turnaround Plan (dated 16th November 2006) four days prior to the meeting (5th January 2007). This followed two formal requests in writing from the Chair to the Turnaround Director.
NHS Guidance has stated that:

> "*The benefits of a total health economy view far outweigh the costs, despite the fact that the parties can sometimes appear to have conflicting objectives*"[12].

Findings

- Poor consultation with key partner agencies, including NHS trusts and the Council. The mental health trust stated that the 5th January was the first in-depth meeting they had held with the tPCT and had had difficulty in getting answers to questions previously.

- Inconsistency in the status of the document. The plan was referred to constant as a "work in progress" or a "rolling" document. However, at the Health Select Committee meeting of the 6th December 2006, the Turnaround Director explicitly stated "implementation starts now"[13].

- The timescale for implementing the plan was deemed "non-negotiable" ignoring the tPCT's duty to consult fully on proposals and expected impacts.

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[12] Primary care trusts (PCTs), Enhancing performance, Department of Health, P5, December 2006

[13] Phil Church, Turnaround Director, Brent tPCT, at a meeting of the Health Select Committee, 6th December 2006, Brent.

- Evidence from CNWL MH (Central & North West London Mental Health NHS Trust) suggested that a 10% reduction in services relating to substance misuse occurred within the context of rising dug 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".***
> *- Dr. Peter Carter, Independent Witness and Former Chief*

- The difficulty to reduce demand in mental health services could result in a loss of beds that would mean an increased reliance on private beds, which in turn would result in a greater cost. Currently, Brent mental health services were working to capacity.

- High quality carers would be lost by withdrawing funding to Brent learning Disability Partnership, a service seen to be working well.

- Evidence from NWLHT (North West London Hospitals NHS Trust) suggested that future operations could be "destabilised" if Brent tPCT chose to transfer large quantities of elective work to external providers.

- Evidence from Housing & Community Care (Brent Council) suggested that a successful turnaround plan would be dependent on a robust assessment of the potential impact of savings on services provided by the Council. Health and social care are inextricably linked.

- Increased transfer of costs to the local authority would have a negative long-term effect on the local health economy. Phased long-term savings could allow for more effective efficiencies through partnership working. A pressured timetable had been forced upon the tPCT.

> **"*There are not enough resources to provide the sustaining level of services that the people of Brent deserve*".**
> *- Martin Cheeseman, Director of Housing and Community Care, Brent Council.*

- The Director of Public Health confirmed that health impact

assessments (HIA) had not been carried out for every proposal. The Board had, however, been given clinical advice on each cluster of savings. HIAs would only be carried out where it was deemed a potentially "*disproportionate effect on the population*" was identified. Agreements with partner agencies would be dependent on such assessments.

- Language and terminology played a part in reducing the accessibility of information to members and to the public. The assertion that certain information should be taken for granted and viewed as an "*implicit watermark*" questions the accountability of tPCT Board's decision-making processes and the evidence upon which decisions are made. The task group failed to be convinced by the tPCT's approach to consultation with partners and information provision.

- Health impacts are seen more in terms of financial risk, than community well-being.

(2) Commissioning & Demand management

Following the Chair's written requests, Brent tPCT provided a "*Turnaround Programme Summary: Version 0.1*" Appendix (C) at the second meeting of the task group.

A final figure relating to the resources "gap" of the tPCT was agreed at its meeting of the 25th January 2007. The process of review and identification of savings will continue until March 2008, the deadline for financial balance.

The emphasis that good commissioning and demand management should provide natural efficiencies for the benefit of the local community was welcomed by the task group. However, members were particularly concerned that this section of the turnaround plan (clusters A&B) made no reference to the impact of proposals on the local authority's community care services or the ability of community health and social care services to provide rapid response to diverted patients with high level needs. Specific proposals contradicted this, such as plans to reduce funding for community nursing.

In addition, monitoring arrangements for patients who had undergone medical procedures were not detailed. It was not clear who would undertake this role if consultant referrals were reduced.

It was agreed that many of the proposals appeared to suggest a reduction in the provision of integrated health services, in contrast to the tPCT's desire to divert patients from A&E services.

Members considered the withdrawal of the bathing services as a short-sighted measure in that it was beneficial to those with long-term conditions. The agreement for this service with the Council is longstanding and the cut places more of the cost pressure with the Adult & Social Care Directorate.

Carers appear to be forgotten in these proposals and no consideration has been given to the increased stress on them as individuals, or the increased likelihood that careers will refuse to take on high need cases. The reprieve given to the Carers Centre, in that they will receive funding until they can identify an alternative source has an unknown rationale. No assistance is suggested in supporting the identification of alternative funding.

Given the diversity of the borough, members were concerned that cuts

interpreting services could reduce both access to, and the quality of, care for significant sections of the local community.

A significant number of “continuing care” cases have been passed back to the tPCT as they have not followed national guidelines to inform patients and relatives that they could be charged for their care. The task group welcomed as positive the tPCT’s promise to allocate and fund a social worker to assist with “continuing care” needs assessments.

Findings

- Delayed discharges need to be addressed as they have an increasing impact on the local health and social care economy. Rapid change has occurred since the last joint audit in 2005 and difficulties are exacerbated by the continued lack of funding in the system as a whole. “Gridlock” in the system is impacting on safe discharge and access to services.

- Social care delays are often dictated by people’s choices, which in turn are determined by a number of complex factors. This was not reflected in the tPCT’s turnaround plan.

- Long and permanent care decisions are being made at speed and under pressure to ensure delivery against national targets, to the detriment of local people.

- Preventative health measures such as smoking cessation and weight loss are facing reduced resources. Whilst it is acknowledged that there are genuine attempts to get staff to “deliver services better” through practice based commissioning, individual GPs, health workers, and nurses this occurs in the context of a smoking ban in public places (from July 2007) and other initiatives that require sustained and strategic approaches across the whole of the borough.

- The tPCT state that cessation of the specialist service for CAMHS/Learning disabilities will improve access to the general provision. These services are based on joint arrangements which have negated a formal, or solid, definition of “health” and “social care” to ensure that no gaps appear. Specialist service is implied as an integral part of the service through Department of Health targets, its withdrawal raises key concerns around the capacity of CAMHS as a whole.

Specialist referrals will no longer be possible and it is evident that mental health users do not access services through the general route. Parent, patients, and users have not been consulted, or even contacted, by the tPCT in relation to the cessation of this specialist service and the likely impact.

> **"On paper this looks like a good idea, but the reality is that no one has been contacted about this proposal".**
> *-Ann O'Neil, Executive Director, Brent Mencap*

> **"The bottom line is that we are paying for people that we shouldn't be paying for to a considerable degree. We expected the local authority to review and pick up on these cases. We will only pay for those with a health need full stop. The council is as complicit as we are. It is not our dispute with the Department of Health".**
> *-Nigel Webb, Interim Chief Executive, Brent tPCT*

> **"With more time and more funds we wouldn't be in this position. There is under investment in general across the local health economy".** *-Phil Church, Turnaround Director, Brent*

- No robust equalities impact assessment has been carried out in relation to these proposals. This is particularly important in considering major factors of the local community, such as the high occurrence of TB within specific ethnic groups and sexual health services for young people.

- No formal consultation took place between the tPCT and the local Police, other than through indirect fora, regarding the potential consequences of cuts to the Drugs and Alchol & Substance misuse Action Team (DAAT).

- There has consistently been no reference to the impact on local authority community care services or the ability of community health and social care services to provide rapid response to diverted patients with high level needs.

A copy of the findings from “Phase 2 of the PCT’s financial savings plan- High level impact assessment of Brent PCT’s financial savings plan” (26th January 2007) was presented to the task group at it’s meeting of the 31st January.

(3) Provider Services

Within this theme the task group wanted to ensure that critical evidence was taken from representatives of local voluntary and community groups, giving the opportunity to attain their perspective on the proposed cuts. Brent tPCT were invited to respond to those questions and concerns raised.

Information shows that the number of health visitors is being reduced and substituted for more junior posts with high caseloads. The task group expressed concern around levels of care and access, particularly with reduced staff and the inability of some vulnerable groups to attend a GP surgery. Members considered that these visitors represented a vital point of contact for some and there loss could reduce the accessibility and personalisation of services.

Members emphasised that there is a real need to consider both “health” needs and “social care” needs in parallel. The needs of individuals are often multi-faceted, not all cases are as straight forward as these proposals suggest, relying on a complexity of factors.

The task group assert that the NHS family needs to consider that they have developed a definition of “systems” which implies “between trusts”. There is a need to look at the health economy as a whole, not simply as a preserve of the NHS and its organisations. A definition of the “system” should also include the capacity of the local authority to move people and to provide aftercare. It is acknowledged that patients often present a complex set of interrelated issues and needs that require a multi-faceted response. For example, the adaptation of properties or provision of new accommodation is dependent on close working with the Council. There needs to be a greater consideration around outcomes, rather than simply focusing on the input, particularly in terms of admissions into hospital.

Nationally, NHS guidance outlines the necessary approach to achieving a “whole systems” approach:

> “*Board members and senior management within the PCT must ensure the engagement of all key decision makers and stakeholders. Without this level of engagement the turnaround plan is likely to fail. Where senior management is unable to ensure that engagement,*

management changes should be considered"[14].

The task group is alarmed that the risk ratings presented in the turnaround plan document represent potential impacts on the achievement of savings rather than there implied impact on the health of individuals.

Where there is clearly a discussion to be had between the Council and the tPCT regarding responsibility for some services, there is a continuing demand for care regardless. Acknowledgement of the scale of this need and the lack of overall resources to meet it within the local health economy demands a more concerted approach from all concerned in making this case centrally.

Findings

- Health visitor and district nursing services would be "clustered" within a community nursing service. A shift from "individual" to "corporate" caseloads would be serviced by a variety of professionals; with caseloads doubling (the average of 300 cases per health visitor would rise to over 600 per team).

- The overall number of health visitors will be reduced, this has the potential to increase the vulnerability of certain groups at risk and weaken preventative "early warning" mechanisms. Provision will be made for additional staff in nursery nursing (9 posts).

- Community Matrons would be employed with higher levels of skills to support people with multiple conditions and high risk of admission to hospital.

- Children's service review (C6) "*To ensure provision of services only where funding has been secured*". This effects delivery of care agreed within service level agreement (SLA) for key stage 1 pupils and the delivery structure of services for children using specialist pathways. This proposal passes on costs to the local authority that has a duty to support statemented children. This will directly impact upon the schools budget.

- Specialist services such as continence services will be withdrawn

[14] Primary care trusts (PCTs), Enhancing performance, Department of Health, P33, December 2006.

which will have an adverse impact on the elderly, those with disabilities, and special schools.

- Diabetes services will be centralised due to low attendance rates. This will reduce the ability of some groups, such as the elderly to access services. Previous initiatives under the health Action Zone were withdrawn in April 2006 with no consultation of service users.

- Occupational therapy and physiotherapy for children now face uncertainty given an implied withdrawal of funding. Brent tPCT have agreed to review this matter in relation to the Children's Centre Community Strategy.

- The smoking cessation service and nicotine replacement therapy will change, placing the service on a less pro-active footing. Those receiving exemptions from prescription will be eligible for free treatment, with professional support being offered through GP surgeries. The Chief Executive gave an assurance that this rationalisation would not impact negatively on smoking cessation in Brent or on those agreed targets within the Local Area Agreement (LAA).
- Proposals (C24) and (C27) regarding school nursing provision were temporarily withdrawn from the turnaround plan pending a decision of the tPCT board. The proposal suggests a reconfiguration of services focused on health, removing educational support through training for teachers and health promotion activities in schools. The task group was given an assurance that the proposed level of funding to be withdrawn would be revised and that child protection issues had been fully considered.

Jo Gilbert, head Teacher of Manor School made a representation to the task group. The document constitutes Appendix (E).

Richard Downes (and Asmila Acharaya) from Brent Advocacy Concerns ("Speak up for yourself") gave a presentation to members Appendix (F).

"There has been no consultation on any of these proposals. This alone has created tension between partnerships within the health and social care economy. How does the PCT plan to meet its national service framework standard on the rights of older people?"
-Helen Cylwick, Elders Voice

"Carers will continue to care regardless of these cuts. But eventually this will impact on them as individuals and they will need support".
-Shirley Bickers, Brent Carers Centre

"These cuts target the very vulnerable however they are packaged and explained. There is no evidence presented as to how they will improve people's lives. We look forward to working properly in partnership once we are over this".
-Ann O'Neil, Executive Director, Brent Mencap

Clare Murdoch, Chief Executive, Central & North West London Mental Health NHS Trust (CNWL MHT). Presented the following case study:

"The impact of de-commissioning the assertive outreach team in Brent mental health service"

In 2003, CNWL was invited to establish a 24 hours Assertive Outreach Team as a specialist multi-professional service to support and treat patients with severe and enduring mental illness who meet the following criteria, as set out by the Department of Health:

- High risk to the public.
- Significant risk of self-harm, suicide and self-neglect.
- Frequent and repeated compulsory re-admissions to hospital.
- Traditional Mental Health Services could not engage with.
- Have multiple and complex health and social care needs including homelessness, substance misuse.
- Have a history of violent behaviour and persistent offending.

Last week (1.2.07) Brent PCT wrote to CNWL Executives, announcing their intentions to decommission the Assertive Outreach Team. Should the PCT proceed with this, the implications are immense. We have highlighted below some of the impact on the service users, the wider mental health economy and the general public.

Service Users and Carers

There are 90 service users currently being supported by the Assertive Outreach Team who meet the above criteria and cannot be supported by any other mental health services in Brent.

Implications:

- The current caseload of 90 service users will instantly be discharged from Brent Mental Health Service and their needs will become unmet.

- The service users will be more socially excluded, deprived, homeless and with poor health.

- Where there are carers, families and friends, they will be unacceptably burdened and may be unable to continue to provide care and support.

- There will be increased incidents of self harm/suicide.

- Service users could face the criminal justice system rather than mental health support.

- 24hr access to specialist service for the service users and the carers will be stopped.

- There will inevitably be a high relapse rate

For these reasons, the service users are likely to come to the attention of the police in public places, which will have the following consequences :

- Frequent hospitalisation
- Increased use of detention powers under the Mental Health Act 1983.
- The service users are likely to be placed in acute mental health services out of the borough, away from their families.
- The service users are likely to be in need of continuing care placements due to lack of support and treatment in the community.

Financial

PCT funding for AOT is £1.1million approximately, per year. Most of the service users have been kept out of hospital since the inception of the service.

Implications:

- Staff redundancies. There are about 18 staff, most of whom are highly qualified. Redundancy costs would be significant.
- There will be high use of in-patient beds in the private sector at an average cost of £500 per night per patient. This is inevitable as bed occupancy at Park Royal Centre for Mental Health is presently at an average of 120%.
- There is a joint PCT and Local Authority obligation to provide aftercare under section 117 of the mental health act at no cost to the service users.

Equality & Diversity

About 80% of the service users are from Black and Minority Ethnic Groups and about 50% are of African Caribbean heritage.

Implications:

- Unequal access to mental health services for the BME community.
- Withdrawal of a service, which disproportionately affects the BME community.
- There is already a significant over-representation of black men detained in psychiatric hospitals. This will worsen.
- This will disproportionately disadvantage BME carers
- The Department of Health's policy of Delivering Race Equality in Mental Health aims to reduce the over-representation of BME patients detained in psychiatric wards, and the impact of decommissioning Assertive Outreach will have the opposite effect.

General Public and Resources

The service users require assertive and prolonged engagement, with staff maintaining frequent visits to ensure stability in service users' mental health.

Implications:

- High risk to public safety, including homicide. A number of Assertive Outreach service users are known to the Brent Multi-Agency Public Protection Panel [MAPPPA].

- Public nuisance, anti-social and disorderly behaviour will be prevalent.

- There will be an increase in police involvement to remove service users from public places to a place of safety or into the Criminal Justice System.

- There will be inappropriate reliance on the Local Authority Emergency Social Services and the police to deal with crises out of hours for this highly vulnerable and high-risk service user group.

- Mental Health resources in Brent will fall further behind other London Boroughs. It is already among the 5 least funded borough in London for mental health services

- The Primary Care Services would clearly be unable to support these service users adequately

Legislation and national targets

- There is a legal obligation on health and local authorities to provide aftercare to patients subject to Section 117 of the Mental Health Act, and all Assertive Outreach service users are entitled to this.

- The PCT will no longer meet the requirements under the Department of Health's National Service Framework for Mental Health, which requires Assertive Outreach services across the country.

It was apparent to the task group that the proposals regarding the Assertive Outreach Team (AOT) were not included within the turnaround plan that the tPCT had presented. The task group was surprised that these plans were not included and dismayed by the Turnaround Director's confirmation that this issue

had been part of the tPCT's "other savings plan".

Clarification was given that the AOT service had been part of a "routine service review" carried out in October 2006. The task group or the Health Select Committee had not received updates in relation to this issue. Members were pleased that the tPCT agreed to negotiate further with CNWL following the debate on this issue.

As the proposal was still in negotiation, the task group considered the matter to be one for further investigation given the potential impacts outlined in the above case study. The vice-chair stated that future engagement on this issue was vital given the severity of the issues involved.

(4) Internal tPCT Issues

The task group was keen to get an understanding of the potential impact of proposed changes to Brent tPCT's management and organisational structure. This was particularly important in relation to its capacity to deliver the turnaround plan competently, to manage those services affected through a period of transition, and its ability to maintain a strategic overview in the planning of preventative care and future services.

Changes to support services and commissioning arrangements would have a domino effect on neighbouring trusts, community and voluntary sector providers, carers, and other Boroughs. Whilst an overview of the tPCT's property portfolio and proposed sales has been received previously by the Health Select Committee, the task group wanted to set this in the context of service prioritisation and "cost effectiveness".

Members were keen to assert that the reconfiguration of services should consider the care pathway of the individual and that accessibility and proximity were important factors for vulnerable groups.

Internal changes were to an extent the concern of the trust itself; however, as a multitude of the trust's activity involves its partners, this is an important area.

Turnaround guidance given to Brent tPCT suggests:

> "*PCTs work with a variety of stakeholders to serve people who rely on a mix of services. Good engagement with all of these around any proposals for change is essential. In other words, a PCT cannot deliver a successful turnaround in isolation. Staff and staff side representatives, the SHA, GPs and practices, local acute and mental heath providers and the media need to be briefed up front and on an ongoing basis and local authorities, social care groups and voluntary bodies engaged*"[15].

The panel was concerned that the rationalisation of estates being attempted by Brent tPCT is a short-term fix and that greater, more effective, economies of scale could have been achieved through working more closely with partner

[15] Primary care trusts (PCTs), Enhancing performance, Department of Health, P50, December 2006.

agencies.

Findings

- Brent tPCT has an advanced strategy of estate rationalisation, which seeks to dispose of properties, which are not “fit for purpose” and replace them with newer, more appropriate properties. The imposition of a turnaround team, however, has stalled its implementation whilst further services are reviewed.

- The tPCT states clearly that its aim is to deliver a wider variety of services within a community based setting. Locating key primary care services within identified “hotspots” is a positive step. However, more must be done to appreciate the needs of those unable to use public transport between them. This would be illustrated as part of a full health impact assessment exercise.

- The Department of Health has withdrawn from a local Private Finance Initiative (PFI) refinancing scheme that would have added capacity to the local healthcare system. Both the tPCT and the Council agree that this could have delivered a £2M saving without any reduction of service.

- The Turnaround Plan does not seem to take into account the changing demographics of the Borough or the cumulative impact these proposals present as a whole. Given the state of flux that the NHS finds itself in, the task group considered that greater flexibility in these proposals was essential.

- The ability of Brent tPCT to lobby the Strategic Health Authority (SHA) had been compromised by a loss of financial and managerial confidence in their provision of services. In turn, the current situation impacted upon Brent Council’s room for manoeuvre with the Department of Health.

"We simply have to go ahead and meet these targets; there is no point in trying to persuade us that it doesn't fit with government policy- we accept that it doesn't, (there is a) clash of national priorities.

Writing to the secretary of state and various luminaries won't make a blind bit of difference. This train has come of the rails and it is our job to get it back".

- Nigel Webb, Interim Chief Executive, Brent tPCT

Summary and conclusion

This task group has investigated the Brent tPCT Turnaround Plan to the best of its ability, given the speed of its implementation and the need to navigate various gaps in the information provided. There remain a number of areas in which the task group is dissatisfied, notably the level of consultation undertaken with key partners and service users, as well as the absence of detailed impact assessments upon which the proposals have been determined.

The recent Department of Health white paper "Our health, our care, our say", determines that a closer integration of "health" and "social" care will provide for a more effective and efficient delivery of health services. The community focus of services, allowing for closer and more appropriate care, necessitates a shift of resources from health (primarily hospital/acute care) to community care (primary care/local authority services). Such a shift is dependent on a **whole systems approach** that cuts across traditional practice and is patient centred.

> *"…to create health and social care services that genuinely focus on prevention and promoting health and well-being; that deliver care in more local settings; that promote the health of all, not just a privileged few; and that deliver services that are flexible, integrated and responsive to peoples' needs and wishes[16]".*
>
> *-Patricia Hewitt, Secretary of State for Health*

[16] "Our health, our care, our say: a new direction for community services", January 2006.

It is our view that the proposed actions of Brent tPCT detailed in their Turnaround Plan are at total variance with these priorities. They have stated that they are faced with a clash of national priorities, which pitches the need for financial balance against the needs of the locality. The cumulative impact of these proposals has been ignored, in favour of a section-by-section assessment of the financial risk of individual savings initiatives.

There is agreement from all parties that there is a lack of resources within Brent's local health economy. However, the local turnaround approach contrast with the national agenda and there is no such recognition from the London Strategic Health Authority or the Department of Health. We appreciate that Brent tPCT are in the difficult position of meeting stringent targets within an enforced timescale, which runs against those aims and objectives, stated by Government.

In addition, the task group considers that by implementing the turnaround plan the PCT have begun to "disinvest" in previously agreed strategies, such as in the care of older people, intermediate care, as well as in staff and services for people with learning disabilities.

The task group believes that there is a need for a genuine and open debate about the resources, structures, and systems in place across health and social care services and how they fit with the needs and aspirations of the people of Brent.

It is our view that Brent tPCT in explaining their turnaround plan have consistently failed to provide an adequate **definition of "core health" services**. It is unclear whether the definition used simply refers to the statutory duties conferred to the PCT. The task group will seek further advice from the London SHA and Department of Health as to how the implementation of the turnaround plan by Brent tPCT fits with this national definition of its role. We consider it imperative that the Department of Health spells out a working definition of core health services and responsibilities.

The task group is disappointed that the London Strategic Health Authority or the Department of Health were unable to provide evidence at any of its sessions. Despite repeated requests no representative was able to explain the current context within which the turnaround plan emerged, its potential impact, or its compatibility with national policy.

It is our view that, at no time, has Brent tPCT considered the impact that this turnaround plan will have on the health and social care economy as a whole.

Brent is one of the most diverse boroughs in the country with people of ethnic backgrounds comprising over 50% of the local population. At no stage has a race equality assessment been undertaken, or planned, to determine the potential impact on those from black and minority ethnic groups.

It is clear that several of the proposals outlined will impact upon children and young people directly. This is particularly important considering major factors of the local community, such as the high occurrence of Tuberculosis (TB) within specific ethnic groups and sexual health services for young people.

The Director of Public Health has confirmed to the task group that **Health Impact Assessments (HIAs)** had not been carried out for every proposal. The Board had, however, been given clinical advice on each cluster of savings. HIAs have only be carried out where it is deemed a potentially "*disproportionate effect on the population*" is identified.

The task group is unsatisfied with the process of assessment applied by Brent tPCT in relation to the scale and nature of the proposals. It considers that its assessment of risks has been too financially focused and that impact assessments have been too clinically focused. Health and Equalities Impact Assessments should be conducted with external expert support, if possible.

It is our view that Brent tPCT's turnaround approach appears to have been to agree proposals internally, publish them, and then invite comment. We do not believe that this equates to genuine consultation.

The task group has heard from local voluntary and community groups, who will be impacted, directly or indirectly, by the proposals outlined in the turnaround plan. Specifically these have been in relation to provider services and have helped identify case studies, which demonstrate the human impact of this situation. Task group members would like to thank those who contributed and will make further provision for this sector to be supported in giving further evidence to the Council, through Scrutiny or the Executive.

We consider that the reputation of Brent tPCT has been severely compromised amongst its key partners. The Council, fellow NHS trusts, and

community groups have all relayed instances of poor consultation, coupled with financially driven initiatives that negate standing agreements.

The Department of Health have stated that:

> *"The majority of (this) the White Paper's proposals for local authorities are about better partnership working with stakeholders to deliver more effective services, while also achieving better value for money from existing resources. However, where there are additional costs for some elements of the proposals, we will make specific resources available to fund them, without placing unfunded new burdens upon local authorities or putting any pressure on council tax[17]"*.

Evidence from North West London Hospitals NHS Trust (NWLHT) has suggested that future operations could be "destabilised" if Brent tPCT chose to transfer large quantities of elective work to external providers.

Increased transfer of costs to the local authority will have a negative long-term effect on the local health and social care economy. Phased long-term savings could allow for more effective efficiencies through **partnership working**. However, this is not possible within the pressured timetable forced upon the tPCT.

We are concerned that formal consultation has not yet taken place between the tPCT and the local Police regarding the potential consequences of cuts to the Drugs and Alcohol & Substance misuse Action Team (DAAT) and mental health services.

This task group received a copy of the turnaround plan prior to its first meeting on the 9th January 2007. This resulted from two formal requests in writing from the Chair. The document was presented to the Brent tPCT Board on the 23rd November 2006, a meeting attended by Councillors and the public. Despite requests for a copy of the full document, upon which the Board had based its decision, only a summary of a PowerPoint presentation was provided.

The status of the turnaround document remains inconsistent. The Health Select Committee was informed at its meeting of the 6th December 2006 that the implementation of the plan had already started. The task group or the

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[17] "Our health, our care, our say: a new direction for community services", January 2006, P21.

committee has yet to receive a formally revised copy of the plan in relation to implementation. Members have refrained from employing the Freedom of Information Act to obtain this, despite concerns around **accountability**.

Whilst it is appreciated that the plan is a "living document" and subject to some change, as progress is made, the task group has since been told that the provided version is irrelevant. The process by which the plan was developed, published, and determined does not appear to be transparent or open. The timescale for implementing the plan was deemed "non-negotiable" ignoring the tPCT's duty to consult fully on proposals and expected impacts.

It is the panel's view that the initial version of the turnaround plan, which the Board formally endorsed, was in effect "a blank cheque" given the speed of the changes which followed. Despite repeated requests, the task group has not seen any of the clinical advice or impact assessments provided to the Board by its Professional Executive Committee (PEC). It is the role of the PECs to provide a professional viewpoint on the strategy and operations of the tPCT.

We consider that the interests of public health have been severely compromised by the production of this turnaround plan. This questions the ability of the tPCT to promote and protect the health and well being of the local population.

At the last task group meeting members were informed that the ability of the tPCT to convince the SHA had been undermined by previous performance. Therefore, it is our view that the people of Brent are being unfairly punished because of the previous financial problems of the tPCT. We believe that a national service should not penalise locally, because of poor local **management**.

The task group remains to be convinced that there is a clear vision internally that will prevent any possible repetition of this situation.

We believe the temporary nature of the Turnaround Team and the Interim Chief Executive compromises the organisation's ability to plan for the long-term care of the community. This is not a personal charge aimed at individuals in post, but more a reference to the potential frequency of turn over in key local personnel. Through our investigations Brent tPCT staff have been co-operative and willing to answer questions frankly.

Furthermore, the Turnaround Plan, upon which the task group based its investigation, has been subject to rapid and repeated changes which militate against long-term solutions. Whilst digests of key areas have been welcomed, a lack of detail has frustrated the task group's investigation.

It is our view that the Turnaround Plan is flawed. The 94 strands that it comprises are considered in isolation, they do not factor in the overall impact of these proposals on the lives of those affected. We are concerned that long and permanent care decisions are being made at speed and under pressure to ensure delivery against national targets.

Task Group Recommendations

1. **That a public hearing on the proposals contained within the Brent tPCT Turnaround Plan is convened to allow residents, services users, and concerned parties to contribute to an open scrutiny of issues and to respond directly to the findings of the task group. The hearing would provide further case studies and examples of the true impact of the proposals.**

2. **That the Health Select Committee resolves to establish a task group panel on NHS finances to monitor the financial position of all local trusts and the continuing PCT deficit. Such a panel would be time limited until April 2008 and meet as required on a regular basis.**

3. **That the Executive endorse an independent review of the Turnaround Plan's Health Impact Assessment to provide an impartial critique of its suitability and, pending its outcome, support an external Health Impact Assessment study, conducted by an expert body.**

4. **That specific elements of the Brent tPCT Turnaround Plan are referred to the other Overview & Scrutiny Committees of the Council to allow for more in-depth investigation on specific issues, for example;**

    - **Children & Families Overview & Scrutiny to investigate the impact of proposals on children's services, schools and their budgets, child protection, school nursing, and education & training.**

    - **Performance and Finance Select Committee to investigate the impact of the plan on the Local Area Agreement, funding, and other key strategies.**

    - **Overview & Scrutiny Committee to examine the impact of the plan, and its handling, on future partnership working.**

5. **That the Executive continue to lobby Government on behalf of the Borough for a recognition and acknowledgement of a lack of resources in the local health economy, the integrated nature of health and social care, and a protection of health services for the local population.**

These recommendations were presented to the Health Select Committee at its meeting of the 13th February 2007 and endorsed by its members.

Due to the timescale and frequency of the task group's meetings, the Chair requested that the initial position paper be considered to allow for its recommendations to be put to the Council's Executive at the earliest possible opportunity. The Executive consider these recommendations at its meeting of the 12th March 2007.

The task group took evidence from the following:

Nigel Webb, Interim Chief Executive, Brent tPCT

Jean Gaffin, Chair, Brent tPCT

Judith Stanton, Director of Public Health, Brent tPCT

Andrew Parker, Director of Strategic Commissioning & Performance, Brent tPCT

Patricia Atkinson, Director of Nursing, Quality and Clinical Governance, Brent tPCT

Bashir Arif, Director of Integrated Health Services, Brent tPCT

Dr. Amanda Craig, PEC Chair, Brent tPCT

Mary Wells, Chief Executive, North West London Hospitals NHS Trust.

Martin Cheeseman, Director of Housing & Community Care, Brent Council

Christabel Shawcross, Assistant Director, Community Care, Brent Council

Clare Murdoch, Chief Executive, Central & North West London Mental Health NHS Trust (CNWL MHT).

Dr. Peter Carter, Independent Witness (former Chief Executive, CNWL MHT).

Ann O'Neil, Executive Director, Brent Mencap

Jo Gilbert, Headteacher, Manor School, Brent

Shirley Bickers, Brent Carers Centre

Helen Cylwik, Elders Voice

Richard Downes, Brent Advocacy Concerns

Asmila Acharaya, Brent Advocacy Concerns

Representation was sought from:

Ruth Carnall, Chief Executive, London Strategic Health Authority (SHA)

David Behan, Director General of Social Care, Department of Health

Despite repeated attempts, such representation was not forthcoming.

List of Appendices

(A) The constitutional and statutory powers of the Health Select Committee (Overview & Scrutiny)

(B) Brent tPCT Turnaround Plan Task Group initial scope and schedule of meetings.

(C) Brent tPCT provided a "*Turnaround Programme Summary: Version 0. (available on request).*

(D) "*Phase 2 of the PCT's financial savings plan- High level impact assessment of Brent PCT's financial savings plan*" (26th January 2007)

(E) "*Representation to the Brent tPCT Savings Plan Task Group*", by Jo Gilbert, Head Teacher Manor School, on behalf of Brent's Heads of Special and Primary Schools.

(F) Richard Downes (and Asmila Acharaya) from Brent Advocacy Concerns ("Speak up for yourself")- "Against the cuts" presentation slides.

(G) Notes from Brent tPCT Turnaround Plan Task Group meetings.

Documents

- Brent Teaching Primary Care Trust Draft Turnaround, 16 November 2006[18].

- "Our health, our care, our say: a new direction for community services", Department of Health, January 2006.

- "Delivering quality and value- Focus on: productivity and efficiency", NHS Institute of Innovation and Improvement, Department of Health, January 2006

- Primary care trusts (PCTs), Enhancing performance, Department of Health, December 2006.

- "Health impact assessment", Karen Lock, British Medical Journal, Volume 320, 20th May 2000.

- "Health Impact Assessments: Main concepts and suggested approach", Gothenburg consensus paper, December, 1999 European Centre for Health Policy, Brussels.

- "The Future Hospital: The progressive case for change", Joe Farrington-Douglas with Richard Brooks. Institute of Public Policy Research (IPPR), January 2007

Correspondence

- Letter from Ruth Carnall, NHS London Chief Executive to all London MPs, December 4th 2006.

- Letter from Patricia Hewitt MP to Cllr Lorber, Leader, Brent Council, December 4th 2006.

- Letter from Patricia Hewitt MP to Cllr Cockell, Leader, London Councils, 29th January 2007.

[18] This (166 page) document is available on request.

Notes from meetings held on:

- **9th Jan 2007**
- **17th Jan 2007**
- **31st Jan 2007**
- **8th Feb 2007**

are attached as **Appendix (G)**

The task group met in closed session on **9th Feb 2007** to agree this final report and recommendations.