Public Document Pack

Health Select Committee

Tuesday, 20 October 2009 at 7.00 pm
Committee Rooms 1 and 2, Brent Town Hall, Forty Lane, Wembley, HA9 9HD

Membership:

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

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The press and public are welcome to attend this meeting

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members

Item		Page
1	**Declarations of personal and prejudicial interests** Members are invited to declare at this stage of the meeting, any relevant financial or other interest in the items on this agenda.	
2	**Minutes of the previous meeting**	1 - 6
3	**Matters arising (if any)**	
4	**Deputations (if any)**	
5	**Implementing Healthcare for London - Strategic Commissioning Plan and Primary Care Strategy Update** NHS Brent has provided the Health Select Committee with an overview of progress in implementing Healthcare for London, which forms a major part of its strategic planning of health services in the borough. The report covers progress in refreshing the organisations Commissioning Strategy Plan, developed in 2008/09, as it needs to be amended to reflect the changing economic situation in the country. It also has to align with wider health priorities in North West London and to reflect the Healthcare for London's care pathways. The Committee will be given an overview on the work to develop primary care services in the borough, following on from previous items on the Primary Care Strategy. Members will also have an opportunity to consider the developments at the Stag Lane Clinic, which NHS Brent is to close in the near future. The Committee will be able to discuss this in the wider context of the primary care commissioning plans for Brent.	7 - 38
6	**GP Access Survey Results** Results of the GP access survey for 2008/09 will be presented to the committee to give members an indication of how satisfied members of the public are with GP access in the borough. GP access is an issue that has been of concern to the Health Select Committee in the past and so members are likely to be interested in these results and how NHS Brent and GPs are responding to improve patient satisfaction.	39 - 52

7 Smoking Cessation 53 - 58

The Health Select Committee has asked for an update on the smoking cessation service in Brent. The Health Select Committee has agreed previously to monitor progress of the smoking cessation programme because of its importance to the health of people in Brent. NHS Brent has provided a brief update on the performance of the service in the first half of 2009/10.

8 Acute Services Review 59 - 66

The Health Select Committee has received reports on the acute services review at its previous meetings and members have also attended a briefing at the Harrow Overview and Scrutiny Committee on plans for paediatric and emergency surgery services at North West London Hospitals Trust. Officers from NHS Brent and North West London Hospitals Trust will attend the committee to update members on the project and also to give a pre-consultation presentation.

Since the committee met last an independent clinical review has taken place on the provision of emergency surgery services during the day at Central Middlesex Hospital. Further information on this development is included in a letter to Councillor Chris Leaman, included as an appendix to this report.

In addition, the chair of the committee had asked for the views of the Local Medical Committee on the acute services review. A letter from Dr Helen Clark, chair of the Brent LMC is also included as an appendix to this report.

9 Audit Commission Review of addressing Health Inequalities in Brent 67 - 86

The Audit Commission has completed a report into Health Inequalities in Brent. This will be presented to the Health Select Committee for comments.

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

Andrew Davies, Policy and Performance Officer, will provide a verbal update on the outcome of the Joint Committee of PCTs meeting on 20th July 2009 where decisions were made on the future of major trauma services and stroke services in London. The decisions that will have the biggest impact on Brent residents was confirmation that a major trauma centre will be located at St Mary's Hospital and a Hyper Acute Stroke Unit will be located at Northwick Park Hospital. Further details will be provided at the meeting.

11 Health Select Committee Work Programme 87 - 98

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

12 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.

13 Date of Next Meeting

The next meeting of the Health Select Committee is scheduled for Wednesday 9th December 2009

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

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

MINUTES OF THE HEALTH SELECT COMMITTEE
Wednesday, 15th July 2009 at 7.00 pm

PRESENT: Councillor Leaman (Chair), Councillor Crane (Vice Chair) and Jackson.

Apologies for absence were received from Councillors Mrs Fernandes, R Moher and Elvis Langley.

1. **Declaration of Personal and Prejudicial Interests**

None declared.

2. **Minutes of Previous Meeting**

RESOLVED:

that the minutes of the meeting held on 9th June 2009 be received and approved as an accurate record.

3. **Matters Arising**

None.

4. **Brent Local Involvement Network Annual Report**

Mansukh Raichura (Chair, Brent Local Involvement Network Management Committee) introduced the report and confirmed that the Council had appointed a host organisation, Hestia Housing and Support, in December 2008 to support Brent Local Involvement Network (LINk). Hestia Housing and Support's functions included maintaining regular dialogue with service providers, capacity building and training of Brent LINk participants, working with the voluntary sector to promote Brent LINk, acting as a contact point, undertaking administrative tasks, financial management of resources, servicing meetings and facilitating workshops. A Management Committee had been elected in May 2009 to provide democratic and transparent governance. Mansukh Raichura concluded by welcoming questions from the Select Committee.

The Chair sought further details of ways in which Brent LINk engaged with present members and to encourage new members to join, and asked how many members were currently involved. He also sought comments on what type of issues the LINk and Select Committee could consider together in the future and if there had been any particular problems whilst setting up and developing Brent LINk.

In reply, Lauretta Johnnie (Brent LINk Co-ordinator) advised that Brent LINk kept in touch with partners in a number of ways, including e-mail, newsletters, public events and presentations, whilst a Community Engagement Strategy was also being developed. She commented that Brent LINk was still in its early stages and that every effort was being

made to develop the organisation and increase membership. Mansukh Raichura added that approximately 80 people had attended a recent consultation event and that Brent LINk would continue to work with its members to identify ways of moving forward. Members heard that the one of the biggest challenges Brent LINk faced was spreading information and empowering its' members.

Tony Ogefere (Brent LINk Management Committee) commented on the need to take into account the need to ensure that membership reflected Brent's diverse community. He explained that the Management Committee wished to engage with the Overview and Scrutiny Committee and this Select Committee to help identify priorities and areas for further discussion.

The Chair indicated that the Select Committee would be willing to engage with Brent LINk on a regular basis.

RESOLVED:-

that the report on the Brent Local Involvement Network Annual Report be noted.

5. **North West London NHS Hospitals Trust 2008 Adult In-Patient Survey Results**

Fiona Wise (Chief Executive, North West London Hospitals NHS Trust) introduced this item, explaining that the results of the survey were obtained approximately a year ago and that the 2009 Adult In-Patient Survey was about to commence. She summarised the results of the Adult In-Patient Survey. The survey had shown that the North West London NHS Hospitals Trust was the lowest performing nationally in the following areas:-

- Being treated with dignity and respect
- Help at mealtimes
- Trust and confidence in doctors
- Pain control
- Doctors and nurses working together
- Answering questions about operations and procedures

Fiona Wise continued that most other London NHS Hospitals Trusts had similarly performed less well when compared nationally. Members heard that the response rate to the survey was low and this could be partly attributed to language issues. However, there had been significant progress in some areas, although other NHS Hospital Trusts had made similar gains. As a response to the results, Fiona Wise advised that the Trust was developing an Action Plan with committees specifically assigned to look at themes where the Trust was performing below the national average, including Waiting Issues, Pain Control, Help at Mealtimes, Respect and Dignity/Communication and Cleanliness. She then drew Members' attention to the detailed Action Plan as set out in the report. Fiona Wise commented that she felt the Trust was reaching its targets in terms of waiting times and delays on

discharge, however patients continued to make complaints despite this. She acknowledged that the Trust faced a challenge in addressing issues regarding Pain Control, Help at Mealtimes, Respect and Dignity/Communication, however the Action Plan was focusing on these, whilst a new contractor had been appointed with regard to Cleanliness and more spot checks were being undertaken.

During discussion, Councillor Jackson enquired whether the questions in the 2008 Survey were the same ones used in the previous survey. He also asked whether Cleanliness and Help at Mealtimes had improved since the survey had been undertaken. Councillor Crane enquired whether the Trust was aware of the problems highlighted by the results prior to the survey being undertaken and he sought an explanation of the results with regard to Help at Mealtimes and Respect and Dignity. He also expressed surprise that staff needed to be reminded that some patients would require assistance at mealtimes.

The Chair enquired on the number of survey forms that had been distributed and what studies had been undertaken as to why London NHS Trusts performed poorly in comparison with other Trusts. He asked whether the Action Plan was on track, including the targets for April/May 2009. The Chair also requested that further information on the We Care Programme be provided for the committee.

In reply, Fiona Wise confirmed that the questions used were the same as for the previous survey and stated that 33 of the 65 questions asked had shown an improvement of 5% or more, whilst only 3 questions had shown a decline. It was noted that 800 forms were distributed. She felt that Cleanliness and Help at Mealtimes had improved since the survey had been undertaken, however she stressed the importance in considering adverse comments to the questions and particular attention needed to be given to Pain Control, Help at Mealtimes, Respect and Dignity/Communication. Members heard that the London NHS Trusts had met the previous year to discuss the particular issues they faced and had agreed that the survey questions were incorrectly weighted to the population they served. London had a higher proportion of ethnic minorities compared to the rest of the UK, and in particular a high percentage of young female Asians and expectations of the NHS may differ to those of other regions. The London Strategic Health Authority had also created a working group to look at the outcome of the results of all London NHS Trusts.

Fiona Wise advised that the North West London NHS Hospitals Trust was already aware of the concerns raised in the survey, although some of the results were surprising. She commented that some staff may have difficulties in communicating to patients in complex situations, particularly where languages may be a factor. The Select Committee was advised that the red tray system for meals was continuing, however if problems persisted, then an alternative system would need to be considered. Fiona Wise added that it was not possible to serve all red tray patients at the same time as there was not sufficient staff to provide the assistance these patients required. She stated that the

Action Plan overall seemed to be on target and she agreed to provide results of the We Care programme.

RESOLVED:-

that the report on the North West London NHS Hospitals Trust 2008 Adult In-Patient Survey Results be noted.

6. **Brent, Harrow and North West London Acute Services Review**

Mark Easton (Chief Executive, NHS Brent) presented the report which provided an update from NHS Brent and details of the meeting that had taken place between NHS Brent, the North West London NHS Hospitals Trust and two members of the Select Committee. Members were advised that the review had concluded that Scenario 2 was the preferred option to pursue, which would entail continuing with the services as presently configured but also reflecting the implementation of Healthcare for London stroke and trauma proposals, maximising the use of Northwick Park Hospital as the main surgical centre and with a particular focus on improving emergency surgery and paediatric services. Mark Easton advised that paediatric services had been highlighted as being in decline in the in-patient survey, however it was to be centralised to use funds to improve services. Members heard that the proposals still required further internal work before being consulted upon and NHS London would require a pre-consultation business case. It was hoped that further progress could be reported upon at the Overview and Scrutiny Committee meeting at the London Borough of Harrow Council on 28th July 2009.

During discussion, Councillor Crane asked if a report would include a response with regard to a recent article in a local newspaper concerning maternity services at Central Middlesex Hospital. The Chair sought clarification that the consultation would be for a 12 week period and further details concerning the financial implications and enquired whether there would be a financial impact on the consultation taking place in October rather than earlier, particularly as this would mean the consultation period extending into the Christmas period. Councillor Jackson sought clarification as to whether Members could attend the Overview and Scrutiny Committee meeting in Harrow on 28th July 2009.

In answer to the issues raised, Mark Easton acknowledged that there was a need to provide an explanation of the changes in respect of maternity services at Central Middlesex Hospital. He confirmed that the consultation period was likely to be for a 12 week period commencing in October, with changes being implemented over February - April 2010. Confirmation that emergency services arrangements were safe would be required before the consultation exercise could commence. The financial details were presently being considered and a projection of costs and other financial implications could be provided. Although the consultation was likely to continue into the Christmas period, Mark Easton felt that the changes had been anticipated for some time and he did not think this would be an issue.

Fiona Wise added that because consultation could not start earlier, there would be financial implications as hoped for savings would not be achieved, however there only existed a £500,000 gap in the Cost Improvement Programme.

Andrew Davies (Policy and Performance Officer, Policy and Regeneration) confirmed that Members were welcome to attend Harrow Council's Overview and Scrutiny Committee on the 28th July 2009.

Members heard that approval from the Select Committee on the consultation process might be needed in early October in order to commence with consultation in late October. The Chair noted that the next meeting of the Select Committee was not until 20th October 2009 and in view that approval to undertake consultation might be required before then, Members agreed that if necessary authority be given to the Chair and Vice Chair of the Select Committee to approve the consultation process in order for it to proceed.

RESOLVED:

(i) that the report on the Brent, Harrow and North West London Acute Services Review be noted; and

(ii) that the chair and vice-chair of the committee approve the consultation process before the end of October 2009, if this is necessary to begin the consultation before the next meeting of the Health Select Committee.

7. **North West London Acute Commissioning Partnership**

Mark Easton presented the report, advising that the objective of the Partnership was to deliver both the individual and collective commissioning intentions of Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea and Westminster Primary Care Trusts (PCTs). In addition, the Partnership would allow PCTs to pool commissioning skills and resources as there was a scarcity of some these skills in London. Members heard that most PCTs outside London were larger and usually county based.

Jim Connelly (Director of Public Health and Regeneration, NHS Brent) commented that evidence would be needed to show that merging PCTs would be better and that local commissioning would need to be retained because of the varying needs of each of the boroughs concerned. However, he felt that merging would be of benefit to specialist, acute services.

Councillor Crane commented that there seemed some merit in merging the PCTs. The Chair sought comments concerning possible implications for staff if mergers took place, and whether any other areas other than Children's Services would benefit from the Partnership. He also enquired whether such a merger was in accordance with NHS London and its desire for fewer PCTs.

In reply, Mark Easton suggested that the Partnership could also benefit other areas such as dentistry and ophthalmology and pooling resources in other specialist areas. He advised that if the Partnership was formed, the main objective would be to ensure consistency of contracts, however some local commissioning would continue depending on whether this was the most appropriate way of providing a service, whilst others would be provided on a regional basis. Although some staff may be affected by such a merger, it was not likely that this would directly affect Brent NHS. Members heard that the future of PCTs continued to be debated and it could not be assumed that PCTs would cease to exist in future. It was noted that consultation with regard to the creation of a Partnership was continuing.

RESOLVED:

that the report on the North West London Acute Commissioning Partnership be noted.

8. **Health Select Committee Work Programme**

Andrew Davies welcomed any suggestions from Members with regard to possible agenda items for the next meeting on the 20th October 2009.

9. **Date of Next Meeting**

It was noted that the next meeting of the Health Select Committee was scheduled for Tuesday, 20th October 2009.

10. **Any Other Urgent Business**

None.

The meeting ended at 8.10 pm.

C LEAMAN
Chair

	Health Select Committee **20th October 2009** **Report from the Director of Policy & Regeneration**
For Action	Wards Affected: ALL
Implementing Healthcare for London – NHS Brent Strategic Commissioning Plan refresh and Primary Care Strategy update	

1.0 Summary

1.1 NHS Brent has provided the Health Select Committee with an overview of progress in implementing *Healthcare for London*, a major part of its strategic planning of health services in the borough. In 2008/09 NHS Brent developed its Commissioning Strategy Plan, that set out a 5 year investment programme to deliver its vision of making a significant improvement to the health and well-being of the people of Brent. The plan contained the following goals:

- Goal 1: Reduce premature mortality and therefore increase life expectancy by three years by 2013
- Goal 2: Reduce the gap in life expectancy by 6 months by 2013
- Goal 3: Promote good health and prevent ill-health
- Goal 4: To improve the quality and safety of services, so that by 2013 health and social care providers commissioned by NHS Brent receive a Care Quality Commission Review Standard at least equivalent to the existing Good rating in the Annual Health Check
- Goal 5: To improve the patient experience of services, so that by 2013 health and social care providers commissioned by NHS Brent will achieve patient experience scores at least as good as the London average

1.2 Since the Commissioning Strategy Plan was signed off, the economic circumstances of the country have changed significantly and so the plan is being reviewed to ensure its goals can be delivered in a more challenging economic environment. Full details of this are included in the slides provided by NHS Brent (appendix 1, pages 20 to 26) In addition the plan needs to align with others in North West London and contribute to the strategic plan for

health in the North West London sector. It also needs to reflect the eight *Healthcare for London* pathways.

1.3 As well as considering the update on the Commissioning Strategy Plan, members have asked for an update on the Primary Care Strategy. There are details on the plans for primary care services contained in the slides provided by NHS Brent (appendix 1, pages 5 to 7). Members should also take the opportunity to ask for a specific update on the Stag Lane Clinic, which is expected to close in the next few months, and the future plans for GP services in the Kingsbury area.

2.0 Recommendations

2.1 The Health Select Committee considers the update from NHS Brent on the review of the Commissioning Strategy Plan and Primary Care Strategy and questions officers on progress and plans for health services in the borough in the light of the challenging financial position facing NHS Brent.

2.2 Members should also seek clarification on the position with Stag Lane Clinic and primary care services in Kingsbury.

3.0 Detail

3.1 NHS Brent has started to review its Commissioning Strategy Plan as a result of changes to the economic situation in the country, so that it aligns with strategic health priorities in the North West London sector and also to reflect the eight *Healthcare for London* Pathways.

3.2 The eight *Healthcare for London* pathways are:

- Acute care
- Planned care
- Maternity and newborn
- Children and young people
- Mental health
- Staying healthy
- Long term conditions
- End-of-life care

3.3 NHS Brent has provided a series of presentation slides that provide an update on progress against each of these pathways. Some of the developments, such as the acute services review, will be well known to members of the Health Select Committee. Other elements will be less familiar and so the Health Select Committee should seek explanations to any of the planned strategic changes that it is unsure of. It is important that the committee is aware of NHS Brent's strategic plans and the possible implications they can have on local services.

3.4 Of particular interest will be the developments in primary and community care in Brent. Members of the committee held a challenge session with officers

from the PCT on the Primary and Community Care Strategy in June 2009. The report contains information on the emerging polysystem of primary care that NHS Brent wishes to implement. Changes are also happening on the ground. The GP led health centre has opened at the Wembley Centre for Health and Care, for example.

3.5 Other recent developments include plans to close the Stag Lane Clinic in Kingsbury. This is to happen in the near future and the committee should explore what this means for the future of primary care services in that area, both in the immediate future for affected patients, and in the longer term. NHS Brent's report shows that a new locality health centre is planned for Kingsbury (and South Kilburn and Mapesbury). Members should consider how these plans are developing, when can patients expect the new services to open and the impact they will have on existing service provision.

3.6 The NHS Brent report also sets out the financial context in which its commissioning plans will have to be delivered. The base case scenario facing NHS Brent if it continues spending each year as it is now, and does nothing to save money each year (i.e. the do nothing scenario) will be a recurrent saving of £60m over three years from 2011/12 in order to maintain a sustainable financial position. Even the best case scenario projects a £45m recurrent saving over the same time period. In simple terms, NHS Brent is going to have to make some significant decisions about the services it commissions. Broad actions are included in the report:

- Provide services via a different pathway, i.e. out of the hospital and closer to home
- Prevent use of hospital services and proactively care for them outside of hospital
- Reduce demand for health services by addressing health behaviours and detecting ill health at an earlier stage through more affective screening
- Stop commissioning low value added intervention (e.g. some out-patient follow ups)
- Eliminate unnecessary and costly service overlaps (e.g. out of hours, extended hours, urgent care, A&E)

3.7 Members should ask officers from NHS Brent what the financial position facing the organisation will mean for health services in the borough. It is important that the committee contributes its views on which services should remain a priority. A challenge session to go through this in detail could be set up if members request this.

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

Contact Officers

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Healthcare for Brent

NHS Brent

Implementing 'Healthcare for London'

NHS Brent Strategic Planning

Mark Easton
Chief Executive
September 30th 2009

Contents

- Introduction
- Emerging provider landscape across Brent
- Emerging polysystem plans
- Polysystem implementation progress to date including stakeholder engagement
- Local application of the care pathways including the borough-level case for change
- Progress to date on activity and affordability modelling
- Next steps

Introduction – Context

In 2008/09 NHS Brent developed a Commissioning Strategy Plan that set out a 5 year investment programme to deliver its vision of **making a significant improvement to the health and well-being of the people of Brent** with the following goals:

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

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

Goal 3: Promote good health and prevent ill-health

Goal 4: To improve the quality and safety of services, so that by 2013 health and social care providers commissioned by NHS Brent receive a Care Quality Commission Review Standard at least equivalent to the existing Good rating in the Annual Health Check

Goal 5: To improve the patient experience of services, so that by 2013 health and social care providers commissioned by NHS Brent will achieve patient experience scores at least as good as the London average

Changing circumstances in the last year, and moving forward, require us to review our CSP to ensure that it both aligns with others across North West London and that it can continue to support progress towards delivering our goals and outcomes in the changing economic environment.

This presentation pack provides an initial statement of our progress and intentions as we review and realign our CSP.

Introduction – Alignment to Healthcare for London Care Pathways

We are redefining our CSP initiatives to align to the 8 Healthcare for London Care Pathways to provide a more robust and transparent platform for delivering Healthcare for London within Brent and the NWL sector.

9 Existing CSP Initiatives
Improve primary care services
Improve childhood immunisation rates
Improve vascular health
Reduce premature mortality from cancer
Improve intermediate care
Improve mental health and wellbeing
Improve maternity services
Give children and young people the best chance in life
Support healthy behaviours

8 Healthcare for London Pathways
Maternity and newborn
Children and young people
Acute care
Planned care
Mental health
Staying healthy
Long term conditions
End-of-life care

6 Healthcare for London Settings
Home
Polyclinic
Elective centre
Local hospital
Major acute
Specialist hospital

Introduction – Retaining commitment to our Goals

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

Existing Provider Landscape Across Brent (top 6 providers)

Acute hospital provision	North West London Hospitals Trust	£104m	• Financially challenged trust • No clear route-map to clinically and financially stable future • Ongoing rationalisation across 2 sites, CMH and NWP
	Imperial College Healthcare Trust	£62m	• Academic Health Science Centre • Preferred specialist provider
	Royal Free Hampstead NHS Trust	£13m	• Local provider for south east of borough • Range of specialist maternity and paediatric care
Community services	Brent Community Services	£39m	• Emerging APO operating independently • Concerns over quality and productivity and ability to deliver some services
Independent contractors	71 GP Practices Dentists Pharmacies	£62m	• Large number of single and two-handed practices with poor infrastructure • Poor achievement for patient access / satisfaction • Variable quality and performance across practices
Mental health	Central & North West London Mental Health Trust	£34m	• Foundation trust • Modernisation programme required

All figures are 09/10 contract values

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The Emerging Acute Provider Landscape Across Brent

North West London Hospital Acute Services Review

- In 2009 a health-economy wide review of North West London Hospitals (NWLHT) has been undertaken with involvement from the following:
  - Clinicians and managers from NHS Brent, NHS Harrow and North West London Hospitals
  - Representatives from both local authorities
  - Local patient participation groups
  - Review Board chaired by CEO, NHS Brent
  - Clinical Reference Group chaired by PEC Chair, NHS Brent
- Extensive scenario planning, with activity and financial modelling was undertaken using both PCTs' CSPs as a starting point and having identified fixed points of:
  - Maximising the use of Central Middlesex Hospital site – as a PFI build
  - Establishing primary care-led urgent care centres on both sites
  - Supporting the establishment of a HASU on Northwick Park site

The Emerging Acute Provider Landscape Across Brent (cont'd)

- Scenario planning workshops involving clinicians, managers, local patients and community representatives focused on care pathways relating to
  - Maternity and women's health
  - Children and young people
  - Urgent and emergency care
  - Planned care
  - Surgery
  - Intermediate care
- The overall outcome from the review concluded that NWLH's financial viability could not be ensured alone and needed to be considered within the wider North West London Transforming Acute Care Programme
- Two more immediate actions arose from the review
  - Further pre-consultation / deliberative work should be taken forward relating to the ongoing provision of in-patient paediatric beds on both sites
  - Relocation of emergency surgery from Central Middlesex Hospital to Northwick Park site

The Emerging Primary and Community Landscape Across Brent

- In April 2009 NHS Brent issued a discussion document " A Strategy for Improving and Developing Primary and Community Services for the Next Five Years"
- Clinical leadership for the document was provided by NHS Brent's Professional Executive Committee, who sponsored the programme. Clinical representatives from each of NHS Brent's five PBC clusters were on the Programme Steering Committee
- The document was developed with extensive involvement from the community of Brent including community forums, area forums, voluntary sector groups, Brent Youth Parliament, street canvassing, open meetings and wider scale media publicity
- The involvement culminated in a Deliberative Event involving 100 people representative of Brent's diverse population and demography - interactive voting yielded the following :
  - 47% participants felt that the current services did not meet their needs well
  - 93% participants agreed that there was a case for change
  - 75% participants felt that the proposed model would improve services
- The discussion document was widely consulted upon across the local Brent community, using a variety of methods for engagement. The feedback from the document was considered at the July meeting of the Board of NHS Brent and the strategy was adopted, noting the support for the direction of travel and improvements in quality required to deliver the outcomes

The Strategy underpins the Polysystem Proposals being taken forward

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Polysystem Vision (1)

All patients will have access to care as close to home as possible, with care transferred from hospital that could be better provided close to home
1. Providing more specialist care close to home. This will include changes to some existing hospital out-patient appointments 2. Helping avoid admissions and helping people be discharged in a timely fashion 3. Providing minor procedures 4. Access to a rapid specialist opinion to support people's treatment being provided in the community

All Brent patients will have access to a standard range of practice based services:
These are expected to include: • minimum 45 hours opening each week • immunisation • child surveillance • level 1 long term conditions care • screening • level 1 health promotion • level 1 sexual health • diagnostics – ECG / phlebotomy / spirometry • choice of male / female GP • use of interpreting services • accepting patients for registration within a PCT agreed area • home visits • access to level 1 health visiting, district nursing and therapy services

All Brent patients will have access to practices that are:
• achieving national targets for preventative screening and quality • open sufficiently to see and manage their patients well • able to offer a range of services • able to recruit sufficient staff to meet their workload • located in suitable premises to meet their patients' needs • able to respond flexibly to change

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Polysystem Vision (2) - All patients will have access to these services

Polysystem Model System of Care

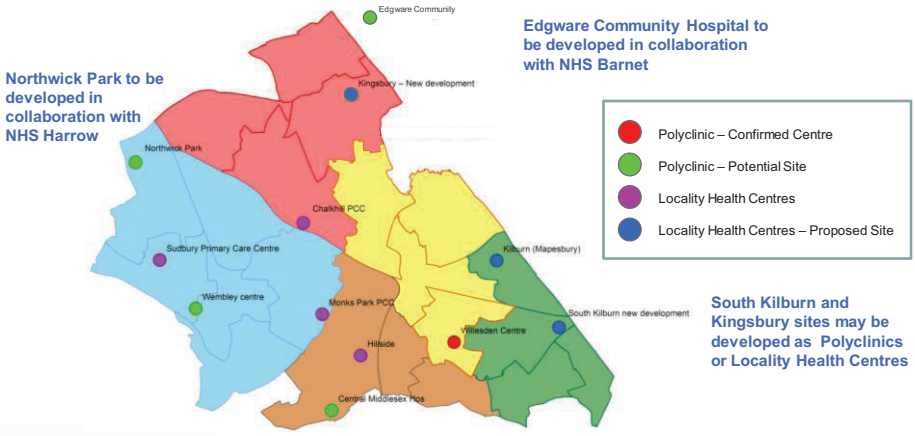
Model is based upon a network polysystem with spokes of practices, pharmacies, locality health centres, children's centres and a polyclinic

- Practice-based commissioning clusters geographically aligned to five polysystems
- Integrated Locality Partnership Boards for Children aligned to five polysystems
- Each cluster has produced a commissioning plan outlining implementation of its polysystem
- Core standards agreed for all GP practices and Neighbourhood Networks of practices
- Specifications for community nursing services based upon neighbourhood networks in polysystems
- Specifications for integrated teams based upon polysystem
- Infrastructure to deliver benefits being developed including
  - Clinical systems and patient records
  - Integrated care teams
  - Rationalised support functions

Emerging Polysystem Sites

Fixed points:

- GP Led Health Centre, Wembley Centre for Health and Care (June 2009)
- Urgent Care Centre, Central Middlesex Hospital (April 2010)
- Willesden Centre for Health and Care (PFI build)



Healthcare for Brent

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Emerging Polysystems Plans

Progress to date and immediate next steps

- The development and agreement of the Primary and Community Services Strategy took longer than initially envisaged but resulted in strong and sustainable commitment from key partners, both to the case for change and to the polysystem as the framework for change
- All five Practice Based Commissioning clusters have developed supporting Commissioning Plans showing how they will work within practices, across networks of practices and within polyclinics to deliver the model of care and agreed quality outcomes
- These Commissioning Plans are the foundation for polysystem development and are currently being challenged and revisited to take account of
  - Healthcare for London Care Pathway developments
  - Revised scale of change / ambition to relocate acute services to polysystem settings of care (in line with the Healthcare for London Affordability Analysis)
  - Estates and workforce implications
  - Revised Market Management Strategy and commissioning / procurement options
  - Opportunities for improved integration and rationalisation with key partners including the local authority
- The overarching Polysystem Implementation Model together with plans for consultation and implementation will be included in our Commissioning Strategy Plan in December

Healthcare for Brent

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Maternity Services – Case for change in Brent

- Brent is an outer London borough with a growing and dynamic population evidenced by a 3% average increase in birth rates since 2002
- Brent's score on the Index of Multiple Deprivation (IMD) has risen since 2004 and we are now one of the 15% most deprived areas in the country
- It is the most culturally diverse area in the country, and only one of two boroughs where black and minority ethnic groups are the majority (54.4%), with nearly 8% of our population classified as refugee or asylum seekers
- The infant mortality rate remains above the national average (2006 saw 6.6 infant deaths per 1000 births in Brent in comparison to the national average of 5.0 per 1000 births). An Infant Mortality National Support team visit to Brent in March 2009 made a number of strategic recommendations
- These factors contribute to the high ratio of complex or high risk pregnancies locally. This factor combined with a high vacancy factor at our local maternity provider (40% vacancy rate for community midwives) necessitates a continued focus on safety and quality of local maternity care

Maternity Services – Progress to date

The focus of progress to date has been a continued attention to improving the safety and quality of care following the Independent Review of Maternity Care provided by North West London Hospitals NHS Trust in 2008. Progress has also been achieved in relation to sector wide developments and implementation of Maternity Matters standards.

- **Safety and Quality**
  - Achievement of recommendations aimed at reducing risk for the large proportion of vulnerable and high risk women attending Northwick Park Hospital
  - Relocation of the stand-alone midwifery-led unit to be co-located with obstetric care at Northwick Park Hospital
- **North West Sector Maternity Project**
  - Implementation of the North West sector approved GP Antenatal Referral Form
  - Progressing and monitoring the implementation of the NWL sector Maternity Service Quality Specification 2009/10
- **Maternity Matters Standards**
  - Joint planning with stakeholders to improve on early access to antenatal care
  - Limited implementation of an integrated midwifery model of care which will offer access to antenatal and postnatal care within community settings i.e. children's centres
  - Audit of one to one care in established labour and development of patient survey to audit experiences and perception of care given
  - Research into characteristics of 'late bookers' in Brent to address barriers to early access
  - Revitalising of Maternity Services Liaison Committee to ensure more service user and Primary Care clinician engagement in service development and commissioning

Maternity Services – Plans for next stage

- **Safety and Quality of Care**
  - Ensure that one to one care in established labour is achieved and maintained
  - Ensure that 96 hours per week of consultant obstetric cover is achieved and maintained
  - Continued monitoring of workforce issues arising from high vacancy rates
  - Implementation of Infant Mortality National Support team recommendations
- **New model of Care which is aligned to integrated polysystem-based services in partnership with local authority children's services in Children's Centres deliver:**
  - Increased range of access points to maternity services for antenatal and postnatal care within community settings reducing dependence on hospital settings
  - Increased choice of units and types of birth focusing on accessible information to support using birth unit or home birth
  - Pathway re-design to ensure continuity of care for all service users
  - Full implementation of the North West London Primary Care Trusts' *Maternity Service Quality Specification 2009/10*
- **Improving the service user experience**
  - Greater engagement of Maternity Service Liaison Committee into pathway development and service re-design
  - Greater stakeholder engagement (clinicians service users) in service design and commissioning decisions

Children and Young People – Case for change in Brent

- Brent is an outer London borough with a growing and dynamic population with just over a quarter of residents being under 19
- The ethnic diversity of Brent's children and young people's population is greater than in the adult population. Over three quarters of Brent's school children are from black or minority ethnic heritage with over 130 languages spoken
- Brent's score on the Index of Multiple Deprivation (IMD) has risen since 2004 and we are now one of the 15% most deprived areas in the country
- Socio-economic deprivation is a known risk factor for poor outcomes in children
- Brent has a high proportion of children and young people living in single adult households which contributes further to the inequalities that exist
- There are significant workforce issues in Brent and this combined with the inequalities and increased demand has created severe capacity constraints in universal children's health services (health visiting and school nursing)
- Current patterns of care show an over-reliance on acute hospital settings for care that would more-appropriately be accessed in the community

Children and Young People – Progress to date

There has been good progress in strengthening local Children's Trust arrangements in Brent. This has enabled:

- A shared vision for the future of children's services in Brent contained in the local Children and Young People's Plan (2009-11)
- A robust strategic governance model which takes into consideration the provider and commissioner roles and contexts across the Children's Trust
- A focus on improving the safety and quality of safeguarding services for children and young people in partnership with the local authority
- Agreement of a new model of integrated and locality based service delivery in partnership with local authority children's services and in alignment with the polysystem network of care
- Establishment of Locality Partnership Boards for each polysystem involving clinicians, social and education professionals, other agencies and users / carers

Children and Young People – Plans for next stage

Brent Children's Trust has a shared vision for more integrated and locality-based service delivery. The next steps for achieving the vision are:

- Reviewing care pathways for universal, targeted and specialist services to ensure alignment with the polysystem network of care
- Improving capacity and access to universal services through community settings (closer integration of health visiting and school nursing to children's centres and schools)
- Improving access to targeted and specialist services providing care closer to home for children and young people with chronic and long term conditions
- Improving access to both planned and urgent care within the polysystem reducing the need for
  - Outpatient appointments at acute hospitals
  - A&E attendances
  - Unnecessary in-patient episodes (including pre-consultation work to determine bed base required across the two North West London Hospitals

Acute Care – Case for change in Brent

Access to Urgent Care services is inconsistent

- A & E attendances by Brent residents are high and rising at a rate of 8% per year
- 60% A & E attendances are for conditions that could/should be managed in Primary Care
- Emergency admissions are continuing to rise
- Patient satisfaction with access to GP services is poor and deteriorating

Stroke pathway

- Brent has a higher incidence of stroke than the London average
- Community rehabilitation services are often unable to respond to demand in a timely fashion
- An audit of stroke cases from July 07-June 08 showed that out of 343 cases of stroke, 24% receive no ongoing therapy on discharge into the community

Delayed Discharge from Acute environment

- Brent suffers from a high proportion of delayed discharges.
- A summary of 08/ 09 Delayed Bed Days recorded 1633 delayed days due to social care
- 60% of long term care decisions are being made by the LA from acute settings

Acute Care – Progress to date

- **A GP-led health centre opened in July 2009**, offering extended opening hours and a walk-in service, improving access to primary care
- **A detailed service specification for Urgent Care at Central Middlesex Hospital has been developed**, and a robust stakeholder engagement exercise conducted following DH guidelines for user engagement in urgent care services. The service is now ready to commence procurement with the new service being in place by Spring 2010
- **An integrated model for intermediate care (STARRs/Virtual Ward) has been created** in partnership with the local authority, involving significant investment in new and changed services to allow care currently delivered in the acute environment to be provided in a community setting. The model includes a Rapid Response service, for which a pilot is in progress, and an Acute Home Care service implemented in July 09. The model includes significant new investment in reablement services
- **The stakeholder consultation exercise regarding stroke and major trauma services received strong local support** with Brent achieving the 2nd highest response rate to the Healthcare for London consultation
- **Stroke early supported discharge and rehabilitation services have been developed** to support the Stroke Pathway. The stroke rehabilitation package was developed by NHS Brent in conjunction with the provider (Clinicenta). The specification is now being adopted by PCTs across North London. These services are in a position to go live, pending provider readiness

Acute Care – Plans for next stage

Improving Urgent access to Primary Care

- Implementation of the balanced scorecard/access improvements access all GP practices
- Implementation of strategy for urgent care including use of GP Led Health Centres; Urgent Care Centre and Out-of-Hours service
- Opening of UCC at CMH

Reducing unnecessary acute hospital admissions

- Implementation of Intermediate Care Strategy/Virtual Ward
- Improvements across all steps of the Brent NHS and Social Care LTC Model
- Integration of health and social care assessment/brokerage systems

Implementing the Health for London stroke pathway

- Implementation of Early Supported Discharge for stroke reducing LOS on Stroke Units
- Implementation of full Health for London Stroke Pathway

Planned Care – Case for Change in Brent

High-throughput procedures

- Community infrastructure underutilised
- Above-average day case rate achieved by local provider
- CMH model of care reflects good practice

Outpatients and diagnostic services

- GP referrals to acute care are increasing
- Variable referral rates between practices
- Lack of primary care pathways for elective care
- Variable timely access to diagnostic services
- Community infrastructure underutilised

Community-based supportive care

- Long waiting times for community therapy services
- Lack of primary care pathways for community supportive care
- Community-based nursing services require review and competence-development

Planned Care – Progress to date

- Practice-based commissioning clusters have agreed Commissioning Plans outlining priority planned care pathways for development, including need for consistent pathways across Brent
- PEC and PBC co-sponsors identified to provide clinical leadership to the programme
- Acute specialists identified to provide clinical expertise to the programme
- Healthcare for London Affordability Model applied to all outpatient and elective inpatient activity
- Agreed to use Map of Medicine as initial starting point for pathway development
- Priority pathways (in line with PBC Commissioning Plans) identified
  - Orthopaedics
  - Gynaecology
  - ENT
  - Urology
  - Dermatology
  - General Surgery
  - Gastroenterology

Planned Care – Plan for the next stage

Clinical Workshops at speciality level will determine :

- Optimum care pathways for priority areas
- Detailed specification requirements to support change within each setting of care
- Optimum activity changes within each setting of care

Polysystem Development

- Outputs from the clinical workshops will be modelled across the polysystem
- PBC clinicians will apply modelling to inform cluster configurations
- PBC / PEC clinicians will review other pathways based upon HfL assumptions
- Outputs will be included in polysystem implementation plan

Market Management Strategy

- Changing pathways will be included in the revised Market Management Strategy and Commissioning / Procurement Plan

Mental Health – Case for change in Brent

NHS Brent has a higher than national average proportion of mental health problems.

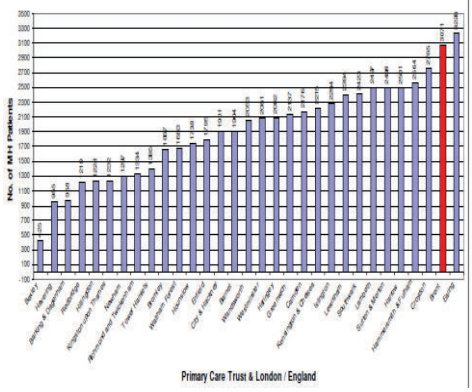
A patient experience survey was carried out across NHS Brent in 2007/8 for mental health. It highlighted "poor patient experience (lower than 80%) in: access and waiting, information and choice, safe, high quality and coordinated care".

The distribution of need varies greatly within the borough, the general needs being higher in the south of the borough with Carlton, Stonebridge, and Harlesden having the highest levels of mental illness, also indicated by the highest level of antidepressant prescribing.

44% of all acute admissions are Black African men compared to Harrow 14%, Westminster 25%, K&C 16% and the national average 9%.

Access to talking therapies is patchy. Currently the majority of spending for psychological therapies occurs within secondary care while the majority of need remains in primary care.

Figure MH3. Number of Patients with Mental Illness in London PCTs and England (2005/2006)



Source: QMAS Data - The Quality and Outcomes Framework (QOF) for April 2006 - March 2007)

Mental Health – Progress to date

- During 2009 NHS Brent made significant progress with their major provider CNWL and agreed a performance management framework including strong clinical leadership in the contract management process
- Planned programme of clinically-led review and development of care pathways across Brent including primary and secondary care clinicians and led by PEC chair
- Improved productivity and increased activity for Crisis Resolution agreed and implemented
- Enhanced Early Intervention Service in Psychosis commissioned
- Investment in a memory clinic to support implementation of the dementia strategy
- NHS Brent has submitted its bid to NHS London and are currently developing an IAPT model that will meet the needs of the local population
- Ongoing collaborative commissioning work with other PCTs to review the current contract arrangements, specifically looking at models of service which deliver efficiencies and improved outcomes in preparation for the implementation of the new NHS contract for Mental Health and Learning Disability services

Mental Health – Plans for next stage

Collaborative Commissioning
- Closer integration between NHS Brent and London Borough of Brent as commissioners of care
- Closer collaboration between main PCTs commissioning care from CNWL
- Robust contract negotiation

Review of mental health care pathways
- Strategic review of mental health care pathways (in collaboration with LBB) to ensure model of care is consistent with forward-looking, care out of hospital approach within established polysystem networks of care

Service Developments
- Ongoing development and implementation of IAPT
- Ongoing development of services in line with Dementia Strategy

Staying Healthy – Case for change in Brent

Circulatory disease and cancers
- Cardiovascular disease is the biggest killer in Brent accounting for 448 deaths in 2008 and disproportionately affects the most deprived areas

Smoking, diet and exercise
- One in six deaths (18%, 310 deaths) in Brent were caused by smoking
- Almost one fifth of Brent's Adult population are estimated to be obese
- Approximately 2/3rds of Brent's population are estimated as not eating the recommended amount of fruit and vegetables per week
- Over half of our population is not taking part in any form of physical exercise

High prevalence of diabetes TB and HIV
- More than 16,924 patients (4.8%) with diabetes are registered with a GP. This is amongst the highest prevalence in the country and the number is set to increase
- The TB notification rate (266.6 per 100,000) during 2005/2007 period was one of the highest in the country
- There are 726 people living with HIV/AIDS in Brent

Uptake of preventive services
- Low uptake of some preventative services, such as smoking cessation, breast and cervical screening, and immunisation and vaccination

Staying Healthy – Progress to date

- Established Tobacco Alliance with key local partners to provide a coordinated approach to tackling all tobacco-related issues
- Launched new incentive-based smoking cessation programme to reduce the number of smokers in Brent with significant increase in registrations through the first quarter of the year
- Developed operational policies and clinical pathways in conjunction with stakeholders for a borough-wide roll-out of NHS Healthchecks
- Child Obesity strategy completed
- Immunisation data quality issues have been identified and cleansing is in progress
- Chlamydia screening available from over 60 sites, including 80% of General Practices
- Cancer screening workshops to investigate low uptake

Staying Healthy – Plans for next stage

- Plans in place to commission stop smoking services from community groups, dentists and opticians in addition to the current providers
- Smoking cessation programme subject to intensive performance management over next two years to ensure targets are achieved
- Plans to offer an NHS Healthcheck to all 40 to 74 year-olds in Brent over the next 4 years
- Obesity, substance misuse and alcohol strategies under development
- An updated immunisations data mechanism is being established in order to manage performance on immunisation uptake
- An Organisation Development Strategy is being developed
- Community outreach strategy in development to support the achievement of the Chlamydia screening target
- Working in Partnership with the local authority to develop and implement London 2012 initiatives
- Cancer screening social marketing campaign

Long Term Conditions – Case for change in Brent

Circulatory disease and cancers

Cardiovascular disease is the biggest killer in Brent accounting for 448 deaths in 2008 and disproportionately affects the most deprived areas.

On our disease registers we have over 37,000 patients with hypertension, nearly 17,000 patients with diabetes and 18,000 patients with a respiratory condition. According to QMAS, Brent prevalence for diabetes is 5% but is probably nearer 8%. The prevalence is expected to increase further by 2012. We perform quite poorly on people having well controlled diabetes. We want to increase the % of people with a HbA1c of <=7 from 63% to 74% by 2012/03.

Pathway development in Brent

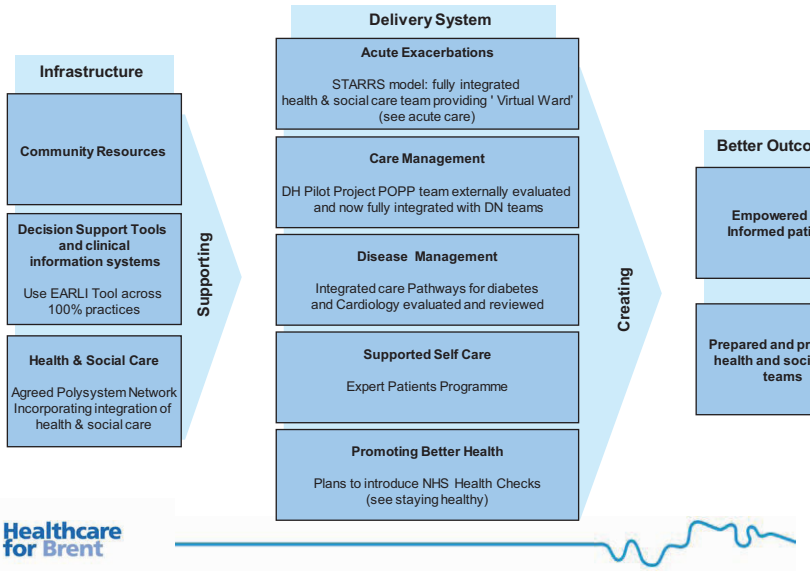
We have well established pathways for diabetes and cardiology with close working between specialist community services and acute care. Some practices provide good chronic disease management. More could be achieved in integrating services around the patient, providing a standard offering to all patients including greater support for self management, better outcomes for patients and improved value for money and the development of a personalised care plan for each patient with a long term condition.

Healthy lifestyles

We have nearly 24,000 adults who are recorded as obese in Brent and have the lowest uptake of recreational facilities in London. We need to identify early those at risk of vascular disease and offer them lifestyle interventions such as weight loss and exercise so they can delay the onset of diabetes and lower their risk of early death or disability. More deprived areas have lower uptake of healthy lifestyles and preventive services.

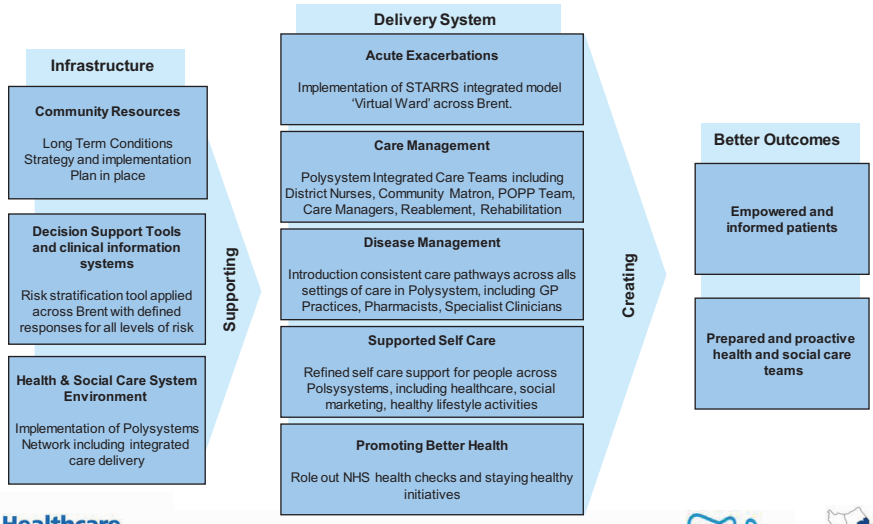
Long Term Conditions – Progress to date

Using an adaptation of the NHS and Social Care Conditions Model it is possible to map progress to date



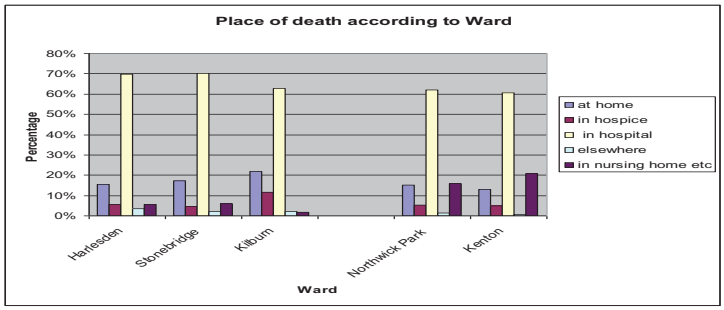
Long Term Conditions – Plan for the next stage

Using an adaptation of the NHS and Social Care Conditions Model it is possible to map future flow



End of Life – Case for change in Brent

- The majority of deaths in Brent are from Cancer and Ischemic Heart Disease
- Currently Brent has 65% of deaths occurring in a hospital setting and 16.1% at home and the majority of the rest are in nursing homes (the current average benchmarked performance for England being 10% at home)
- People living in the deprived wards of Brent are more likely to die in hospital



- Feedback from multi-disciplined stakeholder workshops cited insufficient information and confidence in current community infrastructure as the main barriers to patients and carers exercising real choice in terms of place of treatment and death

End of Life – Progress to date

Stakeholder Review

- Multi-disciplinary stakeholder workshops undertaken to review current service provision and scope local strategy development with the following feedback
  - Hospice at Home too limited
  - People don't know of services or how to access them
  - Pro-active visits by Night District Nurses not available
  - Quality of social services carers & continuity care – different person every day
  - Nursing home staff need training in EOL care
  - Differing response by the two out of hours GP Services within Brent

Service Review

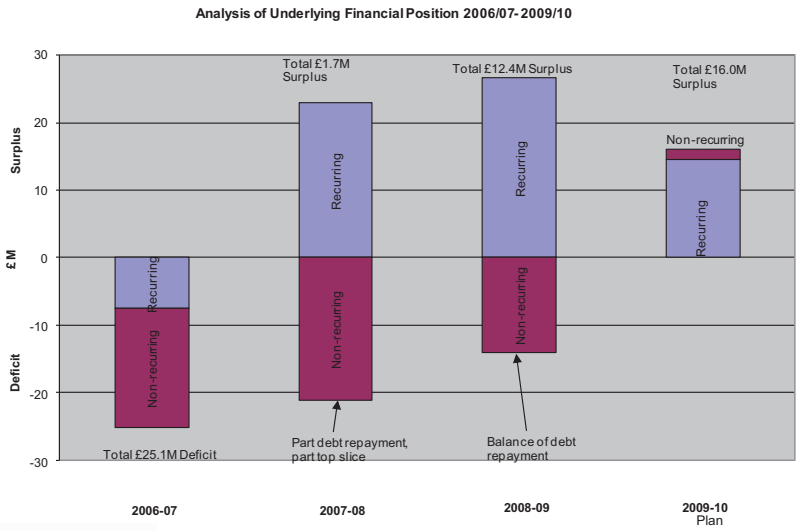
- Initial review of current contract portfolio for EOL suggests most commissioning expenditure in hospices – in-patients
- Difficult to quantify expenditure in acute or in primary and community care

End Of Life – Plans for next stage

End of Life Strategy

- Improved understanding of current services commissioned
- Improved understanding of all stakeholders' experiences
- Development of agreed End of Life Strategy
- Agreement of Business Case and phased implementation plan

Progress to date on activity and affordability modelling



Planning for 2010/11 onwards - Financial Context

The financial outlook for the PCT for 2010/11 onwards will be significantly tighter than projected in the CSP due to a combination of :-

- Tighter economic climate
- Changes in national resource allocation (NHS Brent is currently spending £37m above its weighted capitation target)
- Impact of revised Planning Assumptions 2010/11-2013/14 published by SHA
- Pressures in 09/10 on acute contracts

The medium term financial strategy has been reviewed to incorporate and address the issues above.

Key Financial Assumptions - Overview

Projections have been modelled under a number of key financial assumptions:-

The focus of the financial projections in the following slides is on the PCT's recurrent financial position

2009/10 full year financial outturn forecast has been modelled under the following 3 scenarios based on month 5:-

Planning Assumption Scenarios	Recurrent FY E Under/(Over)
	Rec
	£m
Base case	6.4
Upside	12.8
Downside	-0.2

Base case £6.4m reconciles to the forecast 2009/10 outturn at month 5 as follows:-

Reconciliation to full year effect baseline	£M
Forecast outturn at Month 5- 2009/10	13.5
deduct: Non Recurrent forecast outturn	-3.9
deduct: Full year effect in 2010/11	-3.2
Recurrent full year 2009/10 basecase	**6.4**

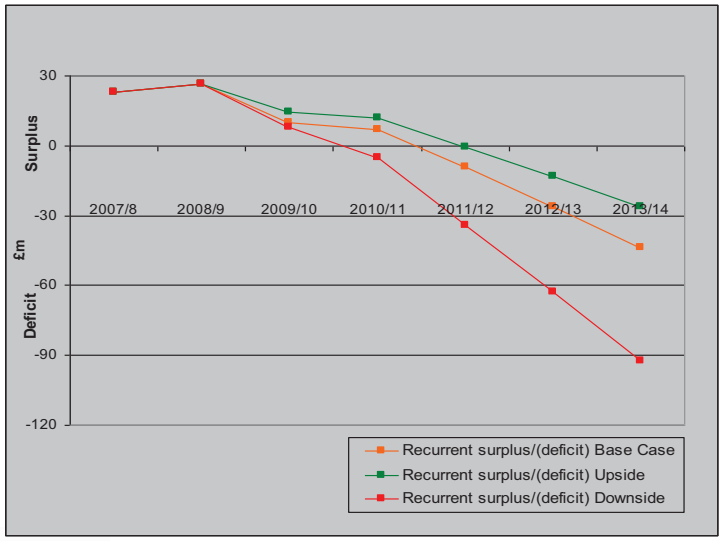
Assumptions for 2010/11-2013/14 reflect NHS London HfL affordability assumptions

All financial scenarios initially have been developed on a PCT 'do nothing' basis i.e. no further investment and, initially no savings after 2009/10

Financial Scenarios

- The financial impact of each scenario covering the period 2010/11-2013/14 is set out in the graph on the next slide
- The analysis reflects the PCT's recurrent financial position under each scenario
- This excludes both the potential mitigation of the PCT's financial position by the use of non-recurrent surpluses carried forward and also the additional pressure of any deficits on the total financial position as a consequence of the need to repay deficits
- All 3 scenarios have been built on a 'do nothing' basis from 2010/11 i.e. no further investment and no savings programme

Financial Scenarios – Recurrent Surplus / (Deficit) (Do Nothing)



Level of Savings / Disinvestment required to achieve sustainable financial position under all scenarios

- The Base case scenario demonstrates a requirement to save recurrently £60m (approx) over the three year period 2011/12 – 2013/14 in order to maintain a sustainable financial position and to allow investment in key priorities (equivalent to an average of £20m p.a.)

- The Upside scenario demonstrates a requirement to save recurrently £45m (approx) over the three year period 2011/12 – 2013/14 in order to maintain a sustainable financial position (equivalent to an average of £15m p.a.)

- The Downside case scenario demonstrates a requirement to save recurrently £105m (approx) over the three year period 2011/12 – 2013/14 in order to maintain a sustainable financial position (equivalent to an average of £35m p.a.)

HFL - Three broad actions for commissioners to take

		Description
1	Shift to lower cost setting	• Reduce unit price for those services that can be safely and more cost effectively provided through a different pathway out of the hospital and closer to home
2	LTC and case management	• Provide care proactively for people outside of hospital to prevent use of hospital services
	Prevention	• Reduce demand for healthcare services by addressing health behaviours to reduce risk of ill-health and by improving screening to detect ill health at an earlier stage
	De-commissioning	• Stop commissioning and providing low value added interventions (e.g., grommets, some joint replacements, some OP follow-ups)
3	Reduced unit costs in the non acute sector	• Reduce unit price of non-acute services to be delivered within a polysystem setting (which will also deliver activity shifted from acute, as well as activity from LTC and prevention) • Eliminate unnecessary and costly service overlaps (e.g., out-of-hours, extended hours, urgent care, A&E)

Source : PCT CEs 18/6/09

HFL initiatives - NHS Brent specific modelling – summary of potential savings

Themes 1, 2a and 2c are based on the application of the HfL methodology to Brent specific 2008/09 actual activity at specialty level

Themes 2b and 3 based on Brent (3.8%) of total London costs

Theme	Savings Initiatives	Core Scenario			Aggressive Scenario		
		Gross Red'n £m	Increased Non-acute £m	Net Reduction £m	Gross Red'n £m	Increased Non-acute £m	Net Reduction £m
1and 2a	**Shift to Lower Cost Settings/ LTC management:-**						
	Out patients	21.8	16.7	5.1	30.6	22.2	8.4
	Admitted patients - elective and day cases	5.4	0.4	5.0	5.4	0.4	5.0
	Admitted patients - non-elective	4.5	0.2	4.3	11.2	0.5	10.7
	A&E	3.8	3.4	0.4	4.6	3.3	1.3
	Community	4.5	2.5	2.0	14.7	5.8	8.9
	Sub total Themes 1 and 2a	40.0	23.2	16.8	66.5	32.2	34.3
2b	**Prevention**	0.0	0.0	0.0	2.7	0.4	2.3
2c	**Decommissioning:-**						
	Out patients (note)	8.6	0.0	8.6	3.4	0.0	3.4
	Admitted patients - elective and day cases	2.0	0.0	2.0	2.3	0.0	2.3
	Sub total Themes 2c	10.6	0.0	10.6	5.7	0.0	5.7
3	**Reduced Unit Costs in Non Acute Sector**	30.1	0.0	30.1	76.3	0.0	76.3
	Grand Total	**80.7**	**23.2**	**57.5**	**151.2**	**32.6**	**118.6**
	Savings target			**60.0**			**105.0**

Note:
The Aggressive savings in relation to 2c (Decommissioning outpatients) are less than the Core savings because of 100% shifts to lower cost setting (1 & 2a) in a number of specialties leaving no residual balance for Decommissioning

HFL Lower cost setting and LTC (1 & 2a) – Analysis of activity and cost

PODs	Brent CSP 2008-09		HFL Core		HFL Aggressive	
	Activity No's	£ 000s	Activity No's	£ 000s	Activity No's	£ 000s
Savings from Shift to Lower Cost Settings:-						
Elective Medicine			(1,900)	(2,876)	(1,900)	(2,876)
Non Elective Medicine (Primary and Intermediate Care)	(2,865)	(4,351)	(1,894)	(4,521)	(4,388)	(11,202)
Elective Surgery	(600)	(360)	(1,411)	(2,547)	(1,411)	(2,547)
Non Elective Surgery			-	-	-	-
Total Inpatient	(3,465)	(4,711)	(5,205)	(9,944)	(7,699)	(16,625)
Outpatient	(57,323)	(7,910)	(172,787)	(21,781)	(241,739)	(30,554)
A&E	(43,008)	(2,408)	(62,908)	(3,837)	(75,489)	(4,605)
Community Services			(33,800)	(4,462)	(111,540)	(14,723)
Total Shift to Lower Cost Settings	**(103,796)**	**(15,029)**	**(274,700)**	**(40,024)**	**(436,467)**	**(66,507)**
Cost of Reprovision in Lower Cost Settings:-						
Elective Medicine			1,900	217	1,900	217
Non Elective Medicine (Including Intermediate Care)	2,526	388	1,894	216	4,388	500
Elective Surgery	600	252	1,411	161	1,411	161
Non Elective Surgery			-	-	-	-
Sub Total Inpatient	3,126	640	5,205	594	7,699	878
Outpatient	57,392	5,670	172,787	16,760	241,739	22,240
A&E	43,278	2,408	62,908	3,397	75,489	3,322
Community Services			33,800	2,467	111,540	5,800
Total Cost of Reprovision	**103,796**	**8,718**	**274,700**	**23,218**	**436,467**	**32,240**
Net Savings		**(6,311)**		**(16,806)**		**(34,267)**

Notes:
HFL Core and Aggressive excludes Decommissioning and Productivity
Community services transfer is assumed at 50% into Home environment and 50% into Polyclinic setting

HFL Decommissioning (2c) – Analysis of activity and cost

POINT OF DELIVERY	HFL CORE		HFL AGGRESSIVE	
	Activity	Cost £ 000s	Activity	Cost £ 000s
Outpatients				
Medical Specialties	39,038	5,514	27,184	3,048
Surgical Specialties	28,560	3,091	2,850	332
Total Outpatients	67,598	8,605	30,034	3,380
Elective & Daycase				
Medical Specialties	61	89	-	-
Surgical Specialties	1,058	1,910	1,270	2,292
Total Elective & Daycase	1,119	1,999	1,270	2,292
Grand Total	**68,717**	**10,604**	**31,304**	**5,672**

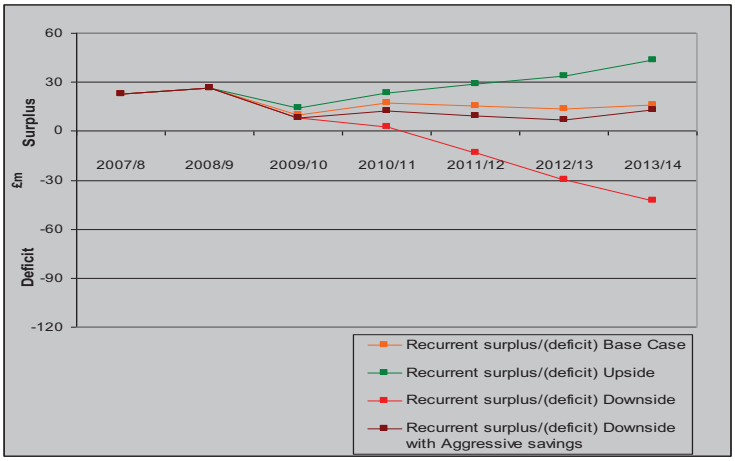
HFL % Activity Transfers (1, 2a & 2c)

	Core			Aggressive		
POINT OF DELIVERY	Transfer to polysystem	Decommissioning	Residual activity in acute	Transfer to polysystem	Decommissioning	Residual activity in acute
	%	%	%	%	%	%
Outpatients						
Medical	38	20	42	53	14	33
Surgical	69	20	11	97	2	1
Total Outpatients	51	20	29	72	10	18
A&E	50	0	50	60	0	40
Elective and Daycase						
Medical	16	0	84	16	0	84
Surgical	8	6	86	8	7	85
Total Elective and Daycase	11	4	85	11	4	85
Non Elective						
Medical	7	0	93	16	0	84
Surgical	0	0	100	0	0	100
Total Non Elective	6	0	94	14	0	86

HFL Reduced Costs in Non-Acute Sector (3)

Reduced Costs in Non-Acute Sector	Core		Aggressive	
Categories	Pan London (£ M)	Brent (£ M)	Pan London (£ M)	Brent (£ M)
Staff Productivity				
GP/ Nurse Practitioner	269	10	593	23
Primary Care skill mix	64	2	65	2
District Nursing	110	4	150	6
Community skill mix	75	3	225	9
Polysystem staff consolidation	47	2	140	5
Reduced appointment times	138	5	570	22
Space Utilisation				
Polysystem consolidation	18	1	55	2
Drug Expenditure				
Reduction in branded prices	30	1	90	3
Reduction in prescribing variability	40	2	120	5
Total	**791**	**30**	**2,008**	**76**

Impact of HFL core savings on underlying recurrent position



- The base case and upside scenarios provide surplus for sustainable investment
- The downside scenario requires additional savings to ensure a sustainable position. This is shown in the downside with aggressive savings line

Current status of plans

Volume of activity change for which there are **definite plans**	5% (Interm. care)
Volume of activity change for which there are **plans in principle**	0%
Volume of activity change for which there are **no definite plans yet**	95% (All other)

Issues and risks to delivery

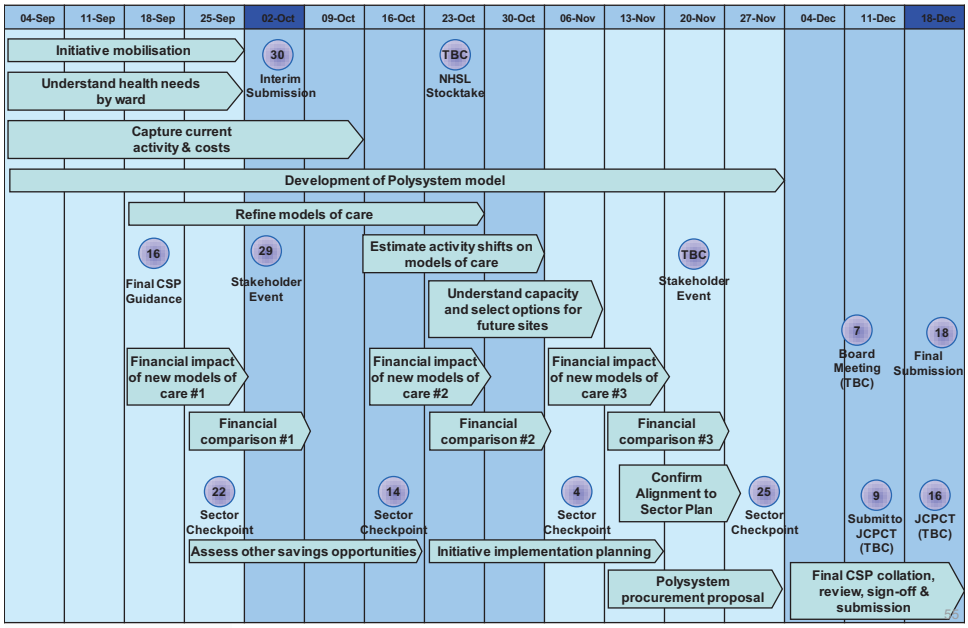
- Basis for projections of transfers of activity out of acute settings (themes 1, 2a and 2c)
- Ownership by PBC of transfers from acute settings
- Compatibility of acute activity shifts with acute sector services reconfiguration
- Implications for enablers (estates, workforce, IT) not yet assessed
- Delivery of polysystem alternative to acute provision in appropriate timescale and at affordable cost
- Deliverability of primary care savings within existing GP contractual arrangements
- Basis for other savings target in non acute sector, particularly under aggressive scenario
- Capability of PCT to deliver the savings targets within the required timeframe
- Resulting instability in established providers

Other potential savings areas under review

In order to mitigate the risks to delivery set out in the previous slide, a number of additional potential savings initiatives are currently being reviewed as summarised below.

- Acute Claims validation – targets for ACV and CSL
- Primary Care
  - QOF payments validation
  - List size validation
  - Dental contract prices
- HQ
- Continuing care procurement
- Mental Health
  - CNWL productivity
  - Whole system review

Next steps – Overall timeline



	Health Select Committee 20th October 2009 **Report from the Director of Policy & Regeneration**
For Action	Wards Affected: ALL
GP Access Survey 2008/09	

1.0 Summary

1.1 The GP access survey for 2008/09 was conducted between January and March 2009. The survey records patients' views against four indicators:

- Telephone access
- 48 hour GP access
- Advanced appointment (2+ days ahead)
- Specific GP

1.2 The Health Select Committee has considered the results of previous GP access surveys, as well as action plans that have been put in place to improve patients' satisfaction with GP services in the borough. The headlines from the 2008/09 survey are:

- The response rate to the survey has fallen to 25% of people contacted to take the survey. Last year the response rate was 28%. The average in London in 2008/09 was 30% and the national average was 38%
- Satisfaction with telephone access was 65%, compared to 82% last year. The London average this year was 67%, the national average 70%
- Satisfaction with 48 hour GP access was 78%, compared to 83% last year. The London average this year was 80%, the national average 84%
- Satisfaction with advanced appointment was 69%, compared to 73% last year. The London average this year was 74% , the national average 76%

- Satisfaction with ability to see a specific GP was 68% compared to 71% last year. The London average this year was 71%, the national average 77%.

1.3 Performance across all indicators is worse than last year and lower than the London and national averages. It should be added that London and national averages have fallen in 2008/09 compared to previous years, suggesting that this isn't a situation unique to Brent.

1.4 GP access is an issue that has been of concern to the Health Select Committee in the past and so members are likely to be interested in these results and how NHS Brent and GPs are responding to improve patient satisfaction. Although the response rate was disappointing, members should be concerned that performance is getting worse despite NHS Brent having an action plan in place to improve performance in this area.

1.5 NHS Brent does intend to use the survey results to improve GP access. An Access Improvement Transformation Programme will be undertaken, which will support a number GP practices to manage demand and in capacity mapping, reduction in DNAs (do not attends), increased efficiency and an increase in the number of appointments available weekly. The Programme will encourage a best practice/shared learning methodology which will enable all Brent practices to gain from the Programme's aims. Particular emphasis will be placed on those practices that have consistently under-achieved in the Patient Surveys. GP contract performance management in 2008/09 will also focus on poor access.

1.6 A steering group to support the Access Improvement Transformation programme is to be established by October 2009. The Health Select Committee should ask for an update on this work.

2.0 Recommendations

2.1 The Health Select Committee should question officers from NHS Brent on the results of the GP access survey and the implementation of the Access Improvement Transformation Programme.

3.0 Financial Implications

3.1 None

4.0 Legal Implications

4.1 None

5.0 Diversity Implications

5.1 None

6.0 Staffing/Accommodation Implications (if appropriate)

6.1 None

Background Papers

Contact Officers

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GP Patient Survey 2008/09

1. Purpose

The purpose of this report is to advise Board members of the results of the GP Patient Survey 2008/09, conducted during the period January to March 2009.

The full results of this Survey were made available to NHS Brent and the public on 1st July 2009.

2. Background

The GP Patient Survey was first established in 2006/07 by the Department of Health (DH) to support PCT assessment of general practices' achievement against national standards set out in two Directed Enhanced Service Agreements (Access and Choice and Booking). These agreements linked results from the administered surveys with the rewards made to GP practices.

The Survey also provided information to PCTs and practices on whether or not patients were satisfied with their practices' existing opening hours.

The DH have given commitment to running the Survey for at least the next three years, with Surveys moving from an annual 'snapshot' of patient views to providing more frequent, quarterly feedback. 2008/09 was the last annual survey, with the first quarterly Survey issued in April 2009 (results due shortly).

The patient sample used for the Survey is drawn from the National Health Application and Infrastructure Services (NHAIS) database and is used by Ipsos MORI (independent survey specialists) on behalf of the DH, under the terms of the Data Processor Agreement (DPA) that the DH has put in place.

3. The GP Patient Survey 2008/09

In line with commitments made in the NHS Next Stage Review, the Survey was developed for 2008/09 to give patients a greater say, including whether practices are providing not just fast, convenient access but an all-round quality patient experience. The new Survey helps support delivery of NHS services that are more responsive to patients' needs and wishes, with approximately 5½ million registered patients invited to take part each year.

The new Survey covers a wider range of issues that are important to patients when visiting their GP practice. These include questions on:

- Aspects of the surgery environment and helpfulness of reception staff
- Getting through on the phone, including for consultations or test results
- Accessing GP appointments (for the first time including questions supporting assessment of QOF patient experience indicator achievement on 48 hour access and advanced booking)
- Waiting time in the surgery
- Seeing a preferred doctor
- Satisfaction with practice opening hours

- Aspects of the consultation with doctors and nurses at the practice
- Overall satisfaction with care received
- Planning of care for patients with long term conditions
- Patient experiences of accessing local out of hours care

The questionnaire continues to include a number of demographic questions to assist with analysis of patient's responses (eg age, ethnicity, employment status etc).

4. NHS Brent Results

The comparative table below offers a brief summary of the 2006/07, 2007/08 and 2008/09 results:

Averages	Response Rate	Telephone Access	48 hour GP Access	Advanced Appointment (2+ days ahead)	Specific GP	Average across all areas
2006 National Average	44%	86%	86%	75%	88%	84%
2007 National Average	41%	87%	87%	77%	88%	85%
2008 National Average	38%	70%	84%	76%	77%	77%
2006 NHS London Average	35%	83%	81%	74%	84%	81%
2007 NHS London Average	32%	84%	83%	76%	84%	82%
2008 NHS London Average	30%	67%	80%	74%	71%	73%
2006 NHS Brent Average	31%	81%	83%	71%	82%	79%
2007 NHS Brent Average	28%	82%	83%	73%	80%	80%
2008 NHS Brent Average	25%	65%	78%	69%	68%	75%

See Appendix 1 for graphical representations of the above.

a. Response Rate

There has been a significant decrease in NHS Brent's response rate for the 2008/09 Survey, with a fall in respondents of 6%, from 31% to 25%. This is in line with the national response rate decreasing from 44% to 38%. London has seen a decrease of 5%.

Overall NHS Brent has seen its average result drop to 75%; however this is again in line with both National and London averages decreasing.

b. Telephone Access

NHS Brent has seen a significant drop in its performance in the area of telephone access, from 82% in 2007 to 65% in 2008. Nationally and across London, performance has also decreased.

The lack of telephone lines available to patients in individual practices is of concern. A number of practices have adopted premium rate 0845 numbers to enable upgraded telephone systems, however these are not recommended by the PCT in line with DH guidance on the use of premium rate telephone numbers, which are to be banned.

Several practices have adopted alternative methods of contact for patients such as internet appointment booking. This has the added benefit of releasing pressure on telephone lines, thereby improving the ease of telephone access for patients who can only use this method. It should be noted, however, that the survey only asks about telephone access.

c. 48 Hour Access to a GP

Locally, performance is 5% down on 2007/08. Nationally and across London, performance is down 3% for this indicator compared to 2007/08.

The Access Improvement Transformation Programme (see Initiatives below) will enable individual practices to be supported in analysing more closely their demand and capacity, with a view to creating an even balance between both elements.

The advent of the GP led health centre which opened on 1st July 2009 in Wembley Centre for Health and Care, means that in reality 100% of patients are able to see a GP within 48 hours as they can attend as walk in patients. However, this is not operated as a referral mechanism from practices in the way that the previous Walk-in Centre did. Further work needs to be undertaken with those practices that have a large number of patients attending the health centre as walk in patients to understand why this is, in order to introduce measures to improve access in a patient's own practice.

d. Advanced Booking

NHS Brent has seen a 4% drop in performance against this indicator, from 73% in 2007 to 69% in 2008. There is a 1% drop nationally from 77% in 2007 to 76% in 2008, with a 2% drop across London, from 76% in 2007 to 74% in 2008

The PCT adopted a Local Enhanced Service (LES) for Extended Opening Hours in 2008, in advance of the release of the national Directed Enhanced Service (DES). The national target for the introduction and roll-out of extended opening hours was 50% of practices signed up by December 2008. NHS Brent achieved 71% of practices offering this service by December 2008, significantly achieving the target.

This will have a positive impact on improving access and responsiveness across Brent, for patients wishing to book an appointment in advance and at a time convenient for them. It is anticipated that achievement against this indicator will raise performance in the Survey results for 2009, by which time the majority of Brent practices will be offering extended hours.

e. Booking an Appointment with a Specific GP

NHS Brent has seen a significant drop in performance against this indicator, from 80% in 2007 to 68% in 2008. This reflects both the national and London averages, which have also decreased significantly.

The late introduction of a specification for extended opening hours may have contributed in some way to the lower than expected results of the Survey overall, as it was conducted from January 2009 and asked patients to consider their experience over the last six months, ie August 2008 to January 2009.

5. Future Initiatives

The Patient Survey is increasingly used as a measure of performance for the PCT for commissioned services from GP practices. NHS Brent therefore needs to consider how best to utilise the results from the survey to encourage individual practices to improve services where patients indicate that there are lower levels of satisfaction or access.

As a result of NHS Brent's overall performance in the surveys, an Access Improvement Transformation Programme will be undertaken, which will support a number practices in demand and capacity mapping, reduction in DNAs, increased efficiency and an increase in the number of appointments available weekly. The Programme will also encourage a best practice/shared learning methodology which will enable all Brent practices to gain from the Programme's aims. Particular emphasis will be placed on those practices that have consistently under-achieved in the Patient Surveys.

This Programme will also enable practices to be benchmarked against each other, London-wide and nationally to enable the PCT to gain a broader understanding of the impact of improved Access both from a patient and practice perspective.

It is imperative that the methodology used is embedded both in practices but also within key teams in the PCT. This will ensure continuous improvement of Access results, greater patient satisfaction and an ethos of improved Access that is central to performance management of commissioned services.

Continued awareness of the Minor Ailments Scheme will also assist in reducing cultural dependency on GP practices.

The PCT may also wish to consider other initiatives that have proved successful around the country in continuously driving up patient satisfaction with Access:

- Recognising that over 85% of the UK population has access to a mobile phone, a text messaging reminder system could be implemented to reduce DNAs and support specific Health Campaigns such as flu vaccinations, medication reviews, screening
- Audit incoming telephone lines per patient head, with additional lines being installed if required. Improve management of incoming telephone lines, for instance a dedicated appointments or test results line.
- Wider use of IT, for instance patients accessing practice services via the Internet to make/amend appointments and order repeat prescriptions

online. Patients are then able to access services at a time and place convenient to them, freeing up both telephone lines and reception staff.

- Increased use of telephone triage and consultations, for which training could be provided.
- Establishment of a formal access forum, with action learning sets for practice managers, designed to share best practice and promote learning on access issues.

6. The GP Patient Survey 2009/10

NHS Brent is required to seek year on year improvements in patient satisfaction with GP services, as measured by the GP Patient Survey. The new quarterly GP Patient Survey will provide data not only on patient satisfaction but also on their wider experience of the quality of GP services.

The following table illustrates the Survey timetable for 2009/10:

	Survey Issued	**First Reminder**	**Final Reminder**	**Quarterly Results**	**Annual Results (aggregated survey results from all quarters)**
Quarter 1	April 2009	May	June	Mid-August	May 2010 (QOF results data to PCTs) July 2010 (full results publication)
Quarter 2	July 2009	August	September	Mid-November	
Quarter 3	October 2009	November	December	Mid-February 2010	
Quarter 4	January 2010	February	March	Mid-May	

7. Conclusion

The Survey results for 2008/09 have shown a decrease in performance generally for NHS Brent. The proposed Access Improvement Transformation Programme will seek to address this, with a programme that is sustainable and maintains activity both in practices and the PCT, so that the full benefits can be realised long-term.

It will be important to ensure all improvements seen as an outcome of this Programme are replicated across the PCT.

It is anticipated that the positive impact of Extended Opening Hours and the GP led health centre will be seen in the Survey results for 2009/10.

8. Next Steps

Expressions of interest for programme manager to lead the transformation programme from existing PCT staff will be sought and Brent GP to provide clinical leadership. A steering group will be stabled by early October including PBC representation.

Contract performance management in 2009/10 will focus particularly on reputed poor access.

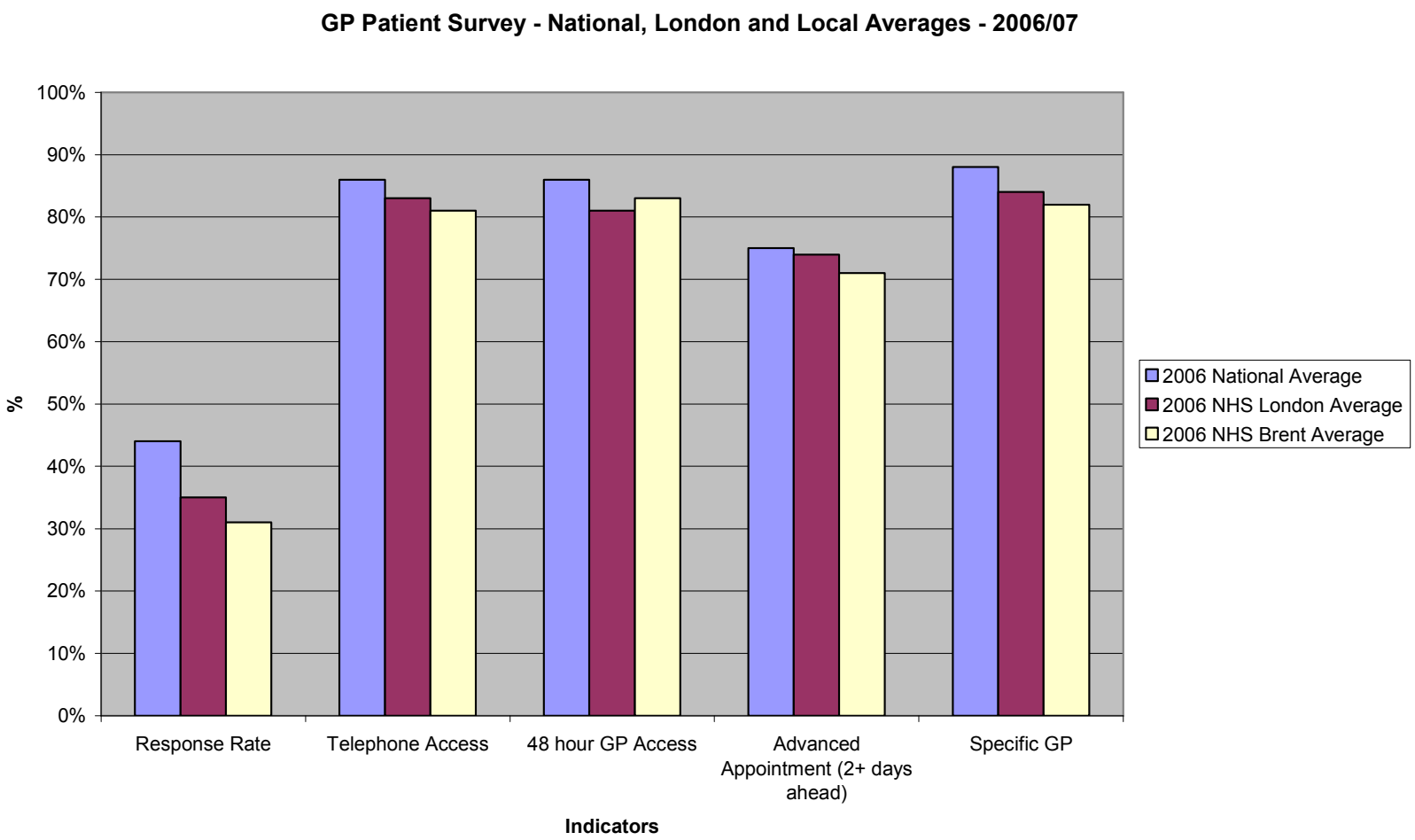
9. Recommendations

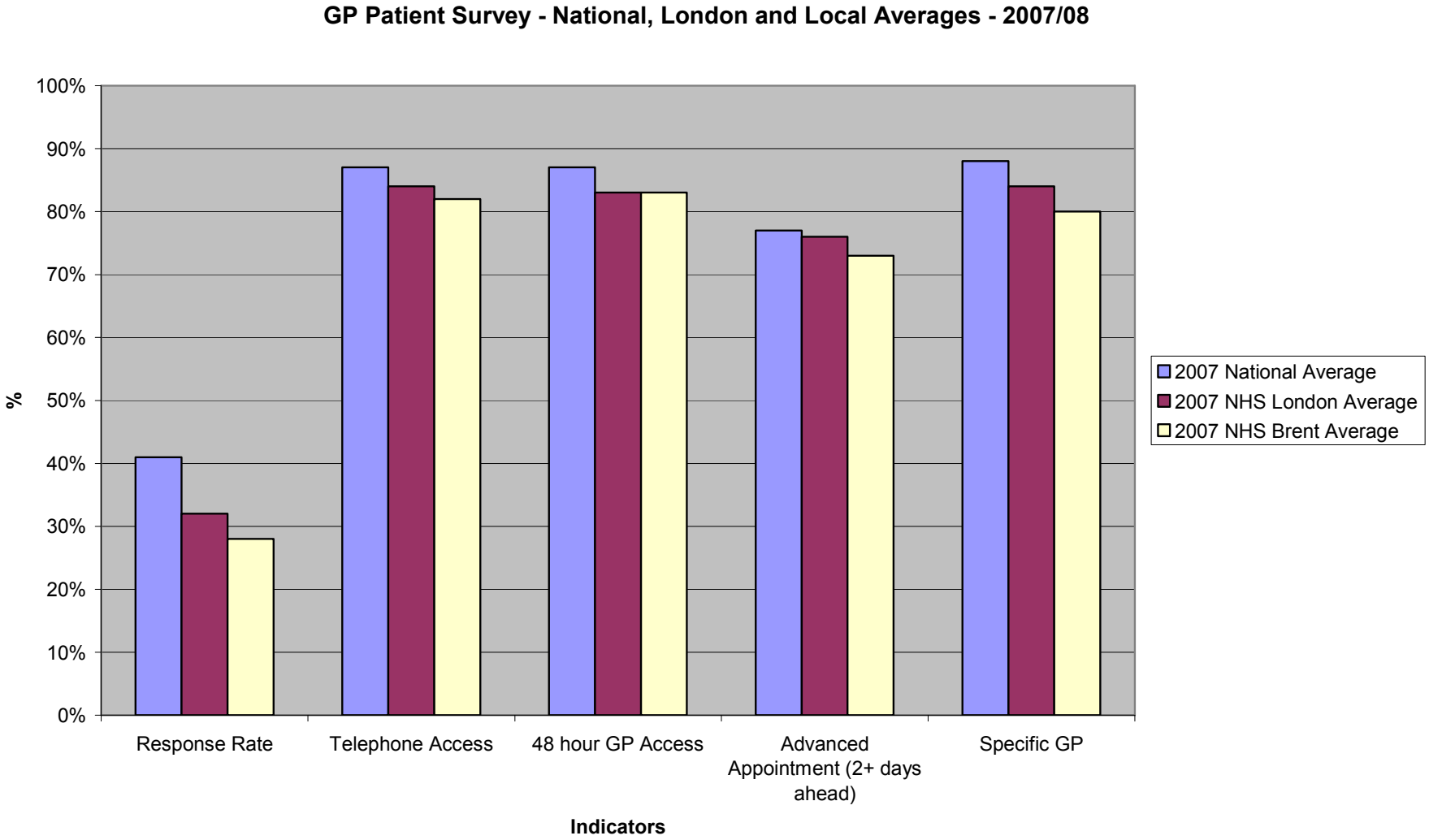
The Board is asked to note the results of the National GP Patient Survey 2008/09 and the proposed actions to be taken:

- to improve achievement scores for subsequent Patient Surveys and;
- to improve patient reported satisfaction with access to primary care.

Paula Beare
GP Commissioning Manager (Interim)
September 2009

Appendix 1


GP Patient Survey - National, London and Local Averages - 2006/07
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
%
Response Rate
Telephone Access
48 hour GP Access
Advanced Appointment (2+ days ahead)
Specific GP
Indicators
2006 National Average
2006 NHS London Average
2006 NHS Brent Average


GP Patient Survey - National, London and Local Averages - 2007/08
100%
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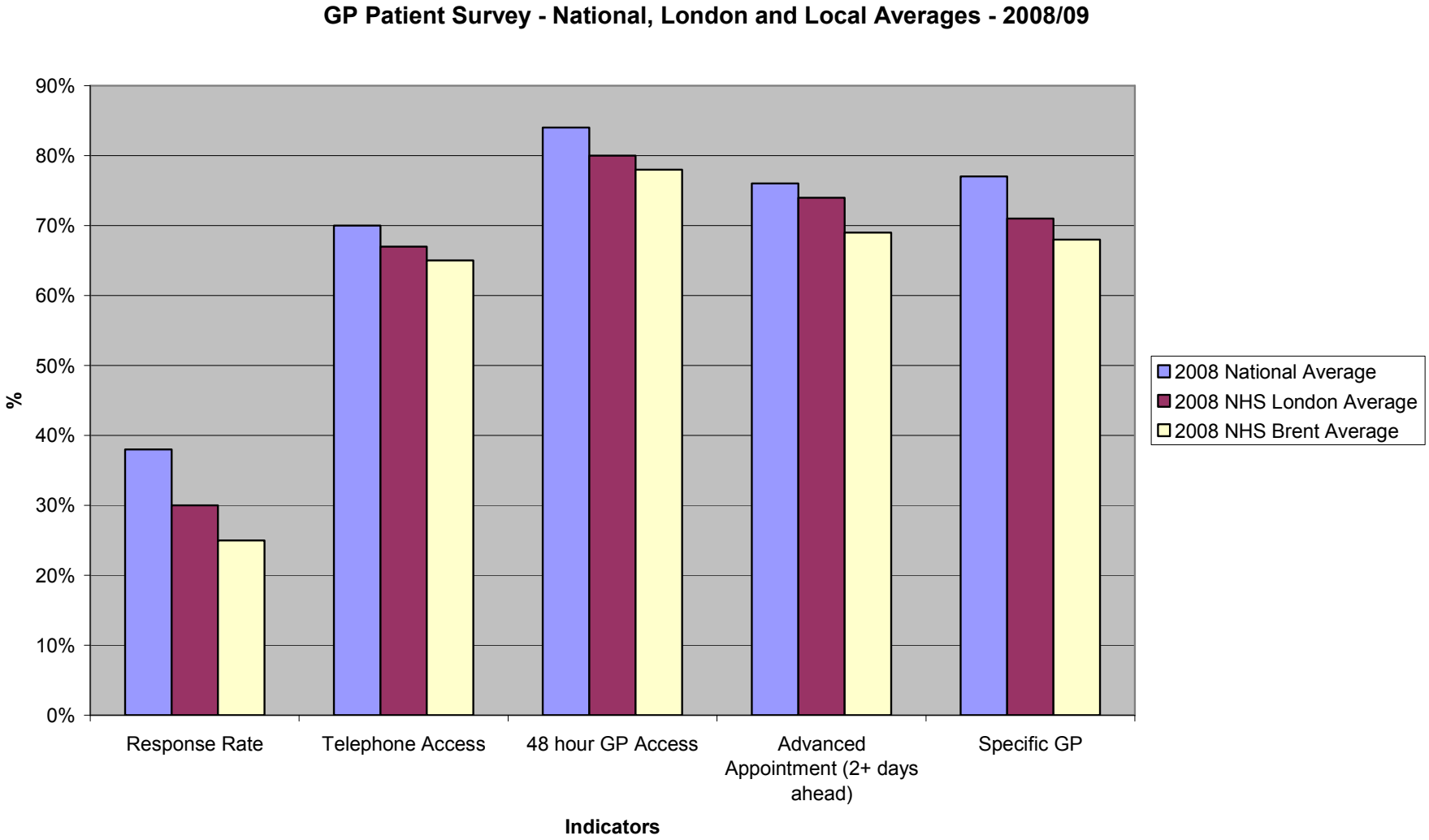
Specific GP
Indicators
2007 National Average
2007 NHS London Average
2007 NHS Brent Average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20%
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0%
%
Response Rate
Telephone Access
48 hour GP Access
Advanced Appointment (2+ days ahead)
Specific GP
Indicators
2008 National Average
2008 NHS London Average
2008 NHS Brent Average

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	Health Select Committee 20th October 2009 **Report from the Director of Policy & Regeneration**
For Action	Wards Affected: ALL
Smoking Cessation Update	

1.0 Summary

1.1 The Health Select has asked for an update on the smoking cessation service in Brent. Smoking cessation is a crucial element of NHS Brent's strategic goal to promote good health and prevent ill health. There has been significant reinvestment in the service following a reduction of funding during PCT turnaround. The Health Select Committee has agreed previously to monitor progress of the smoking cessation programme because of its importance to the health of people in Brent.

1.2 NHS Brent has provided a brief update on the performance of the service in the first half of 2009/10. To put this in context, performance in 2008/09 had been below target. There were 734 four week quitters using NHS services against a target of 1756. Performance in 2009/10 shows that:

- The level of 4 week quits in the first quarter of 2009/10 is at 55% of the planned number (222, against an annual target of 2022).
- The number of people registering with the smoking cessation service is 1304 for the first two quarters of 2009/10, against a target for the same period of 1930.

1.3 It should be noted that NHS Brent have profiled the target for 4 week quitters to show an increase in quitters towards the end of the year, to take into account initiatives that will be introduced during 2009/10. The Health Select Committee should question officers from NHS Brent on those initiatives and how they will contribute to an increase in the number of people giving up smoking.

1.4 Because of the importance of this service and the impact it has on people's health, it is suggested that an update report becomes a standing item on the Health Select Committee agenda so that members can be kept informed of progress in achieving the smoking cessation targets.

2.0 Recommendations

2.1 It is recommended that members of the Health Select Committee question officers on the progress in meeting the smoking cessation targets for 2009/10.

2.2 Members are also asked to endorse the proposal that smoking cessation updates should become a standing item on the Health Select Committee agenda.

3.0 Financial Implications

3.1 None

4.0 Legal Implications

4.1 None

5.0 Diversity Implications

5.1 None

6.0 Staffing/Accommodation Implications (if appropriate)

6.1 None

Background Papers

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Stop Smoking Service Progress – October 2009

Service Model

The Stop Smoking service is made up of around 80 general practices and pharmacy providers. In addition there are clinics that the PCT team run, with a number of health trainers. The service is mainly delivered to clients via one to one consultations over a six week period. During this time clients receive support from a qualified advisor and in most cases, medication or Nicotine Replacement Therapy in addition. Throughout the process clients are supported using best practice techniques and verified as not smoking using a Carbon Monoxide (CO) monitor. After a period of 4 weeks abstinence clients would be regarded as a 4 week quit, although the service provides support for up to 12 weeks. There are a small number of group sessions that the service runs, however clients much prefer to access one to one services.

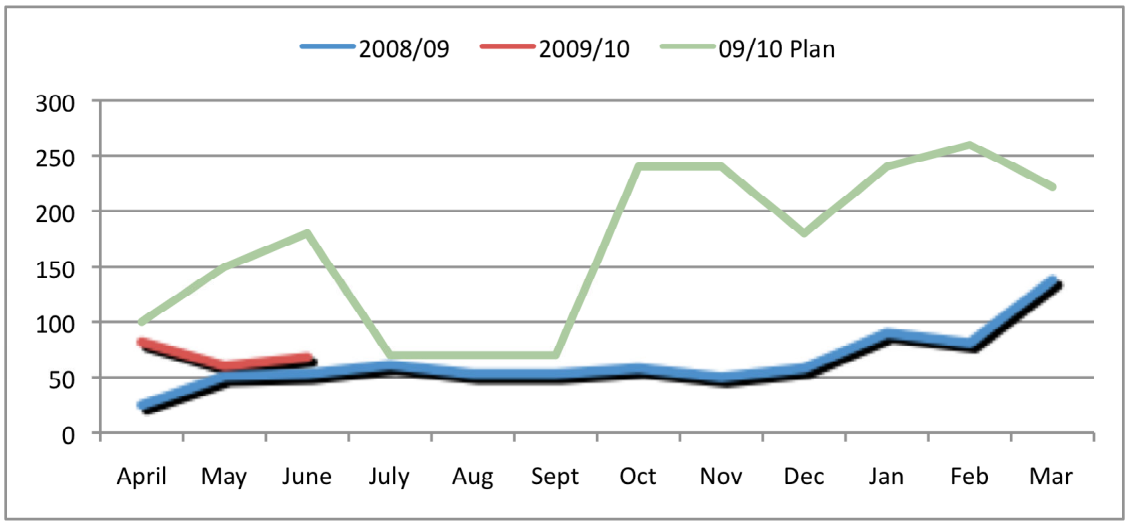
To support the 80 providers the PCT has a team of advisors who support and encourage the providers, commission providers and run initiatives. The service has recently invited interested dentists and opticians to become providers and aims to commission services from community groups over the coming months.

There are a number of routes through which smokers can access the service, either directly through marketing in provider premises, by ringing the service on 0208 795 6669, through the national smokefree helpline/website, through the trust web site or via one of an increasing number of recruitment initiatives. In all instances the full range of providers and services is offered.

Four week quit target Progress

For 2008/09 the service achieved 734, four week quits against the target of 1756 for the year. During 2008/09 the service recruited two additional advisors, an administrative assistant and a team manager. This team came fully into place in December 2008, however the manager has since left the service, being replaced by an interim manager.

The latest figures for the number of monthly quits compared to last year and the current plan are as follows:



This graph shows significant improvement since last year and in the first quarter the increase in 4 week quits is around 70%, however history suggests there may well be many unidentified quits for these months as often paperwork takes time to be completed by

providers. The 4 week quit target for 2009/10 is 2022 for the year, a 15% increase on last year and the number of quits for the first quarter of 2009/10 is roughly 50% of the planned trajectory, which takes into account seasonal fluctuations and the impact of initiatives later in the year.

The service now monitors service registration data on a weekly basis as this is a good indicator for the number of quits due to be reported at a later time. By the end of quarter 2 the number of registrations reached 85% of the planned trajectory, 1304 registrations against the planned position of 1930. This will lead to much higher numbers of 4 week quits being recorded during quarter 2 than in previous years. It is likely that the registration trend will be replicated and within quarter 2 the number of registrations were up 120% on the same quarter last year.

Current Initiatives

There are a number of initiatives that the service has embarked upon to maintain progress towards the target. These are as follows:

- Provider Toolkit and resources – development of best practice guidance and resources to help providers achieve better results.
- New Information System – This will simplify the information processes within the service, aid performance management of providers and more timely performance information.
- Harlesden Pilot – As part of our objective to target health inequalities and pilot to work closely with community groups to target smokers in Harlesden is underway. This initiative is underway and early results look promising.
- Targeted Street Campaigns – The service is in the early stages of developing a specification for targeted street campaigns. The work is based on very successful campaigns NHS Camden have recently undertaken.
- Referral Points – Again an initiative that the service is in the early stage, but the plan is to develop a range of providers who generate referrals to the service.
- Secondary care pilot – The service has recently opened clinics at Central Middlesex Hospital and is working with the Hospital Trust to generate referrals to the service. This is part of a Department of Health pilot for Stop Smoking services in hospital care settings.

Further initiatives are planned for later in the year, these include a marketing campaign and texting service.

Tobacco Alliance

After the appointment of a joint Tobacco Alliance post, work has begun to tackle the wider issues associated with smoking. The first of the reinvigorated Tobacco Alliance meetings will be held in November, at which early priorities will be identified. In readiness for this the new joining post holder has been investigating the situation locally and what works in other parts of London.

Challenges

The service faces a number of challenges, which are outlined below:

- Accessing smokers is becoming increasingly difficult and having visited a number of very successful London services it is clear than a large number of initiatives are needed to

collectively meet the target. Resourcing and managing a wide range of initiatives is therefore one of the key challenges the service needs to address.

- Delays to paperwork from providers present problems in understanding the situation. The new information system will improve this however the new system and the processes will take some time to bed in. The implementation will distract from progress to target, however will provide longer term benefits.
- The wider Tobacco control agenda requires strong support from a number of stakeholders in order to be successful. Partnership will be the focus in order to tackle the complex issues associated with issues like illicit tobacco and shisha smoking.

Steve Sewell

Interim Stop Smoking Service Manager

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	Health Select Committee 20th October 2009 **Report from the Director of Policy & Regeneration**
For Action	Wards Affected: ALL
Acute Services Review	

1.0 Summary

1.1 The Health Select Committee has received reports on the acute services review at its previous meetings and members have also attended a briefing at the Harrow Overview and Scrutiny Committee on plans for paediatric and emergency surgery services at North West London Hospitals Trust. Officers from NHS Brent and North West London Hospitals Trust will attend the committee to update members on the project and also to give a pre-consultation presentation.

1.2 Since the committee met last an independent clinical review has taken place on the provision of emergency surgery services during the day at Central Middlesex Hospital. The review has concluded that emergency surgery should not continue to be provided from CMH as it is currently. The reasons for this are that "it is not possible to maintain the high clinical standards required to ensure safe and effective emergency surgery at both the Northwick Park and CMH sites".[1] Further information on this development is included in a letter to Councillor Chris Leaman, included as an appendix to this report.

1.3 In addition, the chair of the committee had asked for the views of the Local Medical Committee on the acute services review. A letter from Dr Helen Clark, chair of the Brent LMC is also included as an appendix to this report.

[1] Letter to Councillor Chris Leaman from Mark Easton, NHS Brent Chief Executive – 11th September 2009

2.0 Recommendations

2.1 The Health Select Committee is recommended to consider the presentation that will be given on the acute services review and put forward their views on the proposals. Members should take into account the letters from Mark Easton and Dr Helen Clark appended to this report.

3.0 Financial Implications

3.1 None

4.0 Legal Implications

4.1 None

5.0 Diversity Implications

5.1 None

6.0 Staffing/Accommodation Implications (if appropriate)

6.1 None

Background Papers

Contact Officers

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11 September 2009

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Middlesex HA9 9HD

Dear Chris,

Emergency Surgical Services at Central Middlesex Hospital (CMH)

We have been keeping you and your committee up to date with the development of the Acute Services Review, since it was launched at the beginning of this year.

In our last report to you and the Harrow Overview and Scrutiny Committee, we pointed out that an independent clinical review, under the auspices of the National Clinical Advisory Team, was looking at whether we should continue to offer access to emergency surgery during the day at Central Middlesex Hospital, out of hours emergency surgery having moved some time ago.

I am writing to advise you that we have now received that report and a clear recommendation is made from the team that we should not continue to provide emergency surgery during the parts of the week it is currently offered. The reason for this is that the view of the independent reviewers is that it is not possible to maintain the high clinical standards required to ensure safe and effective emergency surgery at both the Northwick Park and CMH sites. Northwick Park Hospital (NWP) has a far greater mass of staff and emergency caseload and it is currently struggling to maintain support for an emergency surgical service at CMH.

You will be aware that for some time CMH has not been providing emergency surgery out of hours and at weekends. There is currently a 9am -5pm surgical receiving model at CMH with complex surgical cases and out of hours admissions transferred to NPH.

The London Ambulance Services already takes major trauma cases such as stab victims or road traffic accidents directly to NWP where there is a better equipped A&E department and a larger, more robust surgical infrastructure.

Implementing the recommendation would mean a further 7-10 patients a week would require transfer from CMH to NPH.

The transfer of emergency surgery does not undermine the continued existence of the Accident and Emergency Department at CMH. There are other hospitals in London with A&E departments that do not undertake emergency surgery. Nor would a transfer of emergency surgery change CMH's core role, of a local hospital offering A&E, emergency medical services, diagnostics, waiting list surgery and outpatient services.

To put the transfer into context, the 527 surgical cases transferring to NPH would be in addition to the 6,453 cases undertaken there in 2008/09 and would leave CMH with a case load of approximately 83,000 A&E attendances, 11,000 medical admissions, 17,000 elective surgical cases and 100,000 outpatients.

These changes would not be made for financial reasons. We do not expect there to be any savings arising from the transfer, rather it is to make sure that all patients have access to high quality care when they need it.

To this end, there are a number of actions we need to take to ensure high clinical standards are achieved.

1. We shall be devising a clear service standard for the revised surgical service at NWP with clear metrics so that we can be assured that the outcome of these changes is, as we intend, high quality surgical care.
2. We will need to ensure that sufficient capacity is in place at NWP to cope with the relatively small increase (8%) in emergency activity that this change will generate.
3. The North West London Hospitals NHS Trust will be developing an implementation plan to assure the local community that these changes can be successfully achieved, including a clear description of the protocols to be applied for transferring emergency surgical cases from CMH to Northwick Park.

You will be aware from previous briefings that there is one further service we are reviewing to ensure it meets current standards: the paediatric service at CMH. Local clinicians are discussing a revised model for the care of children which will comprise of two ambulatory care centres at the two hospitals and an expanded inpatient unit at Northwick Park. We are planning two public events to discuss children's services in Brent and Harrow on the 22 and 24 September. As proposals develop we will consider what, if any, engagement and consultation with the public might be needed before proposals are finalised

I am copying this letter to the Chief Executive of Brent & Harrow Councils and local MPs so that they are fully informed as to the changes we are proposing and the reasons for them.

Yours sincerely,

Mark Easton
Chief Executive

c.c. Gareth Daniel, CEO, Brent Council
Michael Lockwood, CEO, Harrow Council
Barry Gardiner, MP
Dawn Butler, MP
Sarah Teather, MP

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24/09/2009

Mr Andrew Davies
Policy & Performance Officer
Policy & Regeneration Unit
London Borough of Brent

Dear Andrew,

Brent LMC and local GP response to the North West London Hospitals Trust (NWLHT) acute services review for the Health Select Committee

Thank you for requesting the Brent LMC's views on the NWLHT acute services review.

As you know, I was quite surprised when I realised the proposal had been sent to the Brent and Harrow Overview and Scrutiny Committees (OSC) before the LMC had been consulted. NHS Brent had given a commitment in early July at our liaison meeting with them to obtain stakeholder views, develop a corporate view via a Clinical Reference Group and then consult with the LMC. This should have been completed before the proposal was presented externally as an agreed policy. As we are under the umbrella of Londonwide LMCs, which also supports Harrow LMC, I can confirm that NHS Harrow also omitted to consult formally with the Harrow LMC over the proposals before they were discussed at the OSCs.

I have discussed the consultation process with NHS Brent and the proposal will now be discussed with the LMC in October. In the interim, I have discussed the proposal with LMC members and local GP constituents including PBC leads and their views are below.

Consultation process
I attended a PBC Federation meeting on 2 September and the PBC Cluster leads were also unhappy that they had not been consulted before the documents were sent to the OSCs.

For the consultation process to be effective, the proposals need to be developed and clarified with regards basic operational details, for example the hours of operation. The PBC Federation had found it impossible to engage paediatricians for the Federation meeting on 2 September or before in order to discuss the proposals. It was not clear who had been invited to the stakeholder event scheduled for 17 September 2009; GPs did not seem to be aware on 2 September. PBC leads were concerned that the potential impacts on the affected trusts, their patients and neighbouring trusts needed to be investigated further and possible countermeasures put in place.

Potential impact on Trusts and patients
GPs could understand the wish to consolidate and rationalise services across Central Middlesex Hospital (CMH) and Northwick Park Hospital (NPH) and were aware that historically CMH staff had felt challenged by the prospect. However, there were general concerns that NPH might be

disadvantaged by the proposals. There were comments that NPH current services could be poor and that recent special measures had affected its reputation among patients. NPH had not been very responsive since the Paediatric Assessment Unit (PAU) had been set up and St Mary's and Hammersmith Hospitals already had effective integrated ambulatory care model units, therefore GPs were concerned that NWLHT paediatric services could be destabilised if patients moved to St Mary's and Hammersmith Hospitals. GPs also thought that the proposals could disadvantage patients in south Brent.

Lack of link into Healthcare for London proposals
The LMC and PBC were concerned that there did not seem to be a clear link to Healthcare for London proposals.

Potential impact on primary and community care services
LMC members did not think scenario 2 was achievable or safe without strengthening of primary and community care services. NHS Brent has been working hard to strengthen community nursing recruitment, retention and standards, but the current health visiting service is not achieving its targets.

The LMC was disappointed that, although the proposals will shift services from secondary to primary and community care, there does not appear to be a related plan to move supporting resources. The LMC requests that any proposals to move services from secondary to primary and community care are preceded by 'invest to save' plans for the development of the primary care infrastructure. The PCT appears to be targeting its resources in procurement and the development of APMS. The LMC requests investment in current primary medical services infrastructure to accommodate the shift in activity and recommends there is consultation with the PBC clusters over new care pathways and the resources needed. This could include investment in staff training (including the development of GPWSIs), an improvement grant process to support primary care practice premises development, local enhanced services and practice resources for patient education.

I hope this is helpful.

Kind regards

Dr Helen Clark
Chair
Brent LMC

	Health Select Committee 20th October 2009 **Report from the Director of Policy & Regeneration**
For Action	Wards Affected: ALL

Audit Commission Review of addressing Health Inequalities in Brent

1. **Introduction**

1.1 This covering report introduces the review from the Audit Commission looking at the approach Brent Council and its partners are taking to tackle the inequalities in health that are experienced by some residents within the borough. This Audit Commission project is composed of two stages; an initial assessment of the current partnership strategy, plans and services in place to address health inequalities and a follow –up stage covering development work on an agreed local priority.

1.2 The attached report from the Audit Commission is the outcome from the first stage of the project. The field work for the report was undertaken in late 2008 and was composed of a review of relevant strategy documentation, statistical information on health inequalities, performance data and interviews with key officers from both NHS PCT and Brent Council.

2. Recommendations

Members of the Health Select Committee are recommended to:-

2.1 Consider the findings of the Audit Commission review of health inequalities in Brent and the partnership arrangements in place for tackling these issues within the borough.

3. Detailed Considerations

3.1 Statistical data on the health of Brent residents indicates that there are considerable health inequalities experienced by many of our residents. While

at a borough level the overall health of the population is in line with national averages when considered at a ward level there are significant variations. These health inequalities are largely centred on our more deprived wards but can also affect specific communities or ethnic groups. Men from the least deprived areas in Brent can expect to live over nine years longer than those in the most deprived areas and this gap has remained consistent for a number of years. Residents from our most deprived areas typically experience higher levels of cardio vascular disease, diabetes, TB and cancers. In addition they are less likely to take regular physical exercise, eat the recommended five portions of fruit or vegetables a day and are more likely to smoke. These health inequalities are also affected by wider determinants of health such as access to employment, low income levels and poor housing.

3.2 Given the many social, economic and environmental factors that can impact on public health an integrated, partnership approach to tackling inequalities and preventing ill health is critical. NHS Brent and the Council agreed in June 2008 a joint Health and Well Being Strategy which sets out our shared priorities for reducing inequalities in health and promoting healthier life styles in the future. This document was adopted by the Local Strategic Partnership and the key health indicators incorporated to our Local Area Agreement. The rational for the setting of these health priorities is underpinned by the detailed analysis of health needs within the Joint Strategic Health Assessment (JSNA)

3.3 The review conducted by the Audit Commission has focused on the implementation of the Health and Well Being Strategy and the partnership arrangements in place to address the wider determinants of health through our core statutory services and shared strategies such as the Regeneration Strategy. The detailed findings of the review are set out in the attached report. Below is a summary of the key strengths and areas for development identified by the Audit Commission:-

3.4 Key Strengths

- There is a clear commitment from key partners to tackle health inequalities
- Key individuals are strongly supportive of actions to reduce health inequalities
- Key partnership arrangements have been identified to tackle health inequalities.
- The JNSA provides a sound and shared foundation for work on reducing health inequalities.
- There is a high level commitment to performance managing health inequalities.

3.5 Further development

- Need to make the sponsorship and accountability for health inequalities projects more explicit.
- Maintain the effective consideration of health inequalities by the Health Select Committee.
- More effective engagement of provider trust organisations in tackling health inequalities.

- Developing partnership arrangements with the voluntary sector, service users and carers to support preventative work.
- Ensuring that the needs of all diverse communities are captured and reflected in service planning.
- Ensuring that the wider workforce of partner agencies contributes to reducing health inequalities.
- Improving health data collection and ensuring performance management of projects is robust.
- Ensuring partner agencies adopt a 'corporate responsibility' model for addressing the wider determinants of health inequalities within their mainstream service planning.

The detailed findings from the Audit Commission are set out within the accompanying report.

3.6 Following discussions with the Audit Commission partners have agreed that stage two of the project should focus on exploring strategies to increase the levels of physical activity of adults in Brent. This area was selected as it is a key shared priority for NHS Brent and the Council. Currently the level of physical activity of adults within Brent is comparatively low and increasing the proportion of adults taking regular exercise is a target within our partnership Local Area Agreement. Increasing physical activity has a major impact on cardio vascular health, weight management and mental well being and as such has significant preventative benefits.

3.7 The Council and NHS Brent will be working with the Audit Commission to explore best practice models in encouraging and providing greater access to and participation in physical activity in the coming months.

4. Financial Implications

4.1 There are no financial implications arising directly from this report.

5. Legal Implications

5.1 There are no legal implications arising directly from this report.

6. Diversity Implications

6.1 There are no diversity implications arising directly from this report

7. Staffing Implications

7.1 There are no staffing implications arising directly from this report.

8. Background Papers

Brent's Health and Well Being Strategy
Joint Strategic Needs Assessment

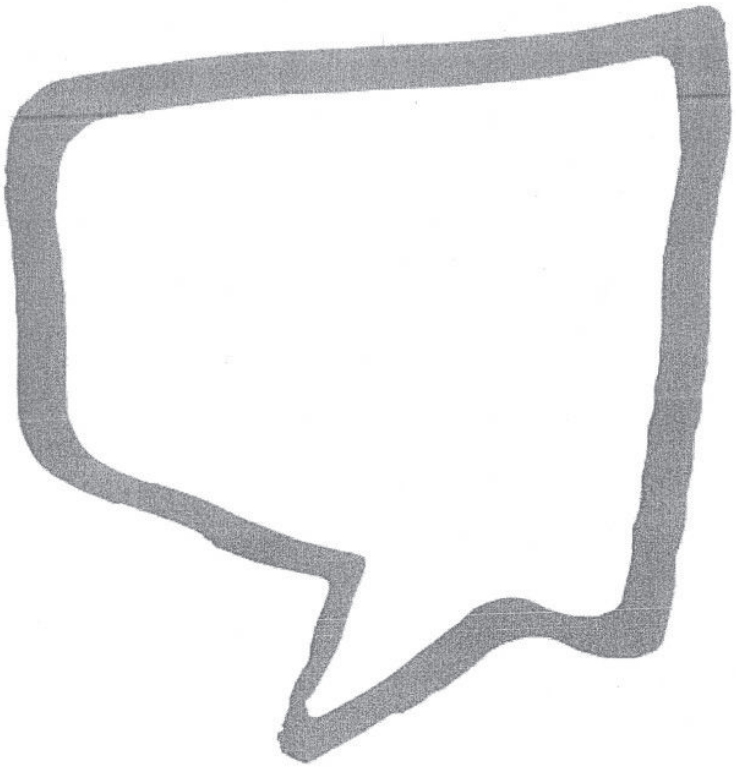
9. Contact Officers

9.1 Cathy Tyson, Assistant Director of Policy

PHIL NEWBY
Director of Policy and Regeneration

Health Inequalities

Brent London Borough Council and
Brent Teaching Primary Care Trust
Audit 2008/09
May 2009



audit commission

Contents

Status of our reports

The Statement of Responsibilities of Auditors and Audited Bodies issued by the Audit Commission explains the respective responsibilities of auditors and of the audited body. Reports prepared by appointed auditors are addressed to non-executive directors/members or officers. They are prepared for the sole use of the audited body. Auditors accept no responsibility to:

- any director/member or officer in their individual capacity; or
- any third party.

Summary report

Introduction

1 Health inequalities are a key issue for both the Department of Health and the Department for Communities and Local Government. The gap in life expectancy between those at the top and bottom of the social scale is wide and has grown since the 1970s.

2 The Local Government Act 2000 places a duty on local authorities to promote the social, economic and environmental well being of their area. The NHS operating framework for 2007/08 requires Primary Care Trusts (PCTs) and local authorities to work together in partnership for the benefit of tax payers and patients.

3 While some action is being taken nationally, the main contribution is made locally. Local authorities and PCTs know that they must act together if they are to address this issue and use their resources effectively. In many areas joint plans to address health inequalities will form part of the Local Area Agreement (LAA). The introduction of local data on all age all cause mortality provides the incentives for effective partnership working between PCTs, local authorities and other partners that need to deliver the life expectancy aspects of the health inequalities target. It will also give flexibility for organisations to focus on the interventions that are most important to their local population.

Background

4 The London Borough of Brent (the Council) is one of only two local authorities serving a population where the majority of people are from ethnic minorities, and these groups are growing faster than any other. Up to 8 per cent of residents are classed as refugees or asylum-seekers. The population is growing and dynamic with recent figures indicating significant numbers of people moving into the borough creating new emerging communities, as well as significant numbers of transient people within the borough. Brent's official ONS population forecast in 2006 was approximately 270,000, although Council-commissioned research suggests that this figure could be at least 10,000 higher and is growing strongly. Almost a quarter of residents are under 19 years old and, within the five renewal neighbourhoods, a third of residents are under 16 years old, compared with a fifth in London more generally.

5 Whilst large sections of Brent are relatively affluent, many residents experience high levels of deprivation and low incomes. The 2007 Index of Multiple Deprivation places Brent within the 15 per cent of most deprived local authorities in the country. The neighbourhoods experiencing the highest deprivation are largely located in the south of the borough, although this situation is changing with high levels of deprivation now seen in pockets to the north of the borough. The most deprived residents also have the lowest income levels, highest unemployment levels, poor and overcrowded housing and the worst health outcomes across the borough. Men from the least deprived areas can expect to live over nine years longer than those in the most deprived areas and this gap has remained constant in recent years.

Audit approach

6 The audit review is being undertaken in two stages. This interim report relates to the first stage, a high level review to identify key risks. This has comprised:

- interviews with key staff and partners; and
- document reviews.

7 The findings of this high level review will inform the scope and audit approach of stage two of the audit.

8 The fieldwork for the first stage of our audit was undertaken during November and December 2008.

Main conclusions

9 There is clear strategic commitment from the Council and NHS Brent to tackle health inequalities. There is broad and shared understanding amongst government and NHS partners that addressing health inequalities is a key issue for Brent. The Health and Well Being Strategy 2008 to 2018 represents a broad based approach capturing the ambitions and priorities for the Local Strategic Partnership (LSP) for improving the health and well-being of Brent's residents and their families. Tackling health inequalities is not consistently embedded in other key strategies with the focus on outcomes variable. The overarching strategic approach enables partners to work together to address health inequalities through agreed priorities and actions. However, the lack of specific outcomes means that partners cannot measure the impact of their activities against their ambitions and priorities.

10 Leadership for the health inequalities approach is supported with good examples particularly from the Council of individuals championing health inequality issues. The effective governance of all actions relating to health inequalities is constrained with the strong individual ambitions to champion the health inequalities agenda vulnerable to changes in key personnel. Clear leadership embracing key partners and workstreams in a systematic and embedded manner will assist with engagement of all parties working to address health inequalities.

11 Key partnerships are identified through the Health and Well Being Strategy. Partnership working to tackle health inequalities between the Council and the PCT has strengthened but partnership arrangements with wider bodies such as research and academic institutions, the voluntary sector and provider trusts are limited. The engagement of the public and communities of interest as partners is not yet embedded and there is limited challenge from Overview and Scrutiny (OSC) on progress in tackling health inequalities. The effective engagement of key partners increases the capacity within Brent to tackle health inequalities

12 The Joint Strategic Needs assessment developed jointly between the Council and NHS Brent is a comprehensive needs analysis which is the prime evidence base for the Health and Well Being Strategy and the NHS Brent Commissioning Strategy Plan. This identifies key issues for Brent and specifically the role of cardiovascular disease as having the most significant impact on life expectancy. Currently capacity issues restrict sufficient data analysis but this is being addressed through the current NHS Brent Organisational Development Plan. At a strategic level there is strong commitment from all partners to understand diverse communities. Further refining is now required to ensure that this understanding is truly comprehensive.

13 The existing workforce is not being used effectively to tackle health inequalities. There are some good examples of local initiatives but there is no overall strategic approach. Public health capacity is developing and Non Executive Directors (NEDs) and Councillors are making good progress in developing the skills and abilities to challenge plans on health inequalities. An integrated approach to using the wider workforces of all the partners increases the capacity to deliver health inequality priorities through using extensive contact with the public.

14 There is commitment at the highest level to the effective performance management of health inequalities. There is no overarching performance management framework for tackling health inequalities and the performance management of current activities linked to health inequalities is not yet systematic and embedded. The Commissioning Strategy Plan has the most developed performance management but the Health and Well Being Strategy and associated action plan lack SMART quantified targets. The absence of performance management of all actions relating to health inequalities limits the ability of partners to measure progress, take appropriate action and demonstrate the link between inputs and outcomes.

15 A corporate responsibility approach in respect of the wider determinants of health has not been formally developed. The Council and NHS Brent have not begun to consider formally the financial implications of corporate responsibility. However, the principles of corporate responsibility are reflected in organisational strategies with a view to making this more explicit in the future. A formally agreed and consistent approach to the principles of corporate responsibility will facilitate the embedding of a commitment to tackling health inequalities across all departments and service areas.

Key Strengths

16 The following key strengths are identified.

- There is clear strategic commitment from key partners to tackle health inequalities.
- Key individuals are strongly supportive of actions to reduce health inequalities for Brent.
- Key partnerships have been identified to tackle health inequalities.
- The Joint Strategic Needs Assessment provides a sound and shared foundation for work on reducing health inequalities.
- There is high level commitment to performance managing health inequalities actions.

Key Risks

17 The following key risks are identified.

- How can the sponsorship of health inequalities projects be made more explicit rather than implicit?
- How can the effectiveness and impact on health inequalities of the Overview and Scrutiny Committee be maintained?
- What actions are available to support engagement of the provider trusts in tackling health inequalities?
- How can partnership arrangements be further developed with the voluntary sector and service users and carers?
- What further refinement might be required to ensure that the needs of all diverse communities are effectively captured?
- What possibilities exist to use of all the wider workforces to contribute effectively to reductions in health inequalities?
- Is additional Public Health capacity required to support the overall work programme?
- Where could further performance management framework support actions relating to heath inequalities?
- What further data is required to monitor performance and demonstrate impact?
- How can a clear plan or cross cutting approach towards corporate responsibility assist in respect of the wider determinants of health across all departments and organisations?

The way forward

18 This is the interim report summarising our findings and key risks from our high level review. The report will be further updated following the completion of our second stage of fieldwork when an action plan will also be added to address our recommendations. The scope for stage two of the work will be set out in a separate specification.

19 From 1 April 2009, Comprehensive Area Assessment (CAA) will be introduced. This replaces comprehensive Performance Assessment (CPA) and will transform the way the performance of local public services is assessed.

20 CAA is the new framework through which the major public service inspectorates will together make independent assessments of how well people are being served by their local public services. Its focus is primarily on the prospects for better outcomes locally rather than the internal workings of individual organisations.

21 Many important priorities, such as tackling the causes of ill-health, improving the local economy and reducing carbon emissions, require public bodies to work effectively together and with their communities. This in turn requires a joined-up assessment framework.

22 CAA will recognise the importance of effective partnership working and the role of councils in leading and shaping the communities they serve. This means CAA will look at services developed in partnership including health and well-being, community safety and cohesion, sustainable communities, economic development, housing, children's and older people s services.

23 It will address issues such as:

- improving access to healthcare;
- increasing the availability of affordable housing;
- reducing the fear of crime, improving educational achievement; attracting investment; and
- reducing the areas carbon footprint.

24 Local audit work, such as this review of Health Inequalities, will inform CAA assessments and in particular will provide evidence of local health outcomes. The first CAA assessments will be reported in Autumn 2009

Acknowledgement

25 The Council and NHS Brent have both worked proactively with us in order to gain some objective insight into its arrangements for addressing health inequalities, and we are grateful to staff and partners for their cooperation.

Detailed report

Do strategies to address health inequalities exist and are they effective?

26 There is clear strategic commitment from both the Council and NHS Brent to tackle health inequalities. There is broad and shared understanding amongst local government and NHS partners that addressing health inequalities is a key issue for Brent. The Health and Well Being Strategy 2008 to 2018 represents a broad based approach capturing the ambitions and priorities for the Local Strategic Partnership (LSP) for improving the health and well-being of Brent's residents and their families. This complements NHS Brent's recently agreed Commissioning Strategy Plan 2008 to 2013 which has at its core a strategic approach to reducing health inequalities. This informs all major initiatives and specifically has targeted, evidence based bio-medical interventions which are focused around the vascular intervention programme. This aims to reduce the gap in life expectancy by six months over five years and raise life expectancy in all Brent residents. The overall approach ensures that a strong focus on health inequalities is present and embedded within the PCT.

27 Tackling health inequalities is not consistently embedded in other key strategies and the focus on outcomes is variable. The Health and Well Being Strategy Action Plan lacks specific outcomes using measures such as improved, reduced or decreased while the Commissioning Strategy Plan has targets which are specific, measurable, achievable, and realistic and time bound (SMART). There is no clear 'golden thread' embedding the reduction of inequalities in all key documents. Good examples include the Sport and Physical Activity Strategy which targets improved access and promoting health benefits to those groups most at risk and the Regeneration Strategy which is focused on key areas for intervention. The overall strategies enable partners to work together to address heath inequalities through agreed priorities and actions. However the absence of a fully embedded approach and lack of specific outcomes in places means that partners could do more to increase the impact of their activities against their ambitions and priorities.

28 Leadership for the health inequalities approach sits with the Director of Public Health, a joint appointment between the Council and NHS Brent. There is a strong level of commitment to tackling health inequalities across key service areas with good examples particularly from the Council of individuals championing health inequality issues. The effective governance of all actions relating to health inequalities is constrained with the strong individual ambitions to champion the health inequalities agenda vulnerable to changes in key personnel. Clear leadership embracing key partners and workstreams in a systematic and embedded manner will assist the engagement of all parties working to address health inequalities.

29 The use of wider public health expertise in developing strategies is good with links to wider areas such as transport, housing and leisure. The Joint Strategic Needs Assessment (JSNA) provides an evidence base which is used in the development of further strategies, for example, strategies for linking with gypsy and traveller communities. The effective use of public health expertise widens the impact and understanding of health inequalities and supports the effective direction of resources.

30 Strategies and health inequality commissioning plans are being embedded in Council activities and are increasing reflected in the plans of NHS Brent. For the Council the planning framework mirrors budget planning and the majority of targets in Health and Well Being Strategy are already budgeted in other plans. For NHS Brent key actions from the Health and Well Being Strategy are reflected in financial plans and budgets. A number of initiatives are at an early stage and for each initiative there is a timeline for when each business case will come forward to be assessed by the PCT. This effective approach ensures that health inequality issues are identified, and have planned outcomes.

Key risks

- How can the sponsorship of health inequalities projects be made more explicit rather than implicit?

Do partnerships addressed with addressing health inequalities function effectively?

31 The Health and Well Being Strategy outlines the ambitions and priorities of Brent's Local Strategic Partnership for improving the Health and Well Being of residents and families. Key partners are involved in the Health and Well Being Strategy and have made reducing the gap in life expectancy at birth between the top five and bottom five neighbourhoods in Brent a key strategic target. Some stakeholders reported variable engagement in the different partnerships with particular strengths in the Drug and Alcohol and Children and Young Peoples Strategic Boards which are well engaged in the Health Inequalities agenda. The effective engagement of all partners will strengthen the wider impact when addressing health inequalities.

32 There is limited challenge from overview and scrutiny (OSC) on progress in tackling health inequalities. The function is being developed having previously had an agenda focused on issues in the acute sector and with NHS Brent. Health inequality areas which have been reviewed include progress on teenage pregnancy and smoking cessation targets. OSC receive updates on all LAA targets paying particular attention to health targets. Insufficient scrutiny of health inequality issues significantly limits the challenge on progress made.

33 The role of provider trusts on health inequality issues is limited and concepts of provider trust involvement differ across different agencies. Key aspects of delivery are captured in the Commissioning Strategy Plan and there is emerging involvement in the Health and Well Being Strategy and developing links with NHS Brent through the Director of Strategic Commissioning. The use of Dr Foster data by NHS Brent enables identification of acute service users if required. Currently there is no plan for brief interventions, for example, support to stop drinking for regular binge drinkers who are treated in Accident and Emergency. Reduced provider trust involvement limits the ability of all partners to deliver priorities and develop whole system solutions to health inequality.

34 Partnership arrangements with wider bodies such as research and academic institutions, and the voluntary sector are limited. The voluntary sector are engaged in the LSP and were involved in consultation on the Health and Well Being strategy. The Health and Social Care Partnership network has wider consultation groups as does the Children and Young Peoples partnership. However further work on comprehensive representation of the voluntary sector is required if it is to be fully representative. This will provide an opportunity to build capacity in the voluntary sector and enable greater co-ordination and mapping of provision to minimise duplication and make the most of resources.

35 The engagement of the public and communities of interest as partners is not yet embedded. Further work on building public and patient engagement is seen by NHS Brent as part of on-going health need assessment. The absence of fully committed and engaged public and communities of interest limits the scope of the Brent partners to improve health inequality issues for all groups.

Key risks

- How can the effectiveness and impact on health inequalities of the Overview and Scrutiny Committee be maintained?
- What actions are available to support engagement of the provider trusts in tackling health inequalities?
- Howe can partnership arrangements be further developed with the voluntary sector and service users and carers?

Does the data and intelligence support organisational and shared strategic and operational decision making to address health inequalities?

36 The JSNA which was developed jointly between the Council and NHS Brent in 2008 is a comprehensive health needs analysis which is shared with appropriate bodies. It reflects health inequalities within the area and is the prime evidence base for the Brent Health and Well-Being Strategy and the NHS Brent Commissioning Strategy Plan. The document identifies circulatory disease as the leading preventable cause of death and that primary and secondary prevention of cardiovascular disease through increasing coverage of antihypertensive and statin treatment has the most significant impact on improving life expectancy. The treatment of cardiovascular disease is also seen as being the most cost effective treatment and will generate long-term efficiencies. Brent also has significant issues with cancer (there is poor local uptake of breast and cervical screening), mental health problems and tuberculosis. Other important areas include smoking as the single greatest cause of preventable illness, obesity where the impact of diet and lack of exercise on future obesity rates is recognised and sexual health. Effectively using information and intelligence to drive and focus decisions will help reduce health inequalities.

37 Both the Council and NHS Brent recognise that lack of capacity issues restricts the data analysis undertaken. The council has a good range of information but there is limited capacity to make full value of the data in areas such as drug and alcohol data. The NHS Brent Organisational Development plan recognises informatics as a key area of development and working with the London Hub the organisation are proposing to develop these skills. This will develop internal capacity and maximise capacity from Hub as they develop. Both Practice based Commissioning and Primary Care are keen to increase the Public Health support at practice level and this will link with the aims of the World Class Commissioning Programme. The absence of sufficient data analysis skills and capacity limits the effectiveness of all parties to use to data collected to maximum effect in targeting health equality actions.

38 Public health data and intelligence (including annual Public Health reports) strongly informs commissioning strategies through the JSNA. This has provided sound foundation to the Health and Well Being Strategy and also the NHS Brent Commissioning Strategy Plan. In both documents the approach for tackling health inequalities is clearly defined and is based on health need. Such sharing of data enables discussion and appropriate challenge within the partnership and supports shared understanding with all key partners.

39 At a strategic level there is strong commitment of all partners to understand the issues facing diverse communities. Further refining is now required to ensure that this is truly comprehensive and universal with all agencies. The Council has a range of mechanisms for engaging communities including black and minority ethnic group forums, area forums and user group forums. NHS bodies have scope for improvement - possibly by linking resources and engaging further with the council. The voluntary sector can also provide information on specific groups that may be overlooked, for example, carers or those with mental health issues. A wide ranging and inclusive approach will ensure that all those with differing health needs are effectively recognised.

Key risks

- What further refinement might be required to ensure that the needs of all diverse communities are effectively captured?

Are workforce planning arrangements adequate to address the skills and competencies needed to address health inequalities?

40 The existing workforce is not being used to effectively tackle heath inequalities. There are some good examples of local initiatives although there is no overall strategic approach. Good local initiatives include park wardens being trained to be park walk leaders to give a wider health understanding, a health walks programme in parks and joint working with leisure centres to deliver specific programmes on exercise on prescription. Within the sports service there is a sports development officer focussing on health and joint working with NHS Brent identifying groups at risk, for example, cardiac rehabilitation courses and weight management courses referred through primary care. The Council has no health and well being programme and no healthy workplace strategy. There are some sessions for staff to improve health and informal staff networks for walking. An integrated approach to using the wider workforce of all the partners increases the capacity to deliver health inequality priorities though using the extensive contact with the public.

41 Public health capacity is developing. There is close working between the Council and NHS Brent and through the jointly appointed Director of Public Health. Public health capacity is being debated within NHS Brent as part of an evolving new structure for 2009/10. Greater capacity would allow better integration of public health with commissioning in order to address health inequalities. The current situation limits the impact public health can have influencing commissioning and actions to reduce health inequalities.

42 Non-Executive Directors (NEDs) and Council Members are making good progress in developing the skills and abilities to challenge plans on health inequalities. Within NHS Brent NEDs are seen as knowledgeable and focussed on health inequalities, for example the recent championing by one NED of the need to improve breast cancer screening where uptake levels were low at 40 per cent. NEDs were widely involved with the Commissioning Strategy Plan. Health inequalities are also a key issue for members because of the health profile of the borough with councillors working hard with NHS Brent to identify key priorities. Suitably equipped NEDs and councillors ensure that plans to address heath inequalities are focused and targeted effectively.

Key risks

- What possibilities exist to use all of the wider workforces to contribute effectively to reductions in health inequalities?
- Is additional Public Health capacity required to support the overall work programme?
- Do performance management systems support the monitoring and evaluation of activities necessary to address health inequalities?

43 There is commitment at the highest level to the effective performance management of health inequalities and targets within the LA performance framework are monitored and managed through the LAA performance framework. There is no overarching performance management for tackling heath inequalities and the performance management of current activities linked to health inequalities is not yet systematic and embedded. The Commissioning Strategy Plan to reduce health inequalities has clear goals, indicators and initiatives with a local measure to narrow the quintiles gap. The Health and Well Being Strategy and associated action plan lacks SMART quantified targets with measures described as 'better' or 'improved' or 'increased'. This limits the partners ability to effectively monitor delivery. The absence of effective performance management of all actions relating to heath inequalities limits the ability of partners to measure progress, take appropriate action and demonstrate the link between inputs and outcomes.

44 Past performance is not yet used explicitly to plan future action. The PCT recognises that some information is weak and this impacts on performance management and so although a trajectory has been set there is not yet the capability and capacity to monitor and manage this. The NHS Brent Organisational Development plan aims to address this gap. Rigorous review of past performance will support all partners in identifying effective and non effective interventions and their linked costs.

Key risks

- Where could further performance management support actions relating to heath inequalities?
- What further data is required to monitor performance and demonstrate impact?

Are corporate responsibility principles in respect to the wider determinants of health adequately reflected throughout organisational strategies?

45 A corporate responsibility approach in respect of the wider determinants of health has not formally been developed and the LB Brent and NHS Brent and have not begun to consider explicitly the financial implications of corporate responsibility. However, progress is being made on taking action with corporate responsibility principles. The principles of corporate responsibility include how the organisation behaves as, for example, an employer, a purchaser of goods and services, as a landholder and commissioner of building work makes a difference to people's health and to the well being of society. Within the Council there is work on green travel plans and walking and highlighting the value of physical activity. There is also work on promoting the Councils range of leisure services within the older people's strategy as a way of developing inclusion. A formally agreed and consistent approach to the principles of corporate responsibility will facilitate the embedding of a commitment to tackling health inequalities across all departments and service areas.

Key risks

- How can a clear plan or cross cutting approach towards corporate responsibility assist in respect of the wider determinants of health across all departments and organisations?

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Health Select Committee Work Programme – 2009/10

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

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

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

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

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

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

	13 week quit - 0			
Acute Services Review	Details on the consultation proposals, plus options for consultation to presented to the committee. Consultation to be on inpatient paediatric services.			
Health Inequalities	The Audit Commission has completed a report into Brent's Health Inequalities. This will be presented to the Health Select Committee for comments.			
Major Trauma and Stroke Services – Update on final report of the Joint Overview and Scrutiny Committee and decisions from Joint Committee of PCTs	The major trauma and stroke services consultation will be completed in May 2009 and the final decisions on the location and number of services will be taken by the Joint Committee of PCTs in July 2009. Health Select Committee considered the consultation in March 2009 and will be updated on the results of this work, including the number and location of Major Trauma Centres and Hyper Acute Stroke Units in August / September 2009.			

Health Select Committee – 9th December 2009				
Pre Meeting Planning		**Post Meeting Actions**		
Subject and Witness	**Issue**	**Outcomes and Actions Arising**	**Responsible Officer**	**Deadline and Status**
Section 75 Arrangements for the delivery of mental health services in Brent	The Committee has asked to be consulted on the proposals to extend the Section 75 agreements for the provision of mental health services in Brent. This is likely to come forward towards the end of 2009 and has been pencilled in for the December meeting of the committee.			
Access to Health Sites Task Group – 12 month follow up	The committee should follow up the access to health sites task group later this year in line with good practice on the completion of task groups.			
Local Area Agreement Targets	The committee agreed in June 2009 to continue to monitor the LAA targets on a six monthly basis. The committee will only consider indicators that have an impact on health and well being.			
Immunisation Task Group	Childhood immunisation has been selected as the next Health Select Committee task group. The task group findings and report will be presented to the committee in October 2009.			
Results of the "We Care" programme at North West	As a result of issues raised by the 2008 Hospital Trust Inpatient Survey, NWL Hospitals has commissioned a piece of work called "We Care", which is aimed at giving			

London Hospitals Trust	patients views to hospital staff, through video interviews with members of the public and use of real time patient feedback. The Committee has asked to see the results of this work and learn about the impact that it has had on the staff who work at the trust.			
Hyper acute stroke unit and stroke unit implementation progress	Northwick Park Hospital has selected as a location for a hyper acute stroke unit and a stroke unit following the London-wide stroke service consultation carried out by Healthcare for London. The committee should receive an update on how the new services are progressing.			
Public Health Annual Report	NHS Brent will present details of the Annual Public Health Report for the committee to consider and comment on.			

Health Select Committee – 17th February 2010				
Pre Meeting Planning		**Post Meeting Actions**		
Subject and Witness	**Issue**	**Outcomes and Actions Arising**	**Responsible Officer**	**Deadline and Status**
World Class Commissioning Strategy Plan	Update on the review of the World Class Commissioning Strategic Plan as the PCT reviews its targets in the lights of revised funding predictions from the Department of Health.			
Sports	The committee is keen to monitor			

Participation	participation in sport data even though the indicator is no longer included in the Local Area Agreement. Performance had been below target when the committee looked at this in June 2009. Members are interested to know what the council is able to do to encourage people to take three, 30 minute periods of exercise each week.			
Childhood Obesity	This issue came out of discussions on the local area agreement in June 2009. Members are concerned about the levels of childhood obesity in the borough. Thought needs to be given about how they want to approach this issue to make best use of committee time.			

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

Items to be timetabled

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

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

	in reducing our well established inequalities. A “stock take” has been suggested.
Swine Flu Update	This was considered by the Health Select Committee at its meeting on 9th June. Members agreed to keep this issue in the work programme and to consider it again at a future meeting if the need arose. This can be added to a meeting agenda if necessary, in due course.