Independent Healthcare Commission for North West London

Submissions of Written Evidence

Volume 6

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SHAPING A HEALTHIER FUTURE

REPORT TO THE INDEPENDENT HEALTHCARE COMMISSION

EVIDENCE FROM HARROW COUNCIL'S COMMUNITY ENGAGEMENT

June 2015

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Executive Summary

Harrow council recognises the need for change to enable the NHS to respond to the changing needs of our population. There has been increasing evidence recently of the difficulties being experienced as a result of the implementation of Shaping a Healthier Future plans, most specifically, the pressures on A&E at Northwick Park hospital. The Council has focussed its evidence on the implementation of the Out of Hospital Strategy to see how effectively residents are being diverted from hospital care. Our residents feel that:

There is insufficient joint planning and delivery of care in the community.

- It is unclear how decisions are being made, and decisions made in a number of cases do not appear to have been the most practical and logical choices.
- There are a multitude of different management structures planning, delivering and financing health and well being services. This is resulting in fragmentation in the provision and delivery of services and contradictory decision making as the impact of changes in one component of the health and well being economy on another are not anticipated.
- The most important planning document driving the delivery of health and well being services is the Joint Strategic Needs Assessment. It is by no means clear that the JSNA is either informed by, or helping to drive, the planning and implementation of Shaping a Healthier Future.
- Whilst there are examples of excellent service integration these tend to be pilots or have limited coverage and are not integral parts of the overall structures and processes – STARRS, Virtual Ward.
- Poor integration of services has had a devastating effect on a number of Harrow's vulnerable service users.

Planning may not have been sufficiently aspirational

- The NHS is 60 years old, and though widely respected and valued, it is questionable whether the 1945 model of provision is still relevant.
- In the context of the poor performance of out of hospital services, it seems that residents may actually be making informed, conscious decisions about how to access health care – sooner wait 4 hours in A&E than 4 days to see a GP.
- The need for change is acknowledge and a shift to the community is welcome. However, none of the proposals regarding shifting care out of hospital are new, but their implementation has never been successfully completed.
- Tinkering at the margins of service delivery will not resolve the fundamental issues and cannot be afforded. Although challenging, the time may now be right to consider fundamental change to how health services are delivered. Experiments such as those in Manchester, offer opportunities to properly fund, integrate and manage services.
- Significant change of such a valued resource as the NHS will need the full engagement of the population if it is to be successful.

Understanding our Community

- The successful delivery of change to health provision must recognise the rich and varied composition of our population: what works for one group of residents may not work for all. Harrow is not alone in having an increasingly transient, ageing, multi-cultural community who may have differing expectations, requirements and different communications needs.

Performance of General Practice

- There are examples of excellent practice amongst some of Harrow's GPs reflecting the needs of local communities and making access to services as simple as possible for all of our residents.
- Despite the very excellent efforts of Harrow Patient Participation Network, it is proving difficult to share this good practice across the borough.
- GP service delivery is thus inconsistent and dependent on where you live. Despite core contracts, issues such as opening hours vary from practice to practice.
- Even if service were consistent and consistently good across the borough, they would still need to be sensitive to the specific needs of more vulnerable residents for whom a standard service isn't enough – one size cannot fit all.
- Whilst there are clearly failings in general practice from a patient/resident perspective, are the changes in service anticipated in Shaping a Healthier Future and the Out of Hospital strategy placing too great a burden on GPs themselves: Are we expecting too much of GPs?:
    - Increasing specialisms as care provided in the community
    - Is the increased pressure demoralising GPs and making the profession less attractive
    - The service is losing older experienced GPs which places an additional pressure on those less experienced

Harrow has concluded that:

There is still need for change in the healthcare system to ensure structures and processes are fit for purpose. However, the out of hospital strategy is not adequately supporting the delivery of the Shaping a Healthier Future plans despite reassurances given.

- Planning and delivery remain disjointed with limited attention paid to the interconnectivity in the health and well-being environment.
- The challenges are not new. The time is ripe to consider more integrated, radical approaches to the delivery and governance of health and well being services.
- The real characteristics of our population are not being properly taken into account.
- General practice is for many in our borough failing to meet need, with no noticeable improvement since the launch of Shaping a Healthier Future:
    - No consistency of care
    - Single model of GP can never meet all needs – there is a particular lack of understanding of the specific needs of our most vulnerable residents
    - GP system is insufficiently resourced (numerically, financially and professionally) to deliver what is expected

None of this is new, for many years policy makers have talked about and tried to organise the preventative and rehabilitative care of residents in their community. It seems the difficulties remain,

perhaps the time is ripe to consider what the blockage to improvements might be whilst assessing need and developing services to meet these needs.

Leader's Foreword

This report summarises the discussions which have taken place between Harrow Council and the residents of Harrow, following the implementation of the proposals in NW London NHS's Shaping A Healthier Future. It constitutes Harrow Council's submission to the Independent Healthcare Commission chaired by Michael Mansfield QC.

The Council wishes to emphasise from the outset that comments or criticisms gathered during this exercise are of systems and processes and not of any individuals or service providers. The National Health Service is a precious resource for all residents and it is not our intention to undermine its attempts to respond to challenges from an increasingly difficult financial, technical and demographic environment. We hope that our comments can be seen in the spirit of constructive engagement with partners in the health and well-being provider community. The Council is committed to partnership working , so we offer this report to support the delivery of services to our residents, not to undermine our partners. I am also keen that, as a result of this exercise, we might be able to work together with our partners and residents to address some of the difficult issues raised by our residents.

Initially, Harrow Council was generally positive about the proposals which have seen our local hospital, Northwick Park, designated as a major hospital for the area and receive significant investment. During the consultation on the proposals however, we highlighted our concern that downgrading of A&E facilities at NW London Hospitals NHS Trust's Central Middlesex Hospital site could create significant pressure on remaining facilities at Northwick Park Hospital. In response to our comments, we received reassurances specifically with respect to NHS NW London's plans to safeguard Northwick Park including investment in the hospital, the transfer of staff from Central Middlesex Hospital and the urgent implementation of Out of Hospital strategy which would minimise the need for local residents to attend hospital to receive care.

The evidence of the failure of these safeguards is plain:

- Weekending 26th April – only 74% of those attending A&E were seen within 4 hours
- At no time since the implementation of the changes has the hospital met its target for A&E waiting times
- During the second week of April, more than 700 people waited for more than 4 hours to be seen in A&E

Our initial enthusiasm for the changes to our hospital has thus diminished and we have reassessed our initial decision not to participate in the Independent Healthcare Commission. The Council decided it should be bold and take a lead as we witnessed the services to our residents suffer serious decline, and that we should bring the difficult issues facing our residents to the attention of the Commission.

We endorse much of the evidence presented by the other boroughs participating in the commission with regard to how the changes have been implemented and would especially endorse the evidence presented by our neighbouring borough Brent with regard to the capacity of Northwick Park A&E and the impact of the downgrading of services at Central Middlesex and the evidence from the Harrow Patient Participation Network on the financial situation in Harrow. We are also aware that Harrow CCG has submitted evidence on the progress on delivery of the Out of Hospital Strategy.

The main focus of our evidence to the commission was therefore the very specific experience of our residents: whilst the statistical information is important, we feel that it is the real experiences of people trying to access health care at times of need which can really demonstrate our concerns to the Independent Healthcare Commission. In addition to a summary of the issues brought to our attention during the workshops, our report is illustrated throughout with statements and real examples of the experiences of our residents.

Our evidence is presented as follows:

- Methodological approach
- Our findings
- Our conclusions

This has been a revealing and rewarding exercise and I would like to take this opportunity to thank the residents, their representatives, our partners and councillors from the authority for the very valuable evidence which their involvement has elicited.

David Perry

Cllr David Perry
Leader of Harrow Council

Talking to Our Residents: Our Methodology

Of necessity, this project has been undertaken over a very short time period. At the outset of Harrow's involvement, we determined to bring a real residents' perspective to the commission's attention and in the time available have sought to involve, not just our residents, but also their representatives: the local voluntary and community organisations who so effectively lobby on their behalf, the patient and user groups set up to ensure the voice of those using services is heard, local GPs who have direct experience of the implementation of the changes and our own ward councillors.

This project is not intended as a statistically-based investigation of the experiences of a representative sample of our residents from which generalisations might be derived. Rather, we have attempted to listen to our residents to try to understand their experience of the changes and how this feels from a human perspective: not simply numbers but real peoples' experiences. We recognise that some may feel this limits the application of these findings but we hope that in offering these personal stories and experiences, a greater appreciation of the impact of failings in our services can help service providers to understand and hopefully resolve the problems in the system. The findings are offered in the spirit of the ongoing improvement of local services.

A key indicator of the difficult implementation of the Shaping a Healthier Future proposals has been the significant failures at the A&E department of Northwick Park hospital, these failings have been well documented and as such, are not the focus of this investigation. Instead, our ambition has been to consider the implementation of the Out of Hospital strategy, designed to alleviate potential capacity issues at the hospital by minimising the need for residents to attend. The three key components of this strategy, which we feel can have maximum impact on the experiences of residents are:

- Access to GP services
- Use of alternative emergency services - for example, Urgent Care Centres
- Maintaining residents with long term conditions in the community

In order to discuss their experiences we held six workshops during weeks commencing 18th and 25th May with:

- Harrow Voluntary Sector Partners
- Harrow's Local Medical Committee
- Harrow Patient Participation Network
- Harrow's Local Account Group
- Harrow Health and Wellbeing Board
- Harrow local ward councillors

In independently facilitated sessions, attendees were invited to share their experiences of the key areas for investigation, not simply their opinions. The following section in this document summarises the issues raised at these sessions.

The purpose of the workshops was not to allocate blame or to simply discuss failings, in identifying the issues, it was also hoped that an opportunity might be offered to participants to suggest ways in which some of the failings might be addressed. These findings are also summarised in the following section.

The launch of the project took place on 14th May and was attended by a number of local organisations, service users and councillors. The launch offered the council the opportunity to explain the purpose of the project, how it would be undertaken and encourage as wide a degree of participation as possible. It was also an initial opportunity for those attending to share their experiences.

What Our Residents Have Told Us: Our Findings

In this section we summarise the issues raised with us by our residents. The points raised have been organised under the following headings:

- Integrating the planning and delivery of services
- Aspirational planning
- The nature of Harrow's population
- The performance of General Practice

Integrating the Planning and Delivery of Services

Key to the success of the out of hospital strategy must be the recognition of the need for joint planning and delivery of services: as people are diverted from emergency care/acute care, there must be parallel developments which can pick up those being diverted.

Perhaps the least surprising comment, but also perhaps the most disturbing is the lack of confidence from the majority of those involved in this project in the capacity of the key service providers to plan and deliver services in a co-ordinated way. Whilst there are ambitions to enhance our integration through such means as the Better Care Fund and there are examples of excellent projects to co-ordinate service delivery, residents remain concerned about poor co-ordination as the benefits of new systems remain unclear and there application remains limited.

The Virtual Ward or whole systems integrated care pilot co-ordinates the care of older people in their own homes preventing hospital admission. Care is co-ordinated via the GP and involves any service necessary to maintain the patient in their home.

The lack of co-ordination is evidenced in the opinion of voluntary sector colleagues in the expectation of the enhanced roles for the sector in the context of diminishing funding

There are now partnership bodies in place with a view to ensuring that services are planned and delivered in co-ordination. Comments were made however about the efficacy of these bodies and their capacity for strategic planning, it is felt that the overall approach is one of individual project management rather than strategic oversight.

Participants in the project are unconvinced about the basis upon which decisions are being made. The Joint Strategic Needs Assessment should present a clear analysis of residents' well-being needs. There is little confidence that the changes, particularly with regard to the development of care out of the hospital are being reflected in this analysis.

Lines of accountability are now blurred – for example CNWL now covers 2 boroughs, how can residents hold providers to account if they don't know who is responsible?

There is a plethora of management bodies and structures with separate planning and budgeting processes and lines of financial accountability which are a disincentive to co-ordination. These bodies must be enabled to function collectively to give any hope of success to co-ordinating the planning and delivery of effective health services. How, for example, are the JSNA and coordinated planning bodies such as the Health and Well Being Board able to influence some of the fundamental questions with regard to General Practice. A number of participants made reference to their concerns about the lack of transparency

and control with regard to GP 'planning'. As virtually independent bodies, how can their critical role in such a significant shift of care be properly planned and co-ordinated?

In particular in this regard, participants raised a number of examples of how they feel this fundamental cornerstone of the out of hospital service is outside of the strategic planning function

Lack of evidence-based decision-making

Practice mergers are being initiated and led by Patient Participation Groups.

Well-articulated, evidenced applications for practice expansions are being turned down with no apparent justification and no explanation.

Decisions have been made with regard to the location of expanded practices (polyclinic/walk-in centres) with no clear justification.

The maintenance of a healthy community is dependent on integration of a number of components: Primary health care – GPs, walk in centres, Emergency health care – UCCs, A&E, Acute health care – hospital beds, Community nursing care – support on discharge, prevention of admission, Social care – support on discharge, prevention of admission, Voluntary sector support, Residents – public health individual responsibilities. A breakdown or imbalance in any single component of this system will inevitably create pressures in other parts of the system. It is the view of those involved in this exercise that this is what has happened, that there has been serious disjoint between proposals to close the A&E at Central Middlesex hospital and the implementation of the out of hospital strategy:

- Insufficient bed space in the acute hospital blocks patients who need to be admitted – step down ward
- Ambulances have been unable to deliver patients to A&E
- Insufficient support from community services prevents patients from being discharged or may mean they are readmitted

Can A&E map 'busy' periods, are staffing/process decisions made in the context of this information i.e. if there is an identifiable peak and trough, do staffing numbers follow this?

Lack of timely access to primary care means residents will access services more immediately via A&E or their conditions deteriorate such that they need more expensive support further down the line, counter intuitive to the ambitions of the Shaping a Healthier Future model of care.

Joining up care, especially for residents with long term conditions

When a patient with a Learning Disability is admitted to Northwick Park hospital, the Learning Disability Liaison Service is required to be notified in order that their specific needs in hospital and in preparation for discharge can be met, thus ensuring a smooth transition and care pathway. There is no logging of admissions of people with Learning Disabilities in the hospital which means the service is not notified and care planning for vulnerable residents is not part of the routine process. Their care whilst in hospital and their supported care on discharge is thus jeopardised.

'Shifting the settings of care' means that for psychiatric patients, their care will be delivered by their GP as they are discharged from CNWL. Unfortunately for many patients this has meant disruption to the drug regime as GPs are unable or unwilling to re-prescribe and they cannot return for drug support from CNWL which has discharged them. Lack of proper drug support places already vulnerable residents at significant risk. Psychiatric patients are further at risk as only half the required number of community psychiatric nurses are in post.

A resident with autism spent a year under mental health services but eventually was told they did not have a mental health issue. They were then referred to learning disability services but again told they didn't have a learning disability but might be on the autistic spectrum. They were referred to a psychologist at Northwick Park but told the service was unsuitable for them. They were referred back to their GP. The mother spent many months liaising with the local authority, GP and mental health service to find out who was responsible for his mental well-being. After many months of phone calls and letters, a social care assessment was undertaken and the GP was asked to make a referral for counselling. After 3 years of negotiation with GP and mental health commissioner the resident received 11 sessions with Improving Access to Psychological Therapies, which helped. They still need continuous support, currently this is unavailable.

Aspirational Planning – Stretching the Boundaries

How far has Shaping a Healthier Future and the Out of Hospital strategy attempted to deliver real change.

> *'It's like an old house...we keep talking about renovations but what we really need to do is knock it all down and build what we really need.'*
>
> *'We need systems leadership, whole systems assessment – an honest collective discussion about need and how to meet it'*

The need for change is understood, our population is significantly different to that of 1945, we live longer, have more complex conditions and our expectations of health are high. A key focus for this change and for the delivery of services such as those incorporated in the Out of Hospital strategy has been on the use, modification or improvement of existing structures: how well we are adapting or modifying the structures, services and staff that we already have. Discussions with participants in this exercise have also however considered whether this constraint on our thinking and planning is helpful or indeed appropriate in the difficult financial circumstances which have precipitated the need for change.

We consider hospitals, walk in clinics/minor injury centres and GPs and a trajectory from the latter to the former to be a given. Participants in all workshops have raised a challenge to this assumption and thus to the fundamental principles on which Shaping a Healthier Future and the Out of Hospital Strategy are based. It is their view that consideration of alternative models should not be outside of the remit for reconfiguration and delivery of services. In particular the question has been raised as to whether the model of NHS set up 70 years ago is still fit for purpose and in fact do some of the precise difficulties Shaping a Healthier Future and the Out of Hours strategy have been set up to address illustrate the need for more fundamental change.

In this context, participants commented that the current structure of health and well-being service delivery is a 'fragmented' and 'broken system'. Whilst the changes envisaged are not new, they have never been successfully implemented and now may be the time for a far more radical approach to service delivery. Services, across both health and social care are experiencing massive resource pressures and tinkering at the margins of service delivery will not resolve this funding crisis. Participants have urged consideration of a radical rethink of resourcing and planning our services, along the lines of the Manchester experiment which is witnessing the aggregation of health, social care and other budgets across the city and the co-ordination of planning and delivery of services.

Participants proposed that it might indeed make smart business sense to develop services in environments which are demonstrably popular. By attending A&E are our residents perhaps expressing a preference for a model of service delivery which should be influencing investment decisions? It was clearly expressed by residents who responded to the public survey that their preferred location of medical support would be somewhere:

- where they can receive care most speedily, and
- where services required could be delivered in one place.

The logic of this is that our residents would prefer to wait for four hours in A&E rather than four days to see a GP. Clearly this begs the question as to whether the right investment in GP services will reduce the delays being experienced by residents, but it also poses an interesting challenge to

service planners: are we investing in the right services, in the right places? Are we effectively just moving the deckchairs around on the ship struggling to stay afloat?

So, is our mind-set unnecessarily and unhelpfully limiting our capacity to successfully reconstruct the delivery of health and well-being services? What prevents us from taking a radical look at what really needs to happen?

Participants have already identified their concerns with regard to the lack of joined up planning, management and delivery of services. Indeed it is possible that there are disincentives in the system which will continue to militate against significant changes unless they are addressed.

But participants also expressed a lack of trust when it comes to changing the NHS. Whilst there are strongly expressed concerns about some of the shortcomings of NHS services, it remains the case that it is one of Britain's most precious resources and one which claims the allegiance of all communities. As such, any attempt at radical change is likely to be met with fierce opposition unless those planning change can engage with service users, allowing them to influence how their care is delivered. Unfortunately, trust appears at an all-time low and as communication of the changes in Shaping a Healthier Future demonstrates, much still needs to be done to take a community with you.

At the end of the day the extent of our ambition will inevitably be tempered by existing constraints, be they powerful lobbies, existing structures, professional opinion, vested interests or public opinion. But this should not prevent planners from approaching the challenging questions and perhaps taking some small steps towards different models of care.

Broadening our horizons

Extend the network of expert patients- supporting people with long term conditions by linking them with people with the same condition. Enabling them to anticipate issues and develop support networks.

GP hubs (in Urgent Care Centres?) to reduce impact on acute services– 4 open 24/7 with 20-30 beds, GP led with nursing support. Satellite surgeries attached to each hub in community

Salaried GPs

Should there be a greater role for citizens in looking out for their neighbours. Could we expect some staff in the care system to take a greater responsibility?

Lifeboats on Land.

The Nature of Harrow's Population

Any recalibration of services must be cognisant of the nature and future development of the population.

Participants in the exercise expressed concern that the planning of health services must reflect the changing nature of our population. In particular, our capacity to divert residents from A&E emergency services to services in the community may be dependent on our understanding of the community and our ability to engage with it.

> *The public survey demonstrated that for some residents registering with a GP is problematic, particularly if they don't intend to stay in the borough for long, as they will need proof of address or if their hours of work make using GP appointment system difficult. For these residents, using emergency care becomes the main option*

Like most London boroughs, the population of Harrow continues to increase: from 206,800 in 2001 to 239,100 in 2011 and is now an estimated 243,400. This population increase is expected to continue as government welfare policy shifts residents from Inner to Outer London and as planned housing developments on sites such as Kodak come to fruition. There are now an estimated 255,000 residents on GP lists but at the same time as this, the number of GPs and GP surgeries is in decline.

Like most London boroughs, Harrow's population is hugely diverse and somewhat transient. Our residents are religiously, culturally, nationally and ethnically diverse which poses some challenges for service providers trying to change how local people access health services. Comments made by participants have included:

- Do people understand our processes – how sure can we be that the complex network of GPs, clinics and hospitals and the appropriate means of accessing this network is clear to people not familiar with our systems. Is it probable that in some of our residents' countries of origin, there is a simpler system which they equate with ours and thus make inappropriate presentations for services?
- Are people able to access information about our services – for those residents unfamiliar with our systems, and for those we wish to advise of changes, do we provide information in a format which is easily accessible and understandable?
- Are the services relevant – for some of our residents, the changes we are attempting to deliver may not be appropriate. For more transient residents, the process of registering with a GP may be irrelevant, particularly those residents with temporary accommodation or employment who are 'only passing through'

> *Some resident are 'sofa surfing' as they are unable to find independent accommodation, they will also be unable to access a GP as they cannot register without proof of residence*

> ***How well informed are we***
>
> *Information provided about the changes has been poor and of limited usefulness. Something more engaging should be used to sell the changes properly.*
>
> *Very little information has been made available about where to go with what care need, how are residents expected to 'self-diagnose' and know where to go in the absence of advice?*
>
> *'Spectrum' has been produced but not circulated widely – is this something the council could do?*
>
> *People with Learning Difficulties and Mental Health issues are not keeping up with the changes in service delivery – very poor communications for them*

Harrow also has a significant and growing elderly population and again, it is possible that their increasingly complex needs and decreasing mobility are placing demands on the system which the reconfigured Out of Hospital service is not able to meet. For the Out of Hospital service to meet the needs of this group and the needs of our residents with long term medical conditions or disabilities the need for integration across the spectrum is critical and increased sensitivity to their vulnerability is essential.

A visit to Northwick Park witnessed a procession of elderly people arriving in A&E by ambulance looking completely dehydrated. How did their conditions deteriorate to such a degree that they needed emergency care?

The experience of finding it difficult to access a local GP and having to wait for hours on end at the local hospital is extremely concerning, especially if you then also include the transport accessibility and excessive parking costs on top

Many residents and service users have also expressed serious concerns regarding the transport accessibility of Northwick Park Hospital in its effectiveness to serve all the residents of our Borough. For the services users who have to drive to Northwick Park find themselves heavily disadvantaged by the excessive cost of car parking. Both vulnerable patients (and their families accompanying them) as well as those on low incomes report that visiting the hospital is a huge worry.

Only if we are really clear about the nature of our community can we properly design services which can meet their needs in a way which reflects their specific circumstances.

Performance of General Practice

The recalibration of services to deliver care outside of the hospital sets the GP as the cornerstone. Without their fully resourced engagement in the process, it will fail.

This is the aspect of the implementation of the out of hospital strategy which has elicited the most comment.

We start by making clear that there are many examples of excellent service across the borough with high standards of care and professionalism from GPs and their surgeries supported by the Patient Participation Groups which work with them to improve their service delivery by championing the needs of local people.

Whilst it is indeed reassuring to hear that there are some excellent aspects of GP provision, it is also quite clearly the case that there is no overall consistency in the delivery of General Practice and that the services available to our residents are thus dependent upon where they live.

Although the core contracted opening hours for GPs are from 8.30 to 6.30 it is clear that there is significant variation on this standard between surgeries.

> *'My elderly grandma will not attend A&E as she doesn't like hospitals. She regularly waits up to a month for a GP appointment'*

Access to appointments also varies dramatically – some surgeries can offer next day appointments, for some there is a wait of a few days and in some a patient can wait significantly longer. If a patient wishes to see a specific doctor, this inevitably increases the delay

> ***Good practice***
>
> *A number of surgeries now offer a triage service which has led to a speedier response time on contacting the surgery and also resulted in shorter waiting times for appointments.*
>
> *A number of surgeries have recognised the needs of people with learning disabilities and mental health concerns and will automatically offer double appointments.*
>
> *Some surgeries will offer appointments in alternative locations (patient's car) to meet with residents*
>
> *The Harrow Patient Participation Network is actively campaigning on behalf of over 180,000 Harrow residents to improve services.*

Where a patient needs to see a doctor urgently, most surgeries have emergency appointment processes:

- patients are asked to ring between certain times to take access an emergency appointment or
- they are asked to attend the surgery to wait.

Neither of these options guarantee a patient will be seen:

- it can be impossible to get through between allotted times
- some more savvy patients take the emergency appointments even though their needs are not urgent rather than waiting for a non-urgent appointment
- attendance does not guarantee an appointment will be available as all time slots are used

It is also of concern to participants, that there do not appear to be consistent sharing of good practice – whilst the Harrow Patient Participation Network's commitment to improvement is patently clear, its ability to influence other surgeries or to require improvements in its own is not apparent. This is a shame, as the opportunity to learn is lost.

Delay in seeing a GP, in what might initially be fairly innocuous circumstances can cause greater pressures further down the line as conditions deteriorate and thus the cost of care increases. This is probably most likely the case amongst our elderly, less mobile population.

'I am the nominated appointment booker in our family as none of the other family members can give up time in the mornings to keep pressing the redial button to get an appointment'

But delays in seeing GPs do not just affect our residents' immediate health and well-being. It is becoming increasingly apparent that some employers are unwilling to offer their staff time away from their employment or paid time off during the working day to attend GP surgeries (during the GPs' normal opening hours) this means that either these people attend A&E to receive medical advice, they ignore their medical conditions or they lose their jobs. Similarly, increasing numbers of people are presenting to the Citizens' Advice Bureau for advice in circumstances where failure to provide medical evidence of their conditions is resulting in loss of benefits, and even in loss of accommodation.

A paid extension to the opening hours of GPs to include late evenings and Saturdays, for which there is already provision, could alleviate this situation. However, even where GP surgeries are offering extended hours, it may not be possible for these to be accessed in emergencies as payments may only cover GP salaries meaning that surgeries have no administrative cover and thus no telephone answering service

For my children to wait in the waiting room for an unspecific amount of time is extremely difficult. The uncertainty of this causes extreme anxiety which in turn causes certain behaviours. This could be running up and down, trying to escape, trying to climb on things or people, moving furniture, screaming, crying, shouting, hitting.

When you add into the mix the crowds buzzers going off etc. it turns a normal waiting room, into a living nightmare.

Then... add on the looks of staff and patients, the comments of 'control your child'. The fear in other people's eyes that my son might hurt someone is beyond description.

This happens EVERY TIME we visit the GP.

However, even if it were the case that our GP services offered a consistently high standard of care across the borough, it is unlikely that the needs of our most vulnerable residents would be met: whilst high quality consistent care must be our ambition, we must also recognise that in many circumstances, these standards will need to be enhanced for some of our residents to enable them to access care. This project has heard from the representatives of vulnerable service users and service users with 'special needs' themselves of the difficulties they face in accessing general practice, not simply for treatment for their conditions but also as residents for the normal ailments of day to day life.

We have included a number of examples to illustrate their experiences but would summarise their concerns as;

'We need to see Dr R as he is the only one, in our very large surgery, that understands the complex needs of my family. Both my sons have Autism.'

- Lack of awareness of their specific condition – autism, mental health
- Lack of sensitivity towards their needs – double appointments, inability to access appointments
- Need for consistency – seeing the same GP

- Inappropriate surgery environment – crowds, noise

All of those who attended our workshops to discuss the issues of access to care for those with 'special needs' talked about the mistakes which are made as inappropriate diagnoses are made by GPs unfamiliar with or untrained about their conditions.

As NHS policy shifts more responsibility for providing care to our vulnerable residents to those who operate in the community, we hesitate to blame GPs for this failing. We would however draw attention to the need for and willingness to ensure that they are fully aware of the specific needs of some of our residents in order that all can be properly supported.

Difficulties for people with autism, which are also acknowledged as difficulties for people with Learning Difficulties and mental health problems and may also be issues for our elderly residents

Cannot get through on the phone so cannot book an appointment. Long waits on the phone can be very stressful
Cannot work an automated phone so just give up
Receptionists are rude and block access to the doctor
Sensory issues:

- *Bright lights*
- *Noisy waiting room*
- *Children running around*
- *Difficult sitting facing people*

Delated appointment, can be too stressful to wait
Some people dislike name being displayed on screen

Participants suggested that considerable difference can be made to more vulnerable residents' experience of health and well-being services with very simple changes to practice. Simple awareness of some of the difficulties experienced and sensitivity in service delivery costs little, if anything, and can result in significant savings as vulnerable residents are able to access services promptly and their conditions are not allowed to deteriorate.

In one instance where training had been offered for GPs about the difficulties which may be experienced by patients with learning disability and how these might be overcome, the question was raised as to whether there would be additional money for GPs to meet these needs. Providing appropriate care to our more vulnerable residents is not necessarily about greater resourcing but about greater awareness, it should not be seen as an additional demand, financial or otherwise on a GP practice's funding.

For the most part of this section of our report, we have focussed on the reported shortcomings of our GP service and the devastating impact these shortcomings have on our residents, especially those with more complex conditions. During our investigations however, considerable sympathy was also expressed for GPs themselves, who, as a result of NHS policy and other influences, find themselves increasingly in situations which stretch their resources to the limit.

I have also had trouble with understanding what GPs have told me and also what I have told GPs. My GP now understands me (when I can get to see her) but some of the others at the surgery become gruff when I want to know a little more and they try to push me out of the door.

When I was first supposed to be diagnosed with Asperger's Syndrome, I was seen by a psychiatrist in the doctor's surgery who said she thought I had depression and she gave me anti - depressants.

Concerns raised are seemingly rooted in the push towards, community care, universal services and shifting the setting of care. All of these also reflect the ambitions of the Out of Hospital strategy to enable people's medical needs to be supported in the community. Participants consistently questioned, not necessarily the logic of this, but the capacity of GPs to deliver some of the specialist services and diagnoses that this shift might expect: For example do our GPs feel confident to deliver some of the psychiatric support offered by the specialist hospitals? The experience of residents with psychiatric needs and their representatives, would suggest the support available to them from general practice is far from what is required and we have already cited a number of examples of the concerns they have raised.

GPs are also becoming increasingly demoralised as pressure on their lists, their time and their skills base increase. Are we expecting too much of our GPs? Do we now expect a 'champagne service at beer prices'?

Impact of unfamiliarity with conditions on vulnerable patients

People being sectioned because their autism not recognised

Attempted suicide after diagnosis of 10 different psychiatric conditions

Failure to monitor medication over 12 month period meant patient almost lapsed into a coma

Suicidal patient escorted home after episode in A&E. She committed suicide

Their capacity was also queried in terms of numbers and experience: Whilst the Government ambition to recruit 500 GPs is laudable, this cannot compensate for the loss of experience as older doctors retire. Participants have pointed to the tendency of less experienced doctors to 'overcompensate' or to delay diagnosis and prescription seeking further advice. Participants have suggested mentoring or shadowing opportunities in an attempt to support new doctors develop in their roles.

Even where confidence and competence can be assured, the fact remains that GP numbers are reducing, with the best will in the world Government Ministers cannot direct 500 students into firstly medicine and then general practice. Our participants felt that the incentives for careers in General Practice are insufficient – Do GPs seek to supplement their earnings in additional roles which detract from their general practitioner roles? Is the pressure being perceived in the profession limiting its attractiveness? Are they sufficiently rewarded?

Some participants questioned whether the pivotal role of GPs as envisaged in the Out of Hospital strategy is a step too far for general practice as it is currently configured. As discussed above, are we simply shifting resources within the existing model of care introduced in 1945 or do we need to take a more fundamental look at health care and how general practice can be properly configured to support a shift of care from the hospital to the community. Whilst there is an accepted logic in the Shaping a Healthier Future proposals and its predecessor 'Healthcare for London' which recognises that recalibration and reorganisation of health provision can allow the most appropriate care in the most appropriate locations, this logic has stopped short of the realm of general practice, where GPs are being expected to pick up much of what can't be dealt with elsewhere. There may be many obstacles in the way of such a rigorous analysis, not least GP contracts and the plethora of management structures, which will need to be considered to deliver real change. But it does seem that an opportunity might have been lost.

Conclusions

Harrow Council acknowledges the need for change in the healthcare system to ensure structures and processes are fit for purpose. However, the out of hospital strategy is not adequately supporting the delivery of the Shaping a Healthier Future plans despite reassurances given.

- Planning and delivery remain disjointed with limited attention paid to the interconnectivity in the health and well-being environment.
- The challenges are not new. The time is ripe to consider more integrated, radical approaches to the delivery and governance of health and well being services.
- The real characteristics of our population are not being properly taken into account.
- General practice is for many in our borough failing to meet need, with no noticeable improvement since the launch of Shaping a Healthier Future:
    - No consistency of care
    - Single model of GP can never meet all needs – there is a particular lack of understanding of the specific needs of our most vulnerable residents
    - GP system is insufficiently resourced (numerically, financially and professionally) to deliver what is expected

None of this is new, for many years policy makers have talked about and tried to organise the preventative and rehabilitative care of residents in their community. It seems the difficulties remain, perhaps the time is ripe to consider what the blockage to improvements might be whilst assessing need and developing services to meet these needs.

APPENDIX ONE: PARTICIPANT ORGANISATIONS

Harrow Citizens Advice Bureau

Harrow Mencap

Harrow MIND

Harrow Healthwatch

Harrow Local Account Group

Harrow Local Medical Committee

Harrow Patient Participation Network

Harrow Councillors

Cllr Anne Whitehead,

Cllr Varsha Parmar

Cllr Simon Brown

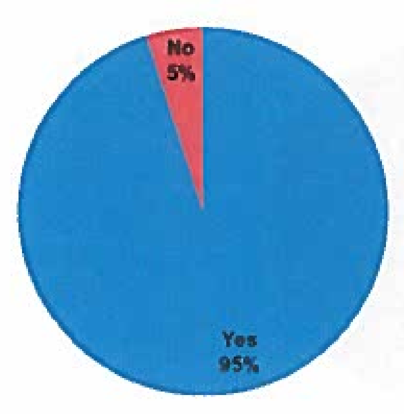
Cllr Rekha Shah

Cllr Chris Mote

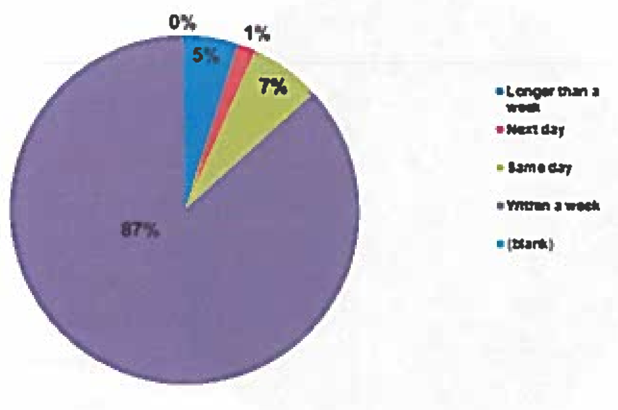
Cllr Janet Mote

Cllr David Perry

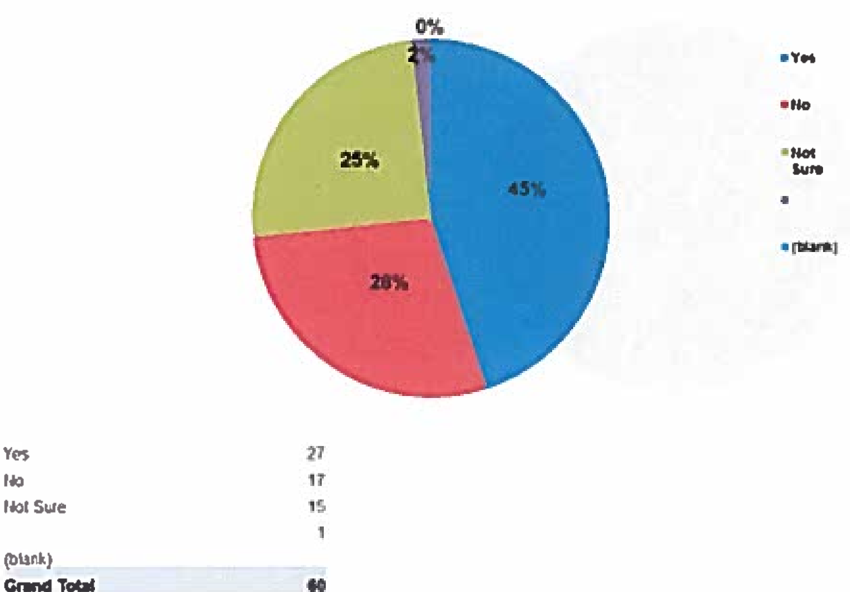
APPENDIX TWO: SURVEY RESULTS



Yes	58
No	3
Grand Total	61

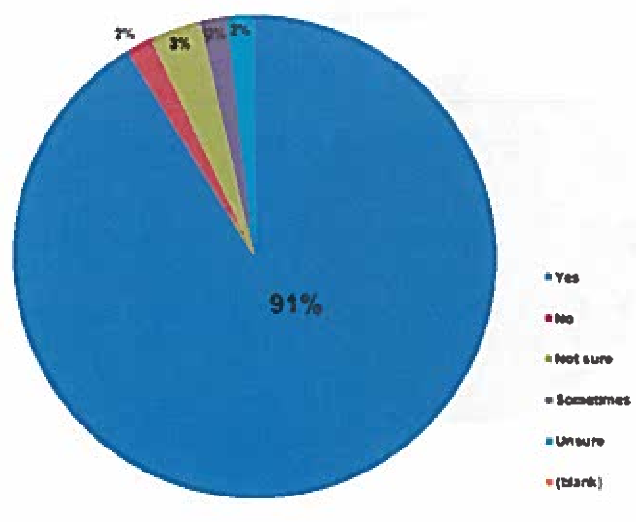


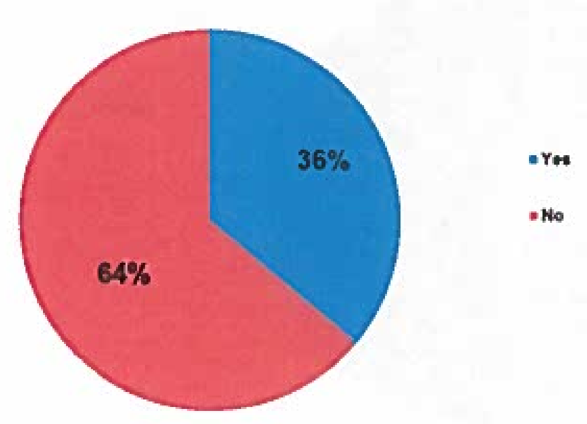
Longer than a week	3
Next day	1
Same day	4
Within a week	52
(blank)	
Grand Total	**60**



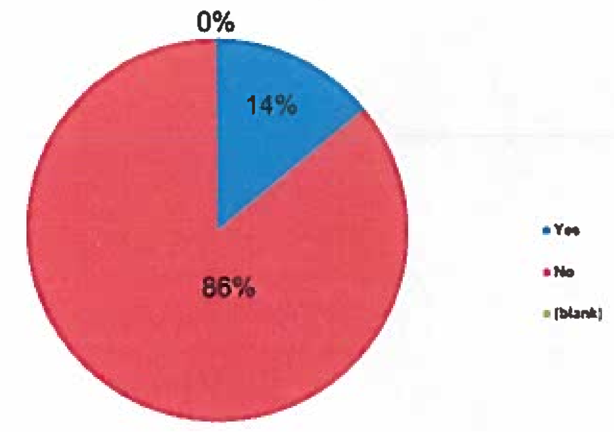
Yes	27
No	17
Not Sure	15
	1
(blank)	
Grand Total	**60**

Yes	4
No	13
Not sure	4
7 days a week	1
8am till 6pm	2
8am till 6pm Just started Saturday	1
[illegible]	1
No	2
No 8am till 8pm	4
No only one day [illegible]	1
No usual hours	1
Not sure	1
One day longer hours	1
One day up to 18:30	1
Unsure	2
Yes [illegible] Thursday [illegible]	1
Yes 8am - 1pm	1
Yes 8am - 8pm	2
Yes - Thursday [illegible]	1
Yes [illegible] Saturday [illegible]	1
Yes [illegible]	1
Yes [illegible] Wed [illegible]	1
Yes early morning	1
Yes evenings and Saturday mornings	1
Yes plus Saturdays	2
Yes 3 practices one open later	1
Yes [illegible] and sometimes longer to meet needs + Saturdays	1
Yes early mornings	1
Yes Monday evening Saturday Morning	1
Yes morning and evenings	1
Yes offers early morning late evening and weekend	1
(blank)	
Grand Total	[illegible]



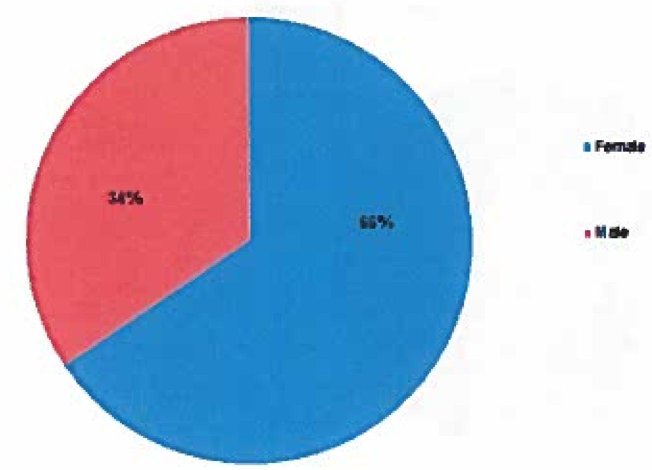


Yes	22
No	39
Grand Total	61



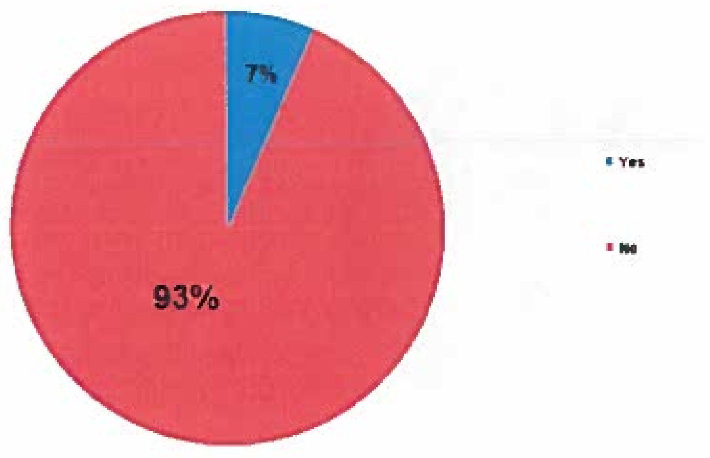
Yes	8
No	49
(blank)	
Grand Total	57

Monitoring Diversity - Gender



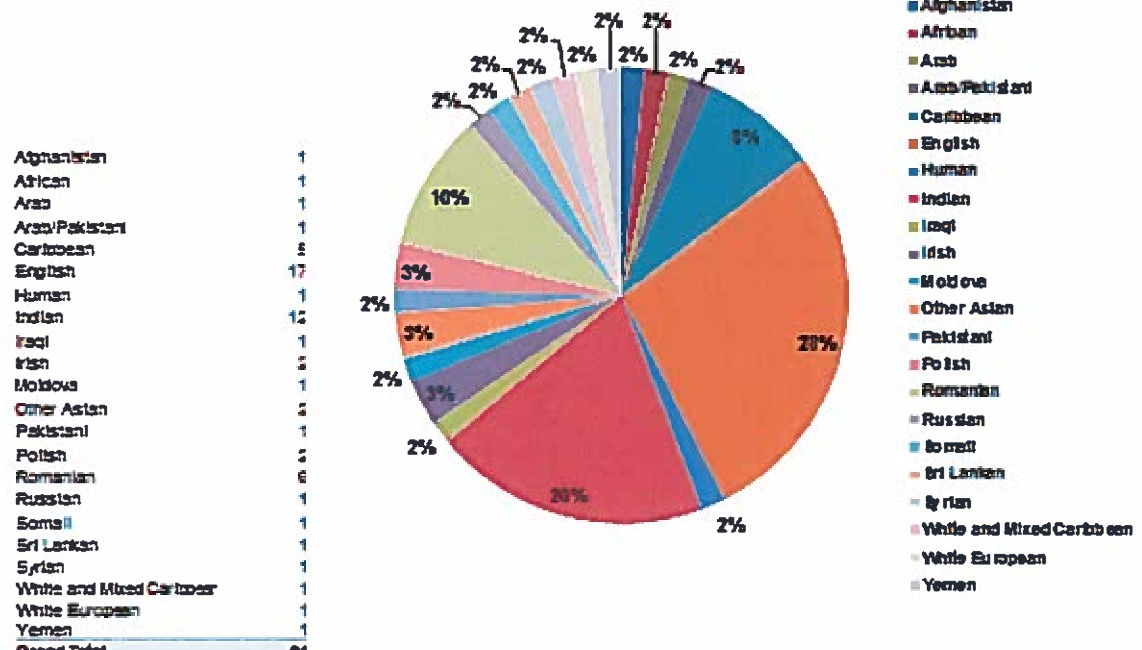
Female	40
Male	21
Grand Total	**61**

Monitoring Diversity - Disability



Yes	4
No	57
Grand Total	**61**

Monitoring Diversity – Ethnic Group



Afghanistan	1
African	1
Arab	1
Arab/Pakistani	1
Caribbean	5
English	17
Human	1
Indian	12
Iraqi	1
Irish	2
Moldova	1
Other Asian	2
Pakistani	1
Polish	2
Romanian	6
Russian	1
Somali	1
Sri Lankan	1
Syrian	1
White and Mixed Caribbear	1
White European	1
Yemen	1
Grand Total	**61**

North West London Collaboration of
Clinical Commissioning Groups

15 Marylebone Road | London | NW1 5JD

ccgfoi@nw.london.nhs.uk

18 May 2015

Dear Mr Standfield,

Freedom of Information request
Ref no: CCG/3194

I am writing further to your Freedom of Information (FOI) request made to the North West London Collaboration of Clinical Commissioning Groups. To note, the Shaping a Healthier Future programme team is hosted by Central London CCG and is a function that covers all 8 CCGs.

I apologise for the delay in responding to your request.

You requested the following:
Under the terms of the Freedom of Information Act, please detail for the following financial years:

2011 – 12, 2012 – 13, 2013 – 14, 2014 – 15 & 2015 to the latest reasonably practicable date,

the amounts spent by all NHS bodies in the North West London Sector on external Consultants in respect of the preparation, design, development, assurance and promulgation of all aspects of the 'Shaping a Healthier Future' programme. Please specify the amount for each Consultancy for each year.

Such Consultancies to include, but not to be limited to, McKinsey, Mott MacdDonald, Coalescence Consulting, Ipsos MORI, the London Communications Agency and PA Consulting.

Please detail the costs, if not included in the foregoing, of any staff seconded from any Consultancy to work with or for any NHS body in the Sector.

I was specifically asked to research this information by the Mansfield Enquiry, to whom I shall direct your response. You may respond by e-mail.

Our response to your request is:
This response covers expenditure on external consultants in respect to the Shaping a Healthier Future programme as incurred by the North West London CCGs (*hosted by Central London CCG*) since April 2013 when the CCGs were formally established.

The CCGs do not hold information relating to the former Primary Care Trusts (PCT) or Strategic Health Authority (SHA) and therefore, cannot provide any cost figures for any previous year before April 2013. Legacy information was passed to the Department of Health which became legally responsible for answering all enquires relating to the historic corporate work for the former PCTs and SHAs. It may be able to assist you with you queries that relate to the former NHS organisations - www.dh.gov.uk and the contact email is informationteam@dh.gsi.gov.uk.

This response covers information held by the North West London CCGs and by the programme team (*as hosted by Central London CCG*). Information of any expenditure by other NHS organisations would be held by those organisations. They are subject to the FOI Act and have their own governance and processes in place. You would need to contact the Trusts direct for any relevant information that they may hold.

Our response data is provided for the financial years of 2013/2014 and 2014/2015. It shows the spending you requested across the Strategy and Transformation Directorate of NW London. We have broken this down by the different programmes and then by the different consultancies.

Strategy & Transformation spend by programme

Work stream title	Total spend 2013/14 £000	Total spend 2014/15 £000
Acute Reconfiguration	5,120	7,138
Communications	358	654
Mental Health		3,218
Primary Care Development	2,602	2,050
Strategy/ Infrastructure	570	2,365
WSIC (Whole System Integrated Care)	3,538	5,148
Total	**12,188**	**20,572**

Strategy & Transformation spend by consultancy

Consultancy	Total spend 2013/14 £000	Total spend 2014/15 £000
Baker Tilly	258	297
Consolidated PR/LCA	358	179
Consortium led by McKinsey & Company		274
Finnamore & Oak Group	344	
Finnamore/ GE Healthcare	576	608
Freshwater UK		200
M&C Saatchi Group		301
McKinsey & Company	3,620	9,964
Methods Consulting Ltd	164	
Mott Macdonald Ltd	59	
PA Consulting	4,074	5,381
Private Public Ltd	676	691
PwC	1,999	1,528
Qi Consulting		1,150
Sky High Technology	59	
Total	**12,188**	**20,572**

If you are dissatisfied with your response you can request an internal review by emailing ccgfoi@nw.london.nhs.uk. This would be conducted by a member of staff not involved in the

original response and the outcome reported to you. Where you feel your request has still not been dealt with properly, you can appeal to the Information Commissioner by writing to: *The Information Commissioner, Wycliffe House, Water Lane, Wilmslow SK9 5AF.*

Further information on the Freedom of Information Act is available at: http://www.ico.gov.uk.

Yours sincerely,

Sarani Tennakoon
Freedom of Information

Smith Peter

From: ColinStandfield@aol.com
Sent: 21 May 2015 22:00
To: casework@ico.org.uk
Cc: ccgfoi@nw.london.nhs.uk; mark.spencer@nhs.net; johnlister@healthemergency.org.uk; Smith Peter
Subject: Re: FOI request [Ref. FS50581534] Clarification of Complaint
Attachments: FOICCG.3194finalresponse.docx

Dear Ms Woodall,

Thank you. My opinion is that whoever is running the programme known as Shaping a Healthier Future is trying to frustrate my efforts to establish how much has been spent, in respect of that programme, on external consultants.

I am dissatisfied with the CCG's response because:

a) it was late;

b) it was a partial response, and I had not been warned at the beginning that they would be unable (or so they said) to provide information for anything spent before April 2013.

First, although SaHF has been represented as an integrated programme, my respondent asserted on 24 March that he could reply only for the conglomeration of CCGs, not for any other NHS bodies: 'Central London CCG hosts the Shaping a Healthier Future programme team on behalf of the other 7 North West London CCGs. The response to your Freedom of Information request will cover the records held by the programme team (and therefore of the NWL CCGs). Our response will explain the information provided. We cannot provide information from other NHS organisations such as Hospital Trusts that were not the responsibility of the programme and any contracting of consultancy services would not have been processed by the programme team.'

This is absurd - the programme has never been divided from the Hospital Trusts; indeed, it relied on a letter of support from all the Hospitals' Medical Directors for its much of its clinical authority. I had also received e-mails recently from a body purporting to be SaHF, whose e-mail address on 23 March was sahf@nw.london.nhs.uk and who sign off:

'Many thanks and kind regards,

Shaping a Healthier Future'

It seems to me that SaHF either has an integrated existence or not. They cannot pick and choose. If it does, as it appears, someone should be answerable for it.

I then waited for 20 days and sent a reminder on 22 April; at 16.58 I had a reply: that the deadline was that day. It was for all intents and purposes overdue, then, especially as the content of the 'reply' was simply a delay: 'I have liaised with my colleagues and the information has been collated. It is currently being double checked and the final response awaiting approval. I am hoping that I will be able to get the response to you by the earliest of Friday 24 April 2015.'

I replied that 20 days was the limit set down in the Act, not 22.

At 16.01 on 30 April I had another apology, that the response was awaiting authorisation for despatch. I made a formal notice of complaint at 16.47, as there was still no response after 26 working days by that date.

On 15 May I complained that 10 working days had elapsed since I had been told that the response was awaiting authorisation. On 19 May a response came, possibly after the intervention of the Medical Director. But it contained information only for the last two complete years of the 5 that I had asked for; that is, 2013/14 and 2014/15. Nothing for 2011/12 or 2012/13 and nothing for the first month of 2015.

This was allegedly because the CCGs had officially come in to being only in April 2013 and they had no historical financial records. I replied that they should have told me that right at the beginning. It appeared that I should now have to find whoever holds these 'legacy' archives at NHS England and start the process all over again. This is unacceptable, and simply a delaying tactic.

I hope this is a sufficient explanation of my frustration. I am attaching the partial response from 19 May; those who have seen it have been astonished at the sums involved, for example £27,000 a day for McKinsey alone last year, for 365 days of that year. It is clear that they wish to disclose no further information, and I believe this frustrates both the letter and the spirit of the Act.

Regards,

Colin Standfield

In a message dated 21/05/2015 08:16:09 GMT Summer Time, casework@ico.org.uk writes:

Colin Standfield
ColinStandfield@aol.com

21 May 2015

Dear Mr Standfield

Your information request to North West London Clinical Commissioning Group (CCG)
Request reference: FS50581534

Thank you for your correspondence of 11 May in which you make a complaint about the above public authority's handling of your request for information. At that point you were dissatisfied that the CCG had not responded to your request.

However, you have subsequently provided us with a copy of an email that you sent to the CCG on 19 May, when it appears to have provided you with a response. We don't have a copy of the CCG's response on our file.

I'd be grateful if you would now clarify the nature of your complaint against the CCG: whether you're dissatisfied with the CCG's response (for example because it's refused to disclose particular information), the length of time it took to respond, or both these matters.

Yours sincerely

Cressida Woodall
Case Officer

The ICO's mission is to uphold information rights in the public interest, promoting openness by public bodies and data privacy for individuals.

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Communication by internet email is not secure as messages can be intercepted

and read by someone else. Therefore we strongly advise you not to email any information, which if disclosed to unrelated third parties would be likely to cause you distress. If you have an enquiry of this nature please provide a postal address to allow us to communicate with you in a more secure way. If you want us to respond by email you must realise that there can be no guarantee of privacy.
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Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF
Tel: 0303 123 1113 Fax: 01625 524 510 Web: www.ico.org.uk

Smith Peter

From: Daly, Councillor Mary <Cllr.Mary.Daly@brent.gov.uk>
Sent: 11 May 2015 11:37
To: Smith Peter
Cc: Tyson, Cathy
Subject: Fwd: Beds at CMH

Dear Peter

On Saturday one gave a graphic account of alleged lack of service/capacity at CMH UCC in the event of a patient collapse claiming a patient had been harmed. Later this was challenged by a representative from Brent CCG claiming there are facilities to manage patients with collapse. The email below where you will note that in addition to A&E at CMH other beds closed as well. Including a CCU needs to be read with a report to Brent Scrutiny Committee on 6th of August
Agenda item 5 where there is a discussion about the nature of Brent UCC and it is described as stand alone. That term needs to be clarified in relation to patients who collapse and need emergency care. Note there is still an intensive care centre there that is the relationship between the centre and the "stand alone" UCC

Yours Sincerely

Mary Daly

Begin forwarded message:

> **From:** "Benson Tina (LONDON NORTH WEST HEALTHCARE NHS TRUST)" <tina.benson@nhs.net>
> **Date:** 26 November 2014 21:29:56 GMT
> **To:** "cllr.mary.daly@brent.gov.uk" <cllr.mary.daly@brent.gov.uk>
> **Cc:** "Gallagher Ursula (BHH CCGS)" <ursula.gallagher@nhs.net>, "Pocklington Chris (LONDON NORTH WEST HEALTHCARE NHS TRUST)" <chris.pocklington@nhs.net>
> **Subject: Beds at CMH**
>
> Hi Mary,
>
> Beds at CMH
> Open beds:
> Gladstone wards 90
> Intensive care and high dependency care 8
> Elective beds 24
>
> Beds not in use
> CCU 8 beds
> Roundwood beds 40
> AE observation ward 10
>
> There are in addition step down recovery trolleys which are fully used.
>
> Happy as always to look at any specific cases.
>
> Regards,
>
> Tina

Sent from my iPad

****
****

This message may contain confidential information. If you are not the intended recipient please inform the
sender that you have received the message in error before deleting it.
Please do not disclose, copy or distribute information in this e-mail or take any action in reliance on its contents:
to do so is strictly prohibited and may be unlawful.

Thank you for your co-operation.

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The use of Brent Council's e-mail system may be monitored and communications read in order to secure effective operation of the system and other lawful purposes.

Smith Peter

From: Daly, Councillor Mary <Cllr.Mary.Daly@brent.gov.uk>
Sent: 11 May 2015 15:59
To: Smith Peter
Subject: Agenda Reports Pack (Public) 24/07/2013, 19.00
Attachments: Public reports pack 24072013 1900 Health Partnerships Overview and Scrutiny Committee.pdf; ATT00001.txt

Dear Peter

Reference was made on Saturday about the fact that A&E at CMH was underused before its closure. You will see in the pack enclosed I think agenda item 6 reports on managing winter pressures included is a report from London Ambulance Service about how they planned to cope with forthcoming winter pressures 2013/4. You will note from the LAS report that they heavily relied on A&E at CMH although it was at that time only open 15 hours per day. There has always been a discrepancy between this evidence and the claims of Brent CCG and NWLH.

The fear is that there is insufficient emergency and secondary care
http://democracy.brent.gov.uk/documents/g2122/Public%20reports%20pack%20Wednesday%2024-Jul-2013%2019.00%20Health%20Partnerships%20Overview%20and%20Scrutiny%20Committe.pdf?T=10

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The use of Brent Council's e-mail system may be monitored and communications read in order to secure effective operation of the system and other lawful purposes.

Public Document Pack

Health Partnerships Overview and Scrutiny Committee

Wednesday 24 July 2013 at 7.00 pm
Board Room 7&8 - Civic Centre, Engineers Way, Wembley HA9 0FJ

Membership:

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

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

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

The press and public are welcome to attend this meeting

recycle for Brent

1903

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members

Item		Page
1	**Declarations of personal and prejudicial interests**	
	Members are invited to declare at this stage of the meeting, any relevant financial or other interest in the items on this agenda.	
2	**Deputations (if any)**	
3	**Minutes of the previous meeting**	1 - 10
4	**Matters arising (if any)**	
5	**Brent CCG: Commissioning Intentions**	11 - 34
	The Health Partnerships Overview and Scrutiny Committee will be aware that from April 2013, Brent Clinical Commissioning Group is responsible for the commissioning of health services in Brent. In view of this the CCG has been asked to provide details of its general approach to commissioning and its immediate commissioning intentions.	
	Ward Affected: All Wards — ***Contact Officer:*** Mark Burgin, Policy and Performance Officer, Cathy Tyson, Strategy, Partnerships and Improvement Tel: 020 8937 1045 mark.burgin@brent.gov.uk, cathy.tyson@brent.gov.uk	
6	**Emergency Services at North West London Hospitals**	35 - 58
	Members of the Health Partnerships Overview and Scrutiny Committee will already be aware of the problems facing Northwick Park Hospital's Accident and Emergency department and the recent risk summit that resulted from concerns over its ability to provide a safe and adequate service	

Ward Affected: All Wards

Contact Officer: Mark Burgin, Policy and Performance Officer, Cathy Tyson, Strategy, Partnerships and Improvement
Tel: 020 8937 1045
mark.burgin@brent.gov.uk,
cathy.tyson@brent.gov.uk

7 Pathology Incidents: Update — 59 - 66

In June, following the serious incidents around pathology test results and the subsequent Root Cause Analysis Investigation, the Health Partnerships Overview and Scrutiny Committee were presented with an Action Plan designed to address the issues raised in the investigation report

Ward Affected: All Wards

Contact Officer: Mark Burgin, Policy and Performance Officer, Cathy Tyson, Strategy, Partnerships and Improvement
Tel: 020 8937 1045
mark.burgin@brent.gov.uk,
cathy.tyson@brent.gov.uk

8 Central Middlesex Hospital UCC Incident: Update Report — 67 - 70

This report provides an update on the patients/cases that needed to be contacted and followed up as a result of the incident, the changes in processes/procedures and an update on staffing, which was one of the key issues highlighted by the investigation.

Ward Affected: All Wards

Contact Officer: Mark Burgin, Policy and Performance Officer, Cathy Tyson, Strategy, Partnerships and Improvement
Tel: 020 8937 1045
mark.burgin@brent.gov.uk,
cathy.tyson@brent.gov.uk

9 Healthwatch Progress Update — 71 - 76

This report outlines the progress that Healthwatch Brent (HWB) has made to date in getting “up and running” and on engaging with the public, community organisations and decision makers to build long term relationships.

Ward Affected: All Wards

Contact Officer: Mark Burgin, Policy and Performance Officer, Cathy Tyson, Strategy, Partnerships and Improvement

Tel: 020 8937 1045
mark.burgin@brent.gov.uk,
cathy.tyson@brent.gov.uk

10 Health Partnerships Overview and Scrutiny work programme 2013-14 77 - 80

The work programme is attached.

11 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.

12 Date of Next Meeting

The next scheduled meeting of the Committee is on 8 October 2013.

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

- The meeting room is accessible by lift and seats will be provided for members of the public.

MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
Tuesday 11 June 2013 at 7.00 pm

PRESENT: Councillor Daly (Chair), Councillor Hunter (Vice-Chair) and Councillors Colwill, Harrison, Hector, Hossain and Ketan Sheth

Also present: Councillor Cheese, Councillor Hirani (Lead Member for Adults and Health) and Councillor Jones.

An apology for absence were received from: Councillor Leaman

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

Councillor Ketan Sheth declared an interest as the Vice Chair of Central and North West London NHS Foundation Trust, however he did not view this as a prejudicial interest and remained present to consider all items on the agenda.

2. **Minutes of the previous meeting held on 19 March 2013**

RESOLVED:-

that the minutes of the previous meeting held on 19 March 2013 be approved as an accurate record of the meeting, subject to the following amendments:-

- page 2, last paragraph, second line, add 'not' after 'could'.
- page 5, last paragraph, third line, replace 'LES' with 'LAS'.
- page 6, second paragraph, sixth line, add 'hospital' before 'care'.

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

None.

4. **Pathology Service - incident and investigation**

Jo Ohlson (Brent CCG Chief Operating Officer) introduced the final report in respect of the incidents and subsequent investigation for pathology services in Brent and Harrow. Pauline Johnson (Interim Head of Quality and Safety, Brent CCG) then drew Members' attention to the six actions listed in the resulting action plan as set out in the report. Dr Patel, chair of the Root Cause Analysis (RCA), was also present to respond to members' questions.

Members then discussed the item and raised a number of issues. One member commented that the incidents may not have happened had there been more staff with the necessary expertise and the number of consultants available was queried. Further comments were sought in respect of the reference in the report to GPs not attending working group meetings and were steps being taken to ensure that they

did. It was acknowledged that there had clearly been communication issues, in particular a lack of cascading information down to staff at all levels, with CROs not sure who was responsible for ensuring this was happening and it was asked whether this had now been addressed. An update on the communications strategy was also sought. In relation to transportation of samples, it was enquired why it had not been specified in the service specification that samples be transported at room temperature, despite clinical opinion stating they should. Information was sought with regard to future arrangements for risk assessments and would this include involvement from GPs. The committee asked for an explanation of the process for when laboratories presently issued tests. A member commented that the incident and the RCA had flagged up issues that were also national ones and it was asked whether there had been a formal response to this.

A member acknowledged that one of the main reasons the pathology contract had undergone a procurement exercise was to test if the market could produce potential savings. However, although this was necessary, there was no evidence to suggest that a proper risk assessment had been undertaken and it was asked what had been learnt from this. It was enquired whether both the previous and current provider of pathology services was clinically accredited and what date had they been confirmed as being so. It was commented that in the Francis report, it had been stated that consultants had been commissioned to advise hospitals as opposed to CCGs and it was asked how expert advice had been sought during the procurement. Members asked what the total costs of the incident had been and what steps were being taken to address management and leadership issues in respect of the CCG and Central Middlesex Hospital. It was commented that the procurement of the pathology contract had been undertaken without the knowledge of GPs and she asked what steps were being taken to keep them informed.

In reply to the issues raised, Pauline Johnson advised that although consultants were being used at around the time the incident happened, some of them had not been able to devote as much as time as had been hoped. In respect of GPs being absent from meetings, initially there had been two GP representatives, however they each had a heavy workload, so the membership allocation for GPs had been extended to increase the likelihood of GP presence at future meetings. Pauline Johnson acknowledged that there had been clinical advice to ensure samples remained at room temperature during transportation and although this had not been specified in the contract, this area was to be re-visited. She stated that a risk assessment would be undertaken in respect of any future procurement exercises. Members heard that there was a communications strategy, however this was presently being reviewed, and GPs and TDL were being involved in this. The review was due to finish at the end of July 2013 and a new communications strategy would follow. Pauline Johnson informed the committee that when a laboratory wanted to issue tests, the Director of Compliance at TDL would report to herself and SROs. If the tests were urgent, the results would be sent to the GP on the same day, whilst all others would be available within either 48 hours or five working days. TDL were also formulating a response in respect of issues that had been identified nationally. Pauline Johnson advised that both the previous and present pathology services provider was clinically accredited and it was noted that TDL had recently revised the accreditation process. In terms of consultants providing advice, for hospitals this was in providing on-going support in respect of quality assurance. The CCG did not have automatic right of access to consultant advice, however they could still make such a request.

Jo Ohlson added that TDL produced a regular newsletter and this was being monitored for the quality of the information it was providing. She acknowledged that there had not been adequate consultation with GPs during the procurement and this had been identified and addressed by the RCA and action plan. The committee heard that information on key changes and developments, such as procurement exercises, would go the lead doctor and practice manager at each practice and this issue would be looked at further. Many lessons had been learnt as a result of the RCA and it was acknowledged that the pathology service had not been sufficiently clinically robust. There had been a risk assessment in terms of the service, although a separate one had not been undertaken specifically in terms of the procurement, although there would be for future ones. With regard to costs of the incident, these had not been quantified as such and would be difficult to do so. The costs would be incurred by the GP practices in using resources to contact patients, whilst there were also delays in receiving test results. However the RCA and action plan had been put together to ensure such an incident did not recur.

Dr Patel confirmed that there was now a minimum of five GP representatives for meetings with the CCG. With regard to issues raised nationally as a result of the incident, he informed members that Ealing Hospital NHS Trust had advised its GPs about this. Rob Larkman (NHS North West London) added that the way CCGs operated was fundamentally different to PCTs and that steps would be taken to ensure grassroots input from GPs. A key priority was to develop leadership and managerial skills within the CCG, whilst the procurement of the pathology service aimed to ensure high quality services at better value for money. Tina Benson (Director of Operations, North West London Hospitals Trust) informed the committee that TDL were responsible for the laboratory contracts and the CCG in managing the acute services contract. Dr Sarah Basham (Brent GP) added that there had been a long history of disseminating information to GPs in Brent and she added that lead GPs, who were responsible for cascading information to other staff, had done this well in Brent.

The Chair felt that concerns for pathology services remained, with a number of serious issues needing further consideration. It was of the utmost importance that a safe and effective pathology services was provided and there was evidence to suggest that this was not completely the case. The Chair requested that an update on this item be provided at the next meeting on 24 July 2013 to show evidence of progress and that the committee would also like to look at the CCG's procurement processes in more detail.

5. **Emergency Services at Northwick Park and Central Middlesex Hospitals**

Tina Benson presented the report and stated that the North West London Hospitals (NWLH) Trust had held a number of discussions, including a risk summit, with staff and other stakeholders to explore ways of reorganising emergency services across both Central Middlesex Hospital (CMH) and Northwick Park Hospital (NPH), to make best use of staff and other resources. A project board had been created and set up three workstreams underpinned by a number of projects, which will require the support of all key health and social care partners to deliver:-

- Increasing bed capacity at NPH
- Maximising capacity at CMH

- Moving more orthopaedic work to CMH

Tina Benson explained that for CMH, the changes in particular focused on moving recovery and rehabilitation care to the hospital for patients who had received surgery for hip fractures. It was also proposed to have an enhanced recovery programme. CMH would sustain an acute medical intake to treat patients with a medical problem, whether they arrived by ambulance or through GP referral, at any time day or night. Currently ambulance arrivals were not accepted out of hours, but this was being discussed with the London Ambulance Service. With regard to NPH, additional bed space on existing wards, including a short term change of 11 private beds on Sainsbury Ward to NHS beds would be undertaken. It was also intended to expand the ambulatory care unit and surgical assessment unit on Fletcher Ward to include the STARRS assessment lounge to accommodate a further 10 to 15 patients a day and move STARRS to focus on the Emergency Department to prevent unnecessary admissions. Other measures included patients in need of a surgical assessment not necessarily having to be assessed in the Emergency Department first and being referred directly to the relevant consultant depending on their condition. Work had also started on a new Emergency Department and state-of-the-art operating theatres at NPH.

During discussion, clarification was sought in respect of acute medical intake at CMH and whether staff numbers would be increased in order that it could remain open at night and was there the budget to be able to do this. Moreover, would the hours be extended at CMH in the event of additional staff being recruited in any case and what was the recruitment policy for the hospitals. Comments were sought as to whether the patient footfall remained low at CMH and was this an attributable reason for the difficulty in recruiting staff there. Members also noted the concerns of residents to the ongoing evening closure of the Accident and Emergency (A and E) department at CMH and it was enquired what was being done to improve communication with residents in the area to keep them informed of services available at the hospital. It was also asked if A and E targets at CMH were being met and were residents in the area visiting A and E less, and if so, where were those who were in a serious condition being treated. Furthermore, was there an increase in the number of patients being taken to CMH by ambulance and was there an issue between patients arriving by ambulance and waiting times at hospitals in the borough.

A member queried whether dealing with patient numbers at NPH remained a serious challenge. Further explanation was sought in respect of the risk summit, including what they were, why they had happened and why had they not been mentioned at the previous meeting of this committee. A member asked if the council had been informed about the outcome of the risk summit. Details were also asked about the inspection that had been carried out in November 2012 and what had instigated it. Another member, in noting the need to improve out of hospital care, sought an update on progress in this area. The number of cancellations of planned surgeries in the last three months was also asked.

With the agreement of the Chair, Councillor Cheese addressed the committee. Councillor Cheese asserted that the London Ambulance Service was diverting patients to CMH because NPH was so busy, and because less services were available at CMH, this was putting patients in the south of the borough at risk and he asked what was being done to address this.

In reply to the issues raised, Tina Benson advised that discussions were underway with regard to acute services at CMH, with one of the suggestions being that patients will be admitted to the hospital at night irrespective of whether the A and E unit was open or not. She confirmed that an additional consultant had been recruited at CMH, however there remained nine vacancies. Although patient numbers remained a challenge for NPH, performance had improved and the waiting times in May 2013 had been met. However, patient demand was always greater in winter and every effort was being made to improve waiting times next winter in comparison with the last. Tina Benson advised that the risk summit looked at all the risks the health economy posed for emergency care and there had been a number of workshops focused on performance, risks to patients and the patients' experience. It was noted that the borough based Urgent Care Board now led the response to the risk summit and workshops. With regard to the inspection of A and E in November 2013, this was as a result of a complaint received about a patient's experience and featured inspections carried out both during the day and night. The inspection had resulted in a favourable report and Tina Benson agreed to provide members with information on this. An audit of 40 patients waiting at A and E had also been undertaken and this had shown that all of them had received the care and treatment required and Tina Benson added that this information could be made available to members if they so wished. She also agreed to undertake to provide information on the number of cancelled planned surgeries over the last three months.

Tina Benson advised that there was not sufficient staff numbers to extend A and E hours at CMH, however if extra staff were recruited, this could be looked at again. The committee heard that staff were recruited as employees of the Trust as opposed to a specific hospital. A budget was currently available to increase staff numbers at CMH, however it needed to be noted that patient numbers particularly in respect of A and E continued to fall. The committee was informed that CMH A and E was meeting its waiting target, although it did see a considerably lower volume of patients than NPH and St Mary's Hospital, which found it easier to recruit staff as it was a major trauma centre. Tina Benson confirmed that presently there were 18 private bed spaces at NPH, although 11 of these were to be reallocated to the Trust. Tina Benson advised that data sharing with partner agencies was taking place to look at specific needs of patients, particularly in relation to out of hospital care.

Jo Ohlson added that prevention of unnecessary visits to hospitals was a key driver in respect of improving out of hospital care and STARRS played an important role in this, with hospital patients referred to them where appropriate. The Willesden Centre for Health and Care also provided therapy weekends and there was a robust protocol in place as to when patients could be discharged from hospital. With regard to A and Es, Jo Ohlson advised that the excellent clinical service required of them was only feasible at NPH, as CMH lacked the necessary support services. The Urgent Care Centre (UCC) also operated on a 24/7 basis at CMH and around 85% of cases were admitted to it. It was noted that the UCC could also refer patients to the appropriate medical practitioners.

David Cheesman (Director of Strategy, NWLHT) added that the UCC had been very successful since opening at the CMH and had exceeded expectations. He also advised that the composition of health services was being reviewed at macro

level through the Shaping a Healthier Future Programme. He acknowledged that explaining the health services available was complex, however it was intended to increase utilisation of each hospital.

Pauline Cranmer (Performance Improvement Manager, London Ambulance Service: West London) advised that the London Ambulance Service was working with UCCs to identify the most appropriate locations to send patients to. During April 2013, around 2,800 patients had been sent by ambulance to NPH, and 670 to CMH. Pauline Cranmer advised that waiting times in A and Es was a London-wide issue, due to increases in patient demand and in acute cases. She added that for critically ill patients, these would be categorised as blue light calls and the hospital concerned would be duly informed so that staff were waiting at the entrance of the hospital to attend to the patient as soon as they arrived.

Phil Porter (Interim Director of Adult Social Services) confirmed that while he had not attended the risk summit, he was aware of the outcome and the council was represented on the Urgent Care Board that was overseeing the three work streams.

The committee noted that the council was informed of the outcome of the risk assessment on 6 March 2013.

The Chair felt that the waiting times for A and E patients were not acceptable at present, whilst she also commented that there needed to be more clarity as to where residents would be treated depending on their condition. She requested an update on A and E, the London Ambulance Service, treatment provided to patients at home and clarification with regard to services at CMH for the next meeting on 24 July 2013.

6. **111 telephone number - service implementation**

Jo Ohlson presented the report and confirmed that the 111 service went live on 26 February 2013, its launch being delayed as a result of the findings of the risk assessment. The launch in February was a 'soft launch', meaning the service was only available for patients contacting GPs on the out of hours telephone line. Since the launch, there had been some performance concerns, particularly in respect of performance over the Easter Bank Holiday weekend, both locally and nationally. This had led to a performance notice being issued to the contractor, Harmoni, and a remedial action plan had been put in place. Since Easter, performance had improved with performance meeting or being very close to the required standard of answering calls in 60 seconds and call abandonment. However, Jo Ohlson added that the performance indicator of call backs to patients within ten minutes of their initial call remained a challenging one, and actions such as queue prioritisation were put in place whilst underlying issues in respect of staff numbers and rotas were addressed. Any call backs talking longer than an hour were investigated. There had also been deemed to be a lack of professionals to transfer the calls to which had led to the number of call backs required increasing. Jo Ohlson advised that NHS London would decide when the full service would be launched in London, although 111 performance was better than the national average.

During discussion, Members sought clarification with regard to the differences between the 111 service and 999 service and what issues presently remained unresolved with the 111 service.

In reply, Richard Penney (111 Project Manager for North West London) advised that the 999 service was for life-threatening situations, whilst the 111 service was for all other urgent and non life-threatening situations. The 111 service helped direct callers where they were not sure who to contact and there was also direct access between 111 and 999 and vice versa. Richard Penney added that a protocol had been agreed between the 111 service and the London Ambulance Service. He advised that the problems the 111 service had experienced were not to do with how the service operated, but in meeting a whole range of standards and issues such as a lack of professional advisers had affected the ability to meet some of these. However, following the problems experienced during the Easter Bank Holiday weekend, meetings with providers had led to a recovery plan and the introduction of a number of measures to address these issues. Richard Penney explained that the call back target was a particular problem at national level and there still remained challenges to overcome, however Harmoni were addressing these and were also recruiting new staff.

The Chair requested details of the training programme for 111 service advisers, the remedial action plan and progress with regard to the key indicators performance at the next meeting on 24 July 2013.

7. **North West London Hospitals/Ealing Hospital merger**

David Cheesman advised that there were no changes to the timescale of the merger since the last update to the committee. He confirmed that the financial aspects of the business case were to be finalised.

8. **Colposcopy Services at Central Middlesex Hospital**

Tina Benson presented the report which outlined the reasons for relocating the colposcopy service at CMH to NPH on a temporary basis from 1 April 2013. This had been done as there had remained only one colposcopist at CMH following the retirement of their colleague and so the relocation was necessary in order that they had retained support and to not be left working in isolation, which would be against the national screening programme's statutory clinical guidelines. Members noted that the Trust was in the process of training one of its gynaecology specialist nurses to take over the vacant colposcopist position and they would be appointed to this post, subject to meeting the required competencies.

During discussion, a member commented that their spouse had received good service at NPH. Another member commented that the Did Not Attend rates were high and were they getting worse. She also noted that a four week wait to be seen following a smear test result was long and what steps were being taken to reduce this.

In reply, Tina Benson advised that a lot of work was being focused on explaining to patients of the importance of taking smear tests to identify conditions such as cancer and to explain the procedures involved in the test. Members heard that the waiting times for smear test results were nationally set standards and four weeks was only the target, however if the smear test had conclusively identified cancer, patients would be seen within two weeks.

9. **Public Health transfer update**

Imran Choudhury (Interim Director of Public Health) confirmed that there had been a successful transfer of staff from the NHS to the council and staff were in the process of being embedded and getting used to the new working culture.

Members commented of the need to receive regular reports on how public health services were working.

Phil Porter (Interim Director of Adult Social Services) added that the first meeting of the Health and Wellbeing Board would be responsible for overseeing the response to the broader issues involved in improving public health services.

10. **Sexual and Reproductive Health Services in Brent**

Members had before them a report on sexual and reproductive health services in Brent. A member commented that the mention of sexual health prevention in the report was perhaps inappropriate and misleading and should be re-termed. It was also enquired whether there was any risk to the contracts for the pan-London HIV prevention services.

In reply, Imran Choudhary advised that pan-London HIV prevention services were not at risk, however there had been some concerns with regard to the robustness of these services so these were being reviewed by the London Borough of Lambeth, the lead borough on this matter. He acknowledged the need to reconsider the term sexual health prevention.

11. **Health Partnerships Overview and Scrutiny work programme 2013-14**

The Chair drew members' attention to the committee's work programme. In respect of commissioning intentions for the 24 July 2013 meeting, she stated that issues concerning CCG procurement, such as how they operated, the main principles and priorities and who was consulted, be explained. In addition, the current procurement programme should also be outlined and explained in the context of the Francis report, the needs of services and the community. The Chair also advised that a report on how Health Watch was working would also be put to the committee.

12. **Any other urgent business**

Dismissal of Deputy Borough Director for Brent NHS

Rob Larkman updated members in respect of the recent dismissal of the Deputy Borough Director for Brent NHS, Craig Alexander, following the revelation that he had a previous conviction for armed robbery. Members heard that he had been recruited through an agency, who were not required to undertake Criminal Records Bureau/Disclosure and Barring Service checks. Craig Alexander had not disclosed the criminal offences during his application and he had provided satisfactory references, whilst his work performance had also been satisfactory. Rob Larkman explained that as soon as the criminal offences were known, an immediate review was undertaken and Craig Alexander was swiftly dismissed. A report had also subsequently gone to the Governing Body making various recommendations in

respect of employing agency staff. The recommendations would be reported in a public meeting.

The committee enquired whether the police had provided any advice in respect of the case and could assurances be given to the person who had bought Craig Alexander's background to the attention of Brent NHS.

In reply, Jo Ohlson advised that NHS Protect were involved in the case and were advising other bodies accordingly. She gave her assurances in respect of the member of staff who had first highlighted the case.

The Chair requested that the number of agency staff in the CCG and the total expenditure on them be provided at the next meeting of the committee on 24 July 2013.

13. **Date of next meeting**

It was noted that the next meeting of the Health Partnerships Overview and Scrutiny Committee was scheduled to take place on Wednesday, 24 July 2013 at 7.00 pm.

The meeting closed at 9.15 pm

M DALY
Chair

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Health Partnerships Overview and Scrutiny Committee
24 July 2013

Report from Strategy, Partnerships and Improvement

For Action

Wards Affected: ALL

Brent CCG: Commissioning Intentions

1.0 Summary

1.1 The Health Partnerships Overview and Scrutiny Committee will be aware that from April 2013, Brent Clinical Commissioning Group is responsible for the commissioning of health services in Brent. In view of this the CCG has been asked to provide details of its general approach to commissioning and its immediate commissioning intentions.

1.2 The CCG report outlines:

- the CCG's corporate vision, objectives and local priorities;
- structure, governance and decision making;
- 2013/13 budgets;
- QIPP plans;
- the CCG's approach to procurement and procurement regulations;
- services where procurement is planned (or is already in progress);
- partnership working;
- the role of the NW London Commissioning Support Unit.

1.3 The second report outlines the CCGs consultation intentions for the patients and public about planned changes to the commissioning of the following services:

- Musculoskeletal;
- Rheumatology;
- Trauma and Orthopaedics;
- Gynaecology.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to consider the report and question officers on its overall approach to commissioning and its decision making process and on the reasons for its decision to make changes to the services that it is recommissioning.

2.2 The Health Partnerships Overview and Scrutiny Committee is further recommended to ask the CCG to return at an appropriate date to provide full details of its

commissioning intentions for musculoskeletal, rheumatology, trauma and orthopaedics and gynaecology services as part of its requirement to consult the committee.

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NHS

Brent
Clinical Commissioning Group

Brent CCG's Commissioning Intentions

Vision

- Vision underpinning our approach to commissioning healthcare is our golden thread

  Working with the assets of our very diverse and mobile population, NHS Brent Clinicians, with partners, are commissioning new forms of high quality, appropriate, accessible, integrated health and social care provision which will reduce inequalities, improve the population's health and healthcare outcomes and provide best value.

- We will do this in partnership with patients, the public, our partners, providers and other stakeholder groups.

- Priorities - developed and agreed our priorities with the CCG Governing Body, the Health and Wellbeing Board, Links, CVS and members of the general public so that strategic priorities:

  – Are based on a shared vision with local partners and communities about the priorities for local services;
  – Contribute to the wider vision for communities shared with partner organisations in Brent;
  – Align with and support the delivery of the Health& Wellbeing Strategy;
  – Give a focus for the work of our established integrated commissioning arrangements with Brent Council;
  – Integrate local planning with Brent Council to enable local resources to have greater impact;
  – Enable, where appropriate, integration of services/ pathways with those commissioned by others; and are
  – Align with Shaping a Healthier Future.

CCG Corporate Objectives 13-14

Brent
Clinical Commissioning Group

- The CCG's corporate objectives for 2013-14 are aligned to the NHS Outcomes Framework and the CCG's Operating Planning Toolkit available on: http://www.brentccg.nhs.uk/media/4317/Brent%20CCG%20Operating%20Plan%20Toolkit%20V5%2028%20March%202013.pdf

- Our corporate objectives for 2013-14 include:

  - Objective 1 - Implement Brent's Health and Well Being Strategy
  - Objective 2 - Undertake meaningful engagement with patients and carers
  - Objective 3 - Develop primary care services and commission services to prevent people from dying prematurely
  - Objective 4 - Develop primary care and commission services to enhance the quality of life for people with long term conditions
  - Objective 5 - Helping people to recover from episodes of ill health or following injury
  - Objective 6 - Ensuring people (patients and carers) have a positive experience of
  - care
  - Objective 7 - Treating and caring for people in a safe environment & protecting them from avoidable harm
  - Objective 8 - Implementing QIPP & investment programme 2013/14 & meeting financial duties
  - Objective 9 - Commissioning Development and Collaboration

- Full detail of work streams underpinning each of the corporate objectives are available on the Brent CCG Website http://www.brentccg.nhs.uk/

CCG Local Priorities

NHS
Brent
Clinical Commissioning Group

- We have selected three local priorities to focus on in Brent (see operating plan on: http://www.brentccg.nhs.uk/media/4317/Brent%20CCG%20Operating%20Plan%20Toolkit%20V5%2028%20March%202013.pdf

- The selection of these priorities was based on our objectives of:

  - Reducing health inequalities
  - Improving access to primary care
  - Improving outcomes for people with learning disabilities

- Our three local priorities include:

  - Health checks for those aged 40-70 who are at risk of CHD
  - Annual health checks for people with learning disabilities
  - Improved access to GP services

Commissioning Process Overview

Brent
Clinical Commissioning Group

JSNA, needs assessment, national priorities and planning guidance

START

Analyse & plan

Community engagement to identify needs and aspirations

Public engagement to develop priorities, strategies and plans

Making it happen

Patient and carer engagement to monitor services

Patient and carer engagement to improve services

Patient, carer and public engagement to procure services

Deliver & improve

Design pathways

Specify & procure

All Year Round

- PPG Meetings
- EDEN Committee
- Service User Groups

Quarter One – (April to June)

Inform and consultation priorities:

- Dementia Pathway – user groups/specific Dementia user group
- Learning Disability Priorities – LD Big Health Check Day
- GP Locality Services – patient surveying on current access to service

Quarter Two – (July to Sept)

Consultation and engagement for:

- **Planned Care Outpatients** – Service Specifications for Gynaecology, Trauma & Orthopaedics, Rheumatology & MSK
- Patient Representation on procurement scoring panel

Quarter Three – (Oct to Dec)

Consulting and engagement of:

Integrated plan and commissioning intentions through Health Partner Forums and other applicable stakeholder groups

Quarter Four – (Jan to March)

Governance – Inform & Engage:

- 15/16 Commissioning Cycle

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Commissioning Decisions

Brent
Clinical Commissioning Group

- The majority of contracts are rolled forward each year in line with DH/NHS England Planning guidance

- Adjustments for QIPP (Quality, Innovation, Prevention and Productivity) are embedded within contracts/budgets for individual service lines where this is possible

- Contracts/budgets are also adjusted for any investments arising from planned service changes or national planning guidance, e.g. dementia

- Examples include acute contract activity for the contract being adjusted to reflect a planned reduction in activity arsing from re-provision in a community setting, e.g. paediatric epilepsy

- Drivers for procurement include:
  - Poor provider performance which has been identified through quality and safety routes or via patient and public engagement
  - Opportunity for commissioning more innovative models of care
  - Opportunity for providing services closer to home
  - National and local priorities to improve quality of care for patients
  - Potential for achieving better value for money

Decision Making and Involvement

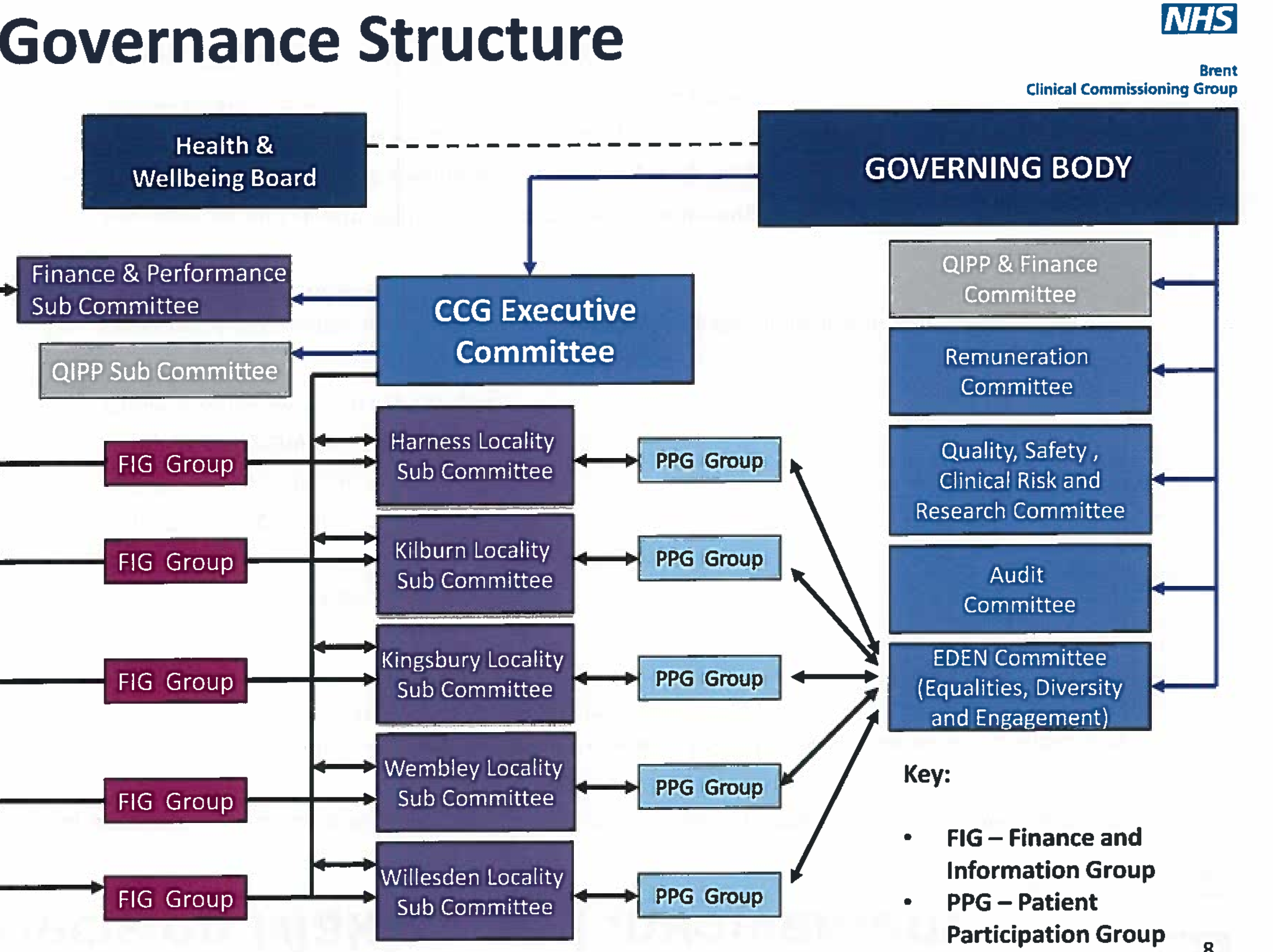
Brent
Clinical Commissioning Group

- Our approach to decision making about commissioning services is embedded in our governance structure

- The CCG Executive , which is accountable to the Governing Body, is responsible for the strategic and operational management of the CCG and comprises:
  - CCG's clinical chair
  - GP locality representatives
  - Chief Officer
  - Chief Finance Officer
  - Chief Operating Officer
  - Director of Quality and Safety
  - Director of Delivery and Performance

- The involvement of patients and the public in commissioning decisions is embedded within our governance structure throughout every level:
  - Lay member and Health Watch representation on Governing Body
  - The EDEN Committee comprising both locality representatives and community representatives
  - Five locality PPGs (Patient Participation Groups)
  - Health Partners Forum – public meetings three times a year
  - Service user and carer engagement on specific commissioning initiatives

Governance Structure



Key:

- FIG – Finance and Information Group
- PPG – Patient Participation Group

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Commissioning Budgets

Brent
Clinical Commissioning Group

Budgets	Opening budgets 2013/14 £m
Acute	222.0
Mental Health	41.5
Continuing Care	13.5
Community (inc Primary Care LES)	45.6
Prescribing	35.4
Estates & Other Corporate	7.8
CCG TOTAL	**365.8**
Contingency & Reserves	2.0
QIPP Re-provision	3.1
2% non-recurrent headroom	8.0
TOTAL	**378.9**
ALLOCATION	404.9
Surplus/deficit	26.0

Acute Budgets Summary

Brent
Clinical Commissioning Group

Acute Budgets	Budget Value £m
North West London Hospitals NHS Trust	98.2
Imperial College Healthcare NHS Trust	59.1
Royal Free NHS Trust	15.8
Other NHS Acute Contracts (smaller values)	47.2
Specialist Commissioning (transferred to NHS England's Specialist Commissioning)	(31.5)
Non NHS Acute Contracts (BMI and Inhealth Diagnostics)	6.3
London Ambulance	9.7
Non Contracted Activity (generally out of area)	2.9
Urgent Care Centres and Walk In Clinics	5.4
High Cost Drugs	0.6
Other (including investment for 18 weeks, winter planning and readmissions)	8.3
Total Acute Budgets	222.0

North West London Hospitals, Imperial, Royal Free and other NHS Acute contract values are pre-reduction for the value of Specialist commissioning services.

Mental Health Budgets Summary

Brent
Clinical Commissioning Group

Mental Health Budgets	Budget Value £m
CNWL	33.9
West London MH	0.4
Barnet, Enfield & Haringey MH	0.6
Camden & Islington MH	0.4
Tavistock & Portman	0.1
Non-contracted Activity	0.7
Dementia investment	0.9
Voluntary sector contracts	0.5
Child & Adolescent Mental Health	1.1
IAPT	0.4
Learning Difficulties	2.3
Mental Capacity Act	0.1
Total Mental Health Budgets	41.5

Community (incl. Primary Care LES) Budgets Summary

NHS
Brent
Clinical Commissioning Group

Community (including Primary Care LES) Budgets	Budget Value £m
Ealing ICO	19.8
CLCH	0.4
CNWL	0.2
Improving Breast Screening Rates	0.2
HIV Care & Support	0.4
Children & Families	0.4
Joint Finance - Community	1.3
NHS 111	0.5
Outer NWL ICP	1.1
Case Management	0.2
Self Care project	0.4
TB project	0.2
Integrated Nursing	0.5
Diabetes	0.3
Re-ablement	1.8
Other Community Services	2.2
Carers	0.8
Hospices	1.1
STARRS	4.4
Palliative Care (Pembridge)	1.2
Out of Hours	0.2
Local Enhanced Services (LES)	6.4
Primary Care Schemes / Projects	1.7
Total Community Budgets	45.6

QIPP Plans

Brent
Clinical Commissioning Group

- Our QIPP plans are developed in collaboration with all providers e.g. Acute, Community and Mental Health

- Plans will enable the CCG to invest in other priority areas to achieve improved health outcomes for Brent patients
- The anticipated benefit realisation for QIPP in 2013-14 is £11.5m – approximately 2.75% of the overall CCG budget

- This year's QIPP plans focus on planned care with a view to moving more services into the community

- This is in line with NHS NWL *Shaping a Healthier Future* and our local *Out of Hospital* Strategies

- So why are CCG delivering a QIPP plan when they are in a strong financial position?
  - to enable investments in primary and community services to support more proactive management of patients in networks of GP practices who are supported by community teams to achieve better health outcomes for patients

CCG Procurement Regulations

Brent
Clinical Commissioning Group

- CCGs will secure services that they commission in three broad ways:

    1. through the contracts with existing providers that they have inherited from PCTs and through future variations in those contracts;

    2. through enabling patients, when they are referred for a particular service, to choose from Any Qualified Provider (AQP) that wishes to provide the service;

    3. through tendering for a new or replacement service, i.e. identifying the single exclusive provider or group of providers that will be chosen to provide that service.

- As a public body, a CCG will need to adhere to legislation that governs the award of contracts by public bodies, including the Public Contracts Regulations 2006, and will need to satisfy the obligations of transparency, equal treatment and non-discrimination set out in the regulations.

- CCGs will also need to comply with regulations to be implemented under section 75 of the Health and Social Care Act2, which will place requirements on commissioners to ensure that they adhere to good practice in relation to procurement, do not engage in anti-competitive behaviour, and protect and promote the right of patients to make choices about their healthcare

- Under the new regulations, NHS money can only be legally spent through one of the two permitted competitive markets, AQP or competitive tendering, and any other way to arrange services is now illegal (except for the contract renewals permitted for previously tendered contracts).

Current and planned procurement

To achieve our strategic aim of better care closer to home, in 12-13 we re-procured outpatient care for

- Cardiology
- Ophthalmology

In 13-14 we have given notice to existing providers about procurement of:

- Musculoskeletal Outpatient Services
- Gynaecology Outpatient Services
- Disease Modifying Anti Rheumatic Drugs (DMARD)
- Community Phlebotomy services

Improving Patient Outcomes and Safety

- Looked After Children and Community Paediatric services

Engagement and Inclusion

NHS
Brent
Clinical Commissioning Group

- The CCG is required to effectively engage and involve a wide variety of stakeholders and partners.

- CCGs are also required to engage with national and regional regulatory bodies such as the Trust Development Agency (TDA) and NHS England regional team for commissioning plans that impact a health economy, e.g. A&E performance, Shaping a Healthier Future

- As part of its local engagement with partners and stakeholders the CCG regularly liaises with the Council in a number of areas and variety of levels. These include:

  – Health and Well-Being Board
  – Health Overview and Scrutiny Committee
  – Safeguarding Adults and Children
  – Joint Executive Team meetings (bi-monthly) for adults and children
  – Partnership Boards including learning disabilities and urgent care

- The foundation of our CCG are member practices, without whom, the CCG cannot be effective.

- Our engagement with member practices is enabled through our locality structure which ensures a monthly meeting of all member practices within a locality to share information, monitor performance, identify issues. This further supports two way communication between practices, the locality and the CCG Executive.

- The CCG Executive holds three Brent wide member practice forums a year and regularly communicates with its members through monthly newsletters and the development of a new website designed to increase member practice engagement in the CCG's activities.

Brent
Clinical Commissioning Group

Collaboration level	*Features of collaboration*	*Purpose of collaboration*
Local	• Local Authority • Public Health • Health Watch • Community and voluntary • Member practices	• **Joint Service Redesign** • **Safeguarding** • **PPE** • **Accountability/Decision making H&WBB)**
Federation of four CCGs	Shared team and Governance Structures: • AO • CFO • Director of Quality and Safety • Head of Governance • Director of Delivery and Performance	• **Provider Management** • **QIPP Delivery** • **Audit** • **Remuneration** • **Chairs' Forum** • **Sharing Best Practice** • **Managing the CSU SLA**
North West London across the 8 CCGs	• Director of Strategy Delivery Team • CSU	• **SaHF** • **Strategic planning & delivery support** • **Collaborative commissioning** • **Financial Strategy** • **Financial Risk Share** • **Workforce Planning**

Commissioning Support Unit

Brent
Clinical Commissioning Group

- The following services are provided by the North West London Commissioning Support Unit:
  - Business Intelligence
  - Communications
  - Finance
  - Governance
  - GP IT
  - Human resources
  - IFR/PPWT (individual funding requests/planned procedures with a threshold)
  - IFR/PPwT Clinical support
  - IT support service
  - Medicines management
  - Other Service Provision
  - Procurement support
  - Provider management

Commissioning Support Unit

Brent
Clinical Commissioning Group

- The support provided enables the CCG's in house team to delegate transactional processes arising from procurement, contract and performance management as well as business intelligence to support commissioning decisions.

- We are working to embed an effective interface between the CSU, who is providing commissioning support for 8 CCGs, and ourselves at a local CCG level.

- We are actively working with CSU colleagues to ensure that this service operates effectively and enables the CCG to discharge fully its statutory responsibilities.

Brent
Clinical Commissioning Group

Questions

25 June 2013

Planned Care Outpatients Wave Two: Patient and public consultation

1. Introduction

NHS Brent is in the process of procuring planned care outpatient services for the following specialities:

- MSK
- Rheumatology
- Trauma and orthopaedics
- Gynaecology

The CCG has decided to use competitive dialogue as the procurement mechanism to ensure improved patient experience, clinical outcomes and value for money.

Currently, there are qualified bidders for Rheumatology, Gynaecology, trauma and orthopaedics. MSK (including physiotherapy) will be advertised on Supply2Health, and bidders qualified over the summer. It is anticipated the service specification and competitive dialogue phases will start in September 2013.

There have been discussions with Harrow CCG about the possibility of working collaboratively on this procurement. Harrow CCG's Governing Body will decide, at is meeting at the end of July, whether this is an appropriate approach to planned care procurement in Harrow. In the interim, Brent CCG is seeking approval to commence with statutory duties associated with this planned procurement in order to progress work within the identified timescales.

2. Statutory duties

As part of the statutory duties, NHS Brent has a legal duty to consult about the proposed changes to the services.

- Section 242 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) places a statutory duty on commissioners and providers of NHS services to engage and involve the public and service users in:
  - planning the provision of services;
  - the development and consideration of proposals to change the provision of those services; and
  - decisions affecting the operation of services

  This duty applies to changes that affect the way in which a service is delivered as well as the way in which people access the service.

- Section 244 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) places a statutory duty on commissioners and providers of NHS services to consult local authority health overview and scrutiny committees (HOSCs) on any proposals for significant development or substantial variation in health services. This is distinctive from the routine engagement and discussion that happens with local authorities as partners and stakeholders.

3. Patient and Public consultation plan

The proposed plan for the patient and public consultation has two main strands. One strand consists of the formal patient and public consultation and the other is the participation as full members of the procurement panel.

25 June 2013

3.1. Formal public and patient consultation

A formal patient and public consultation has two main outputs. The first is to inform about the proposed changes, and the potential impact on these services. The second is to gather feedback to input into the service specification. This can include factors which will ensure patient satisfaction.

The proposed approach will be to incorporate this as part of the scope of work included within the Holistic Impact Assessment. This has the benefit of ensuring the findings are independent.

The target audience for the public consultation will be:

- NHS Brent population
- Patients who have or currently use the specific outpatient services

This process will use a variety of methods to inform and gather feedback. These include formal presentations, focus groups, leaflets, surveys as well as the potential use of social media.

Key stakeholders will include Health & Well-being Boards, relevant patient support groups, and the Health overview and scrutiny committees.

3.2. Patient representation on the procurement panel

Once the bidders have been qualified, the next phase will be to expand the procurement panel to involve both clinical and patient representatives. Two patient representatives, preferably patients who have used the specialty, will sit on each speciality's panel. This means eight patient representatives will be involved.

They will participate in the following activities:

- Review and input into the Outline and Final Service Specifications
- Scoring of specific questions
- Attending all procurement panel meetings, including the moderation panel and bidder presentations

The NHS Brent guidance on subsidy for travel and expenses for patient involvement will be followed.

4. Proposed Timetable

4.1. Formal Public Consultation

4.1.1. External supplier commences work on the 22nd July 2013

4.1.2. Formal public consultation commences week of the 22nd July 2013

4.1.3. Interim report due on the 9th September 2013 to feed into the service specification

4.1.4. Final report due on the 1st November 2013 to feed into the final specification

4.2. Patient participation on the procurement panel

4.2.1. Patient representatives will be sought through Healthwatch, and any other relevant bodies to start in September.

Health Partnerships Overview and Scrutiny Committee
24 July 2013

Report from Strategy, Partnerships and Improvement

For Action

Wards Affected: ALL

Emergency Services at NW London Hospitals: Update

1.0 Summary

1.1 Members of the Health Partnerships Overview and Scrutiny Committee will already be aware of the problems facing Northwick Park Hospital's Accident and Emergency department and the recent risk summit that resulted from concerns over its ability to provide a safe and adequate service. The risk summit resulted in an Implementation Plan being agreed with stakeholders, in particular Brent CCG.

1.2 The first report (from North West London Hospitals Trust) reiterates the plans given to the committee in June for changes in provision at Northwick Park and at Central Middlesex that are designed to alleviate pressure and gives additional explanation of the services to be provided at both sites.

1.3 The second report from the London Ambulance Service provides statistics on ambulance attendances in Brent for January to May 2013 compared to the same period in the previous year.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to consider the report and question officers from North West London Hospitals Trust, Brent CCG and the London Ambulance Service on the issues faced, the measures proposed, overall progress against the Implementation Plan and current performance at Northwick Park A&E.

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The North West London Hospitals NHS
NHS Trust

Wednesday 24 July 2013

Brent Overview and Scrutiny Committee

CONFIDENTIAL

Transforming emergency care

The following briefing provides information about what we are doing to improve emergency care at our hospitals.

Introduction

About 37% of the patients who visit our hospitals use our emergency departments at Northwick Park and Central Middlesex Hospital (based on figures for 2011/12). Sometimes they need to be admitted for more treatment or surgery, but in other cases they can go home or be cared for by another part of the NHS.

Whatever care our patients need and whenever they need it, we all want to provide the very best. While our clinical outcomes are good, some patients do not have as good an experience as we would like and we owe it to them and our staff to do better.

At Northwick Park Hospital, the number of patients visiting our emergency department (ED) has gone up by at least 10% a year for the last three years. At Central Middlesex, we have seen numbers arriving in the emergency department decline. In winter 2011/12, we decided to close the ED at Central Middlesex overnight, as we did not have enough permanent senior staff to run the department out of hours. Currently at CMH there is a 24/7 Urgent Care Centre, (UCC), with ED open from 8am to 7pm, and a 24/7 acute medical team taking patients from the UCC, ED (when open) and GPs.

Despite repeated attempts over many years, like many other Trusts we continue to struggle to recruit to substantive ED medical posts across the Trust. As a result of extra pressure on our emergency services and despite the hard work of our staff, we failed to meet the target of 95% of patients waiting no longer than four hours in our EDs for the year ending March 2013.

So what are we doing about it?

We have already taken some immediate action and continue to invest in emergency care. This included an extra £10 million for more staff and emergency beds last year (2012/13).

We have set up a project board to look at reorganising our emergency services to make best use of our staff and other resources. Although none of us want to start thinking about the winter months ahead this early in the year, it is vital to put in place sustainable changes in time for then.

We are closer to opening our new £21 million emergency department and £14 million operating theatres, which will be more efficient and closer to each other. Building work is well under way and developers held an open day on the new emergency department site in June for staff and members of the public to have a look round. With our staff, we are making plans to increase capacity and working with clinical teams to change systems and processes to improve care for patients and our working environment.

This briefing provides more information about what we are doing to renew our focus on transforming emergency care

What we are doing

You may remember that, with support from our commissioners, we have started discussions with staff and other stakeholders to explore how to reorganise our emergency services across the two sites to make the best use of staff and other resources. We have a project board to oversee this work, which includes senior representatives and clinicians from our organisation and our NHS partners.

It has set up a number of workstreams for specific projects:

- care of elderly & therapy
- communication
- critical care, outpatients & theatres
- education & training
- estates & facilities
- information & finance
- management of fractured neck of femur (hip fractures)
- medicine
- operational site management
- out of hospital/primary care (including LAS and UCC)
- paediatrics
- surgery & diagnostics
- workforce

Our improvement programmes

In summary, three of the changes we intend to make immediately are:

- increasing bed capacity at Northwick Park
- maximising capacity at Central Middlesex
- moving more orthopaedic work to Central Middlesex

We will be exploring further options with our local commissioners and will update you once we have more information.

What's happening at Northwick Park Hospital?

With no change, Northwick Park would continue to struggle to meet the four-hour waiting time target. Therefore, the Trust is planning to:

- **create additional bed space on existing wards**, including a short-term change of 11 private beds on Sainsbury Ward to NHS beds
- **expand the ambulatory care unit and surgical assessment unit** on Fletcher Ward to include the STARRS assessment lounge – to allow us to see another 10 to 15 patients a day
- **remodel STARRS to focus on the front end** (ED) in order to prevent unnecessary admissions
- **following on from this, we are also looking at creating a new 25-bed ward** by removing offices used by paediatric staff from Carroll Ward – we aim to do this by October

What's happening at Central Middlesex Hospital?

We want to make the most of the excellent staff and facilities at Central Middlesex Hospital. Plans include:

Moving recovery and rehabilitation care to CMH
For patients who have had surgery for hip fractures (fractured neck of femur). A few days after surgery, patients would be transferred by ambulance to CMH. Eventually, it might be possible to accept other patients who have had surgery at NPH who require lengthier inpatient stays.

Sustaining an acute medical take at CMH
This means caring for patients with a medical problem (not requiring surgery) who arrive by ambulance or are referred by their GP at all hours of the day or night. This happens at CMH during the day, but ambulance arrivals are not accepted out of hours at the moment.

This would exclude patients with chest pain, stroke and upper gastrointestinal bleeds, who would continue to be seen at Northwick Park Hospital. This model has been used elsewhere (Hammersmith and West Herts) and is common during a transition period. We would continue to retain an intensive therapy unit at Central Middlesex.

Creating a further 10 beds for medical patients
To facilitate the new medical model detailed above.

It's not just about the emergency department

Improving care means that all our services need to work together so that everything is joined up as patients travel through our hospitals. One of the most important things to improve is the way we plan for patients to leave hospital. We need to do this at an early stage so that our colleagues in primary and social care, such as GPs, Clinical Commissioning Groups and social services, can plan the services that are required in the community to support them when they go home.

An example of a service that can help to join up the discharge process is our STARRS service. Working in close collaboration with GPs and hospital specialists, it helped reduced the length of hospital stay for more than 2,000 patients in Brent by supporting them at home in 20011/12. STARRS is a multi-skilled, multidisciplinary team of nurses, physiotherapists, occupational therapists, therapy technicians and assistant practitioners. Pivotal to its efficiency is the single point of access administration team, who process all referrals, audit the service, support clinicians and answer patient queries.

The team regularly liaises with GPs and hospital specialists, agreeing patients' individual plans and providing progress updates to ensure safe and excellent patient care. While patients benefit from not having to leave their homes (where many elderly patients tend to feel most at ease), the service also helps to free up beds in our hospitals. It has been working on a similar model in Harrow for 18 months.

Direct admission pathways
In many cases, patients who need surgical assessments do not need to be assessed in the emergency department first and could be referred directly to a consultant who is an expert in their conditions. We are discussing with ear, nose and throat, as well as maxillofacial divisions, how this could be organised, alongside general surgery, gynaecology and urology.

Impact on staff
As is normally the case, we will continue to ask staff to work flexibly to meet the needs of our patients. We will also be recruiting more staff in certain areas.

New £21 million emergency department
Work has started on our new £21 million ED, children's ED and urgent care centre at Northwick Park Hospital. The new department will incorporate 40 individual bays, to allow patients greater privacy, and waiting areas will be improved as part of the state-of-the-art design. In the longer term, we will move the acute admissions unit and surgical admissions unit to the 3rd floor of the ward block, next to the new ED. This will enable us to increase the number of assessment beds.

State-of-the-art operating theatres
We are investing £14 million in world-class, state-of-the-art facilities, including nine large new theatres, three refurbished theatres and a new interventional imaging suite

for vascular surgery at Northwick Park Hospital. Phase 1 of our building programme is due to open in summer 2013, with the remainder completed by Easter 2014. When the theatres open, patients will benefit from improved facilities for emergency, vascular, maxillofacial and colorectal surgery, and staff will have better working conditions and training facilities.

Care Quality Commission scrutiny

Earlier this month, Northwick Park Hospital had an unannounced visit from the Care Quality Commission, which examined a number of wards and departments, particularly the ED. The feedback in regards to ED was positive. Given that the inspectors visited a number of departments across the emergency pathway, this was a real credit to the hard work of Trust staff over a sustained period to maintain and improve standards of care for patients.

Quality monitoring

In order to ensure we maintain a safe and good-quality service for our patients, the emergency pathway team, which includes all staff disciplines, meet weekly to look at the data relevant to quality, such as time to assessment for patients arriving in ED, time to treatment, patients who waited more than 4 hours and LAS handover times, to name a few. In addition, the department's development manager reviews all the reported clinical incidents every day.

Every month, we triangulate clinical incidents, complaints and performance data to review as a whole ED (NPH and CMH together) how we could improve the service we give to our patients. It is vital that we keep open communication with our staff and we achieve this by daily staff team briefings, weekly meetings and informal floor walks by director at least once a week. The senior team, general manager and head of nursing are on the floor every day, along with the service manager and matron.

We also monitor patients' experiences, which is another way to monitor quality. As well as taking part in the National Friends and Family scheme, we run a local ED-based campaign called 100 Voices. This has led to lots of minor, but important, changes; for example, a health care assistant is available to support patients who have individual care needs while in the department, and we have installed a television in the waiting room.

We are now addressing the need to have water available in the waiting room and to reduce the current situation in which patients have to give their medical histories several times to different healthcare professionals. I am happy to update you on this at a later date.

Tina Benson
Director of Operations
24 July 2013

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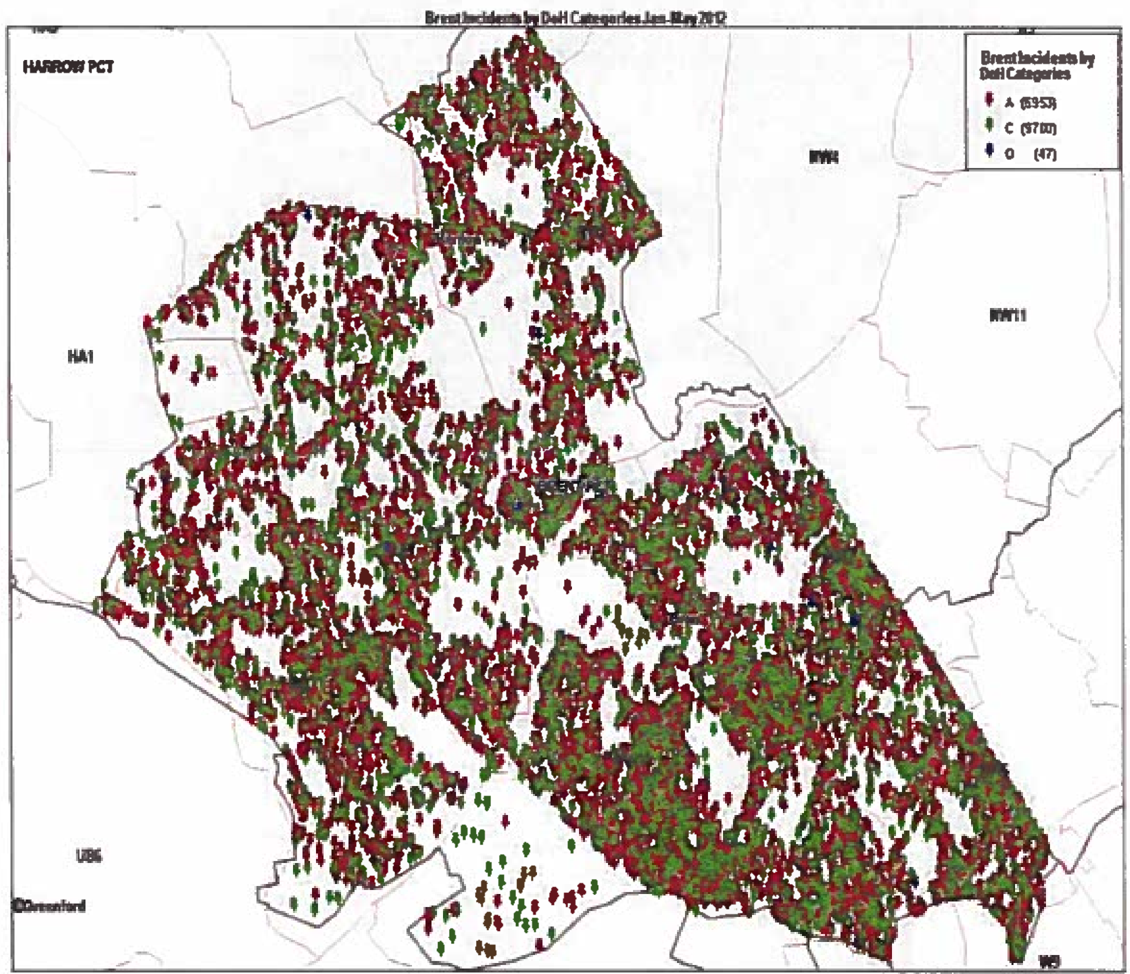
London Ambulance Service NHS Trust
London Borough of Brent

The London Ambulance service attended to 16700 calls in the borough of Brent between January and May 2012. Of these calls, 6953 were categorised as Department of Health category 'A' call. A category 'A' call is deemed to be immediately life threatening and an emergency response will reach 75% of these calls within eight minutes. In the same period, the LAS attended 9700 category 'C' calls. Category 'C' calls are made up of four sub categories (Green 1 & Green 2 serious but non-life threatening, Green 3 & Green 4 Non-life threatening). There were 47 'other' calls. These can be seen in Figure 1 below.

Figure 1



Between January and May 2013 the LAS attended 16964 calls in the borough of Brent, this was a total increase of 264 calls. 7397 of these calls were Category 'A', 9552 were category 'C' and 15 other. These can be seen in figure 2 below.

Figure 2

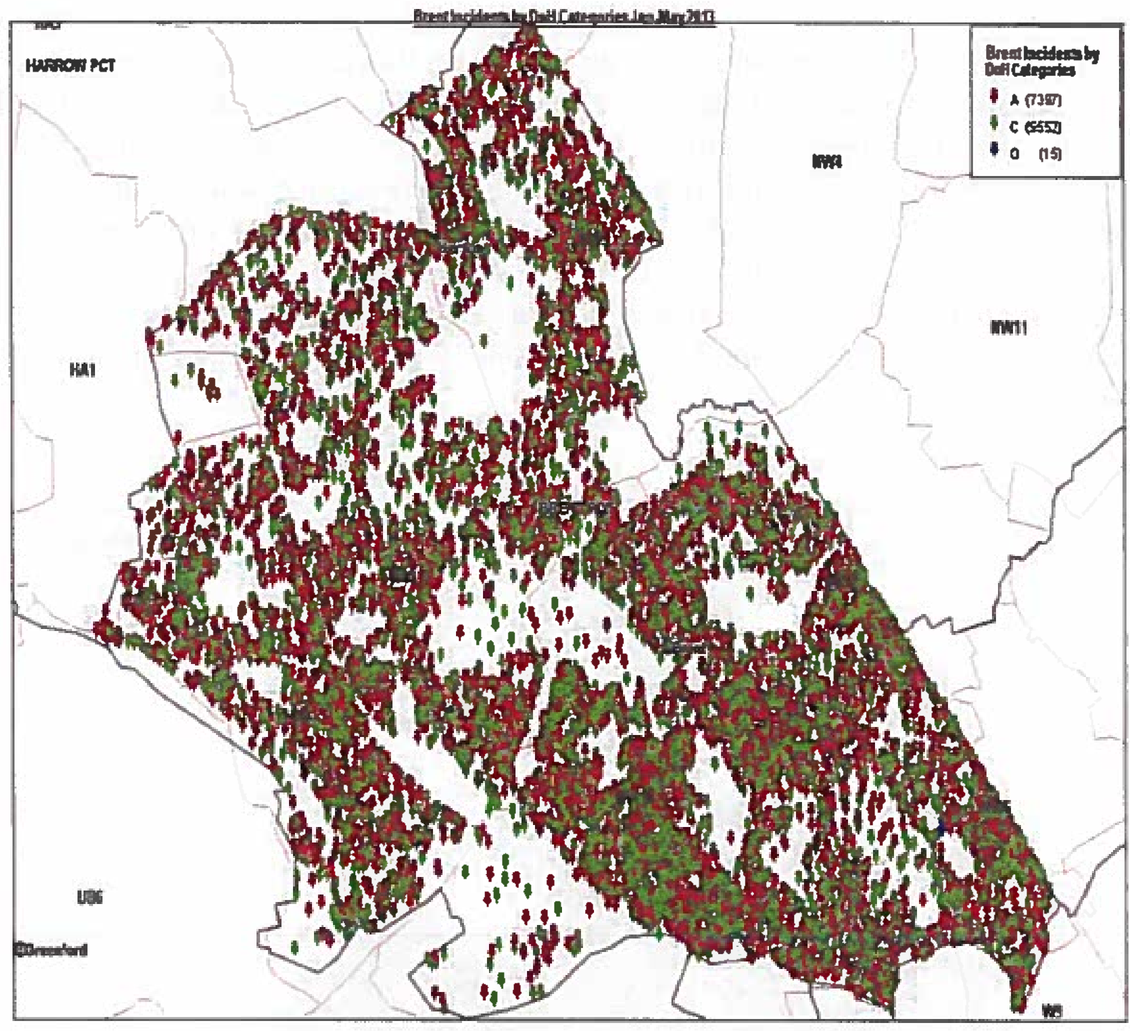


Table 1 below shows the breakdown of calls by ward for January to May 2012 and 2013, included in this is the percentage change between each year.

Table 1

Brent Borough Incidents Jan-May 2012 & Jan-May 2013				
Jan-May 2012 Brent Borough Incidents by Ward		Jan-May 2013 Brent Borough Incidents by Ward		% Change Jan-May 2013 Vs Jan-May 2013
Brent Borough	Total Incidents	Brent Borough	Total Incidents	% Change 2013 Vs 2012
Alperton	561	Alperton	616	9.8%
Barnhill	849	Barnhill	901	6.1%
Brondesbury Park	755	Brondesbury Park	660	-12.6%
Dollis Hill	651	Dollis Hill	610	-6.3%
Dudden Hill	728	Dudden Hill	751	3.2%
Fryent	730	Fryent	700	-4.1%
Harlesden	948	Harlesden	988	4.2%
Kensal Green	838	Kensal Green	801	-4.4%
Kenton	510	Kenton	656	28.6%
Kilburn	938	Kilburn	897	-4.4%
Mapesbury	748	Mapesbury	765	2.3%
Northwick Park	765	Northwick Park	774	1.2%
Preston	746	Preston	716	-4.0%
Queens Park	698	Queens Park	732	4.9%
Queensbury	678	Queensbury	732	8.0%
Stonebridge	1423	Stonebridge	1479	3.9%
Sudbury	655	Sudbury	664	1.4%
Tokyngton	788	Tokyngton	844	7.1%
Welsh Harp	661	Welsh Harp	646	-2.3%
Wembley Central	959	Wembley Central	935	-2.5%
Willesden Green	1071	Willesden Green	1097	2.4%
Total	**16700**	**Total**	**16964**	**1.6%**

Please see below table 2 showing the conveyance figures to a hospital for January to May 2012 and 2013.

Table 2

Brent Borough Incidents - Conveyances by DoH Categories (Jan-May 2012 & Jan-May 2013)														
Jan-May 2012 Brent Borough Conveyances by DoH Categories					Jan-May 2013 Brent Borough Conveyances by DoH Categories					% Change Jan-May 2012 Vs Jan-May 2013				
Conveyance	A	C	O	Total	Conveyance	A	C	O	Total	Conveyance	A	C	O	Total
Conveyed	5894	7513	39	13446	Conveyed	6209	7409	12	13630	Conveyed	5.3%	-1.4%	-69.2%	1.4%
Not Conveyed	1059	2187	8	3254	Not Conveyed	1188	2143	3	3334	Not Conveyed	12.2%	-2.0%	-62.5%	2.5%
Total	6953	9700	47	16700	Total	7397	9552	15	16964	Total	6.4%	-1.5%	-68.1%	1.6%

Figure 3 and 4 show the Borough of Brent conveyance to an Accident and Emergency Department.

Figure 3 - January to May 2012

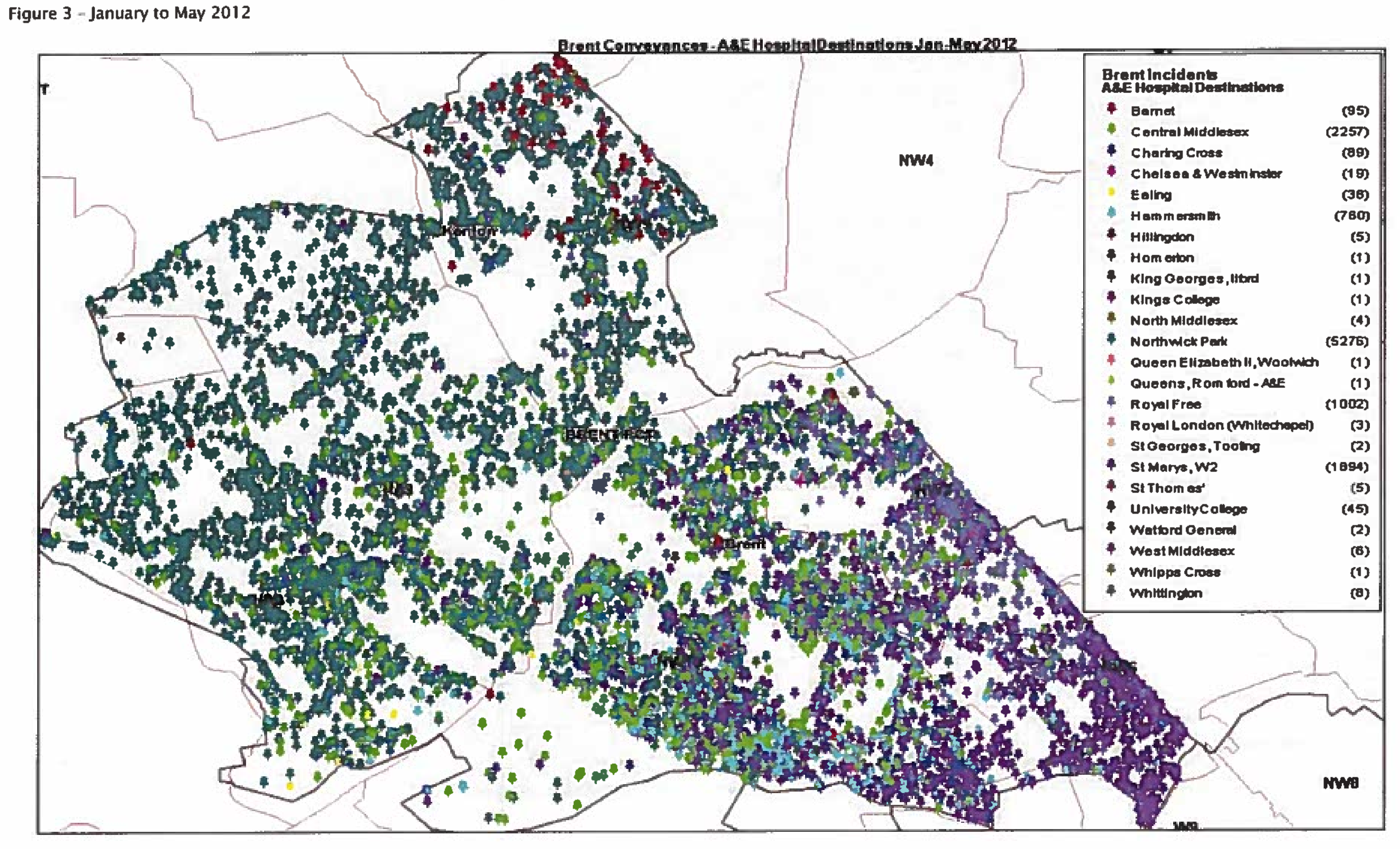


Figure 4 - January 2013 to May 2013

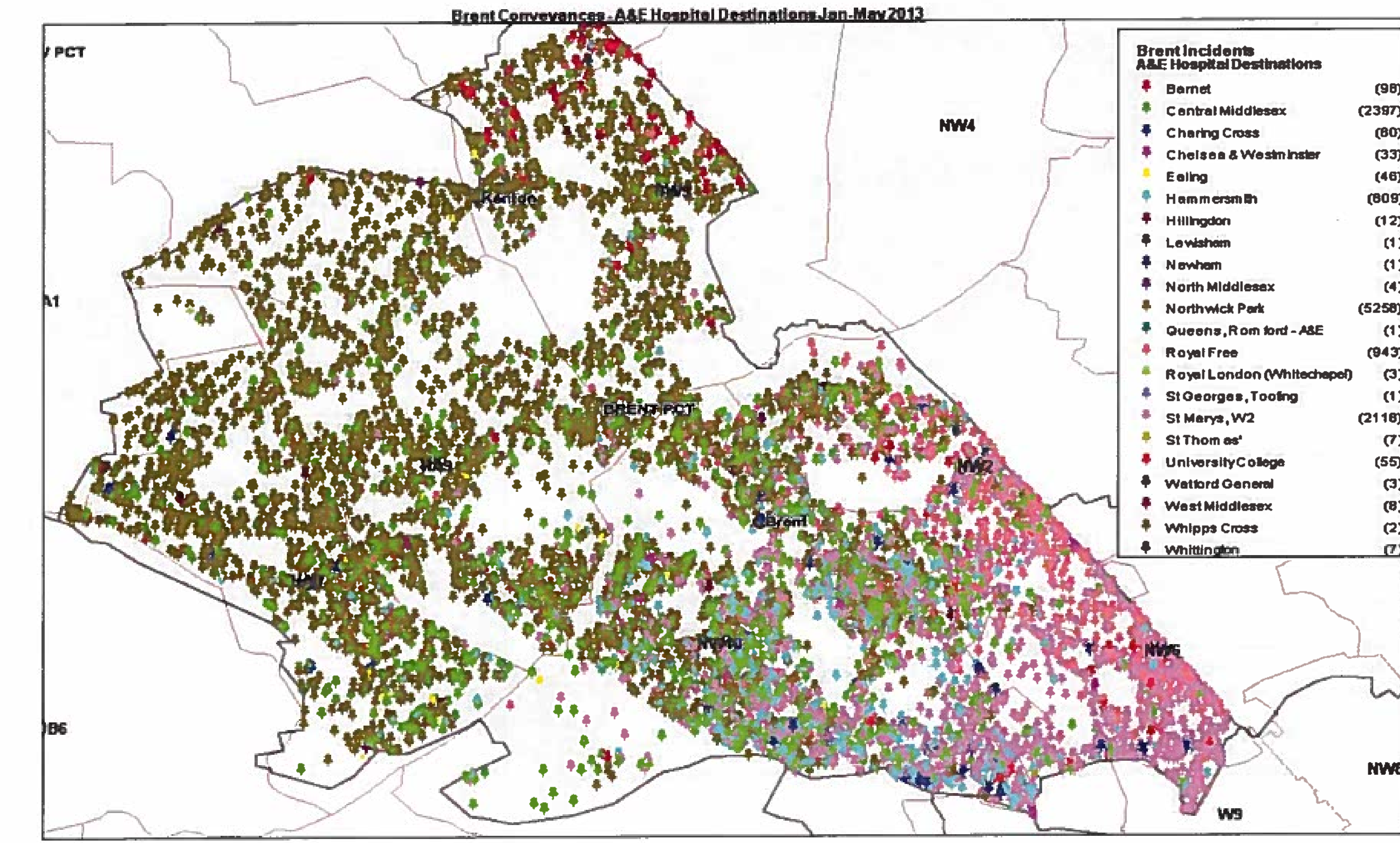


Table 3 below shows the Borough of Brent conveyance to an Accident and Emergency Department for January to May 2012 and 2013.

Table 3

Brent Borough Incidents - A&E Hospital Destinations (Jan-May 2012 & Jan-May 2013)				
Jan-May 2012 Brent Borough Incidents - A&E Hospitals		**Jan-May 2013 Brent Borough Incidents - A&E Hospitals**		**% Change Jan-May 2013 Vs Jan-May 2013**
A&E Hospital	**Total Incidents**	**A&E Hospital**	**Total Incidents**	**% Change 2013 Vs 2012**
Barnet	95	Barnet	98	**3.2%**
Central Middlesex	2257	Central Middlesex	2397	**6.2%**
Charing Cross	89	Charing Cross	80	**-10.1%**
Chelsea & Westminster	19	Chelsea & Westminster	33	**73.7%**
Ealing	38	Ealing	46	**21.1%**
Hammersmith	760	Hammersmith	809	**6.4%**
Hillingdon	5	Hillingdon	12	**140.0%**
Homerton	1	Homerton	0	**-100.0%**
King Georges, Ilford	1	King Georges, Ilford	0	**-100.0%**
Kings College	1	Kings College	0	**-100.0%**
Lewisham	0	Lewisham	1	**100.0%**
Newham	0	Newham	1	**100.0%**
North Middlesex	4	North Middlesex	4	**0.0%**
Northwick Park	5276	Northwick Park	5258	**-0.3%**
Queen Elizabeth II, Woolwich	1	Queen Elizabeth II, Woolwich	0	**-100.0%**
Queens, Romford - A&E	1	Queens, Romford - A&E	1	**0.0%**
Royal Free	1002	Royal Free	943	**-5.9%**
Royal London (Whitechapel)	3	Royal London (Whitechapel)	3	**0.0%**
St Georges, Tooting	2	St Georges, Tooting	1	**-50.0%**
St Marys, W2	1894	St Marys, W2	2118	**11.8%**
St Thomas'	5	St Thomas'	7	**40.0%**
University College	45	University College	55	**22.2%**
Watford General	2	Watford General	3	**50.0%**
West Middlesex	6	West Middlesex	8	**33.3%**
Whipps Cross	1	Whipps Cross	2	**100.0%**
Whittington	8	Whittington	7	**-12.5%**
Total	**11516**	**Total**	**11887**	**3.2%**

Table 4 shows the Borough of Brent conveyance to a hospital and department.

Table 4

Brent Borough Incidents - Conveyance Destinations (Jan-May 2012 & Jan-May 2013)

Brent Borough Incidents - Conveyed/Non Conveyed Destinations (Jan-May 2012 & Jan-May 2013)

Jan-May 2012 Brent Borough Incidents - Conveyance Destinations			Jan-May 2013 Brent Borough Incidents - Conveyance Destinations	
Conveyed to	**Total Incidents**		**Conveyed to**	**Total Incidents**
Barnet	95		Barnet	98
Barnet - Maternity	8		Barnet - (other departments)	1
Barnet - Urgent Care Centre	1		Barnet - Maternity	6
Brent GP Access Centre	4		Brent GP Access Centre	4
Broomfield, Essex	1		Central Middlesex	2397
Central Middlesex	2257		Central Middlesex - (other departments)	26
Central Middlesex - (other departments)	20		Central Middlesex - MAU/CDMU/GPU	6
Central Middlesex - Psychiatric	25		Central Middlesex - Urgent Care Centre	268
Central Middlesex - Urgent Care Centre	320		Charing Cross	80
Charing Cross	89		Charing Cross - (other departments)	9
Charing Cross - (other departments)	2		Charing Cross - HASU	9
Charing Cross - HASU	7		Charing Cross - Urgent Care Centre	2
Charing Cross - Urgent Care Centre	2		Chase Farm - (other departments)	2
Chase Farm - Psychiatric	3		Chase Farm - Psychiatric	1
Chelsea & Westminster	19		Chase Farm - Urgent Care Centre	1
Chelsea & Westminster - (other departments)	5		Chelsea & Westminster	33
Chelsea & Westminster - Maternity	5		Chelsea & Westminster - (other departments)	8
Ealing	38		Chelsea & Westminster - Maternity	6
Ealing - (other departments)	1		Chelsea & Westminster - Urgent Care Centre	1
Ealing - Maternity	2		Ealing	46
Ealing - Urgent Care Centre	10		Ealing - (other departments)	1
Edgware	1		Ealing - Maternity	5
Edgware - Walk-In Centre	16		Ealing - Urgent Care Centre	5
Gordon - Psychiatric	1		Edgware - Psychiatric	1
Great Ormond Street	11		Edgware - Walk-In Centre	9
Hammersmith	760		Great Ormond Street	7
Hammersmith - (other departments)	11		Hammersmith	809
Hammersmith - CathLab	56		Hammersmith - (other departments)	13
Hammersmith - Psychiatric	1		Hammersmith - CathLab	51
Hammersmith - Urgent Care Centre	2		Hammersmith - Urgent Care Centre	4
Hammersmith Centre for Health	4		Hammersmith & Fulham Mental Health (Claybrook) Unit	1
Harefield	9		Harefield	8

Harefield - CathLab	31	Harefield - CathLab	33
Hillingdon	5	Hillingdon	12
Hillingdon - (other departments)	1	Hillingdon - (other departments)	2
Hillingdon - Maternity	1	Hillingdon - Pyschiatric	3
Hillingdon - Pyschiatric	1	Hillingdon - Urgent Care Centre	1
Homerton	1	John Radcliffe, Oxford	1
King Georges, Ilford	1	Kings College - (other departments)	1
Kings College	1	Lewisham	1
Maudsley	1	Moorfields Eye	2
Moorfields Eye	1	Mount Vernon	2
Mount Vernon	2	National, Queen Square	29
National Neuro, N2	3	Newham	1
National, Queen Square	49	North London Hospice	1
North Middlesex	4	North Middlesex	4
North Middlesex - Maternity	3	North Middlesex - Maternity	1
North Middlesex - Urgent Care Centre	3	Northwick Park	5258
Northolt Mental Health Centre	1	Northwick Park - (other departments)	43
Northwick Park	5276	Northwick Park - HASU	99
Northwick Park - (other departments)	59	Northwick Park - Maternity	134
Northwick Park - HASU	127	Northwick Park - MAU/CDMU/GPU	5
Northwick Park - Maternity	155	Northwick Park - Psychiatric	9
Northwick Park - MAU/CDMU/GPU	3	Northwick Park - Urgent Care Centre	377
Northwick Park - Psychiatric	15	Other arranging hospital (unlisted)	1
Northwick Park - Urgent Care Centre	283	Park Royal Centre for Mental Health	41
Other arranging hospital (unlisted)	7	Queen Charlottes & Chelsea	2
Park Royal Centre for Mental Health	25	Queen Charlottes & Chelsea - Maternity	27
Priory, The Bourne, N14	2	Queens, Romford - A&E	1
Queen Charlottes & Chelsea	1	Queens, Romford - Maternity	1
Queen Charlottes & Chelsea - Maternity	28	Royal Brompton	3
Queen Elizabeth II, Woolwich	1	Royal Brompton CathLab	1
Queen Elizabeth II, Woolwich - (other departments)	1	Royal Free	943
Queen Marys, Roehampton - Psychiatric	1	Royal Free - (other departments)	3
Queens, Romford - A&E	1	Royal Free - CathLab	19
Queens, Romford - MAU/CDMU/GPU	1	Royal Free - Maternity	18
Royal Brompton	5	Royal Free - Urgent Care Centre	58
Royal Free	1002	Royal London (Whitechapel)	3
Royal Free - (other departments)	10	Royal London (Whitechapel) - Major Trauma Centre	1
Royal Free - CathLab	17	Royal National Orthopaedic, Stanmore	1
Royal Free - Maternity	18	St Charles - (other departments)	16
Royal Free - MAU/CDMU/GPU	2	St Charles - Psychiatric	5
Royal Free - Neurosurgical Trauma Unit	7	St Charles - Urgent Care Centre	2
Royal Free - Psychiatric	2	St Georges, Tooting	1
Royal Free - Urgent Care Centre	102	St Georges, Tooting - (other departments)	1
Royal London (Whitechapel)	3	St John & St Elizabeth, NW8	2

Royal London (Whitechapel) - Major Trauma Centre	1
Royal National Orthopaedic, Stanmore	1
St Charles - (other departments)	17
St Charles - Urgent Care Centre	8
St Georges, Tooting	2
St Georges, Tooting - Major Trauma Centre	1
St John & St Elizabeth, NW8	5
St Lukes Hospice, Kenton	12
St Marys, W2	1894
St Marys, W2 - (other departments)	27
St Marys, W2 - Major Trauma Centre	73
St Marys, W2 - Maternity	133
St Marys, W2 - Psychiatric	9
St Marys, W2 - Urgent Care Centre	20
St Thomas'	5
The Heart - CathLab	1
The Heart Hospital, W1	1
University College	45
University College - (other departments)	3
University College - HASU	15
University College - Maternity	3
Victoria Walk-In Centre	1
Watford General	2
Watford General - Maternity	1
Wembley - Minor Injuries Unit	1
Wembley NHS - Walk-in Centre	17
West Middlesex	6
West Middlesex - Urgent Care Centre	1
Western Ophthalmic	7
Whipps Cross	1
Whittington	8
Willesden BPAS	1
Willesden General	1
.Other location by request	9
.Home by request	65
Total Conveyed	**13446**
Non-Conveyed	**Total Incidents**
.Left crew dealing	5
.Taken by another ambulance	52
.Taken by other means	26
_none	327
Apparent hoax	37

St Josephs Hospice	1
St Lukes Hospice, Kenton	11
St Marys, W2	2118
St Marys, W2 - (other departments)	22
St Marys, W2 - CathLab	2
St Marys, W2 - Major Trauma Centre	88
St Marys, W2 - Maternity	89
St Marys, W2 - MAU/CDMU/GPU	3
St Marys, W2 - Urgent Care Centre	12
St Thomas'	7
St Thomas' - (other departments)	1
St Thomas' - Maternity	1
Tolworth - Psychiatric	1
University College	55
University College - (other departments)	2
University College - HASU	20
University College - Maternity	4
Watford General	3
Watford General - Maternity	1
Wembley - Minor Injuries Unit	2
Wembley NHS - Walk-in Centre	8
West Middlesex	8
West Middlesex - (other departments)	3
West Middlesex - Urgent Care Centre	1
Western Ophthalmic	5
Whipps Cross	2
Whittington	7
Whittington - (other departments)	1
.Other location by request	12
.Home by request	53
Total Conveyed	**13630**
Non-Conveyed	**Total Incidents**
.Left crew dealing	4
.Taken by another ambulance	45
.Taken by other means	31
_none	397
Apparent hoax	20
Assisted and referred	38
Assisted but not conveyed	790
Cancelled before arrival	2
Cancelled to another ambulance	10
Cancelled, no further action required	80

Assisted and referred	26
Assisted but not conveyed	666
Cancelled before arrival	2
Cancelled to another ambulance	11
Cancelled, no further action required	70
Deceased, not removed	118
Declined aid against advice	692
Duplicate call	4
False alarm/not required	114
Gone before arrival	165
GP call, left in care	95
No trace	193
not required	130
Police arranging removal	43
referred to A&E	3
referred to district nurse	5
referred to EBS	1
referred to GP	316
referred to hospice/palliative care	2
referred to Mental Health Team	1
referred to MIU/WIC/UCC	6
referred to other	11
referred to social services	5
referred to specialist team	3
Treated and referred	1
Treated but not conveyed	124
Total Conveyed	**3254**
All Incidents	**16700**

Deceased, not removed	116
Declined aid against advice	559
Duplicate call	2
False alarm/not required	124
Gone before arrival	82
GP call, left in care	104
No trace	141
not required	110
Police arranging removal	48
referred to A&E	3
referred to Brent & Harrow STARRS	19
referred to Camden REACH	1
referred to district nurse	8
referred to EBS	85
referred to ECP	1
referred to GP	342
referred to hospice/palliative care	2
referred to intermediate care	1
referred to Mental Health Team	4
referred to MIU/WIC/UCC	4
referred to other	12
referred to social services	3
referred to specialist team	8
Treated and referred	3
Treated but not conveyed	135
Total Conveyed	**3334**
All Incidents	**16964**

Table 5 shows Northwick Park closures and redirects for the period January to May 2013 for Accident and Emergency and the maternity unit. The table also shows the north Brent divert which is currently in place 7 days a week from 0800hrs to 1900hrs. Appropriate patients picked up by the London Ambulance Service in the post areas HA0, HA9, NW9 will be taken to Central Middlesex hospital.

Table 5

Code	hospital name	blue only	update time	notification/destination	hospital status	remarks
149	Northwick Park	0	17/01/2013 13:09:58	B6DG C3DG B3DG B5DG D4DG F2DG	REDIRECTION	REDIRECTION UNTIL 1440 CMIDX AND EALING COVERING
149	Northwick Park	0	18/01/2013 20:20:36	B6DG C3DG B3DG B5DG D4DG F2DG	OPEN	NWICK OPEN TO ALL
149	Northwick Park	0	24/01/2013 12:47:06	B6DG C3DG B3DG B5DG D4DG F2DG	OPEN	NWICK MAT CLOSED PATS TO QCHAR BARNT RFNW3
149	Northwick Park	0	03/02/2013 09:42:30	B6DG C3DG B3DG B5DG D4DG F2DG	CLOSED	NWICK MAT STILL CLOSED PATS TO HDON EALNG RFNW3
149	Northwick Park	0	03/02/2013 16:05:57	B6DG C3DG B3DG B5DG D4DG F2DG	OPEN	NWICK MAT NOW OPEN
149	Northwick Park	0	19/02/2013 22:40:24	B6DG C3DG B3DG B5DG D4DG F2DG	REDIRECTION	DIVERT TO EALING AND HDON FOR 90 MINS OPEN TO BLUE CALLS
149	Northwick Park	0	20/02/2013 00:08:17	B6DG C3DG B3DG B5DG D4DG F2DG	OPEN	NULL
149	Northwick Park	0	21/02/2013 09:59:06	NULL	OPEN	NULL
149	Northwick Park	0	26/02/2013 20:02:28	B6DG B3DG C3DG D4DG B5DG	REDIRECTION	REDIRECT TO EALNG/HSMITH UNTIL 2115
149	Northwick Park	0	26/02/2013 21:16:41	B6DG B3DG C3DG D4DG B5DG	OPEN	DEPT OPEN
149	Northwick Park	0	03/03/2013 11:21:45	B6DG B3DG C3DG D4DG B5DG	OPEN	REMEMBER NORTH BRENT PATS TO GO TO CMIDX EXCEPT BLUE CALLS
149	Northwick Park	0	04/03/2013 22:04:45	B6DG B3DG C3DG D4DG B5DG	REDIRECTION	360 REDIRECT IN PLACE UNTIL 2330
149	Northwick Park	0	05/03/2013 00:05:10	B6DG B3DG C3DG D4DG B5DG	OPEN	REMINDER NORTH BRENT PATIENT DIVERT TO CMIDX FROM 08-1900
149	Northwick Park	1	07/03/2013 21:43:26	B6DG B3DG B5DG A2DG F2DG C3DG D4DG E3DG	REDIRECTION	ON REDIRECT FOR ALL BLUE CALLS EXCEPT PAED CARDIAC ARREST UNTIL 2330
149	Northwick Park	1	07/03/2013 23:45:03	B6DG B3DG B5DG A2DG F2DG C3DG D4DG E3DG	OPEN	NWICK NOW FULLY OPEN
149	Northwick Park	0	18/03/2013 14:02:22	B6DG B3DG C3DG D4DG B5DG	REDIRECTION	NORTHWICK PARK ON REDIRECT TO BARNT, HDON, EALNG AND HSMITH UNTIL 1530
149	Northwick Park	0	18/03/2013 16:24:49	B6DG B3DG C3DG D4DG B5DG	OPEN	NORTHWICK PARK NOW OPEN
149	Northwick Park	0	26/03/2013 05:49:18	B6DG B3DG C3DG D4DG B5DG	CLOSED	NORTHWICK PARK MATERNITY CLOSED UFN EALING COVERING

149	Northwick Park	0	26/03/2013 12:41:00	B6DG B3DG C3DG D4DG B5DG	REDIRECTION	REDIRECTUNTIL 1340 CMIDX EALNG HDON COVERING
149	Northwick Park	0	26/03/2013 13:46:08	B6DG B3DG C3DG D4DG B5DG	OPEN	OPEN
149	Northwick Park	0	30/03/2013 15:02:05	B6DG B3DG C3DG D4DG B5DG	REDIRECTION	DIVERT TO BARNT AND CMIDX UNTIL 1620
149	Northwick Park	0	30/03/2013 16:29:05	B6DG B3DG C3DG D4DG B5DG	OPEN	NULL
149	Northwick Park	0	08/04/2013 12:30:46	B6DG B3DG C3DG D4DG B5DG	REDIRECTION	NORTH BRENT DIVERT TO CMIDX UNTIL
149	Northwick Park	0	08/04/2013 12:31:01	B6DG B3DG C3DG D4DG B5DG	REDIRECTION	NORTH BRENT DIVERT TO CMIDX UNTIL 1626
149	Northwick Park	0	09/04/2013 03:01:16	B6DG B3DG C3DG D4DG B5DG	REDIRECTION	NIWCK ON DIVERT FROM 0300 TO 0400 WILL ACCEPT PAEDS AND BLUE CALLS
149	Northwick Park	0	09/04/2013 04:05:38	B6DG B3DG C3DG D4DG B5DG	OPEN	NWICK NOW FULLY OPEN
149	Northwick Park	0	09/04/2013 13:28:00	B6DG B3DG C3DG D4DG B5DG	OPEN	NWICK ON REDIRECT OF NORTH BRENT PATIENTS TO CMIDX UNTIL 1430
149	Northwick Park	0	09/04/2013 15:49:01	B6DG B3DG C3DG D4DG B5DG	OPEN	NWICK NOW OPEN
149	Northwick Park	0	10/04/2013 11:28:41	B6DG B3DG C3DG D4DG B5DG E3DG	REDIRECTION	NWICK ON 360 REDIRECT TO ALL HOSPITALS EXCEPT BLUE CALLS AND HASU UNTIL 1230
149	Northwick Park	0	10/04/2013 13:02:35	B6DG B3DG C3DG D4DG B5DG E3DG	OPEN	NWICK NOW OPEN TO ALL
149	Northwick Park	0	12/04/2013 23:22:30	B6DG B3DG C3DG D4DG B5DG E3DG	REDIRECTION	NWICK REDIRECT UNTIL 0030 EALNG HDON AND BARNT COVERING
149	Northwick Park	0	12/04/2013 23:52:34	B6DG B3DG C3DG D4DG B5DG E3DG	REDIRECTION	NWICK REDIRECT UNTIL 0030 EALNG AND BARNT COVERING
149	Northwick Park	0	13/04/2013 00:36:55	B6DG B3DG C3DG D4DG B5DG E3DG	OPEN	NWICK OFF REDIRECTION
149	Northwick Park	0	13/04/2013 01:37:42	B6DG B3DG C3DG D4DG B5DG E3DG	OPEN	NWICK OPEN TO ALL
149	Northwick Park	0	15/04/2013 04:06:59	B6DG B3DG C3DG D4DG B5DG E3DG	REDIRECTION	NWICK REDIRECT UNTIL 0535 EALNG COVERING
149	Northwick Park	0	15/04/2013 06:16:59	B6DG B3DG C3DG D4DG B5DG E3DG	OPEN	NWICK OPEN
Code	**hospital name**	**blue only**	**update time**	**notification/destination**	**hospital status**	**remarks**
1577	Northwick Park - Maternity	0	02/02/2013 19:05:22	B6DG B5DG D4DG C3DG E3DG B3DG	REDIRECTION	RFNW3 AND EALNG (EALNG CASE BY CASE)
1577	Northwick Park - Maternity	0	02/02/2013 21:53:23	B6DG B5DG D4DG C3DG E3DG B3DG	REDIRECTION	RFNW3, HDON AND EALNG (EALNG CASE BY CASE)
1577	Northwick Park - Maternity	0	04/02/2013 16:56:55	B6DG B5DG D4DG C3DG E3DG B3DG	OPEN	NWICK MATERNITY OPEN
1577	Northwick Park - Maternity	0	08/02/2013 12:10:54	B6DG B5DG D4DG C3DG E3DG B3DG	REDIRECTION	NWICK REDIRECTION CMIDX COVERING 90 MINS 1340
1577	Northwick Park - Maternity	0	08/02/2013 13:52:20	B6DG B5DG D4DG C3DG E3DG B3DG	OPEN	NWICK OPEN

1577	Northwick Park - Maternity	0	08/02/2013 15:35:01	B6DG B5DG D4DG C3DG E3DG B3DG	REDIRECTION	NWICK REDIRECT 1530 > 1700 CMIDX COVERING BLUE OK
1577	Northwick Park - Maternity	0	09/02/2013 01:25:07	B6DG B5DG D4DG C3DG E3DG B3DG	OPEN	NULL
1577	Northwick Park - Maternity	0	19/02/2013 15:22:36	B6DG B5DG D4DG C3DG E3DG B3DG	CLOSED	360 REDIRECT HDON EALNG CMIDX COVERING UNTIL 1615
1577	Northwick Park - Maternity	0	19/02/2013 16:16:31	B6DG B5DG D4DG C3DG E3DG B3DG	OPEN	NWICK NOW OPEN
1577	Northwick Park - Maternity	0	21/02/2013 09:59:26	NULL	OPEN	NULL
1577	Northwick Park - Maternity	0	26/03/2013 12:38:29	NULL	CLOSED	NORTHWICK PARK MATERNITY CLOSED UFN EALING COVERING
1577	Northwick Park - Maternity	0	29/03/2013 21:36:40	NULL	OPEN	NORTHWICK PARK MATERNITY OPEN

Clinical Quality Indicators

The London Ambulance currently have eleven clinical quality indicators

1. **Outcome from acute ST-elevation myocardial infarction (STEMI)**
   STEMI is an acronym meaning 'ST segment elevation myocardial infarction', which is a type of heart attack.

2. **Outcome from cardiac arrest - return of spontaneous circulation**
   This indicator will measure how many patients who are in cardiac arrest but following resuscitation have a pulse/ heartbeat on arrival at hospital.

3. **Outcome from cardiac arrest - survival to discharge**
   Following on from the second indicator, this one will measure the rate of those who recover from cardiac arrest and are subsequently discharged from hospital.

4. **Outcome following stroke for ambulance patients**
   This indicator will require ambulance services to measure the time it takes from the 999 call to the time it takes those F.A.S.T-positive stroke patients to arrive at a specialist stroke centre so that they can be rapidly assessed for treatment called thrombolysis.

5. **Proportion of calls closed with telephone advice or managed without transport to A&E (where clinically appropriate)**
   This indicator should reflect how the whole urgent care system is working, rather than simply the ambulance service or A&E, as it will reflect the availability of alternative urgent care destinations (for example, walk-in centres) and providing treatment to patients in their home.

6. **Re-contact rate following discharge of care (i.e. closure with telephone advice or following treatment at the scene)**

If patients have to go back and call 999 a second time, it is usually because they are anxious about receiving an ambulance response or have not got better as expected. Occasionally it may be due to an unexpected or a new problem. To ensure that ambulance trusts are providing safe and effective care the first time, every time, this indicator will measure how many callers or patients call us back within 24 hours of the initial call being made.

7. **Call abandonment rate**
   This indicator will ensure that we and other ambulance services are not having problems with people phoning 999 and not being able to get through.

8. **Time to answer calls**
   It is equally important that if people/patients dial 999 that they get call answered quickly. This indicator will therefore measure how quickly all 999 calls that we receive get answered.

9. **Service experience**
   All ambulance services will need to demonstrate how they find out what people think of the service they offer (including the results of focus groups and interviews) and how we are acting on that information to continuously improve patient care.

10. **Category A 8 minute response time**
    This indicator measures the speed of all ambulance responses to the scene of potentially life-threatening incidents and measures that those patients who are most in need of an emergency ambulance gets one quickly.

11. **Time to treatment by an ambulance-dispatched health professional**
    It is important that if patients need an emergency ambulance response, that the wait from when the 999 call is made to when an ambulance-trained healthcare professional arrives is as short as possible, because urgent treatment may be needed.

In addition to these, all ambulance services are also continuing to be monitored against the standard of an ambulance reaching 95 per cent of Category A calls within 19 minutes.

The clinical dashboard can be found by accessing the link below

http://www.londonambulance.nhs.uk/about_us/how_we_are_doing/clinical_quality_indicators/clinical_dashboard.aspx

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Agenda Item 7

	Health Partnerships Overview and Scrutiny Committee 24 July 2013 **Report from Strategy, Partnerships and Improvement**
For Action	Wards Affected: ALL

Pathology Incidents: Update Report

1.0 Summary

1.1 In June, following the serious incidents around pathology test results and the subsequent Root Cause Analysis Investigation, the Health Partnerships Overview and Scrutiny Committee were presented with an Action Plan designed to address the issues raised in the investigation report. The committee requested an update on progress against this plan at this meeting.

1.2 The report gives an overview of the Governance and Quality Framework that is being used with the aim of ensuring quality in the pathology service. It includes a list of the standards that need to be met and some of the processes that aim to ensure quality. The report also lists a number of governance and accountability arrangements that the service users (Brent and Harrow CCGs and NW London Hospitals Trust) have in place, that are designed to monitor the quality of the pathology service.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to consider the report and the original Route Cause Analysis and Action Plan and question officers on: the general progress of the action plan and on the governance and quality framework, whether all of these measures/processes are now in place, and what assurances the CCG and NWLHT can now give that these will guarantee a reliable and safe service.

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Brent
Clinical Commissioning Group

Pathology Governance and Quality Framework

Background

Pathology services provide diagnostic results to clinicians to support in defining diagnosis, prognosis and to effectively manage the care of patients.

The Pathology provision delivered by TDL for the contract with Brent CCG, Harrow CCG and NWLH NHS Trust represent a mid-scale scale service with 1.654M individual reported items in May 2013.

Quality assurance and governance of Pathology services is a process that is delivered cooperatively between the provider, the customers and external agencies.

This paper describes this governance framework and the interplay between the various organisations at a high level with an intention to offer reassurance that all reasonable measures are in place to ensure quality.

Governance and quality arrangement with the Provider

The provider is bound by a regulatory framework within which they must work. Bodies such as the MHRA and CQC are responsible for monitoring and ensuring compliance at this level.

This regulatory framework is then further consolidated by an accreditation process which is undertaken by the body Clinical Pathology Accreditation UK (CPA) which is now part of United Kingdom Accreditation Service (UKAS).

The standards[1] that CPA/UKAS require the pathology service to evidence compliance with cover a very broad remit and cover all analytical and non-analytical functions of the laboratories:

A. ORGANISATION AND QUALITY MANAGEMENT SYSTEM
B. PERSONNEL
C. PREMISES AND ENVIRONMENT
D. EQUIPMENT, INFORMATION SYSTEMS AND MATERIALS
E. PRE EXAMINATION PROCESS
F. EXAMINATION PROCESS
G. THE POST EXAMINATION PHASE
H. EVALUATION AND QUALITY ASSURANCE

The provider also has a range of clinical and operational groups and mechanisms to ensure that quality is maintained and that the services are performing against all of the compliance requirements.

[1] http://www.cpa-uk.co.uk/files/PD-LAB-Standards_v2.02_Nov_2010.pdf

Notable aspects of the quality process with the provider include:

A corporate quality management group

This group facilitates the local laboratory quality management teams with compliance management and monitoring

This group also manage the regulatory and accreditation compliance feeding back to the service users via a number of forums any remedial corrective and preventative actions that have been taken or need to be planned.

Internal and External quality assurance schemes

Every test available in the laboratories has a regimen of internal quality control (IQC) to assess and mitigate issues relating to any day to day variance in results and to ensure that confidence is provided for all patient results undertaken.

Eternal quality assurance (EQA) schemes are also in place whereby special samples are sent by a third party to be run with the results being compared to peer groups of laboratories and analytical methods.

The combination of the two allows the laboratory and its users to have a be comfortable that the results provided are comparable to an expected value (EQA) and consistent over time (IQC).

Clinical, scientific and Operational groups

Forums of clinical and laboratory scientific staff meet regularly to discuss any issues and to identify any changes that need to be made to the services to ensure clinical suitability and analytical quality are maintained within the services.

Governance and quality arrangement with the service users

The service users, Brent CCG, Harrow CCG and NWLH NHS Trust have equally robust mechanisms of ensuring accountability for the delivery of clinically appropriate and analytically correct results.

Consultant led services

The services are termed as 'Consultant Led' services which means that we have invested in procuring a service whereby consultant grade clinicians and clinical scientists are responsible for the clinical leadership and quality of their respective specialities. These act as the patient advocate for all aspects of service delivery and governance including quality.

Transitional governance arrangements

Every test that was transferred from the old analytical platforms to the new equipment had in depth statistical analysis undertaken to assess many elements of the performance of the tests including important areas such as sensitivity, specificity and correlation. Only where assays were shown to perform in a clinically appropriate fashion were they authorised for use.

Consultant Heads of Departments forum

Monthly Consultant Heads of Departments meeting allow for a wide discussion of clinical and technical performance issues to be discussed and to monitor any areas where concern has been raised from other clinical forums.

Information is fed from the Quality Management Group of the provider along with operational and management data which is available within the service to be able to clearly identify and manage any risks.

Contract Clinical Management Committee

A forum is available as part of the contractual management processes which includes representation from Bret and Harrow CCGs and the Consultant Heads of Department to ensure engagement of both Primary and Secondary care clinical service users.

This forum feeds into the Contract Operational Management Committee.

Contract Operational Management Committee

This forum takes clinical and operational leads from all parties to the contract and has devolved authority to implement changes that are required for safe and effective service provision. This group is responsible to the Contract Clinical Management Committee and reports to the Contract Review Committee.

Contract Review Committee

This forum takes recommendations from the Operational Management Committee where financially significant or contractual changes are required to facilitate change and improvement of the services.

Contract Manager

The entire service provision is managed on a day to day basis by the Contract Manager which is a senior scientific post to ensure that any operational issues that arise can be managed appropriately and that continual monitoring of quality and service provision occurs.

CCG Clinical Responsible Officers

Both Brent CCG and Harrow CCG have a named Clinically Responsible Officer tasked with oversight of the services from a Primary Care perspective. These individuals lead a group of GPs within locality groups or other similar structural groups to ensure that information and concerns are passed through to the provider and also likewise back from the provider

Regulatory and clinical oversight framework

Regulatory Framework
(CQC, MHRA)

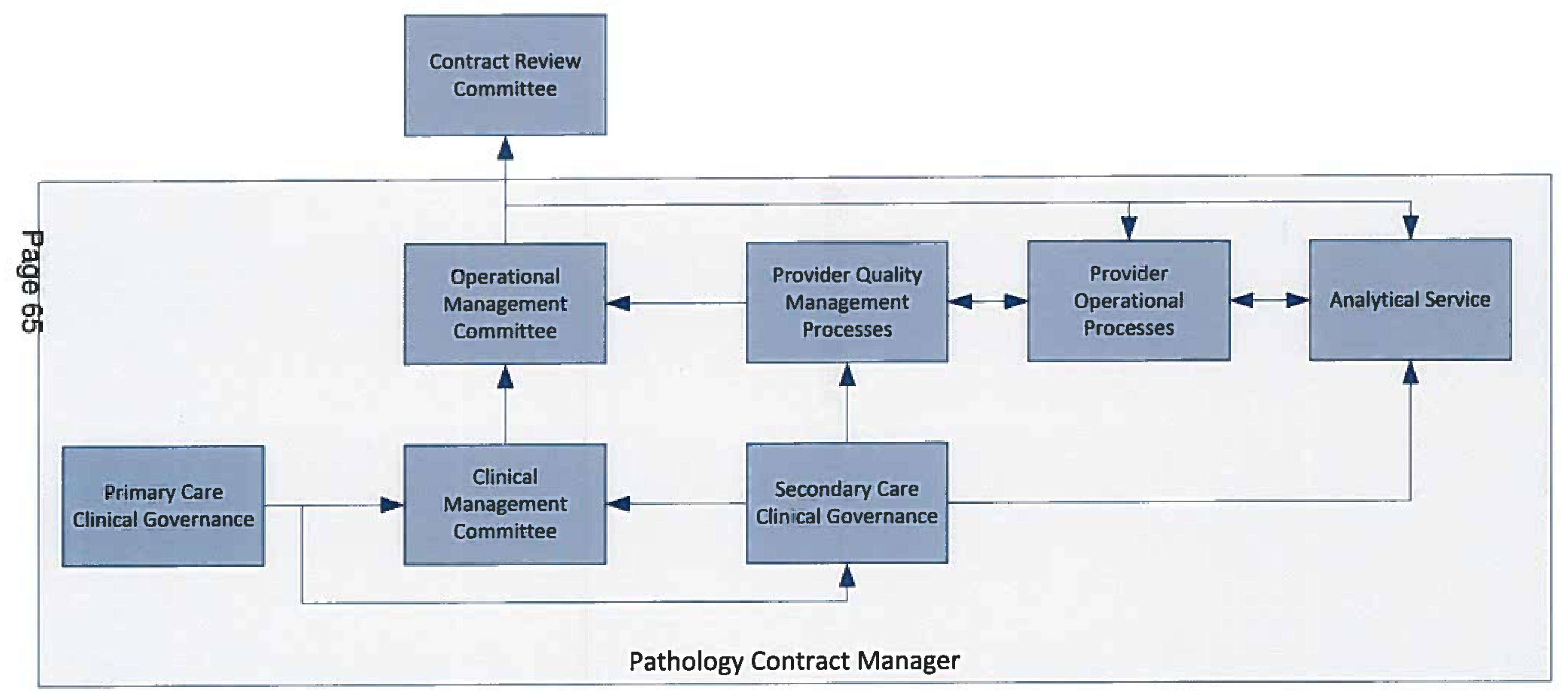
Accreditation Framework
(CPA, UKAS)

Primary Care Clinical Governance (Clinical Responsible Officers, Locality Groups)	Provider Quality Management Group	Secondary Care Clinical Governance (Consultant Heads of Department)

Laboratory Quality and Management Structures

Analytical Service

Clinical governance overview and interdependencies



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Health Partnerships Overview and Scrutiny Committee
24 July 2013

Report from Strategy, Partnerships and Improvement

For Action

Wards Affected: ALL

Central Middlesex Hospital UCC Serious Incident: Update Report

1.0 Summary

1.1 Members of the Health Partnerships Overview and Scrutiny Committee will remember that there was a serious incident at the Urgent Care Centre at Central Middlesex Hospital where a large number of X-rays had not been properly reviewed and in addition, discharge notifications had not been issued to GPs for these patients. There was a serious risk that these patients had not been properly diagnosed and that possible issues had not been dealt with.

1.2 Following a full investigation of the incidents a report was presented to the committee in October 2012, which included the full investigation report, outlined the key issues and recommendations, the actions intended to address the issues and the current status of contacting all of the patients affected.

1.3 This report provides an update on the patients/cases that needed to be contacted and followed up as a result of the incident, the changes in processes/procedures and an update on staffing, which was one of the key issues highlighted by the investigation.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to consider the report and question officers on its contents, what actions are still needed and what the remaining challenges are (including staffing).

Contact Officers

Mark Burgin
Policy and Performance Officer
Tel – 020 8937 5029
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Cathy Tyson
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Brent
Clinical Commissioning Group

Update report to the Brent Health Overview and Scrutiny Committee on the Urgent Care Centre X-ray incident

Incident in Brief:

There was a discovery of a substantial number of x-rays (some un-reviewed) that were not automatically sent to the patient's GP surgery. - The Governance team undertook a full Root Cause Analysis Investigation (RCA) and submitted to NHS London at the beginning of June 2012. Throughout the investigation a Clinical Governance Manager from the Governance team worked closely with NHS Brent.

The UCC undertook a comprehensive programme of tracing those patients that required follow up appointments following the discovery.

The majority of patients were contacted in the following weeks and offered follow up appointments. This process involved contacting the patients by letter which was then followed up with a telephone call to ensure they had received and understood this information. It was clearly explained to each patient what had happened and the process agreed for following up their individual conditions.
The GP surgery was also informed and given the appropriate briefing about the condition, x-ray result and to expect the patient to attend a follow up appointment.

In cases where the patient had moved GP surgeries the patients were traced and the same process followed.

There were a number of "cold cases" (those who could not be initially traced), 11 in total, which took considerably longer to trace. It is not unusual for a number of these to remain outstanding when a Serious Untoward Incident is closed but by December 2012 all patients had been traced and contacted and had completed their follow up.

While the patients remained the primary focus, a number of actions were required from Care UK to give assurance that the Serious Untoward Incident had led to change in the processes and procedures that would significantly reduce the chance of an incident of this type occurring again, specifically;

1) A full review of the recruitment processes of Senior Operational Staff and Senior Clinical Staff to be undertaken including:
   - A review of the recruitment assessment procedures, competency assessments and CRB clearance
2) Robust re- training of the radiology process at Brent UCC from first contact to discharge for all staff including the Brent UCC management team.
3) Robust induction programme which includes the radiology process for all Non-Substantive staff.
4) An operational process to ensure the radiology reports are reviewed by a competent clinician on a daily basis and scanned, attached, closed and sent to GP surgery in a timely fashion.
5) Newly mobilised services to have "post go live IT test audits" at regular intervals i.e. monthly for the first three months and then bi monthly for next six months and then quarterly thereafter.
6) Ionising Radiation Medical Exposure Regulations 2000 (IRMER) update training for all clinical staff referring to radiology.
7) "Datix DIFF Two" (risk and clinical safety tool) training made mandatory training for all Service Managers and their deputies.
8) To ensure reception staff to check and log all child attendances as per procedure in the local Brent UCC safeguarding Children policy.
9) Ensure that all non- substantive staff are provided with the appropriate safeguarding children policies & referral procedures and training.
10) Ensure all employed staff undertake the required Safeguarding training at the appropriate level.

While there remain challenges the Brent Urgent Care Centre is now nearly fully recruited to in respect General Practitioners with 0.75 whole time equivalent (wte) vacant and being filled by locums in a complement of 8 wte GP staff. Nursing staff remain a concern with 2 wte staff vacant in a complement of 7 wte nursing staff.

It is important to note that there is never an occasion when there is a non -substantive member staff on the rota without robust and experienced UCC staff also on duty.

In January this year 2013, CQC undertook an unannounced visit and reviewed Outcomes of the service. CQC's report deemed Brent UCC to be fully compliant on all outcomes reviewed.

8th July 2013

Health Partnerships Overview and Scrutiny Committee
24 July 2013

Report from Strategy, Partnerships and Improvement

For Action

Wards Affected: ALL

Healthwatch Progress Update

1.0 Summary

1.1 As the Health Partnerships Overview and Scrutiny Committee is aware, under the Health and Social Care Act 2012, from April 2013 Local Healthwatch became the consumer champion for health and social care.

1.2 This report outlines the progress that Healthwatch Brent (HWB) has made to date in getting "up and running" and on engaging with the public, community organisations and decision makers to build long term relationships.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to consider the report and question representatives from Healthwatch on its contents, the progress made to date and their intended priorities for the rest of the year.

Contact Officers

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HealthwatchBrent Progress Update July 2013

healthwatch brent

HWB is just over 3 months old but significant progress has been made in all areas.

Governance

HealthwatchBrent, a company limited by guarantee was established on March 27th. The 4 consortium partners- Brent Mencap, Age UK Brent, Brent Citizens Advice Bureau and Elders Voice Brent are the founding members of this company and their chief executives are the company directors. A 5th founding member was admitted at a directors meeting on April 10th-Brent CVS. Their Chief Executive became the 5th company law director then.

A public meeting had been set for Monday21st June at the Village School in Kingsbury but is now planned for 15th July. As a CIC, HWB does not need to hold AGMs but the constitution allows for an annual review meeting. The meeting on 15th July will concentrate on progress to date, the election of community directors and getting member feedback on what the work plan for the next 6 months should include.

The CLG was converted to a Community Interest Company by mid May 2013. We then developed adverts and detailed role descriptions for an independent Chair and 5 other directors. These were circulated to each organisations mailing list, through newsletters, the Brent Magazine, through the HWB website and by Brent CVS. The 3 applications received were reviewed by an appointments panel in early July and members will be able to approve these applications if they wish on 15th July. 2 out of 3 candidates are new and were not previously involved in Brent Link. This leaves a vacancy for an independent chair and 2 community directors. We will publicise these vacancies over the summer in the press and have another appointments panel in late August.

The CIC bank account has been set up and relevant insurance is being sought.

Membership. After discussion we decided that membership would be open to someone who

- is a past, current or potential user of health and social care services for people of all ages in Brent or a nearby area. This includes any person living, working, studying or caring for someone in such area; or
- is committed to improving health and social care services for people of all ages in Brent or a nearby area; or
- is committed to being actively involved in the Company's activities; or
- is a child or young person living, studying or working in Brent or a nearby area; or
- is committed to equality and willing to challenge discrimination,

The membership form has been available on the HWB website and has been distributed in paper form by HWB workers at community events and the link has been publicised in HWB emails and fliers. We currently have 37 members and 5 friends- other paper applications still need to be inputted. However we have publicised Healthwatch Brent to many more people as reported elsewhere.. There have been some difficulties with the website(which is a template provided by Healthwatch England) and we have amended the form after feedback from some potential members. Our aim is to empower as many people as possible to give their views on health and social care, through wide involvement in consultation processes, related groups, complaining, etc and people should be able to do this without becoming formal HWB members.

Policies. Research on which policies HWB will need is underway. HWB paid staff and volunteers will operate within host organizations policies so HWB will only need certain overarching policies such as conflict of interest, finance and safeguarding children and adults

Community meetings

Our target was to achieve 40 visits targeting 400 people in first year. We have visited 14 community groups and events and reached about 176 people, with another 100 spoken to at Chalkhill and Gladstonebury. The list below shows the breadth of groups visited.

All consortium partners have spoken about HealthwatchBrent at a range of partnership meetings they attend and distributed information and links.

HWB's first formal meeting was at Age UK Brent and Brent Pensioners Forum Event on 29th April – which was publicised throughout the Borough. Event attended by 117 older people. We then attended the Kilburn PPG in early May

Gathering Views Outreach meetings

1. Visit to Hibiscus Senior Citizens Club Monday 3rd June - 15 to 16 people in the group

The Hibiscus Club is mainly for older members of the West Indian Community. It has been running for over 15 years and the current organiser feels that the group is not often heard.

2. Roundwood Youth Club 29th May & 31st May approx. 10 people

Visited to speak with Youth Worker and attended evening session (7 to 8) on 31st May. The youth centre age range is from 13 to 25. They have a mixed group attending on Friday evenings for sporting activities. On Mondays young people with a range of disabilities come to a group.

3. L and Q Open day. 29th May South Kilburn Estate. This was poorly attended due to weather). Only spoke to a handful of people.

4. Brent Learning Disability Health Check day 30 June Event attended by a lot of people.

5. Brent Mencap Health discussion Group 4th June. 10 individuals at the meeting

6. Dudden Hill Community Centre 7th June. About 30 people attended.

7. Chalkhill Open Space Day. 8th June. A lot of people asked for information.

8. Carers Hub Launch 10th June. There were 20 carers present.

9. Asian People's Disability Alliance. 13th June. There were approx 30 service users present.

10. Brent Youth Parliament 29th June. Age range 10 - 19. 15- 20 attended the event while I was there.

11. Gladstonebury Festival Park 30th June. 3HWB staff were at this event for part of the time. Many people came to talk and take leaflets. They also spoke to other service providers at the event.

12. Bheard Service user meeting. Friday 5th July 12 people attended meeting.

High level Formal meetings

Our Target was to prepare for and attend 25 high level strategic meetings a year. By 24 July we will have attended 7

Tessa Awe (Brent CVS) has attended Brent CCG Governing Body Meetings

Ann O'Neill (Brent Mencap) has attended 2 Brent CCG Quality, safety and Clinical Risk Committees as well as a North West London Quality and Surveillance group

Daksha Chauhan Keys (Age UK) attended the Health and Well being Board on July 3rd

Jacqueline Carr Brent CAB will attend the EDEN committee.

Directors will attend Health Partnerships Overview and Scrutiny Committee

2 Directors attended the Healthwatch launch event in London on 11th April

We have been invited to attend a meeting to discuss public engagement re the possible merger of Northwest London Hospital Trust with Ealing hospital on 12 July. Ealing and Harrow Healthwatch representatives will also be there.

Staffing

There are staff in post for all posts, the co-ordination post will be advertised and recruited to by September 2013, and in the meantime Brent Mencap Executive director will work 14hrs per week on this role. All HWB workstreams have HWB email addresses except the co-ordination and making views known ones. All HWB staff are available on Wednesdays as well as other times during the week.

An induction session was held on 24th April so the team members could meet each other and work plans finalized and they began to work as the HWB team. They have also had fortnightly staff meetings since then, and a planning day will take place with directors and staff on 24th July. Most staff also attended a training day recently on background to HWB, current health and social care issues, equality and safeguarding Adults and children alongside new volunteers.

Volunteers

Our target is to recruit 35 volunteers during the first year.

A HWB volunteer policy has been developed. Some are due to begin volunteering with HWB in July 2013. The calibre of volunteers has been high. To end of June we have interviewed 13. We have 2 good references for 9 of them. 6 have been passed to workstreams. The rest are awaiting training. 3 new applications so far in July

Publicity and access

The HWB flier was finalized with contact details of work-streams, website, and freephone number by 28th April and circulated via email. An updated printed version will be circulated and distributed in July. The website was up and running with initial information by the end of April but there have been glitches with the website template. 3 bulletins with a mix of national and local health and social care news have been developed and distributed through the website.

So far we have had 12 phone enquiries about health and social care issues, (evidence from other areas shows that telephone enquiries are low) many emails about events, membership. There have been no drop in enquiries.

Links with Health Watch England and other local Healthwatches

HWB's contact details have been given to HWE so HWB details are now on the national HW map; we are receiving their updates and newsletters. We have also begun to receive emails from other local healthwatches with queries and expect to start meeting some of them soon. We will be part of a London wide action learning set for representatives who attend health and well being boards

Links with CQC

We receive a regular update from CQC re inspections they have undertaken in the London area. Links to local reports will be established on the HWB website. We have been in contact with Andreas Schwarz, our Compliance Inspector and will be setting up regular meetings with him soon. We will be publicising the CQC consultation documents and collating local feedback

Ann O'Neill 10/07//2013

www.healthwatchbrent.co.ukenquiries@healthwatchbrent.co.uk or our free phone number is 0800 9961839. The line is open Mondays from 10am - 1pm and Wednesdays from 2–5pm

Health Partnerships OSC

Work Programme 2013-14

Meeting Date	Item	Issue	Keep/Remove
Recurring	Emergency Services	Current issues around emergency services/A&E at North West London Hospitals and immediate, mid and long term plans to address current problems and improve services.	
Recurring	NWLHT and EHT Merger	Update on the merger between North West London Hospitals Trust and Ealing Hospitals Trust and on current progress against financial targets.	
TBC	Public Health	At the June 2013 HOSC members commented of the need to receive regular reports on how public health services were working.	
TBC	Health Visitors	Following previous concerns about the recruitment and retention of Health Visitors, the committee	
TBC	Out of hospital care strategy	As part of the Shaping a Healthier Future work, Brent will be preparing an Out of Hospital Care Strategy. The committee will consider the strategy and respond to the consultation.	
TBC	Palliative care	Following a presentation from the CCG followed by St Luke's Hospice in March 2013, the committed requested that the CCG return with a more detailed report on Palliative Care in Brent and that included the Brent End of Life Strategy which was not available to members at the time of the meeting.	
TBC	Diabetes and physiotherapy services – plans to re-commission services in Brent	NHS Brent plans to re-commission diabetes and physiotherapy services in the borough. The committee should consider the plans for the new services, as well as the consultation plan.	
TBC	Housing Advice in a Hospital Setting	Care and Repair England has produced a report on integrating housing advice into hospital services. Brent Private Tenants Rights Group would like to bring this report to the committee to begin a conversation on the best way to take this forward in Brent.	

TBC	Health Inequalities Performance Monitoring	The Health Select Committee should make health inequalities a major focus of its work in 2010/11. As part of this, a performance framework has been developed to monitor indicators relevant to the implementation of the health and wellbeing strategy, which relate to the reduction of health inequalities in the borough. This framework will be presented to the committee twice a year, with a commentary highlighting key issues for members to consider.	
TBC	Sickle Cell and Thalassaemia Services Report	The Committee has asked for a report Sickle Cell and Thalassaemia services at North West London NHS Hospitals Trust. The committee will invite sickle cell patient groups to attend for this item to give their views on services in the borough. This follows a previous report on changes to paediatric in patient arrangements at NWL Hospitals. Members are keen to know how sickle cell patients have been dealing with this change.	
TBC	Fuel Poverty Task Group	Recommendation follow up on the task group's review.	
TBC	Breast Feeding in Brent	Following a report in March 2011 on the borough's Obesity Strategy, the committee has requested a follow up paper on the Breast feeding service in the borough. Members were particularly interested in the role of peer support workers and how mothers are able to access breast feeding services. The committee would also like to have accurate data on breast feeding initiation and prevalence in Brent.	
TBC	TB in Brent	Added at the request of the committee (meeting on 20th Sept 2011).	
TBC	GP access patient satisfaction survey results	In December 2011 the results of the six monthly patient survey will be published. Members should scrutinise the results with Brent GPs to see how their initiatives to improve access are reflected in patient satisfaction.	
	Teenage Pregnancy	Members have asked for a report on teenage pregnancy in Brent, the services available and conception rates amongst teenagers.	
	Abortion services in Brent	Councillors have asked for a report on abortion services in Brent, and the abortion rates in the borough, including repeat abortions. This could include a more general update on sexual health provision in Brent.	
TBC	Brent MENCAP Update on work	At the November 2012 HOSC members heard from MENCAP on their work around Health Services for People with Learning	

		Disabilities. Members requested an update on MENCAPs work at a future meeting.	
TBC	Diabetes Task Group	Update on progress of the Diabetes Task Group recommendations.	

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Smith Peter

From: Smith Peter
Sent: 11 May 2015 09:51
To: johnlister@healthemergency.org.uk; Hirst Stephen (NHS HOUNSLOW CCG) (s.hirst1@nhs.net)
Cc: 'Katy Rensten' (Katy.Rensten@coramchambers.co.uk); Marcia Willis Stewart (StewartM@birnbergpeirce.co.uk); rescue_uk@yahoo.com; rgst@iconism.net; cathy.tyson@brent.gov.uk
Subject: FW: North West London Healthcare Commission - Evidence

Dear Commissioners

Saturday's penultimate witness has asked that this response to the statement requested by Ursula Gallagher, of Brent CCG, be forwarded to you.

Peter

From: Ruth Bradshaw [mailto:ruth@ruthbradshaw.myzen.co.uk]
Sent: 10 May 2015 21:21
To: Smith Peter
Subject: RE: North West London Healthcare Commission - Evidence

Dear Mr Smith

Thank you for all the advance information about the hearing at Brent Civic Centre, and particularly for the warning that the Jubilee Line would not be running.

Please would you forward the following comment to the Independent Healthcare Commission for North West London.

At the end of the hearing at Brent Civic Centre, the Chair announced that one of the witnesses who manages the SaHF programme had notified him that, if she had been questioned about my evidence, she would have stated that there are staff at the Urgent Care Centres who are able to resuscitate patients. I am glad to hear this.

However, all the detailed information that has been circulated about Urgent Care Centres states that they treat a list of conditions which does not include breathing difficulties, nor does it include chest pain. The information that has been circulated about Accident and Emergency departments clearly states that they are the right places to take patients who are suffering breathing difficulties or chest pain. The problem is that most of the public have not studied and memorised all this information, nor should they be expected to have done so. The name of a facility should make clear what kind of conditions it treats.

The whole justification for concentrating acute care and Accident and Emergency departments in fewer hospitals is that seriously ill patients receive a better quality of care from more highly qualified doctors who are dealing with such patients all the time. Therefore, even if the General Practitioners at the Urgent Care Centres have been trained in resuscitation and have the necessary equipment for it, patients who require it should still be clearly directed to an Accident and Emergency department.

The so-called "urgent" conditions that are listed as suitable for an "Urgent Care Centre" are unlikely to do serious damage to a patient who has to wait several hours for treatment. Breathing difficulties and heart attacks can kill in a few minutes and are therefore more urgent than the minor injuries and ailments that are to be treated in a so-called "Urgent Care Centre".

I still believe that giving a different name to the stand-alone Urgent Care Centres may save lives in the future. I repeat my request that you recommend this change in your report.

Yours sincerely
Ruth Bradshaw.

> -----Original Message-----
> **From:** Smith Peter [mailto:Peter.Smith@lbhf.gov.uk]

Sent: 08 May 2015 11:42
To: 'Ruth Bradshaw'
Subject: RE: North West London Healthcare Commission - Evidence

Dear Ruth

Thank you for your submission of written evidence to the Healthcare Commission. All evidence received and considered by the Commission has now been published, along with transcripts of the oral evidence hearings to date. As you know, the final hearing is to take place at Brent Civic Centre tomorrow and I thank you for agreeing to partake in this hearing.

An interim report, with recommendations directed at a new Government, has also been published and all of this documentation can be found via the following link: www.lbhf.gov.uk/healthcarecommission. The Commission expects to publish its final report in the Summer.

Thank you once again for your significant contribution to the important work of the Commission.

Kind regards,

Peter Smith
Clerk to the NWL Healthcare Commission
Communications and Policy Division
Finance and Corporate Services Department
London Borough of Hammersmith and Fulham
tel. 020 8753 2206

From: Ruth Bradshaw [mailto:ruth@ruthbradshaw.myzen.co.uk]
Sent: 23 February 2015 15:37
To: Smith Peter
Subject: North West London Healthcare Commission - Evidence

Dear Sir

Please forward the following submission to the Independent Healthcare Commission for North West London.

The name "Urgent Care" is too similar to "Accident and Emergency"

A small but possibly life-saving change should have been made when the Accident and Emergency department was removed from Central Middlesex Hospital. The Urgent Care Centre there should have been given a different name. This can still be done.

One of my neighbours was taken ill in the last week of December 2014. His brother, knowing that the Ambulance Service was very busy, took him to Central Middlesex Hospital in a cab. In the Urgent Care Centre his condition worsened and he collapsed. The staff at the Urgent Care Centre had neither the right equipment nor the specialist knowledge to revive him, so they called an ambulance. By the time he was revived, he had not been breathing for about 15 minutes and had suffered brain damage. He died in hospital two weeks later.

The brother does not know whether the outcome would have been different if he had called an ambulance. Nobody can know that. However, in conversation with several neighbours it has become clear to me that most of them do not understand the present provision for emergency care, and that the name "Urgent Care Centre" is misleading. When the Urgent Care Centre was opened, the Accident and Emergency department was in the next room. If something really was urgent, the patient was immediately taken through the door to the Accident and Emergency Department. This has changed completely. An ambulance staffed

by paramedics can now offer emergency treatment better and more quickly than the mis-named Urgent Care Centre.

The other "Urgent Care Centre" without an Accident and Emergency department, at Wembley Centre for Health and Care, used to be called a "Minor Accident Treatment Centre" or "Minor Ailment Treatment Service". It was then quite clear that it did not deal with life-threatening conditions. Its name should not have been changed to "Urgent Care Centre".

The minor treatment provision at Edgware Community Hospital, which also has a walk-in GP service, is known to local people simply as "The Walk-In Centre", so it is known that it does not deal with emergencies. However, I am not sure whether it is also now officially called an Urgent Care Centre; if it is, this also is a mistake.

I do not know whether my neighbour would still be alive if the stand-alone Urgent Care Centres had been given a different name. However, I do believe that re-naming them now may save lives in the future. Please recommend this change in your report.

Yours faithfully
Ruth Bradshaw (Mrs)

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Willesden
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NW10 1BG

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Email: ruth@ruthbradshaw.myzen.co.uk

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Hammersmith & Fulham - Local Government Chronicle "Council of the Year" 2010