Public Document Pack

# Health Partnerships Overview and Scrutiny Committee

**Tuesday 19 March 2013 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 |
| Gladbaum | Ketan Sheth | Van Kalwala |
| Harrison | Naheerathan | Singh |
| Hector | Aden | Al-Ebadi |
| Hossain | Ogunro | RS Patel |
| Leaman | Sneddon | Clues |

**For further information contact:** Lisa Weaver, Democratic Services Officer
(020) 8937 1358 lisa.weaver@brent.gov.uk

For electronic copies of minutes, reports and agendas, and to be alerted when the minutes of this meeting have been published visit:
**www.brent.gov.uk/committees**

**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** 1 - 12

**4 Matters arising**

**5 Incident involving pathology service for Brent and Harrow PCTs** 13 - 18

There have been problems reported with pathology services being provided to Brent GPs. These are currently being investigated and the report outlines the findings and position to date.

**Ward Affected:** All Wards

***Contact Officer**:* Mark Burgin, Policy and Performance Officer, Phil Newby, Director of Strategy, Partnerships and Improvement
Tel: 020 8937 1032
mark.burgin@brent.gov.uk,
phil.newby@brent.gov.uk

**6 Shaping a Healthier Future** 19 - 26

The report summarises the services that each of the affected hospitals is intended to provide once the changes are implemented and how the changes affect different areas.

**Ward Affected:** All Wards

***Contact Officer**:* Mark Burgin, Policy and Performance Officer, Phil Newby,

Director of Strategy, Partnerships and Improvement
Tel: 020 8937 1032
mark.burgin@brent.gov.uk,
phil.newby@brent.gov.uk

**7 North West London Hospitals and Ealing Hospital Merger**

A verbal update will be provided at the meeting.

**8 Emergency Services at Northwick Park and Central Middlesex Hospitals** 27 - 34

The Health Partnerships Overview and Scrutiny Committee requested an update on issues faced by the Emergency Department at Central Middlesex Hospital (CMH), particularly its ongoing overnight closures. This report covers wider long-term plans and prospects for the provision of Emergency Services at the two hospitals.

**Ward Affected:** All Wards ***Contact Officer****:* Mark Burgin, Policy and Performance Officer, Phil Newby, Director of Strategy, Partnerships and Improvement
Tel: 020 8937 1032
mark.burgin@brent.gov.uk,
phil.newby@brent.gov.uk

**9 Tackling Violence Against Women And Girls in Brent task group** 35 - 42

Members of the Health Partnership Overview and Scrutiny Committee on a number of occasions, expressed an interest in forming a task group to tackle violence against women and girls in Brent; focusing on Female Genital Mutilation (FGM), Honour Based Violence (HBV) and Forced Marriages (FM), a scope for the group has been attached.

**10 Public Health transfer** 43 - 58

The Health Partnerships Overview and Scrutiny Committee has requested an update on the transfer of Public Health functions to the council. The attached report will be presented to the Executive on 11 March setting out the final arrangements for the transfer of public health functions and staff from NHS Brent to the local authority.

**Ward Affected:** All Wards ***Contact Officer****:* Mark Burgin, Policy

and Performance Officer, Phil Newby, Director of Strategy, Partnerships and Improvement
Tel: 020 8937 1032
mark.burgin@brent.gov.uk,
phil.newby@brent.gov.uk

**11 Khat Task Group update** 59 - 70

The Health Partnerships Overview and Scrutiny Committee has asked for an update on the recommendations made by the Khat Task Group. This report provides an update.

**Ward Affected:** All Wards ***Contact Officer****:* Andrew Davies, Policy and Performance
Tel: 020 8937 1609
andrew.davies@brent.gov.uk

**12 End of life palliative care in Brent** 71 - 76

The report gives an overview of palliative care provision in Brent and the End of Life Care Strategy for Brent, which seeks to reduce the number of patients with end of life need dying in hospital. The report outlines some of the related areas that have been invested in during 2012/13 and lists the service providers, with a brief summary of the services provided and an explanation of how the service is funded.

**Ward Affected:** All Wards ***Contact Officer****:* Mark Burgin, Policy and Performance Officer, Phil Newby, Director of Strategy, Partnerships and Improvement
Tel: 020 8937 1032
mark.burgin@brent.gov.uk,
phil.newby@brent.gov.uk

**13 Work programme** 77 - 88

The work programme is attached.

**14 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.

## 15 Date of next meeting

The next scheduled meeting of the Committee is to be confirmed at the meeting of the Annual Full Council on 15 May 2013.

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

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

This page is intentionally left blank

# MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
**Tuesday 29 January 2013 at 7.00 pm**

PRESENT: Councillor Kabir (Chair), Councillor Hunter (Vice-Chair) and Councillors Colwill, Harrison, Hossain and Leaman

Also present: Councillors Butt, Hirani and Lorber

Apologies for absence were received from: Councillors Gladbaum

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

Councillor Leaman declared a personal interest in item 5, Mental Health Services in Brent, as he worked for a mental health charity.

2. **Deputations (if any)**

None

3. **Minutes of the previous meeting**

RESOLVED:-

that the minutes of the previous meeting held on 27 November 2012 be approved as an accurate record of the meeting.

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

Brent Tobacco Control Service – Update
Councillor Hunter noted that at the previous meeting she had advised that the Brent Pension Fund Sub-Committee had considered the recommendations of the Health Partnership Overview and Scrutiny Committee and had decided to amend the Statement of Investment Principles to incorporate the current practice of not directly investing in tobacco companies. The wording of the Brent Pension Fund Sub-Committee's recommendation was due to be agreed at the next meeting of the committee, and would be available as an update to members at the next meeting of the Health Partnerships Overview and Scrutiny Committee.

Health Visitors
Councillor Hunter referred to the information provided to the committee at its previous meeting regarding the salary of health visitors. She explained that the committee had been advised that health visitors received the same pay nationally and that pay differentials between boroughs was not considered an incentive or disincentive to work in particular areas. However, having made enquiries of the NHS following the previous meeting, it was evident that significant differences in pay existed as a result of eligibility for either the Inner or Outer London allowance.

For those in receipt of the Outer London allowance (£3,414 to £4351), this accounted for 15 per cent of their overall salary, whilst the Inner London Allowance (£4,036 to £6,217) accounted for 20 per cent. Councillor Hunter explained that this created a clear incentive for a health visitor to work in areas where they could receive the additional allowance. Sarah Mansuralli (NHS Brent Clinical Commissioning Group) advised that the Agenda for Change pay banding was applied nationally. Health visitors working in London could receive a London allowance which acknowledged the increased costs of living in London. It was clear that the return to work strand had not yielded the intended outcomes and it was suggested that the Ealing ICO be asked what measures had been considered to attract health visitors.

Time to Change Pledge

Councillor Hirani (Lead member for Adults and Health) provided an update to committee on the Time to Change Pledge, advising that all actions had been carried out and all councillors had been urged to sign.

5. **Mental Health Services in Brent**

Sarah Mansuralli (NHS Brent Clinical Commissioning Group) presented a report to the committee on the findings of a recent review of IAPT (improving Access for Psychological Therapies) services and pathways to psychological therapy services in Brent. The report had been provided following the committee's request for a report on the mental health provision for people with more complex mental health needs.

Sarah Mansuralli advised that IAPT was a Department for Health (DfH) programme aimed at supporting the implementation of the National Institute for Health and clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders. Roll-out of IAPT had begun in 2008 and Brent IAPT had been established following a successful application by Brent Primary Care Trust (PCT) in 2010. Investment in Brent IAPT from Brent PCT had initially been achieved via a redesign of existing mental health services, including psychological services provided by Central and North West London NHS Foundation Trust (CNWL). Part of this re-design encompassed diverting a proportion of investment from secondary care psychological services to primary care based IAPT services. This diversion of funds was based on an analysis of the annual referrals and examination of therapy provision by IAPT London Lead which indicated that the majority of referrals seen in secondary care would be appropriate for an IAPT service. Brent IAPT currently provided services at Step 2 (primary care, low level interventions) through to Step 4 (secondary care, high level interventions).

Sarah Mansuralli explained that the review of IAPT services and pathways to psychological therapy services had concluded that capacity of Step 4 interventions in secondary care, which encompassed psychological treatment for more complex mental health needs, was currently limited. This had resulted in delays for patients in accessing appropriate therapeutic interventions. Nationally the average split between individuals requiring low level interventions and high level interventions was approximately 60:40. It had been found that in Brent this trend was reversed, with 60 per cent of those individuals accessing mental health services requiring high level interventions and the remaining 40 per cent requiring low level interventions. In response to the outcome of the review, it was proposed to combine

funding within IAPT and vacant sessions in secondary care services to increase the provision of step 4 interventions within secondary care. This would effectively result in a realignment of services to meet demand by shifting service capacity from Step 2 to Step 4. Brent PCT would continue to monitor the level and type of demand on the services. It was also proposed that a review would be held in the forthcoming financial year of art therapies and psychotherapy to determine how this resource would be utilised.

During in the subsequent discussion the committee sought assurance that the proposed shift in funding to increase capacity at Step 4 would not result in a lack of capacity for services provided at Steps 1 to 3. Members also noted the importance of preventative care and queried whether there was a danger that redirecting funding away from primary care services might result in a further increased demand on secondary care services. The committee noted that at present IAPT services were meeting the needs of approximately 10 per cent of those with depression and/or anxiety and further information was sought on the progress made in meeting the target set out in the NHS Planning guidance for 12-13 and 13-14 of 15 per cent. Members also queried, in light of the proposed review, whether there was an intention to retain art therapies.

Sarah Mansuralli advised that the realignment of services sought to target the level of need. Data gathered at the time of patients' referrals indicated that at the point of accessing these services, there was a greater demand for higher level intervention than lower level intervention. Therefore, whilst it was acknowledged that Stage 2 services had an important preventative role to play in reducing escalation of lower level need cases, it remained necessary to increase capacity at Stage 4 whilst maintaining a good service at Stage 2. The committee was advised that in addition to the realignment of services already described, there was a further £200,000 IAP funding for 2012/13 and a further £200,000 for 2013/14 dedicated to staffing to help meet demand. In response to a query requesting further clarification of these funds, Sarah Mansuralli explained that these funds were drawn from the Primary Care Groups (PCG), which had prioritised mental health. With regard to the performance of IAPT services in meeting the needs of those with depression and/or anxiety disorders in Brent, this currently stood at nearly 9 per cent; it was anticipated that this would be increased to 11 per cent in the forthcoming year and it was intended that the 15 per cent target would be reached by 2014/15. Natalie Fox (Service Director CNWL) added that this was the national target. The art therapy service would be maintained and it was intended that a range of therapy services would continue to be accessible to support the differing needs of patients.

RESOLVED:

That the report be noted.

6. **Role of Community Pharmacists in improving Health and Wellbeing**

Michael Levitan (Brent and Harrow Local Pharmaceutical Committee) delivered a presentation to the committee exploring the role of community pharmacists in improving public health and wellbeing. The committee heard that community pharmacists, as fully trained healthcare professionals who provided a range of services, were a highly valued resource. Importantly, community pharmacists were

also highly accessible to the public, with opening hours of between 50 to 100 hours per week and the majority of services accessible appointment free.

Michael Levitan outlined several examples to the committee of how the role of community pharmacists could be developed to the benefit of both patients and other healthcare providers. In particular, the possibility of utilising community pharmacists to reduce pressures on other healthcare providers was highlighted. The Minor Ailments service which had been introduced by Brent PCT and had ceased at the end of 2011, had enabled people to be diagnosed by community pharmacists for minor issues and obtain the appropriate medicines without attending a General Practitioner (GP). Work had been conducted which indicated that up to 20 per cent of GP appointments could be freed-up via this service. Similarly, there was evidence to suggest that up to 30 per cent of attendances at Northwick Park Accident and Emergency could have been dealt with at community pharmacies. Services that were currently being delivered by community pharmacists in Brent included flu vaccinations and an increased support role as part of hospital discharge planning. This latter service had been introduced at the end of 2012 and encompassed the provision of advice to patients or domiciliary carers on medicines received in hospital and on other therapeutic options. This service helped to encourage and enable patient compliance in taking their medicines. Martin Levitan concluded his presentation by noting it was essential that community pharmacists were included within discussions on public health issues.

In the subsequent discussion, members sought clarification on what actions were being taken by the Brent and Harrow Local Pharmaceutical Committee to champion good practice and the implementation of innovative initiatives in Brent. Further information was also requested on the level of demand from community pharmacists for expanding their role in public health and wellbeing. It was queried why the Minor Ailments service in Brent had ceased at the end of 2011. Members noted that incidents of community pharmacists providing medicines illegally had recently been publicised, with two of these incidents occurring in Brent. In light of this, several queries were raised on the mechanisms in place for self-regulation and inspection within the professional association for community pharmacists and the sector in general.

Responding to members' queries, Michael Levitan advised that the Brent and Harrow Local Pharmaceutical Committee had previously met regularly with the PCT and there had been some cases of very successful collaborations, such as the smoking cessation service. Many community pharmacists were very interested in expanding the types of services offered but it was acknowledged that the short length of contracts coupled with the investment in equipment and staffing often required could prove significant obstacles. A benefit of involving community pharmacists in the discussions around public health would be the increased confidence of community pharmacists in pursuing such developments. Ethie Kong (Chair of Brent Clinical Commissioning Group) added that minor ailment service would be revisited but would need to be developed to work more effectively. All public health services were working very hard to empower patients to engage to a greater extent in self-care and workshops were would be held to ensure that duplications in service provision would be avoided.

Turning to the incidents involving community pharmacists supplying medicines without prescription, Michael Levitan advised that the two cases that had occurred

in Brent had involved the supplying of antibiotics and not opiate based painkillers. Unlike the other cases that had been publicised, formal investigations had not been held for the incidents which took place in Brent. The committee was advised that community pharmacists were subject to very high levels of regulation and inspection by the Pharmaceutical Council. The PCT also had the right to conduct inspections on community pharmacies. It was emphasised that there were procedures which allowed community pharmacists to issue medication without prescriptions in emergencies.

Members noted that it would be useful to have greater information in respect of the evidence base for the initiatives and suggestions outlined in the presentation. The Chair advised that a deeper working relationship with the PCG, Public Health and Brent Council would be required to support community pharmacists developing a greater role in improving public health and wellbeing. It would also be important establish a substantive strategy setting out clear outcomes, expected benefits and budgets.

RESOLVED:

(i) that the report be noted
(ii) that an update be brought to the Committee in June 2013

7. **Tackling Diabetes in Brent Task Group - Final Report**

Councillor Colwill (Chair of the Tackling Diabetes in Brent Task Group) presented the final report of the task group to the committee. Members were advised that diabetes was a significant issue in the UK, with over 2.2 million people in the UK having been diagnosed with the condition. It was estimated that a further 850,000 people in England had diabetes but were unaware and had not been diagnosed. Diabetes currently accounted for 10 per cent of the National Health Service budget. The implications for Brent were compounded by the level of deprivation in the borough and the ethnic profile of Brent's residents. Specifically, there was a higher prevalence of diabetes amongst people of South Asian descent and African and African Caribbean origin and at present, 58 per cent of the Brent population originated from Black and ethnic minority backgrounds. Furthermore, deprivation had been linked with the diabetes and Brent was currently ranked within the top 15 per cent of the most deprived areas in the country.

Councillor Colwill explained that the task group had proceeded with the understanding that supporting preventative measures based upon education and the promotion of self-management was a key priority. The task group had concluded that whilst there was a lot of good work already being done to raise awareness of the disease, it was clear that further targeting of high risk groups was necessary. Members' attention was subsequently drawn to the ten recommendations of the task group set out in the report which encompassed a range of educational measures and proposed actions to be taken by the council to promote healthier lifestyles amongst Brent residents and council staff. In concluding, Councillor Colwill expressed his thanks to the members of the task group and to colleagues from the council and the NHS for their contributions and support.

RESOLVED:

(i) that the recommendations of the Tackling Diabetes in Brent Task Group be endorsed.
(ii) that the recommendations of the Tackling Diabetes in Brent Task Group be passed to the Executive for its consideration.

8. **Update on proposed merger of Ealing Hospital NHS Trust (EHT) and the North West London Hospitals NHS Trust (NWLH) and finances**

A report updating members on the proposed merger between Ealing hospital NHS Trust (EHT) and the North West London Hospitals (NWLH) NHS Trust was presented to the committee by David Cheesman (North West London NHS Hospitals Trust). The committee was advised that progress continued to be made towards merging the two trusts and it was expected that the earliest that the full business case for the merger would be submitted to the NHS London Board would be July 2013. NHS London had requested that financial modelling of the impact of "Shaping a Healthier Future" programme be included in the business case. At present, it was intended that the merger would go live on 1 April 2014. The committee was advised that the two trusts had begun to combine some back office functions, including the creation of shared IT and Estates departments. The trusts would continue to implement service sharing in other areas. In addition, as a result of vacancies arising in posts at EHT, the Chief Executive of NWLH had become the Acting Chief Executive of EHT and the Director of Nursing at NWLH had assumed the position of the Acting Director of Nursing at EHT. Steady progress was being made towards the financial targets associated with the merger which for 2012/13 equated to circa £16m for NWLH and £14m for EHT. NWLH was forecasting that it would deliver £13.4m of the planned savings, with the balance made up through other non-recurrent measures. The trusts were also working directly with the National Trust Development Authority (NTDA) which was the new NHS governing body due to take over responsibility for the oversight and support of non-Foundation Trusts from 1 April 2013.

During members' discussion, the committee raised a number of queries. Clarification was sought regarding the non-recurrent measures that would be taken to reduce meet the savings target of NWLH. A concern was also expressed by a member over whether those officers holding dual positions across the two organisations had sufficient capacity to manage the additional responsibilities over a time of significant change.

Tina Benson (North West London NHS Hospitals Trust) provided an example of the non-recurrent measures employed by NWLH to help reach its savings target for the year, explaining that where a vacancy arises in the organisation the Trust might chose to wait for a period before recruiting to the position to release a short term saving. David Cheesman confirmed that he was confident that the officers undertaking corresponding roles within the two organisations were able to manage in the present circumstances. Having one body to work with in the merger process was extremely beneficial. Furthermore, given the financial pressures the organisations were under it was appropriate to make cut-backs on senior posts where possible.

Responding to a further query, David Cheesmen advised that the Shaping a Healthier Future (SaHF) programme created both challenges and advantages for the Trusts. It had been hoped that the merger would have been completed prior to the implementation of SaHF to allow the organisations to undertake the challenges as a joint organisation; however, this had not been possible. SaHF did put pressure on Northwick Park Hospital and work was currently underway to explore issues of capacity.

RESOLVED:

That the report be noted.

9. **Accident and Emergency performance and activity at Northwest London Hospitals NHS Trust**

Tina Benson (North West London NHS Hospitals Trust) presented a report updating the committee on Accident and Emergency (A&E) performance and activity at North West London Hospitals (NWLH) NHS trust. It was highlighted that Northwick Park Hospital A&E continued to be under considerable pressure, principally in respect of assessment space within the department and bed capacity across the hospital. Performance against the four hour A&E waiting target had worsened over the winter and bed capacity was a key underlying cause of this. To address the assessment and acute bed capacity problems the trust was undertaking a complete site review. It was recognised that the Shaping a Healthier Future (SaHF) model was very different to the existing model in operation and relied significantly on an out of hospital strategy. This drew on evidence which indicated that a third of patients in hospital beds did not need to be in an acute setting. It was also anticipated that the £20m redevelopment of the A&E at Northwick Park would address some of the issues around the lack of assessment space. Turning to activity at Central Middlesex A&E, the committee was advised that this had continued to decline, although it had been busy in recent weeks due in part to the intentional pushing of activity away from Northwick Park in the interim period. The trust would be looking at how the emergency pathway could be consolidated and improved within the context of the possible outcomes of the SaHF programme.

In the subsequent discussion the committee requested an update on the redevelopment of the A&E at Northwick Park Hospital. Members also sought an update on the introduction of the 111 telephone service.

On the redevelopment of the A&E site at Northwick Park Hospital, Tina Benson explained that construction work was already underway and artists' impressions of the finished development were available. The business case had now been signed off. The underlying principal of the building was improved flow and flexible space. There would be no treatment specific rooms and instead the rooms would be suitable for the different purposes of various healthcare providers. Jo Ohlson (Brent Borough Director, NHS Brent), advised that it was important that a shift was made towards a focus on preventative care, noting that under the current system resources were predominantly orientated towards acute crisis management. Without such a shift in position, hospitals would face growing patient admissions. The perspective of the clinical commissioning group was focussed towards supporting good preventative primary care. With regard to the 111 service, a start

date of 19 February was currently in place; however, advertising of the new number would not begin until the following month. The delay in implementing the service had been due to IT issues. The contract would be signed by the forthcoming week.

In response to a question from a member of the public on potential issues of access for the redeveloped A&E facility at Northwick Park Hospital, Tina Benson advised that the access route to the facility would no longer be one-way as originally planned and that the London Ambulance Service (LAS) had signed off the plans for the new building.

RESOLVED

That the report be noted.

10. **Public Health Transfer Update**

A report was presented to the committee by Phil Newby (Director of Strategy, Partnerships and Improvement) and Alison Eliot (Director of Adult Social Care) updating members on the progress made in preparing for the transfer of public health functions from NHS Brent to the council. The transfer would take effect as of 1 April 2013, as required by the Health and Social Care Act 2012.

The report set out the agreed arrangements for the transfer of staff from NHS Brent to the council. Brent would have 19 public health staff split between the Adult Social Care department and Environment and Neighbourhood Services department. There would be a Director of Public Health (DPH) for Brent, who would manage the public health staff and would report to the Director of Adult Social Care. There would also be two public health consultants which would work across both departments on public health activity. A review would be held of the effectiveness of the functions and structure of the staffing arrangements after a period of 12 months. It was envisaged that all staff, with the exception of the DPH, would be appointed by the middle of February 2013. As the comparable DPH position was currently vacant in NHS Brent the council was in the process of recruiting to the post. However, it was considered unlikely a DPH would be in post in time for 1 April 2013.

The report also highlighted the current work taking place to ensure the successful transfer of existing contracts for public health services. The Executive had agreed that the majority of public health contracts would be extended and continued in 2013/14. The transfer of these contracts would take place under a statutory transfer arrangement (transfer order) and would take effect from 1 April 2013. Unfortunately, due to the complexity of the existing contract arrangements, officers were currently examining each contract individually to ensure it could be extended and included within the transfer order. It was emphasised that the council was committed to reviewing and re-commissioning public health services over the coming two years to comply with the council's procurement rules and ambitions for public health.

Phil Newby advised the committee that the public health allocation for the next two years had been better than anticipated and exceeded the baseline estimate of £16.007m. The ring fenced public health allocation would be £18.355m for 2013/14 and £18.848m for 2014/15. This would allow the council to meet contract and staffing costs and also have funding for development opportunities in public health.

A working budget was in place for 2013/14 and an indicative budget was being developed for 2014/15.

During discussion a member queried the current uptake of drug and alcohol services and the arrangements in place for sign posting service users to other appropriate services. Noting the three contracts that would not be extended in to 2013/14, the committee sought further details regarding alternative provision, particularly in relation to the Young Addaction – teenage pregnancy services and sexual health services for young people. Several queries were raised in relation to the structure and arrangements for public health staff. It was queried why the DPH was unlikely to be in post by 1 April 2013. A member also queried who would hold corporate responsibility for ensuring that teams who had not been used to supporting public health functions were doing so appropriately. Clarity was sought regarding public health staff within the Children and Families Department. A query was raised regarding the current number of public health staff compared to the number of posts transferring to the council. It was queried whether the public health consultants would be medical professionals.

Allison Elliot advised the committee that information on the take up of drug and alcohol services could be provided to the committee. These services were all delivered from the same location in Brent which eased the process of sign posting service users to other appropriate services. Brent was one of the most successful boroughs for treatment completion for these services. Information on Brent's ranking for successful treatment completion would be circulated to the committee. With regard to the sexual health advice provided under the Young Addaction service, the committee was advised that the contract would continue.

Turning to the issue of corporate responsibility for public health functions, Alison Elliot advised that this would fall to the DPH, and whilst that post was vacant, to other public health colleagues and the Director of Adult Social Care. At present, there were 26 permanent public health staff and there would be 19 public health posts transferring to the council. It was confirmed to the committee that the public health consultants would be clinical consultants. With regard to public health staff in Children and Families, the committee heard that colleagues in Children and Families had worked with the NHS to identify what public health investment was needed for children's services. This process was managed through the Adult Social Services commissioning board as it had capacity to support this. The committee was reminded that at present, the council did not have public health responsibilities for children under the age of 5 years old.

RESOLVED:

That the report be noted.

11. **Brent LINk Annual Reports 2011/12 and 2012/13**

The annual reports for Brent LINk (Local Involvement Network) for 2011/12 and 2012/13 were presented to the committee for its consideration by Mansukh Raichura (Chair of Brent LINk). Brent LINk was an independent network comprising individuals, community groups, voluntary sector organisations and local businesses, which worked together to improve local health and adult social care services in Brent. The annual reports detailed Brent LINk's structure, main activity and

achievements. With reference to the 2012/13 report it was noted that as this was the final year of Brent LINk's existence, it was allowed to produce the substantive part of its 2012/13 annual report earlier than would usually be required. Funding for Brent LINk would cease at the end of March 2013 and a new consumer champion organisation, Healthwatch Brent, was due to absorb into its broader functions the role currently carried out by Brent LINk. A legacy document was being developed to pass to Healthwatch Brent. Mansukh Raichura emphasised that the success of Brent LINk was due to the contribution and commitment of its members who had given a great deal their time and personal expertise to the organisation. It was intended that all existing Brent LINk members would become active members of the local Healthwatch when the service commenced.

The committee expressed its admiration for the work undertaken by Brent LINk and commended the organisation for its achievements.

RESOLVED:

That the annual reports of Brent LINk for 2011/12 and 2012/13 be noted.

12. **Work Programme**

The Chair drew the committee's attention to the work programme, noting the items scheduled for the next meeting. The committee was advised that an update following the publication of the Advisory Council on the Misuse of Drugs report on khat would be added to the work programme for the next meeting.

13. **Any Other Urgent Business**

ACMD Khat Report

Councillor Hunter advised that the Advisory Council on the Misuse of Drugs (ACMD) had published its report on Khat usage in the UK. The report was entitled 'Khat: A review of its potential harms to the individual and communities in the UK' and had concluded that there was insufficient evidence to warrant a ban on Khat. This mirrored the view of the Brent task group which had explored the health and social impact of Khat usage. The task group had contributed significantly to the ACMD review and an update on the task group's recommendations would be brought to the committee at its next meeting. Councillor Hunter highlighted that of the 24 members of the ACMD review, 15 were clinically qualified.

14. **Date of Next Meeting**

The committee noted that the next meeting of the Health Partnerships Overview and Scrutiny Committee was scheduled for 19 March 2013.

The meeting closed at 9.00 pm

S KABIR
Chair

This page is intentionally left blank

| | |
|---|---|
| | **Health Partnerships Overview and Scrutiny Committee**<br>19 March 2013<br><br>**Report from the Director of Strategy, Partnerships and Improvement** |
| | Wards Affected:<br>ALL |

# Incident involving Pathology Service for Brent and Harrow PCTs

## 1.0 Summary


1.1 There have been problems reported with pathology services being provided to Brent GPs. These are currently being investigated and the report outlines the findings and position to date.

1.2 The company TDL began providing pathology services to Brent PCT, Harrow PCT and North West London Hospitals Trust in May 2012. Services provide include Haematology, Biochemistry, Microbiology, Histopathology and Cytopathology.

1.3 A serious incident was logged in December 2012 after a concern was raised by a GP about the new system. It became clear that this was not an isolated case, and another GP complained of spurious results, missing results and samples not processed. It was further identified that training for GPs had not taken place and that alleged meetings with GPs had not in reality occurred. A number of issues have now been identified with different test results and these are listed in the report.

1.4 A number of issues have now been identified which are included in the report. Root causes identified so far include; general equipment stability, IT systems and sample handling systems, laboratory staff familiarity with equipment and systems, customisation of system to meet clinical needs of the trust and primary care.


## 2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to consider the report and question officers on the problems with the pathology service; including the impact it has had on patients results and diagnoses to date, the remedial measures being taken and what assurances can be offered that similar problems will not occur again.

**Contact Officers**

Mark Burgin
Policy and Performance Officer
Tel – 020 8937 5029
Email – mark.burgin@brent.gov.uk

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

# Investigation into incidents involving the Pathology Service for Brent and Harrow PCTs

## Background and context

In May 2009, Harrow PCT issued a letter to NWLHT the existing provider of the pathology service to Harrow GPs, notifying them that with effect from 2010/11, they intended to follow a tendering process to commission a new pathology service. Their stated intention was to lead the development of a joined-up approach to the commissioning and possible market testing of Direct Access pathology services.

The aims of the project were to ensure that the future configuration of pathology services provided capacity and capability to grow the pathology business and provide a robust, cost effective clinical service for NWLHT, NHS Brent and NHS Harrow. The service needed to be fit for the future and able to deal with increased volumes of activity going forward.

Other benefits, more difficult to quantify, would result from the proposed partnership. These included:

- Improved Primary Care access to service through order communications roll-out
- Reduction of duplication through visibility of results across the local health community
- Ability to support a robust demand management scheme
- Detailed activity reporting to understand requesting patterns and educate requesters in appropriate use of Pathology Services
- Ability to limit financial liability of existing growth through marginal pricing above baseline activity

The procurement process was paused in March and April 2011 to allow time to consider the implications of the NHS London review of pathology for the sector. It was considered prudent to proceed as the final London solution was likely to take 2-3 years to realise, and the existing pathology system at NWLH was in a critical state and not expected to be operational beyond October 2012.

The procurement scope included all of the general diagnostics pathology services i.e. Haematology, Biochemistry, Microbiology, Histopathology, Cytopathology. Out of scope of the procurement were:

- Consultant pathologists (they remain employed by the NWLHT)
- Transport (a separate procurement was required for this element)
- The mortuary
- Specialist Genetics Laboratories within the Kennedy Galton Unit of NWLHT

### *Timeline of significant events preceding the incidents*

TDL were appointed as Preferred Bidder in September 2011 with the aspiration that the service would go live on the 5th January 2012. This did not happen because of issues with leases and licenses and also because of a problem with the generator on the North West London Hospital Trust (NWLHT) site at Northwick Park Hospital.

The TDL contract as Pathology Provider to the three authorities (NWLHT, Brent PCT and Harrow PCT) commenced on the 01 May 2012. The contract management of this contract is a NWLHT manager on behalf of the three commissioners and the performance management of the contract sits with the CSU, with local support from the non-acute contracts manager for Brent and Harrow.

### *Courier Service*

The courier service was not part of the pathology service and was procured through a separate tendering process. The existing service provider was the successful bidder and the service continues to be provided by Revisecatch Limited (Courier Systems) who were appointed in October 2012 for a period of 4 years and 7 months to tie in with the Pathology service.

## Detection of incident

A Brent GP noted that individual patient results are now batched and that it was possible to view, action and if choose to file and archive, then all the results for that patient would be filed. He was concerned about the ability for results to be filed automatically into the patient's notes without the GP having authorized each of the results as normal or requiring action. This concern prompted the GP to alert the Chief Operating Officer at Brent PCT / CCG on 20 December 2012 who agreed to treat this as a near miss and log as a Serious Incident on the StEIS and Datix systems.

When the GP raised this with the PCT, a preliminary enquiry into the concerns was raised with the pathology service contract manager from NWLHT to determine the cause. It was thought to be an isolated incident and reassurances were given that appropriate support would be given. The GP subsequently contacted the PCT with other issues relating to the pathology service including missing results, codes had changed and samples returned as unable to process.

Upon further investigation, it became apparent that the assumption that the GP was alone in not being aware of the communications sent out by TDL and not having access to training provided around the new system, were erroneous. It became clear by 08 January 2013 that training had been not provided to any practices, that the alleged meetings with Practice Managers had not taken place and that this was not the only GP practice to experience these problems and steps were taken to resolve the issues raised.

Within days another GP contacted the PCT concerned about spurious results, missing results and samples not processed and it became clear that the remit of the investigation would have to be broadened to take account of both the formatting of results and the processing of samples. It was also found that reference ranges had changed and that there was a difference in the presentation of the results into groupings that did not make sense.

## Care and service delivery problems

From the date of go-live a number of issues presented themselves to clinicians as missing results, poor turnaround times and general poor quality of service provision. Specific issues that have caused difficulty in patient management include:

- Turnaround times, particularly noted by hospital clinicians in A&E and paediatrics;
- Un-reportable HbA1c results as a consequence of machine failure;
- Calcium results missing from some requests;
- A perceived increase in haemolysed samples;
- Second glucose results missing from glucose tolerance test requests;
- Missing results (sent to unknown inbox).

Other symptoms of a problematic service transition were also apparent such as:

- High levels of incorrect Potassium results, either too high a value or too low;
- Calcium – excessive numbers of low calcium levels were reported by many GPs;
- Unexpectedly low INR results with ensuing problems with clinical management of the patient;
- Abnormal results not phoned through to GP practices and not flagged on reports.

Spurious results and other issues relating to the reporting of results can arise through the many laboratory processes such as instrumentation e.g. laboratory equipment used (but also phlebotomy equipment and technique used), laboratory methodology for performing the tests, laboratory techniques used, the actual lab procedure may yield false-positive or false-negative results, chemicals or reagents used in the lab may be out-dated or contaminated or defective, clerical errors may occur that will give wrong test results, technical errors (problems with the machines that perform some automated tests) may occur that give false results and a variety of human errors in the laboratory may occur (mixing the wrong chemicals, wrong proportions, and so on). Each area has now been thoroughly investigated, a report is being finalised and will be available in mid-March.

## Initial Root Cause Analysis

As issues were identified NWLHT and TDL worked to understand and resolve the root causes. A number of concurrent factors occurred at the point of go-live to cause these issues which, in root terms have identified a combination of:

- General equipment stability,
- IT systems and sample handling systems set-up,
- Laboratory staff familiarisation with equipment and systems,
- Customisation of a system to meet the clinical needs of the trust and primary care.

This page is intentionally left blank

| | |
|---|---|
| | **Health Partnerships Overview and Scrutiny Committee**<br>19 March 2013<br><br>**Report from the Director of Strategy, Partnerships and Improvement** |
| | Wards Affected:<br>ALL |

# Shaping a Healthier Future

## 1.0 Summary

1.1 The Health Partnerships Overview and Scrutiny Committee has previously been presented with the proposals in the Shaping a Healthier Future programme. The final proposals were approved by the Joint Committee of Primary Care Trusts on February 19th and NHS North West London has asked for the opportunity to present the committee with details of how the programme will now be implemented.

1.2 The report summarises the services that each of the affected hospitals is intended to provide once the changes are implemented and how the changes affect different areas.

## 2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to consider the report and question officers on the plans and the timetable for their implementation.

### Contact Officers

Mark Burgin
Policy and Performance Officer
Tel – 020 8937 5029
Email – mark.burgin@brent.gov.uk

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

This page is intentionally left blank

Shaping a healthier future

NHS North West London

# Major decision made on the future of healthcare in NW London

On 19 February, the Joint Committee of Primary Care Trusts (JCPCT) agreed with all the recommendations put forward by the 'Shaping a healthier future' programme following public consultation.

This will mean:

- Investing over £190m in out-of-hospital care to improve healthcare facilities and services in the community including care provided by GPs.
- The five major acute hospitals with a 24/7 A&E and Urgent Care Centre (UCC) will be: Chelsea and Westminster; Hillingdon; Northwick Park; St Mary's; and West Middlesex.
- Both Ealing and Charing Cross Hospitals will have local hospital services which include outpatient services, diagnostics and a 24/7 Urgent Care Centre. But the JCPCT also recommended that further proposals for these two hospitals are developed in future by the relevant Clinical Commissioning Groups (CCGs).
- Central Middlesex Hospital will be a local and elective hospital – which includes a 24/7 Urgent Care Centre.
- Hammersmith Hospital will be developed as a local and specialist hospital and will include a 24/7 Urgent Care Centre.
- Investing in new, 21st Century hospital facilities, especially at St Mary's, Northwick Park, Hillingdon, Ealing and Charing Cross.

The 'Shaping a healthier future' proposals will now take 3-5 years to implement, ensuring that improvements in out-of-hospital care are in place before changes to hospital services that rely on good out-of-hospital services are implemented.

The full press release, which includes the 13 recommendations, can be found on our website: www.healthiernorthwestLondon.nhs.uk/news

# Decision by Ealing Council O&SC to refer decision to Secretary of State

Ealing Council has asked the Secretary of State for Health to consider the programme. This is a shame, as this process normally takes a few months and will delay implementation of much needed improvements to local services which the majority of clinicians, local GPs and other local councils want to see go ahead.
However, the NHS will continue what planning it can and remains committed to working with Ealing Council and further developing its local community health strategies, of which Ealing Hospital will be a critical part.

# What this means for each hospital

**Central Middlesex** – an elective and local hospital with a UCC, outpatient services and tests, non-complex planned surgery and medicine with associated high dependency beds. Brent CCG is considering whether additional services could be provided on the same site. These could include primary care services, community therapies, community diagnostics, neurological rehabilitation beds and specialist renal services.


**Charing Cross** – a local hospital with a UCC and outpatient services and tests, providing mental health services (inpatient and outpatient), and undergraduate and postgraduate training for local hospital services. Hammersmith & Fulham CCG is considering whether Charing Cross could be developed into a specialist health & social care hospital. This would provide primary care services, community therapies and beds, sexual health clinics and specialist renal and ambulatory cancer care (see below for more information on additional proposals).

**Chelsea & Westminster** – a major and local hospital with a 24/7 A&E and associated emergency surgery, complex medicine and surgery and intensive care beds. It would have specialist inpatient children's services and consultant-led and midwife-led maternity units. It would also have a 24/7 UCC and provide outpatient services and tests.

**Ealing** – a local hospital with a 24/7 UCC and outpatient services and tests. West London Mental Health Trust would continue to provide mental health services from this campus. Ealing CCG is considering whether additional services could be provided on the same site. These could provide primary care services, community therapies and beds, sexual health clinics, mental health services (inpatient) and specialist renal and chemotherapy services (see below for more information on additional proposals).

**Hammersmith** – a specialist and local hospital with a consultant-led maternity unit with specialist cardiothoracic, colorectal, urology, transplantation, gynecology and cancer services. It would have a UCC, outpatient services and tests.

**Hillingdon** – a major and local hospital with a 24/7 A&E and associated emergency surgery, complex medicine and surgery and intensive care beds. It would have inpatient children's services and consultant-led and midwife-led maternity units. It would also have a UCC, outpatient services and tests.

**Northwick Park** – a major and local hospital with a 24/7 A&E and associated emergency surgery, complex medicine and surgery and intensive care beds. It would have inpatient children's services and consultant-led and midwife-led maternity units. It would also have a UCC, outpatient services and tests. It would continue to have a hyper acute stroke unit.

**St Mary's** – a major and local hospital, a hyper acute stroke unit (moved from Charing Cross Hospital) and a specialist ophthalmology hospital (moving the Western Eye Hospital) with a 24/7 A&E and associated emergency surgery. It would also deliver complex medicine and surgery and have intensive care beds. It would have inpatient children's services and consultant-led and midwife-led maternity units. It would also have a UCC, outpatient services and tests, and continue to be the major trauma centre for NW London.

**West Middlesex** – a major and local hospital with a 24/7 A&E and associated emergency surgery. It would also deliver complex medicine and surgery and have intensive care beds. It would have inpatient children's services and consultant-led and midwife-led maternity units, as well as a UCC, outpatient services and tests.

# Charing Cross & Ealing

During consultation, we heard from a wide range of people. We listened to the concerns and began to develop proposals for Ealing and Charing Cross hospitals. These proposals seek to:

- bring together some services that are dispersed across the boroughs in poor quality facilities; and
- retain other services where it is clinically reasonable and cost effective to do so – especially services for people who need regular treatment or who are often weakened by their illness – for instance people with cancer or needing renal dialysis.

The JCPCT agreed that an Outline Business Case and then a Full Business Case should be developed on these alternative proposals. It will take around six months to create the Outline Business Case.

**Additional services proposed at Charing Cross**
The proposals for Charing Cross already include a 24/7 urgent care centre which would be able to accept non-blue-light ambulances, diagnostics and outpatients. The new plans would involve up to £88m of investment, including:

- Around 50 'step up/step down' beds which would be able to accept overnight stays in urgent (but not critical or life-threatening) situations
- A primary, secondary and social care hub for the local population, particularly for elderly patients and those with long-term conditions
- A diagnostics service, comprising X-ray, Ultrasound, CT and MRI scanning, endoscopy and ECG
- An ambulatory cancer care centre, including delivery of radiotherapy and chemotherapy and the continued presence of Maggie's Cancer Care Centre
- A kidney dialysis centre
- Imperial College teaching facilities

**Additional services proposed at Ealing:**
The proposals for Ealing already include a 24/7 urgent care centre which would be able to provide outpatient appointments, accept non-blue-light ambulances and perform a variety of tests. In fact most people currently attending the hospital would continue to go there. The new plans would involve up to £83m of investment, including:

- Around 50 'step up/step down' beds (through the potential relocation of Clayponds, which would require further consultation) which would be able to accept overnight stays in urgent (but not critical or life-threatening) situations
- A primary, secondary and social care hub for the local population, particularly for elderly patients and those with long-term conditions
- An enhanced diagnostics (tests) service, comprising X-ray, Ultrasound, CT and MRI scanning, endoscopy and ECG
- A day assessment centre
- Pregnancy assessment centre
- Specialist palliative care at Meadow House
- Ambulatory chemotherapy
- Kidney dialysis

# What this means for each area

These proposals are not just about changes to A&Es, they also aim to improve the care that residents receive outside of hospitals. The £190m we aim to invest in out-of-hospital care will go to improving GP access and local health centres or 'hub's (which will provide a greater range of services that they do now) and providing treatment in patients' homes.

**Brent CCG:**

- Develop three hubs: Central Middlesex Hospital and existing sites at Wembley Centre for Health and Care and Willesden Centre for Health and Care

- At the end of the five-year programme, Brent CCG's budget for out-of-hospital services will be £30m higher than it is currently
- £10–30m of capital investment in estate, including £9m for the local hospital Central Middlesex Hospital, £1–4m in hubs/health centres (including Central Middlesex Hospital), and up to £17m in primary care

**Central London CCG:**
- Investing in three hubs/health centres in the north, centre and south of the borough supported by two GP centres
- At the end of the five-year programme, Central London CCG's budget for out-of-hospital services will be £16m higher than it is currently
- £1–19m of capital investment in its estate, including £1–17m in hubs/health centres and up to £2m in primary care

**Ealing CCG:**
- Establishing five hubs/health centres supported by services at Ealing Hospital to support network operations and provide better access to care for Ealing residents
- At the end of the five-year programme, Ealing CCG's budget for out-of-hospital services will be £31m higher than it is currently
- £20–67m of capital investment in its estate, including £19m for local hospital services at Ealing Hospital, £1–32m in hubs/health centres (including hub services at Ealing Hospital in the higher estimate), and up to £16m in primary care

**Hammersmith and Fulham CCG:**
- Developing three sites to support five networks of care in the north, centre and south of the borough including the use of Charing Cross Hospital as a hub/health centre offering primary care, therapies and further diagnostic services
- In addition, two further satellite sites will provide co-ordinating functions to ensure coverage of all five networks
- Over the five-year life of the programme, Hammersmith and Fulham CCG plans to increase the funding of out-of-hospital services by £17m a year
- £17-41m of capital investment in its estate, including £15m local hospital services at Charing Cross Hospital, £1–25m in hubs/health centres (including Charing Cross Hospital), and up to £1m in primary care

**Harrow CCG:**
- Developing at least three hubs/health centres and six care networks (which will provide a more comprehensive service, sharing expertise, staff and facilities
- At the end of the five-year Programme, Harrow CCG's budget for out-of-hospital services will be £30m higher than it is currently
- £1–21m of capital investment in its estate, including £1–11m in hubs/health centres and up to £10m in primary care

**Hillingdon CCG:**
- Developing three hubs: to the north, potentially either at Mount Vernon Hospital or Northwood and Pinner Hospital, a central hub, potentially either at a new build at RAF Uxbridge or Hillingdon Hospital, and a southern hub at the HESA Health Centre
- At the end of the five-year programme, Hillingdon CCG's budget for out-of-hospital services will be £28m higher than it is currently
- £2–22m of capital investment in its estate, including £2–11m in hubs/health centres and up to £11m in primary care

**Hounslow CCG:**

- Implementing a modern primary care model by maximising clinical space in existing sites and relocating GP practices with estates challenges
- To this end, the CCG plans to maximise the use of its largest site, the Heart of Hounslow, by providing services such as integrated adult and social care, sexual health and an additional GP practice from the site. The CCG is also drafting plans to co-locate GPs to modern primary care estates
- Proposes the rebuilding of Heston and co-locating two additional practices into the site, developing a 'Bedfont' solution for two practices (at a site to be agreed), and co-locating three practices each into Meadows and West Middlesex University Hospital
  At the end of the five-year programme, Hounslow CCG's budget for out-of-hospital services will be £23m higher than it is currently
- £2–12m of capital investment in its estate, including £1–11m in hubs/health centres and up to £1m in primary care

**West London CCG:**

- Developing two sites: a hub/health centre at St. Charles to serve the north of the Borough and a hub/health centre spanning two sites in Earl's Court to serve the needs of the south
- The CCG is also looking at developing its provider networks as a way for practices to work together
- At the end of the five-year programme, West London CCG's budget for out-of-hospital services will be £15m higher than it is currently
- £1–19m of capital investment in its estate, including £1–2m in hubs/health centres and up to £17m in primary care

Chapter 8 and appendix J in the DMBC set out each CCG's plans in more detail.

## Shaping a Healthier Future – March 2013

This page is intentionally left blank

| | |
|---|---|
| | **Health Partnerships Overview and Scrutiny Committee**<br>19 March 2013<br><br>**Report from the Director of Strategy, Partnerships and Improvement** |
| | Wards Affected:<br>ALL |

# Emergency Services at Northwick Park and Central Middlesex Hospitals

## 1.0 Summary

1.1 The Health Partnerships Overview and Scrutiny Committee requested an update on issues faced by the Emergency Department at Central Middlesex Hospital (CMH), particularly its ongoing overnight closures. This report covers wider long-term plans and prospects for the provision of Emergency Services at the two hospitals.

1.2 The report outlines a number of issues faced by Emergency Services within the trust. These are principally that:

- the trust has ongoing problems recruiting staff and is heavily reliant on locum staff;
- the Emergency Department at Central Middlesex has ongoing overnight closures due to concerns over the ability to properly staff the service overnight;
- increasing patient levels at Northwick Park along with decreasing patient levels at Central Middlesex.

To address these issues, the Trust has established a project board to explore with staff and stakeholders how it can reorganise its emergency services across the two sites.

1.3 The proposals in the Shaping a Healthier Future programme were agreed by the Joint Committee of PCTs for North West London in February. These proposals include the closure of the Emergency Department at Central Middlesex. Whilst these changes are expected to take up to three years, the Trust believes it is sensible to start discussions now.

## 2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to consider the report and question officers on the impact of the proposals and what outcomes they expect the changes to deliver.

**Contact Officers**

Mark Burgin
Policy and Performance Officer
Tel – 020 8937 5029
Email – mark.burgin@brent.gov.uk

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

March 2013

# Update for Brent Health Partnership Overview and Scrutiny Committee

This report provides an update on key developments that are being discussed in relation to emergency services at Northwick Park and Central Middlesex Hospitals.

---

## 1. Exploring a new model for emergency services at The North West London Hospitals NHS Trust

### 1.1 Overview

The North West London Hospitals NHS Trust is beginning to discuss with key stakeholders some developments in relation to its emergency services at Northwick Park and Central Middlesex Hospitals.

### 1.2 The case for change

In line with developments across the country, urgent care centres were commissioned at Northwick Park and Central Middlesex. At Central Middlesex this resulted in activity through the Emergency Department (ED) dropping significantly from an average of 200 to fewer than 40 patients per day.

The Trust has one of the lowest ratios of consultant-medical-staff-to-patient activity in London, and has been heavily reliant on locum medical staff at consultant and middle-grade levels for a number of years, despite repeated attempts at recruitment. For example, it has advertised for consultants three times in the last 12 months and is about to advertise again.

In October 2011, following concerns regarding the Trust's ability to provide consistent senior medical staffing in the CMH unit over winter, with NHS North West London it agreed an interim overnight closure of the ED, which commenced on 14 November 2011 and continues to date.

At Northwick Park Hospital (NPH), emergency activity has risen at a rate of at least 10% per annum for the last three years. This affects the Trust's ability to meet the four-hour waiting target and to schedule operations in a timely manner. In the last 12 months, the CMH ED overnight closure has accounted for only 2% of the total increase in emergency activity on the NPH site.

The Trust is reluctant to face another winter as busy as the last two, running two Emergency Departments with not enough permanent senior and middle-grade doctors, too much activity on the larger site and too few patients on the smaller site.

For example, Central Middlesex ED is seeing an average of only 38 people a day, but that has dropped to as low as 12 and is regularly below 25, and at the most only about 18 people a day are admitted to the hospital. Northwick Park regularly admits more than 70 patients per day and sees more than 250 patients in the ED each day.

### 1.2 Next steps

Taking all this into account, the Trust Board, with support from commissioners, has agreed that it should start discussions with staff and other stakeholders to explore how it reorganises its emergency services across the two sites to make the best use of staff and other resources, given the issues it is facing.

It has now established a project board to oversee this work, which includes senior representatives and clinicians from the Trust and its NHS partners. It met for the first time last month (February) to agree its terms of reference and, among other considerations, will examine how the Trust can develop a more robust emergency department at Northwick Park.

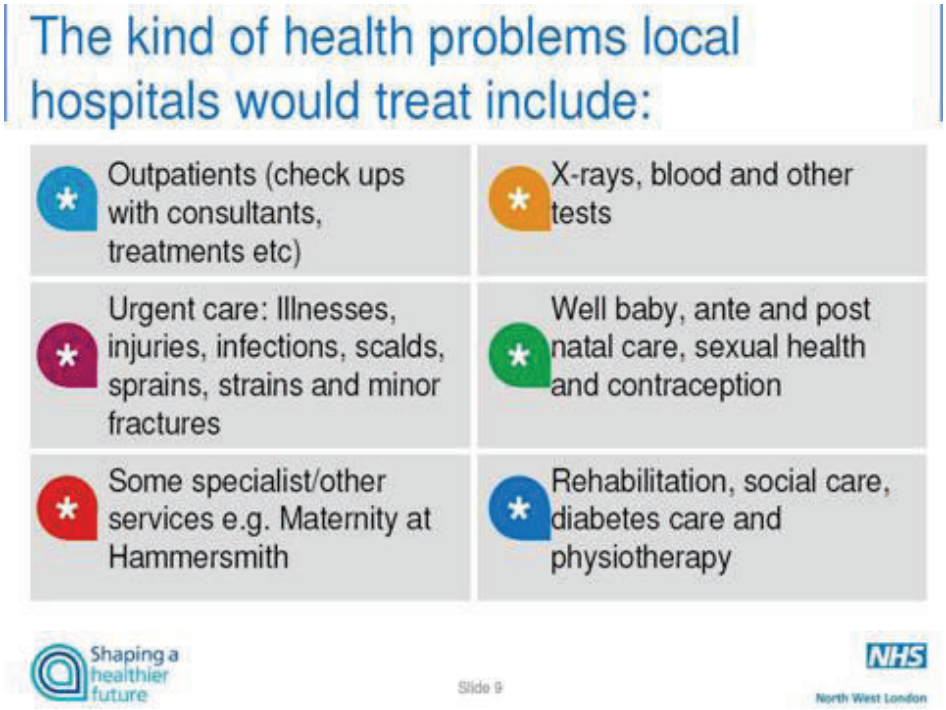
## 2. The future for Central Middlesex Hospital

### 2.1 *Shaping a healthier future*

You may also be aware that the Joint Committee of PCTs for north-west London met in public last month (February) and agreed with all the recommendations put forward by the *Shaping a healthier future* programme following public consultation, which includes the closure of the Central Middlesex Emergency Department: http://www.healthiernorthwestlondon.nhs.uk/news/major-decision-made-future-healthcare-nw-london.

The *Shaping a healthier future* programme has recommended that Central Middlesex becomes a local hospital. It would continue to provide planned procedures and services such as outpatients and routine surgery, as well as a 24/7 Urgent Care Centre. Acute services would, however, no longer be provided on site.

It is important to acknowledge that Central Middlesex Hospital will continue to have a very important role to play, albeit a different one, in caring for people locally in the future.




Although the *Shaping a healthier future* proposals are expected to take up to three years to implement, the Trust believes it is sensible to start discussions now (for the reasons mentioned above).

### 2.2 Staff engagement

The Trust understands that change can be very unsettling for staff and it is sharing as much information as it can with them. No changes will take place until it has worked through all the detail and can assure its Board that it understands all the implications of any changes to services. A key part of this assurance will be creating extra capacity at Northwick Park.

These changes are not a reflection on staff or the services provided at Central Middlesex, who continue to do a terrific job, but the Trust cannot pretend that there will be no changes. What is important is that any changes are made in a planned way and with their full involvement.

Staff are naturally anxious about what all these changes mean for them personally, but the Trust is clear that it does not want to lose the valuable skills and talent it has in the organisation and expects that, with its level of vacancies and staff turnover, and with flexibility on everyone's part, the likelihood of people losing their jobs is small.

Once there is a clearer picture about what these decisions mean for every ward and department, the Trust will discuss with every member of staff what any changes mean for them personally. None of these changes will happen overnight.

In the meantime, senior managers and executive directors have made themselves available on site very day at Central Middlesex for a period of two weeks and staff forums have been arranged at both the Trust's hospital sites.

### 2.3 Local engagement

The Trust is engaging with a wide variety of local stakeholders, including the following:

***Operationally***
- LAS (via Cluster)
- UCC (via NHS Brent)
- Ealing Hospital – ICO borough directors
- Imperial
- Barnet Hospital
- Royal Free
- Hillingdon
- West Middlesex
- West London Mental Health
- CNWL
- C&W
- CCGs – Brent CCG Chair due to take questions at CMH staff forum on 19 March
- All GPs

***Opinion formers:***
- MPs
- London Assembly member
- LBB & LBH
    - Leaders of Council
    - Chief Executives
    - Councillors
    - Directors
    - Overview and Scrutiny Committees/Health Select Committees
- NHS NW London
- PCTs and CCGs
- LINks
- NHS London
- NTDA

***Wider stakeholder groups***
- All staff and staff side representatives
- Voluntary organisations, campaign groups, support groups, community leaders, faith groups
- DH, NHS London
- Professional bodies
- Health regulators (CQC)
- Deanery and Foundation school

These are never easy discussions to have and the Trust accepts that they may be difficult for the Committee and for local people generally, but it strongly believes this is in the best interests of patients and staff. By starting these discussions now it can ensure any changes are made in a planned way.

The Trust would like to acknowledge all the hard work of staff working in its two Emergency Departments and the emergency pathway generally. Its priority is to support them so it can continue to provide the best service it can.

Finally, I would like to thank you for the interest you have shown in this Trust over the years. Naturally, I will keep you updated in the coming weeks and months.

**David Cheesman**
**Director of Strategy**
**The North West London Hospitals NHS Trust**

This page is intentionally left blank

| | |
|---|---|
| | **Health Partnership Overview and Scrutiny Committee**<br>19 March 2013<br><br>**Report from the Director of Strategy Partnership and Improvement** |
| | Wards Affected:<br>ALL |

# Scope Document - Tackling Violence Against Women And Girls in Brent

## 1.0 Summary

1.1 Members of the Health Partnership Overview and Scrutiny Committee on a number of occasions, expressed an interest in forming a task group to tackle violence against women and girls in Brent; focusing on Female Genital Mutilation (FGM), Honour Based Violence (HBV) and Forced Marriages (FM). A scope for this task group is attached as appendix A.

## 2.0 Recommendations

2.1 The Health Partnership Overview and Scrutiny Committee to agree the set up of the task group;

2.2 The Health Partnership Overview and Scrutiny Committee to agree the members of the task group.

## 3.0 Detail

3.1 The attached scope covers four main areas, the first is “Why?” we are looking at FGM, HBV and FM; this section looks at Brent’s ethnic diversity and the communities that use these practises. Recent legislative developments and a description of the three practises the task group will be reviewing.

3.2 The second area focuses on “What are the main issues?” These have been highlighted as: high prevalence levels, lack of knowledge and underreporting; and prosecuting perpetrators.

3.3 The third section centres on “What should the review cover?” It is proposed that members focus the five main areas below:

1. Highlight and educate communities about reporting

2. Improving access to support - Mapping existing services
3. Addressing health, social and economic consequences of violence
4. Protecting women and girls at risk
5. Getting tougher with perpetrators

A researched list of potential partners, best practise councils and government bodies is included in the scope. This will give members credible sources for reliable data and evidence.

3.4 The final section "What could the review achieve?" highlights eight areas that the task group could focus on achieving. This includes supporting the Brent FGM steering group and informing the Brent Violence Against Women and Girls in Brent (VAGAW) strategy, currently being produced.

## 4.0 Financial Implications

4.1 None

## 5.0 Legal Implications

5.1 None

## 6.0 Diversity Implications

6.1 None

## 7.0 Staffing/Accommodation Implications (if appropriate)

7.1 None

## Background Papers

Scope – Tackling Violence Against Women And Girls in Brent

## Contact Officers

Kisi Smith-Charlemagne
Policy & Performance Officer

## Scope Document

## Tackling Violence against Women and Girls in Brent – Female Genital Mutilation, Forced Marriages and Honour Based Violence

**1. Why are we looking at this area?** Have there been recent legislation/policy changes? Are there any performance or budgetary issues?

Violence against women is an illegal, intolerable act and is a human rights violation. It is both fundamentally wrong and has wider affects in preventing women from fully contributing in; and as part of society. Violence against women is both a barrier to equality and an effect of inequality.

Brent is recognised as *the* most ethnically diverse local authority in the country; and a significant proportion of Brent's communities have religious and cultural ties to the practises' of Female Genital Mutilation (FGM), Honour Base Violence (HBV) and Forced Marriages (FM). These practises are prevalent in more than 28 African countries, some Asian and South American countries and Afghanistan, Iraq and some Kurdish communities. All of the offenses that we wish to tackle with this review are considerably under reported, and it is imperative to raise awareness, provide advice and support our communities to tackle inequality and violence; and prosecute perpetuators when ever these offenses occurs in Brent.

In September 2012, The Home Office announced that the definition of domestic violence be implemented in March 2013 and states: "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: Psychological, Physical, Sexual, Financial and Emotional".

"Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. "Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim". * This definition of controlling behaviour, which is not a legal definition, includes so called **'honour' based violence, female genital mutilation (FGM)** and **forced marriage**, and is clear that victims are not confined to one gender or ethnic group.

In June 2012 the Prime Minister announced, forcing someone to marry will become a criminal offence in England and Wales. The decision to create a specific offence of forced marriage follows a 12 week consultation which took views from the public, victims, charities and frontline agencies. The new law will be accompanied by a range of measures to increase protection and support for victims and a continuing focus on prevention.

**Female genital mutilation/cutting (FGM/C)** – involves the complete or partial removal or alteration of external genitalia for non-medical reasons. It is mostly carried out on young girls at some time between infancy and the age of 15; and its extensive harmful health consequences are widely recognised.

**Honour' based violence** – violence committed to protect or defend the 'honour' of a family and/or community. Women, especially young women, are the most common targets, often where they have acted outside community boundaries of perceived

acceptable feminine/sexual behaviour. In extreme cases the woman may be killed.

**Forced Marriage** – One or both people do not (or in cases of people with learning or physical disabilities, cannot) consent to the marriage and pressure or abuse is used. The pressure put on people to marry against their will can be physical (including threats, actual physical violence and sexual violence) or emotional and psychological (for example, when someone is made to feel like they're bringing shame on their family).

## 2. What are the main issues?

### *1. Reducing Violence against women and Girls - Prevalence*

**Violence against women**

London has the highest rate of female victimisation in England and Wales.[1] Compared to the rest of the country, London has the lowest percentage of successful outcomes (measured as convictions of prosecuted cases) for violence against women offences (only 62 per cent were successful last year compared to 72 per cent nationally).[2]

**Female genital mutilation (FGM)**

An estimated 6.3 per cent of pregnancies in inner London [3] and 4.6 per cent in outer London are to women with FGM.[4] There have been no convictions for FGM since it was outlawed in 1985, compared to 100 in France.

FGM has been illegal in the UK since 2003 and is prevalent in 28 African countries as well as in parts of the middle East and Asia. FORWARD[i] estimated that over 20,000 girls under the age on 15 are at risk of FGM and 66,000 women in the UK are living with the consequences.

**Honour' based violence (HBV)**

Nationally, there are around 12 so-called 'honour' murders a year.

The Metropolitan Police recorded 256 incidents linked to 'honour' in the year 2008/09, of which 132 were criminal offences. This is a 60 per cent rise for the year to April 2009.

**Forced Marriage (FM)**

January to May 2012 [5] - 594 cases where the FMU has given advice or support related to a possible forced marriage. 14% of calls involved victims below 15 years old, 87% involved female victims and 13% involved male victims. Countries of Origin: Pakistan (46%), Bangladesh (9.2%), UK (8.7%), India (7.2%), Afghanistan (2.7%), Within the UK the geographical distribution of instances was as follows: London (20.9%), West Midlands (16.7%), South East (10.4%), North West (5.1%), 25 instances involving those with disabilities (23 with learning disabilities, two with physical disabilities and two with both) were brought to the FMU's attention. Seven instances involved victims who identified as lesbian, gay, bisexual, and transgender (LGBT).

### *2. Highlighting Awareness and Under reporting of Violent Offenses*

FGM, HBV and FM are all criminal offenses which carry jail sentences, however many women and girls are unaware of this fact. With all three of the issues that we wish to review there is significant under reporting; as these subjects are highly sensitive, often secretive and often experienced by groups who are hard to reach using traditional approaches.

"Female Genital Mutilation is a taboo; Honour Based Violence and Forced Marriages are suffered in secret"

### *3. Perpetrators should be prosecuted*

The Crown Prosecution Services (CPS) announced in November 2012 its 10 point action plan on improving prosecution for FGM. This will involve looking at existing reporting duties for ***medical professionals, social care professionals and teachers*** in referring possible FGM cases to the police. As part of the action plan the CPS will explore whether evidence to prosecute offences under other legislation is possible and may be easier to support; such as section 5 Domestic Violence, Crime and Victims Act (DVCVA) 2004, as amended by DVCVA 2012, which creates an offence of causing or allowing a child or vulnerable adult to die or suffer serious physical harm. In March 2010 the Mayor of London launched his strategy "The Way Forward"[ii] Taking action to end violence against Women and girls, using a pan London approach.

**3. What should the review cover?** Brief outline of what members could focus on, which partners to engage with, how residents/public can be involve.

***1. Highlight and educate communities about reporting***
Highlight the prevalence of violence against women and girls and educate our communities about reporting violent crimes. We want to make violence against women and girls a priority for service providers.

***2. Improving access to support - Mapping existing services***
Consider how to improve the safety, wellbeing and freedom of women and girls through better access to improved Brent and partner services that meet the needs of individual communities. Promote integrated support services for the most marginalised and at-risk females.

***3. Addressing health, social and economic consequences of violence***
Reduce the long-term consequences of violence for women who experience it, improve their life chances and support them in rebuilding their lives.

***4. Protecting women and girls at risk***
Ensure that council services are aware of all the risks and can identify women or girls that may be at risk, with clear guidelines and paths to follow. Working in partnership with key statutory and voluntary sector support services to improve the support, safety and satisfaction of victims.

***5. Getting tougher with perpetrators***
Consider how to stop perpetrators and hold them to account. Perpetrators must be deterred from violence against women and girls.

**Potential Service Partners**

FORWARD (The Foundation for Women's Health, Research and Development) - Was established in 1983 in the UK, in response to the emerging problems caused by female genital mutilation being seen by health professionals. Since this time FORWARD has been working to eliminate the practice and provide support to women affected by FGM; and also tackles child and forced marriages

IKWRO (Iran and Kurdish Women's Rights Organisation) - The Iranian and Kurdish Women's Rights Organisation provides advice and support to Middle Eastern women and girls living in the UK who are facing 'honor' based violence, domestic abuse, forced marriage or female genital mutilation.

Ashiana Network – Provide refuge and outreach services to South Asian, Turkish and Iranian women aged 16-30 who are experiencing domestic violence, forced marriages and /or sexual violence. Ashiana also provide generic training, counseling and support services for adults and young people affected by domestic violence.

Daughters of Eve - Daughters of Eve is a non profit organisation that works to protect girls and young women who are at risk from female genital mutilation (FGM). By raising awareness about FGM and sign-posting support services we aim to help people who are affected by FGM and ultimately help bring an end to this practice.

White Ribbon Campaign - The WRC is unique as the first male oriented organisation to oppose violence against women. The White Ribbon Campaign (WRC) is the UK branch of the global campaign to ensure men take more responsibility for reducing the level of violence against women.

**Local Partners**

Brent Safeguarding Children Board/ADVANCE in Brent
Provides guidance and information to all professionals that work with Children in Brent. ADVANCE is a specialist project that supports survivors of intimate partner domestic abuse and honour based violence / Forced marriages.

Brent NHS – Northwick Park and Central Middlesex Hospital Midwifery units (African Well Women clinic) Specialist clinics that are also linked to the antenatal clinics. Most clinics are run by specially trained doctors, nurses, or midwives who understand FGM and are able to treat some of the medical problems caused by it.

Brent Police - The MPS adopts an intelligence-led approach, identifying individuals at risk - such as a girl talking about going abroad with a relative for a 'special procedure' - and, with other agencies, will intervene. There are powers to remove at-risk children from families.

**Potential Best Practise Partners**

Bristol City Council - The Bristol CC has been leading a multi-agency effort for several years to raise awareness of the issue and train professionals to spot signs that a girl might be vulnerable to FGM. This has included an information campaign which has supported public health funding for a contract for FORWARD to work with community groups, train local advocates, talk to young people, run a drop-in advice centre and provide feedback and training to health workers.

London Borough of Barking and Dagenham (LBDB) - One of the first London boroughs to develop and produce a FGM strategy. The strategy acknowledged that FGM is a form of violence against women and girls. The strategy outlines how LBDB aim to prevent FGM from happening, improve borough services and professionals responses to women and girls who have undergone or are at risk of FGM, and ensure sensitive specialist support, information and advice is available to them.

Royal Borough of Kensington & Chelsea (RBKC), LB Hammersmith & Fulham (LBHF) and Westminster City Council (WCC) – Tri borough – These three neighbouring boroughs are working together to deliver awareness training on FM, HBV and FGM. Awareness of Cultural Practices and Safeguarding Women and Children, is delivered by the IKWRO (Iran and Kurdish Women's Rights Organisation) one of the leading charity in this area and a very creditable source.

London Borough of Lambeth (LBL) –Based on the LBL's approach to violence against women and girls; are rolling out awareness courses for FGM. The course aims to assist professionals to recognise indicators that a person is at risk, and what actions they should take to prevent and intervene where they suspect that female genital mutilation is a concern. It will also raise participants' awareness of legislation (Female Genital Mutilation Act 2003) and national government guidelines. The course places FGM within a child protection framework.

**Central Government Partners**

The UK All Party Parliamentary Group on Population, Development and Reproductive Health - The group aims to raise awareness on population, Development and reproductive health issues, providing a forum for facilitating negotiations between key stake holders and parliamentarians and encouraging initiatives that increase access to and improve reproductive and sexual health programmes worldwide.

Home Office - Violence against women and girls is the government department responsible for leading the national effort to protect the public from these crimes

Foreign and Commonwealth Office - Protecting British nationals who are at risk of being taken overseas for the purpose of FGM and forced marriages.

**Engaging with the Public**

Public events to raise awareness, sending a very clear message that community engagement, including men and boys, is the best way forward to tackle any ingrained views about these practice and that we will use the law to protect women and young people at every opportunity. The general public should be encouraged tackle inequality whenever and however it arises.

**4. What could the review achieve?** Influence policy change? Improvement to service delivery? Budget savings? Develop partnerships?

1. Highlighting areas where there is the potential to reach women and girls at risk, from domestic violence.
2. Work with partners to ensure that pathways for reporting risks and offences committed are clear, easy and stress free for women and girls.
3. Educate our uninformed communities about the changes in law, the human rights breaches and the consequences of such breaches – through Schools, GP's partners and voluntary groups such as FORWARD and IKWRO.
4. Identifying any funding available to support partners with work they are currently doing within Brent, providing support to reach more affected women and girls.
5. Empowering communities to inform and provide support from within; targeting hard to reach (underground) areas of some communities.
6. Inform the Brent VAWAG strategy currently being developed
7. Support the wok being carried out by the Brent FGM Steering Group
8. Inform the Health and Wellbeing board and Community Safety Partnership
9. Best Practise for other London boroughs to follow, through recognition of local authority responsibility to address these issues, and could hence establish Brent as an example of good practice in this area.

**Endnotes**

1. Home Office, 2004-8, British Crime Survey. Analysis of data comparing London rates with overall findings
2. Crown Prosecution Service, 2009, Violence against women Crime Report 2008-2009, p.70
3. These figures come from the only study in the UK that seeks to estimate prevalence. The research was funded by the Department of Health and undertaken by the Foundation of Women's Health
4. Forward, 2007, A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales
5. The Foreign and Commonwealth Office's Forced Marriage Unit (FMU) May 2012

[i] FORWARD, 2007, A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales

[ii] The Way Forward is the Mayors of London strategy to end all forms of violence against women in London launched in March 2010

This page is intentionally left blank

| | |
|---|---|
| | **Health Partnerships Overview and Scrutiny Committee**<br>19 March 2013<br><br>**Report from the Director of Strategy, Partnerships and Improvement** |
| | Wards Affected:<br>ALL |

# Public Health Transfer

## 1.0 Summary

1.1 The Health Partnerships Overview and Scrutiny Committee has requested an update on the transfer of Public Health functions to the council. The attached report will be presented to the Executive on 11th March setting out the final arrangements for the transfer of public health functions and staff from NHS Brent to the local authority.

## 2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to note the contents of the report and question officers on its contents and the progress of implementation.

### Contact Officers

Mark Burgin
Policy and Performance Officer
Tel – 020 8937 5029
Email – mark.burgin@brent.gov.uk

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

This page is intentionally left blank

| | |
|---|---|
| | **Executive**<br>11 March 2013<br><br>**Report from the Director ofStrategy, Partnerships and Improvement and the Director of Adult Social Care** |
| | Wards Affected:<br>ALL |

# Public Health Transfer Final Arrangements

## 1. Summary


1.1 This report sets out for the Executive the final arrangements for the transfer of public health functions and staff from NHS Brent to the local authority. Members have considered two reports previously on the transfer; the first relating to the staffing structure; the second on the extension and transfer of public health contracts. Since those reports have been considered further work has taken place and members need to be updated on the final arrangements ahead the formal transfer on 1st April 2013.

1.2 Arrangements also have to be made for the council to sign off the Transfer Scheme that will be issued setting out the assets and liabilities the council will be taking on. The Transfer Scheme is unlikely to be published before 11th March and so authority will need to be delegated to an individual to sign this on behalf of the council.


## 2. Recommendations

That the Executive:

2.1. Notes the update on the public health transfer

2.2 Notes the arrangements relating to the public health staffing structure and appointment of the Director of Public Health

2.3 Notes the final list of contracts transferring to the local authority from NHS Brent and arrangements for contracts where the council will be an associate commissioner

2.4 Approves the council's participation in a collaborative procurement exercise for the provision of Genitourinary Medicine (GUM) Services for 2013/14

2.5 Approves the collaborative procurement exercise detailed in paragraph 2.4 above being exempt from the normal requirements of Brent's Contract Standing Orders in accordance with Contract Standing Order 85(c) and 84(a) on the basis that there are good operational reasons as set out in the report

2.6 Delegates authority to the Interim Chief Executive to award contracts for the provision of GUM Services for 2013/14

2.7 Delegates authority to the Interim Chief Executive to sign the Public Health Transfer Scheme following consultation with the Director of Legal and Procurement ahead of the formal transfer on 1st April 2013.

**3. Report**

3.1 The council has been preparing for the transfer of public health responsibilities and functions from NHS Brent. As members will know from previous reports on staffing and contracts, there are numerous elements to the transfer which are coming together ahead of the formal transition on 1st April 2013. As with any project of this nature, changes and developments that have occurred since previous reports were presented to the Executive and it is important that members are clear on arrangements before the transfer happens.

**3.2 Public Health Staff**

3.3 One of the most significant elements of the public health transition is the transfer of staff from NHS Brent to the council. The Executive has considered a report previously on the public health staff and agreed a structure for the service. Once agreed by the Executive the structure was the subject of a 30 day engagement period with staff from NHS Brent. The Chief Executive also commissioned an independent review of the proposals as part of this process. As a result of the engagement with staff and the independent review it was agreed that:

- Twenty-two public health staff will be transferred from NHS Brent to the council, with staff split across three departments – Adult Social Care, Environment and Neighbourhood Services and Children and Families.
- There will be a Director of Public Health for Brent only, based in the Adult Social Care Department ("ASC") and reporting to the Director of Adult Social Care. For the first 12 months after the transfer, the DPH will manage the public health staff in the ASC directorate and the public health budget. This arrangement will then be reviewed to assess the effectiveness of the function and the staffing structure.
- The public health staff in ASC will be responsible for commissioning public health services (such as substance misuse services and sexual health services); the staff in Environment and Neighbourhood Services will focus on delivering services directly and implementing health improvement programmes.
- Three members of staff will be based in the Children and Families Department, working on children's health in schools, early years settings such as nursery's and children's centres and providing training resources, especially around safeguarding. These posts have been added to the council's public health service since the original structure was published and will be reviewed in 12 months time to ensure that the arrangement is working.

3.4 At the time of writing, not all staff transferring to the council have been confirmed in their posts, but the majority have. Job matching panels have taken place to confirm appointments, and interviews held where it was not possible to match an existing member of staff, or where staff decided not to accept job offers from the council.

3.5 Currently five posts remain unfilled, although interviews are to take place for one of the posts on the 11th March. Posts that remain vacant on 31st March will pass to the council unfilled and the authority will be able to recruit to them in due course.

3.6 Two posts will take longer to confirm appointments. An Advisory Appointments Committee (AAC) is required to appoint the Public Health Consultant (Children), as this post was not successfully job matched. The AAC is still to be set up. Interim arrangements to cover this post will be made if a permanent appointment can't be confirmed before 1st April 2013. The second post affected is the Director of Public Health (DPH). Brent has agreed to appoint a DPH for the borough, and abandoned plans to share with another council. The post is vacant at NHS Brent and so it wasn't possible to job match. This means that the council will need to recruit to the post and this has started, but it is unlikely that the recruitment will be completed and the post holder able to start in post by 1st April 2013. NHS Brent has appointed an interim Director of Public Health and the council could continue with this arrangement after 1st April if it wishes to do so.

3.7 Between January and April staff transferring to the council will attend the corporate induction, Civic Centre induction and training and work with their receiving departments on departmental specific inductions as part of their integration into the local authority. Ahead of the transfer work plans for the coming six to 12 months will be agreed within departments so that staff are clear on their work priorities before they move to work full time for the council. Arrangements will also be made to enable staff to work from the council's buildings before April to aid integration into the local authority.

3.8 Public health structure charts are attached as appendices to this report so that members are familiar with the job titles, work areas and reporting lines ahead of transition.

**3.9 Public Health Contracts**

3.10 The majority of the public health budget is spent on contracts with NHS, private and third sector organisations that deliver public health services. Ensuring that the contracts are successfully transferred and services continue from April 2013 onwards is critical. The council is determined that services should be unaffected during the transition period and that service users are not disadvantaged by changes in contracting arrangements.

3.11 The Executive has previously approved a report on the public health contract transfer. Members agreed that the majority of public health contracts would be extended and transferred so that services continue in 2013/14 in line with the existing arrangements. Once public health services are successfully transferred to the local authority members will consider how they wish to commission services in the future, but the focus up to now has been on achieving a successful transfer of contracts and service continuity.

3.12 The process for transferring contracts from NHS Brent to the local authority is now less clear following announcements by the Department of Health. Officers had been working with colleagues from NHS Brent and provider organisations to ensure that

the work was done to progress the extension of contracts so that services continue after the 1st April 2013. This is still the intention. However it is possible that the council and PCT will have to put in place new contracts for each public health service if the Department of Health decides not to grant approval to contract extensions. Officers are still working to clarify this, and an addendum to this report will need to be tabled at the Executive meeting with the most up to date information.

3.13 In working with colleagues from NHS Brent, the council is clear that there are 37 public health contracts with external providers. It should be noted that this does not include the individual contract agreements with all GP practices and pharmacists in Brent that deliver services under local enhanced service agreements (LES agreements). Instead, each LES specification, e.g. with GPs to deliver Health Checks, is counted as one contract. The council does know that LES contracts can be extended and aren't affected by the Department of Health's announcements on contract extensions.

3.14 Work has taken place with the providers to prepare them for arrangements after 1st April. A series of due diligence meetings has been held with each organisation providing public health services to ensure that they are aware of the changes that are happening and that they are happy to continue providing services on the council's behalf beyond April 2013. These meetings have been very productive and all of the current contractors have confirmed that they are willing to have their contracts extended for 12 months and to continue providing services. It is not known whether they would be prepared to accept new contracts, but the assumption is that most, if not all, would.

3.15 Separately, discussions are being held with local GPs and pharmacists about the services they provide for public health (such as smoking cessation), which are commissioned via Local Enhanced Service (LES) agreements. The intention is to extend these agreements for 12 months, assuming GPs and pharmacists agree to this. Indications are that they are willing to have their LES agreements extended and arrangements are being made to do this.

3.16 Members of the Executive will recall that there were three contracts that they agreed shouldn't be continued in 2013/14 following recommendations from NHS Brent. They were:

- Central London Community Services - Contraceptive services.
- Young Addaction - Teenage pregnancy services and sexual health services for young people.
- Lonsdale Practice - Shared care for opiate users with high levels of need had been provided from the Lonsdale Practice.

3.17 In working through the regulations relating to the transfer and conducting due diligence with providers it has become clear that since the original report to the Executive, other contracts listed as transferring to the council no longer will. Similarly, not all contracts in scope to transfer had been confirmed in December 2012. The Executive should note that the following contracts will also not be transferring to the council and the reasons why:

- Infection Control Nurse – Ealing Hospital Trust – There has been some confusion about the future location of infection control services. However, the council has been advised that the infection control nursing contract is not a local authority responsibility and so this contract will transfer to the Brent Clinical Commissioning Group. The council only has to provide infection control services in care homes, and there is a separate contract which deals with this.
- Non-GUM Data Collection – NSCP / Health Protection Agency – In undertaking its due diligence the council contacted NSCP about this contract but was advised that as of January 2013 data collection from non-GUM services would be done by the Health Protection Agency / Public Health England from April 2013, without the need for a contract with the local authority. Therefore, the contract will not be transferring.
- Pan London HIV Prevention – This contract has been commissioned by NHS Kensington and Chelsea on behalf of PCTs across the capital, but it has not been possible (to date) to set up an arrangement to continue commissioning the service on a pan-London basis. London Council's are looking at the alternatives that can be put in place and in the meantime, because of the importance of this work, Brent will set aside the contract amount in a budget line to commission either a service in the borough in due course, or join pan-London arrangements if they emerge. But, the current contract will not transfer and will come to an end on 31st March.

3.18 The arrangement for contracts with acute trusts, such as North West London Hospitals, Ealing Hospital Trust and Central and North West London NHS Foundation Trust are slightly different to those with third sector providers. The council will be responsible for a number of services that are part of a larger contract with the acute trusts. NHS Brent is already working to agree new contracts with these providers, including the public health elements within those contracts. Guidance has indicated that the council will be associate commissioners of these services, with the contract transferring to Brent CCG as the majority of services in the contract will be the CCGs responsibility. This is how the Department of Health have asked council's to manage this, if they did not disaggregate the public health elements from the main contract. In the time available, it was not possible to disaggregate the contracts and retender the services provided under these contracts.

3.19 Under the proposed arrangement the council will manage its elements of the contract and the provider will be answerable to the council for contract performance. The council will agree appropriate agreements with Brent CCG for these services, so that payments can be made from the council to providers, via the CCG. The services affected are:

- Chlamydia screening services - North West London Hospitals
- Clinical prescribing services - CNWL Foundation Trust
- School nursing and national child measurement programme - Ealing Hospital Trust
- Intensive Lifestyle Advice - Ealing Hospital Trust
- Infection control – Ealing Hospital Trust
- Looked After Children's Nurse

3.20 The final contract for which a different solution is being developed is for Genitourinary Medicine (GUM) Services. The council will have a statutory duty to ensure that residents in Brent have access to GUM services, which diagnose and treat sexually transmitted infections. It is the single biggest area of spend in the public health budget, and members should be under no illusions that demand for this service presents one of the biggest risks to the council in connection to this transfer. Data on activity is patchy and there is significant potential for costs to vary depending on the activity data reported.

3.21 Officers have been working with colleagues from other boroughs in North West London to try to agree an approach to agree contracts with providers in the sector for GUM activity which would help limit the council's financial exposure. It had been hoped to secure contracts by commissioning via the North West London Commissioning Support Unit (CSU). However, despite many months of work to try to secure contract agreements through the CSU, which already has existing contacts and connections with providers, it now appears unlikely that this will be possible. The only viable alternative that borough's in North West London can realistically consider at this stage is to directly commission with providers in a collaborative arrangement.

3.22 It is proposed that each council in North West London would lead the negotiations with their local trust on behalf of the other North West London boroughs. For example, Brent would negotiate with North West London NHS Hospitals Trust using a service specification, price and contract that each borough would have agreed to. Brent would then hold the contract with North West London Hospitals, and the other boroughs would be associate commissioners. Similarly, Brent would be associate commissioners to contracts held by other boroughs with their local trust. The services of the CSU would be retained for contract management and invoice payments, if council's felt that this was worthwhile.

3.23 Members need to agree that they are happy for officers to work with other North West London council's to try to secure GUM contracts via a collaborative commissioning arrangement, to cover 2013/14. If contracts can't be agreed, then all activity would be carried out on a non-contract basis. The council will be invoiced for each element of activity provided by acute trusts, there will be no control over costs and no possibility of any savings from this service. Securing a contractual mechanism that limits to some degree the financial risk remains a priority. However, at the time of writing agreements are still to be reached.

3.24 Around 75% of Brent GUM cases are seen by providers in North West London with whom, it is hoped, there will be a GUM contract. Around 25% of cases are seen at hospitals across the rest of London or outside London. Members should note that the council will not have contracts with these providers, and that it will be invoiced for activity. So, even if a contracts are secured in North West London, that will only protect the council for around 75% of its activity and costs.

3.25 Members will recall from previous financial advice provided to the Executive that the Director of Finance has recommended that a contingency of £500,000 is set aside to cover any overspend in GUM services. Officers still strongly endorse this given the uncertainties about the contract position and the ability to control demand for GUM

services. Whilst the transfer of public health functions and duties present the council with many opportunities, it comes with some significant risks, none bigger than those associated with GUM services.

3.26 A full list of public health contracts, providers and values is included as an appendix to this report.

**3.27 Public Health Budget**

3.28 The council has received details of the public health allocation in 2013/14 and 2014/15. In 2013/14 the ring fenced public health allocation will be £18.335m. In 2014/15 it will be £18.848m. This grant allocation is good news for Brent, although the percentage growth in the budget is at the lower end compared to council's nationally and in London. However, it is more than the £16.007m in the baseline estimate that the council received in February 2012 and means that the authority will be able to meet contract and staffing costs and have some funding for development opportunities in public health.

3.29 Development opportunities have been investigated by the departments and it is proposed that those that meet the most pressing on-going priorities for the local authority is funded for a period of 1 year.

| | £'m |
|---|---|
| Budget Allocation 2013/14 | £18.334 |
| Staffing structures | -£1.522 |
| Contracts | -£13.247 |
| CCG Rental Recharge for Offices | -£0.170 |
| Reserve for GP prescribing for substance misuse clients | -£0.250 |
| Reserve for GUM Open Access Service | -£0.500 |
| Contingency for unknown contractual and development budgets, not yet identified | -£0.400 |
| Overheads e.g. IT / Finance / Audit / Insurance / Phones / Management costs – 2.5% of allocation | -£0.458 |
| Drug & Alcohol Services - Adult Social Care | -£0.249 |
| Health Improvements – Environment & Neighbourhood Services | -£0.380 |
| Maternity & Children's Services – Children | -£0.665 |

| | |
|---|---|
| Services | |
| Funding available to be allocated | £0.494 |

3.30 The budget position taking into account the most pressing development areas of work means that the council has available £0.494m to look at investing, after reviewing the strategic priorities and the way current services are delivered to ensure that they outcomes are being achieved.

3.31 What isn't clear is how long public health budgets will be ring fenced, or how the Government will fund public health in the future. Final details of the funding formula are not available (to the best of our knowledge) and so there needs to be a degree of caution about the direction of public health budgets in the future. Under the formula originally proposed by ACRA, Brent would have seen an 11% reduction in funding and there has to be a risk that funding for public health will eventually fall if the Government implements the formula as originally proposed. There is also a risk that funding could be reduced in the future if it cannot be demonstrated that the grant is being spent on projects and work areas that address the indicators in the public health outcomes framework.

3.32 As would be expected in a project of this nature, practical work such as arranging public health payroll, adding cost centres to Oracle (the council's finance system) and other preparatory work is taking place under this work stream to ensure that the council is prepared ahead of the 1st April transfer.

**3.33 Public Health Transition – what will happen before the 31st March 2013?**

3.34 The contracts held by NHS Brent for public health services due to transfer to the council will be transferred under a statutory transfer arrangement (Transfer Scheme). The Transfer Scheme's documentation will list all contracts, staff and other property and liabilities currently held by the PCT relevant to the council that are in scope to transfer. The legal transfer will take effect from 1st April 2013.

3.35 The council has been asked by NHS London to make arrangements to sign the Transfer Scheme once it is available. This is likely to be in the middle of March 2013. Once signed by the local authority, it will be returned to the Department of Health for sign off by the Secretary of State. It is recommended that the Executive delegates authority to the Interim Chief Executive to sign the transfer order on behalf of the council following consultation with the Director of Legal and Procurement. Officers will ensure that the necessary arrangements are made for this to happen.

**3.36 Conclusions**

3.37 Work will continue up to the 31st March and beyond on the transfer and integration of the public health team and functions into the council. As members know, in 2013/14 work will have to take place to re-commission and procure public health services in line with the council's vision for public health and importantly the council's

procurement rules. Further reports will be brought to the Executive as this work progresses.

3.38 The transfer of public health presents the council with opportunities to make a significant difference to the health and wellbeing of local people and reduce health inequalities. However, councillors also need to be aware of the risks associated with the transfer, such as the GUM service contract. The next 12 months will give members and officers a chance to understand how public health can contribute to the council's aims and objectives and where there is a possibility of doing things differently to reduce health inequalities. It is an exciting opportunity for the council, in spite of the risks, and officers and members will work to design a public health service that meets the borough's requirements.

**4. Legal Implications**

4.1 The Health and Social Care Act 2012 (the "ACT") confers powers on Local Authorities with respect to Public Health and other health related functions. The Act imposes a number of obligations on local authorities to improve public health and develop sustainable community health related services. The relevant sections are due to come into force by 1st April 2013.

4.2 Local authorities will be responsible for commissioning Public Health services locally, informed by Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies developed by health and wellbeing boards on which they are represented, including regard to the Public Health Outcomes Framework which sets out key indicators of public health.

4.3 For the reasons detailed in section 3.9 the recommended approach is to extend the majority of contracts expiring by 31st March 2013 to continue provision of service until 31st March 2014 with such contracts thereafter procured by the Council in accordance with its Contract Standing Orders and Financial Regulations. Contracts to be extended are currently subject to the NHS terms and conditions of contract. These contracts as extended will continue to operate existing terms and conditions of contract following transfer although the intention is to agree introduce certain council standard terms and conditions such as with regard to payment in arrears and the introduction of break clauses.

4.4 Contracts, staff and liabilities transferring to the Council effective from 1st April 2013 will be transferred under a statutory transfer arrangement ("Transfer Scheme") as detailed in paragraph 3.33 of this report.

4.5 Due diligence meetings with providers of contracts to be transferred to the Council have indicated no known pending litigation or contract disputes. This however is still subject to written confirmation from the service providers.

4.6 In addition to those contracts to be extended, Section 3.9 sets out arrangements with regard to certain other contracts such as for GUM services. As detailed in Section 3.9 specific contractual arrangements are necessary for these contracts and Officers intend to pursue such contractual arrangements in accordance with government

guidance and external legal advice being sought in association with other North West London boroughs.

4.7 In relation to GUM Services as set out in paragraphs 3.21 to 3.25, it will be noted that the intention is for each council in North West London to lead on negotiations with their local trust on behalf of other North West London councils. It is proposed that the council leading the negotiations will hold the contract with the other councils being associate commissioners. Approval is sought to enter into such collaborative procurement arrangements and under Contract Standing Orders 85(c) such collaborative procurements need to be tendered in accordance with Brent Standing Orders and Financial Regulations, unless the Executive grants an exemption in accordance with Standing Order 84(a). A request for an exemption under Standing Order 84(a) can be approved by the Executive where there are good operational and / or financial reasons.

4.8 For contracts transferring to the Council from 1st April 2013, there is no Clinical Governance policy framework in place by the Council and it is noted that there is therefore a risk with respect to Clinical Governance issues in the provision of services under these contracts.

4.9 Section 73A of the NHS Act 2006 provides for Local Authorities acting jointly with the Secretary of State to appoint an individual (the Director of Public Health) to have responsibility for prescribed functions.

4.10 Staff transferring to the council from NHS Brent will be entitled to retain their pre-existing terms and conditions of employment, meaning that they will be on their own terms and conditions unless an agreement can be reached to expressly waive them. The council will also need to be aware that as there is a proposed cut in the budget, reorganisation may potentially require redundancy of staff that have transferred from the NHS. Furthermore, if the NHS redundancy policy is contractual then careful attention will need to be paid to its terms and conditions in order that these provisions are not broken should any staff be made redundant.

## 5. Finance Implications

5.1 On 10th January 2013, the public health grants for 2013/14 and 2014/15 were announced. Brent has been allocated £18.334m in 2013/14 and £18.848 in 2014/15. These are ring fenced grants to be spent on public health services for the local population of Brent which have been made under Section 31 of the Local Government Act 2003.

5.2 Whilst a lot of work has been undertaken between the Primary Care Trust and the authority to understand current public health spend, there is still a concern that two services areas are entirely demand-lead (sexual health and health checks) and current spend accounts for around 25% of the total budget. In 2012/13, the projected spend has increased by £0.288m more than first thought on GUM services.

5.3 It was initially thought that the council might have to pick up any redundancy costs associated with the transfer. It has now been clarified that the NHS will do this. Therefore the proposed reserve of £¼m that was requested in the last report to Executive is no longer required.

5.4 After taking into account staffing and other contractual arrangements, the available grant funding for initiatives is £1.938m. The Public Health Transition Board have requested that £0.400m be held in reserve until later in the financial year to cover for any committed spend not identified at this stage.

5.5 The expectation is that funds will be utilised in-year, but if at the end of the financial year there is any underspend this can be carried over, as part of a public health reserve, into the next financial year.

5.6 Under new section 2B of the National Health Service Act 2006 (as inserted by section 12 of the Health and Social Care Act 2012), the local authority has a duty to take steps, as it considers appropriate, for improving the health of the people in its area. The local authority may also be required by regulations under new section 6C of the NHS Act (as inserted by section 18 of the Health and Social Care Act 2012) to take steps to protect the public in England from disease or other dangers to health.

5.7 These services form part of the comprehensive health service and are therefore subject to the general prohibition on charging under section 1(3) of the NHS Act unless exempted through regulations. Therefore the local authority is unable to charge for any public health services provided.

5.8 There are not expected to be any capital requirements arising from this transfer.

**6. Diversity Implications**

6.1 The Council will need to comply with the Equality Act 2010 in the provision of Public Health Services. The Public Sector equality duty imposed by Section 149 of the Equality Act 2010 will need to be addressed at the time when both the services and contracts are reviewed. The transfer and extension of the existing contracts is an interim measure designed to secure continued service within a very tight time scale and it is not practicable to consider and address the equalities issue within this transitional period during which the contracts are extended for a short period of 12 months.

**7. Staffing/Accommodation Implications**

7.1 These are included in the body of the report.

**Contact Officer:**

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

**Phil Newby**
**Director of Strategy, Partnerships and Improvement**

**Alison Elliott**
**Director of Adult Social Care**

**Appendix 4 – Public Health Contracts List**

| Provider | Service |
|---|---|
| NHS Ealing Hospital Trust | Infection control in care homes – this is a small element of a larger infection control service specification, but the council is only required to cover the care home element. |
| Central and North West London NHS Foundation Trust | Clinical prescribing substance misuse services |
| Compass via NHS Harrow | Alcohol Brief Interventions |
| Addaction | Substance misuse - treatment and recovery |
| Young Addaction | Substance misuse services for young people |
| LIFT | Service user involvement for substance misuse clients |
| CRI | Substance misuse outreach and engagement |
| EACH | Counselling and abstinence based substance misuse programmes |
| WDP | Substance misuse services |
| Central and North West London NHS Foundation Trust | Contraceptive services |
| NW London Hospitals | GUM Services |
| NW London Hospitals | Chlamydia screening services |
| Ealing Hospital Trust | School nursing and National Child Measurement Programme |
| Ealing Hospital Trust | LAC Nurse |
| SHOC | Sexual health primary care development |
| CHAT | HIV Prevention |
| The African Child | Teenage Pregnancy and sexual health services for young people |
| Naz Project London | HIV Prevention |
| SHOC | Teenage Pregnancy – condom distribution |
| Therapy Audit | Web based distribution and stock ordering system for condoms |
| The Doctors Laboratory | Sexual health pathology services |
| Sonar | IT support for condom distribution |
| General Practices | Chlamydia screening LES |
| General Practices | IUCD – long acting contraception |
| Pharmacies | Emergency Hormonal Contraception |
| Pharmacies | Stop Smoking (Local Enhances Services) LES |
| General Practices | Stop Smoking LES |
| community providers | Stop Smoking LES |
| General Practices | Primary care pregnancy stop smoking LES |
| CHAT | Health Trainers |
| Ealing Hospital Trust | Intensive Lifestyle Advice |
| General Practices | Oral Health LES |
| General Practices | Health of the Population (Breast Feeding) LES |
| General Practices | Health checks LES |
| Slimming World | Community Weight Management Service |
| LPC | Pharmacy Mentoring Scheme |
| Sonar | Stop Smoking Specialist IT Provision |

This page is intentionally left blank

| | |
|---|---|
| | **Health Partnerships Overview and Scrutiny Committee**<br>19 March 2013<br><br>**Report from the Director of Strategy, Partnerships and Improvement** |
| | Wards Affected:<br>ALL |

# Khat Task Group Update

## 1. Introduction

1.1 The Health Partnerships Overview and Scrutiny Committee has asked for an update on the recommendations made by the Khat Task Group. The task group reported its findings in early 2012 and it is good practice to follow up recommendations within 12 months of them being endorsed by the Executive. The Advisory Council on the Misuse of Drugs (ACMD) has also recently reported its findings following a review into khat, commissioned by the Home Office. Therefore, it is a good time for the committee to re-examine the issues connected to khat use in Brent.

## 2. Background

2.2 Khat is a herbal product that is chewed to create a mild stimulant effect. It is used mainly by people from the Somali, Ethiopian, Kenyan and Yemeni communities in the UK. Brent has a significant Somali population and it was the use of khat amongst this group that was of concern to councillors and to some members of the Somali community, which prompted the establishment of the task group. Some people believe that there are negative consequences associated with taking khat, most of which were repeated to the task group during the course of their investigations. Khat is said to:

- Contribute to family breakdown and violent behaviour
- Effect employment prospects if users spend too much time taking khat
- Encourage men to spend household income on the drug, rather than on food and paying bills
- Prevent immigrant communities from integrating with wider society
- Contribute to the onset of psychosis
- Lead to sleeping problems, loss of appetite, tiredness and a depressed feeling the day after use.

2.3 However, as the task group found out during the course of its investigation there are also people who regard khat as an important part of the culture of user communities, particularly at social occasions such as weddings, funerals and parties.

2.4 The khat task group was set up as members wanted to better understand the health and social impacts of khat on Brent's communities and to determine which of the opposing views on khat was closest to the truth in Brent. There were three main issues members wanted to investigate:

- The perceived impact of khat use on the community in Brent, particularly the health and social consequences of khat use.
- Anti-social behaviour associated with khat cafes or *mafrish*
- The perceived lack of treatment services and diversionary activities in Brent aimed specifically at khat users.

## 3. Main Findings

3.1 The task group discovered that even estimating the number of people taking khat in Brent is difficult. At the time of the review the council was unsure how many people of Somali origin lived in the borough (assuming that the majority of khat users in Brent are of Somali origin). This is because the main source of information on ethnicity is the Census, which does not have a "Somali" category. But, irrespective of the number of people in Brent who use khat, what was a concern was the pattern of use amongst some people. In Somalia, khat is an important part of the culture, but something that is normally taken in moderation, either at a celebration or after a meal. It is used, mainly by men, to stimulate conversation and as a way of relaxing. It does not normally interfere with working life, nor does it dominate lives as it can do in the UK. A number of the people who the task group spoke to during the review were concerned that the pattern of use had changed dramatically in the UK and that in the absence of anything else to do, men in particular, were spending their time with friends chewing khat.

3.2 The task group found that the pattern of use was the key determinant of how big an impact khat had on a user's life. Khat is not physically addictive, but those who abuse khat do show signs of psychological addiction and it becomes a habit that some clearly find difficult to stop. The task group considered why the pattern of use may have changed in the UK and heard powerful opinions on this issue, many of which came back to one issue – the erosion of the traditional male role for Somali men in the UK. What was clear to people that the task group spoke to, particularly women, was that the traditional societal roles are not as clearly defined in the UK as they are in Somalia. The task group was told that it is possible that men have questioned themselves as a result of this. The alienation they feel because of their displacement, coupled with the trauma of war and loss of status, may have led some to seek a form of escape by taking khat to excess.

3.3 Unemployment was cited throughout the task group's work as a reason why people chew khat to excess. Khat is seen as a barrier to employment by members of the Somali community, as people who overuse khat are unable,

or unwilling to work. There is little doubt that employment improves an individual's self-esteem and health and wellbeing. It is also the case, that at this current time an increasing number of people are unemployed in Brent. Benefit dependence was raised as an issue during the review. A logical conclusion to draw is that if someone is unemployed they will have more time to take khat during the day than if they were in work.

3.4 The task group heard of numerous reasons why people in the Somali community may be unemployed, in addition to the "khat factor". These included:

- Immigration status
- Language barriers
- Skills barriers
- Lack of confidence caused by long term unemployment

3.5 The task group was told by people in the Somali community that they are concerned that those who abuse khat are able to sustain their habit because they are claiming benefits and that this is acting as a disincentive to work. The task group did not buy into the theory that all khat abusers are relying on benefits to sustain their habit, and that if benefit was withdrawn people would find work. This is too simplistic and there are many ways to sustain a habit without claiming benefits. Additionally, khat use was not restricted to the unemployed or those claiming benefit and it would be wrong to promote this view. Many use it after work as a legitimate way to relax and socialise. The task group believes that unemployment is not the only reason why people take khat to excess. Nor is khat the only reason why some people from Brent's Somali community are unable to find work.

3.6 The task group was not unanimous on whether khat should be banned as some within the Somali community believe that it should. As a result it did not make a recommendation in relation to this. It is for Government to decide whether khat should be banned and the issue has to be seen in a nation-wide context, not just the experience of our borough. However, the task group did advocate for the regulation of khat in some form. Among the views it heard during the review with regards to this were:

- It should not be sold to those under 18.
- Limiting the hours of sale could make it harder for people to stay up all night chewing.
- Owners of mafrish should ensure that they complied with legislation relating to:
    - Health and safety / building regulations
    - Smoking
    - Hygiene
    - Ventilation
    - Noise nuisance
    - Protect the wellbeing of staff who work in the mafrish

3.7 Working on the khat task group was an enlightening experience for councillors. It was clear that, for some, khat is a problem. But for many people it is not and the report tried to present a balanced view on the issue.

3.8 The task group made nine recommendations which can be broadly split into five categories:

- Resolving immigration problems
- Training, employment and diversionary activities
- Treatment services
- Regulation
- Raising awareness of khat, its possible negative side effects, and promoting positive health messages

3.9 Progress against the recommendations is set out in the table at the end of this report.

## 4. Advisory Council on the Misuse of Drugs Findings

4.1 The ACMD review into khat, commissioned by the Home Office, reported in January 2013. Members of the ACMD review team visited Brent during the course of their work and their final report references the work done by the Khat Task Group on numerous occasions. Many of the findings from the ACMDs review and the task group's review overlap. The ACMD made the following observations:

- Khat has no direct causal link to adverse medical effects, other than a small number of reports of an association between khat use and significant liver toxicity.
- Anecdotal evidence reported from communities in several UK cities link khat consumption with a wide range of social harms. Research into these concerns has been undertaken but no robust evidence has been found which demonstrates a causal link between khat consumption and any of the harms indicated.
- Somali groups that made representations to the ACMD claimed khat use was a significant social problem within their local areas and in domestic settings. In contrast it was asserted that the Yemeni community had no problem with khat use, as it takes place within the family setting and is integrated into other social domestic events.
- BME groups are not homogenous communities, but range from well settled fourth generation families to asylum seekers fleeing civil war. The complex multi-factorial issues facing khat using asylum seekers/refugees may include: unemployment; legal uncertainties and irregular status; trauma; no social or family networks; social dislocation; discrimination; poor English literacy; gender politics; lack of inspirational realisation; devalued refugee identity; lack of validation of previous qualifications; lack of or limited access to accommodation and health care service provision.

4.2 The ACMD felt that without the necessary data and robust evidence to support proportionate intervention, khat should not be controlled under the Misuse of Drugs Act 1971. They made the following recommendations.

1. The ACMD recommends that the status of khat is not changed and is not controlled under the Misuse of Drugs Act 1971.

2. It is recommended that Commissioners and Directors of Public Health from Local Health Boards, NHS Boards, Health and Wellbeing Boards, and Health and Social Care Boards should:

- Include khat in local needs assessments, particularly where there are population groups of relevant BME groups;

- Where khat use is found to be present in local communities, this substance should be included in local generic substance misuse education and prevention initiatives;

- Where khat use is found, the commissioning of culturally specific and tailored treatment and recovery services incorporating mutual aid‘ models of support should be considered;

- Consider dialogue and partnership working with appropriate NGO, third sector, voluntary organisations and BME communities, so holistic needs of health and social issues are met.

3. It is recommended that where concerns are expressed about social harms associated with the use of khat, Local Authorities and new Police and Crime Commissioners should address them through engagement and dialogue with the local community and good inter-agency working, supported as necessary by the use of existing measures coordinated through the relevant Community Safety Partnerships and the use of community remedy.

4. It is recommended that Commissioners of Public Health services, as well as Criminal Justice System bodies and the new Police and Crime Commissioners should include the use of khat in regular monitoring returns required from treatment and enforcement agencies and publish annual figures. This data should form the basis of future research on khat to address the concerns raised in this report.

4.3 The recommendations from the ACMD review are to some extent, already being addressed in Brent through various agencies including public health and providers of substance misuse services in the borough. Organisations such as CRI and EACH are working with people from Brent’s Somali community on substance misuse issues, including khat. The committee may want to consider whether it should recommend any further action regarding khat as a result of the ACMDs conclusions. How the Government responds to the ACMD report remains to be seen and it could, if it chooses, ban khat regardless of the ACMD’s view. The ACMD is an advisory body, but decisions over drug classification are taken by the Government. If any announcements are made by the Government relating to khat before the committee’s meeting, members will be updated verbally.

## 5. Conclusions

5.1 It is recommended that the Health Partnerships Overview and Scrutiny Committee notes this update report and questions officers on the progress in implementing the recommendations from the review. Members should also decide whether they want to take any further action following the ACMD's report and recommendations on khat use.

**Background Papers:**

(i). The health and social impacts of khat use in Brent

(ii). Khat: A review of its potential harms to the individual and communities in the UK (2013) – report by the Advisory Council on the Misuse of Drugs

**Contact Officer:**

Andrew Davies
Policy and Performance Officer
020 8937 1609
Andrew.davies@brent.gov.uk

**Phil Newby**
**Director, Strategy, Partnerships and Improvement**

## Appendix 1 – Task Group Recommendations

| Recommendation | Comments – January 2012 | Update – March 2013 |
|---|---|---|
| **Recommendation 1** – The task group recommends that local Somali community groups, Brent Council and Job Centre Plus work with Brent's Somali community to signpost them when necessary, to refugee and immigrant support services in Brent so that they are able to resolve their immigration problems. | **From Brent Council Customer Services** - Enquiries about immigration do not feature in the range of face to face / phone enquiries dealt with by customer services however members of the Somali community do make contact about benefit, Council tax and other council services. I would suggest that the signposting is not limited to CS – but is extended to include Housing enquiries currently dealt with at MG House, localities teams within C&Fs and also across social care professionals in ASC.<br><br>There will need to be clear information provided to staff responsible for signposting – it would be helpful to clarify who will provide this and deliver briefing / training sessions to enable signposting to be carried out confidently and effectively.<br><br>Jobcentre Plus supports this recommendation.<br><br>T. Dackombe 15.02.12 | Update to follow. |
| **Recommendation 2** – The task group recommends that Job Centre Plus, BACES and the College of North West London works with local Somali organisations to advertise the ESOL courses and work-specific courses that are available in Brent to local Somali people in the most appropriate way. | Jobcentre Plus will fully support this recommendation. We would be pleased to receive advice from the Somali organisations and residents in terms of the best way to reach as many of our customers as possible.<br><br>T. Dackombe 15.02.12 | Update to follow. |

| | | |
|---|---|---|
| **Recommendation 3** – The task group recommends that the Government commissions further research into the pharmacological and medical impacts of khat. At present there is a lack of clarity about the drug's effects and given the concerns with khat that exist in communities in the UK it should be given a greater priority by the Government. | The task group's report will be sent to the ACMD and Home Office if approved by the Executive. | The task group's report was sent to the ACMD after its approval by the Council's Executive. The chair of the Task Group, Cllr Ann Hunter, Andy Brown, Head of Substance Misuse at NHS Brent and Andrew Davies, Policy and Performance Officer met with representatives from the ACMD during their review into khat. |
| **Recommendation 4** – The task group recommends that a full evaluation of the CRI khat outreach project is carried out by NHS Brent and CRI prior to the end of the six month contract in March 2012, to determine whether there is enough demand to continue the project. | **From NHS Brent Drug and Alcohol Service** - The CRI Khat Outreach project has worked at ensuring that people from the Somali community who presented to the project as result of the outreach programme have been linked into local treatment services with a pathway developed that has ensured that those presenting are engaged in effective treatment.<br><br>Brent CRI have also recruited a number of volunteers from the local Somali community who will work with project staff to continue to facilitate a peer mentoring group and to train more volunteers from the Somali community.<br><br>All those presenting with concern regarding their khat use have had more serious treatment needs in relation to problematic alcohol and Class A (Opiate/Crack cocaine) drug use.<br><br>Brent Drug and Alcohol Action Team (DAAT) has received a significant increase (15%) based on performance for increasing the numbers in effective treatment and successful completions. Extra funding will made available to CRI Brent Outreach and Engagement Team (BOET) for an extra project worker and nursing post to be able to address future treatment interventions for khat and other hard to | **Advisory Council ON the Misuse of Drugs (ACMD):** Representatives from Brent Council and NHS Brent were invited by the ACMD to present evidence at ACMD Khat Evidence - Gathering Meeting held in Central London on the 12.09.12 to present the findings of the project undertaken by CRI with the Somali community over the summer of last year in which the project aim was to further develop existing service provision and tailor it to the specific needs of the Khat using population by allocating a dedicated Somali speaking worker to work in partnership with local community organisations.<br><br>Included as an appendix to this report is a presentation which includes full details on the evaluation of the CRI project and outreach with khat users. |

| | | |
|---|---|---|
| | reach groups to reduce harm cause by khat and problematic substance misuse. | |
| **Recommendation 5** – The task group recommends that the Council and Somali community groups work with the owners of mafrish (khat cafes) and shops in Brent selling khat, to develop a voluntary agreement to prevent the sale of khat to those under the age of 18, as originally recommended by the Advisory Council on the Misuse of Drugs. | | Update to follow. |
| **Recommendation 6** – The task group recommends that the Council runs a targeted enforcement campaign to ensure that the mafrish (khat café) owners are complying with various pieces of legislation with regard to:<br><br>• Health and safety / building regulations<br>• Smoking<br>• Hygiene<br>• Ventilation<br>• Noise nuisance<br>• Refuse disposal – that the cafes have trade waste contracts in place<br>• Payment of business rates<br>• Improvement of shop fronts<br><br>This is to ensure the immediate environment in and around the cafes | **From NHS Brent Public Health -** The rate of TB is particularly high in the Somali community and there are concerns around individuals from this community spending long periods in confined smoke-filled environments. This is of particular concern where shisha pipes are shared and the role this may play in increasing transmission of TB and other communicable disease. | Update to follow. |

| | | |
|---|---|---|
| is improved and to protect the wellbeing of staff who work in the mafrish. | | |
| **Recommendation 7** – The task group recommends that NHS Brent works on raising awareness of khat with health professionals, including GPs, and the police, especially the Safer Neighbourhood Teams, as advocated by the Advisory Council on the Misuse of Drugs, so that users can be offered any help and support they may need. | **From NHS Brent Public Health** - NHS Brent will allocate a public health consultant to lead on working with the Somali community to address a number of health inequalities including khat but relating to a wider agenda of access to primary care services, forensic mental services and to ensure that community members know how to access services and are able to participate in local health campaigns. This work will include developing more effective signposting to specialist treatment interventions.<br><br>A public health fair is being organised (March 2012) to allow the Somali community to raise concerns and issues over a broader public health agenda including access to primary care, immunisations, screening and NHS Health Checks.<br><br>Work is also planned within Public Health to address issues in uptake of childhood immunisation, particularly MMR, amongst the Somali community and to increase awareness and early diagnosis of both TB and meningitis. This work will include the employment of a Somali project worker, advisory sessions with Somali parents and TB awareness training for community representatives. The Brent TB Community Group includes representation from the Somali community and effort is being made to ensure involvement of the community in Brent's World TB Day event on 22nd March at Brent Town Hall. | A number of key projects and initiatives are still continuing outlined in the original report still continue and are now fully mainstreamed with substance misuse interventions commissioned through Brent Drug and Alcohol Team DAAT and public health partnership work plans these include the following;<br><br>**Training and workforce development:** Two one day training courses have been facilitated which focus specifically on KHAT, SHISA and PAAN. Key elements of this course are incorporated into all basic drug awareness courses facilitated through public health.<br><br>**EACH Counselling** presented a well received KHAT and Treatment Awareness session at the Multi Faith Forum on 28th January and a KHAT awareness stall for a week at Wembley Centre for Health and Care which was accessed by women who were attending primary care and clinical services. Five primary KHAT users are currently engaged with EACH's counselling and group work services working in partnership with Capital Home Care services. |
| **Recommendation 8** – The task group recommends that NHS Brent's Public Health Team and DAAT service works with the local authority and the local | **From NHS Brent Public Health -** NHS Brent and the DAAT have identified funding for 2012/13 for a number of community engagement events and a wider event to address khat will be a key priority for | The planned workshop for North West London Borough has not taken place due to the priorities of the Public Health contract transfer and the change of key personnel due to the current re-structure of the NHS. |

| | | |
|---|---|---|
| Somali community to organise a conference on khat in Brent for all stakeholders including people working in the drug treatment sector, health professionals, council staff, voluntary sector organisations and the local community. The purpose of the conference would be to raise awareness about khat and to give people from the community an opportunity to discuss ways of addressing some of the problems associated with the drug. | the prevention element of the DAAT Integrated Substance Misuse Plan 2012/13. | However the transfer of the public health functions to Brent Council will present an ideal opportunity for a more strategic consultation to identify the public health needs alongside ensuring that existing services are able to address the substance misuse treatment needs of the Somali community in Brent. |
| **Recommendation 9** – The task group recommends that NHS Brent and drug treatment agencies in the borough consider a campaign aimed at khat users to advise them on where to go if they wish to stop using khat, as well as drawing to their attention some of the issues associated with the drug, such as lack of sleep and lack of appetite. Efforts should be made to engage Somali community organisations in this work. | **From NHS Brent Public Health -** NHS Brent and the DAAT have identified funding for 2012/13 for a social marketing campaign which will include khat.<br><br>Representatives from the local Somali community will be invited to work with the DAAT Training and Workforce Development Manager and treatment sector managers to develop a targeted awareness around health and social effects of KHAT and signposting to local treatment services. | **Cobbold Road Treatment and Recovery Services:** continues to remain the single point of contact for borough residents who need access to substance misuse services not just for class drugs and alcohol but also the range of legal highs and counselling interventions for all sections of the community.<br><br>The project will be developing a closer working relationship with Help Somalia Foundation to develop a range of targeted services specifically for the local Somali community.<br><br>**KHAT Group:** The weekly khat Support Group at CRI Brent Outreach and Engagement Team (BOET) continues to be well attended with a core group of 5 KHAT users meeting on a regular basis for support and to access onward referral. |
| **Recommendation 10** – The task group recommends that steps are taken to involve Somali young people in the One Council Review of Youth Services in Brent, so that their views can be taken into account. | This project is currently at the exploratory stage, and a detailed project plan has not yet been agreed. However, a robust Equalities Impact Assessment and appropriate consultation will be key stages.<br><br>The project is envisaged as assessing whether or not | Update to follow. |

| | | |
|---|---|---|
| | sufficiently targeted provision is available to meet the needs of the borough's very diverse youth population, including groups with high levels of need, such as Somali young people. A key piece of work which is already underway is the mapping of that need (which notes the growing young Somali population over the last ten years), and of the provision currently available. | |
| **Recommendation 11** – The task group recommends that Brent Council's Communications Team works with local Somali community groups to publicise positive achievements within the community more widely, using methods such as the Brent magazine. This would raise the profile of the community in Brent, and help to celebrate successes. | The council's Communications Team works to promote the council to the residents of the borough. It engages in specific community issues via council led initiatives but direct contact with community groups to promote their work is rare, other than if they contact us with information for the Council Magazine.<br><br>However, the Communications Team would, for example, promote a health campaign or enforcement campaign on Khat to the wider community in Brent (including Brent's Somali community). It would also promote council led work with the Somali community that was having positive outcomes, for example we would highlight achievements of young Somali's in our schools, library initiatives on Somali literature or ward working delivering a specific project for the Somali community. Engagement would be project specific and there would need to be council involvement in that project. | The Council's Communications Team has worked to promote the impact of the welfare reforms and the impact that they could have on families. They have used a Somali family case study in the Feb/March 2013 edition of the Brent Magazine to illustrate the impact the cuts could have. They are used on posters and leaflets and will continue to be used during the lifetime of the campaign.<br><br>http://issuu.com/brentcouncil/docs/tbm130/36?mode=a_p<br><br>The council has also facilitated a benefit cuts advice day for the Somali community around November/December 2012 – we use a toolkit and it was translated into Somali for the advice day and for council advisors to use going forward. |

# CRI Project – the view from Brent DAAT

**Presentation to ACMD - 12.09.12**

Andy Brown Head of Substance Misuse
NHS Brent.

## About Brent

- 278,500 resident population, 351,000 registered population.
- 55% of residents are from black and minority ethnic communities.
- Most heterogeneous borough in England.
- Over 130 different languages are now spoken in our schools.
- The population is relatively young with 43% of residents under 30 years of age.
- Over 30,000 are over the age of 65.
- Brent is 53rd most deprived borough in England.

## Somali Community in Brent

- Brent's Somali population has grown significantly over the last 20 years.
- Impossible to determine know how many Brent residents are of Somali origin and how many use Khat.
- Somali is now the 3rd most common first language spoken by Brent school children.
- Increased numbers of premises where Khat is readily available
- This includes a number of convenience shops that sell Khat for consumption off premises.
- Mapping indicates that there are Khat cafes, or mafrish, in the Church Road area, Kilburn High Road, Wembley Central, Harrow Road near Stonebridge Park Station, Neasden Lane and in Harlesden.

## Project Vision

"To further develop existing service provision and tailor it to the specific needs of the Khat using population by allocating a dedicated Somali speaking worker to work in partnership with local community organisations".

## Project aims

- To offer triage assessment to any individual using Khat.
- To refer problematic Khat (Alcohol and Cannabis) into treatment services.
- To ensure all Khat users are registered with a GP and other appropriate health care services.
- To deliver a "Khat Group" and community based response.
- To improve links to mental health services and facilitate engagement where appropriate.
- To train "Help Somalia Foundation" to identify substance misuse problems and refer into treatment services.
- To refer clients and facilitate engagement to EACH counselling services.
- To increase knowledge of Khat use in health professionals.

## Brent Treatment and Recovery Se (TARS)

An integrated approach to substance misuse;

- Clinical and prescribing services
- Treatment and recovery services
- Abstinence based structure day programmes
- Outreach and engagement
- Criminal justice interventions

## Treatment priorities

- Need to target the increasing emergence of alcohol and other illegal drugs.
- Maintain the commitment to ensure that more drug users from ethnic minority communities have every opportunity to respond to their treatment needs by taking up services.
- Emphasis on the delivery of Treatment Outcome Profiles, which supports the specific needs of different clients.
- Increase the numbers of those entering the treatment system.
- Maximise the numbers of clients in effective treatment.
- Work to address the recovery agenda and drive forward the increase in Successful Completions for the borough.

## Project Methodology

- **Identification of key partners to support the initiative and to help develop joint working and referral pathways.**
- **Local community organisations welcomed the service as they felt the health and care needs of their were not being met by existing services.**
- **CRi and EACH agreed to co-facilitate a CBT based structured group which continues to run every Thursday, attracting 8 service users a week who engage with treatment and recovery programmes**
- **CRI Brent delivered an accredited 6 session peer mentor training programme to train the volunteers of the Help Somali Foundation and equip them with the tools and skills to engage with the community and begin the mentoring process.**
- **CRI Brent worked to support 8 individuals from the community who wanted to undertake peer mentoring training.**
- **Three of the peer mentor graduates have been formally recruited as CRI volunteers and are utilised in engaging Khat users into treatment.**

## Project Findings:

| | | | | |
|---|---|---|---|---|
| **Numbers accessed** | 23 | **Level of engagement** | 17 structured treatment | 6 open access |
| **Ethnicity** | 20 Somali | 1 Ethiopian | 1 Eritrean | 1 French |
| **Gender** | Male 21 | Female 2 | | |
| **Marital status** | Single 20 | Married 1 | Divorced 1 | Not disclosed |
| **Dual diagnosis** | 1 | **Referral Source** | Probation 1 | Outreach 22 |
| **KHAT Secondary** | Heroin 1 | Crack 3 | Cannabis 6 | Alcohol 16 |
| **KHAT Primary** | 7 | | | |
| **Completions** | 5 completed drug free | 2 completed but occasional user | 2 dropped out | 14 ongoing support |

## Initial findings

- Majority (91%) of those assessed were single Somali males
- Khat use appears to be predominantly a male problem but there is anecdotal evidence that more females are taking up Khat use,
- The honesty of service users applies to the findings – there is shame and stigma attached to Khat use and there is a possibility they may not disclose their families
- Those assessed may have already experienced family breakdown or cast out by their families
- CRI is a service that traditionally works with those with the most problematic use and those that were assessed and worked with were using at problematic levels where as those maintaining families may have lower level use
- Outreach was delivered during the day and may have missed the cohort who use in the evening.
- Local research indicates that the links between Khat use and mental health are tenuous

## Wider findings

- 30% were primary Khat users/
- 69% also reported problematic alcohol misuse
- 26% using cannabis in addition to Khat
- 17% (3) were (OCU's) Opiate Crack users
- Indication of a lack of knowledge of what services are available and how to access them.
- Communication is a barrier as in some cases English is a real issue
- Access to employment, education and training is problematic due to the lack of knowledge of options and poor English language.
- CRI are working to establish pathways into ETE providers that offer skills language courses.
- It was also evident that many do not prioritise health , few are registered with GPs and rarely attend.
- All engaging have now been registered with a GP.

## Summary: Next steps

- **It is apparent that there are issues relating to problematic substance use, Khat in isolation appears to be less of a problem.**
- **The use of cannabis, alcohol and potentially class A substances is evident and it is the combination of these with Khat that appear to be causing the most public health harms to this community.**
- **CRi Brent will continue to deliver a structured Khat group and offer brief assessment, advices, information and onward referral.**
- **Services will need to continue to offer access to specialist treatment for those with poly drug us.**
- **There is certainly a need for culturally sensitive interventions to engage and to address substance misuse issues and work alongside local agencies to provide appropriate healthcare, employment, education and training.**

| | |
|---|---|
| | **Health Partnerships Overview and Scrutiny Committee**<br>19 March 2013<br><br>**Report from the Director of Strategy, Partnerships and Improvement** |
| | Wards Affected:<br>ALL |

# End of Life Palliative Care

## 1.0 Summary

1.1 The Health Partnerships Overview and Scrutiny Committee has asked for a report from Brent Clinical Commissioning Group on the provision of End of Life Palliative Care in Brent.

1.2 The report gives an overview of palliative care provision in Brent and the End of Life Care Strategy for Brent, which seeks to reduce the number of patients with end of life need dying in hospital. The report outlines some of the related areas that have been invested in during 2012/13 and lists the service providers, with a brief summary of the services provided and an explanation of how the service is funded.

## 2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to consider the report and question officers on the services currently provided and the End of Life Strategy and future plans under the strategy.

**Contact Officers**

Mark Burgin
Policy and Performance Officer
Tel – 020 8937 5029
Email – mark.burgin@brent.gov.uk

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

This page is intentionally left blank

Brent
Clinical Commissioning Group

**Overview and Scrutiny Committee March 2013**

**End of Life Care**

## INTRODUCTION

The Overview and Scrutiny Committee have made a request for information regarding the services commissioned by NHS Brent for End of Life Care. In particular they have asked some specific issues,namely :

- What services are provided and by whom
- How are the services generally run
- How are the services funded
- What are the policies around people having to pay towards these services

This is a short briefing paper detailing the responses to the issues raised.

## OVERVIEW

Currently, 64% of people in Brent die in hospital, a higher proportion than the English average, and 19% die at home, a lower proportion than the English average Brent's has an End of Life Care Strategy which seeks to reduce the number of those patients with an end of life need dying in hospital by 70% (over the duration of the strategy)

Brent has invested in the following areas during 2012/13.

- Roll-out the London-wide End of Life Register called Coordinate my Care across Health and Social care

- Building up workforce capacity and capability of all staff involved in the delivery of end of life care across health and social care. Increasing the skills of practitioners is an essential element of the strategy to improve End of Life Care in Brent. We have developed an outcomes based Service Specification for training. This is based on the National Guidelines for training in End of Life Care which includes the Gold Standards Framework. We are increasing skills across all staff groups in Brent including Nursing Home staff.

- Supporting primary care clinicians in building up their capacity and capability to improve their current management of end of life care patients in primary care During 2012/13 we are incentivising Primary Care and have developed a Locally Enhanced Service for End of Life Care which focuses on the identification of patients in the last 12 months of their life irrespective of diagnosis and the subsequent management of these patients until their death

  We are also working with the relevant Contracts Leads to examine any need to incentivise other providers from 2013/14 onwards

Communications with Stakeholders Part of the success of improving End of Life care for patients and their families depends on their involvement. They need to be made aware of, and discuss the options with their clinicians for, better End of Life Care, and avoiding issues surrounding the adverse publicity re the Liverpool Care Pathway (Appendix A). Therefore, we are developing awareness through press publicity, through engagement with relevant patients' and faith groups, and by making suitable literature[1] available to end of life patients detailing the support available. This will ensure patients know that an End of Life pathway is available, and know what care they can expect, from whom, where, and when and most importantly that they have a choice

In addition to these investments NHS Brent also commission End of Life Care Services from a number of providers. End of Life Care is provided in a number of settings and by a range of stakeholders such as Primary Care, Nursing Homes, Acute Hospital Trust, Community Services and Specialist Palliative Care from Hospices. The purpose of the Register is to ensure that all agencies that have an interaction with the patient and their families during their illness have access to the same care record and information.

**WHAT SERVICES ARE PROVIDED AND BY WHOM? In** terms of Specialist provision for End of Life Care these are commissioned through the following agencies:

**South Brent**
St Johns Hospice
Pembridge Unit
Marie Curie
**North Brent**
St Lukes Hospice

Services commissioned include Specialist Palliative Care, Hospice at Home and they also provide respite services. The clinicians working within these organisations also provide support and advice to other clinicians across Brent when needed i.e. advice re pain relief etc.

Pembridge Unit is an NHS organisation, whereas St John's, St Luke's and Marie Curie are charitable organisations.

We also commission an organisation called Cancer Black Care which provides support and advice services on cancer for Black Minority and Ethnic (BME) name patients.

**HOW ARE THE SERVICES FUNDED?**
NHS Brent has formal contracts with the providers and funding is through this route.

**WHAT ARE THE POLICIES AROUND PEOPLE HAVING TO PAY TOWARDS THESE SERVICES**
All service are provided at 100% of the cost for all Brent patients through NHS Brent funding

**Appendix A**

**Liverpool Care Pathway**

The Liverpool care pathway is an integrated care pathway that is used at the bedside to drive up sustained quality of the dying in the final days or hours of life.

It is a means to transfer the best quality for care of the dying from the hospice movement into other clinical areas, so that wherever the patient is dying, there can be an equitable model of care.

The LPC has been implemented into hospitals, care homes, in the individuals own home/community and into hospices.

The Liverpool Care Pathway was developed by Royal Liverpool University Hospital and Liverpool's Marie Curie Hospice for terminal ill cancer patients. Since then the scope of LCP has been extended to include all patients deemed dying.

**Steps**
1) Clinical decision Making:A multi-professional team caring for the patient agree that all reversible causes of the patient's conditions have been considered and that the patient is in fact "dying".

2)The assessment suggests what palliative care options to consider and whether non-essential treatments and medications should be discontinued, and addressing physical, psychological, social and spiritual domains of care.

3) The programme suggests treatment provision to manage pain, agitation, respiratory tract secretions, nausea and vomiting, or shortness of breath ( dyspnoea) that the patient may experience and hence enhancing patient dignity and symptom management including nutrition and hydration.

4) the approach is communicated with families/carers.

5) there will be initial assessment, on going assessment and care after death

6) system in place to review the appropriateness of continuing on the pathway at any time if concern is expressed by either the patient, a relative or a team member

This page is intentionally left blank

**Health Partnerships OSC**

**Work Programme 2012-13**

| Meeting Date | Item | Issue | Outcome |
|---|---|---|---|
| 30th 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. | Members noted the number of vacancies in health visiting posts in Brent and have requested a follow up paper in six months time (November meeting) to follow up on the recruitment and retention of health visitors. |
| | 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:<br>• The consultation plan for the two services<br>• The consultancy costs associated with the retender of cardiology and ophthalmology services | Report noted, along with the concerns of Brent LINk about the consultation process. |
| | 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. | The members noted the report and requested some additional information from NWL Hospitals:<br>• A request for a breakdown of what happens to patients who attend A&E – i.e. the proportion admitted, treated and discharged etc.<br>• The transfer time from ambulance to A&E – i.e. the time patients wait in ambulances |

| | | | |
|---|---|---|---|
| | | | before being seen in A&E.<br>• Information on the longest length of time people are waiting in A&E above the four hours<br>• Treatment times for those seen in A&E compared to those seen in the UCCs |
| | 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. | The root cause analysis of the incident will be presented to the next committee meeting and representatives from Care UK will also attend to answer questions on this issue. |
| | Primary Care Update in Brent | The committee will receive a report setting out an update on two medical centres in the borough:<br>• Willesden Medical Centre, which is considering relocating to Willesden Hospital.<br>• Kenton Medical Centre, which is to close | Members requested a follow up report in July 2012 setting out how many patients have been re-registered and where they have re-registered since notice was served on the Kenton Medical Centre. |
| | 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. | The committee has agreed to set up a separate meeting to scrutinise the Out of Hospital Care Strategy in full and respond to the consultation. This will be done once it is clear when consultation on the strategy is to begin. |

| **Meeting Date** | **Item** | **Issue** | **Outcome** |
|---|---|---|---|
| 18th 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 | Members have recommended that the Brent Pension Fund Sub- |

| | | | |
|---|---|---|---|
| | | interested in specific issues, such as the licensing of shisha bars, to see how this issue is being addressed in Brent. | Committee considers again its tobacco investments, and referred the Clear Assessment Report and ASH report on pension investments to the committee for consideration. |
| | Kenton Medical Centre | The committee has asked for a follow up report after considering the Primary Care Update in May 2012. They are interested in Kenton Medical Centre and how many patients have been re-registered, and where they have re-registered since notice was served on the practice that it was to close. NHS North West London has been asked to provide this paper. | Report noted. Members have asked for an update on what has happened to the three vulnerable patients being helped to reregister with another practice. |
| | Serious Incident at CMH | NHS Brent and Care UK will provide their report on the serious incident at the CMH UCC, concerning the missed pathology on radiology reports. | Report deferred until October as Care UK was not present. |
| | Shaping a healthier future | Members have requested information on the Shaping a Healthier Future plans for acute trusts in Brent, focussing on plans for Northwick Park Hospital and Central Middlesex Hospital, as well as St Mary's (a hospital used by residents in the south of Brent). The committee will also need to consider how it will respond to the consultation, bearing in mind the NWL JOSC. | The committee has agreed to form a working group to prepare a response to Shaping a Healthier Future by the 8th October. |
| | NWL Hospitals and Ealing Hospital Trust merger – Full Business Case | An Executive Summary of the Full Business Case will be presented to the committee for comment and scrutiny. | Report noted, but it was agreed to take an update on this at the October committee meeting. |
| | Brent's Improving access to psychological therapies scheme | The committee has requested a report on the Brent IAPT scheme which has been in place since December 2010. Members would like the report to include information on:<br>• How the scheme is functioning for both children and adults<br>• The referral process<br>• Average waiting times for treatment from the point of referral<br>• GP attitudes to the scheme | It was agreed to follow up with CNWL in October 2012 on the mental health provision on offer for people with more complex mental health needs, to get a better understanding of the services available and how the realignment of resources into IAPT has affected services for patients with more complex needs. |

| Meeting Date | Item | Issue | Outcome |
|---|---|---|---|
| 9th October 2012 | Serious Incident at CMH | This item was deferred from the July meeting as Care UK weren't represented. NHS Brent and Care UK will provide their report on the serious incident at the CMH UCC, concerning the missed pathology on radiology reports. | The committee has requested an update in six months times from Care UK and NHS Brent on the work of the UCC to ensure there have been no further problems and to understand that the recommendations from the SI report have been implemented in full. |
| | A&E at Central Middlesex | Update on the service, following closure of overnight A&E. | The committee endorsed the hospital trust's recommendation that the service remained closed overnight pending a review in six months time. A report should come back to members in six months on this, and the general issue of recruiting A&E doctors as there is a national shortage. |
| | NWL Hospitals and Ealing Hospital Trust merger – Update following approval of the Full Business Case | This was requested by members in July 2012, so that they are kept informed of the project as the merger progresses. | Report noted. David Cheesman was asked to inform members of the outcome from the Trust Board meetings and NHS London's Board meeting where the FBC for the merger will be considered. A request for a follow up at the next meeting was made on the merger and also efforts to make the £72m savings required from the hospital trust. |
| | Shaping a Healthier Future | For approval of the committee's response to the Shaping a Healthier Future consultation. | The committee agreed their response, which was sent back to the SAHF consultation team. |
| | Sharing a DPH | Report on plans for the role of the DPH and outline structure for | The committee made two |

| | | | |
|---|---|---|---|
| | | comment and recommendations for the Executive. | recommendations:<br><br>(i) that proposals to mainstream public health services, as outlined in the report for the proposed structure of the Brent Public Health Service, be supported; and<br><br>(ii) that because of the importance of public health, the committee is concerned about the proposal to share a Director of Public Health with another borough and recommends that the Executive does not agree to share the post with Hounslow Council. |



| **Meeting Date** | **Item** | **Issue** | **Outcome** |
|---|---|---|---|
| 27th November 2012 | Recruitment of health visitors in Brent | At the committee's meeting in May 2012, members agreed that they would receive a progress report from Ealing Hospital ICO on the recruitment of health visitors in Brent and their progress in meeting the Government's target for health visitors in England. | Report and ongoing issues with health visitor recruitments in Brent and across London and remedial actions being taken was noted. The committee wishes to be kept up to date on progress. |
| | 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 November 2012 to look at two issues: | The committee noted the update and asked for more information on Mencap's input into the Joint Strategic Needs Assessment. Mencap to circulate details of their comments to the JSNA to members. |

| | | | |
|---|---|---|---|
| | | • The NHS health check day being organised by NHS Brent, which will involve MENCAP<br>• How MENCAP has been able to build on the initial project to train NHS staff members on working with people with learning disabilities. | |
| | Time to change pledge | Members have requested a progress report on how the council is responding to the Motion to Council in July 2012 on the Time to Change Pledge. | The committee noted progress on the Time to Change pledge and work being done with managers and employees in Brent.<br>The committee requested that this be extended to all Councillors. Cllr Hirani agreed to arrange a members development session around stress. |
| | Health Watch in Brent | Update on progress on the development of Health Watch in the borough. The committee has also asked for an overview of the patient involvement work happening in Brent at present – for information only. | The committee endorsed the council's approach to procuring a local Healthwatch and noted current progress. The committee asked to be kept updated on progress. |
| | Brent LINk work in 2012/13 | Brent LINk has asked to feed back to members details of their recent work on their health needs survey, the Shaping a Healthier Future consultation and the "Enter and View" programme. | The committee noted the update from the LINk. The LINk's annual report for 2011/12 had been circulated in addition to the main report at the LINk's request, to be included in this item, but due to the lateness of receiving the report, the committee deferred this report, which will be considered in tandem with the 2012/13 report, which the Department for Health has now advised can be produced for Apr-Dec in 2012/13 due to this being the final year of the LINk. Both reports to be taken as a single item at the January committee. |

| | | | |
|---|---|---|---|
| | NWL Hospitals / Ealing Hospital Merger | Update from NHS London Board meeting in October, where a decision on the merger should be taken. Members would also like the update to cover the progress that the trust is making in achieving its £72m savings target as there are concerns this has fallen behind schedule. | The committee noted the report on delays and problems with the merger and the update on progress on savings and on the situation at Central Middlesex A&E, and related issues. As there were a number of unknowns and David Cheesman could not at this stage give any definite timetable, the committee requested further update at the next meeting in January. |
| | Update on DPH | Update on the position on the Director of Public Health. Expected to be discussed at Exec on 12th November. So presumably a decision will have been made by the 27th. | The committee asked to be notified immediately of any decisions or major updates on the appointment of a DPH (ie not waiting until the next meeting). They further requested a report at the January committee on the position of the DPH and progress on the transition of Public Health. |



| **Meeting Date** | **Item** | **Issue** | **Outcome** |
|---|---|---|---|
| 29th January 2013 | Mental Health Services in Brent | Following a previous agenda item on IAPT services, the committee want to follow up with CNWL on the mental health provision on offer for people with more complex mental health needs, to get a better understanding of the services available and how the realignment of resources into IAPT has affected services for patients with more complex needs. | |
| | 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. | |
| | Diabetes Task | The final report of the diabetes task group will be presented to the | |

| | | | |
|---|---|---|---|
| | Group | committee for endorsement before going to the council's Executive for approval. | |
| | LINk report 2011/12 and 2012/13 | The LINk added their annual report to the item in November, but this was provided too late for the committee to be able to read and digest it. The report was therefore deferred to January. As the LINk are now allowed to produce the substantive part of their annual report for 2012/13 early, covering up to December 2012, these two reports will be presented together. | |
| | Update on DPH and transition of Public Health | At the meeting in November, the committee requested a report at the January committee on the position of the DPH and progress on the transition of Public Health. | |
| | NWL Hospitals / Ealing Hospital Merger | At the November meeting the committee were given an update on the delays and problems with the merger and an update on progress on savings. As there were still a number of unknowns, and David Cheesman could not at that stage give any definite timetable, the committee requested further update at the next meeting in January. | |
| | A&E Waiting Times | Follow up from information provided in July 2012 – the chair has asked to include this on the work programme. | |



| **Meeting Date** | **Item** | **Issue** | **Outcome** |
|---|---|---|---|
| 19th March 2013 | NWL Hospitals / Ealing Hospital Merger | Update on position. At the January meeting NWLH introduced a new planned timetable for the merger, based on the need to provide a revised business case to NHS London (by the time the case is submitted it will now be the National Trust Development Agency). NWLH will continue to update the HOSC on its revised business case up until June, prior to the planned submission of the business case in July. | |
| | A&E at Central Middlesex | Members requested in October 2012 an update in six months on the closure of A&E overnight. The update should cover the efforts to recruit A&E staff to the trust, but also the national context around the issue of a shortage of A&E doctors. | |
| | Violence against Women and Girls | Members requested a task group around Female Genital Mutilation to investigate whether this practice is prevalent in Brent. This has | |

| | | | |
|---|---|---|---|
| | in Brent - Scoping Document | been extended to Violence against Women and Girls in Brent. The committee will be asked to approve the scope of the task group. | |
| | Pathology Testing in Brent | The chair has requested that pathology testing in Brent be discussed. | |
| | 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. | |
| | Shaping a Health-er Future | The final decision on options is expected on 19 Feb. The JCPCT will update the committee on this decision and next steps in Brent. | |
| | Khat: Update | Update on progress on the recommendations made by the committee based on the report from the Khat Task Group. | |
| | Update on transition of Public Health | The committee have requested a further update on progress of the transition of Public Health and the appointment of a DPH. | |
| | | | |



| **Meeting Date** | **Item** | **Issue** | **Outcome** |
|---|---|---|---|
| TBC | Serious Incident at CMH | Members requested in October 2012 a six month update from Care UK and NHS Brent on the work of the UCC to ensure there have been no further problems and to understand that the recommendations from the SI report have been implemented in full. | |
| 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 | 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 | 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 | 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. | |
| | Teenage Pregnancy | Members have asked for a report on teenage pregnancy in Brent, the services available and conception rates amongst teenagers. | |
| | Abortion services in Brent | Councillors have asked for a report on abortion services in Brent, and the abortion rates in the borough, including repeat abortions. This could include a more general update on sexual health provision in Brent. | |

| | | | |
|---|---|---|---|
| TBC | Brent MENCAP Update on work | At the November 2012 HOSC members heard from MENCAP on their work around Health Services for People with Learning Disabilities. Members requested an update on MENCAPs work at a future meeting. | |
| TBC | Diabetes Task Group | Update on progress of the Diabetes Task Group recommendations. | |

**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.

This page is intentionally left blank