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Health Partnerships Overview and Scrutiny Committee

Wednesday 30 May 2012 at 7.00 pm
Committee Rooms 1 and 2, Brent Town Hall, Forty Lane, Wembley, HA9 9HD

Membership:

Members Councillors:	**first alternates** Councillors:	**second alternates** Councillors:
Kabir (Chair)	Mitchell Murray	Moloney
Hunter (Vice-Chair)	Cheese	Ms Shaw
Colwill	Baker	Kansagra
Daly	Ketan Sheth	Van Kalwala
Harrison	Naheerathan	Singh
Hector	Aden	Al-Ebadi
Hossain	Ogunro	Mitchell Murray
Leaman	Sneddon	Clues

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The press and public are welcome to attend this meeting

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members

Item		Page
1	**Declarations of personal and prejudicial interests** Members are invited to declare at this stage of the meeting, any relevant financial or other interest in the items on this agenda.	
2	**Deputations (if any)**	
3	**Minutes of the previous meeting held on 27 March 2012** The minutes are attached.	1 - 10
4	**Matters arising (if any)**	
5	**Recruitment of health visitors in Brent** The report addresses issues raised by the Members on this item at the last committee meeting on 27 March 2012.	11 - 16
6	**Accident and Emergency waiting times** Report to follow.	
7	**Shaping a healthier future - Brent out of hospital care strategy and an update on the North West London Joint Overview and Scrutiny Committee** The report provides an update on this item from the last committee meeting on 27 March 2012.	17 - 66

8	**Primary care update - Willesden Medical Centre, Kenton Medical Centre and Kilburn Medical Centre**	67 - 90

NHS Brent has provided an update on three GP practices in Brent. Their report covers three main issues:

- Willesden Medical Centre – The possibility of relocating the practice to Willesden Centre for Health and Care.
- Kenton Medical Centre – This centre is to close, and the report highlights the work that has gone on since the GPs gave notice that they intended to retire.
- Kilburn Medical Centre – On the plans to disperse the patient list for this practice, which is also set to close.

The issues connected to Willesden Medical Centre and Kilburn Medical Centre have been previously considered by the committee. However, Kenton is a new issue. More information on this practice is set out below.

9	**Serious incident at Brent Urgent Care Centre**	91 - 98

The report is attached.

10	**Update on the procurement of new community cardiology and ophthalmology services**	99 - 102

NHS Brent has provided a report updating members on the progress of the procurement of community cardiology and ophthalmology services in the borough. Members requested this update at their meeting in March 2012.

Although the update is essentially for noting, previously members have had questions about the consultation plan for the service procurement and the consultancy costs associated with the procurement. These are addressed in the paper.

11	**Clinical Commissioning Group update**	

Members will receive a verbal update on this item.

12 Health and Wellbeing Board update

Members will receive a verbal update on this item.

13 Health Partnerships Overview and Scrutiny Committee work programme 103 - 108

The work programme is attached.

14 Date of next meeting

The next meeting of the Health Partnerships Overview and Scrutiny Committee is scheduled to take place at 7.00 pm on Wednesday, 18 July 2012.

15 Any other urgent business

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

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

MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
Tuesday 27 March 2012 at 7.00 pm

PRESENT: Councillor Kabir (Chair), Councillor Hunter (Vice-Chair) and Councillors Cheese (alternate for Councillor Beck), Daly and Ogunro

Also Present: Councillors John (Leader of the Council) and R Moher (Lead Member for Adults and Health)

Apologies were received from: Councillors Colwill, Hector and RS Patel

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

Councillor Daly declared an interest as a health visitor in relation to item 12, 'Recruitment of health visitors in Brent', however, as she did not work for an organisation in Brent, she did not regard the interest as prejudicial and remained present for this item.

2. **Minutes of the previous meeting held on 7 February 2012**

RESOLVED:-

that the minutes of the previous meeting held on 7 February 2012 be approved as an accurate record of the meeting, subject to the following amendments:-

6th line, 4th paragraph, page 5 – replace 'Members heard' with 'Abukar Awale alleged'
2nd line, 6th paragraph, page 6 – after 'mental health centres' add 'in West London' and add 'direct' before 'contributor'.

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

Khat task group – final report

The Chair confirmed that the Executive had endorsed the Khat task group's final report at its meeting held on 12 March 2012.

4. **Health services for people with Learning Disabilities - A report from Brent MENCAP**

Ann O'Neil (Brent MENCAP) introduced the item and stated that changes to health services would impact significantly upon those with learning disabilities and considerable health inequalities existed. She advised that the number with learning disabilities was increasing, particularly those with profound disabilities. Ann O'Neil

informed the committee that she had undertaken a piece of work with the council three years previously focusing on those with learning disabilities' health needs and a council funded health action project had operated last year which acted as a catalyst for raising relevant issues, such as the need for learning disability nurses. As a result, two local acute learning disability nurses were to be appointed. She stressed the importance of ensuring that both the council and NHS Brent remained accountable to learning disability needs and suggested that a focus group be created involving both patients and their carers. Members heard that a recent national report had referred to there being 74 people with learning disabilities who had died through lack of care and this number would continue to rise if the appropriate measures were not in place. However, Ann O'Neil added that no deaths attributed to lack of care had been recorded in Brent.

Claudia Feldner (Brent MENCAP) then informed the committee about the GP training on learning disability awareness that had been undertaken. She advised that 104 people had attended the training and there had also been a shorter workshop that had been attended by 30 GPs. Claudia Feldner commented that most felt that they had benefitted from the training and that it had provided a theoretical background as to how to improve communications between staff and people with learning disability. Staff had indicated that they felt that further training should be provided, whilst others had expressed interest in attending training, but had been unable to due to being unable to get the necessary time away from their post. The acute sector had adopted an action plan to undertake a number of measures to improve the healthcare experience for those with learning disabilities, including improved signage and it had also been suggested that 'hospital passports' be introduced. Brent MENCAP had also participated in Obesity Strategy Group meetings to advise on the learning disability element. Furthermore, Brent MENCAP would also be encouraging those with learning disabilities to take a greater part in consultation and to contribute to the Joint Strategic Needs Assessment (JSNA). Claudia Feldner advised that Brent MENCAP had received funding to help with the Annual Health Check Day.

Ann O'Neil then suggested that the committee closely monitor changes, particularly in respect of learning disability nurses and the role of acute liaison officers. She felt that the action plan should be reported to the committee on an annual basis and there should be an active programme to promote learning disability awareness.

During Members' discussion, Councillor Daly asked if the regulator had expressed views on the health provision for those with learning disabilities and had their homes been inspected. Councillor Hunter welcomed the report and referred to a health day event for the Somalian community that had taken place the previous week that had raised a number of overlapping issues that were also faced by those with learning disabilities, such as communication and signage. She felt that training on this issue should continue as it had been a useful experience and that councillors would also benefit from such training. Councillor Cheese asked if the hospital passport system could be expanded. The Chair commented that in respect of council responsibility, there was a need for the Health and Wellbeing Board to acknowledge the needs of those with learning disabilities who would need additional care.

In reply, Ann O'Neil confirmed that Brent MENCAP were not subject to an assessment from the regulator and commented that there was a general lack of

awareness on learning disability issues, with GPs sometimes uncertain who to refer patients with a specific learning disability to. She stated that Brent MENCAP could offer training in areas of learning disability, such as autism. Members noted that Brent MENCAP had agreed with NHS Brent that another health day for those with disabilities be undertaken.

Claudia Feldner advised that there were funding limitations in respect of expanding the hospital passports system and there would also be issues to consider such as who would be responsible for printing the passports.

Jo Ohlson (Brent Borough Director, NHS Brent and Harrow) added that NHS Brent was responsible for some patients placed outside the borough and all the appropriate spot checks and safeguarding measures had been assessed as sound, however she agreed that monitoring should continue to ensure the appropriate safeguarding measures were in place. The committee noted that some inspections of homes of those with learning disabilities had been undertaken and she was not aware that any issues had arisen from this.

The Chair requested that a report be presented to the committee in around six months' time advising how many staff had received learning disability awareness training and what improvements had taken place in respect of signage in health facilities.

5. **Planned Care Initiative**

Jo Ohlson introduced the item and explained that the purpose of the initiative was to outline how planned care outside of hospitals would function in future. The main focus of the initiative was to re-commission some outpatient services to be provided within the community through a phased process involving procurement through competitive dialogue. Thirteen specialities had been identified, of which a primary one was cardiology and it was envisaged that £1.8m savings could be achieved through such a move which would allow more funds to be reinvested into community facilities. Jo Ohlson advised that once it had been identified what services would be proposed to be provided within the community, a consultation would be undertaken with a view to delivering the services in the community by the autumn.

Councillor Hunter sought a further explanation of the term competitive dialogue and whether Members would be involved in the consultation. Councillor Daly enquired why a procurement exercise was necessary and whether there was any information on what organisations were interested in delivering community services. She sought confirmation that an equality impact assessment (EIA) was taking place and if so who was conducting it and what were the costs involved. With regard to cardiology and ophthalmology, Councillor Daly commented that as these were acute services, what steps would be taken to ensure quality of service was maintained. The Chair asked if patient input would be discussed with potential providers at any stage.

In reply, Jo Ohlson explained that a competitive dialogue involved inviting bids through a process of advertising what services it was proposed to provide in the community and offering dialogue with potential bidders to discuss how this would be provided. To date a variety of providers had expressed an interest, with 24

expressing an interest in respect of cardiology and 15 for ophthalmology. A number were local acute organisations and others were private providers. The next stage would involve compiling a delivery specification based on the discussions that had taken place, followed by streamlining the providers still in contention prior to entering the formal procurement process. Consultation, including with this committee, would also be undertaken in respect of drawing up the specification of service. Jo Ohlson explained that conducting a procurement exercise would help to reduce costs whilst improving services and she confirmed that an EIA was being undertaken by NHS Brent in conjunction with consultants PPL. Members heard that it was anticipated that there would be fewer acute services in hospitals. Jo Ohlson stated that NHS Brent was the first to undertake such an exercise, however all eight north west London boroughs would be following suit. NHS Brent would decide whether to continue with the initiative, and if so, to go ahead and appoint providers. The £1.8m savings would contribute to the £12m savings required next year.

Rob Larkman (Chief Executive, NHS Brent and Harrow) added that the main objectives in hospitals were to maintain safe and sustainable services, whilst the planned care initiative was part of a wider programme to provide better services and value for money. Alison Elliott (Director of Adult Social Care) advised Members that it would be commercially inappropriate to provide the list of providers expressing an interest in running services at this stage.

Ethie Kong (Brent GP) stated that the planned care initiative was part of the overall North West London Hospitals Trust strategy and would involve partnerships with a range of organisations.

Councillor R Moher (Lead Member for Adults and Health) commented that it was important that the council be consulted at an early stage where far reaching changes were being proposed and she welcomed NHS Brent's early timing of their presentation to the committee.

The Chair thanked NHS Brent for their report and she requested that Members be updated on progress at the next meeting in order that they could provide some input into the process.

6. **Waiting list information**

Jo Ohlson introduced the report and explained that the 18 weeks target had been changed in 2011/12 to that of 95% of patients to be seen in outpatients within 18.3 weeks and 95% of patients overall to be seen within 23 weeks. To date, 95% of Brent patients had received treatment after referral within 23.84 weeks. Members noted the waiting times overall for incomplete pathways for patients still waiting for treatment had dropped which was an encouraging trend and overall waiting times remained within target. The rise in waiting times for inpatients, however would continue to be monitored to consider what measures may be need to be undertaken. Jo Ohlson stated that she could provide information by speciality to Andrew Davies (Performance and Policy Officer, Strategy, Partnerships and Improvement).

Councillor Daly sought further explanation with regard to waiting list times increasing and asked for a comparison of waiting times both before and after the

closure of the Accident and Emergency Services unit at Central Middlesex Hospital at the next meeting. The Chair asked for waiting times in respect of Accidents and Emergencies at the next meeting.

In reply, Jo Ohlson advised that although the targets had been revised, the patients experience did not necessarily mean that waiting times were increasing and she agreed to liaise with Andrew Davies regarding the information requested by the Chair and Councillor Daly.

7. **Public Health Transfer Update**

Phil Newby introduced the item and advised that the White Paper setting out the plans for public health had been confirmed in the Health and Social Care Bill which was subject to Parliamentary approval. The council was due to formally take on public health responsibilities on 1 April 2013. There was a real desire by the council and NHS Brent to integrate public health functions, however guidance from the Government was still awaited. Phil Newby advised that there was a sister project with regard to adult social care in the One Council Programme as it made sense to integrate this area as much as possible. Discussion was also taking place with other West London boroughs as to what services would be logical to share. However, there remained uncertainties in the Bill which presented additional challenges and there were also issues to discuss in relation to commissioning, although the overall conclusion that could be made was that there should be as much integration as possible and a rigorous project approach would be undertaken to help achieve this. Page 57 in the report set out the financial allocation, although in respect of Brent's allocation, there were some anomalies and these were being raised with the Department for Health.

Councillor R Moher added that transferring public health was a complicated process exacerbated by the drip feeding of information by Government, however the final plans were now coming together.

Simon Bowen explained that there had been long discussions on this issue and the model of public health in Brent would be much different to the present one. He was confident that the model would be delivered and work was underway to finalise various details.

Councillor Daly stated that there appeared to be a very few number of measures outlined that the council was obliged to undertake. In respect of funding, she asked if this meant that the council would need to trim its public health budget.

Phil Seely was invited to address the committee by the Chair. He commented that Brent had the second highest incidences of tuberculosis (TB) in London and asked what action was being taken to address this. Councillor Ogunro also sought information in respect of this issue. Councillor Cheese added any clinics offering TB treatment should be located in areas of London where cases were high, such as Brent. Councillor Hunter informed Members that a TB awareness day had taken place the previous week and this had been well attended by health professionals.

Councillor R Moher asked if the Mayor of London had any public health responsibilities.

The Chair commented that the issue of TB was a prominent feature in the JSNA. She sought further information in respect of abortion services and added that it was reassuring that the overall shape of public health provision was coming together, despite the many challenges to overcome.

In reply to the issues raised, Phil Newby advised that abortion services had originally been intended as a local authority responsibility, however it had since been determined that this would remain under the Department for Health who had disproportionally clawed back funding for this. In addition, the Department for Health would also be retaining 0-5 years services, however Phil Newby felt that it would have been more logical if this had been given to local authorities for purposes of consistency. He advised that the Bill provided clues as to what the council could provide by using the term 'local', however ultimately the local authority could determine what the priorities were.

Simon Bowen confirmed that TB services would remain a responsibility of the NHS and there was a proposal to designate clinics offering TB treatment across London. He added that there were a number of issues that transcended London borough boundaries in terms of provision. However, the local authority could play a role in promoting and educating issues in relation to TB.

Andrew Davies advised that public health functions had not been taken into account in respect of the Mayor of London, however the Mayor would be entitled to a 3% slice of funding from each borough and could obtain an additional 3% on top of this if London boroughs agreed. The Mayor had established a Health Improvement Board that had selected four initial priorities, preventing cancer and early detection, childhood obesity, alcohol and data sharing.

8. **Shaping a Healthier Future Update**

Andrew Davies introduced this item which provided an update since the last meeting of the committee. A meeting with some members of the other health scrutiny committees in North West London had taken place on 29 February, with Councillor Hunter representing this committee, to consider a presentation on the shaping a healthier future project and a North West London Joint Health and Overview Scrutiny Committee (JHOSC) would consider this topic in future. A consultation event had also taken place at Lords Cricket Ground the previous week and proposals would be circulated to Members. However, Andrew Davies advised that this committee may still comment on the project. Brent's nominations for membership of the JHOSC would be submitted in May, however in the meantime Councillors Kabir and Hunter would continue to attend any future events in respect of the JHOSC and shaping a healthier future. The terms of reference for the JHOSC were also to be agreed.

Councillor R Moher added that she had requested that this item be presented at all the Area Consultative Forums.

During discussion by committee, Councillor Daly felt that in view of the substantial savings that were proposed by the project, there was not presently an opportunity to undertake proper scrutiny prior to the consultation and she suggested that an extraordinary meeting of this committee be arranged to allow this. Councillor Hunter commented that the meeting at Lords Cricket Ground had provided more

details and had been helpful in providing Members a greater understanding of the project. She felt that there was a need to consult both on a local and a West London level, however in her view the clinical case for change was clear.

The Chair commented that there may be issues over consulting on such an issue whilst the Olympics was taking place, however Andrew Davies would liaise with Members in providing them information during the consultation and any new information on the JHOSC would also be provided. Should any critical issues arise from these, then discussions could take place as to whether an additional meeting of the committee should be arranged.

In response to the issues raised regarding the consultation, Councillor R Moher advised that the plans were still be put together and once this process had been completed, consultation would take place over the summer which should be sufficient to receive considerable feedback. Rob Larkman (Chief Executive, NHS Brent and Harrow) added that the consultation was due to end in August. He acknowledged the local implications of the changes and advised that the full statutory consultation would include both local and West London wide arrangements.

9. **Proposed merger of North West London Hospitals NHS Trust and Ealing Hospital NHS Trust**

Andrew Davies introduced this item and referred to the letter reflecting the committee views that had been sent to Peter Coles, Acting Interim Chief Executive of the North West London Hospitals NHS Trust and Peter Coles' subsequent response to it. Andrew Davies advised that the full business case was to be put to both trust boards on 29 March 2012, before subsequent formal review by the NHS London Board and NHS North West London Board prior to submission to the Department of Health Transactions Board in May or early June. Andrew Davies added that a copy of the full business case would be circulated to Members as soon as it was available and Simon Crawford, Senior Responsible Officer, Organisational Futures Programme Board, had indicated that he would be happy to attend a meeting of the committee once the full business case had been published.

10. **GP Commissioning Consortia update**

Ethie Kong updated Members on progress on GP Commissioning Consortia and advised that plans to put together the final commissioning plans would commence in April subject to the delegated commissioning budget being agreed. Brent, Ealing, Harrow and Hillingdon were working together to meet the health needs of West London. Providing the plans were approved, the intention was to go live with arrangements in April 2013.

Alison Elliott advised that consideration was being given as to what services could be integrated and a feasibility study was being undertaken to see if better services at lower costs could be achieved. If integration was seen as economically viable, this item would then be presented to the committee for further consideration.

Jo Ohlson commented that both disability and physiotherapy services were community services and a year's notice was being given of the intention to integrate these services. For single practices, integrating such services would be a relatively

straightforward exercise, although this would be more complex for partner practices and a number of possible models were being considered.

Councillor R Moher added that the work focused on designing the services where there was a desire to commission them and organisations were being given notice of what they needed to do to ensure that they were able to operate under the new arrangements.

11. **Health and Wellbeing Board update**

Andrew Davies advised that the Shadow Health and Wellbeing Board had met at the end of February to discuss issues including shaping a healthier future, clinical commissioning groups, and integration of public health and adult social care. Councillor Kabir and Mansukh Raichura (Chair, Brent LINk) had also attended the meeting as observers.

12. **Recruitment of Health Visitors in Brent**

Jo Ohlson introduced the item and explained that health visitors had been an important issue in Brent for a number of years and this service was significantly stretched. Plans were being put together to improve the service and she referred to the London trajectories for health visiting in Brent in the next few years in the report which identified a need to increase the number of health visitors each year. Members noted that NHS Brent had identified additional funding to support recruitment for the level required up to April 2013, which amounted to 44 posts, and this would involve both recruiting to vacancies and to additional posts. Consideration was also being given as to how recruits could be found and Jo Ohlson advised that the shortage of health visitors was also a problem nationally. In addition, Brent would need to have a greater increase in health visitors than both Harrow and Ealing because of projected population trends and this represented a significant challenge.

During discussion, Councillor Ogunro enquired why there was a shortage of health visitors in Brent. Councillor Daly commented that she did not feel that Brent was any more challenging than other London boroughs and suggested that the management structure may be a more likely explanation as to why there was a problem in filling health visitor places. She asked for information on the type of health visitors recruited and what salaries were being paid for these posts. She also asked if there was to be training to increase the number of practice teachers. Councillor Hunter suggested recruitment could be helped by emphasising that health visitors were key health workers. She also sought clarification in the report in reference to a transition model for new delivery aligned with the emerging system architecture and responsibilities for commissioning and reasons as to why domestic violence had been categorised as red and why were there no benchmarks available for a number of areas.

The Chair commented that health visitors played an important role, particularly in respect of 0-5 years children and felt that the more health visitors there were, the greater number of families that would benefit from this. She sought assurances that more health visitors could be recruited and retained.

In reply, Jo Ohlson felt that Brent was a challenging place for heath visitors and other reasons for the shortage could be attributed to focusing resources on safeguarding, an ageing workforce, the smaller London weighting in Brent and the overall lack of health visitors nationally. It was noted that the number of practice teachers would need to double and Jo Ohlson would provide information on salary information at a later date, whilst Ealing Hospital NHS Trust could provide figures on their own health visitor recruitment. However, every effort was being made to plan for the expansion of health visitors. Jo Ohlson advised that although there was a large number of incidences of domestic violence recorded, it was felt that other areas of London may not be so thorough in recording them.

Phil Newby (Director of Strategy, Partnerships and Improvement) advised that Genny Renard, Head of Community Safety, could provide a written answer in respect of Councillor Hunter's query with regard to domestic violence. He explained that other London boroughs used varying methods of recording domestic violence.

Simon Bowen (Acting Director of Public Health, NHS Brent) added that it was more difficult to obtain information on community health issues because there was no national data set available.

The Chair requested that Ealing Hospital NHS Trust provide information in respect of health visitors recruitment to Andrew Davies.

13. **Work programme 2011/12**

The work programme was noted by the committee.

14. **Date of next meeting**

It was noted that the next meeting of the Health Partnerships Overview and Scrutiny Committee would be confirmed at the Annual Council meeting on 16 May 2012.

15. **Any other urgent business**

Willesden Medical Centre

Councillor Hunter commented that there had been media and public rumours that Willesden Medical Centre may close or relocate and she sought further clarification on this.

In reply, Jo Ohlson advised that the lease on Willesden Medical Centre was due to expire and discussion was taking place as to whether to renew the lease or to relocate to the Willesden Centre for Health and Care. It was noted that the Willesden Centre for Health and Care already had a number of facilities on-site and was presently less than half full, however all factors needed to be considered before making a decision. Members noted that a patient consultation would be undertaken if it was proposed to relocate Willesden Medical Centre.

The meeting closed at 9.35 pm

S KABIR
Chair

Health Partnerships Overview and Scrutiny Committee
30th May 2012

Report from the Director of Strategy, Partnerships and Improvement

For Action

Wards Affected: ALL

Recruitment of Health Visitors in Brent

1.0 Summary

1.1 Members will recall that at the March 2012 meeting of the Health Partnerships Overview and Scrutiny Committee NHS Brent presented a report on the recruitment of health visitors in the borough. This issue relates to the Government's commitment to recruit an additional 4,200 health visitors in England by 2015.

1.2 As Ealing Hospital Trust ICO leads on recruitment it was agreed to put this issue back on the committee's agenda to follow up questions with the ICO. Ealing Hospital Trust has provided members with a report on their work, appendix 1 to this covering note. The main issues identified in it are:

- The current funded establishment for Health Visitors in Brent is 39.8 WTE. The trust has averaged 12 WTE vacancies over the last two years.
- A recruitment drive in March 2012 has seen an increased number of external applicants who have been appointed subject to the usual pre-employment checks. Five health visitors have been appointed following the March 2012 recruitment exercise.
- Community Services Brent traditionally supports five internal students. However, it is not compulsory for internal students to remain with the Trust that has trained them once they have qualified. Hence it is imperative that students are well supported and encouraged to take up permanent posts in Brent.
- Community Services Brent has plans in place to enable a total of ten Health Visitor posts to be filled, predominantly with newly qualified staff, by the end of September 2012.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to consider the full report and question officers from Ealing Hospital ICO on their strategy to recruit more health visitors in Brent.

Contact Officers

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Community Services Brent

Briefing Paper for Brent Health Partnership Overview and Scrutiny Committee on Health Visiting Recruitment in Brent

1. Introduction

This paper provides an update to the Brent Health Overview & Scrutiny Committee on the progress made by the Trust to improve the recruitment of Health Visitors. This is part of the national "Call to Action" implementation plan for health visiting which is being co-ordinated locally by the NHS Brent Health Visitor Implementation Plan Project Board.

2. Health Visiting in Brent

In February 2011 the "Health Visitor Implementation Plan – A Call to Action" was published by the Department of Health. In June 2011 a "Task & Finish group" was set up locally to progress the work, led by a Consultant in Public Health (Maternal and Child Health) from NHS Brent. As the local provider of the health visiting service, Community Services Brent have been closely involved in the design of the Brent plan, represented by the General Manager for Children's Services and the Deputy Director of Nursing & Clinical Standards – Brent. The outcomes and progress of the group are monitored by the Director of Nursing and Clinical Practice for the Trust and contribute to the Health Visiting Plans for the three boroughs (Brent, Ealing and Harrow)covered by the Trust.

3. Historic Recruitment Status in Brent

The national shortage of Health Visitors over the last decade has impacted most on recruitment in areas of high deprivation. Across the capital the situation is intensified by relatively high numbers of child protection cases and Looked After Children making it more difficult to attract staff into the service. In Brent, as in many London boroughs, there have been vacancies constantly over the past four years. The current funded establishment for Health Visitors in Brent is 39.8 WTE. Table 1 below outlines vacant Health Visitor posts over the past 2 years which have averaged 12 WTE vacancies.

Table 1: Band 6 & 7 Health Visitor Vacancies from April 2010 - March 2012

Vacancies	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average Vacancy
2010-11	13.54	11.07	11.43	13.03	10.2	13.8	12.8	12.8	12.2	9.5	12.1	12.1	12.05
2011-12	11.5	11.3	12.2	12.2	13.2	12.2	13.2	13.2	9.88	11.46	13.22	12.22	12.15

Recruitment drives during this period have delivered only one to two qualified health visitors per year and this has been offset by the number of staff that have retired, again one to two per year. Currently six of the twelve WTE vacancies are backfilled by internal bank staff (temporary staff service).

4. Current Health Visitor Recruitment Status as of April 2012

A recent recruitment drive in March 2012 has seen an increased number of external applicants who have been appointed subject to the usual pre-employment checks. It must be noted that four of the applicants interviewed are currently Health Visiting students who are due to qualify in September 2012.

Table 2: HV recruitment applicants

External Recruitment	March 2012
Shortlist	6
Interview	5
Offered Post	5
Accepted Offer	**5**

Community Services Brent also traditionally supports five internal students. This year three full-time students are being supported by our Specialist Community Practitioner Teachers (SCPTs) as well as two return-to-practice students (qualified health visitors who have had an absence from service of more than 3 years and are now on a refresher course). The internal students have all been interviewed and offered health visiting posts upon qualifying in September 2012. It is not compulsory for internal students to remain with the Trust that has trained them once they have qualified. Hence it is imperative that students are well supported and encouraged to take up permanent posts in Brent.

Table 3: HV applicants in total including Brent supported students

Applicants	Numbers
Externally Recruited HVs	5
Internal HV Students	3
Return to Practice HVs	2
Total	**10**

Consequently Community Services Brent have plans in place to enable a total of ten Health Visitor posts to be filled, predominantly with newly qualified staff, by the end of September 2012. The Trust is now planning how this number of newly qualified staff entering a service simultaneously can best be supported in terms of appropriate induction, mentoring systems, clinical supervision and child protection advice.

5. Ealing Hospital NHS Trust Recruitment & Retention Strategy

The Trust is developing a recruitment & retention strategy which will be an important component of the Brent Health Visitor Implementation Plan. Given that the main requirement of the plan is to increase the number of Band 6 health visitors, the Trust will also be looking to recruit additional health visitors via a new NHS London centralised recruitment process.

A number of recruitment areas are being investigated as part of the strategy. The following two elements provide an example:

5.1 Newly Qualified Health Visitors

Some provider organisations in London appear to be training more health visitors than they have available vacant posts to accommodate. The Trust is therefore asking NHS London to set up a system whereby excess health visiting staff can be identified and offered posts (after interview) in other parts of London.

NHS London may also be able to expand the system enabling a clearing house process with neighbouring areas that have excess health visiting students. Community providers in NW

London would be interested in setting up such arrangements with Buckinghamshire, Hertfordshire, Surrey and Berkshire.

5.2 Student Health Visitors

The Trust has assumed that the new centralised recruitment system will achieve the required target of doubling the number of student health visitors in this recruitment round (22 across the Trust in total). In June 2012 the Trust will find out if this target has been met and if not, the Trust will take a series of actions to attempt to boost the number of students.

6. Summary

The Health Visiting Service in Brent has maintained an average vacancy rate of 12 WTE over the past two years. It is anticipated that the new methods of recruiting and the planned Trust recruitment & retention strategy will support attracting more newly qualified Health Visitors to the service in the long-term.

The recruitment & retention component of the Health Visitor Implementation Plan has provided an opportunity to plan for an incremental increase in qualified staff based on a more equitable and needs-based approach. Overall the Implementation Plan has made good initial progress and is on target to deliver the trajectory agreed for 2012.

7. Recommendation

The Overview & Scrutiny Panel is asked to note the good progress of the Health Visiting recruitment plan in Brent.

Jacinth Jeffers
General Manager Children's Services – Brent
14 May 2012

Health Partnerships Overview and Scrutiny Committee
30th May 2012

Report from the Director of Strategy, Partnerships and Improvement

For Action

Wards Affected: ALL

Shaping a Healthier Future – Update on JOSC and Brent Out of Hospital Care Strategy

1.0 Summary

1.1 NHS North West London is working on its programme for health service improvement in the cluster area – Shaping a Healthier Future. There are three overarching principles guiding plans for service change in North West London. These are:

- **Localising** routine medical services means better access closer to home and improved patient experience
- **Centralising** most specialist services means better clinical outcomes and safer services for patients
- Where possible, care should be integrated between primary and secondary care, with involvement from social care, to ensure **seamless** patient care

1.2 There are two main elements to Shaping a Healthier Future. The first relates to the future of acute hospital services in North West London and is influenced by the aim of delivering more services in non-hospital settings. The Case for Change documents for Shaping a Healthier Future set out the reasons why NHS North West London is looking to reconfigure hospital services in the area, reducing the number of hospitals providing a full range of acute services. These are summarised below.

Challenges in North West London:

- A growing population – an extra 113,000 people in NW London over the next ten years
- An ageing population
- 31% of the population have long term chronic conditions such as heart disease, diabetes and dementia conditions which require longer term care and management
- The cost of care – drugs and technology – is increasing, while money for the NHS is limited
- Workforce shortages affect some hospital specialities

- The way our hospitals and primary care is currently organised will not meet the needs of the future

Hospital care varies:

- More hospital space in NWL than in other parts of the country and uses a greater proportion of the NHS budget on hospital care than average – not the best use of resources
- Three quarters of hospitals require upgrading to meet modern standards, at an estimated cost of £150m
- Hospitals in NW London have significant financial challenges even if they become as efficient as they can be
- Hospitals vary in the quality of care and the time it takes for them to see and treat patients
- Recent study showed patients treated at weekends and evening in London hospitals – when fewer senior staff are available – stand a higher chance of dying than if they are admitted during the week.
- The NHS needs to ensure that senior doctors and teams are available more often, seven days a week, 24 hours a day
- Changes in the last few years to London's heart attack, stroke and major trauma services have shown how more lives can be saved by concentrating specialist services on a smaller number of sites. Not every hospital can safely do everything

Differing outcomes for patients:

- Difference of up to 17 years in life expectancy between different boroughs in NW London
- Some ethnic groups have poorer health outcomes than others
- One in four patients in NW London dissatisfied with access to their GP
- Six of the eight boroughs in NW London are in the bottom 10% nationally for patient satisfaction with out-of-hours GP services.
- 20-30% of patients who are currently admitted to hospitals in NW London as emergencies could be more effectively cared for in their own community

1.3 NHS North West London is working on options for acute services that will mean a reduction in the number of major hospitals in the area, possibly to five. However, out-of-hospital services will be expanded and improved in all areas and all nine current hospitals will retain Local Hospital services, providing around 75% of all current activity (excluding specialist activity).

1.4 The possible reconfiguration of major hospitals in North West London will include, whatever option is chosen, Hillingdon Hospital and Northwick Park Hospital. These hospitals will remain major acute sites because of their geographical location, serving as they do large populations in outer North West London. Central Middlesex Hospital is likely to become an elective care centre and will no longer provide emergency care services (overnight A&E has already closed at CMH), although an Urgent Care Centre will remain on the site.

1.5 The consultation on hospital services will start at the end of June 2012 and is likely to focus on the following options:

- Option 1 – a reduction of nine major hospitals to five, with major acute services located at West Middlesex, St Mary's, Chelsea and Westminster, Northwick Park and Hillingdon Hospitals. The remaining hospitals

(Hammersmith, Charing Cross and Ealing will become local hospitals). This is likely to be the preferred option.

- Option 2 – As above for Option 1, but Charing Cross becoming a major acute site rather than Chelsea and Westminster.

- Option 3 – As above for Option 1, but Ealing becoming an acute site rather than West Middlesex.

1.6 Because of the cross borough nature of the proposals for hospital services, a Joint Overview and Scrutiny Committee made up of all boroughs in North West London (except Hillingdon who have declined to take part) has been established to scrutinise the proposals. The JOSC has been meeting informally, to contribute to the pre consultation work carried out by NHS London. Cllr Sandra Kabir and Cllr Ann Hunter have represented Brent at these informal meetings. Terms of reference have been drafted, along with a work programme for the JOSC. These need to be agreed by the JOSC once it is properly constituted. Participating council's have also agreed that each borough should have two representatives on the JOSC, but that there will only be one vote per council, should a vote need to be taken during JOSC proceedings. Some boroughs, including Brent, wanted one representative per council, others wanted two. This was agreed as a compromise.

1.7 As the consultation on hospital services begins, the JOSC will move into its formal meetings. The consultation will last for at least three months, and in the time the JOSC will hold a number of meetings with witnesses who will be able to provide evidence on the changes, and whether they should be endorsed or not. At the end of the process all participating boroughs will have to agree a final report for consideration by NHS North West London. NHS North West London will have to respond to this report and its recommendations.

1.8 The second main issue is the development of an Out of Hospital Care Strategy for each borough in North West London. Each Clinical Commissioning Group in North West London is working with its PCT and local authority to develop separate Out of Hospital Care Strategies. Consultation on the Out of Hospital Care Strategies will take place within each borough, and the Health Partnerships Overview and Scrutiny Committee will spend time at this meeting scrutinising Brent's strategy which is to go out for public consultation. Brent's Out of Hospital Care Strategy is an appendix to this report.

1.9 There are key themes emerging from the Out of Hospital Strategies across North West London:

- Easy access to high quality, responsive care to make out-of-hospital care first point of call for people
- Clearly understood planned care pathways that ensure out-of-hospital care is not delivered in a hospital setting
- Rapid response to urgent needs so fewer people need to access hospital emergency care
- Providers working together, with the patient at the centre to proactively manage LTCs, the elderly and end of life care out-of-hospital
- Appropriate time in hospital when admitted, with early supported discharge into well organised community care

1.10 Members of the Health Partnerships OSC should use the committee time to question representatives of Brent's Clinical Commissioning Group on their plans for out of

hospital care in the borough. A response to the consultation can also be sent from the committee, with recommendations for the Clinical Commissioning Group to consider and respond to.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to:

(i). Note the update on Shaping a Healthier Future and the North West London Joint Overview and Scrutiny Committee
(ii). Scrutinise the Brent Out of Hospital Care Strategy and question representatives from Brent Clinical Commissioning Group and NHS Brent on its contents
(iii). Decide whether it wishes to respond formally to the consultation on the Out of Hospital Care Strategy.

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Better Care, Closer to Home

Our strategy for co-ordinated, high quality out of hospital care

May 2012

DRAFT

Foreword

Growing up in Brent and being a local GP for 25 years, I am aware that we need to change the way we deliver and receive care. We need to ensure we preserve what we have done well and develop with our residents, partners from secondary care, local council and voluntary sectors, improved care for our patients.

We recognise demand for health care services is increasing as our population is living longer (which is good!), with increased long term conditions and lifestyle diseases, and available interventions are complex, expensive and require high level specialist skills. To respond to these challenges we need to improve our delivery of care in a more co-ordinated integrated approach, without compromising quality, delivering care in settings closer to home. This needs to be done by utilising people's skills and the buildings around us, in a cost effective manner. We also believe that we need to comply with good standards of care to bring about equity in health, quality and access.

Our ultimate goal is to maintain a healthy population with the ability to self-care, supported by healthy lifestyle choices, and the ability to get appropriate health and social care advice and care with ease and in a joined up manner, avoiding layers of duplication.

Brent residents have experienced the positive changes we have already made towards achieving this goal – such as the ability to be cared for at home (through our Short-Term Assessment, Rehabilitation and Reablement Service) and more proactive care (through Case Management). This is supported by practices working in established Locality networks, sharing extended services between practices, ensuring access of services is fair disregarding which practice one is registered with.

This strategy sets out how we will continue to improve care out of hospital, including:

- Our vision for future- our level of ambition and the out of hospital standards we will adhere to
- What we will do to make this change happen, how we will organise and the key enablers for success
- The financial investment we will make and the time frames for implementation

Brent CCG's vision "Our Health is in our Hands" signifies health is everyone's business. Let's work together to make our plans a reality!

Dr. Etheldreda (Ethie) Kong, CCG Chair, Brent.

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Executive summary

This strategy sets out how Brent CCG will commission and deliver better care for people, closer to home. It focuses on care provided out of hospital and follows the launch earlier this year by NHS North West London of Shaping a Healthier Future.

1. The case for improving out of hospital services

There are three main challenges for Brent that mean how health care in the borough is delivered needs to change.

1. The residents of Brent have changing health needs, as people live longer and live with more chronic and lifestyle diseases – putting pressure on social and community care
2. Under our current model of care, we cannot afford to meet future demand. We need to have more planned care, provided earlier to our population in settings outside of hospital. This should provide better outcomes for patients, at lower cost
3. However, this needs a **transformation of primary, community and social care**. Currently there is variation in both **quality and access** and standards must improve.

2. How care will be different for patients in future

We have a clear vision for delivering better care, closer to home in Brent and have started to commission new services that are allowing people to receive the care they need in their homes. At the heart of our vision is providing the right care, in the right place, at the right time to reduce reactive, unscheduled care and do more planned care earlier. There are 5 main areas where we will take action to achieve our vision:

A. **There will be easy access to high quality, responsive primary care** to make out of hospital care first point of call for people. GPs and primary care teams will be at the heart of ensuring everyone who provides care does so to consistently high standards of care.

B. **There will be clearly understood planned care pathways** that ensure wherever possible care is delivered outside of a hospital setting. Patients will have access to services closer to home.

C. **There will be rapid response to urgent needs** so that fewer patients need to access hospital emergency care. If a patient has an urgent need, a clinical response will be provided within 4 hours.

D. **Providers (social and health) will work together**, with the patient at the centre, to proactively manage people with long term conditions, the elderly and end of life care out of hospital.

E. **Patients will spend an appropriate time in hospital** when they are admitted, with **early supported discharge** into well organised community care.

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Health and Social Care commissioners are considering how they can work closer together to achieve this vision.

3. Delivering better care, closer to home

We will implement a number of key initiatives in each of these five areas. These will include:

- The new 111 phone number throughout North West London to provide a single point of access to health and care services
- A new referral facilitation and peer review system to support GPs making referrals on from primary care
- Providing some outpatient appointments in the community
- Establishing rapid response teams to deliver care in patient homes when appropriate
- Redesigning our pathways of care, encouraging providers to increase productivity by employing new ways of working
- Implementing a new model of care so that different providers work together in multi-disciplinary groups to provide seamless, integrated care for patient
- Investing and developing in primary care capacity so our existing gp practices can support more care outside hospital

4. How we will work together

To achieve our vision and implement these ambitious new initiatives will mean we need to change the way we work to deliver care in Brent.

Ensuring more care is delivered in the right setting and out of hospital means we need to change the way we do things. We have agreed on some organising principles as the basis for this change. Primary, community, social and mental health providers in the localities need to work together in networks to ensure care is coordinated and effective. We have **5** established localities, which will continue to function as existing networks, sensitive to locality needs of Brent's residents and working collectively to address pan Brent needs. The five Locality networks will consolidate their inter-practice relationships, ensuring there is an enhanced level of care in community settings and effective co-ordination of care across providers.

As we take activity into the community, we need to allocate both clinical and office space to this increased level of activity. We propose **four** Locality Health Centres, **two** Standard Hubs and **one** Hub+, based on our existing sites.

Out of hospital care will be organised and coordinated on three levels:

- **69 individual GP practices** will be responsible for routine primary care and have overall responsibility for patient health in their area.

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- **Five locality networks**, based on the current locality structures, will manage services like rapid response, case management, integrated care, specialist primary care, community nursing, community outpatients and end of life care.
- **The Borough/CCG** will be responsible for commissioning the new 111 phone service, rapid response out of hours care, diagnostics, community beds and acute care, including accident and emergency care.

5. Enabling improved healthcare

We will invest in better information systems, put in place stronger governance structures to hold providers to account and make sure patients have easy ways to tell us what is not working at every stage of care

We will invest in 5 key enablers to support better care, closer to home:

1. We will step up **patient, user and carer engagement** and improve our patient education and information. We will utilise the existing 5 Locality Patient Participation Groups to enable us to deliver on this commitment.
2. We will put in place clear **locality governance** and a system of support and **performance management** so that the benefits set out in this strategy are delivered.
3. We will put in place the right **information systems** and tools to support networks.
4. We will ensure that we have the right **contracts and incentives** to improve care and to underpin the new ways of working we need.
5. We will provide **training to localities** to support professional and organisational development, in particular in leadership, governance, culture and teamwork, IT skills and patient engagement. We will work closely with the NWL Local Education and Training Board (LETB) and Health Education and Innovation Committee (HEIC) and our practices to train and develop a **multi-disciplinary workforce**.

6. Next steps

The strategy set out here will form the basis of further, detailed discussions in the next few weeks with GPs, patients and families, other clinicians, partners in social care and public health, health and well-being board and others, leading to full public consultation in June. A detailed implementation plan for the strategy is outlined in this document.

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1. The case for improving out of hospital services

In this strategy, we are setting out our plans to transform out of hospital care and provide better care, closer to home. Excellent out of hospital services are essential if Brent is to maintain quality of care in the face of increasing demand and limited resources. If we hope to maintain and improve standards in the face of these challenges, we must dramatically change the way we deliver primary, community and social care. In particular, in order to provide better care out of hospital, we will need to improve the quality of and access to primary care. The challenges we face are laid out in Exhibit 1:

EXHIBIT 1

This section has described why out of hospital care in Brent needs to change so that we respond to these challenges urgently. The next section describes our vision for out of hospital care in Brent and what these changes will mean for patients.

2. Our vision for how care will be different for patients

We have a clear vision for how out of hospital care in Brent will look in future:

> Brent CCG will provide an integrated preventative model of health and social care services across intermediate care. Building on existing work by the Short-Term Assessment, Rehabilitation and Reablement Service (STARRS) and case management, we will broaden the preventative model by targeting a wider cohort of patients, removing duplication and improving productivity across the health and social care economy. The scope of primary care will be expanded to be central to co-ordination of multidisciplinary services. This may also involve integrating community reablement services provided by Brent social services, with the rehabilitation service provided by Brent Community Services

At the heart of our vision is providing the right care, in the right place, at the right time to reduce reactive, unscheduled care and provide more planned care earlier in the patient's journey. We will achieve our vision by improving patient care in 5 areas as shown on Exhibit 2.

EXHIBIT 2

We will achieve our vision by improving patient care in 5 areas

		Specifically, this means
	Easy access to **high quality, responsive primary care** to make out of hospital care first point of call for people	GPs and primary care teams will be at the heart of ensuring everyone who provides care does so to consistently high standards of care
	Clearly understood planned care pathways that ensure out of hospital care is not delivered in a hospital setting	Whenever possible, patients will have access to services closer to home
	Rapid response to urgent needs so that fewer patients need to access hospital emergency care	If a patient has an urgent need, a rapid clinical response will be provided
	Providers (social and health) working together, with the patient at the centre to proactively manage **LTCs**, the **elderly and end of life care** out-of hospital	Patients will have a named coordinator who will make sure they have all the services they need. If a patient's condition becomes more complex, GPs will be able to direct to a clinician with specialist skills close to home
	Appropriate time in hospital when admitted, with **early supported dis-charge** into well organised community care	Care providers will know when an individual patient is in hospital and will manage discharge into planned, supportive out of hospital care

2.1 EASY ACCESS TO HIGH QUALITY, RESPONSIVE PRIMARY CARE

We are committed to expanding and improving primary care so it meets patients' expectations and is fit for the future. We will provide recurrent investment in more GPs and nurses so that practices and networks so that we can offer the following:

- Improved access through all practices being open from 0830hrs to 1830hrs Monday to Friday and extended hours access at some locality practices, and at our GP Access Centre, Wembley and Urgent Care Centres (at Central Middlesex Hospital, Northwick Park, and St Mary's).
- Bookable GP sessions across both mornings and afternoons.
- Access to a health care professional within 24 hours for urgent care and 48 hours for routine care
- 100 bookable clinical appointments per 1,000 weighted population as well as appointments being bookable up to 4 weeks in advance.
- At least one FTE nurse per 3,000 patients (e.g. for wound care)
- Choice of male or female GP
- Better Outcomes for patients as set out in our Commissioning Plans.

This will be supported by providing individuals with up-to-date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and well-being.

This will mean that our patients' experience of primary care will improve (as outlined in Exhibit 3).

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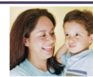
EXHIBIT 3

Easy access to high quality, responsive primary care

Claire is 36. She is a working mother who struggles to manage her work and home life. She has a young son, Jason who is 4 years old and has a fever and rash.



Primary care has been difficult for some patients to access, putting pressure on other parts of the health system…

Claire comes home form work at 6pm to find her son has come back from nursery with a fever and rash	Claire rings her GP but cannot get through. After several attempts decides to take Jason to her local A&E	A&E is crowded and there is long wait. The conditions are stressful and Jason's condition worsens.	Treatment is transactional. Jason misses out on opportunity for broader child welfare e.g., staff do not make sure jabs up to date, check Claire is coping
Claire uncertain what best course of action is and who to contact	Stressful and time consuming process for Claire to find a solution	A&E staff feel overwhelmed by flow of unscheduled patients	Claire grateful for treatment and idea of A&E as place to get care is reinforced

In future, patients will have better access to primary care and know how to get it . . .

Claire comes home form work at 6pm to find her son has come back from nursery with a fever and rash and calls 111	111 gives her an appointment in a local practice which is running extended hours on that day.	An appropriate member of the Primary Health Care (PHC) team accesses and examines the child having access to the child & family's health records. A diagnosis of viral rash is made and they are sent home.	If it was something more serious (e.g. rash with query meningitis), then the member of the PHC would administer antibiotic and dial 999 and alert the appropriate Paediatric team
Claire understands that 111 can direct her to the most appropriate care	She is relieved and reassured, feeling confident in the system	Claire is reassured and feels confident to see episode through	A complete record of the event is communicated to the family's GP by the next morning

2.2 CLEARLY UNDERSTOOD PLANNED CARE PATHWAYS

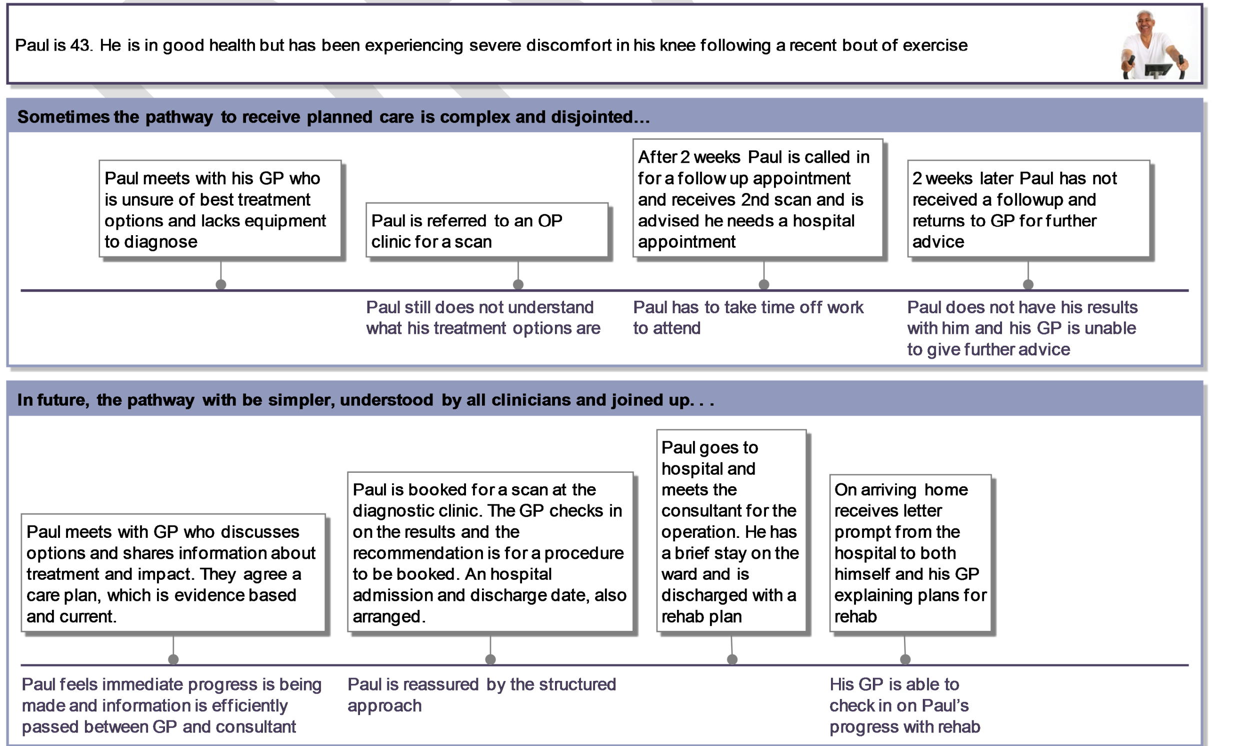
We will put in place more specialist services in the community so that out of hospital care is delivered in a more appropriate setting:

- Out of hospital care will be a seven days a week service.
- Community health and care services will be accessible, understandable, effective and tailored to meet local needs. Service access arrangements will include face-to-face, telephone, email, SMS texting and video consultation.
- To ensure that care pathways are effective, with an individual's consent, relevant parts of their health and social care record will be shared between care providers improving the way we work together.
- Monitoring of patients by health professionals will identify any changing needs so that care plans can be reviewed.
- The intention is that by 2015, all patients will have online access to their health records.

As part of our process of pathway re-design, we have re-designed our diabetes pathway, with a Local Enhanced Service in place on provision of diabetic care up to insulin management and support, either at one's own practices or within the setting of the localities.

This will mean that our patients' experience of planned care will improve (as outlined in Exhibit 4).

EXHIBIT 4



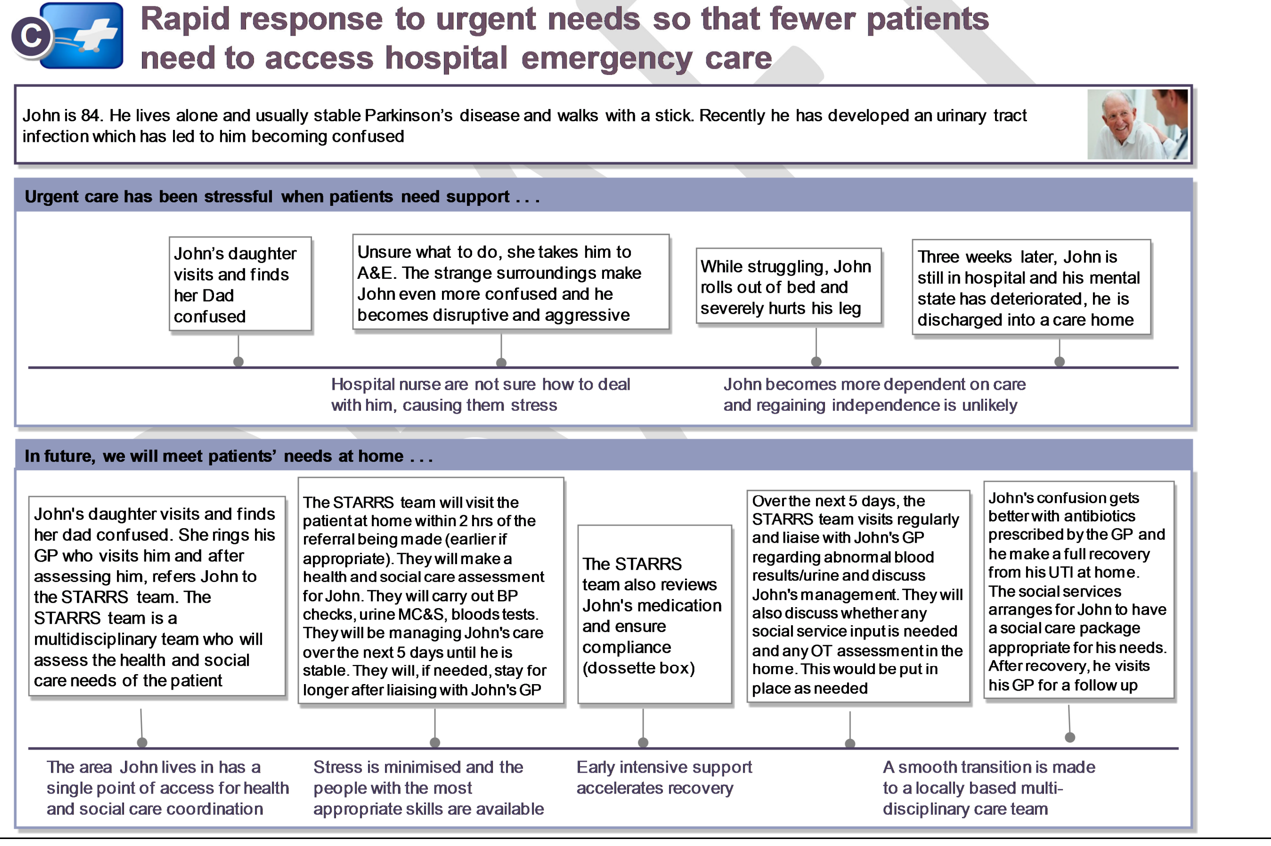
2.3 RAPID RESPONSE TO URGENT NEEDS

Hospital admissions should be appropriately prevented wherever possible. We know at present people are admitted to hospital when a rapid community response could keep them in their own homes. To support this, we have set up multi-disciplinary rapid response team, who will go to the patient's home where they have been assessed as being at risk of admission to hospital. We will aim to avoid unnecessary admission by providing expert advice, services, diagnostics or the supply of equipment. Patients will access the service by calling the 111 number and a response will be made within two hours.

The rapid response team and other out of hospital care initiatives are expected to prevent 2,000 emergency admissions a year in Brent.

This will mean that our patients will be able to receive rapid care when their need is urgent (as outlined in Exhibit 5).

EXHIBIT 5



2.4 INTEGRATED CARE FOR PEOPLE WITH LONG TERM CONDITIONS AND THE ELDERLY

We will ensure that there is more effective working between social and health teams to support people with long term conditions, the elderly and people nearing the end of their lives to stay out of hospital and have the support they need.

Patients and their carers tell us that they sometimes fall between the gaps in services.
In future, we will ensure that patients and their families in Brent who need community health and social care will experience coordinated, seamless and integrated services using evidence-based care pathways, case management and personalised care planning.

This will be facilitated by 5 multidisciplinary groups (MDGs), based on our current locality structures, working across Brent as part of the Outer North West London Integrated Care Pilot. The MDGs will be made up of local GP practices and other providers from community health, mental health, acute hospitals and social care for those patients most at risk of a hospital admission They will work together to identify and review patients at risk of becoming ill. Initially these groups in Brent will focus on the over 75s. Additionally, case management systems currently piloted at 2 localities will be rolled out to all 5 localities. Such integrated care will be better for patients as they will receive proactive care to keep them well, will not suffer from gaps in provision between services and will not have to constantly repeat their story. It will also be better for professionals as they will have access to full patient information and will be able to learn from colleagues with different expertise developing shared priorities for patients. Integrated care should be better value for taxpayers by reducing costly emergency admissions and visits to hospital, making preventative care across health and social care settings a reality.

Some of the benefits of integrated and proactive care we will have for our patients are outlined in Exhibit 6.

EXHIBIT 6

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Providers (social and health) working together, with the patient at the centre

Laura, 75 years old smoker has recently been diagnosed with COPD and lives at home with her husband Jim.

Urgent care has been stressful when patients need support . . .

- After visiting her GP, Laura is diagnosed with having a Stage 2 COPD and is put on an inhaler. After a period of no improvement Laura's GP prescribes her a stronger dose
- After a series of complications, Laura is referred to a Chest physician. Laura's visit is extended as the specialist does not have access to Laura's records, and has no indication about the progression of Laura's condition.
- Unexpectedly, Laura is admitted to A&E and inpatient care for one week later with breathlessness
- Laura is discharged to home, but her records and history are not available to either social care works or district nurses during their follow up visits.

In future, we will meet patients' needs at home . . .

- Laura is indentified as a patient in need of an integrated care plan by her GP. Her care plan and results of investigations is made available to all health care professional involved in her care
- Laura is discussed by her GP at a case conference with a specialist Chest physician and other members of the community and hospital respiratory team . They identify that Laura needs education on how to use her inhaler properly, rather than a stronger dose prescription.
- Nonetheless, Laura experiences complications, however on referral, her Chest physician has access to Laura's care records both at primary and secondary care so that a full assessment can be made of her condition and progress
- Admissions to A&E or interaction with social care are also supported by having her care plan accessible to all. Upon discharge the care plan recommends multi-disciplinary pulmonary rehab and self management and would be followed up with a visit at home by a specialist team

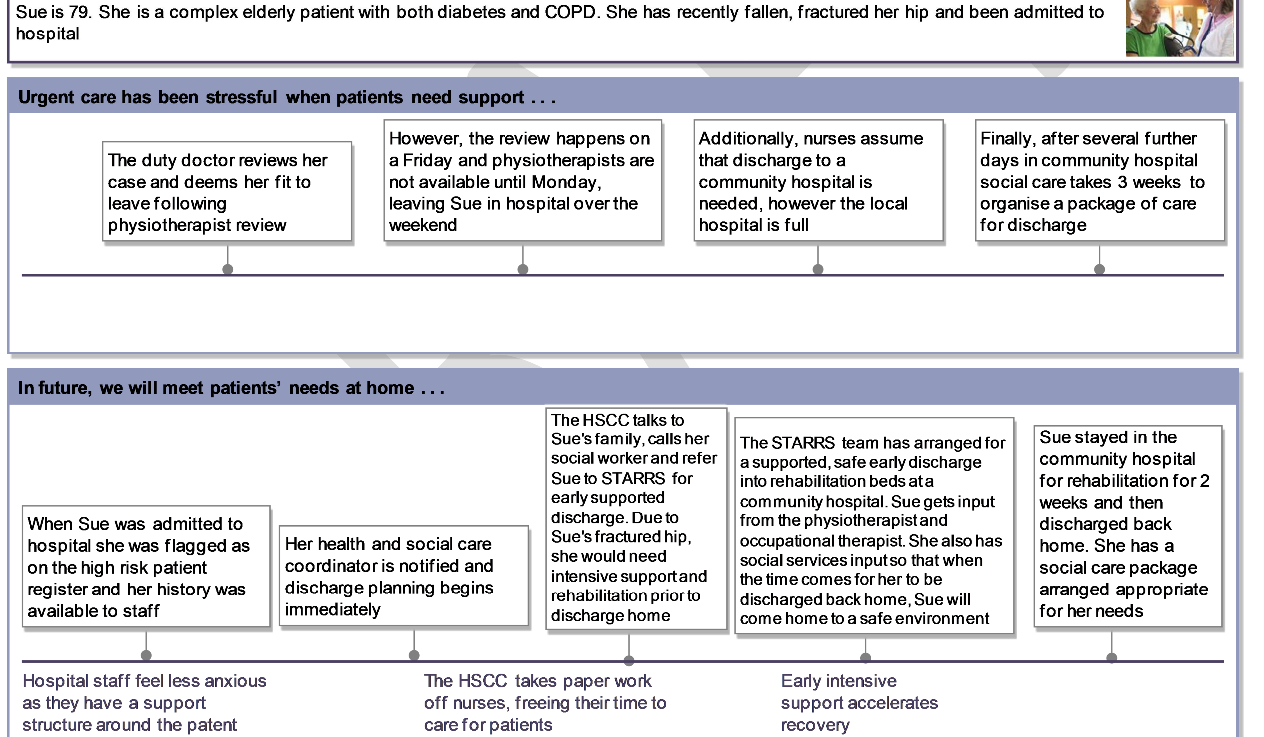
2.5 APPROPRIATE LENGTH OF TIME IN HOSPITAL AND SUPPORTED DISCHARGE

We will put in place properly planned discharge and support for patients who can be discharged from hospital so that they avoid longer stays than they need. The patient's GP and other providers of health and social care will be involved in coordinating an individual's discharge plan (including intermediate care and reablement) as well as continuing care needs.

There will be more joined-up discharge support, with an appropriate step-down in care (e.g. step-down beds in a community hospital), prompt communication to other providers and clear advice and information for patients.

This will mean that our patients will not stay in hospital when it is not best for their care (as outlined in Exhibit 7).

EXHIBIT 7



2.6 STANDARDS TO MAINTAIN THE QUALITY OF CARE

Patients and the public need to be confident that as we change where and how patients are cared for, we will hold ourselves to high clinical standards of care in the community. Therefore, we have agreed standards that set our aspirations for the future. They emphasise the central role of the GP in the coordination and delivery of out of hospital care. The standards encompass both core primary care delivered by GP practices and, more broadly, care delivered outside of hospital. They aim to shift care delivery from more reactive unplanned care to proactive planned care.

EXHIBIT 8

Domains	The standards are covered in four key domains
Individual Empowerment & Self Care	▪ Individuals will be provided with up-to-date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and wellbeing
Access convenience and responsiveness	▪ Individuals will have access to telephone advice and triage provided 24 hours a day, seven days a week. As a result of this triage: ▪ Cases assessed as urgent will be given a timed appointment or visit within 4 hours of the time of calling ▪ For cases assessed as not urgent and that cannot be resolved by phone, individuals will be offered the choice of an appointment within 24 hours or an appointment to see a GP in their own practice within 48 hour
Care planning and multi-disciplinary care delivery	▪ All individuals who would benefit from a care plan will have one. ▪ Everyone who has a care plan will have a named 'care coordinator' who will work with them to coordinate care across health and social care ▪ GPs will work within multi-disciplinary groups to manage care delivery, incorporating input from primary, community, social care, mental health and specialists
Information and communications	▪ With the individual's consent, relevant information will be visible to health and care professionals involved in providing care ▪ Any previous or planned contact with a healthcare professional should be visible to all relevant community health and care providers, ▪ Following admission to hospital, the patient's GP and relevant providers will be actively involved in coordinating an individual's discharge plan

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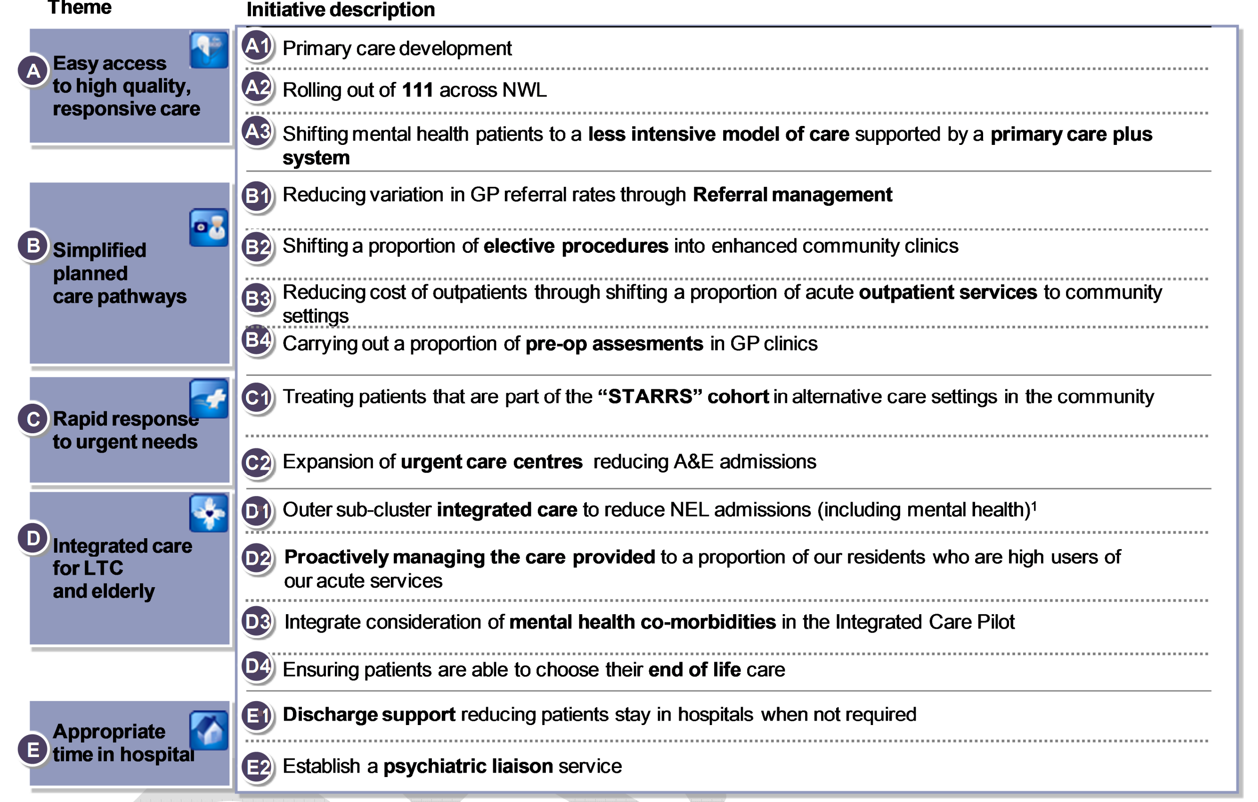
3. How we will deliver better care, closer to home

This section sets out the key initiatives we will take to deliver improved care out of hospital in each of the six areas described previously. Some of these initiatives are new and specific to Brent, while others are part of broader work such as the 111 service. Exhibit 9 outlines the out of hospital initiatives we will be implementing.

EXHIBIT 9



Theme	Initiative description
A Easy access to high quality, responsive care	A1 Primary care development
	A2 Rolling out of **111** across NWL
	A3 Shifting mental health patients to a **less intensive model of care** supported by a **primary care plus system**
B Simplified planned care pathways	B1 Reducing variation in GP referral rates through **Referral management**
	B2 Shifting a proportion of **elective procedures** into enhanced community clinics
	B3 Reducing cost of outpatients through shifting a proportion of acute **outpatient services** to community settings
	B4 Carrying out a proportion of **pre-op assesments** in GP clinics
C Rapid response to urgent needs	C1 Treating patients that are part of the **"STARRS" cohort** in alternative care settings in the community
	C2 Expansion of **urgent care centres** reducing A&E admissions
D Integrated care for LTC and elderly	D1 Outer sub-cluster **integrated care** to reduce NEL admissions (including mental health)[1]
	D2 **Proactively managing the care provided** to a proportion of our residents who are high users of our acute services
	D3 Integrate consideration of **mental health co-morbidities** in the Integrated Care Pilot
	D4 Ensuring patients are able to choose their **end of life** care
E Appropriate time in hospital	E1 **Discharge support** reducing patients stay in hospitals when not required
	E2 Establish a **psychiatric liaison** service

3.1 EASY ACCESS TO HIGH QUALITY RESPONSIVE PRIMARY CARE

Initiative A1: Primary care development

We have established a programme to expand and improve the quality of primary care in Brent in four key areas: clinical outcomes, service, enhanced primary care, patients and the public. The programme will have an incentive scheme with ten indicators taken from the London Outcomes Framework (LOF). Each practice will be supported to develop a practice plan for how they will achieve the indicators and how that will improve services. The programme will strengthen working relationships between practices, encourage the development of Clinical Commissioning Group, and will enable primary care to be better placed to deliver more services in the context of current NHS changes.

Improved quality of primary care will be supported by an expansion in primary care capacity. We will agree capacity and delivery plans with practices to support them in meeting the out of hospital standards through funding additional healthcare professional capacity.

For patients, this will mean improvements in quality, consistency and access so that their choice of GP will be based on location and convenience. This will also mean that patients have a choice of a male or female GP.

Initiative A2: Single point of access through the new 111 phone number

The roll out of the new 111 phone number across NHS North West London will provide a single point of access for patients, carers and clinicians to the appropriate level of care. The free to call 111 number is available 24 hours a day, 7 days a week, 365 days a year. Patients will call 111 when:

- They need medical help fast, but it is not a 999 emergency
- They do not know who to call for medical help or do not have a GP to call
- They think they need to go to A&E or another NHS urgent care service
- They require local health information or reassurance about what to do next

The NHS 111 service will provides management information to commissioners on the demand for and usage of services to enable the commissioning of more effective and productive services that are designed to meet people's needs.

Call handlers will be highly trained and supported by experienced clinicians. They will follow agreed clinical pathways and will have access to a local directory of services, with escalation to clinical support as appropriate. Agreed service standards will mean that urgent cases will be dealt with within 4 hours, and those whose needs are not urgent will be seen within 24 hours, or 48 hours if they want to go to their own GP practice.

For patients, this will mean quick and easy direction to the right level of care.

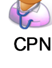
Initiative A3: Shifting mental health patients to a less intensive model of care supported by a primary care plus system.

For people who are being treated by a mental health provider, there is an opportunity to provide more care from primary care. As many as 10% of patients currently under the care of mental health trusts have low level needs that could be met in primary care.

Having GPs responsible for more patients with non-complex mental health needs will require a structured approach. It is proposed that an agreed pathway is adopted for the transfer of responsibility for care from community mental health teams to GP practices. This will include setting criteria for the transfer of responsibility, a case review to confirm criteria have been met and joint work between the community mental health team, the GP and the patient to develop a care plan. Primary care will also have access to ongoing support in the form of a "primary care plus system" outlined in Exhibit 10.

EXHIBIT 10

Ongoing CPN support for more complex patients



- CPNs provide low level step down care to patients transferred from secondary care into primary care
- Average 2-3 contacts per patient in first 6 months step down
- Annual assessment
- 2-3 appointments per patient per year
- Follow up aid from care support worker
- CPN work overseen by 1 psychiatrist in each borough
- Patient care remains the overall responsibility of the GP at all other times

Mental health training for GPs

- Dedicated course aimed at providing education in basic mental health care, for example:
  - 4-6 week course, 1 evening per week
  - Run by experienced mental health experts
  - Each practice nominates 1 members to participate
- Courses run annually to ensure continual training

Expert mental health advice for GPs

- Telephone and e-mail support from mental health consultant:
  - Part of "on call" duties for consultant
  - 5 hour per week per CCG dedicated to answering GP mental health questions (e.g., advice on medication, care plans etc.)
- Informal coaching of GPs as part of involvement in ICP MDG meetings

Mental health induction for GP surgeries

- Annual session run by CPN in each GP surgery to provide overview of care for mental health patients, including:
  - Discussion of unique care requirements of mental health patients
  - Introduction to patient care pathway
  - Provision of information on further support for mental health patients (e.g., voluntary sector)

SOURCE: Working group

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3.2 CLEARLY UNDERSTOOD PLANNED CARE PATHWAYS

Initiative B1: Referral facilitation

We will launch a new referral facilitation and peer review system to support GPs in the decision making process when they make referrals on from primary care. In this way, we will not only reduce the number and costs of referrals but also improve the quality of decision making by GPs.

The system will involve continuous professional development, peer review, implementation of best practice and increased use of benchmarking and current data.

GPs will take part in skills development sessions, undertake regular and frequent peer review and will attend referral panels with GP clinical champions.

This will mean that patients will only be referred for further investigation or treatment when it is really necessary.

Initiative B2: Move some elective procedures from secondary to primary care

Brent CCG has identified procedures that could be performed outside a hospital setting by GPs and specialist providers in enhanced community clinics. This project will be carried out in full discussion with GPs and potential specialist providers. Primary care services will, as a result, be able to identify potential specialist procedures they are able to provide though clinical networks. Those procedures that cannot be provided in primary care can be opened up to other potential providers on the basis of quality and cost.

For patients, this will mean having services delivered closer to home.

Initiative B3: Move a proportion of acute outpatient services to community settings

Similarly, we will take a two-tier approach to plan outpatient care. Some services will be provided by GP networks as a Local Enhanced Service. Where services can be provided by a specialist provider, including networks, this will be done through competitive dialogue (developing specifications in collaboration with potential providers). In Brent, this is already the case for ophthalmology and cardiology outpatient services.

Services will be commissioned on the basis of outcomes, with providers expected to deliver on a set of clearly defined clinical and patient reported measures. Bids will be assessed on three criteria: quality of service, cost effectiveness and capacity and resilience.

For patients, this will mean high quality outpatient services and better value for money.

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3.3 RAPID RESPONSE TO URGENT NEEDS

Initiative C1: Treating patients that are part of the "STARRS" cohort in alternative care settings in the community

Brent CCG has already begun to implement the STARRS program which involves short-term, intensive interventions which prevent hospital admissions and enable patients to reach their rehabilitation potential before moving on to their ultimate care destination. This includes both time-bound rehabilitation (health therapy care) and reablement (social care, with therapy management).

The key operational elements of the service are a Rapid Response team and a short-term service. The rapid response team will carry out urgent assessment and intervention to stabilise a patient for a maximum of 72 hours as an alternative to A&E attendance or short term hospital admission, whilst the short-term service will include temporary beds (health step-up and step-down beds and social care beds) and time-bound reablement/rehabilitations services. To ensure the continued success of our rapid response service we will focus on improving awareness of the service among patients and carers.

For certain patients, the STARRS programme will mean they will not have to go to hospital to receive rapid assessment and medical support but will receive this promptly in their own home.

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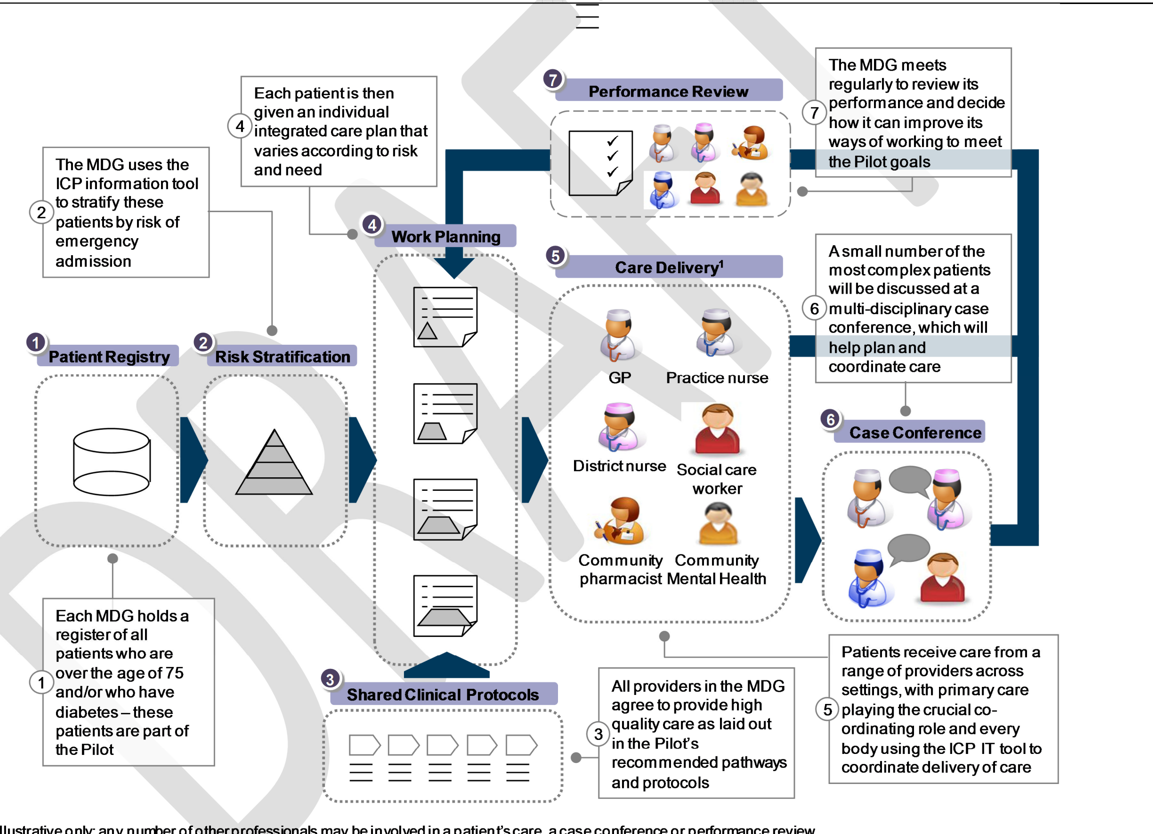
3.4 INTEGRATED CARE FOR PEOPLE WITH LONG TERM CONDITIONS AND THE ELDERLY

Initiative D1: Integrated care pilot

Brent will implement a model of integrated care with other CCGs in outer North West London. Integrated care is an internationally proven system of bringing health and social care services together to work in a model of care that supports and develops multidisciplinary working between local GP practices and other providers from community health, mental health, acute hospitals and social care for those patients most at risk of a hospital admission.

We will establish five multidisciplinary groups across Brent who will work together to identify and review patients at risk of becoming ill. Initially their focus in Brent will be on the over 75s. Exhibit 11 outlines how the integrated care model will work in practice.

EXHIBIT 11



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Aligned services will

- Enhance patient, user and career involvement
- Share joint governance through the integrated management board and borough-based management groups with a shared performance framework
- Align incentives through an innovative financial model (e.g, innovation fund to pump-prime investment into services)
- Have access to timely data analysis and information sharing

- Develop a strong organisational culture (through holding each other to account in performance review discussions)
- Deliver substantial financial savings
- Improve professional experience via joint governance, aligned incentives and transparent information sharing

For patients, integrated care by multi-disciplinary groups will mean seamless, preventive care, which will reduce the likelihood of unplanned admission to hospital.

Initiative D2: Integrate consideration of mental health co-morbidities in the integrated care pilot

People who have a physical long term health need, such as diabetes, are also more likely to have mental health problems. And where these mental health "co-morbidities" exist, care can be between 45-75% more expensive than for patients with just the physical ailment[1].

Therefore, it is crucial that the Integrated Care Pilot consider mental health needs. For patients this will include mental health screening as part of annual reviews and specially tailored psychological therapy sessions when necessary. Exhibit 12 below outlines how mental health will be considered at each stage from patient registry through to case conference discussions.

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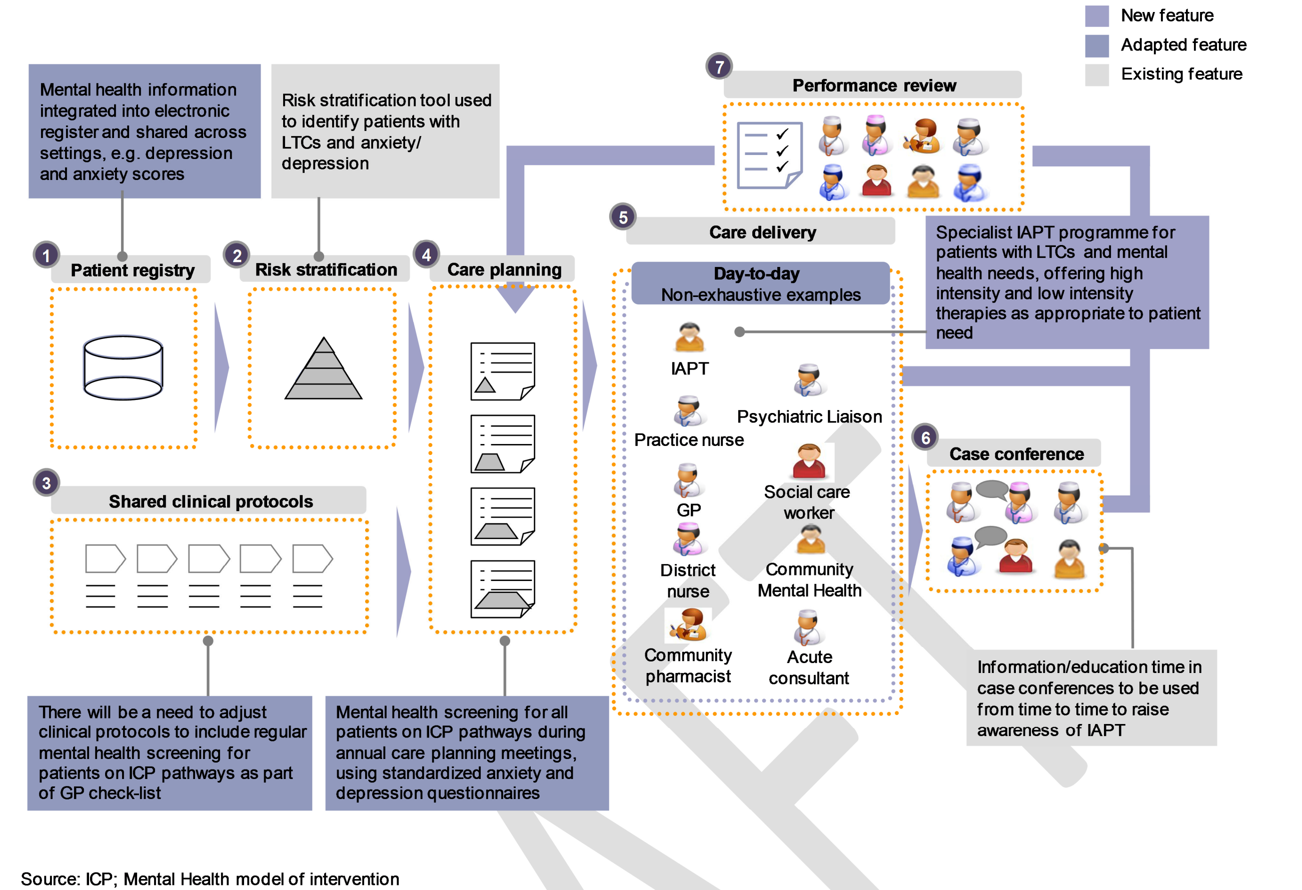
[1] "Long-term conditions and mental health: the cost of co-morbidities," Chris Naylor et al., February 2012, King's Fund and Centre for Mental Health.

EXHIBIT 12



Source: ICP; Mental Health model of intervention

Initiative D3: Proactive case management for frequent users of hospital services

All patients who have had three or more emergency admissions in the previous year or who are identified as being at significantly increased risk of emergency admissions will be referred for case management by experienced community nurses. These patients will have care plans and support in primary care to reduce their need for hospital admissions, which will be better for patients and better for the health system. The community nurses will work closely with GPs to ensure these patients have appropriate proactive care in place.

Initiative D4 : Ensuring patients are able to choose their end of life care

Patients who have expressed a wish to remain in their own homes as they approach the end of their lives frequently end up being admitted to hospital. The Brent end of life strategy seeks to move the place of death for 70% of people on the end of life pathway out of hospital and back into the community, preferably their own homes. For this group of patients, we also aim to reduce by 70% the number of spells in hospital for unplanned care.

We will achieve this by using the London-wide end of life register in Brent which records patients' wishes on their place of death; raising skills of staff and standards of care by greater use of the Gold Standards Framework and the Liverpool Care Pathway; and by providing incentives for practices to ensure staff time for training on these tools. We will increase our capacity to provide care outside hospital and this will include 24/7 support for hospice at home.

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3.5 APPROPRIATE LENGTH OF TIME IN HOSPITAL AND SUPPORTED DISCHARGE

Initiative E1: Reducing patients stay in hospitals with our discharge team

One function of our STARRS team is to facilitate the safe early discharge of patients from acute hospital wards

The service is designed for patients who would benefit from a short-term crisis intervention in a community setting. The team will be accessed by a single point of contact. Staff will undertake a full assessment of patient needs within 2 hours. The team will draw up a care plan with clear goals for the patient to work towards that is responsive to their needs. Each patient will be allocated a single case manager to coordinate the care for that patient across the health and social care economies as part of the virtual team. Where appropriate, the patient will receive a package of care over a 24 hour period, 7 days a week. The case manager will monitor the patient's progress throughout the intervention. Referrals will be made by the case manager in consultation with the patient and directed to appropriate health and social care agencies.

This will mean patients who are medically fit for discharge but require continued support will be able to receive this in their own home, avoiding unnecessarily lengthy hospital stays.

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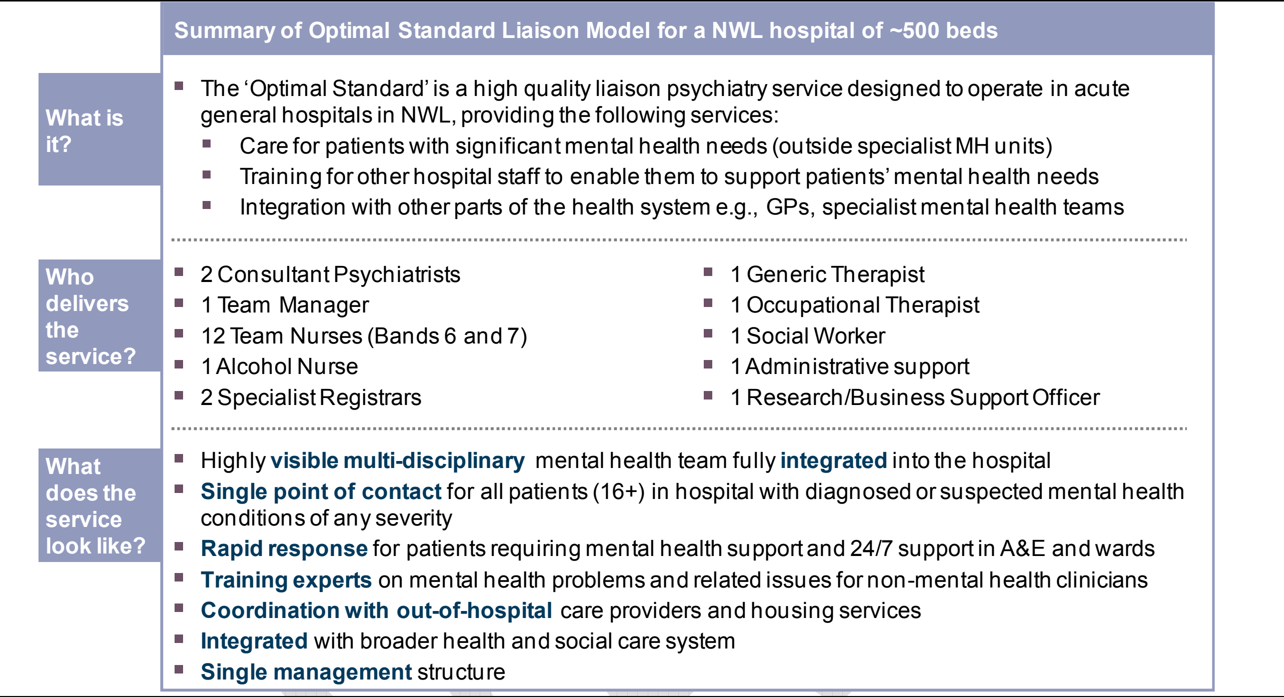
Initiative E2: Establish a psychiatric liaison service

A psychiatric liaison service will be set up. The liaison team will be multidisciplinary as outlined in Exhibit 13. These teams are a flexible resource within the hospital that can be deployed anywhere to support patients with mental health problems. This may prevent unnecessary admission into hospital or for existing inpatients it should mean quicker discharge (more often to a patient's own home) and overall improved outcomes.

EXHIBIT 13



Having the psychiatric liaison team in place should help all clinicians by ensuring better mental health care in acute hospitals with improved risk management. One of the roles of the liaison team will be to train staff members in mental health care. For the whole health and social care system, there should be benefits in terms of fewer admissions, reduced length of stay and lower accommodation costs for local authorities (with more patients discharged directly home).

For patients psychiatric liaison will mean their mental health needs are treated earlier.

Conclusion

The new services that we have described in this section will mean that we need to put in place new ways of working. The next section sets out how we will do this so that patients, carers, users and professionals are well informed and have confidence in the success of the new services and so that the changes are handled well.

4. How we will work together

To achieve our vision and implement these ambitious new initiatives will mean we need to change the way we work to deliver care in Brent. Exhibit 14 outlines the 6 aspects to this:

EXHIBIT 14

1. We need to change the way we do things – and we have agreed some **organising principles** we need to stick to as we change
2. Primary, community, social and mental health providers in the localities need to work together in **networks** to ensure care is coordinated and effective
3. As we take activity into the community, we need to allocate both **clinical and office space** to this increased level of activity – we are proposing making use of our existing sites to support this
4. There are three distinct **'levels' of care** where it makes sense to co-ordinate **services** locally vs. Borough level – and have therefore organised how services are managed and delivered outside the GP and acute setting
5. To deliver care effectively in networks requires new ways of working, including care coordinators, and network coordinators

The following sections look at these 6 aspects in more detail.

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4.1 ORGANISING PRINCIPLES

The strategy we are proposing for Brent involves big changes in how and where care is delivered: it includes integrated care, case management and rapid response; beds in the community; and some outpatient appointments and some elective procedures taking place in the community. To deliver these significant changes, **providers need to work more closely together to ensure care is organised around the patient and to extend the range of services offered in the community.**

To guide this closer working, we have developed some organising principles:

- We need to organise in a way that enables **collaboration and co-ordination** of care across Brent
- We must **avoid duplication** of activity
- Activity should be delivered at most efficient point **financially**, equally balanced with where it is **most effective** for the patient
- **Care will be GP-led, with primary care teams** remaining central to patient care
- We should design our care around Locality **network practice population** which broadly reflects geographical boundaries
- **Existing contracting arrangements** should not constrain the design.
- **Workforce, training and planning should support these organising principles.**

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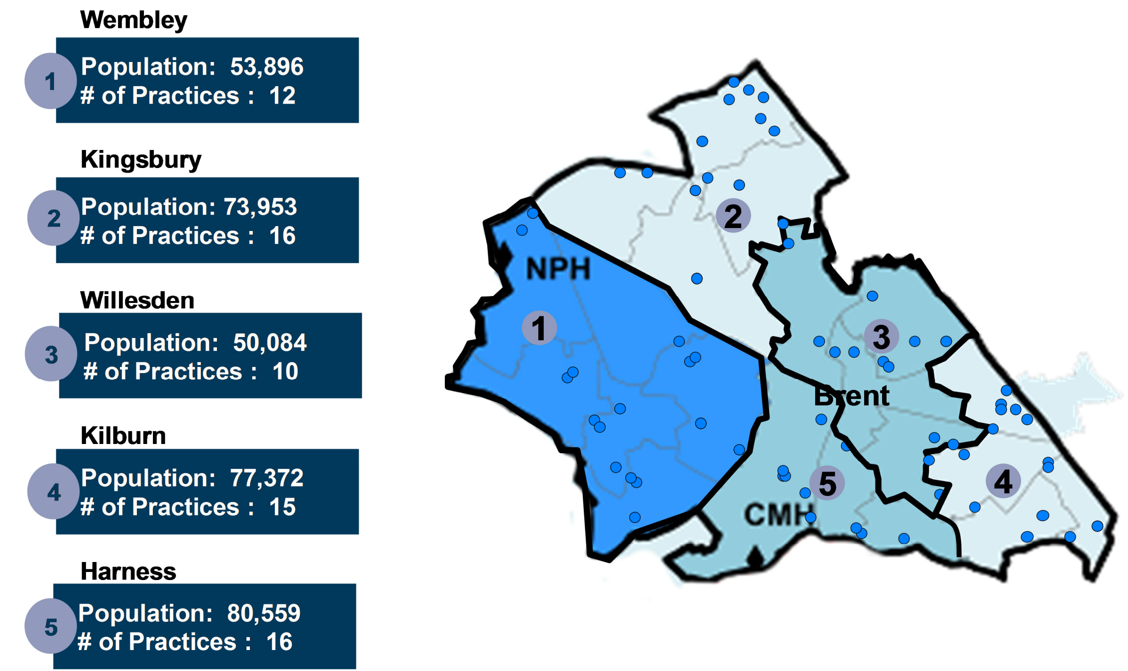
4.2 PRIMARY, COMMUNITY, SOCIAL AND MENTAL HEALTH PROVIDERS IN THE LOCALITIES NEED TO WORK TOGETHER IN NETWORKS

In Brent we have established GP networks working together to improve outcomes for patients, we have already successfully worked together to deliver effective immunisation, health risk checks, and stop smoking campaigns. We will continue to organise ourselves as 5 Locality networks based on our current localities/multi-disciplinary groups. The five Locality networks will provide an enhanced level of care in community settings and will also collaborate with other providers to provide integrated primary and secondary care services.[2] Exhibit 15 shows the location and sizes of the 5 Locality networks in Brent.

EXHIBIT 15



3 out of 5 of our localities already have established social enterprise bodies for provision of care as networks.

4.3 WORKING WITH OUR PARTNERS TO PROVIDE COORDINATED CARE

In order to provide seamless and well-co-ordinated care in Brent, the CCG is committed to working very closely with its partners.

One of the important ways in which we will improve the way we work together is by establishing five multidisciplinary groups across Brent who will work together to identify and review patients at risk of becoming ill. The role of multidisciplinary groups is outlined below in Exhibit 16:

EXHIBIT 16

The role of multidisciplinary groups:
Multidisciplinary groups are made up of primary care, social care and mental health staff. They share a database of patients which they can utilise to identify the patients most at risk of hospital admission (known as "risk stratification"). The multidisciplinary group has agreed clinical pathways of proactive interventions to keep people out of hospital and through a regular process of work planning, each patient will have an integrated care plan, developed in consultation with them.
High risk patient cases are discussed at monthly case conferences by the members of the multidisciplinary group. There will also be regular performance review meetings to hold different providers to account, evaluate the effectiveness of local care pathways and propose key investments to close gaps in care delivery. An IT tool is being procured which will automate much of the data for the ICP, including risk assessment, work planning and messaging between providers. Providers will be reimbursed for the care coordination activities (work planning, case conferences and performance reviews) done to deliver integrated care. Exhibit 5 shows the working arrangements of the multidisciplinary groups.

In addition to MDGs, Brent CCG and social care are exploring the benefits and risks of integrated commissioning. If this was pursued health and social care budgets could be pooled to support earlier intervention.

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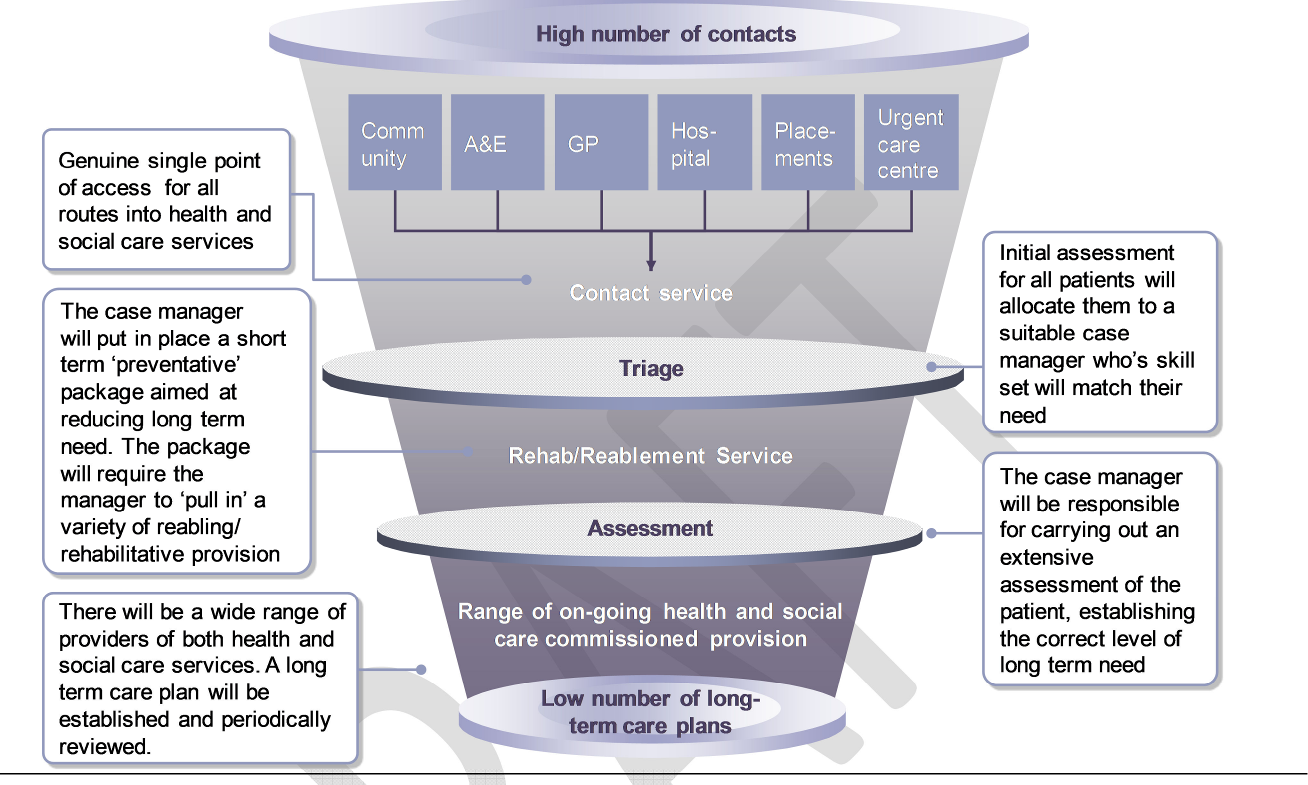
To improve coordination amongst providers, we will put in place a genuine single point of access to coordinate patient referrals from multiple providers. This will be supported by a case manager who will put in place care packages (for those patients who it is deemed necessary) aimed at reducing long term need of patients. The structure of our integrated, preventative model of care is outlined below in Exhibit 17.

EXHIBIT 17



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4.4 ALLOCATING SPACE TO SUPPORT THIS INCREASED LEVEL OF ACTIVITY

As we take activity into the community, we need to allocate both clinical and office space to this increased level of activity. There will be three tiers where services are provided: **the Hub+, Standard Hubs** and **Locality Health Centres**.

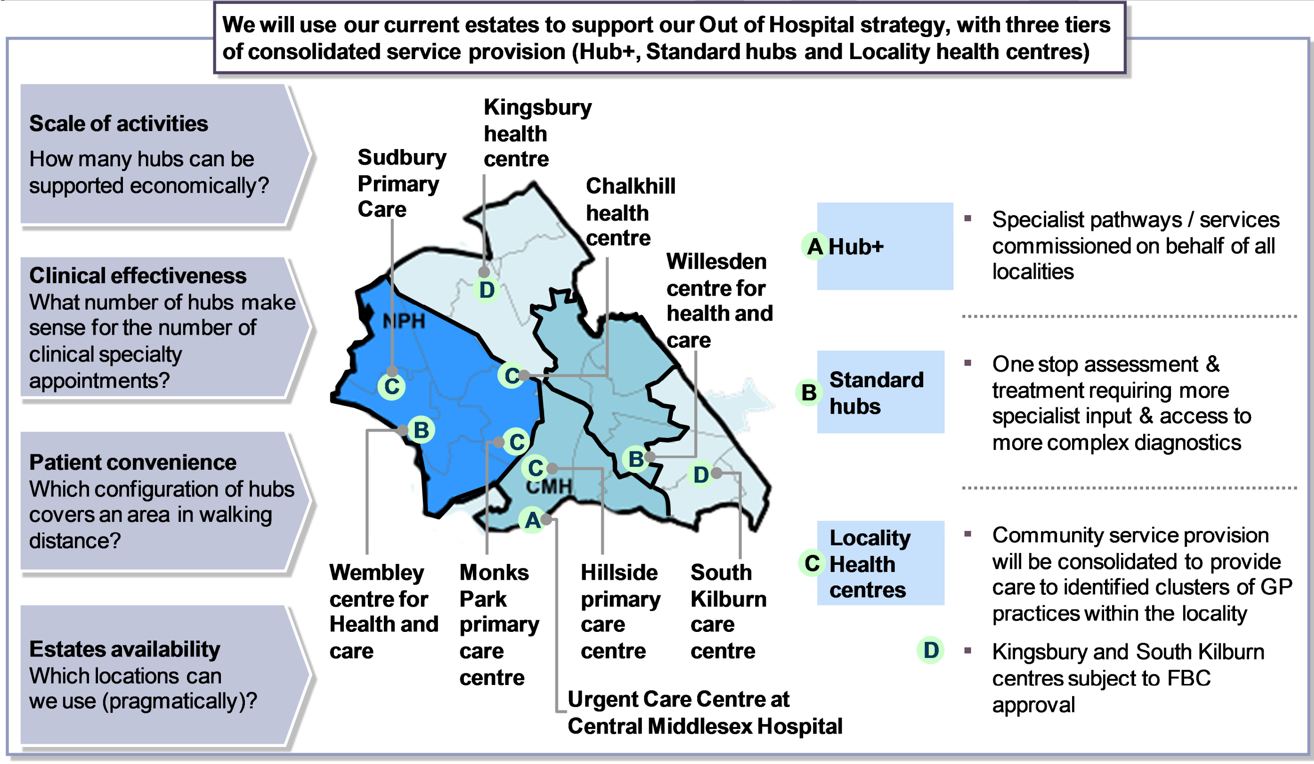
The Hub+ will provide specialist pathways and services commissioned on behalf of all localities.

Standard Hubs will provide one-stop assessment and treatment that requires more specialist input or access to more complex diagnostics.

Locality Health Centres will provide community services. They will be consolidated to provide care to identified groups of GP practices within the locality.

We can make use of existing sites to deliver our out of hospital strategy in Brent. We propose **six** Locality Health Centres, two Standard Hubs and one Hub+. Exhibit 18 shows the proposed locations based on existing sites.

EXHIBIT 18



4.5 THREE LEVELS FOR THE CO-ORDINATION OF CARE IN BRENT

In future, out of hospital care will be organised and co-ordinated on three levels.

The 69 individual GP practices will be responsible for routine primary care and navigating patients through the health system. They will have overall responsibility for patient health in their area. GPs, nurse practitioners, practice nurses and district nurses will deliver care at this level.

We will retain our current locality structure as Locality networks. These will manage the following services:

- Rapid response – admission avoidance, discharge support
- Social services reablement and rehabilitation
- Walk-in centres
- District nursing – case management
- Integrated care – multi-disciplinary groups for elderly patients
- Specialist primary care
- Community outpatients
- End of life care
- Referral management

At this level, care will be delivered by community mental health representatives, social care representative, community matrons and district nurses.

The Borough/CCG level will be responsible for:

- 111 phone service
- Rapid response out of hours care
- Community beds
- Acute care including accident and emergency care.

At this level, care will be delivered by acute specialists, mental health specialists and social care specialists.

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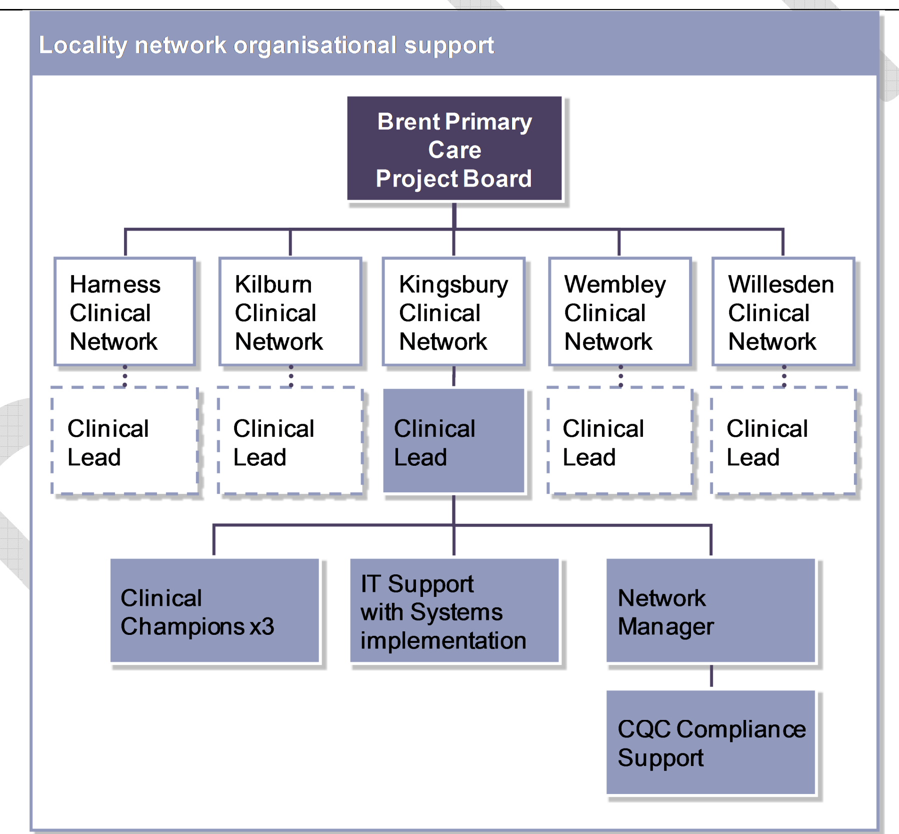
4.6 NEW ROLES TO SUPPORT LOCALITY NETWORKS

In each of the 5 Locality networks, we will create new roles to enable them to deliver care effectively. Each Locality network will have:

- 1 clinical lead responsible for overseeing clinical governance (1 session per week)
- 3 clinical champions responsible for being champions of new clinical pathways (2 sessions per month)
- 1 Locality network manager responsible for network coordination including organizing network meetings and providing materials for performance conversations (full-time equivalent)
- IT support for systems implementation.

Exhibit 19 shows the additional support we will put in place for our networks.

EXHIBIT 19



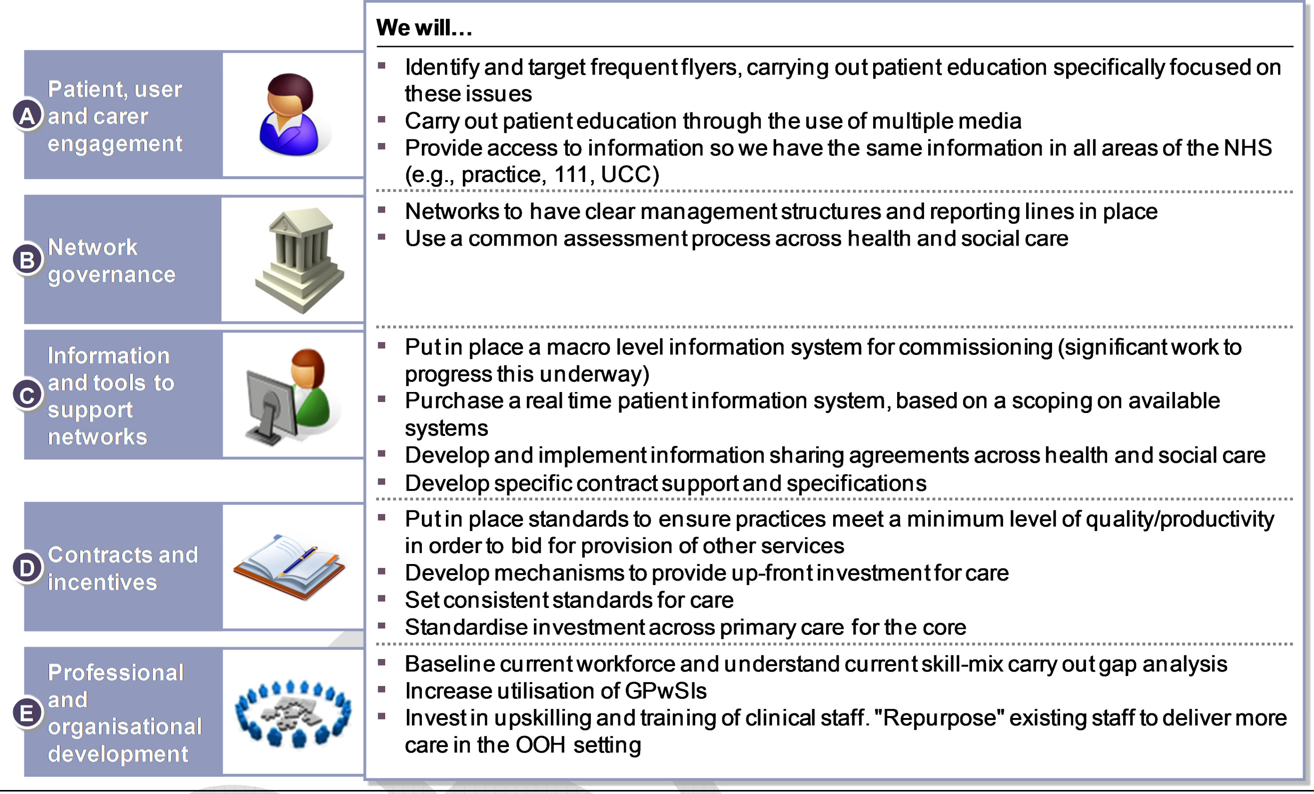
Conclusion

This part of the report has outlined new ways of working together to deliver the strategy. The next section builds on this further by examining the enablers that will facilitate the changes needed in this strategy.

5. Supporting improved out of hospital care for Brent

We have identified 5 key enablers to support better care, closer to home. These are summarised in Exhibit 20 below.

EXHIBIT 20



The following sections describe the actions we will take around each of these areas.

5.1 PATIENT, USER AND CARER ENGAGEMENT

We will build on the plans we already have in place to increase patient, user and carer engagement, which is essential for success as we make the changes outlined in this strategy.

In addition to the engagement already taking place through Patient Participation Groups in localities, we will build on our existing Borough-wide equality, diversity and engagement strategy.

We will carry out patient education using a variety of different media. Focussing on supporting our diverse population with multilingual access guides, engaging with community structures (e.g. religious and community centres) and identifying the key segments of our population who can benefit from increased engagement (e.g., young mothers, those with long term conditions).

We will identify people who have frequent contact with the health system and carry out patient education specifically aimed at their needs.

Exhibit 21 sets out the specific commitments we are making to patients, users and carers in Brent about how they will be involved.

EXHIBIT 21

Our commitment	How we'll deliver
You'll be involved	▪ Ensure patient representation on key committees and decision making bodies, including CCG Board ▪ Work with LINk and other partners to ensure as broad a range of service users as possible are consulted
You'll be informed	▪ Be pro-active in explaining services changes and the reasons for decisions to the public through regular communication ▪ Use clear concise language in all communication to ensure it is meaningful ▪ Work with partners, such as the Council to ensure consistent use of language
Your feedback will shape services	▪ Use nationally and locally collected patient experience data to inform decision making ▪ Commission services which provide evidence of listening to service users' views ▪ Run patient events to get more detailed input on existing services and future plans
We'll respond to your concerns	▪ Explain how patient input has influenced decisions ▪ Commission services to demonstrate that they have reacted to service users' views

5.2 LOCALITY NETWORK GOVERNANCE

In Brent CCG, we recognise the potential conflict of GPs as both commissioners and providers. Our arrangements for managing this will be embedded in our CCG constitution. We will have a separation of practice and locality commissioning and provision roles so that a locality is not commissioning from itself. The CCG as a commissioning body will be responsible for placing contracts with networks and monitoring performance in addition to the networks' governance arrangements. Our governance arrangements for GP networks are emerging. While there will be a separation of commissioning and provision responsibilities to manage conflict, GP networks will be integral to our Clinical Commissioning Group. The GP network and networks for the ICP will overlap. However, as the ICP is a provider network with social care and other providers, the governance structures for the ICP and the GP networks will be distinct.

As part of our development of GP networks and as a Clinical Commissioning Group, we will strengthen arrangements for supporting improvements in outcomes for our patients.

Data on organisational performance will be reviewed at 3 levels:

- By GP practices, daily and in real time
- By localities, fortnightly, reviewing clinical performance and benchmarking against others
- By a performance sub-group, monthly looking at priority areas, such as prescribing.

Robust performance metrics need to be developed. These could include key areas of a practice's work, such as the number of patients with long term conditions or at end of life who have care plans; Quality and Outcomes Framework scores and MORI access poll results; and response times for community services and social care. Indicators could also include whether practices are reducing outpatient referral rates, emergency admissions rates and accident and emergency rates of admission.

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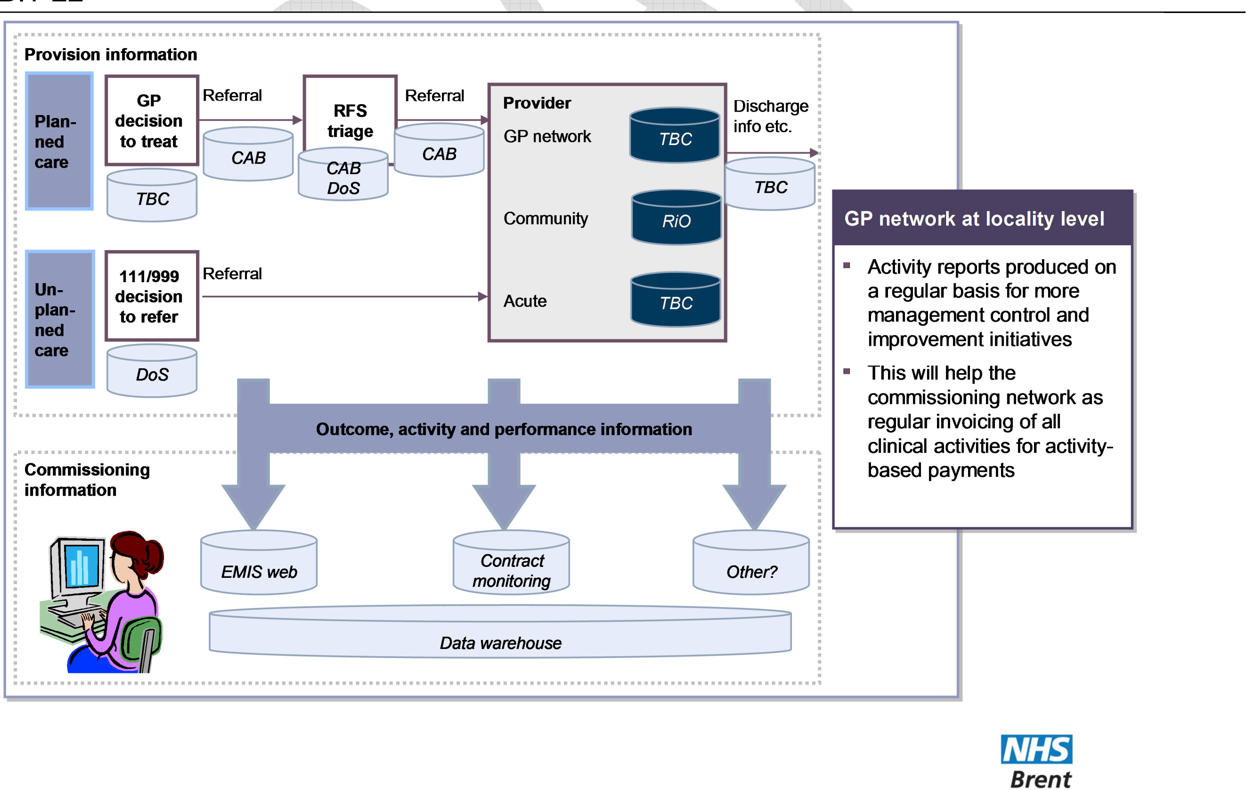
5.3 INFORMATION AND TOOLS TO SUPPORT LOCALITY NETWORKS

Better sharing of information will be central to achieving our vision. It will achieve the following:

1. Real-time shared records will inform health care providers and link GPs, community, acute and mental health teams. Duplication will be reduced.
2. Transparency of information gathered will help us drive up standards and deliver equality of care across Brent.
3. Planned care will become more streamlined as referrals follow precisely defined pathways and GPs have access to granular reporting on referrals.
4. Urgent care will become better informed as information input by the GP is visible to staff at the UCC and care is visible to GPs and prompts are given for follow-up actions
5. Long term care will become more proactive as a result of risk stratification of patients by GPs, care plans being put in place and regular check ups and early intervention based on these.

Exhibit 22 shows the key information flows and IT systems that enable an integrated approach.

EXHIBIT 22



5.4 CONTRACTS AND INCENTIVES

We need to create the right contracts and incentives to improve care and to ensure that they underpin the new ways of working that are needed to deliver better care, closer to home.

We have already developed, working closely with Brent LMC, specific incentives to bring about change and will invest in these so that GPs can deliver change effectively. These include:

1. **Improvement plans for primary care: practices will develop individual improvement plans.** We will reward practices that achieve better outcomes. We will also reward practices that participate in the Locality GP network. We will fund protected time for practices to develop their improvement plan and network plan.
2. **Moving towards a common core specification and more equitable funding for primary care**: we will make funding available to practices each year so that they can increase their capacity for care outside of hospital in a sustainable and planned way
3. **Support for GP networks to establish their business model for delivery of out of hospital services**: funding will support the development of business models, including governance arrangements, implementation plans, inter-practice payment mechanisms and new infrastructure.

In future, we will go further. Exhibit 23 summarizes how targets, contracts and incentives could be aligned to support each of the five goals of our better care, closer to home strategy.

EXHIBIT 23

	Target	How we can achieve this	Re-imbursement to support this
Easy acc-ess to high quality, res-ponsive care	▪ Improve access ▪ Improve satisfaction	▪ Meeting minimum primary care requirements	▪ Incentives for delivery ▪ Penalties for failing to meet requirements
Simplified planned care pathways	▪ Reduce Outpatient attendances ▪ Elective admissions	▪ Peer review/referral management system ▪ Inter-practice referrals	▪ Referral incentive scheme ▪ Activity-based reimbursement ▪ Shared incentives across network to reach targets
Rapid response to urgent needs	▪ Reduce A&E attendances ▪ Improve reliability	▪ 111, UCC, extended hours ▪ Walk-in centres	▪ Shared budget allocation for urgent care split across UCC, A&E, OOH ▪ Shared incentives across network to reach targets
Integrated care for LTC and elderly	▪ Reduce NEL admissions ▪ Increase Integration ▪ Increase proactive care	▪ Coordination ratings ▪ Care plans	▪ Payments for care plans ▪ Payments for clinicians to attend case conference ▪ Shared incentives across providers to reach targets
Appropriate time in hospital	▪ Reduce length of stay	▪ Discharge coordinator ▪ HSCC ▪ Rapid response	▪ Contracting HSCC, Discharge coordinator and rapid response teams

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5.5 PROFESSIONAL AND ORGANISATIONAL DEVELOPMENT

The Government's ambition for the NHS to deliver health outcomes among the best in the world is rooted in the three principles of giving patients more information and choice, focusing on healthcare outcomes and quality standards, and empowering frontline professionals with a strong leadership role. At the heart of these proposals are clinical commissioning groups (CCGs).

CCGs will be different from any predecessor NHS organisation. Whilst statutory NHS bodies, they will be built on the GP practices that together make up the membership of a CCG. CCGs must ensure that they are led and governed in an open and transparent way which allows them to serve their patients and population effectively.

It will be vitally important that CCGs are clinically led, with the full ownership and engagement of their member practices, so that they can bring together advice from the broadest range of health and care professional to influence patterns of care and focus on patients' needs. At the same time they will need to demonstrate probity and governance commensurate with their considerable responsibilities for their patients healthcare and taxpayers money.

NHS Brent CCG will build on its experience to date, through Professional Executive Committees, Practice Based Commissioning and now as a shadow CCG, to further develop leadership and governance to deliver Brent's Out of Hospital Strategy.

This will mean:

- Practices will work together in localities to provide services and work in integrated care networks with other providers to provide joined up services for patients.

- Practices will work together in the CCG to hold each other to relevant on improving primary care services and to hold other providers to account for senior delivery through contracts the CCG holds.

- NHS Brent CCG will adopt a constitution that clearly sets out our governance arrangements for undertaking our statutory duties.

1. Governance

In order to ensure that Locality networks engage in decision making on their structures, that working groups meet regularly and that board structures are formalised, we will focus on outlining roles and responsibilities, decision making, resource sharing, legal issues and performance management.

2. IT skills

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We will provide training for all relevant staff to ensure that they have the necessary IT skills to deliver the changes we are putting in place, such as care packages, which will rely on IT support to be fully effective.

3. Patient engagement

We will provide training for clinical leaders to ensure that we reach out to communicate more effectively with the diverse communities that make up Brent. This will help to ensure that we engage patients and the wider public in planning.

4. Professional Training

We will work closely with the NWL Local Education and Training Board (LETB) and Health Education and Innovation Committee (HEIC) and our practices to train and develop a multi-disciplinary workforce, fit for purpose, with the ability to implement the out of hospital work plans with innovative technology. We will add to the training set out above with development for particular professional groups:

- We will support GPs to specialise where appropriate, increasing the number of GPs with a special interest
- We will up skill our practice nurses so that they are able to carry out tasks that GPs have traditionally carried out (e.g. chronic disease management)
- We will build the capabilities of our healthcare assistants so that they are able to carry out technical procedures (e.g. ECG scans, ear syringing and audiometry)
- We will develop the skills of our managers so that they are effective at coordinating Locality networks, monitoring outcomes and developing strong relationships with CSS.

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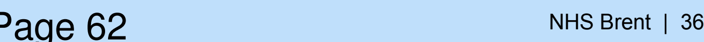

6. Investing for the future

This strategy has started to lay out our vision for a fundamentally different model of care. To deliver our vision, we will make significant investments in staff and estates across different settings of care. Exhibit 24 broadly outlines the investment we will aim to make in services delivered at home, in GP practices and community health centres over the next three years as investment shifts from hospital to out of hospital sector.

These investments will be subject to approval of full business cases that are likely to be investment led and include disinvestments in other services and will have measureable benefits that will be performance managed.

EXHIBIT 24

Investment by 2015[1,2]

Where you will receive care[3]	Services offered	Additional Investment	Additional space	Additional workforce
At Home[2]	▪ Community care ▪ Elderly care ▪ Postnatal care ▪ Rapid Response	▪ £0.5-1.0m	▪ Access to consulting rooms/team room	▪ 20 – 25 WTE
At a GP Practice[3]	▪ nGMS plus extended hours ▪ Core primary care services	▪ £3.5-4.0m	▪ 150-200 m² ▪ <3 consulting rooms ▪ Team room	▪ 10 – 15 WTE
In a Local hub	▪ ECG, possibly ultrasound ▪ Rapid access to blood tests ▪ Rapid access referral to hub/ hospital	▪ £6.0-6.5m	▪ 1,300-1,350 m² ▪ <18 consulting rooms ▪ Team rooms ▪ <5 beds	▪ 60 – 70 WTE
	TOTAL	£ 10-12m		

1 Based on bottom up calculation of saving initiatives. Each initiative build on granular assumptions: e.g. "Outpatient at lower cost" initiative assumes re-provision cost of 0.8 GP appointment of 12 minutes & 0.2 Consultant appointment of 30 minutes per patient per year for 5% of total outpatient cohort
2 Assumptions based on pilots outcome of Brent Intermediate Care 2009 and BRENT Unplanned Care Initiatives 2011, QIPP 11/12 business cases, Healthcare for London, CCG input and expert interviews
3 Initiatives includes: "At Home" - e.g. Rapid Response (Nursing), Case Management, ICP; "AT a GP Practice" - e.g. Outpatient at lower cost, Outpatient at lower cost (telephone advice), ICP; "In a community health centre" - e.g. Rapid Response (Bed), Outpatient at lower cost, Outpatient at lower cost (telephone advice), ICP

SOURCE: NHS NWL Team; Commissioning Service Plan, 1st December 2011, QIPP plans 15th December 2011, QIPP revision, Healthcare for London; HES; CCG input and expert interviews

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The staffing and investment identified in the figure above is indicative based on CCG strategic plans and is dependent on the release of funding from acute providers as activity transfers from acute settings to community settings. Specific investments will be agreed through the normal planning and governance processes of the CCG and as such the production and agreement of robust business cases demonstrating both value for money and affordability to the CCG.

The reductions in acute activity planned by the CCG are consistent with and reflected in the acute PCBC base case modelling.

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7. Next steps

The strategy set out here will form the basis of further, detailed discussions in the next few weeks with GPs, patients and families, other clinicians, partners in social care and public health, health and well-being board and others, leading to full public consultation in June.

In order to ensure the success of the strategy, we need to take the following critical steps outlined below in Exhibit 25.

EXHIBIT 25

Five immediate steps critical to success of strategy

Crucial step	Status
1 **12/13 budget is set** in line with strategy	✓
2 **Strategy is endorsed** by: – Health and Wellbeing board – CCG board – All practices	☐
3 **Performance framework is agreed** by CCG (including metrics, targets, thresholds and escalation process)	☐
4 Appropriate **governance structures** in place for **managing performance**	☐
5 **Capabilities are in place** to deliver strategy including: – Management support in CCG – CSS support – New workforce required to deliver service	☐

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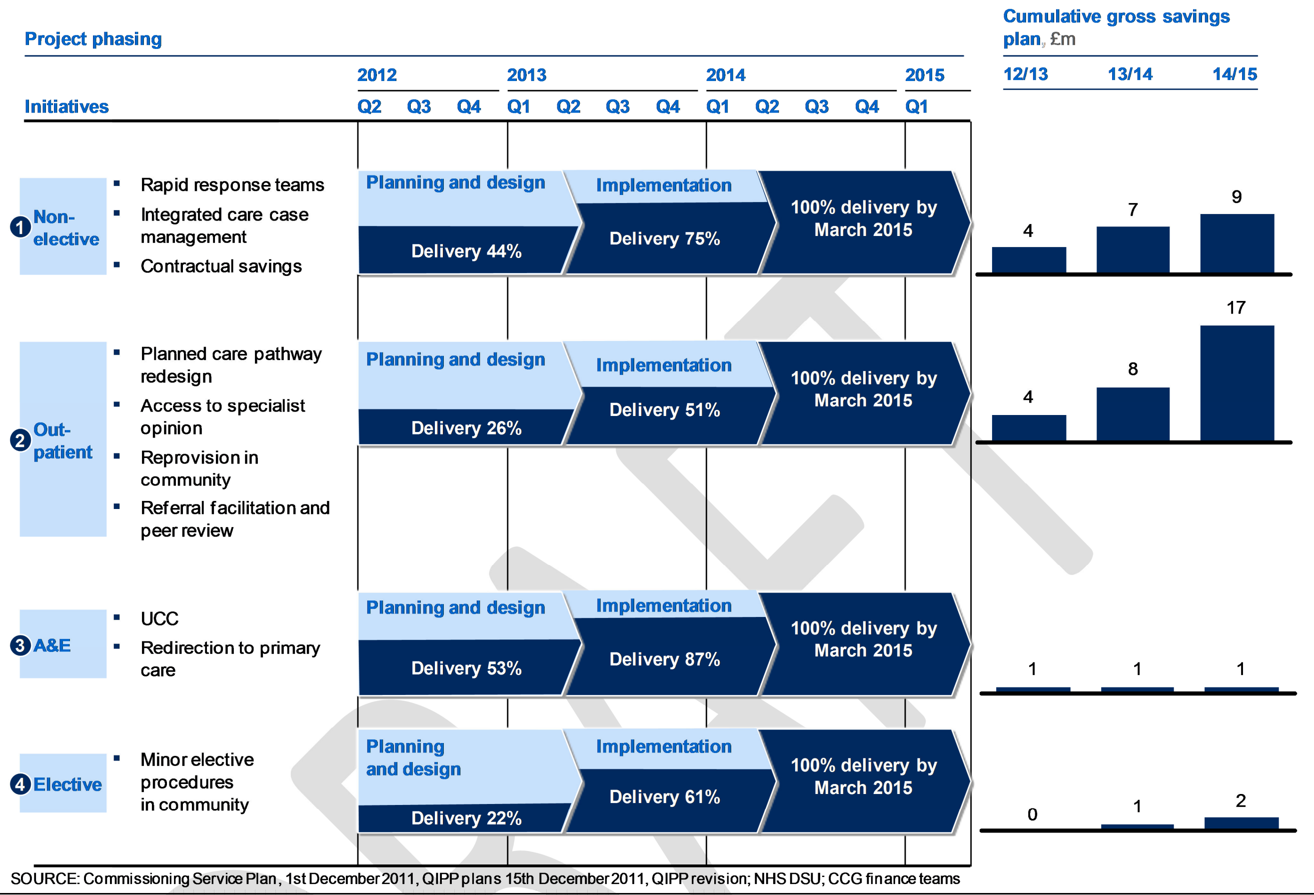
7.1 INITIATIVE IMPLEMENTATION PLAN

Implementation of many of our initiatives is already underway. Exhibit 26 outlines our implementation plan and benefits realisation for our key initiatives.

EXHIBIT 26



SOURCE: Commissioning Service Plan, 1st December 2011, QIPP plans 15th December 2011, QIPP revision; NHS DSU; CCG finance teams

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7.2 ENABLES TO DELIVER

Successful delivery of our initiatives will rely on our successful implementation of enablers identified in section 5. The delivery plan for these is outlined in Exhibit 27.

EXHIBIT 27

Improved picture under construction by DSU to be shared with Brent

	Health Partnerships Overview and Scrutiny Committee **30th May 2012** **Report from the Director of Strategy, Partnerships and Improvement**
For Action	Wards Affected: ALL

Primary Care Update – Willesden Medical Centre, Kenton Medical Centre and Kilburn Medical Centre

1.0 Summary

1.1 NHS Brent has provided an update on three GP practices in Brent. Their report covers three main issues:

- Willesden Medical Centre – The possibility of relocating the practice to Willesden Centre for Health and Care.
- Kenton Medical Centre – This centre is to close, and the report highlights the work that has gone on since the GPs gave notice that they intended to retire.
- Kilburn Medical Centre – On the plans to disperse the patient list for this practice, which is also set to close.

1.2 The issues connected to Willesden Medical Centre and Kilburn Medical Centre have been previously considered by the committee. However, Kenton is a new issue. More information on this practice is set out below.

2. Closure of Kenton Medical Centre

2.1 At the end of April 2012, the chair of the Health Partnerships Overview and Scrutiny Committee received notice from NHS North West London (which is responsible for GP contract management) that Kenton Medical Centre was to close at the end of June 2012. NHS North West London has provided a briefing on this decision, setting out the reasons for the closure, the options for the patients who are currently registered at the Kenton Medical Centre, and the engagement with stakeholders on this decision.

2.2 There has been some concern from ward councillors about this decision. The main areas of concerns were:

- How many patients are affected by the closure of the practice?

- How patients are being helped to re-register with alternative practices, especially vulnerable patients?
- Do the GPs at the Kenton Medical Centre have specialist skills that other providers may not have on which patients rely? If so, how will these skill sets be replaced in the locality?
- Communication – ward councillors only found out about the closure in early May 2012 and they have concerns that patients may also be unaware of the plans and are seeking reassurances about this.
- Whether continuation of "expensive" patient care will be affected by the fact that most of the alternative practices are in Harrow and NHS Harrow is going through financial turnaround.

2.3 NHS North West London's briefing on the Kenton Medical Centre is included within NHS Brent's report on primary care for members to consider.

3.0 Recommendations

3.1 The Health Partnerships Overview and Scrutiny Committee is recommended to consider the primary care update and;

(i). Question officers from NHS Brent and NHS North West London on their plans for the practices in Willesden, Kenton and Kilburn.

(ii).Ensure that members are satisfied enough help is being given to vulnerable patients affected by the closures of Kenton Medical Centre and Kilburn Medical Centre, so that they are able to re-register with a GP.

Background Papers published on the agenda:

1. Primary Care Update in Brent (including NHS North West London's briefing on Kenton Medical Centre)
2. Kenton Medical Centre Stakeholder Letter
3. Kenton Medical Centre Profile
4. Kenton Medical Centre map

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Overview and Scrutiny Committee Paper
Primary Care Update in Brent

1. Willesden Medical Centre

NHS Brent instructed the estates department to undertake a feasibility study on the space available in Willesden Health and Well Being Centre with a view to working with local practices on possible relocation to this purpose built health facility that is not fully occupied. A number of practices have been approached including Willesden Medical Centre and Dr Fletcher's practice, to discuss potentially moving into the centre. A meeting hosted by the CCG chair and interested parties is being arranged for early June. Separately the Willesden Medical Centre has worked with their current landlord to improve their existing accommodation and provide space for Dr Fletcher's practice. Following the meeting with the practice, NHS Brent will consider both proposals and make a decision on which option best meets patient needs and value for money. The Willesden Medical Centre's current lease expires on 31 August 2012. We will keep the OSC updated.

2. Kenton Medical Centre

NHS Brent has received a letter of resignation from a two partner doctor practice and the attached paper sets out the proposed way forward for the practice.

3. Kilburn Medical Centre

The Kilburn Medical Centre has been operating under a temporary contract and following consultation and consideration of the options of how to put in the permanent arrangements for the management of this population, a decision has been made to disperse the list. The attached paper sets out the background to this decision and the action we are taking as a result of a health inequalities assessment.

Overview and Scrutiny Committee Paper
Closure of Kenton Medical Centre

1. Background

1.1. Drs PK Das and B Das of Kenton Medical Centre gave notice to NHS North West London (NWL) on 1 March 2012 that they intended to retire from general practice. Originally, they requested a termination date of 31 May 2012; however this was negotiated to 30 June 2012.

1.2. The doctors hold a Personal Medical Service (PMS) contract with NHS Brent, and own the current premises. They have confirmed the premises will not be available for use as a GP practice once they retire.

1.3. As Drs P Das and B Das are the only contractors the PMS contract will terminate upon their retirement and therefore a decision must be taken on how patients will access primary medical services in the future. The practice list size at the time of the termination notice was 2500; this has now reduced to 2200.

1.4. GPs are independent contractors and are responsible for the running of their practices and ensuring they meet the needs of the patients registered with them. Part of their responsibility is to ensure where possible that a succession plan is in place to secure continuity of care for patients. However, in some cases this is not always possible and so NHS NWL must then decide how to ensure those patients can continue to access services after contract terminates.

2. Options considered for re-provision of GP services to practice registered population

2.1. In light of the contract termination, NHS NWL had to determine how to proceed and identified two options.

2.1.1. Option One - enables patients to choose to register with a GP from an existing list of established practices in the area. There are five general practices within one mile and 4 slightly further away who are all accepting new registrations. Most of these practices hold contacts with NHS Harrow but this is not a barrier to patients living in Brent wanting to register.

2.1.2. Option Two - involves inviting applications from providers to take up a contract to provide primary medical services for the former patients of the surgery. There is a formal procurement process that should be followed in such cases that ensures the process of selecting a provider is fair and transparent. This procurement would be a competitive tendering exercise.

3. Capacity in the surrounding practices

3.1. The ten nearest practices to Kenton Medical Centre have been contacted and asked about their capacity to register large numbers of patients within a short period of time. They have all confirmed they are willing to register patients within their catchment area and most practices have confirmed that they have sufficient capacity to register high numbers of patients. The table below details practices' responses.

Practice	Distance from KMC	Is your list open	How many new registrations with one month could the practice cope with without adversely affecting their ability to provide primary care services	In the last 3 months has your practice reviewed your current list size with the intention of developing/expanding?
Kenton Bridge Medical Centre (Dr Golden)	0.22 miles	Yes	400+	Yes
Kenton Bridge Medical Centre (Dr Raja)	0.22 miles	Yes	400	Yes
The Northwick Surgery	0.42 miles	Yes	400	Yes
The Civic Medical Centre	0.95 miles	Yes	400+	Yes
Headstone Road	0.98 miles	Yes	A handful	No
Sudbury & Alperton Medical Centre	1.06 miles	Yes	100	No
Primary Care Medical Centre	1.06 miles	Yes	400	Yes
The Streatfield Medical Centre	1.09 miles	Yes	150	Yes
Savita Medical Centre	1.11 miles	Yes	250	Yes

3.2. The additional and enhanced services provided by Kenton Medical Centre were compared those offered by other practices in the area and it was found that the surrounding practices were offering a similar range of services to Kenton Medical Centre and catering to similar population health needs.

4. Consideration of Population Needs

4.1. The NHS NWL must consider the needs of the local population, how those needs might change or increase and how existing services are able to respond when deciding how services will be provided to those patients in the future.

4.2. Annex One outlines the practice population profile and how they compare with the NHS Brent and national profiles. The Kenton Medical Centre has a larger proportion of patients aged 25-39 than the National or PCT populations. The practice population is within the least deprived super output area in NHS Brent. Expected and reported disease prevalence is generally in line or less than PCT and national averages.

4.3. The map at Annex Two shows the distribution of patients registered at Kenton Medical Centre and the location of the closest practices in the area.

5. Financial and Contractual Landscape

5.1. There are cost implications to both options. Option One would mean the patients register with other practices. The practices would receive a cost per patient from their PCT for any additional patients they registered. There would however be little cost in facilitating people to re-register and no costs related to new premises, maintenance or set up.

5.2. Option Two would mean undertaking a procurement process to select a new provider. This would incur cost for the administration of a procurement process. There would then be the new contract cost and premises and IT costs.

5.3. If the decision were made to procure a new practice then the NHS NWL is obliged to ensure that the contract is awarded through a competitive process that complies with relevant EU regulation and guidance for Part B services as well as NHS NWL London Standing Financial Instructions. This process is estimated to take between 9-12 months.

5.4. In addition, there are no premises currently available for a new service meaning that the Commissioner or Provider would have to source, refit

and fund (rent and rates) new suitable premises in the area. The current premises attracts notional rent payments as it is owned by the contractor which is lower than recent current market rents in the area. Requiring a new provider to supply suitable premises and refit for use would further increase the contract price.

6. Stakeholder Engagement

6.1. The Primary Care Contracts team worked with Brent and Harrow LINk to develop a stakeholder engagement plan.

6.2. A four week engagement process was undertaken to inform patients and stakeholders of the proposed option and to ask for feedback on what information would be of use to patients in choosing a practice to register with. The following external stakeholders were written to;

- All patients over the age of 16
- The Brent Overview and Scrutiny Committee
- Councillors in the Kenton Ward of Brent and Kenton West Ward of Harrow
- Bob Blackman MP and Barry Gardiner MP

6.3. It was brought to our attention on 4 May by Cllr Margaret McLennan that there had been an oversight in the list of stakeholders and the Councillors for Northwick Park Ward (where the practice is based) had not been included in the engagement process. All the information sent to the other stakeholders was immediately passed on to all three Councillors in this ward.

6.4. Six responses were received during the engagement period, these were as follows;

6.4.1. Two responses from patients were received asking for advice about how to register with another GP practice

6.4.2. One response from a patient asking for more information about the nearby practices e.g. premises access and waiting times.

6.4.3. One patient asked if patients could be automatically transferred to a GP practice of choice, instead of having to re-register

6.4.4. A GP in a Brent practice, not included in the list of nearest practices, stating that they had capacity to register additional patients

6.4.5. Barry Gardiner, Member of Parliament for Brent North, requesting further clarification on the notice period for the practice closure.

Conclusion

6.5. In light of the responses during the engagement period and after reviewing both of the options in detail it was recommended to the NHS NWL Board that patients should be asked, and supported where needed by the practice and local PALs team, to register with an alternative practice in the local area, as described in option one above. The reasons for this are as follows:

- Existing GP practices in the surrounding area have capacity to register additional patients
- The list of 2500 is well below the local average practice list size and, with list inflation in Brent at around 24%; the actual list size is likely to be somewhat lower. This suggests that this is not a viable list to put out to procurement or attract sufficient interest from the market.
- It presents more individual choice for patients when choosing where they would like to be registered in future.
- As the practice premises will no longer be available for use, the availability and affordability of suitable new premises in the local area may be challenging for new providers.
- The length of time to procure a new practice and premises would be between 9 – 12 months.

6.6. Following a Board decision patients and stakeholders will be written to informing them of the decision.

6.7. If the final decision is to ask patients to re-register then the letters will include details of other practices in the area (with their opening times, services offered and patient satisfaction survey results). The lists of practices will be reviewed to ensure that the practices listed are those closest to where patients live, rather than closest to the Kenton Medical Centre.

6.8. The practice will be asked to work with district and community nursing teams to identify vulnerable patients and provide them extra assistance to re-register. The practice will keep NHS NWL updated with regards to these patients so that we can have assurance that they have re-registered prior to the practice closing.

ANNEXES

1. The Network of Public Health Observatories: Profile for Kenton Medical Centre
2. Map of distribution of patients registered with Kenton Medical Centre.

Overview and Scrutiny Committee Report May 2012

List Dispersal of The Medical Centre GP Practice, 18 Cambridge Gardens, Kilburn, NW6 5AY

Background

Elahi HealthCare Ltd is the current provider of medical services at The Medical Centre which is based at 18 Cambridge Gardens, Kilburn, NW6 5AY. Following the death of the original contract holder in October 2005, the PCT provider arm maintained the practice. Subsequently, the PCT entered into a temporary APMS contract with Elahi Healthcare Ltd for the provision of medical services at the practice.

Patients registered at The Medical Centre span a wide geographical area stretching from Kilburn to Kensington, Chelsea and Westminster as well as patients from other PCT areas. The total registered list as at April 2012 was 2113.

The Contract held with Elahi Healthcare Ltd was a temporary contract. The contractor was given six months notice in December 2011 with the termination taking effect at midnight on the 30th June 2012. To ensure that the registered patients of The Medical Centre continued to access primary medical services NHS Brent undertook a review and considered the following two options available to it:

- **i)** Develop specification and tender on open market:
- **ii)** List dispersal of the registered population.

Decision

On 1 May 2012, NHS Brent's Executive Management Team (EMT) considered the options appraisal for the future management of the practice. They concluded the following:

"The concerns and views of the patients who attended the two meetings were noted and their preference for the practice to continue at the current site. However procurement could not be justified on these grounds. There was no guarantee that a contract would be awarded to a new provider or a service could be provided from the existing site."

EMT agreed to recommend to NHS Brent Board that the practice list be dispersed on the basis that there were 32 practices within a 1 mile radius. The existing providers within a 0.5 mile radius reported that they had current capacity to take on new patients, with 7 providers reporting capacity to allow for an increase within a month of up to 200 patients and above. This level of capacity to take on new patients in Kilburn and the

neighbouring PCTs outside of Brent was not evident in the Willesden locality at the time of the options appraisal for Burnley GP Practice

On the 9th May 2012 NHS Brent Board endorsed the decision that:

- The Medical Centre GP service is closed
- The patient list is dispersed to other nearby GP Practices

The NHS Brent Board requested that in implementing the dispersal, a full equalities impact assessment WAS undertaken so that the PCT ensured that it mitigated any risk of vulnerable groups being disadvantaged by this dispersal.

Equality impact screening-

Analysis was done to understand the demographics of the practice registered list. The analysis highlighted that there were some vulnerable people. As part of the dispersal process the PCT has considered this information and has taken steps to mitigate against any one of these vulnerable people not being able to access primary medical services once the contract is terminated.

The analysis is shown below:

Gender :	**1273 male and 1054 female**
Sexual orientation	**Not recoded**
Race:	**approximately 85% Afro Caribbean**
Religion:	**approx 80% Christian, 4% Jewish**
Disability	**2 wheelchair bound, 1 deaf**
Number of patients for Dossetting [1]	**37**
Housebound	**20**
Safeguarding	**4**
Vulnerable adults	**1 (learning disability)**
Carers	**8**
Refugees	**none**

[1] Dossetting is organising medications individually, by day and time, into boxes with compartments so as to simplify the taking of medications and may indicate the need for additional support

Mitigating Actions

Registered patients will have a choice of GP practices to re-register with and in the majority of instances this will be nearer to their home. There are 32 practices within a one mile radius of the Medical Centre all of whom are operating open lists.

The PCT has written to all registered patients informing them of the decision. Enclosed with the letter is information that shows patients the nearest 13 practices to 18 Cambridge Gardens. The PCT will be writing

again to patients ahead of the practice closing and will enclose this information again.

For those patients that are wheel chair bound or elderly 7 of the practices within half a mile have step free access into the practices.

Six practices within half a mile of 18 Cambridge Gardens have both male and female GPs, which will provide greater choice for patients.

Given the high Afro Caribbean registered population the PCT will work with local community, voluntary, church who have links back into this community to help support the dissemination of the information that has been sent out. The PCT will similarly make links with the Jewish community to support the dissemination of the information that has been sent out.

The PCT will write to the patient who is deaf offering the assistance of The Silent Sounds organisation to accompany him to register at the practice of their choice to ensure that they are able to re-register easily.

The PCT have contacted the Safeguarding team to support the 4 children who are on the safeguarding list. We will ensure support is offered, via the practice, to the vulnerable adult patient who has a learning disability in choosing where to re-register. The nearest practice to The Medical Centre is signed up to the national Learning Disability Directed Enhanced Service. The PCT is currently updating the list of practices who will also offer this service.

Contact will be made with the housebound patients to find out if they need any support in registering with a new practice. We will seek with the practice's cooperation, consent to approach the house bound patients to see if they need our help in re-registering.

Over the coming weeks the PCT will monitor the progress of the closure of the practice, including the decreasing list size.

This paper summarises the main points of a full equalities impact assessment which is being finalised and would be available to share.

Jo Ohlson
NHS Brent Borough Director
May 2012

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NATIONAL GENERAL PRACTICE PROFILES

PROFILE FOR

KENTON MEDICAL CENTRE

7 NORTHWICK AVENUE, KENTON,HARROW, MIDDLESEX, HA3 0AA

These profiles are designed to support GPs, clinical commissioning groups (CCGs) and PCTs to ensure that they are providing and commissioning effective and appropriate healthcare services for their local population. Using a variety of graphical displays such as spine charts and population pyramids, the tool presents a range of practice-level indicators drawn from the latest available data, including:

- local demography;
- Quality and Outcomes Framework domains;
- disease prevalence estimates;
- admission rates; and
- patient satisfaction.

In addition to displaying individual practice profiles, the web tool allows you to view summary profiles for PCTs and CCGs. Each practice can be compared with its PCT, CCG and with England, and also with the practices in the same deprivation decile and 'peer group' (although PDF generation is limited to PCT, CCG and England comparisons). The profiles do not provide an exhaustive list of primary care indicators, but they do allow a consistent approach to comparing and benchmarking across England. More indicators will be incorporated as the tool is developed further.

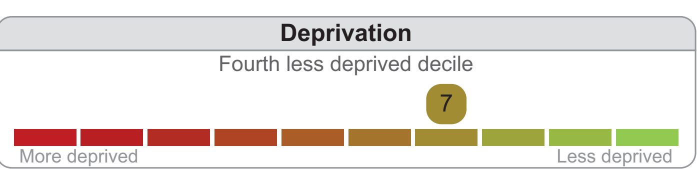
The profiles have been designed as a web tool and the full functionality is only available via the web version. For more information consult the User guide and FAQs via the Supporting documents tab on the web pages.

The development of this tool has been led by erpho, the East of England Public Health Observatory, on behalf of the network of PHOs in England. For further information contact: feedback@erpho.org.uk

Registered Persons	
KENTON MEDICAL CENTRE	2,934
Brent Teaching PCT	5,224 (average)
England	6,919 (average)

Deprivation

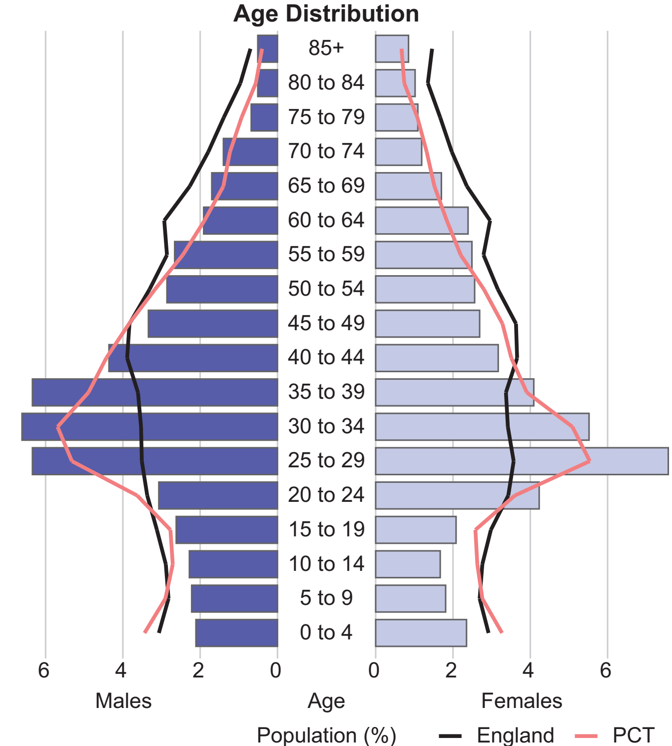
Fourth less deprived decile



QOF achievement	969.2 (out of 1000)
Male life expectancy	80.1 years
Female life expectancy	82.5 years
% of patients that would recommend their practice	66.7%

Ethnicity Estimate

52.1% asian, 3.2% black, 14.8% other non-white ethnic groups



www.apho.org.uk/PracProf

How to read the indicator spine charts

The light grey bar shows the range of values found in England. The dark grey sections mark out the range within which the middle half of the observed values lie (25th to 75th percentile).

The red line shows where the England average is. The position of the circle shows the practice value, a diamond the PCT value, a triangle the cluster value, in relation to this scale.

The corresponding numbers can be found in the cells next to the chart.

If significance has been calculated for the indicator, then it is determined by whether the practice value is significantly higher or lower than the England average using 95% confidence intervals.

A significant difference is marked in blue, non-significance in yellow.

A significant difference is marked in blue, non-significance in yellow.

- No significant difference from England average
- Significantly different from England average
- Significance not calculated

- ○ Practice
- △ PCT
- ▽ Clinical Commissioning Group

England Lowest — England Average — England Highest; 25th Percentile — 75th Percentile

Practice Summary

Indicator	Period	Practice Value	PCT Value	England Average	England Lowest	England Range	England Highest
% aged 0 to 4 years	2011	4.5%	6.7%	6.0%	0.0%		16.5%
% aged 5 to 14 years	2011	8.0%	11.0%	11.2%	0.0%		28.0%
% aged under 15 years	2011	12.4%	17.7%	17.1%	0.0%		43.2%
% aged 65+ years	2011	10.7%	9.9%	15.9%	0.0%		45.8%
% aged 75+ years	2011	4.7%	4.4%	7.5%	0.0%		26.6%
% aged 85+ years	2011	1.4%	1.1%	2.2%	0.0%		14.3%
Deprivation score (IMD)	2011	16.3	30.5	21.5	2.9		68.5
IDACI (Income Deprivation Affecting Children)	2011	0.202	0.393	0.218	0.011		0.684
IDAOPI (Income Deprivation Affecting Older People)	2011	0.215	0.305	0.181	0.038		0.802
% satisfied with phone access	2010/11	76.1%	69.4%	74.5%	17.3%		100%
% able to see a doctor within 2 days	2010/11	81.4%	75.3%	79.7%	24.8%		100%
% able to book appointment >= 2d ahead	2010/11	75.0%	64.2%	69.7%	0.0%		100%
% satisfied with opening hours	2010/11	65.8%	73.0%	78.3%	43.9%		100%
% able to see preferred GP	2010/11	39.3%	61.4%	69.8%	11.8%		100%
% would recommend practice	2010/11	66.7%	72.0%	83.5%	34.0%		100%
Total QOF points	2010/11	96.9%	92.2%	94.7%	39.2%		100%

Modelled Disease Prevalence

Indicator	Period	Practice Value	PCT Value	England Average	England Lowest	England Range	England Highest
Estimated prevalence of CVD	2011	7.0%	7.8%	9.5%	2.6%		19.4%
Estimated prevalence of CHD	2011	3.3%	3.9%	4.7%	0.0%		12.9%
Ratio of recorded vs expected CHD prevalence	2010/11	0.769	0.540	0.723	0.00		1.87
Estimated prevalence of COPD	2011	2.7%	3.2%	2.9%	0.62%		6.47%
Ratio of recorded vs expected COPD prevalence	2010/11	0.102	0.220	0.559	0.00		2.54
Estimated prevalence of hypertension	2011	21.5%	22.8%	24.9%	4.2%		44.7%
Ratio of recorded vs expected hypertension prevalence	2010/11	0.513	0.506	0.543	0.01		1.14
Estimated prevalence of stroke	2011	1.3%	1.7%	2.1%	0.16%		5.44%
Ratio of recorded vs expected stroke prevalence	2010/11	0.610	0.588	0.827	0.00		2.15

CVD - Coronary heart disease

Indicator	Period	Practice Value	PCT Value	England Average	England Lowest	England Range	England Highest
CHD: QOF prevalence (all ages)	2010/11	2.5%	2.1%	3.4%	0.00%		9.89%
Estimated prevalence of CHD	2011	3.3%	3.9%	4.7%	0.0%		12.9%
Ratio of recorded vs expected CHD prevalence	2010/11	0.769	0.540	0.723	0.00		1.87
Heart failure w LVD: QOF prevalence	2010/11	0.1%	0.2%	0.4%	0.00%		2.63%
Exception rate for CHD indicators	2010/11	7.5%	6.9%	7.5%	0.0%		100%
CHD Emergency Admission Rate (per 1000)	2009/10	3.00	2.30	2.50	0.0		13.9
CHD Elective Admission Rate (per 1000)	2009/10		1.80	1.80	0.00		10.00
CHD 2: Angina referred for exercise testing &/or assessm.	2010/11	92.3%	93.2%	94.6%	0.0%		100%
CHD 5: Record of BP in the previous 15mths	2010/11	100%	97.3%	97.8%	77.6%		100%
CHD 6: Last BP reading in last 15mths is <=150/90	2010/11	90.5%	89.5%	90.2%	46.5%		100%
CHD 7: Record of total cholesterol in last 15mths	2010/11	93.3%	92.0%	93.7%	50.0%		100%
CHD 8: Last total cholesterol is <=5mmol/l	2010/11	84.0%	81.3%	82.1%	40.0%		100%
CHD 9: Record that aspirin, APT or ACT is taken	2010/11	98.6%	94.3%	93.5%	62.5%		100%
CHD 10: Currently treated with beta blocker	2010/11	88.5%	74.0%	73.5%	28.6%		100%
CHD 11: History of MI: treated with ACE-I	2010/11	100%	89.2%	88.8%	40.0%		100%
CHD 12: CHD patients given flu immunisation 1 Sep - 31 Mar	2010/11	98.4%	92.5%	92.4%	40.0%		100%

CVD - Stroke and TIA

Indicator	Period	Practice Value	PCT Value	England Average	England Lowest	England Range	England Highest
Stroke: QOF prevalence (all ages)	2010/11	0.8%	1.0%	1.7%	0.00%		5.90%
Estimated prevalence of stroke	2011	1.3%	1.7%	2.1%	0.16%		5.44%
Ratio of recorded vs expected stroke prevalence	2010/11	0.610	0.588	0.827	0.00		2.15
Exception rate for stroke indicators	2010/11	8.3%	6.9%	7.1%	0.0%		100%
Stroke 13: New patients referred for further investigation	2010/11	75.0%	84.8%	89.8%	0.0%		100%
Stroke 5: BP recorded in last 15mths	2010/11	91.7%	96.3%	96.8%	73.1%		100%
Stroke 6: Last BP reading is 150/90 or less	2010/11	77.3%	87.0%	88.6%	0.0%		100%
Stroke 7: Total cholesterol recorded in last 15mths	2010/11	100%	90.0%	91.5%	48.4%		100%
Stroke 8: Last measured total cholesterol <=5mmol/l	2010/11	77.3%	75.3%	77.3%	0.0%		100%
Stroke 12: Record of aspirin, APT or ACT taken	2010/11	93.8%	94.5%	93.7%	55.0%		100%
Stroke 10: Influenza immunisation given 1 Sep-31 Mar	2010/11	100%	90.7%	89.6%	0.0%		100%

CVD - Heart failure and atrial fibrillation

Indicator	Period	Practice Value	PCT Value	England Average	England Lowest	England Range	England Highest
Heart failure: QOF prevalence (all ages)	2010/11	0.2%	0.5%	0.7%	0.00%		3.88%
Heart failure w LVD: QOF prevalence	2010/11	0.1%	0.2%	0.4%	0.00%		2.63%
Exception rate for heart failure indicators	2010/11	20.0%	14.5%	14.8%	0.0%		100%
Atrial fibrillation: QOF prevalence	2010/11	0.6%	0.6%	1.4%	0.00%		5.19%
Exception rate for atrial fibrillation indicators	2010/11	7.1%	4.4%	3.8%	0.0%		100%
HF 2: Diagnosis conf. by ECG/specialist assessm.	2010/11	50.0%	93.6%	95.8%	0.0%		100%
HF 3: HF w LVD: treated with ACE-I or ARB	2010/11	100%	89.8%	89.5%	0.0%		100%
HF 4: Heart failure w LVD: treatment w ACE inh. or ARB, and beta-blocker	2010/11	100%	82.9%	82.1%	0.0%		100%
AF 4: diagnosed with ECG or by specialist	2010/11	100%	96.2%	96.1%	0.0%		100%
AF 3: treated w anti- coag./platelet therapy	2010/11	94.1%	94.5%	93.6%	0.0%		100%

CVD - Risk factors for CVD

Indicator	Period	Practice Value	PCT Value	England Average	England Lowest	England Range	England Highest
Hypertension: QOF prevalence (all ages)	2010/11	11.0%	11.5%	13.5%	0.1%		37.4%
Estimated prevalence of hypertension	2011	21.5%	22.8%	24.9%	4.2%		44.7%
Ratio of recorded vs expected hypertension prevalence	2010/11	0.513	0.506	0.543	0.01		1.14
Exception rate for hypertension indicators	2010/11	0.9%	2.5%	2.5%	0.0%		22.5%
Exception rate for smoking indicators	2010/11	0.8%	0.8%	0.7%	0.00%		8.75%
Obesity: QOF prevalence (16+)	2010/11	6.8%	9.3%	10.5%	0.4%		31.0%
BP 4: Record of BP in last 9mths	2010/11	92.0%	90.8%	91.6%	66.8%		100%
BP 5: Last (9mths) blood pressure <=150/90	2010/11	75.4%	78.3%	79.3%	35.1%		100%
PP 1: CV risk assessment for new hypertension cases	2010/11	100%	76.9%	80.2%	0.0%		100%
PP 2: life style advice for new hypertension cases	2010/11	94.4%	81.8%	81.9%	0.0%		100%
Dep 1: Depression case finding in CHD and/or diabetes patients	2010/11	97.6%	90.2%	88.8%	0.2%		100%
Smoking 3: status recorded in last 15mths (certain conditions)	2010/11	99.6%	95.8%	95.4%	66.7%		100%
Smoking 4: cessation advice/referral offered (certain conditions)	2010/11	97.4%	92.6%	92.9%	47.6%		100%

Diabetes

Indicator	Period	Practice Value	PCT Value	England Average	England Lowest	England Range	England Highest
Diabetes: QOF prevalence (17+)	2010/11	6.7%	6.9%	5.5%	0.0%		15.2%
Exception rate for diabetes indicators	2010/11	5.6%	6.1%	6.5%	0.3%		100%
Hypertension: QOF prevalence (all ages)	2010/11	11.0%	11.5%	13.5%	0.1%		37.4%
Exception rate for hypertension indicators	2010/11	0.9%	2.5%	2.5%	0.0%		22.5%
Exception rate for smoking indicators	2010/11	0.8%	0.8%	0.7%	0.00%		8.75%
Obesity: QOF prevalence (16+)	2010/11	6.8%	9.3%	10.5%	0.4%		31.0%
Diabetes admission rate (per 1000)	2009/10	0.000	0.900	1.10	0.0		10.9
Ratio of recorded vs expected diabetes prevalence	2008/09	1.44	1.38	0.883	0.19		5.79
DM 2: Record of BMI in the last 15mths	2010/11	97.0%	94.1%	94.8%	52.0%		100%
DM 5: Record of HbA1c/equivalent last 15mths	2010/11	95.8%	95.4%	97.5%	63.6%		100%
DM 23: Last HbA1c is <=7 in last 15mths	2010/11	47.4%	47.9%	54.2%	0.0%		99.4%
DM 24: Last HbA1c is <=8 in last 15mths	2010/11	79.6%	73.7%	78.0%	2.7%		100%
DM 25: Last HbA1c is <=9 in last 15mths	2010/11	90.0%	85.0%	88.4%	2.7%		100%
DM 21: Retinal screening in last 15mths	2010/11	90.1%	88.2%	91.6%	26.1%		100%
DM 9: Record of peripheral pulses last 15mths	2010/11	92.5%	91.8%	91.6%	9.6%		100%
DM 10: Record of neuropathy test last 15mths	2010/11	92.5%	91.6%	91.4%	22.8%		100%
DM 11: Record of BP in last 15mths	2010/11	98.8%	97.6%	98.4%	78.8%		100%
DM 12: Last BP is <=145/85	2010/11	80.6%	81.4%	81.2%	34.6%		100%
BP 4: Record of BP in last 9mths	2010/11	92.0%	90.8%	91.6%	66.8%		100%
BP 5: Last (9mths) blood pressure <=150/90	2010/11	75.4%	78.3%	79.3%	35.1%		100%
DM 13: Record of micro-albuminuria test last 15mths	2010/11	93.1%	88.3%	89.0%	0.0%		100%
DM 22: eGRF or serum creatinin testing in last 15mths	2010/11	94.6%	95.4%	97.2%	56.3%		100%
DM 15: Proteinuria/micro-album. treated w inhibitors	2010/11	100%	89.1%	88.2%	0.0%		100%
DM 16: Record of total cholesterol last 15mths	2010/11	95.8%	94.7%	96.1%	67.3%		100%
DM 17: Measured total chol (last 15mths) <=5mmol/l	2010/11	80.7%	80.4%	82.9%	46.0%		100%
DM 18: Influenza immunisation given 1 Sep - 31 Mar	2010/11	94.9%	89.9%	90.7%	47.1%		100%
Dep 1: Depression case finding in CHD and/or diabetes patients	2010/11	97.6%	90.2%	88.8%	0.2%		100%
Smoking 3: status recorded in last 15mths (certain conditions)	2010/11	99.6%	95.8%	95.4%	66.7%		100%
Smoking 4: cessation advice/referral offered (certain conditions)	2010/11	97.4%	92.6%	92.9%	47.6%		100%

Mental Health

Indicator	Period	Practice Value	PCT Value	England Average	England Lowest	England Range	England Highest
Psychoses: QOF prevalence (all ages)	2010/11	0.7%	1.0%	0.8%	0.0%		23.8%
Exception rate for patients with psychoses indicators	2010/11	0.0%	6.1%	10.4%	0.0%		81.5%
Dementia: QOF prevalence (all ages)	2010/11	0.0%	0.3%	0.5%	0.0%		10.5%
Exception rate for dementia indicators	2010/11	0.0%	10.2%	7.4%	0.0%		100%
Depression: QOF prevalence (18+)	2010/11	2.9%	5.9%	11.2%	0.0%		46.1%
Exception rate for depression indicators	2010/11	3.2%	4.3%	5.9%	0.0%		52.9%
MH 9: full review in last 15mths	2010/11	100%	91.6%	92.6%	0.0%		100%
MH 4: Li-therapy: record of s.creat. & TSH last 15mths	2010/11	100%	95.7%	98.1%	0.0%		100%
MH 5: Lithium therapy: record of Li-levels last 6mths	2010/11	100%	85.3%	92.2%	0.0%		100%
MH 6: with comprehensive care plan	2010/11	100%	92.0%	89.4%	0.0%		100%
MH 7: Pychoses patients who DNA review: followed up < 14 d	2010/11	%	81.9%	94.6%	0.0%		100%
Dem 2: Dementia care has been reviewed last 15mths	2010/11	100%	83.2%	79.2%	0.0%		100%
Dep 1: Depression case finding in CHD and/or diabetes patients	2010/11	97.6%	90.2%	88.8%	0.2%		100%
Dep 2: Depression cases with severity assessment	2010/11	100%	86.0%	92.1%	0.0%		100%
Dep 3: second severity assessment for new depression cases	2010/11	100%	69.1%	74.5%	0.0%		100%

Respiratory Disease

Indicator	Period	Practice Value	PCT Value	England Average	England Lowest	England Range	England Highest
COPD: QOF prevalence (all ages)	2010/11	0.3%	0.7%	1.6%	0.00%		7.81%
Estimated prevalence of COPD	2011	2.7%	3.2%	2.9%	0.62%		6.47%
Ratio of recorded vs expected COPD prevalence	2010/11	0.102	0.220	0.559	0.00		2.54
Exception rate for COPD indicators	2010/11	0.0%	11.3%	12.4%	0.0%		100%
COPD admission rate (per 1000)	2009/10		0.900	2.00	0.0		17.2
Asthma: QOF prevalence (all ages)	2010/11	3.4%	4.4%	5.9%	0.0%		12.4%
Exception rate for asthma indicators	2010/11	1.7%	1.9%	5.5%	0.0%		100%
Exception rate for smoking indicators	2010/11	0.8%	0.8%	0.7%	0.00%		8.75%
COPD 12: Diagnosis conf. by spirometry in last 15mths	2010/11	100%	87.7%	89.7%	0.0%		100%
COPD 10: Record of FeV1 in last 15mths	2010/11	100%	87.1%	88.9%	0.0%		100%
COPD 13: assessed using MRC dyspnoea score last 15mths	2010/11	100%	90.2%	91.6%	0.0%		100%
COPD 8: Influenza immunisation given 1 Sep - 31 Mar	2010/11	100%	92.8%	93.2%	50.0%		100%
Asthma 8: with measures of variability/reversibility (8+)	2010/11	100%	89.5%	87.7%	0.0%		100%
Asthma 3: smoking recorded in last 15 mths (14-19y w asthma)	2010/11	100%	90.5%	89.2%	20.0%		100%
Asthma 6: review in the last 15mths	2010/11	80.0%	80.6%	78.6%	32.4%		100%
Smoking 3: status recorded in last 15mths (certain conditions)	2010/11	99.6%	95.8%	95.4%	66.7%		100%
Smoking 4: cessation advice/referral offered (certain conditions)	2010/11	97.4%	92.6%	92.9%	47.6%		100%

Chronic Kidney Disease

Indicator	Period	Practice Value	PCT Value	England Average	England Lowest	England Range	England Highest
CKD: QOF prevalence (18+)	2010/11	0.6%	2.0%	4.3%	0.0%		21.5%
Exception rate for CKD indicators	2010/11	1.9%	3.9%	4.0%	0.0%		100%
CKD 2: Record of BP in last 15mths	2010/11	93.8%	97.6%	97.5%	76.9%		100%
CKD 3: Last BP reading measured in last 15mths is <=140/85	2010/11	87.5%	75.6%	74.2%	0.0%		100%
CKD 5: Hypertension treated with ACE inhibitor/ARB	2010/11	100%	91.2%	90.5%	0.0%		100%
CKD 6: Urine albumin : creatinine ratio test last 15mths	2010/11	81.3%	82.6%	82.2%	0.0%		100%

Other Conditions

Indicator	Period	Practice Value	PCT Value	England Average	England Lowest	England Range	England Highest
Cancer: QOF prevalence (all ages)	2010/11	1.0%	1.0%	1.6%	0.00%		4.51%
Exception rate for cancer indicators	2010/11	0.0%	1.4%	1.6%	0.0%		100%
Cancer admission rate (per 1000)	2009/10	18.0	16.7	28.1	1.3		105.2
Epilepsy: QOF prevalence (18+)	2010/11	0.1%	0.5%	0.8%	0.00%		3.76%
Exception rate for epilepsy indicators	2010/11	0.0%	10.0%	8.1%	0.0%		66.7%
Learning disability: QOF prevalence (18+)	2010/11	0.2%	0.3%	0.4%	0.00%		5.86%
Hypothyroidism: QOF prevalence (all ages)	2010/11	2.7%	1.7%	3.0%	0.00%		7.88%
Exception rate for hypothyroidism indicators	2010/11	0.0%	0.5%	0.5%	0.0%		100%
Palliative/supportive care: QOF prevalence (all ages)	2010/11	0.0%	0.1%	0.2%	0.00%		2.76%
Cancer 3: review within 6mths of diagnosis	2010/11	100%	92.5%	93.7%	0.0%		100%
Epilepsy 6: Record of seizure frequency	2010/11	100%	96.8%	95.6%	22.0%		100%
Epilepsy 7: Medication review w patient/carer last 15mths	2010/11	100%	97.0%	95.2%	27.5%		100%
Epilepsy 8: Seizure free for last 12mths	2010/11	100%	70.6%	73.9%	0.0%		100%
Thyroid 2: function test recorded last 15mths	2010/11	97.5%	95.0%	95.9%	71.1%		100%

Secondary Care Use

Indicator	Period	Practice Value	PCT Value	England Average	England Lowest	England Range	England Highest
All GP referrals (1st attendance) (per 1000)	2009/10	153.7	172.5	186.8	34.0		615.0
All attendances (per 1000)	2009/10	661.2	705.4	739.9	105		1582
Dermatology, GP referrals (1st attendance) (per 1000)	2009/10	4.90	10.1	13.7	0.0		71.8
General Medicine, GP referrals (1st attendance) (per 1000)	2009/10	6.20	7.00	10.9	0.0		81.3
General Medicine - return ratio	2009/10	3.60	4.10	2.70	0.5		31.0
General Surgery, GP referrals (1st attendance) (per 1000)	2009/10	13.1	18.4	23.1	1.9		70.8
General Surgery - return ratio	2009/10	1.50	1.40	1.50	0.30		5.10
Gynaecology, GP referrals (1st attendance) (per 1000)	2009/10	19.3	17.9	17.1	2.2		56.4
Gynaecology - return ratio	2009/10	1.40	1.50	1.30	0.20		8.50
Orthopaedics, GP referrals (1st attendance) (per 1000)	2009/10	16.1	17.1	20.2	0.0		81.4
Orthopaedics - return ratio	2009/10	2.20	1.70	1.80	0.70		5.00
Paediatrics, GP referrals (1st attendance) (per 1000)	2009/10	8.20	7.80	5.70	0.0		34.6
Urology, GP Referrals (first attendance) (per 1000)	2009/10	7.50	6.80	7.90	0.0		29.7
Urology - return ratio	2009/10	1.90	2.00	2.10	0.3		20.5
A&E attendances per 1000 population (per 1000)	2009/10	237.6	342.1	372.8	9		1191
All admissions - All ages (per 1000)	2009/10	161.5	189.1	231.6	26.5		503.0
All admissions - A&E (per 1000)	2009/10	8.50	13.2	9.60	0.0		84.5
All admissions - CHD (per 1000)	2009/10	4.60	4.40	4.70	0.0		25.9
All admissions - Respiratory (per 1000)	2009/10	11.8	13.1	16.0	1.2		51.7
Elective Admission Rate (per 1000)	2009/10	74.7	91.3	120.6	10.5		354.4
Emergency Admission Rate (per 1000)	2009/10	63.6	69.0	86.7	10.7		267.4
Ambulatory Care Sensitive Conditions Rate (per 1000)	2009/10	9.83	13.0	14.5	1.5		61.0
CHD Elective Admission Rate (per 1000)	2009/10		1.80	1.80	0.00		10.00
CHD Emergency Admission Rate (per 1000)	2009/10	3.00	2.30	2.50	0.0		13.9
Diabetes admission rate (per 1000)	2009/10	0.000	0.900	1.10	0.0		10.9
COPD admission rate (per 1000)	2009/10		0.900	2.00	0.0		17.2
Cancer admission rate (per 1000)	2009/10	18.0	16.7	28.1	1.3		105.2
Emergency readmissions within 28d of discharge	2009/10	9.1%	8.2%	7.7%	0.0%		31.3%

Indicators for Needs Assessment

Indicator	Period	Practice Value	PCT Value	England Average	England Lowest	England Range	England Highest
Life expectancy - MSOA based estimate (Years)	2004 - 08	82.5	83.6	81.8	75.3		102.5
Fertility - MSOA based estimate (per 1000)	2003 - 07	55.1	69.1	59.2	11.1		122.5
Low birthweight births - MSOA based estimate	2003 - 07	9.7%	9.1%	7.9%	2.9%		13.3%
Smoking attributable mortality - MSOA based estimate	2003 - 05	63.2	79.4	100.0	38.4		245.9
Mortality from causes amenable to healthcare - MSOA based estimate	2003 - 05	92.1	104.4	100.0	25.6		241.1
Obesity prevalence - MSOA based estimate	2003 - 05	15.1%	20.7%	23.4%	8.7%		33.4%
Elective Admissions for All causes - MSOA based estimate	2003/04 - 07/08	94.4	98.9	100.0	47.2		168.5
Emergency Admissions for All causes - MSOA based estimate	2003/04 - 07/08	84.3	93.4	100.0	40.0		219.1
Elective Admissions for CHD - MSOA based estimate	2003/04 - 07/08	125.5	115.3	100.0	36.8		299.2
Emergency Admissions for CHD - MSOA based estimate	2003/04 - 07/08	108.0	138.5	100.0	41.8		300.3
Elective Admissions for Respiratory diseases - MSOA based estimate	2003/04 - 07/08	93.1	91.1	100.0	29.3		392.7
Emergency Admissions for Respiratory diseases - MSOA based estimate	2003/04 - 07/08	85.7	94.0	100.0	34.0		293.2
Emergency Admissions for Myocardial Infarction - MSOA based estimate	2003/04 - 07/08	91.6	84.9	100.0	19.8		265.9
Emergency Admissions for COPD - MSOA based estimate	2003/04 - 07/08	57.6	80.5	100.0	15.8		433.1
Elective Admissions for Hip replacement - MSOA based estimate	2003/04 - 07/08	56.6	57.2	100.0	22.9		198.7
Emergency Admissions for Hip replacement - MSOA based estimate	2003/04 - 07/08	56.4	56.7	100.0	37.6		236.3
Elective Admissions for Knee replacement - MSOA based estimate	2003/04 - 07/08	127.4	107.8	100.0	17.2		178.6
Emergency Admissions for Stroke - MSOA based estimate	2003/04 - 07/08	73.9	107.3	100.0	41.8		225.5
First Outpatient Attendances - MSOA based estimate	2007/08	82.7	98.5	100.0	34.4		213.0
Subsequent Outpatient Attendances - MSOA based estimate	2007/08	100.7	116.0	100.0	41.6		202.4
Outpatient Re-attendances - MSOA based estimate	2007/08	2.67	2.52	2.24	1.20		3.81

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North West London

NHS North West London
Southside, 105 Victoria Street
London
SW1E 6QT

5 April 2012

To patients registered at Kenton Medical Centre

Dear Sir/Madam

I am writing to inform you that your family doctors, Dr PK Das and Dr B Das, are retiring on 30th June 2012. Dr PK Das and Dr B Das hold a contract with NHS Brent to provide GP services and are the owners of the premises where their practice is based. The doctors have told us that their premises will not be available for use as a GP practice after 30th June 2012. Therefore when the contract ends on the 30th June the practice will close.

I enclose a message from the doctors to all patients registered at the practice.

NHS Brent, together with NHS North West London, the organisation responsible for managing GP contracts, have to decide how patients who are currently registered at the practice can continue to access GP services in their local area. We need to decide whether it is necessary to procure a new practice or whether existing practices in the area can take on the patients from Kenton Medical Centre.

We are proposing that patients are asked, and supported where needed, to register with an alternative practice in the local area. The reasons for this are as follows:

- Existing GP practices in the surrounding area have capacity to register additional patients
- Due to the small size of the patient list, it may be difficult to find a suitable new provider or ensure long term financial sustainability of the new practice.
- It presents more individual choice for patients when choosing where they would like to be registered in future.
- As the practice premises will no longer be available for use, the availability and affordability of suitable new premises in the local area may be challenging for new providers.
- The length of time to procure a new practice and premises would be between 9 – 12 months.

Patients can register with a GP from an existing list of established practices in the area. A list of the practices nearest to Kenton Medical Centre is enclosed. All of these practices have confirmed they are taking new patients and many have said they will put in extra resources to take more patients.

Further information about these practices, like opening hours or satisfaction survey results, can be found at www.nhs.uk or www.myhealth.london.nhs.uk. If you experience difficulties finding a new practice you can call our Patient Advice and Liaison Service (PALS) on 020 8795 6754.

We want to hear your views on this proposal. **Please send your comments to us, or any questions you may have about this letter, by 2 May 2012, to the contact details given below**.

By email: Please send your comments to engagement@nw.london.nhs.uk

By post: Please write to Primary Care Engagement, 9th Floor, Southside, 105 Victoria Street, London SW1E 6QT

We would also like your feedback on what additional information about the other nearby GP practices you would find useful in helping you choose a GP practice to register with.

I look forward to receiving your comments and feedback.

Yours sincerely

Julie Sands
Assistant Director of Primary Care
NHS North West London
(on behalf of NHS Brent)

Health Partnerships Overview and Scrutiny Committee
30th May 2012

Report from the Director of Strategy, Partnerships and Improvement

For Action

Wards Affected: ALL

Serious Incident at Brent Urgent Care Centre

1.0 Summary

1.1 Members will be aware that the Urgent Care Centre at NHS Brent is managed by Care UK. At the end of March 2012, Care UK notified NHS Brent (the commissioner of the service) of a serious incident at the Urgent Care Centre.

1.2 Care UK had become aware of a queue of 6000 patients who had not been discharged from their systems. Upon investigation it became clear that many of these patients had been sent for x-ray but it could not be confirmed that the radiology reports had been reviewed for missed pathology. In addition, discharge notifications will not have been issued to GPs for these patients. Clearly this presented a risk that patients were not properly diagnosed, or potential problems not picked up in a timely fashion.

1.3 A review of 5% of patients undertaken shortly after this issue came to light found that the proportion of patients with a missed pathology was 2%. The issue was been logged as a serious incident and a full investigation is underway.

1.4 The briefing and letter from NHS Brent sets out the details of the serious incident and the steps taken by NHS Brent and Care UK to rectify the situation. At this stage a root cause analysis report of the incident is not complete and so information on the lessons to be learned are not yet available. However, NHS Brent representatives should be questioned on how they are working with Care UK to manage their Urgent Care Services at CMH.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to question officers from NHS Brent as to how they are working with Care UK to rectify the problems that caused the serious incident at Central Middlesex Hospital Urgent Care Centre.

Contact Officers

Andrew Davies
Policy and Performance Officer
Tel – 020 8937 1609
Email – andrew.davies@brent.gov.uk

Phil Newby
Director of Strategy, Partnerships and Improvement
Tel – 020 8937 1032
Email – phil.newby@brent.gov.uk

Serious incident at Brent Urgent Care Centre

Brent Urgent Care Centre (UCC) became operational on 28th March 2011. It is situated at the front of the Central Middlesex Hospital Accident & Emergency Department. The service provides urgent primary care services to patients with minor illness or injury 24/7. The purpose of the service is to see, treat and discharge patients giving high quality care and advice or referring to the most appropriate setting. There are and referral pathways to the secondary care services such as Accident & Emergency, Medicine, Surgery, and Paediatrics.

Details of the incident

NHS Brent was notified on Friday 30th March 2012 by Care UK of a serious incident at Brent UCC.

Care UK had become aware of a queue of approximately 6000 patients who had not been discharged from the IT system. Upon investigation it became clear that many of these patients had been sent for x-ray and Care UK could not confirm that the radiology reports had been reviewed for missed pathology. In addition, discharge notifications had not been issued to GPs for these patients.

The issue was logged as a serious incident and a full investigation is underway. Brent commissioners and NWLHT radiology department are represented on the team undertaking the investigation. The full report into the SI with findings and recommendations for actions will be available on 6th June 2012.

The terms of reference of the review are:

- To establish the facts of the events which led to the discovery of the back log of X-ray reports and un-discharged patients at Brent UCC on the 14th March 2012.
- To review any problems with care or service delivery.
- To identify opportunities for improvement.
- To establish any actions which can reduce or eliminate the risk of re-occurrence.
- To formulate recommendations and action plan from any items identified in above terms.
- To provide a report as a record of the investigation.
- To provide a means of sharing the learning from the incident.

Clinical Review Progress Update:

At the point of identification there were a total of 5978 patients' electronic notes on the X-ray queue of the patient administration system. There was no evidence or assurance these patients' radiology reports had been reviewed by a doctor at the Brent UCC.

A process was put in place for these x-ray reports to be clinically reviewed by a competent team of radiographers and doctors. The cases were then categorised using the following traffic light system.

Red	Confirmed fracture/ other pathology which may have altered the course of treatment given
Amber	An abnormality identified but on review of patient consultation notes, appropriate care was provided
Green	No fracture or abnormality identified and/or treated appropriately at time of consultation

As at the 3rd May 2012 all of the 5978 cases had been reviewed and categorised as the following:

Red = 96 cases

Amber = 153 cases

Green = 5656

X-Ray unavailable = 73 *

*(in these cases the system notes an x-ray was requested and none is available or an image is on the system without a patient reference. Further work is underway to reconcile these)

All patients in the amber or red categories have been written to inviting them to call the patient hot line set up for this purpose. If a patient rings in, their call is answered, details are taken and a convenient appointment made for an initial telephone consultation with a doctor from the Clinical Investigation Team.

Further updates are scheduled at the Investigation Team Meeting on Wednesday 16th May 2012.

Current systems
Care UK has assured us that the correct process for review of radiology reports has now been implemented and adherence to it validated. The details of the correct process are set out below:

X-ray patient pathway at Brent UCC for Adults – over 18 years of age.

- A patient presents at Brent UCC, if the patient meets the inclusion criteria the patient is booked in and then is seen by a triage nurse.
- If the patient then requires further medical attention the patient is referred onto a Nurse Practitioner or Doctor for a full clinical consultation.
- Once clinically assessed if it is identified the patient requires an X-ray the patient is then referred to the x-ray department in the Central Middlesex Hospital.
- On completion of the x-ray the patient returns to the UCC and is seen by a doctor or a Nurse Practitioner who will make a clinical diagnosis based on the initial x-ray film and treat and/or refer the patient appropriately (please note at this stage the x-ray film has not been reviewed by a reporting expert. consultant Radiologist).

- A Reporting Expert from Central Middlesex Hospital then reviews the films of patients from Brent UCC and returns a full report to Brent UCC electronically within 48 hours.
- The report is then printed off and put into a review file at Brent UCC administration office to be checked by a doctor the next day.
- On review of the Radiologist's report, the doctor categorises the x-ray according to the findings and takes the appropriate actions.
- The doctor then adds any remarks if required to the patients record on Adastra.
- The patient's radiology report goes into a scanning file which is kept in the administration area at Brent UCC.
- The administration staff scan the radiology report into the patient administration system and attach it to the patient's electronic record.
- The completion box is ticked on the patient record as being completed and the electronic discharge file with the radiology report is faxed out to the patient's GP.

X-ray patient pathway at Brent UCC - for patients under the 18 years of age/ vulnerable people

- A patient presents at Brent UCC if the patient meets the inclusion criteria the patient is booked in.
- If on registration the patient is under 18 years of age or is aged 18, 19 or 20 and has a learning disability or it is identified has been in care since 16 years of age this patient's name is checked against the Child Protection Plan Register. For Brent UCC registers are received from the following Social Services Departments: Brent, Ealing, and Hounslow boroughs. If a child's name is found on the register an alert is put onto the patient's file so the consulting clinician is aware the child has a protection plan. The consulting clinicians then have a duty to inform the child's social services department with whom they are known to of the child's attendance and to ensure a special note is put on the child's records so their GP and their community HV team are made aware of the attendance.
- In addition a referral is made to the Liaison Health Visitor at Brent UCC informing them of the child's attendance. The liaison health visitor tracks all attendances of children on the Child Protection Plan register.
- The patient's immediate safety is also assessed and if there are any concerns then the Brent Safeguarding Policy is followed.
- Steps 5 – 10 of the above x-ray process are the same.

Safeguarding

NHS Brent have sought assurance about this incident in relation to safeguarding children. Of the 5,978 patients, approximately 1,300 are children and these records have been checked against the child protection lists and for repeat attenders. The designated professionals for NHS Brent are due to meet with Care UK to review actions taken in respect of these cases on Wednesday 16th May. We are seeking assurance that their systems in relation to safeguarding are fail safe.

Recommendations:

Until completion of the root cause analysis, we can speculate on the factors contributing to the breakdown in systems and that these have been addressed.

We can be assured:

- Care UK promptly reported this incident to us and have taken steps to avoid x-ray reports being overlooked again.
- Patients affected by the incident are being followed up.

Once the report is available, OSC may wish to invite Care UK to a future meeting.

Mary Cleary
Deputy Director
020 8795 6767

www.brentpct.nhs.uk
Borough Director of NHS Brent
Brent Primary Care Trust
Wembley Centre for Health & Care
116 Chaplin Road
Wembley,HA0 4UZ
Tel: 020 8795 6298
Fax: 020 8795 6262

Dear Doctor

Regarding: Serious incident at Brent Urgent Care Centre

NHS Brent was notified last Friday 30th March 2012 by Care UK of a serious incident at Brent UCC.

Care UK recently became aware of a queue of 6000 patients who have not been discharged from the Adastra system. Upon investigation it became clear that many of these patients had been sent for x-ray and the provider cannot confirm that the radiology reports have been reviewed for missed pathology. In addition, discharge notifications will not have been issued to GPs for these patients

A review of 5% of patients undertaken to date has found that the proportion of patients with a missed pathology is 2%. The issue has been logged as a serious incident and a full investigation is underway. Brent commissioners are represented on the team undertaking the investigation. Guidance and support is being provided by the sector Medical Director and Director of Nursing.

A review of the backlog of cases is underway and is expected to take 2-3 weeks to complete.

Records are also being reviewed to:

- ascertain any repeat attenders
- cross reference against the child protection register
- compare to the complaints register

The table below sets out how the review is categorising patients reviewed and the actions that will follow in each case.

Category	What this means	Actions
Green	No missed pathology	GP will receive a letter to explain and the missed discharge notification. GP will have the opportunity to feed in any relevant clinical information.
Amber	Missed pathology but no clinical risk to patient	GP will receive a letter to explain and the missed discharge notification. GP will have the opportunity to feed in any relevant clinical information. Patient will receive a letter to explain what has happened
Red	Missed pathology with potential for patient harm	GP will receive a phone call and a letter from Care UK and the missed discharge notification. GP will have the opportunity to feed in any

		relevant clinical information. Patient will receive a phone call and a letter from Care UK and will be offered a review clinic with a senior Care UK clinican.

Care UK has assured us that the correct process has now been implemented and adherence to it validated.

NHS Brent will keep you fully informed of progress on the review of the cases and the investigation. Care UK will provide details of a dedicated phone line for concerns in their communications with you about individual patients.

In the meantime if you have any queries please contact Mary Cleary, Deputy Borough Director on 020 8795 6767 or Terilla Bernard on 020 8795 6181.

Yours faithfully

Jo Ohlson
Borough Director
NHS Brent

Health Partnerships Overview and Scrutiny Committee
30th May 2012

Report from the Director of Strategy, Partnerships and Improvement

For Action

Wards Affected: ALL

Update on the procurement of new community cardiology and ophthalmology services

1.0 Summary

1.1 NHS Brent has provided a report updating members on the progress of the procurement of community cardiology and ophthalmology services in the borough. Members requested this update at their meeting in March 2012.

1.2 Although the update is essentially for noting, previously members have had questions about the consultation plan for the service procurement and the consultancy costs associated with the procurement. These are addressed in the paper.

2.0 Recommendations

2.1 It is recommended that the Health Partnerships Overview and Scrutiny Committee considers the report on the procurement of community cardiology and ophthalmology services and questions officers from NHS Brent on the progress with this, particularly the numbers of people responding to the consultation to shape the service.

Contact Officers

Andrew Davies
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Tel – 020 8937 1609
Email – andrew.davies@brent.gov.uk

Phil Newby
Director of Strategy, Partnerships and Improvement
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NHS Brent Progress paper for

Brent Health Partnerships Overview and Scrutiny Committee

on the public consultation of the procurement of new community cardiology and ophthalmology services

Introduction

NHS Brent and its Clinical Commissioning Group presented a briefing paper to the Brent Health Partnerships Overview and Scrutiny Committee on 27th March 2012 regarding the procurement of new community cardiology and ophthalmology service. The purpose of the procurement is to commission community based services with equal or better patient outcomes at lower cost.

The procurement of the two services is now underway and it has reached the competitive dialogue stage where discussions about the service specification are being conducted with the three shortlisted bidders for each service. The final service specification will be issued at the end of June 2012.

The Brent Health Partnerships Overview and Scrutiny Committee requested a further paper on the public consultation relating to the procurement activity. This paper therefore sets out:

- The aim and timeframe of the consultation.
- What has been completed to date and what further activity is planned.
- How the findings will feed in to the development of the service.
- The amount NHS Brent is paying external consultants to support the procurement process.

Overall aim of the consultation

The aim with the consultation is to engage Brent patients and the public of Brent at an early stage in developing new outpatient cardiology and ophthalmology services in the community.

NHS Brent wants to understand the needs of the community in Brent with regards to outpatient ophthalmology and cardiology services. The consultation is carried out to help shape the type of services that are offered to Brent patients, to ensure the services achieve greater impact and success.

The consultation will run for 12 weeks. It started on 2nd April and will inform the development, purchasing and arrangement of the two services in the community. As such, it runs alongside the development of the new services and reflects NHS Brent's aspiration to design the services in a way that will meet the needs of patients and respond to the views of the public.

The consultation plan

The public and the patients of Brent will have the opportunity to feed into the consultation through the following channels:

- Patient participation group meetings across the localities in NHS Brent.
- Online web survey through NHS Brent's and the Brent Council's websites.
- Hard copy questionnaire, available through the GP practices and at the patient participation group meetings.
- Brent Citizens Panel

Brent LINks group is being engaged in the procurement process and it is hoped that they can feed into the development of patient satisfaction areas of the specification.

To date NHS Brent has received 32 responses online and 1 paper response to the questionnaire. We expect this response rate to increase significantly as the consultation is further promoted at GP surgeries and through engagement with other groups. Two patient participation group meetings have taken place in Willesden and Harness. An email has also been sent to the 600 strong Brent Citizens Panel about the consultation, with a link to the online questionnaire.

Two more patient participation group meetings are planned for 7th June (Kingsbury) and 14th June (Kilburn).

Impact on the service design

The findings from the consultation are feeding in to the design of the two services as and when it is becoming available with the final amendments to the service design to take place in the last week of June. NHS Brent is therefore able to discuss the findings directly with the shortlisted bidders ensuring patient views are reflected in the final service specification.

Consultancy support

NHS Brent commissioned Private Public Ltd to support the process from January 2012 to June 2012 at a value of £107,104 + VAT. PPL have provided 165 days of support at a daily rate of £649. This is equivalent to 1.5 whole time equivalents. The borough team has been running on a 40% vacancy rate. The alternative to using PPL would have been to use interim project management support ranging from £600 to £700 per day + VAT. It is usual for procurements to incur additional costs for specialist support. These costs are usually recouped through recurrent savings achieved. The projected savings for the re-provision over the course of the 3 year contracts is £3.938 million.

David Peck
Deputy Borough Director

16th May 2012

Health Partnerships OSC

Work Programme 2012-13

Meeting Date	Item	Issue	Outcome
May 2012	Recruitment of health visitors in Brent	Following consideration of a report on the recruitment of health visitors in Brent in March 2012, members agreed to follow up with Ealing Hospital ICO their plans to recruit and train more health visitors in line with the Government's plans to increase the number of health visitors in England.	
May 2012	Planned Care Initiative – ophthalmology and cardiology services in Brent	NHS Brent brought a paper to the committee in March 2012 on their plans to re-commission services for ophthalmology and cardiology in Brent. At the meeting in March 2012, members agreed to follow up two issues with NHS Brent at their May 2012 meeting: • The consultation plan for the two services • The consultancy costs associated with the retender of cardiology and ophthalmology services	
May 2012	A&E Waiting Times in Brent	The Committee considered a report on waiting times at its meeting in March 2012. That report was missing information on A&E waiting times, and so a second paper has been requested – members have asked for a report on A&E waiting times for the committee's May meeting, and to invite representatives from NWL Hospitals to attend for this item to account for performance in A&E. The report should include information on ambulance transfers from CMH to Northwick Park Hospital.	
May 2012	X-ray records at Central Middlesex Hospital Urgent Care Centre	NHS Brent is investigating a serious incident at Central Middlesex Urgent Care Centre. 6000 patients sent for x-ray but Care UK, the Urgent Care Centre provider, cannot confirm whether the radiology reports have been reviewed for missed pathology or whether discharge notifications have been issued to GPs. The committee will be presented with a report on the investigation into this incident and	

		steps being taken to ensure that it doesn't happen again.	
May 2012	Primary Care Update in Brent	The committee will receive a report setting out an update on two medical centres in the borough: • Willesden Medical Centre, which is considering relocating to Willesden Hospital. • Kenton Medical Centre, which is to close	
May 2012 and future meetings	Shaping a healthier future	NHS North West London is to start consulting on plans for major service changes in the cluster. Although a JOSC has been set up to scrutinise the changes, Health Partnerships OSC will also be able to scrutinise the proposals affecting Brent. This will be standing item on the committee's agenda for the duration of Shaping a Healthier Future. Focus at this meeting will be on Brent's Out of Hospital Care Strategy.	
July 2012	Brent Tobacco Control Strategy	The committee would like to follow up the Brent Tobacco Control Strategy, to check the progress of its implementation. It is also interested in specific issues, such as the licensing of shisha bars, to see how this issue is being addressed in Brent.	
September 2012	Health needs of People with Learning Disabilities	Brent MENCAP has carried out work with NHS Brent to train GPs, hospital staff and community staff about the health needs of PWLD. A report was presented to the committee in March 2012 setting out the results of the project and some of the key challenges facing those with learning disabilities accessing healthcare. It was agreed to follow up this work in Sept-Oct 2012 to look at two issues: • The NHS health check day being organised by NHS Brent, which will involve MENCAP • How MENCAP has been able to build on the initial project to train NHS staff members on working with people with learning disabilities.	
September 2012	Diabetes Task Group	The final report of the diabetes task group will be presented to the committee for endorsement before going to the council's Executive for approval.	
TBC	Out of hospital care strategy	As part of the Shaping a Healthier Future work, Brent will be preparing an Out of Hospital Care Strategy. The committee will	

		consider the strategy and respond to the consultation.	
TBC	Diabetes and physiotherapy services – plans to re-commission services in Brent	NHS Brent plans to re-commission diabetes and physiotherapy services in the borough. The committee should consider the plans for the new services, as well as the consultation plan.	
TBC	NWL Hospitals and Ealing Hospital Trust merger plans	The hospital trust merger is progressing and a Full Business Case will be available in May 2012. The committee needs to decide how it wishes to scrutinise plans for the merger, which will be built into the work programme. Follow up will also happen once the merger is approved to ensure services aren't affected during the transition period.	
TBC	Housing Advice in a Hospital Setting	Care and Repair England has produced a report on integrating housing advice into hospital services. Brent Private Tenants Rights Group would like to bring this report to the committee to begin a conversation on the best way to take this forward in Brent.	
TBC	Role of community pharmacists in improving health and wellbeing	The chair is keen to look at community pharmacists in Brent, and how their role in delivering health services can be best utilised. She also wants to look at the way that different elements of the health system, such as GPs and social care work with pharmacists in the borough.	
TBC	Mental health services in Brent	Report to committee on 29/11/11 may provide basis for further enquiries about mental health services. Chair of the committee has suggested support for carers of those with mental health problems.	
TBC	Health Inequalities Performance Monitoring	The Health Select Committee should make health inequalities a major focus of its work in 2010/11. As part of this, a performance framework has been developed to monitor indicators relevant to the implementation of the health and wellbeing strategy, which relate to the reduction of health inequalities in the borough. This framework will be presented to the committee twice a year, with a commentary highlighting key issues for members to consider.	
TBC	Sickle Cell and Thalassaemia Services Report	The Committee has asked for a report Sickle Cell and Thalassaemia services at North West London NHS Hospitals Trust. The committee will invite sickle cell patient groups to attend for this item to give their views on services in the borough. This follows a previous report on	

		changes to paediatric in patient arrangements at NWL Hospitals. Members are keen to know how sickle cell patients have been dealing with this change.	
TBC	Fuel Poverty Task Group	Recommendation follow up on the task group's review.	
TBC	Breast Feeding in Brent	Following a report in March 2011 on the borough's Obesity Strategy, the committee has requested a follow up paper on the Breast feeding service in the borough. Members were particularly interested in the role of peer support workers and how mothers are able to access breast feeding services. The committee would also like to have accurate data on breast feeding initiation and prevalence in Brent.	
TBC	End of life / palliative care in Brent	The committee has asked for a report on end of life care in Brent. Members are keen to look at how the End of Life Strategy is being implemented and to know what services exist in Brent and how effective they are in delivering care.	
TBC	TB in Brent	Added at the request of the committee (meeting on 20th Sept 2011).	
TBC	GP access patient satisfaction survey results	In December 2011 the results of the six monthly patient survey will be published. Members should scrutinise the results with Brent GPs to see how their initiatives to improve access are reflected in patient satisfaction.	

Current Task Groups

Diabetes Care in Brent – The task group is looking at services to prevent and treat diabetes in Brent and will report its findings before the end of 2012.

Future Task Groups

Female Genital Mutilation – to investigate whether this practice is prevalent in Brent, to examine the impact on victims, to see what preventative work takes place in the borough and to highlight this issue to those working with young people who are potential victims.

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