OVERVIEW AND SCRUTINY COMMITTEE

TUESDAY 25 SEPTEMBER 2007
7.30 PM

COMMITTEE AGENDA

COMMITTEE ROOM 5
HARROW CIVIC CENTRE

MEMBERSHIP (Quorum 4)

Chairman: **Councillor Stanley Sheinwald**

Councillors:

Don Billson	**Mrs Margaret Davine**
Mrs Janet Cowan	**B E Gate**
Mrs Myra Michael	**Mitzi Green (VC)**
Anthony Seymour	**Jerry Miles**
Dinesh Solanki	
Yogesh Teli	
Mark Versallion	

Representatives of Voluntary Aided Sector: Mrs J Rammelt/Reverend P Reece
Representatives of Parent Governors: Mrs Despo Speel/Mr Ramji Chauhan

(Note: Where there is a matter relating to the Council's education functions, the "church" and parent governor representatives have attendance, speaking and voting rights).

Reserve Members:

1. Robert Benson	1. Bill Stephenson
2. Ashok Kulkarni	2. Phillip O'Dell
3. Manji Kara	3. Navin Shah
4. Mrs Kinnear	4. Mrs Rekha Shah
5. Barry Macleod-Cullinane	
6. Mrs Lurline Champagnie	
7. Mrs Vina Mithani	
8. Jeremy Zeid	

Issued by the Democratic Services Section,
Legal and Governance Services Department

Contact: Daksha Ghelani, Senior Democratic Services Officer
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HARROW COUNCIL

OVERVIEW AND SCRUTINY COMMITTEE

TUESDAY 25 SEPTEMBER 2007

AGENDA - PART I

1. **Attendance by Reserve Members:**

   To note the attendance at this meeting of any duly appointed Reserve Members.

   Reserve Members may attend meetings:-

   (i) to take the place of an ordinary Member for whom they are a reserve;
   (ii) where the ordinary Member will be absent for the whole of the meeting; and
   (iii) the meeting notes at the start of the meeting at the item 'Reserves' that the Reserve Member is or will be attending as a reserve;
   (iv) if a Reserve Member whose intention to attend has been noted arrives after the commencement of the meeting, then that Reserve Member can only act as a Member from the start of the next item of business on the agenda after his/her arrival.

2. **Declarations of Interest:**

   To receive declarations of personal or prejudicial interests, arising from business to be transacted at this meeting, from:

   (a) all Members of the Committee, Sub Committee, Panel or Forum;
   (b) all other Members present in any part of the room or chamber.

3. **Arrangement of Agenda:**

   To consider whether any of the items listed on the agenda should be considered with the press and public excluded on the grounds that it is thought likely, in view of the nature of the business to be transacted, that there would be disclosure of confidential information in breach of an obligation of confidence or of exempt information as defined in Part 1 of Schedule 12A to the Local Government Act 1972.

4. **Minutes:**

   That the minutes of the meeting held on 6 September 2007 be deferred until printed in the next Council Bound Minute Book.

5. **Public Questions:**

   To receive questions (if any) from local residents/organisations under the provisions of Overview and Scrutiny Procedure Rule 8.

6. **Petitions:**

   To receive petitions (if any) submitted by members of the public/Councillors under the provisions of Overview and Scrutiny Procedure Rule 9.

7. **Deputations:**
To receive deputations (if any) under the provisions of Overview and Scrutiny Procedure Rule 10.

8. **References from Council/Cabinet:**
(if any).

9. **Report from the Scrutiny Policy and Performance Lead Members Quarterly Briefings:** (Pages 1 - 6)

10. **Brent Birthing Centre - Future Services:** (Pages 7 - 20)
Paper submitted by the Chief Executive of the North West London Hospitals NHS Trust

[There will be a presentation on this item].

11. **Standing Scrutiny Review of NHS Finances – Carers Case Study – Interim Report:** (Pages 21 - 46)
Report of the Director of People, Performance and Policy

12. **Healthcare for London: A Framework for Action – Preparing for a possible joint Overview and Scrutiny Committee:** (Pages 47 - 68)
Report of the Director of People, Performance and Policy

13. **Standing Scrutiny Review of the Budget – Initial Scope:** (Pages 69 - 76)
Report of the Director of People, Performance and Policy

14. **Scrutiny/Executive Protocol:** (Pages 77 - 82)
Report of the Director of People, Performance and Policy

15. **Any Other Business:**
Which the Chairman has decided is urgent and cannot otherwise be dealt with.

AGENDA - PART II - Nil

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Meeting:	Overview and Scrutiny Committee
Date:	25th September 2007
Subject:	Report from the scrutiny Policy and Performance Lead Members Quarterly briefings
Key Decision: (Executive-side only)	N/A
Responsible Officer:	Lynne McAdam, Service Manager Scrutiny
Portfolio Holder:	
Exempt:	No
Enclosures:	Appendix One: Report from the Policy and Performance Lead Members

Section 1 – Summary and Recommendations

This report sets out the items that have been considered by the scrutiny policy and performance leads at their quarterly briefings and details the recommendations they would like the committee to consider with regard to further action/escalation

Recommendations:

Councillors are recommended to:

i Consider the report from the Scrutiny policy and performance leads and consider recommendations as included therein.

Reason: (For recommendation)

To ensure that the activities and recommendations for further action as agreed during the ¼ly briefings of the scrutiny policy and performance leads are publicly reported and endorsed by committee

Section 2 – Report

Background (if needed)

This report records the outcomes of quarterly briefings of scrutiny lead policy and performance councillors and seeks the endorsement of committee of the action proposed. The report is divided into 5 sections and individual reports are included from each policy and performance lead team:

- Adult Health and Social Care
- Children and Young People
- Corporate Effectiveness and Finance
- Safer and Stronger Communities
- Sustainable Development and Enterprise

Current situation

Not appropriate to this report

Why a change is needed

Not appropriate to this report

Main options

Not appropriate to this report

Other options considered

Not appropriate to this report

Recommendation:

To consider and endorse the reports from the scrutiny policy and performance leads

Considerations

Resources, costs and risks

Any costs associated with these recommendations will be met from within existing resources. Where specific projects are escalated for more detailed consideration in the scrutiny process, specific implications of these projects will be considered during the scoping process

Staffing/workforce

There are no staffing or workforce considerations specific to this report. Where specific projects are escalated for more detailed consideration in the scrutiny process, specific staffing implications of these projects will be considered during the scoping process

Equalities impact

There are no specific equalities implications in this report. Where specific projects are escalated for more detailed consideration in the scrutiny process, specific equalities implications of these projects will be considered during the scoping process

Community safety (s17 Crime & Disorder Act 1998)

There are no specific equalities implications in this report. Where specific projects are escalated for more detailed consideration in the scrutiny process, specific community safety implications of these projects will be considered during the scoping process

Legal Implications
There are no legal implications arising from this report

Financial Implications
Any costs to carry out these recommendations will be met from existing budgets.

Performance Issues
Current KPI's and Likely impact of decision on KPI's

Scrutiny performance management issues

Recommendations matrix attached as appropriate ☐

Section 3 - Statutory Officer Clearance

Name: Sheela Thakrar Date: 14th September 2007	✓	on behalf of the Chief Financial Officer
Name: Jill Travers Date: 14th September 2007	✓	on behalf of the Monitoring Officer

Section 4 - Contact Details and Background Papers

Contact: Lynne McAdam, Service Manager Scrutiny
020 8420 9387

Background Papers:

If appropriate, does the report include the following considerations?

1.	Consultation	YES / NO
2.	Corporate Priorities	YES / NO

APPENDIX ONE

REPORTS FROM THE SCRUTINY POLICY AND PERFORMANCE LEADS QUARTERLY BRIEFINGS – AUGUST – SEPTEMBER 2007

Adult Health and Social Care

The quarterly briefing for the Policy and Performance Leads for Adult Health and Social Care is planned for 5 October. Nevertheless a number of issues have been brought forward to the Leads and discussed informally:

Brent Birthing Centre

North West London Hospitals Trust approached scrutiny members regarding their proposals for the future of Brent Birthing Centre and the consultation process surrounding this. The proposals have implications for Harrow women and Northwick Park Hospital. A report was requested for O&S Committee on 25 September.

Local Involvement Networks

A briefing paper has been produced on the proposals for LINks and the local preparations needed pending legislation. The briefing was noted.

'Healthcare for London: A Framework for Action' ('Darzi Review')

A briefing paper was produced summarising the review and outlining the implications for scrutiny (e.g. the need to possibly form a pan-London joint OSC to discuss the broad principles). A report was requested for O&S Committee on 25 September to ascertain Harrow's stance on the possible participation in a JOSC.

Children and Young People

The Policy Lead and the Scrutiny Officer met on 30 August. The Performance Lead was unavailable to attend due to illness.

"Care Matters" White Paper

Identified as a potential area for review and to be included in further report on work programme.

The future of schools

(including the wrap-around services provided by schools and the effectiveness of this provision) was identified as a potential area for review. This is already included as a potential item on the work programme.

The performance of the schools advisory function

Future updates on progress required on this issue - possibly via Q&A with the relevant portfolio holder.

Corporate Effectiveness and Finance

The Policy and Performance Leads for Corporate Effectiveness and Finance met on 10th September

IIP
Briefing noted

Strategy for People
Briefing noted

IPADs
Briefing noted

Staff Survey
Briefing noted. Head of Human Resources to be invited to the next briefing to discuss morale across the organisation and how staff are being empowered/ encouraged to deliver change.

Employment legislation changes
Briefing was noted but councillors have asked that future legislative changes are only included in so far as their likely impact on the council can be quantified

Local Area Agreements
Briefing was noted and further information will be provided as the future arrangements for the Local Area Agreement become clearer.

Comprehensive Area Agreements
Briefing was noted and further information will be provided as the future arrangements for Comprehensive Area Agreements become clearer.

BVPI General Satisfaction Survey
Briefing was noted. Further information will be provided via the briefings

Safer and Stronger Communities

There is no report from the Policy and Performance Leads for Safer and Stronger Communities.

Sustainable Development and Enterprise

The Policy and Performance Leads for Sustainable Development and Enterprise met on 15 August 2007.

Policy review
Briefing noted. It was agreed that an update would be provided on transport issues at the next meeting.

Skills White Paper
Briefing noted.

Housing Green Paper
Briefing noted. A decision on further action will be taken upon the publication of a White Paper.

Nottingham Declaration
Briefing noted. Further information will be carried out on the council's ongoing response through work on the energy use review.

Feasibility studies on demography review, energy use review, town centre redevelopment review
Briefings noted. Decided that Overview and Scrutiny should be recommended to pursue these projects.

Work programme long list
Briefing noted. It was suggested that reports on the progress on implemented recommendations from the water management and information pack light touch reviews might be considered by Overview and Scrutiny relatively soon.

Brent Birthing Centre – Future Services

1. Purpose

This paper outlines why The North West London Hospitals NHS Trust is considering changes to the Brent Birthing Centre (BBC) at Central Middlesex Hospital in Park Royal. It goes on to outline some possible options for the service as well as the next steps which will be required before any public consultation with key stakeholders and the local community

2. Background

The Brent Birthing Centre was opened in 2004 and is managed by North West London Hospitals NHS Trust. The Centre has six ensuite rooms, one with disabled access and two with birthing pools. The building was designed to create a home from home environment for women and is situated on the site of the new Central Middlesex Hospital. Midwifery-led units, like the Brent Birthing Centre, are designed for women who are expected to have straightforward deliveries and who want midwife support during their labour and delivery.

Full antenatal clinic services are also provided within the Centre, together with office accommodation for consultant and secretarial staff. Clinics are currently held daily between Monday and Friday. Postnatal care is currently provided in women's homes by community midwives, employed by the Trust. This service would continue regardless of any decisions for change affecting the Brent Birthing Centre.

3. Why we are considering change

There are a number of reasons why North West London Hospitals NHS Trust is considering changes to the Brent Birthing Centre. These are listed below:

- **To improve clinical care**

Currently 25% of women at the Brent Birthing Centre who had expected straightforward deliveries need to be transferred to Northwick Park Hospital as they need care by obstetricians. If we were to move the service to Northwick Park Hospital women would have on site access to obstetric care 24 hours a day, seven days a week.

- **Lack of demand for the current service**

Despite actively promoting the Brent Birthing Centre, midwives deliver in the region of 300 births a year. The centre currently has a 16 per cent occupancy rate.

Given the size of the catchment area for Brent and Harrow we would have expected to see around 1,200 – 1,500 women choosing to deliver their baby at the Brent Birthing Centre.

Women living in Harrow
In general, women living in Harrow do not use the Brent Birthing Centre. In 2006/2007 18 Harrow residents delivered their baby at the centre which represents less than 0.5% of Harrow births. Given the size of the female population in Harrow (with an overall number of births registered to Harrow GPs in the region of 2,520) we would expect around 600 women to have been able to use a facility like the Brent Birthing Centre. Currently there is no midwifery led unit in Harrow.

Women living in Brent
90% of the women who use the Brent Birthing Centre are Brent residents. Only five per cent of all births registered to a Brent GP took place at the Brent Birthing Centre. That is 274 births out of a total of 5,440 births registered to Brent GPs. Given the size of Brent's population and overall birth numbers the Trust could deliver in the region of around 800 - 1,000 births for low risk women living in Brent at the Brent Birthing Centre.

- **Preparing for the future**

London is facing an increasing number of births, with an overall projected increase of five per cent by 2016. It is important that we are able to support these changes and use our resources efficiently so that we can provide enough midwives and obstetricians to care for future mothers and babies.

- **Choice for women**

If we were to provide the service at Northwick Park Hospital women from across both Brent and Harrow would have access to midwifery led care. Antenatal care would continue to be provided at Central Middlesex Hospital which would ensure continuing local access for women in the south of Brent.

Moving the service to Northwick Park Hospital would still allow women to be cared for in a home-from-home environment similar to the Brent Birthing Centre but with the comfort of knowing there is on-site obstetric care available 24 hours a day, seven days a week.

- **Making the best use of taxpayers' money**

The Brent Birthing Centre currently costs the local NHS £1.2m a year to run but because of the lack of demand for the service the Trust is running the service at a loss of £300,000 a year. In order to meet minimum staffing levels and provide a safe level of care for those women who do use the facility, the unit is staffed 24 hours a day and seven days a week by two midwives at any one time. The unit also has administrative support.

4. Possible options for the future

In thinking about the future of the Brent Birthing Centre a number of options have been considered. These are initial thoughts and are subject to further discussions with local Patient Forums, Scrutiny Committee and NHS partners prior to formal consultation. The options so far considered are as follows:-

1) Do nothing - the Trust would continue to provide midwifery led services at the Brent Birthing Centre at Central Middlesex Hospital.

2) Transfer all maternity care to Northwick Park Hospital's Maternity Unit. There would no longer be a Midwifery Led Unit on either site, and antenatal services would not be provided at Central Middlesex Hospital

3) Transfer inpatient (delivery) maternity care to Northwick Park Hospital's Maternity Unit. Create a midwifery-led unit within Northwick Park Hospital's recently refurbished maternity unit. Antenatal care would continue to be provided from the Brent Birthing Centre.

4) Transfer inpatient (delivery) maternity care to Northwick Park Hospital's Maternity Unit. Establish a midwifery led unit at Northwick Park Hospital. Keep antenatal services at Central Middlesex Hospital but not in the Brent Birthing Centre.

This is not a final list and other options may be considered in the light of discussions with staff and other stakeholders. A summary of the main advantages and disadvantages of each option is provided below:-

OPTION 1 Do nothing	
Advantages	**Disadvantages**
Local access. Maintains local access to a midwifery led unit for women living in Brent. **Lack of disruption**. The Trust does not have to find accommodation for existing activities.	**Transfer rate**. Women who experience complications during delivery at Brent Birthing Centre currently have to be transferred to Northwick Park Hospital. 25% of women who currently present for delivery are transferred. **Inefficient use of staff and buildings**. The Trust would continue to lose £300,000 a year by running the service. The Trust has a duty to ensure that it makes the best use of taxpayers' money.

OPTION 2 Transfer all maternity care to Northwick Park Hospital's Maternity Unit. There would no longer be a midwifery led unit at either Northwick Park or Central Middlesex hospitals. There would be no antenatal services provided at Central Middlesex Hospital.	
Advantages	**Disadvantages**
Generates income to be reinvested into patient care. The Trust would be able to sell or rent the current Brent Birthing Centre building. This would also mean that the Trust would not be running the service at a loss of £300,000 and would save an estimated £185,000. This money would be re-invested in patient care.	**Additional demands on Northwick Park Hospital Maternity Unit**: Absorbing the activity from the Brent Birthing Centre would put pressure on the maternity service at Northwick Park Hospital in terms of space and staffing. **Change in location for women living in Brent**: Women living in Brent would need to travel to Northwick Park Hospital for all of their care or they may in fact choose to go to another hospital such as St Mary's Hospital or Queen Charlotte's Hospital. **Restricts choice**. This means local women would not have access to a local midwifery led service. This would limit their choices of birth environment. **Change for staff and patients:** The Trust would not be proposing any redundancies or loss of jobs. However this option would mean some changes for staff in their place of work and some working practices. Staff would be fully supported during this period of change.

OPTION 3 Move Brent Birthing Centre inpatient (delivery) facilities to Northwick Park Hospital and create a midwifery led unit there. Keep antenatal facilities in the Brent Birthing Centre building.	
Advantages	**Disadvantages**
Improving clinical care: All women would now be cared for in a unit which has on-site access to obstetricians 24 hours a day, seven days a week. **Reduced pressure:** By developing a midwifery led unit at Northwick Park Hospital, the Trust will be able to respond to the anticipated increase in the number of births in London by increasing capacity at Northwick Park Hospital. **Retains local access to some aspects of maternity services for women in south of Brent**: This option would allow antenatal care to continue to be provided at the Brent Birthing Centre. **Dedicated facilities:** Unlike option two, a new dedicated midwifery led unit at Northwick Park Hospital would ensure no additional pressure on space. Staff would be offered the opportunity to transfer to the Unit at Northwick Park Hospital. **Generates income to be reinvested in patient care**: The Trust would be able to generate income by renting the six bedded area within the Brent Birthing Centre. This money would be reinvested into patient care. **Continues to offer women choice** for their birth environment, promoting midwifery led care and a normal (without medical intervention) birth experience where possible.	**Women choose to go elsewhere** Some women in Brent may choose to go outside of the two boroughs to have their baby. Eg. a substantial number of women living in the south of Brent already travel to St Mary's or Queen Charlotte's Hospital. This may result in a loss of income for the Trust. **Maximising income:** By retaining antenatal care at the Brent Birthing Centre the Trust will not generate as much income as it could if it were to rent out the whole of the Brent Birthing Centre or indeed sell it. **Change for staff and patients**: The Trust would not be proposing any redundancies or loss of jobs. However this option would mean some changes for staff in their place of work and some working practices. Staff would be fully supported during this period of change. **Local access to antenatal care but no inpatient facility**: Women in Brent would have access to local antenatal clinics but they would have to travel to Northwick Park Hospital for the delivery of their baby.

Improves choice for women living in Harrow: Women living in Harrow would have better access to a midwifery led unit.	

OPTION 4 Move Brent Birthing Centre inpatient (delivery) facilities to Northwick Park Hospital and establish a midwifery led unit there. Provide antenatal services at Central Middlesex Hospital but not within the Brent Birthing Centre.	
Advantages	**Disadvantages**
Improving clinical care: All women would now be cared for in a unit which has on-site access to obstetricians 24 hours a day, seven days a week **Reduced pressure:** By developing a midwifery led unit at Northwick Park Hospital, the Trust will be able to respond to the anticipated increase in the number of births in London by increasing capacity at Northwick Park Hospital. **Retains local access to antenatal maternity services for women in the south of Brent** Antenatal care would continue to be provided at Central Middlesex Hospital. **Dedicated facilities:** Unlike option two, a new dedicated Midwife Led Unit at Northwick Park Hospital would ensure no additional pressure on space. Staff would be offered the opportunity to transfer to the Unit at Northwick Park Hospital. **Generates income to be reinvested in patient care**: The Trust would be able to generate more income by renting or selling the whole of the Brent Birthing Centre rather than just a section of it, as suggested in option three. This money would be reinvested into patient care. It would also deliver savings of approximately £385,000 for the Trust.	**Women choose to go elsewhere** Some women in Brent may choose to go outside of the two boroughs to have their baby. Eg. a substantial number of women living in the south of Brent already travel to St Mary's or Queen Charlotte's Hospital. This may result in a loss of income for the Trust. **Relocation of services** Services will require relocation within the Central Middlesex Hospital, and this will include the reprovision of clinics and offices for staff. **Change for staff and patients**: The Trust would not be proposing any redundancies or loss of jobs. However this option would mean some changes for staff in their place of work and some working practices. Staff would be fully supported during this period of change. **Local access to antenatal care but no inpatient facility**: Women in Brent would have access to local antenatal clinics but they would have to travel to Northwick Park Hospital for the delivery of their baby.

Continues to offer women choice for their birth environment, promoting midwifery led care and a normal (without medical intervention) birth experience where possible. **Improves choice for women living in Harrow:** Women living in Harrow would have better access to a midwifery led unit.	

5 Financial Appraisal

A full financial appraisal is provided in Appendix 1. The current service costs £1.2m to run, against an income of £890k. It makes a financial loss of £310 k per annum.

The table below provides an overview of the financial impact of each of the above options and the assumptions made regarding the proposal.

Option	Surplus/ (Deficit) £'000	Capital* £'000	Assumptions
1	(311.3)	-	- No change to costs or income
2	185	100	- Rental income on BCC - Midwives transfer to NPH - Facilities savings on BBC - A&C transfer to NPH
3	311	75	- Reduced rental income BBC - Midwives transfer to NPH - ANC midwives remain BBC - Facilities savings form BBC - Facilities costs MLU - Staff released from Delivery Suite
4	389	100	- Full rental income BBC - BBC midwives transfer and ANC midwives remain at CMH - Facilities costs for new MLU - Facilities costs at CMH - Staff released from Delivery Suite

* Indicative capital costs to be confirmed.

A full financial appraisal would be done of any further options that emerged from discussions with local stakeholders and NHS partners.

5.2 Activity and income assumptions

The following assumptions have been made regarding activity and costs to local Primary Care Trusts.

- That deliveries and women who are admitted to the antenatal ward for observation but do not deliver during their stay will remain at the same level and income will remain constant, unless otherwise negotiated and agreed with the Trust and PCTs through the normal commissioning process.
- The only increased income to the Trust will be via the rental of the BBC. (unless increase activity agreed as per above)
- That costs to the local PCTs will remain the same in terms of tariff for maternity care.
- That antenatal care will be re-provided at same cost to the Trust. Activity and income will remain constant.
- This proposal does not change the requirement at this stage for improved community midwifery staffing levels.

6. Consultation timetable

Any changes to the service will require public and staff consultation. Consultation papers will need to be approved by Brent Teaching Primary Care Trust (PCT) and North West London Hospitals NHS Trust (NWLHT) at their board meetings in September following discussions and input from local Patient Forums, Overview and Scrutiny Committees and other PCTs whose mothers currently use the centre. This is in accordance with section 242 of the NHS Act 2006 which has replaced section 11 HSCA 2001.

Following the consultation responses will be collated and presented in a report which will be made public. The report will be considered by the Boards of the Trust and the PCT at their public Board meetings before any final decisions are made.

7. Next steps

This paper has highlighted why the Trust is considering changes for the provision of midwifery led services at Brent Birthing Centre at Central Middlesex Hospital.

It has set out a number of possible options for discussion. These are subject to further discussions with local stakeholders and NHS partners, prior to the launch of formal consultation with the local community

The Trust Board is asked to:

- Discuss and note the contents of this paper.
- Agree that the Trust now goes ahead and discusses the provisional options and the process for formal public consultation with its

Patient's Forum, Overview and Scrutiny Committee and NHS partners. This is in accordance with section 242 of the NHS Act 2006 which has replaced section 11 HSCA 2001 where the duty under both sections is identical.

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North West London Hospitals NHS trust

Potential Savings Full Year Effect @ 2007/08 Current Prices

Description

Closure of the Brent Birthing Centre

Savings are relefected as a credit

	Option 1	Option 2	Option 3	Option 4
Potential Income	**FY (£000's)**	**FY (£000's)**	**FY (£000's)**	**FY (£000's)**
Rental Income from BBC	-	(155.0)	(77.0)	(155.0)
Total	-	(155.0)	(77.0)	(155.0)
Reduction in Costs For the Brent Birthing Centre / Delivery Suite	**FY (£000's)**	**FY (£000's)**	**FY (£000's)**	**FY (£000's)**
Medical	-	(105.0)	-	-
Midwives - BBC	-	(633.0)	(504.0)	(504.0)
Midwives - Delivery Suite		-	(234.0)	(234.0)
Admin & Clerical	-	(51.0)	-	-
Facilities & Estates	-	(60.0)	(30.0)	(60.0)
	-			
Total	-	(849.0)	(768.0)	(798.0)
Additional Costs for Reproviding Service				
Medical	-	105.0	-	-
Midwives	-	633.0	504.0	504.0
Admin	-	51.0	-	-
Facilities & Estates				
Reproviding ANC and Office Space @ CMH		-	-	30.0
Reproviding ANC and Office Space @ NPH		30.0	-	-
Provision of MLU @ NPH		-	30.0	30.0
Total	-	819.0	534.0	564.0
Total Savings () / Cost	**-**	**(185.0)**	**(311.0)**	**(389.0)**
Capital Cost				
ANC		**100.0**		
MLU			**75.0**	**100.0**
	-	**100.0**	**75.0**	**100.0**

Notes

Option 4 would yield savings of a further £234k if the activity through the MLU increases to 1500. This relates to 5.4 WTE midwives.

The costs and savings based on floor area are estimated.

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SHEET 1- Actual Maternity Capacity - based on 4858 births 2006/07 OUTTURN ACTIVITY

Activity	Deliveries	Beds	Birth per bed
NPH	4558	11	370
Total Birth Centre Activity	300		
Brent Birth Centre	300	6	50
NPH Birth Centre	0	6	0
Total Births	4858		

Bed Capacity

Delivery Suite	100% occupancy	85% occupancy
Number of women requiring D/S bed	4072	
Low risk women on D/S	2129	
High risk women on D/S	1943	
Bed days required for low risk @ avLOS 18hrs	1597	
Bed days required for high risk @ avLOS 24hrs	1943	
Delivery Suite bed days required	3540	
Delivery Suite beds required @ 100% occupancy	9.70	
Delivery Suite beds required	9.70	11.41

Average LOS for high risk - 24 hours & for low risk - 18 hours

Note: Additional capacity/space for assessments is needed when Day Assessment Unit is closed.

Recovery Beds		
Number of Elective C/Sections per day	3	Mon - Fri
Number of Emergency theatre work per day	3	Full week
Recovery Beds required	3 - 6	

Recovery beds also function as HDU when required

Elective Caesarian Sections (not requiring D/S bed) = 10%

Emergency Caesarian Sections and other Emergency theatre work is on average 3 cases per day with approx 70% being out of hc

Case mix ratio - 50% high risk (categories IV&V),30% low risk (categories I- II) & 20% medium risk category (III) - Ref: BR + Interim

Postnatal Beds	100% occupancy	85% occupancy
Av LOS (days) on PN ward	2	
Postnatal Bed days required	9116	
Postnatal beds required	25	
Postnatal beds required	24.98	29.38

Average LOS - 2 days - however by changing casemix this may increase

Birth Centre Occupancy

BBC		
Available beds	6	
Annual bed days available	2112	
Bed days required, assuming av LOS - 1.1 day	330	
Occupancy %	16	%

NPH MLU		
Available beds	0	
Annual bed days available	0	
Bed days required, assuming av LOS - 1.1 day	0	
Occupancy %		%

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Meeting:	Overview and Scrutiny Committee
Date:	25 September 2007
Subject:	Standing Scrutiny Review of NHS Finances – Carers Case Study – interim report
Responsible Officer:	Paul Najsarek, Director People, Performance and Policy
Portfolio Holder:	Adults services
Exempt:	No
Enclosures:	Interim report – carers case study

SECTION 1 – SUMMARY AND RECOMMENDATIONS

This report sets out detail of activity undertaken so far by the Standing Scrutiny Review of NHS Finances. It also provides a report of the carers' case study undertaken as part of that project for the committee's consideration.

RECOMMENDATIONS:

That the Committee:
1. Note progress made by the review.
2. Approve the interim report on the carers case study.
3. Agree that the report form an appendix to the eventual full report of the Standing Scrutiny Review of NHS Finances.

SECTION 2 - REPORT

Brief Background
The Standing Scrutiny Review of NHS Finances was established in July 2006 to consider the financial performance and consequent strategic direction of the council, Harrow PCT and NW London Hospitals Trust and to investigate the impact of the financial deficits and related recovery plans on the quality of life and well being of Harrow residents.

Since the last interim report made to this committee in March 2007, the Standing Review has met on 19 April, 3 May, 7 June and 14 August.

The Standing Review has also undertaken a case study to evaluate the impact that changes in NHS and local authority budgets are having on carers and the person they are caring for. The attached report outlines the findings of the case study and will form a major plank of the supporting evidence for the final report of the Standing Review.

The meeting held on 19 April focused on preparations for the focus group held with carers to gather evidence for the case study. The meeting of 3 May received updates on the financial position of the hospitals trust and the PCT and examined evidence gathered at the focus group with carers. The meeting of 7 June consisted of a roundtable discussion of outcomes from carers' focus group with partners, and updates on local health finances and continuing care issues. The meeting of 14 August was focused on the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care.

Consultation
The report was considered by the Standing Review at its meeting held on 14 August. The Corporate Director of Adults and Housing and the Chief Executives of the Harrow Primary Care Trust and the North West London Hospitals Trust were offered the opportunity to comment on the factual accuracy of the report. Comments received from the Corporate Director and the Chief Executive of the PCT have been reflected in the report.

Fair Access to Care Services (FACS) criteria
The scope of the Standing Review also includes consideration of the impact of financial difficulties at the interface between health and social care. As such the potential impact of changes to the Fair Access to Care Services criteria has been raised by the review.

The decision made by Cabinet to meet only needs falling into the 'critical' band under the Fair Access to Care Services criteria was called-in and a meeting held on 13 August. The call-in was rejected by the committee. The High Court has now ordered a stay of the decision of 25 July 2007 until 31 October 2007, by which date the Court will have determined the legal challenge to the policy.

The agreement of the criteria does not mean that scrutiny could not consider this issue in future. The Performance and Finance scrutiny sub committee will monitor the effects that the criteria are having on residents and other service users. At the monthly meeting of the Performance and Finance chairman and

vice-chairman, performance information relating directly to social care and associated areas of activity, including information from the Harrow Strategic Partnership, will be considered. If this performance information demonstrates that changes in the criteria mean that service being provided by the council and its partners does not meet the need of the council's clients, the issue can be examined in more detail.

Issue to be determined
That the report of the case study be approved and appended to the forthcoming final report of Standing Review.

Options considered (statutory requirement for Executive-side reports)
Not applicable.

Option recommended and reasons for recommendation
The interim report sets out the evidence gathered by the Standing Review via the carers' case study. As this case study is likely to form the main body of evidence for the overall report of the Standing Review it is proposed that this interim report by appended to the main report when it is completed.

Resources, costs and risks associated with recommendation
The overall aim of the Standing Review is to address and monitor the impact of changes in NHS and local authority budgets are having on local people. The case study has sought to safeguard value for money by considering more effective means of supporting carers.

There may be possible financial implications for the authority which would need to be reported on further when the full report is completed.

Staffing/workforce consideration
There are none specific to this report.

Equalities Impact consideration
The attached report explores equalities issues as they relate to provision and support to carers provided by the authority and by partners.

Scrutiny performance management issues
A matrix setting out the recommendations of the case study, which will be used to monitor progress against the recommendations, is attached to the report as Appendix B. Performance monitoring will also be addressed in the overall report of the Standing Review.

Current KPIs and Likely impact of decision on KPIs
There are a number of KPIs that may well be impacted upon by the changes in delivery of care to more vulnerable residents. The outputs from this review can help to minimise the impact of the changes.

Legal and Financial Comments
There are no legal comments. Financial comments are addressed under 'Resources costs and risks' above.

Community Safety (s17 Crime & Disorder Act 1998)
There are none specific to the report.

Recommendations matrix attached as appropriate

SECTION 3 - STATUTORY OFFICER CLEARANCE

Name: Barry Evans Date: 30 August 2007	✓	On behalf of the Chief Finance Officer
Name: Helen White Date: 3 September 2007	✓	On behalf of the Monitoring Officer

SECTION 4 - CONTACT DETAILS AND BACKGROUND PAPERS

Contact: Heather Smith, Scrutiny Officer, 020 8420 9203, heather.smith@harrow.gov.uk

Background Papers*:*
Reports to the Overview and Scrutiny Committee, 18 July 2006 and 27 March 2007

IF APPROPRIATE, does the report include the following considerations?

1.	Consultation	YES
2.	Corporate Priorities	N/A

August 2007

Overview and Scrutiny Committee

Report of the Standing Scrutiny Review of NHS Finances

Carers Case Study

DRAFT REPORT

Members of the Standing Review Group
Councillors:
Cllr Myra Michael, Chairman
Cllr Margaret Davine, Vice Chairman
Cllr Jean Lammiman (until May 2007)
Cllr Rekha Shah
Cllr Stanley Sheinwald

Community co-optees:
Ruth Coman
Julian Maw, Harrow PCT Patient and Public Involvement in Health Forum
Avani Modasia, Age Concern Harrow
Janet Smith, Mind in Harrow

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Chairman's introduction

This report on carers is a case study undertaken as part of the Overview and Scrutiny Committee's Standing Scrutiny Review of NHS Finances. The purpose of the case study was to investigate the impact that changes in NHS and local authority budgets are having on carers and the person they are caring for.

The key function of the Standing Review has been to monitor the financial difficulties being experienced by NHS partners by meeting with chief officers of the council, Harrow Primary Care Trust (PCT) and the North West London Hospitals Trust. These meetings provided us with an insight into how local financial pressures are being addressed, but we could not help but be concerned about how the impact of key resource decisions on patients and carers have been assessed.

The evidence we received from carers has painted a challenging picture. We have heard a number of disquieting stories from carers, including from an 84 year old carer contemplating returning to work to fund care for his wife. Taken together with evidence from the Commission for Social Care Inspection (CSCI) on best practice, these individual anecdotes point toward much larger strategic questions concerning the planning and delivery of services, partnership working and value for money. We believe that by working together organisations can mitigate some of the troubling impacts of cuts on local people.

Acknowledgements
The Standing Review group would like to thank Michel Syrett for his paper on *Carers Resource Needs*, which informed our preparations for the carers' conference. We would like to thank Mike Coker and Sue Springthorpe for their contributions of advice and evidence to the review.

Finally we would like to thank all of the carers who provided us with evidence. We recognise that caring for a relative or friend can be a time-consuming activity and are very appreciative of the time carers have given up to share their views with us.

Councillor Myra Michael
Chairman, Standing Scrutiny Review of NHS Finances

Methodology

The scope of the Standing Scrutiny Review of NHS Finances is attached to this report as Appendix A. Paragraph thirteen of the scope identifies a number of proposed case studies. During the Standing Review's deliberations, it was decided that considering the experience of carers would provide the most useful means of assessing the impact of the financial challenges.

Carers Conference – A Life Beyond Caring
The main evidence directly from carers was gathered through a one-hour focus group convened as part of the council's carers' conference (arranged by adult social care) entitled 'A Life Beyond Caring'. The event was held on 24 April at Pinner Village Hall.

The overall purpose of the conference was to raise awareness of national developments on carers' issues and the vision for delivery of local adult social care services, as well as informing the development of new local multi-agency carers' strategy.

In the first section of our focus group, carers were asked to think about their needs. The areas of need identified as prompts for discussion were 'my rights as a carer', 'getting the right information and support', 'getting support from other people', 'time to be me', and 'my emotional needs'. Carers were encouraged to review and add to this list.

In the second section of the exercise, carers were encouraged to think about changes that they had noticed over the last eighteen months. It was possible to identify some areas where there had been changes, but there were also comments made about the quality of services, which were also captured.

Other opportunities for carers
We also sought to ensure that carers had other means of contacting the Standing Review, other than through the conference. We published details of our work on the council's website and encouraged carers to contact us with their views. We are also grateful to Carers Support Harrow and Harrow Crossroads who also communicated with carers about this piece of work.

Additional evidence
Evidence from carers was supplemented by evidence gathered through a desktop research exercise of best practice.

The group is also grateful for a paper from Michel Syrett on *Carers Resource Needs*, which informed the development of the focus group structure and materials.

Executive summary

National evidence on support to carers demonstrates many challenges, which are reflected locally. This case study has highlighted the importance of carers to the wider wellbeing of the community and has illustrated how recent changes are impacting on carers' ability to cope. Losing support, such as a few hours of respite care or support from a care worker, has a major impact and may make all the difference to a carer's willingness to continue caring. Providing support such as respite is considerably cheaper than an extended stay in hospital or care home provision, so it is becoming clear that greater co-ordination between the agencies could potentially save the PCT, hospitals trust and council large sums. Money spent supporting carers has been demonstrated to us to be money well spent.

RECOMMENDATION 1

- We recommend that communication between all agencies be improved, as there is significant potential for fostering stronger relationships between the council, PCT and hospitals trust.

RECOMMENDATION 2

- We recommend that partners come together to seek innovative solutions that provide timely and appropriate services for carer and cared-for as well as delivering opportunities to make the best use of limited resources.

RECOMMENDATION 3

- Given the important role of the voluntary sector in mitigating the effects of cuts and making linkages between services we recommend that the overall strategy for engaging the voluntary sector in public service delivery be clarified. That there are plans to refresh the Harrow Compact offers a valuable opportunity to do this and to secure Harrow Strategic Partnership commitment to an improved way of working.

RECOMMENDATION 4

- We recommend that routes for carers into services and support be strengthened, for example by ensuring all GPs and other primary care providers have knowledge and information to share with carers. Further work should be undertaken to reach those who do not recognise themselves carers. Changes in service provision should also be better communicated.

RECOMMENDATION 5

- We recommend that the forthcoming multi-agency carers strategy set out the context for partnership working and set out clear deliverable and SMART priorities for carers in Harrow. The strategy should also address major policy developments and opportunities such as direct payments.

Appendix B of this report sets out how scrutiny will monitor progress against the recommendations.

Context

Who are carers?
The Commission for Social Care Inspection (CSCI) describes carers as follows:

> "Carers are not paid. They are people who look after a spouse, relative or friend who needs support because of a physical or learning disability, illness or mental ill health. Most people will be carers at some point in their lives. Many people do not want to be defined by their caring role and will not associate themselves with the description of 'carer'."[1]

Table 1: National statistics on carers[2]

- Over a lifetime, 7 out of 10 women will be carers, and nearly 6 out of 10 men.
- 4.7 million people over the age of 18 are carers in England.
- There is a turnover in the population of carers. In any one year, 301,000 adults in the UK become carers.
- 70% of the people cared for are over 65.
- 1.5 million carers in England provide over 20 hours of care per week. 985,000 provide over 50 hours of care per week.
- 1.5 million carers combine full-time paid employment with unpaid care. 58% of these working carers are men.
- People from Bangladeshi and Pakistani ethnic groups are more likely to be carers than those from other ethnic groups, taking account differences in age structure.
- 471,000 carers reported they were in poor health (2001 census). Of these, 30% were aged 65-plus.

There are approximately 20,550 carers in Harrow. Approximately 2,000 are in contact with the local authority, primarily through social care provision.

Table 2: Carers in Harrow

- 1 in 10 people in Harrow are carers (Census 2001).
- 72% provide 1-19 hours of care.
- 12% provide 20-49 hours of care.
- 17% provide 50 or more hours of care.
- 3,000 carers provide 50 hours or more of care.
- There are 634 young carers aged 5-17 years; 84% provide 1-19 hours, 9% 20 - 49 hours, and 7% 50 hours or more hours of care.
- 100 young carers provide 20 hours or more of care.

[1] CSCI (2006). *The State of Social Care in England 2005-06*. Accessed 28 February 2007. p. 85 http://www.csci.org.uk/about_csci/publications/the_state_of_social_care_in.aspx
[2] Ibid.

Findings

Introduction
The Commission for Social Care Inspection's (CSCI) report on *The state of social care in England 2005-06* included a review of councils' progress in adopting a strategic approach to supporting carers and meeting their needs. This section of the report is divided into thematic areas. Within each area there is information on the national picture derived from the CSCI research and a section on local findings.

Developing services strategically
Nationally, against CSCI criteria about a fifth of councils could be considered to have adopted a strategic approach to meeting carers' needs. A strategic approach would include:

- A multi-agency carers' strategy.
- An identified social services lead on carers.
- A corporate approach within the council, displaying a shared ownership of the carers' agenda.
- A strategy based on local profiling to map numbers and needs of carers, including carers in work, black and minority ethnic carers and young carers.
- Proactive initiatives and good practice going beyond the basic legal requirement of taking carers' employment, education, training, and leisure needs into account in the carers' assessment. For example, the provision of flexible, reliable and emergency cover which enables carers to take part in chosen activities; imaginative ways of increasing paid employment opportunities for carers.
- Innovative carers' services and use of direct payments.
- Carer engagement in commissioning, service development and evaluation and workforce training.
- Outreach activity beyond traditional social service networks to ensure equal opportunity and equity.[3]

Locally, we are pleased to note that a multi-agency strategy is under development in Harrow, and that there is a lead officer for carers, the Prevention and Carers Strategy Manager. The current inter-agency strategy (between Harrow PCT and Harrow Council) maps a range of demographic information on carers; as the Harrow Vitality Profiles evolve, we hope that further scope for developing the mapping of carers is strengthened and includes data from a range of agencies.

At the conference carers commented that:

"Services need to join up including their budgets"

"[There is] poor partnership between health and social care teams"

Carers are well aware of the lack of co-ordination between services. One group of carers had concerns about the level of provision in Harrow and also commented that working with other councils to provide services across north west London – adopting a regional approach – should be considered.

[3] Ibid. Paragraph 7.12.

Having considered best practice from CSCI and IDeA[4] we were struck by the way in which evidence we had received from individual carers pointed to much larger strategic questions of value for money, the planning and delivery of services and partnership working by the council, the PCT and the hospitals trust. However, it is not clear that such considerations feature in the planning of services and decision-making about the allocation of scarce resources. Whilst we are pleased to learn that the PCT and hospitals trust financial positions have considerably improved, we are worried that there seems to have been only limited attempts to assess the impact of the financial decisions on service delivery. We would expect this consultation process to extend beyond discussions with health professionals and to include patients and their carers.

The PCT has advised us that they have engaged in a series of consultations with the public on health services and the next consultation is planned for 24 September. The PCT will offer further opportunities to engage with residents later this year with regard to the proposed consultation on the service models set out in the Healthcare for London report.

It was concerning that both the hospitals trust and the PCT perceived that they had not been formally consulted on the proposed changes outlined in the council's Fair Access to Care Services consultation. While the council can evidence the provision of the consultation document to both trusts it appears that organisational change may have impacted on the effectiveness of communications with the trusts. We welcome the Chief Executive of North West London Hospitals trust's desire to facilitate joint meetings to address some of the initial challenges relating to patients with hospital stays beyond 14 days. Given that there are new chief executives at the council and hospitals trust and a future new chief executive to be appointed at the PCT, we strongly urge the three organisations to take the opportunity to form new working relationships at the strategic level, which can then be cemented at operational level.

RECOMMENDATION 1: We recommend that communication between all agencies be improved, as there is significant potential for fostering stronger relationships between the council, PCT and hospitals trust.

Developing services in partnership – financial arrangements

Whilst 37% of councils reported to CSCI that they were engaged in collaborative working with health partners, 25% of councils reported that PCT restructuring or NHS financial pressures, or difficulties establishing collaboration with GPs had had an impact on the ability to deliver on their vision for 2006-07.[5] Forty-six percent of councils report that financial constraints have impacted on the delivery of support to carers; CSCI found that strategic approaches to managing the pressure were not apparent in all councils.[6]

We are acutely aware of the financial pressures facing the council, hospitals trust and PCT. We accept that this places pressure on partners but we also feel that this provides all the more incentive for partners to come together to identify ways to improve efficiencies. The following example, reported to us by a voluntary sector organisation, clearly illustrates considerations including the timeliness and appropriateness of provision as well as value for money:

> *A couple ended up in separate care homes because the cared-for, a man with dementia, wandered off while the carer was out receiving dialysis. The couple had not received assessment and support quickly enough. Had respite care been provided, the carer*

[4] Improvement and Development Agency. Carers self assessment tool available at www.beacons.idea.gov.uk
[5] CSCI (2006). *The State of Social Care in England 2005-06*. Paragraphs 7.21 – 7.22.
[6] Ibid. Paragraphs 7.28 – 7.29.

could have attended dialysis without leaving her husband unattended and at risk because of his dementia.

The implication of this example is that the cost of providing residential care for a week for the couple (never mind an ongoing period) could have funded many weeks of respite provision to help the couple to remain in their own home.

RECOMMENDATION 2: We recommend that partners come together to seek innovative solutions that provide timely and appropriate services for carer and cared-for as well as delivering opportunities to make the best use of limited resources.

Developing services in partnership – working with the voluntary sector

The Commission for Social Care Inspection (CSCI) reports that whilst councils have commissioned services from the voluntary sector, there was concern that “councils report they are unsure as to how, precisely, the funds made available for carers’ services are being spent, how many people are accessing the services and what the outcomes are for carers of the services commissioned.”[7]

Locally there is clearly a range of support available to carers from voluntary providers. Carers who are actually able to access support such as respite were extremely positive about the impact of that provision on their well-being and quality of life.

Table 3: Background: Harrow Crossroads

Harrow Crossroads is one of 200 Crossroads schemes run across the country to provide high quality respite care for carers. In Harrow carers are offered three hour sessions, every week, which are often used by the carer to enable them to undertake their own medical appointments, collecting prescriptions or other practical tasks. Harrow Crossroads’ work has a preventative emphasis, as it enables carers to look after their own well being, as well as that of the person they care for, and helps people remain in their own homes.

Staff are trained to a level above that of domiciliary care workers. Respite is provided by the same individual every visit to allow relationships to be developed. Crossroads is rated as ‘excellent’ by CSCI and has achieved Investors in People status.

From the point of view of a number of voluntary sector organisations that provided us with evidence, there is potential for extending services currently provided. This finding appears to fit with the view expressed by carers through our focus groups that the voluntary sector is key in making linkages between services and filling gaps, and that there is more that could be done. Given the limited level of investment in supporting carers, the quality of outcomes achieved appears to us to represent value for money.

Yet in the context of the current cuts, one respondent also commented that the council needed to be honest with the sector and to explain how it should relate to the cuts. One voluntary sector chair commented that “there is one pot of money and therefore it makes sense for organisations to work closely together.”

Harrow Crossroads has a service level agreement (SLA) with the council and the Primary Care Trust. The SLA sets out the level of funding Harrow Crossroads receives from the council for a set number of hours of respite care. In addition to this, the SLA provides for Harrow Crossroads to be reimbursed for additional hours of respite care that are provided over and above the

[7] Ibid. Paragraph 7.24.

agreed hours. Harrow Crossroads has reported having been encouraged to exceed the targets and to provide additional care (including training and recruiting staff), but we were advised that the council has decided not to reimburse them for the additional care that has already been provided. We received evidence at one of our meetings that it would not represent good practice for an SLA to be open-ended and that there was a need to work within resource constraints. We would encourage all partners to ensure that future arrangements for commissioning accord with best practice and that there is a clear understanding of responsibilities on all sides.

We heard from voluntary sector partners that the shift to contracting for services has meant that organisations are no longer receiving support for core functions, yet the voluntary sector needs infrastructure to run the services that providers are looking to contract. The Harrow Compact (the Harrow Code of Practice on Funding and Procurement) partly addresses this in that partners are expected to recognise that "it is legitimate for voluntary and community organisations to include the relevant overhead cost in their estimates for providing a particular service, and where a full service is funded apply the full cost recovery principle". However, it does not appear that negotiations over provision are this sophisticated. Voluntary sector partners felt that capacity building is not addressed and that overall strategy for bringing the voluntary sector into public service delivery is unclear.

Additionally, the carers' grant is no longer ring-fenced and local reductions have served to increase uncertainty in the sector. Local concerns reflect CSCI's view that many voluntary organisations have significant concerns about the security of their funding – particular when, as in Harrow, PCT and council budgets are under pressure.[8] Whilst the Harrow Compact speaks of respecting the independence of the sector and also encouraging the sector to "diversify its funding base", without a clear framework within which to operate it is unclear whether this is a realistic prospect.

RECOMMENDATION 3: Given the important role of the voluntary sector in mitigating the effects of cuts and making linkages between services we recommend that the overall strategy for engaging the voluntary sector in public service delivery be clarified. That there are plans to refresh the Harrow Compact offers a valuable opportunity to do this and to secure Harrow Strategic Partnership commitment to an improved way of working.

Routes for carers into services and support

Sixty-three percent of councils reported to CSCI that they have been raising awareness and providing information to carers though it is not clear how successful this has been.[9] Fifty-nine percent of councils report that they provide training for staff in providing assessments, and 52% provide assessment tools.[10] Seventeen percent of councils have appointed specialist staff. Evidence from Beacon councils suggests that a strong working relationship between social services and GP surgeries improve the chances of effective referrals for assessment and services.[11]

When inspecting services for adults with a learning disability in eleven authorities, CSCI found that only 46% of carers reported that they that they had been told about their entitlement to an assessment of their needs.[12] We are concerned that locally, out of the sixty carers in

[8] Ibid. Paragraph 7.95
[9] Ibid. Paragraph 7.36 – 7.37
[10] Ibid. Paragraph 7.42
[11] Ibid. Paragraph 7.38
[12] Ibid. Paragraph 7.40

attendance at the conference only one had ever had their own needs assessed, though we acknowledge that this information must be put in the context of the overall numbers of carers in Harrow that have received assessment in accordance with the council's reporting to CSCI. In any case, as the carers assessment is considered to be the route through which carers' immediate and wider needs are assessed this is an area of concern. Carers commented that:

"If you don't know what you're entitled to you can't ask for it"

"Assessment of needs [are] practically non-existent"

Carers need to have confidence in assessment, especially in the context of tightened funding and eligibility criteria.

Carers commented that carers' support (e.g. Harrow Carers group, MENCAP, HAD) has developed over the last couple of years, which helps to fill gaps in information and support in other services. It was commented that this activity developed infrastructure. Carers groups were able to fill gaps left by social care, in particular by working with GPs. Speaking of support to carers:

"[It is] Very helpful to have those contacts and to have emotional support"

GPs were referred to by many carers particularly in terms of providing information and support and as signposts to other organisations and services. Views on the level of support available from GPs varied widely. Carers Support Harrow provides literature to GPs, including information on support available, including from other organisations such as Harrow Crossroads. The reaction of a PCT representative at one of our meetings was that GPs engaged with carers in their capacity as patients, not in their role as carers. At a recent event for mental health carers it appeared that not all GPs keep records of carers, however it is a positive development that there are efforts to require GPs to do, in accordance with best practice.[13] The PCT has advised that:

- Practice managers in Harrow meet on a regular basis and carer support representatives attend these meetings to discuss issues.
- Under the Quality and Outcomes Framework (QoF),[14] GPs are required to maintain a Carers Register.
- Under the QoF, and in relation to palliative care, GPs are required to review plans with carers.
- Many practices have a carers representative and recruit carers.
- GPs are required to have in place systems to identify carers for onward referral to social services where there are particular needs that require addressing.

We are very aware that many carers often would not describe themselves as such, treating the care and support that they provide as an extension of their role as spouse, partner, family member or friend. We therefore strongly support all efforts to reach these 'unidentified' carers.

[13] A member of the PCT's Professional Executive Committee (PEC) commented at a recent mental health carers' event that she intended to work to ensure that carers were properly recorded by GPs.
[14] The Quality and Outcomes Framework (QoF) is part of the contract primary care trusts (PCTs) have with GPs. It is nationally negotiated and rewards best practice and improved quality of services (source: Department of Health A-Z glossary).

RECOMMENDATION 4: We recommend that routes for carers into services and support be strengthened, for example by ensuring all GPs and other primary care providers have knowledge and information to share with carers. Further work should be undertaken to reach those who do not recognise themselves carers. Changes in service provision should also be better communicated.

Supporting carers to care

Nationally, CSCI reports that there is a wide range of performance in provision of services to carers but even those rated 'very good' have a low baseline of 12% of carers receiving support in their own right.[15] Access to breaks for carers varies considerably. The use of direct payments for the full potential range of support to carers is limited.

Looking at diversity and equal opportunities, CSCI reports that assisting carers to continue or return to work is a high priority for councils but that only 35% say they are taking proactive steps.[16] The voluntary sector, often funded by councils, plays a significant role in supporting carers to have their own lives. The report also highlights the importance of supporting young carers as services for adults and children divide.[17]

The national picture highlights that there is a long way to go. Locally, when asked about changes to the level of support received, carers reported a number of recent changes, listed in Table 4.

Table 4: Changes identified by carers in the support that they receive

- Lack of flexibility – for example a GP ladies morning was moved to an evening; no flexibility for those who can't leave the person they are caring for unattended.
- Lack of planning for discharge, including lack of training for the carer
- Lack of interface between continuing care/social services and lack of information about the new reassessment.
- Lack of assessment of carers' own needs.
- Respite care is valued enormously by those who can access it.
- There is not enough respite during day/night.
- Carers did not know who would fit the criteria for respite care. Others felt the quality of assessment for requirements for respite care was poor.
- Less respite care available now. Respite that is available is more expensive and difficult to get hold of.

Locally, the impact of major statutory consultations being undertaken by the council at the time of the focus groups should not be underestimated. Some of the feedback illustrated great anxiety about the future. For example, one carer wanted information about the impact of the proposed changes to the criteria for who qualifies for social care services on direct payments. Strategy for direct payments was not clear to some of the carers attending the conference and there appeared to be a lack of awareness of what direct payments could be used for. There is clear potential to develop direct payments and to develop innovative approaches to providing support to carers, for example in helping carers cope with emergencies. However, direct payments require a change in culture and approach; it is not clear that this has been articulated at this stage or that this is shared by all partners. For example, there was willingness but uncertainty among some voluntary organisations about what it might mean for providers and

[15] CSCI (2006). *The State of Social Care in England 2005-06*. Paragraph 7.60
[16] Ibid. Paragraph 7.83
[17] Ibid. Paragraph 7.99

service users. Strategy for direct payments could be developed as part of the multi-agency strategy and related to the 'self-directed care' initiatives.

Table 5: Changes reported by carers - a range of reduced services for the cared-for

- Homeopathic treatment no longer funded.
- Treatment at the Maudsley hospital no longer available.
- Reduction in agency time from 20 minutes to 10 minutes.
- Wiseworks under threat of closure*
- Merger of Amner Lodge and Orme Lodge (NHS)
- Reduced funding for epilepsy outreach nurses is being reduced. Lack of clarity about when the changes will occur and who is responsible.
- Admiral nurses team that supports carers of people with dementia cut from two to one.
- Physiotherapy cut back generally. Rehabilitation physiotherapy after a stroke is given for a limited period only.
- Delays in accessing physiotherapist [teenager, mental health]. Referrals not followed up.
- Delays in accessing occupational therapy equipment.
- Reduction in the hours of care that people are receiving in their own homes. Rationale for reducing the number of visits from three to two or two to one not given.
- Residential placement for learning disabilities cut by the PCT and not picked up by social services.
- Lack of provision for dental care for people with a learning disability (using general anaesthetic for diagnosis) and long waits at Northwick Park.
- Lack of training for staff to help people with a learning disability – for example helping distressed patients cope with waiting rooms, taking blood.

* Note: Cabinet has since decided not to re-provide the Wiseworks service and a value for money review is underway (18 January 2007 Cabinet (Special), Minute 159 refers).

The importance of breaks to Harrow carers has already been highlighted in the report. It is important to note that Harrow Crossroads reported to us that they have a waiting list of 50 carers; though the organisation has the capacity to support 202 carers per week at the time we gathered evidence the organisation was only able to give services to 152 (it is worth noting that the council is aware of 3,000 carers who provide 50 hours or more of care). Harrow Crossroads reported they were:

- Unable to provide support to more than one client per household - for example, respite cannot be provided for two twins with autism because of the costs involved in providing two carers.
- Unable to provide overnight respite - Crossroads is only able to provide overnight respite to one client because a nine-hour session involves three funded slots.
- Unable to provide support in crisis situations - in the past Crossroads has been able to provide additional support to carers in crisis situations; there are now no resources for providing 'duplicate' support

Harrow Crossroads is considering offering private respite provision in order to continue offering a service. That the Government is providing additional funds for emergency respite[18] is an

[18] Department of Health. Emergency respite care: Determination of funding additional to the Carers' Grant for 2007-08, and guidelines to local authorities.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076717

incentive to begin to address carers' concerns about coping with emergencies. However, national developments and priorities need to be set in the context of local needs and resources.

The role of other types of provision such as day centres and specific activities in providing breaks for carers should not be underestimated; one carer commented that the Wealdstone Centre has been excellent in providing three days per week of voluntary work for her daughter, increasing her confidence and also provided respite for the carer.

RECOMMENDATION 5: We recommend that the forthcoming multi-agency carers strategy set out the context for partnership working and set out clear deliverable and SMART priorities for carers in Harrow. The strategy should also address major policy developments and opportunities such as direct payments.

Conclusions

Final thoughts
We have set our findings in the context of the national picture because we are aware that support to carers is an evolving and challenging area – Harrow is not alone in facing a demanding financial climate.

Nationally, CSCI reports that there are some positive examples of services being developed to meet carers' needs. However, progress is limited and patchy given the number of carers in England. Emphasis is placed on supporting carers in their caring role rather than on promoting equal opportunities (for example remaining in employment or returning to work). There is a lack of multi-agency strategic planning, which is even more important given the tight constraints facing health and social care.[19] Support to the voluntary sector to build capacity is likely to be an increasingly important element of multi-agency strategy.

Locally there are major pressures ahead in developing support to carers in the context of restricted and tightening budgets. Yet there is undoubtedly a need for all partners – including carers themselves – to the see bigger picture from each other's perspective in terms of working in partnership to produce better outcomes. For many carers, caring is a highly charged role – it is unsurprising and understandable that carers react strongly to what is often a difficult and unnatural situation. Yet the odds are that most of us will become a carer at some stage in our lives. A key question for Harrow is the extent to which carers bear the cost of tightened eligibility criteria for support. Whilst it cannot be quantified, CSCI suggests that carers provide care and support in the absence of formal services, which in turn implies that an even greater burden will fall on them if criteria are tightened.[20]

Caring is highly charged and there is a need for providers to recognise what people are feeling and why, and to overcome the high emotion of the situation by listening. At a recent mental health carers' event a consultant psychologist commented to that he could not give a single example where carer input had not improved patient outcomes. Whilst it may be easier to exude positive values in the context of sufficient resourcing (the mental health trust has recently attained foundation status), we would hope this supportive attitude spreads across health and social care providers locally.

We conclude with a telling summary from CSCI's report:

> "At the heart of this picture on the state of support to carers, there are major tensions for councils in their policies to support carers. They are charged with improving efficiency and targeting resources effectively and are consequently restricting eligibility to services. But at the same time they are looking to support carers, recognising the risk that without support many carers own health and well-being may suffer and they, too, will need help in their own right. The danger, as ever, is that carers are only seen as a 'resource' and some carers continue to be socially excluded and barred from the opportunities others would expect."[21]

[19] Ibid. Paragraph 7.102 – 7.103
[20] Ibid. Paragraph 7.52 – 7.54
[21] Ibid. Paragraph 7.106

Times are tough but agencies must be honest with each other and more importantly with those voluntary organisations that provide a critical support service to vulnerable residents. Without this, local agencies would be required to make a much greater financial contribution.

Appendix A: Standing Scrutiny Review of NHS Finances - Scope

1	**SUBJECT**	Review of the financial recovery proposals of NW London NHS Trust and Harrow PCT, the strategic consequences and the impact on Harrow residents
2	**COMMITTEE**	Overview and Scrutiny Committee
3	**REVIEW GROUP**	Councillor Myra Michael – Chairman Councillor Margaret Davine – Vice Chairman Councillor Jean Lammiman, Chairman Overview and Scrutiny Committee Councillor Rekha Shah Councillor Stanley Sheinwald
4	**AIMS, OBJECTIVES & OUTCOMES**	The Standing Scrutiny Review of NHS Financial Performance will consider the financial performance and consequent strategic direction of the Harrow PCT and NW London Hospitals Trust and investigate the impact of the financial deficits and related recovery plans on the quality of life and well being of Harrow residents by: • reviewing the effectiveness of respective financial recovery plans; • receiving regular financial updates from the respective Chief Executives on the delivery of these plans; • considering strategic proposals of the trusts • gathering evidence of the specific experiences of local people; and • investigating the impact of financial difficulties at the interface between health and social care The Standing Review will support local health providers to return to financial balance. The Standing Review will report its proceedings to the Overview and Scrutiny Committee
5	**MEASURES OF SUCCESS OF REVIEW**	• Comments from review endorsed by health providers • Impact of financial deficit minimised • Indicators suggest Trusts returning to balance
6	**SCOPE**	• Analysis of the trusts' financial position • Challenge of the proposed recovery plans – how robust are they? Have the real source(s) of financial difficulty been identified and effective solutions identified? • Investigation of the strategic proposals resulting from the financial position. Are they viable? Will they deliver the sustainable financial savings needed? • Investigation of the impact of the recovery plans and associated strategic proposals on the well being of local residents.
7	**SERVICE PRIORITIES (Corporate/Dept)**	Making Harrow safe, sound and supportive Tackling waste and giving real value for money
8	**REVIEW SPONSOR**	Jill Rothwell
9	**ACCOUNTABLE**	Chief Executive Harrow PCT

	MANAGER	Chief Executive NW London Hospitals NHS Trust
10	**SUPPORT OFFICER**	Lynne McAdam
11	**ADMINISTRATIVE SUPPORT**	Review administrator
12	**EXTERNAL INPUT**	Review group members to include: • CfPS expert advisor • Community experts • Expert patients/PPI • Group Manager People First Finance • Director Community Care • Director Children's Services Advisers • Health Care Commission Witnesses to include: • Chief Executives and financial directors – NW London Hospital NHS Trust, Harrow PCT • Director of recovery • NHS auditors • Other NHS Trusts • Other boroughs dealing with NHS deficits
13	**METHODOLOGY**	Background to Health Service financial systems – desk top research and expert briefings Written and oral evidence of • NHS policy and financial framework • Financial situation • Recovery plan and health impact assessment • Methodology for development of recovery plan • Strategic proposals – NWP and CMH hospital reconfiguration Challenge of evidence presented: • Robustness of recovery plan • Alternative approaches to restoring financial balance • Comparison with other health providers? • Expert witnesses – auditors opinion of recovery plan? Audit Commission Regular monitoring and update of financial information Case studies: Impact of recovery proposals and resultant reconfigurations on quality of life of local residents – care pathway analysis – separate specific scopes to be provided. • NW London Hospitals Trust reconfiguration • School Nursing • Domiciliary Care
14	**EQUALITY IMPLICATIONS**	Changes in the availability of health service may have a disproportionate impact upon the health and well being of the more vulnerable, elderly, less mobile members of the community or those whose first language is not English
15	**ASSUMPTIONS/**	Availability of experts advisor to the review group

	CONSTRAINTS	
16	**SECTION 17 IMPLICATIONS**	None
17	**TIMESCALE**	18 months – 2 years
18	**RESOURCE COMMIMTENTS**	Service Manager Scrutiny
19	**REPORT AUTHOR**	Service Manager Scrutiny
20	**REPORTING ARRANGEMENTS**	Outline of formal reporting process: To accountable managers [ ] When January 2007 To O&S: • *Interim report* [√] *When March 2007/September 2007* • *Quarterly updates* [√] *When from March 2007* • *Final report* [√] *When March 2008 (approx)* To Portfolio Holder [ ] When *September 2007/March 2008* To CMT [√] When June 2008 To Cabinet [√] When June 2008
21	**FOLLOW UP ARRANGEMENTS (proposals)**	Regular reports to O&S

Appendix B: Recommendations Matrix

The aim of this matrix is to allow Members to monitor the implementation of the recommendations they are making.

Prioritisation: (TS)	Requiring action immediately:	S
	Requiring action in medium term:	M
	Requiring action in long term:	L
Incorporated information: (Info)	Evidence received from officers	O
	Evidence received from best practice	BP
	Evidence received from local people	LP
	Evidence received from voluntary groups	VG

Recommendation	TS	Identified officer/ member/ group to action	Info	P/ship (Y/N)	Action taken (6 months or 1 year)	Measure of success
RECOMMENDATION 1 • We recommend that communication between all agencies be greatly improved, as there is significant potential for fostering stronger relationships between the council, PCT and hospitals trust.	S	- Council - Harrow PCT - North West London Hospitals Trust	BP O	Y		Now – 6 months: Partners can demonstrate closer working and discussion on major issues and have established relevant joint bodies. For example organisations can show that they consult each other early on (e.g. service reconfiguration). Work with carers should also be a feature of this dialogue.
RECOMMENDATION 2 • We recommend that partners to come together to seek innovative solutions that provide timely and appropriate services for carer and cared-for as well as delivering opportunities to make the best use of limited resources.	M/L	- Council - Harrow PCT - North West London Hospitals Trust	BP LP VG	Y		6 months – 2 years: Evidence of joint working to address 'tricky issues' (see recommendation 1). For example regular inter-agency meetings to address stays in hospital of over 14 days. This should be both at operational and strategic levels.

Recommendation	TS	Identified officer/ member/ group to action	Info	P/ship (Y/N)	Action taken (6 months or 1 year)	Measure of success
RECOMMENDATION 3 • Given the important role of the voluntary sector in mitigating the effects of cuts and making linkages between services we recommend that the overall strategy for engaging the voluntary sector in public service delivery be clarified. That there are plans to refresh the Harrow Compact offers a valuable opportunity to do this and to secure Harrow Strategic Partnership commitment to an improved way of working.	M/L	- HSP - Council (Strategy and Improvement; Community and cultural services)	BP VG	Y		1 year: Revised Harrow Compact. 1-2 years: Improved rating of perception of joint working with partners.
RECOMMENDATION 4 • We recommend that routes for carers into services and support be strengthened, for example by ensuring all GPs and other primary care providers have knowledge and information to share with carers. Changes in service provision should also be better communicated.	L	- Council (Carers Prevention and Strategy Manager) - PCT	BP VG LP	Y		1-2 years: PCT can demonstrate that it is working with GPs to identify carers and that GPs are engaging with the requirements of the QoF. 1-2 years: Relevant elements of the multi-agency strategy (see recommendation 5) contain appropriate performance measures in order to track improvement.
RECOMMENDATION 5 • We recommend that the forthcoming multi-agency carers strategy to set out the context for partnership working and set out clear deliverable and SMART priorities for carers in Harrow. The strategy should also address major policy developments and opportunities such as direct payments.	L	- Carers Prevention and Strategy Manager - PCT - NW London Hospitals Trust - Relevant voluntary Groups	BP LP	Y		1-2 years: Multi-agency strategy developed and 'owned' across partners. 1-2 years: Clear priorities established with associated performance measures against which robust information can be provided.

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Meeting:	Overview and Scrutiny Committee
Date:	25 September 2007
Subject:	'Healthcare for London: A Framework for Action' – preparing for a possible joint overview and scrutiny committee
Key Decision: (Executive-side only)	N/A
Responsible Officer:	Director of People, Performance and Policy
Portfolio Holder:	Strategy and Business Support Portfolio Holder
Exempt:	No
Enclosures:	1) Healthcare for London Summary document 2) Discussion paper from London Scrutiny Network informal officers' meeting 10 September 2007

Section 1 – Summary and Recommendations

This report sets out a brief summary of the *Healthcare for London: A Framework for Action* report (the 'Darzi Review'). It also outlines the issues that the Overview and Scrutiny Committee need to consider in deciding whether Harrow should participate in a Joint Overview and Scrutiny Committee on the models of care and the consultation process, should other London boroughs establish one.

Recommendations:

The Committee is asked to:

1. Consider the summary of *Healthcare for London: A Framework for Action*.
2. Consider the relative merits of Harrow participating in a pan-London JOSC, should one be established, to consider the models of care and consultation process (first-stage consultation).
3. Arrive at a decision as to whether Harrow scrutiny should participate in the first-stage JOSC, and if so, ask full Council to appoint Harrow representative(s) and reserve(s).
4. Give preliminary thought to participation in the second-stage JOSC(s) on area-specific proposals (geographical and clinical areas).

Section 2 – Report

Summary

In December 2006, NHS London asked Professor Ara Darzi to carry out a review of London's healthcare. Professor Darzi worked with clinical experts throughout the capital and abroad, held large-scale public engagement events and undertook an opinion survey on the public's perception of London's healthcare to help formulate his recommendations.

Healthcare for London: A Framework for Action sets out:

- Eight reasons why the status-quo of healthcare in London is unacceptable.
- How healthcare in London will need to change over the next ten years, driven by demographic changes and technological developments.
- Common principles for future healthcare services and seven specific clinical areas.
- Future models for how care should be organised.
- Some of the drivers that will make the report's recommendations a reality, and the next steps.

The framework for consultation from NHS London proposes a first-stage pan-London formal consultation on the models of care and delivery models set out in *Healthcare for London A Framework for Action*. Second-stage consultation on the application of these models of service in London would be subject to the outcome of consultation on the models and follow on from that consultation.

Local authorities have been notified that NHS London expect decisions by individual PCT Boards in September to trigger a statutory requirement on London Boroughs and the Common Council of the City of London to form a Joint Overview and Scrutiny Committee (JOSC):

- JOSC on first-stage consultation (pan-London) to consider and respond to consultation on the models of care and delivery set out in *A Framework for London* and to assess the adequacy of the consultation process.
- JOSC(s) on second-stage consultations to consider and respond to the consultation on area-specific proposals (geographical and clinical areas) and to assess the consultation process.

The full *Healthcare for London A Framework for Action* document can be found at:
http://www.healthcareforlondon.nhs.uk/framework_for_action.asp

Background

In December 2006, NHS London asked Professor Ara Darzi to carry out a review of London's healthcare. Professor Darzi worked with clinical experts throughout the capital and abroad, held large-scale public engagement events and undertook an opinion survey on the public's perception of London's healthcare to help formulate his recommendations. The report was published in July 2007.

HEALTHCARE FOR LONDON: A FRAMEWORK FOR ACTION – THE

DARZI REPORT

The case for change

The report states a number of arguments for a fundamental change in healthcare for London:

- The need to improve Londoners' health – there are some health challenges specific to London e.g. high rates of HIV, substance abuse, mental health problems and childhood obesity.
- The NHS is not meeting Londoners' expectations – 27% of Londoners are dissatisfied with the running of the NHS compared with 18% nationally.
- London is one city, but there are big inequalities in health and healthcare – London-wide data can mask significant disparities e.g. the variation in GP distribution.
- The hospital is not always the answer – as set out in the health white paper last year, most people are best cared for by community services, yet 97% of London outpatient appointments still take place in hospital.
- The need to provide more specialised care – so as to ensure sufficient volumes of work to maintain specialist staff expertise, support high-tech facilities and allow comprehensive consultant presence, specialised services need to be centralised in fewer hospitals catering for large populations.
- London should be at the cutting edge of medicine.
- The NHS is not using its workforce and buildings effectively – productivity levels in London are lower than elsewhere in England.
- The need to make best use of taxpayers' money.
- Building an NHS with the capacity to meet not only today's challenges but also those of the future - possibly the biggest such challenge will come form London's growing and ageing population.

Five principles for change

The report's recommendations are based on five principles:

1. Services focused on individual needs and choices – patients should feel in control of their care and be able to make informed choices.
2. Localise where possible, centralise where necessary – routine healthcare should be close to home with more complex care centralised to ensure it is carried out by the most skilled professionals with most cutting-edge equipment.
3. Truly integrate care and partnership working, maximising the contribution of the entire workforce – better cooperation and communication is needed. Care should be multidisciplinary.
4. Prevention is better than cure – health improvement, including proactive care for people with long-term conditions, should be embedded in everything the NHS does.
5. A focus on health inequalities and diversity - the most deprived areas of London, with the greatest health needs, need better access to high-quality healthcare.

More detail on these principles is provided in the attached Healthcare for London Summary document (Appendix B).

Models of healthcare provision

The review's focus has been on services, not institutions and buildings and therefore the process was built around looking at what form future care should take in seven different forms. At present, London does not have the infrastructure and facilities to provide the ideal care outlined by the clinical working groups and new models of provision will be needed.

There are two stark needs. Firstly there is a need to provide a new kind of community-based care at a level that falls between the current GP practice and traditional district general hospitals. Secondly there is a need to develop hospitals that are more specialist and able to deliver excellent outcomes in complex cases. These two needs lead to the proposal of seven models of healthcare provision for the future:

1. More healthcare should be provided at **home**.
2. New facilities called **polyclinics** will be where most routine healthcare needs will be met. The range of services at polyclinics will far exceed those currently offered at GP practices and will be large high-quality community facilities. Polyclinics will offer extended opening hours across a wide range of services e.g. antenatal/postnatal care, healthy living information, community mental health services, community care and social care, as well as the infrastructure to move services out of hospital settings. Professor Darzi identifies the development of five to ten polyclinics by April 2009 as one the short-term activities to show that the NHS is serious about this *Framework*.
3. **Local hospitals** should provide the majority of inpatient care.
4. Most high-throughput surgery should be provided in **elective centres**.
5. Some hospitals should be designated as **major acute hospitals** and handle the most complex treatments.
6. Existing specialist hospitals should be valued and others encouraged to specialise.
7. **Academic Health Science Centres** should be developed as centres of clinical and research excellence.

Detailed feasibility modelling suggests that the proposed new model saves the NHS £1.4 billion each year.

More detail on the report is contained in the attached Healthcare for London Summary document. The full document can be found at:
http://www.healthcareforlondon.nhs.uk/framework_for_action.asp

IMPLICATIONS FOR SCRUTINY

Joint Overview and Scrutiny Committees (JOSC)

In July 2003 the Secretary of State for Health issued a Direction that when an NHS body consults with more than one health OSC (because proposals affect residents in each of their areas) and those health OSCs consider the proposals to be “substantial” variations to service delivery, the health OSCs are required to form a joint OSC (JOSC). Only the JOSC has the statutory power to request information relating to the issue being consulted upon.

First-stage consultation

The framework for consultation from NHS London proposes a first-stage pan-London formal consultation on the models of care and delivery models set out in *A Framework for Action*. Local authorities have been notified that NHS London expect decisions by individual PCT Boards in September to trigger a statutory requirement on London Boroughs and the Common Council of the City of London to form a Joint Overview and Scrutiny Committee (JOSC) to consider and respond to consultation on the models of care and delivery set out in *A Framework for London* and assess the consultation process.

The formal 14-week first-stage public consultation period led by PCTs will run from November 2007 to early February 2008.

Second-stage consultation

Second-stage consultation on the application of these models of service in London would be subject to the outcome of consultation on the models and follow on from that consultation. It is likely that these consultations would take place at different levels – pan-London, sector (a cluster of PCTs), or individual PCT – reflecting the nature of the changes being proposed e.g. changes to local service provision.

Preparatory steps for a Joint Overview and Scrutiny Committee

As an initial step, NHS London has already met with met with Hillingdon and Lambeth officers and the chair of the London Scrutiny Network (member) to discuss the arrangements that will be needed for the consultation and a possible JOSC. The London Scrutiny Network (officers) convened an informal meeting on 10 September to discuss preparation for arrangements and local authorities were asked to liaise with each other in determining who will lead on establishing a Joint Overview an Scrutiny Committee and details around composition, chairing and officer support.

Informal meeting of London Scrutiny Network Officers' meeting – 10 September

Scrutiny officers from across the London boroughs had been asked to gauge their own members' preliminary views on the prospect of a JOSC and met on 10 September to discuss this. Appendix A provides the briefing paper that formed the basis for the discussions. In preparing for this meeting, the Scrutiny Team had sought the initial views of Councillors Michael and R Shah as the scrutiny policy and performance leads for health and social care respectively.

In relation to a borough's possible participation in a JOSC for the first-stage consultation (broad models of care and consultation process), the Network established a number of advantages and disadvantages. These are summarised in the table below:

Possible advantages for the local scrutiny committee	Possible disadvantages for the local scrutiny committee
Understanding - Develop an understanding of the Darzi review and its implications, especially for the future area-specific proposals concerning specific clinical areas or geographical areas.	**Lack of clarity** - As yet, there is a lack of clarity on what exactly NHS London/joint PCTs committee will be consulting upon. It will not be the *Healthcare for London: A Framework for Action* document per se but rather the broad models of care contained within it. Thus any JOSC cannot yet determine its terms of reference.
NHS duty to respond - The NHS is only obliged to formally provide evidence to and respond to the comments from the JOSC and not individual boroughs that may respond in their own right to the public consultation.	**Logistics** – A JOSC can be a logistical nightmare, in this case the resources and timing of involvement of possibly 30+ boroughs will be particularly challenging.
Networking - Networking	**Member commitment** – Extra

opportunities afforded by scrutiny councillors from London boroughs coming together to examine a shared health issue. This could help prepare for future JOSC work.	meetings to prepare for and attend, across London must be absorbed in to members' current commitments.
Executive/scrutiny interface - Using JOSC evidence and NHS responses could inform the development of any separate local authority response. Scrutiny and the Executive could work together to formulate a local authority stance.	**Detailed proposals** - Previous JOSC work across London has shown that often it is difficult not to agree with the broad principles of proposals but the more pertinent issues are in the finer detail e.g. area-specific proposals.
Raising scrutiny's profile - Raise the profile of scrutiny locally as Harrow is seen to be actively participating in a important piece health policy development.	**Later consultations (second-stage)** – The perceived risk that the first-stage JOSC 'ties your hands' with regard to future scrutiny of proposals. However support for the broad principles should not colour the views expressed in later consultations – they are separate consultations.
Second-stage consultation - Involvement in first-stage consultation could be seen to provide more 'validity' to any comments made in the second-stage consultation on more local proposals.	

The North West London Health Scrutiny Officers' Network has also had early discussions to gauge any regional perspective on possible JOSC work. These discussions involved scrutiny colleagues from Brent, Ealing, Hammersmith & Fulham, Hillingdon and Hounslow.

<u>Timeline</u>
The proposed timetable from NHS London for governance arrangements is as follows:

Key date	Activity
September 2007	PCT Boards to agree to consult
W/e 7 September	Draft consultation document agreed and patient/public involvement programme discussed with JOSC and PPI group
W/e 5 October	JOSC to consider draft consultation paper and outline PPI programme
29 October 2007 to 1 February 2008	14-week formal public consultation
W/e 1 February	Health Inequalities Impact Assessments
W/e 4 April	JOSC to consider outcome of consultation and the HIIA
April	Joint PCT formally responds to JOSC views within 28 days

Main options

Overview and Scrutiny Committee is asked to either:

- Agree to participate in a pan-London JOSC on the models of care and consultation process (first-stage consultation);
  or
- Decline the offer to participate in a JOSC on the models of care and consultation process (first-stage consultation) but consider the models of care as an individual borough;
  or
- Decline the offer to participate in a JOSC on the models of care and consultation process (first-stage consultation) and do not give consideration to the implications of the *Healthcare for London A Framework for Action* report. Leave open the option to participate in a JOSC on more detailed proposals (second-stage consultation).

Legal Implications

The Scrutiny Team has sought advice from colleagues in Legal Services with regard to the authority's legal/constitutional position on participating in a JOSC. Having checked the provisions of the LGA 1972 (appointment of committees), LGHA 1989 (in relation to political balance), s21 of the LGA 2000 (as amended) and the provisions of the NHSA 2006, the advice was as follows:

The LGHA Sch 1 para 2 (h) requires committees (to include joint committees) to achieve political balance. However, sch 1 para 1(c) indicates that this requirement only applies if the authority can appoint at least 3 seats. The LGA places an obligation on local authorities to establish O&S committees to which the political balance provisions applies.

Any joint committee to deal with health services matters should therefore achieve political balance. However there is no requirement to achieve this balance if the number of seats to which the authority can appoint is less than 3.

Only full Council can establish a joint committee(s).

Financial Implications

This project will be managed within the scrutiny budget. No additional funding will be sought. Harrow's scrutiny budget for 2007/08 is £260,270 and Harrow's contribution to any JOSC would be provided for within this provision.

Other considerations:

Equalities impact

Scrutiny work across London makes a significant contribution to the improvement of services for London's multicultural community. The scope of this JOSC includes considering in particular the impact of changes concerning the most vulnerable in the community and how best to meet their needs, through a Health Inequalities Impact Assessment conducted for NHS London.

Community safety (s17 Crime & Disorder Act 1998)

There are none specific to this report.

Performance Issues – Scrutiny performance management issues

There are none specific to this report.

Section 3 - Statutory Officer Clearance

Name: Barry Evans Date: 13 September 2007	✓	on behalf of the Chief Financial Officer
Name: Sharon Clarke Date: 12 September 2007	✓	on behalf of the Monitoring Officer

Section 4 - Contact Details and Background Papers

Contact:
Nahreen Matlib, Senior Scrutiny Officer
Email: nahreen.matlib@harrow.gov.uk

Background Papers:
- Attached in appendices:
  - Discussion paper from London Scrutiny Network informal officers' meeting 10 September 2007
  - *Healthcare for London A Framework for Action* Summary Document
- http://www.healthcareforlondon.nhs.uk/framework_for_action.asp

If appropriate, does the report include the following considerations?

1.	Consultation	N/a
2.	Corporate Priorities	N/a

APPENDIX A

Joint Overview & Scrutiny Committee (JOSC) to review 'Healthcare for London' - Issues for discussion at London Scrutiny Officers meeting 10th September 2007

1. Who wants to take part?

London Boroughs may decide not to participate in the JOSC. However, only the JOSC has the statutory power to request information relating to the issue being consulted on (in this case Healthcare for London). The NHS body consulting only has to consider and respond to the report of the JOSC. It is under no duty to respond to any comments submitted by individual OSCs.

Issue for meeting

- *Does your Borough want to participate?*

2. Who should the JOSC be open to?

It is the London Boroughs and not the London Assembly who hold the health scrutiny powers. Government health scrutiny guidance 'recommends' that authorities work with the London Assembly to avoid duplicating scrutiny regimes on pan-London services. Boroughs will need to decide whether to invite London Assembly Members to sit on the JOSC.

The London Commissioning Group (representing London PCTs) is intending to invite non-London OSCs to take part in the JOSC as it suggests that implementation of the Darzi review could impact on areas neighbouring London.

For practical purposes (e.g. size of meeting) it may only be possible for London Boroughs to appoint one Member each. Officers will also need to attend.

Issue for the meeting

- *If most/all Boroughs take part, is it practical for the JOSC to have more than one Member representative per Borough?*
- *Should London Assembly Members be involved in the JOSC?*
- *How should non-London OSCs be represented on the JOSC?*

3. What will the JOSC do?

A joint committee is only able to undertake the functions allocated to it. The purpose of this JOSC will be to respond the consultation of the 'models of care' in the Healthcare for London review. The JOSC may also wish to review whether it feels the consultation is adequate.

Each participating authority must be clear on the terms of reference of the JOSC. Each authority will need to agree the same terms of reference. Experience from the first joint health scrutiny review (on cancer services at Mount Vernon Hospital) suggests that these need to be proposed by an officer meeting such as this.

Issue for the meeting

- *What should be the terms of reference for the JOSC?*

4. How will JOSC Members be appointed?

Boroughs will make their own appointments to the JOSC. Under the Local Government Act 2000 OSCs must generally reflect the political make up of the full council. When a JOSC is set up and there is more than one place per local authority, the political balance requirement applies for each participating local authority unless members of all those authorities agree to waive that requirement. Executive members of an authority cannot sit on a JOSC.

Many Councils require JOSC appointees are made at a full Council meeting.

Issue for the meeting

- *How does your constitution require the Member(s) of a JOSC be appointed?*
- *What would be the timescale for this appointment? Could representatives be appointed by the start of November?*

5. What could be the timescale for the JOSC?

The formal consultation is due to run from 29th October 2007 to 1st February 2008 (14 weeks). The NHS would then have 28 days to respond to all consultation responses. Having considered a Health Impact Assessment, the NHS will then issue recommendations on the way forward.

In addition to submitting comments as part of the 14 week consultation, the JOSC would also have an opportunity to comment on the NHS response to the consultation. In effect, this gives the JOSC 'two bites of the cherry' and means that the JOSC needs to meet again after the end of the 14 week consultation.

A possible JOSC timetable is outlined below. However, Member ownership is vital and Members of the JOSC themselves would need to decide their work programme.

November: **First meeting:** NHS present consultation document and JOSC takes clinician evidence

December: **Second meeting:** JOSC takes further evidence (perhaps from community groups and clinicians not involved in the Darzi review). JOSC indicates contents of consultation response.

January: **Third meeting:** JOSC signs off consultation response

Late February/ Early March: Fourth meeting: JOSC considers the Health Impact Assessment and the NHS response to the consultation

NB: The JOSC may wish to ask the NHS if the Health Impact Assessment could be produced before the consultation ends.

Issues for the meeting

- *How many meetings should the JOSC have?*
- *From whom should the JOSC take evidence?*
- *Should the Health Impact Assessment be available as part of the consultation?*

6. How will the JOSC operate and be supported?

The Government health scrutiny guidance suggests that participating authorities should share the costs and resource implications of working together. The JOSC will require resourcing, including: officer support, meeting rooms, meeting refreshments and printing of paperwork.

There are several options for providing these resources. In theory, separate authorities could provide different aspects of support. However, given the large number of possible participants it is likely to require a subset of Boroughs to provide (or commission) support and for the costs to be divided between each participating authority. For example, Bedfordshire County Council supported the Mount Vernon review and subsequently billed the other seven authorities.

The practicalities of holding the meetings could also be difficult. Fairly large meeting rooms will be required and these should be accessible for people travelling from across London. Many London Borough meetings take place in the evening. However daytime meetings may be preferred given that participants will be travelling greater distances.

Issues for the meeting

- *What would be an acceptable solution for resourcing the JOSC? Would Boroughs be prepared to contribute an equal amount?*
- *Where could the meetings be held?*
- *When would be the best time to hold the meetings?*

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Summary

Introduction

1. London is a world-class city and Londoners deserve a world-class healthcare system. But, though there are many areas of real excellence in London, of which we should be proud, world-class care is not currently what every Londoner can expect. There are stark inequalities in health outcomes across London, and the quality and safety of patient care is not always as good as it could, and should, be.

2. This report makes recommendations for change. It is based on a thorough, practitioner-led process, and rooted in evidence – gathered from a wide range of people and organisations from the world of healthcare and from the NHS's partners in local government and beyond, from thorough reviews of the literature and data, and from the use of a range of analytical modelling techniques. It also reflects a major exercise to hear what Londoners say they want from their healthcare system. It sets out a compelling ten-year vision for healthcare in London.

The case for change

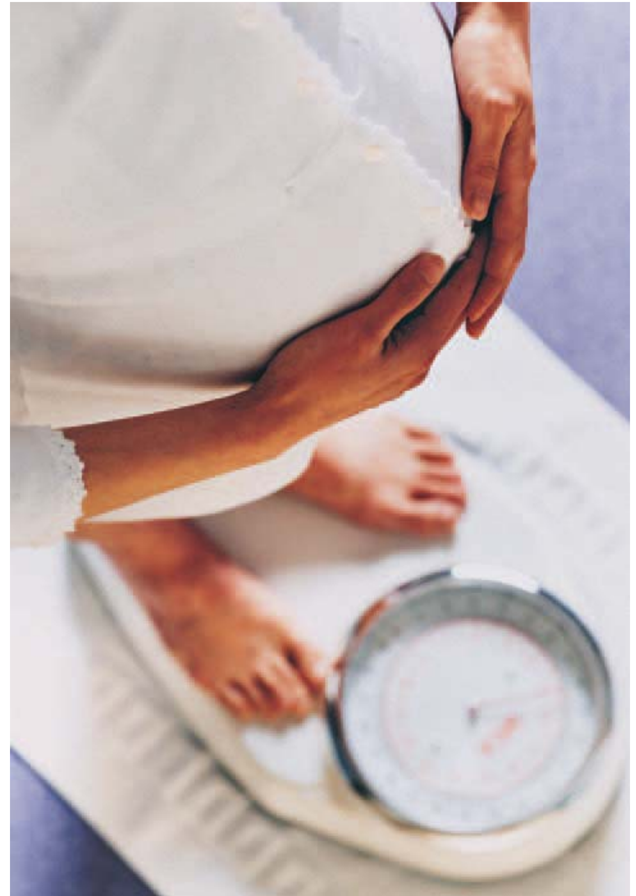
3. Healthcare in London needs to change. There are many excellent reports considering how healthcare must change in the future, both in general and in particular specialties. This report focuses on the specific challenges for London.

- **We need to improve Londoners' health.** London's health services need to be able to tackle some health challenges that are specific to London – notably high rates of HIV, substance misuse, mental health problems, and high rates of childhood obesity. They also need to be able to meet the needs of our wonderfully diverse and highly mobile population. The NHS must be accessible to all.
- **The NHS is not meeting Londoners' expectations.** There is much public support for the work done by the NHS. But not all expectations are being met. Twenty-seven per cent of Londoners are dissatisfied with the running of the NHS compared with eighteen per cent nationally. Londoners are also less satisfied than people nationally with their GP services. Though the NHS has improved considerably over the last twenty years, it has not kept pace with rising expectations. The NHS in London will have to work harder to meet the expectations of Londoners and respond to their concerns.
- **London is one city, but there are big inequalities in health and healthcare.** Equity of care is a founding principle of the NHS, but healthcare in London is not equitable, either in terms of mental and physical health outcomes, or in terms of the funding and quality of services offered. London-wide data mask significant disparities. For example, Westminster and Canning Town are separated by just eight stops on the Jubilee Line, and by a seven-year disparity in life expectancy. And there is significant variation in GP distribution, with overall fewer GPs per head in some of the areas where health need is greatest.
- **The hospital is not always the answer.** As set out in the White Paper, *Our health, our care, our say*, most people are best cared for by community services. This is what Londoners have told us they want and medical advances make it more possible now than ever. But 97 per cent of London outpatient appointments still take place in hospital. And, dissatisfied with the availability of GP services out of

working hours, Londoners are instead using A&E departments for urgent care.

- **We need to provide more specialised care.** Whilst most people can be cared for by community services, the most seriously ill need more specialised care. For instance, a detailed review of stroke services has found that dedicated, high-quality, specialist stroke units save lives. In order to ensure sufficient volumes of work to maintain specialist staff expertise, to support high-tech facilities, and to allow comprehensive consultant presence, specialised services need to be centralised in fewer hospitals catering for large populations. Yet London has one of the smallest average catchment populations per hospital in the country.
- **London should be at the cutting edge of medicine**. Many great medical breakthroughs have occurred in London, which remains the leading centre for health research in the UK. But the UK as a whole risks lagging behind its international competitors. London needs to explore the model of Academic Health Science Centres being followed by other large cities if it wants to be at the cutting-edge of research and clinical excellence.
- **We are not using our workforce and buildings effectively.** The NHS's staff are its greatest asset but their abilities are not always fully used. Productivity levels in London are lower than elsewhere in England – for example, doctors in a large acute hospital in London see 24 per cent fewer patients than their counterparts. Staff are also not employed in ways that make it easy for them to move between hospital and community settings. The NHS estate is a huge and hugely under-utilised resource.
- **We need to make the best use of taxpayers' money.** Funding is not the major reason for change, but the NHS in London would be failing in its duty to its population if

it did not make best use of the money it has. Money wasted through inefficiency in one aspect of healthcare is money that could have been used to save lives elsewhere. Over the last five years, there has been unprecedented national growth in funding but this growth will slow down from April 2008. The only way for future healthcare provision to be sustainable is changing to ensure care is provided in the most cost-effective way.



Future health needs

4. We want to build an NHS for London that meets not only today's challenges (outlined above) but also the challenges of the future.

5. Probably the biggest challenge for the NHS over the next ten to twenty years will come from London's growing and ageing population. Population projections suggest an increase in London's population from 7.6 million in 2006 to 8.2 million in 2016. These increases are being driven not by migration into London (which is balanced by migration out of the capital) but by a birth rate that exceeds the death rate.

6. London's population is also becoming older. The fastest-growing sections of the population are the 40-64 age group and the over-85s, both of which have higher health needs than younger age groups.

7. A population that is both bigger and older will have a significantly greater need for healthcare. This need will not be spread evenly throughout London, but will be concentrated where the greatest population growth is predicted – mainly along the Thames Gateway on the eastern side of London.

8. Any vision for the future of London's NHS also needs to take into account the likelihood of technological changes and of ever-rising patient expectations. Although some new technology can save the NHS money, the overall trend is that new technologies increase the demand for healthcare by making new interventions and procedures possible. At the same time, a new generation will expect NHS services to fit with their lifestyles, not the other way around. People will demand the very best care as a right, not a privilege, and the NHS will have to respond.

9. It is clear that demand for NHS services is only going to grow. Our detailed modelling makes it clear that continuing with the old ways of doing things will not only be ineffective, it is also likely to be unaffordable. Any proposals for change need to show that they take into account our best predictions of what the future will bring.

Five principles for change

10. During the course of this review we discussed healthcare in London with a huge

range of people. Some common themes quickly began to emerge. Whether it was a meeting of a clinical working group or a public deliberative event, five principles for the provision of future healthcare came through again and again.

11. This report's recommendations are based on these five principles.

- **Services focused on individual needs and choices**. Provision should, wherever possible, be tailored to the particular needs of each individual. Patients should feel in control of their care and be able to make informed choices.
- **Localise where possible, centralise where necessary.** Routine healthcare should take place as close to home as possible. More complex care should be centralised to ensure it is carried out by the most skilled professionals with the most cutting-edge equipment.
- **Truly integrated care and partnership working, maximising the contribution of the entire workforce.** Better communication and co-operation is needed – between the community and the hospital, between urgent and planned care, between health and social care – to stop people from falling through the gaps. Care should be multidisciplinary, bringing together the valuable contributions of practitioners from different disciplines. The NHS should be committed to working in partnership with other organisations, including local government and the voluntary and private sectors.
- **Prevention is better than cure.** Health improvement, including proactive care for people with long-term conditions, should be embedded in everything the NHS does. Close working with local authority partners is needed to help people stay mentally and physically healthy.
- **A focus on health inequalities and diversity.** As discussed above, the most deprived areas of London, with the greatest health needs, need better access to high-quality healthcare. The whole thrust of this report is to tackle health inequalities by improving services across London, giving everybody access to the best possible care. Healthcare should be intelligently commissioned to tackle health inequalities. Preventative and outreach work should focus on the most deprived populations and new facilities should be located in the areas of greatest need. Improvements also need to take into account London's rich ethnic and cultural diversity. We are advocating that patients have more information to make choices about their care and this should be accessible to all.

12. The proposals in this report have undergone a preliminary inequalities impact review. A full inequalities impact assessment will be undertaken post-publication as part of the discussion period. The preliminary review indicated that the way in which the *Framework* is implemented will be the most important factor in reducing inequalities.

Improved care from cradle to grave

13. This review commissioned six clinical working groups to look at six patient pathways – maternity and newborn care, staying healthy, acute care, planned care, long-term conditions and end-of-life care - and make recommendations for change. In addition, the chief executives of London's mental health trusts helped develop robust proposals in their particular area. Taken together, these seven groups make proposals for improving care from cradle to grave.

14. The main report contains a great deal of material setting out the thinking and recommendations of each group. This summary cannot do justice to the huge amount of work that went into each group's proposals. What it does do is set out, under the five principles outlined above, each group's key proposals (though of course most recommendations address more than one principle).

Universal services focused on individual needs

- Women's social and medical needs should be assessed at an early stage, and then reassessed during their pregnancy, with their care based on these assessments (maternity and newborn working group).
- As many women as possible should receive continuity of care throughout the antenatal, labour and postnatal periods (maternity and newborn working group).
- Women should be offered a genuine and informed choice of home birth, birth in a midwifery unit or birth in an obstetric unit (maternity and newborn working group).
- All women should be given one-to-one midwifery care in established labour (maternity and newborn working group).
- Mental health service users should be put in control and their recovery and social inclusion should be supported (mental health working group).
- Access to GPs for routine appointments should be improved (planned care working group).
- People with long-term conditions should be at the centre of a web of care (long-term conditions working group).
- People should have an end-of-life care plan, including preferences on place of death, and this should be registered electronically (end-of-life working group).

Localise where possible, centralise where necessary

- Antenatal care should be provided in local, one-stop settings, and postnatal care should be provided in local, one-stop settings as well as at home (maternity and newborn working group).
- There should be a significant increase in the number of midwifery units, with each obstetric unit having an associated midwifery unit, either co-located or stand-alone depending on local circumstances (maternity and newborn working group).
- Obstetric units should have at least 98 hours a week consultant presence (maternity and newborn working group).
- More use should be made of "talking" therapies in the community complemented by a strategy for developing inpatient care (mental health working group).
- There should be centralisation and networks for major trauma, heart attack and stroke (acute care working group).
- Dispatch and retrieval protocols for London Ambulance Service need to be aligned with centralisation (acute care working group).
- Routine diagnostics and outpatients should be shifted out of large hospitals (planned care working group).
- Increased use should be made of the day case setting for many procedures (planned care working group).
- Rehabilitation should be done at home wherever possible (planned care working group).
- More specialised inpatient care should be centralised into large hospitals (planned care working group).
- Specialist providers should offer care on other hospital sites (planned care working group).
- There should be greater investment to support people to die at home (end-of-life working group).

Truly integrated care, maximising the contribution of the entire workforce

- Maternity networks – involving maternity commissioners and all providers – should be formally established across London and be linked with neonatal networks (maternity and newborn working group).

- There should be a clear pathway for care, so that mental health service users and partner organisations know what to expect and how to be involved (mental health working group).
- Community mental health teams should have a more focused remit (mental health working group).
- There should be a single point of contact (by telephone) for urgent care (acute care working group).
- London care bundles for intensive care and hospital-acquired infections should be developed (planned care working group).
- Integration of services should be improved (both between GP practices and hospital specialists and between health and social care) for people with long-term conditions (long-term conditions working group).
- London-wide best practice care pathways should be developed for different long-term conditions – for example, diabetes, chronic obstructive pulmonary disease, coronary heart disease and asthma (long-term conditions working group).
- End-of-life service providers should be commissioned to co-ordinate end-of-life care (end-of-life working group).

Prevention is better than cure

- Promoting health and wellbeing means the NHS working more energetically with other public services and organisations (staying healthy working group).
- More should be invested in proven health improvement programmes and initiatives (staying healthy working group).
- There should be a pan-London campaign for activity and healthy eating linked to the 2012 Olympic and Paralympic Games (staying healthy working group).
- All health organisations and their staff should be incentivised to take every opportunity to promote physical and mental health (staying healthy working group).
- There should be a greater focus on health protection, with improved sexual health, tuberculosis and childhood immunisation services (staying healthy working group).
- The NHS should play a greater role in improving the physical and mental health and wellbeing of its employees (staying healthy working group).
- Early intervention services need to be improved (mental health working group).
- There should be more pro-active community care to reduce emergency admissions and lengths of stay (long-term conditions working group).

A focus on health inequalities and diversity

- Mental health services should be developed for those at risk – offenders, asylum seekers and refugees and the black and minority ethnic population (mental health working group).
- Access should be significantly improved through urgent care centres with doctors on-site. Urgent care centres in hospitals should be open 24/7, the hours of those in community settings will depend on local need (acute care working group).
- Long-term conditions should be prevented where possible by outreach and tailored

advice to the most deprived (long-term conditions working group).

- All organisations should meet existing good practice guidelines – for example, gold standards framework (end-of-life working group).

Models of healthcare provision

15. This review's focus has been on services, not institutions and buildings. That is why the process was built around looking at what form future care should take in seven different clinical areas. But it is clear that at present London does not have the infrastructure and facilities to provide the ideal care outlined by our clinical working groups. New models of provision will be needed in order to deliver the kind of high-quality care Londoners need and deserve.

16. There are two particularly stark needs. First, we need to provide a new kind of community-based care at a level that falls between the current GP practice and the traditional district general hospital. In London, primary care is mainly provided in GP practices, the majority of which have just one or two GPs. Practices are often in cramped, converted residential spaces with little opportunity to expand and provide a greater range of services. Secondary care by contrast is offered by the 32 acute trusts and ten mental health trusts. Most hospitals are large, with thousands of employees and hundreds of beds each.

17. Second, we need to develop hospitals that are more specialist, delivering excellent outcomes in complex cases. Although many of our district general hospitals try to provide a wide range of specialist care, there are simply not the volumes of patients with complex needs to make this either viable or as safe as possible for patients. We need fewer, more advanced and more specialised hospitals to provide the most complex care, some linking directly into universities to foster research and development.

18. These two needs lead us to propose seven models of provision for the future:

- more healthcare should be provided at **home**
- new facilities – **polyclinics** – should be developed that can offer a far greater range of services than currently offered in GP practices, whilst being more accessible and less medicalised than hospitals
- **local hospitals** should provide the majority of inpatient care
- most high-throughput surgery should be provided in **elective centres**
- some hospitals should be designated as **major acute hospitals**, handling the most complex treatments
- existing **specialist hospitals** should be valued and other hospitals should be encouraged to specialise
- **Academic Health Science Centres** should be developed in London to be centres of clinical and research excellence.

19. Each model is fully described in the main part of this report. This summary restricts itself to describing in more detail the way a polyclinic – which will be at the heart of delivering the improved services – might work.

Polyclinic

20. If London is to gain the improved services we envisage, then large, high-quality community facilities are needed, providing a much wider range of services than is currently provided by most GP practices. Following the testing of various names for these facilities with Londoners, we are provisionally labelling them polyclinics.

21. We propose that the polyclinic will be where most routine healthcare needs are met. Londoners will view their local polyclinics as their main stop for health and wellbeing support. GP practices will be based at polyclinics, but the

range of services available will far exceed that of most existing GP practices.

22. In terms of the clinical working groups' recommendations, polyclinics will offer access to antenatal and postnatal care, healthy living information and services, community mental health services, community care, social care and specialist advice all in one place. They will provide the infrastructure (such as diagnostics and consulting rooms for outpatients) to allow a shift of services out of hospital settings. They will be where the majority of urgent care centres will be located. And they will provide the integrated, one-stop-shop care that we want for people with long-term conditions.

23. The scale of the polyclinics will allow them to improve accessibility by offering extended opening hours across a wide range of services. Scale should also make it more possible to provide the expertise necessary to improve accessibility for some disadvantaged groups, and to implement much more sophisticated telephone booking systems.

24. We are aware that this proposal may be challenged as de-personalising GP care. Many patients are understandably keen to maintain a relationship with their own GP. However there is no reason why larger polyclinics should not be able to provide exactly this kind of personalised care. For instance, whilst a patient attending the urgent care centre at their local polyclinic at 10pm may not necessarily see their regular GP, there is no reason why they shouldn't be able to book to see their GP within a bigger practice just as they do now.

25. We believe these new models of healthcare provision will provide better, more tailored healthcare closer to home for most people, whilst also delivering excellent specialised care in centralised major hospitals for those who need it. They will provide truly integrated care, bridging the current divides between primary and secondary care, between those working within

different disciplines, and between healthcare and social care. They will provide a greater focus on prevention. And they will deliver more, better quality, more accessible healthcare to all Londoners but in particular to those who have traditionally been less well-served by their NHS.

26. Our detailed feasibility modelling suggests that our proposed new model would, in the most likely growth scenario for demand in health services, save the NHS £1.4 billion each year. So these changes are necessary not just to improve services, but also to make future activity affordable. An NHS with a strong emphasis on prevention and early intervention saves lives and saves money.

From vision to reality

27. A huge amount of energy and enthusiasm has gone into this report. People across London who really care about improving the NHS in the capital have contributed their time and knowledge to this review. The challenge will be to carry that energy and enthusiasm forward into implementation.

28. It is unfortunately the case that previous strategic frameworks have been at best only partly implemented. Both opposition to change, and a lack of understanding of how to bring change about, have stopped the momentum. People working in the NHS have believed that their organisations will be changed by powers above them, rather than by them themselves.

29. I am determined that things should be different this time. This report identifies the main drivers for change and improvement that will ensure the vision in this *Framework* becomes a reality, and demonstrates the part that everyone in the NHS can play.

- **Commissioning.** Commissioning is potentially a very powerful lever for driving change. We need the right commissioning skills and structure, and we need to commission in partnership with others.

- **Partnerships to improve health.** The NHS has often made the mistake of thinking it can change healthcare outcomes on its own. It cannot. The NHS must work with its partners – the London boroughs, the Greater London Authority and the Mayor's Office, the voluntary and private sectors, and the higher education sector – to implement this *Framework*.
- **Public support.** For change to succeed both the public and politicians need to believe that it is in the public's interest. The clinical case for change needs to be clearly made. And there needs to be up-front investment to help put new services in place quickly and win public support for change.
- **Clinical leadership.** The whole approach of this review has been to develop clinical support for our proposals. But it is easy to support principles for London, harder to support change in the hospital or locale where you work. Many clinicians understandably fear that change will affect their job satisfaction, their autonomy, their clinical reputation. To confront and assuage these fears, NHS London needs to identify clinical champions to make the case for change.

- **Training and the workforce.** Clinical leadership is important but so too is the development of the workforce more broadly. New models will call for new roles and new skills. NHS London needs a single workforce strategy to help align recruitment and training with changing needs.
- **Patient choice and information.** The choices that patients make about their healthcare will increasingly drive change and improvement. The better the information, the more those choices can drive improvement. Information for choice needs to be developed in priority areas such as GP and maternity services.
- **Funding flows.** Commissioning can only drive change if it has a direct impact on the income of healthcare providers. Funding flows need to be used to incentivise the best practice contained in this report. At its simplest, this means commissioners defining the best, safest practice for a patient pathway and then ensuring that this and only this is the practice they pay for.
- **Better use of our estates.** The NHS in London has a huge and under-utilised estate. We need a comprehensive estates strategy to support this *Framework*, including exploring how surplus or underused estate can be used to finance new developments.

30. These are the drivers for change. I have also identified four short-term activities that I think will be necessary to show that the NHS in London is serious about this *Framework* – the development of five to ten polyclinics by April 2009, the urgent London-wide re-configuration of both stroke and trauma services, and rapid work to further improve the skills and capacity of our already-remarkable London Ambulance Service.

31. And finally, one of the main themes of this report is the importance of reducing health inequalities by giving everyone access to the best possible care. Whether this *Framework* succeeds in this goal will depend on how it is implemented. So I will be expecting both local and strategic implementation to make systematic use of health inequalities impact assessments to ensure improvements are helping those who are currently the least well-served by the NHS.

32. I feel passionately about London, and I feel passionately that Londoners deserve world-class healthcare. From here on in, taking things forward will be the collective responsibility of the NHS in London, together with its partners. Specifically, NHS London, the strategic health authority for London, will need to co-ordinate the task of turning the vision into the reality of improving healthcare for London. I hope that all those who have a stake in creating a world-class healthcare system for London will keep working with them to make the vision a reality.

Meeting:	Overview and Scrutiny Committee
Date:	25th September 2007
Subject:	Standing Scrutiny Review of the Budget – Initial Scope
Key Decision: (Executive-side only)	No
Responsible Officer:	Lynne McAdam, Service Manager Scrutiny
Portfolio Holder:	Cllr David Ashton Finance and Portfolio Co- ordination Portfolio Holder
Exempt:	No
Enclosures:	**Appendix One – Initial scope for the Standing Scrutiny Review of the Budget**

Section 1 – Summary and Recommendations

This report introduces initial discussion on the potential scope for the Standing Scrutiny Review of the Budget

Recommendations:
Councillors are asked to:

i. Comment on the content of the initial scope for the standing review
ii. Ask members of the review to develop this scope further
iii. Report back with a final version of the scope to a future meeting of the Overview and Scrutiny committee

Reason: (For recommendation)
To enable the work of the standing scrutiny review of the budget to commence

Section 2 – Report

Background (if needed)
One of the key roles of the Overview and Scrutiny committee is to comment on and support the development of the council's budget. Traditionally this has been done via a presentation from the Director of Finance to a regular meeting of the Overview and Scrutiny committee.

As scrutiny has developed, and the options available to councillors to undertake their role have expanded, the committee has used different methods to investigate the budget making process. Last year saw the establishment of a challenge panel and this year councillors have decided to establish the standing scrutiny review of the budget. This will see the same group of councillors meet on a regular basis throughout the year to consider how budget planning is progressing.

The committee has also decided that, in order not to duplicate the work of other groups that support the development of the budget, the focus of the review should be on the longer term context within which the budget is set and also how far the council has considered the longer term impact of the budget decisions it makes in year.

The initial scope for the review is attached as Appendix One

Current situation
Arrangement for scrutinising the budget currently consist of one-off budget challenge panel or item on committee agenda

Why a change is needed
These processes do not offer a sufficiently robust challenge to the budget making process.

Main options
The option under consideration is the establishment of a standing scrutiny review of the budget to consider long term context within which the budget is set.

Other options considered
Previous options for challenging the budget setting process have lacked the rigour that councillors have identified as necessary to make a effective contribution to budget making.

Recommendation:
To consider the initial scope for the standing scrutiny review of the budget.

Considerations
Resources, costs and risks
Resources necessary to establish and support the standing review will be met from the scrutiny budget. Support, will be also be required from the Director of Finance.

The establishment of the standing review represents an opportunity to improve scrutiny of the budget. Consideration of the longer-term context within which the budget is set offers an opportunity to enhance the council's budget setting process and reduce duplication of effort.

Staffing/workforce
There are none specific to this report.

Equalities impact
A longer-term approach to the scrutiny of the budget will mean that all of the implications of change, and their potential adverse impact on specific communities within the borough can be identified and addressed as appropriate

Community safety (s17 Crime & Disorder Act 1998)
There are none specific to this report

Legal Implications
There are no legal implications arising from this report.

Financial Implications
Any costs relating to the standing review will be met from the scrutiny budget

Performance Issues
Current KPI's and Likely impact of decision on KPI's

Scrutiny performance management issues

Recommendations matrix attached as appropriate [x]

Section 3 - Statutory Officer Clearance

Name: Sheela Thakrar Date: 14th September 2007	✓	on behalf of the Chief Financial Officer
Name: Jill Travers Date: 14th September 2007	✓	on behalf of the Monitoring Officer

Section 4 - Contact Details and Background Papers

Contact: Lynne McAdam, Service Manager Scrutiny
020 8420 9387

Background Papers: None

If appropriate, does the report include the following considerations?

1.	Consultation	YES
2.	Corporate Priorities	YES

APPENDIX ONE

HARROW COUNCIL

OVERVIEW AND SCRUTINY COMMITTEE

2007/08

STANDING SCRUTINY REVIEW OF BUDGET - DRAFT SCOPE

1	**SUBJECT**	Standing Scrutiny Review of Council Budget
2	**COMMITTEE**	Overview and Scrutiny Committee
3	**REVIEW GROUP**	Cllr Noyce – Chairman (has been invited) Cllr Gate Cllr Green Cllr Idaikkadar Cllr Kinnear Cllr McLeod Cullinane Cllr Stephenson Cllr Teli Cllr Weiss Cllr Mudhar
4	**AIMS/ OBJECTIVES/ OUTCOMES**	To support the council to develop a robust budget that is prepared in the full understanding of the changing local government financial environment and the changing policy environment for service delivery
5	**MEASURES OF SUCCESS OF REVIEW**	• Budget setting process is informed of impending policy changes • Long term budgetary implications are flagged up and risks mitigated • Cabinet acknowledge the support of the standing review
6	**SCOPE**	• To consider the long term policy and financial framework within which the budget is being prepared • To consider the long term implications of the decisions made in-year
7	**SERVICE PRIORITIES (Corporate/Dept)**	Deliver Value for Money
8	**REVIEW SPONSOR**	Chief Executive
9	**ACCOUNTABLE MANAGER**	Corporate Director of Finance
10	**SUPPORT OFFICER**	Service Manager Scrutiny
11	**ADMINISTRATIVE SUPPORT**	TBC
12	**EXTERNAL INPUT**	Deloitte & Touche Audit Commission

13	**METHODOLOGY**	To meet as a standing review group on a regular (possibly quarterly) basis to consider the council's budget preparation process and assess: • how effectively the council is addressing changes to the local government financial regime and policy changes in other areas of service delivery that will have a consequence for the borough and • the long term implications of budget decisions and how risks associated with these decisions have been addressed. **Phase One** • Desktop analysis to clarify the regime within which the council's budget is set • Desktop analysis of potential changes to this regime • Desktop analysis to identify other potential changes to policy which may have significant impact on council's financial standing **Phase Two** Roundtable discussion with officers to confirm the assessment of impact of change **Phase Three** Round table consideration of budget proposals in the light of the impact of change identified in phases one and two to assess how well the council is addressing these changes **Phase Four** Consideration of budget proposals to assess how effectively the council is anticipating the impact of current funding decisions in the longer-term.
14	**EQUALITY IMPLICATIONS**	A longer-term approach to the scrutiny of the budget will mean that all of the implications of change, and their potential adverse impact on specific communities within the borough can be identified and addressed as appropriate.
15	**ASSUMPTIONS/ CONSTRAINTS**	• The review assumes the availability of financial information at appropriate times in the budget making process • The project will be constrained by the finances available to the scrutiny team
16	**SECTION 17 IMPLICATIONS**	There are none specific to this report
17	**TIMESCALE**	Ongoing
18	**RESOURCE COMMIMTENTS**	Service Manager Scrutiny
19	**REPORT AUTHOR**	• Lynne McAdam • Chairman of the review

20	**REPORTING ARRANGEMENTS**	Outline of formal reporting process: To Service Director [ ] When………………….. To Portfolio Holder [ ] When………………….. To CMT [ ] When………………….. To Cabinet [ ] When…………………..
21	**FOLLOW UP ARRANGEMENTS (proposals)**	

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Meeting:	Overview and Scrutiny Committee
Date:	25th September 2007
Subject:	Scrutiny/Executive Protocol
Key Decision: (Executive-side only)	N/A
Responsible Officer:	Paul Najsarek, Director People, Performance and Policy
Portfolio Holder:	
Exempt:	No
Enclosures:	***Delivering Effective Scrutiny – A Framework of Responsibilities***

Section 1 – Summary and Recommendations

This report accompanies the proposed protocol for relationships between scrutiny and the executive 'Delivering Effective Scrutiny – A Framework of Responsibilities

Recommendations:

Councillors are asked to:

i Agree the Scrutiny/Executive protocol attached as Appendix One
ii Submit the protocol to cabinet for their endorsement
iii Submit the protocol to the Council's Corporate Strategy Board for information

Reason: (For recommendation)
To clarify relationships and responsibilities between Scrutiny and the Council's Executive in order to maximise scrutiny's contribution to service improvement.

Section 2 – Report

Background (if needed)

Following the reconfiguration of the council's scrutiny process, discussions between the Chairman and Vice Chairman of Scrutiny, the Chief Executive and the Leader and Deputy Leader have resulted in the development of proposals to secure the effective delivery of scrutiny through the agreement of a framework of responsibilities that will clarify the respective responsibilities of scrutiny and executive councillors.

Current situation

There is no formal protocol governing relationships between the Executive and Scrutiny

Why a change is needed

An agreement between the parties as to how to engage and the respective roles and responsibilities will ensure an effective relationship between the parties and that the contribution that scrutiny can make to the council's improvement processes is maximised.

Main options

The options are included in Appendix One

Other options considered

Not appropriate to this report

Recommendation:

- i Agree the Scrutiny/Executive protocol attached as Appendix One
- ii Submit the protocol to cabinet for their endorsement
- iii Submit the protocol to the Council's Corporate Strategy Board for information

Considerations

Resources, costs and risks

There are no specific resource implications associated with the adoption of the protocol, its adoption will simply reflect improved practice. However, the introduction of additional meetings between the Chairman and Vice Chairman of Scrutiny, the Leader and Deputy Leader and the Chief Executive will represent an additional demand on their respective time.

Training proposals will be funded from within existing resources.

Staffing/workforce

The protocol proposes a number ways to refine the communications between officers which represent different ways of working. However, there are no additional staffing or workforce implications

Equalities impact

There are none specific to this report

Community safety (s17 Crime & Disorder Act 1998)

There are none specific to this report

Legal Implications
There are no legal implications

Financial Implications

Performance Issues
Current KPI's and Likely impact of decision on KPI's

Scrutiny performance management issues

Recommendations matrix attached as appropriate [x]

Section 3 - Statutory Officer Clearance

Name: Barry Evans Date: 13th September 2007	✓	on behalf of the Chief Financial Officer
Name: Jill Travers Date: 14th September 2007	✓	on behalf of the Monitoring Officer

Section 4 - Contact Details and Background Papers

Contact: Lynne McAdam, Service Manager Scrutiny 020 8420 9387

Background Papers: None

If appropriate, does the report include the following considerations?

1.	Consultation	YES
2.	Corporate Priorities	NO

APPENDIX ONE

DELIVERING EFFECTIVE SCRUTINY – A FRAMEWORK OF RESPONSIBILITIES

CONTEXT - THE PRINCIPLES OF SCRUTINY

Scrutiny is an independent, member-led function working with local people to improve services It is an integral function in the delivery of service improvement, enhancing the democratic capacity of the council by ensuring that councillors are contributing to the 'management/analysis' of services and securing the most effective services for residents of the borough by responding to and systematically investigating their concerns – people's champions.

Scrutiny is a critical friend to the organisation that will challenge poor performance and identify ways of improving services, it will support the council in identifying innovative responses to the evolving policy framework and it will hold the organisation to account for its performance against stated priorities. The principle functions are to:

- Hold local decision-makers to account
- Consider, comment on and challenge local decision-makers' performance and delivery of services
- Identify and investigate areas of service delivery which appear to be problematic (or indeed highly successful)
- Identify options for improving service performance
- Help decision-makers and the council as a whole to respond to the changing policy environment

Where scrutiny is well connected to the local community and integrated into the performance structures of a council it offers the authority an excellent resource with which to respond to the needs of residents and advocate on their behalf, analyse performance and drive service improvement. However, the relationship between cabinet, senior management and scrutiny is of necessity complex – scrutiny must be in a position to provide effective challenge to the organisation but cannot do so without the positive, practical co-operation of cabinet and senior managers and the leadership of the council must be prepared to respond constructively to the challenge offered by scrutiny.

Scrutiny councillors and officers must maintain their independence but must at the same time develop a co-operative and constructive relationship if the full benefits of the scrutiny process are to be realised. Cabinet remains solely responsible for the determination of the policies and priorities of the council and senior managers and staff will deliver these on their behalf. However, the role of scrutiny as a challenge to the exercise of the executive's power and the value that this can bring to the authority as a whole must be agreed, safeguarded and promoted. At the same time, scrutiny must arrange its purpose and processes in such a way as to be able to deliver these potential benefits. Once agreed it is critical to the effectiveness of the overview and scrutiny function that roles and responsibilities are observed and respected. Failure to do so will mean that resources are wasted, reviews are ineffectual and that ultimately the residents of Harrow do not receive the efficient and effective services they deserve.

RESPECTIVE RESPONSIBILITIES

What The Organisation Can Expect From Scrutiny

The following are proposed as the fundamental protocols that will guide scrutiny's relationship with the council and partners:

- *Scrutiny commits to working across political lines in a non-partisan way to secure maximum benefit for local people*
- Scrutiny will offer challenge to the organisation and provide non-partisan checks and balances on behalf of local people
- Scrutiny commits to ensuring that its work programme is targeted appropriately and that it is able to complement the council's and partners' other improvement processes and in order to add value to them
- Scrutiny will engage with the organisation (councillors and officers) and partners in determining items for inclusion on the work programme
- Scrutiny will engage with appropriate officers and portfolio holders in the development of the methodology and scopes adopted for the consideration of specific projects and will have a mind to the impact that these investigations will have upon the resource commitments of the specific services
- Scrutiny investigations will be proportionate to the issue under consideration and will be closely project managed to ensure that the agreed scope is safeguarded
- Scrutiny investigations will provide a professional and well-informed challenge to service provision
- Scrutiny will ensure that at all times councillors and senior officers are kept informed of its deliberations in order to ensure that there are 'no surprises' as the result of investigations
- Scrutiny will endeavour to ensure that the recommendations it makes following investigation are SMART (Strategic, Measurable, Achievable, Realistic and Timed). These recommendations will at all times be discussed with appropriate officers and portfolio holders prior to the preparation of a final report
- Scrutiny will endeavour to provide an effective means of championing the interests of the council and residents through partnership scrutiny

What Scrutiny Can Expect From The Organisation

Whilst scrutiny councillors undertake to operate in accordance with the principles and protocols outlined above to deliver effective outcomes for local people, it will only be able to do this if the executive and senior management of the organisation makes a similar commitment to work with and respond to scrutiny in an equally constructive manner. The following are proposed as the protocols, roles and responsibilities that will govern the council's (executive's and senior management's) relationship with scrutiny:

- The executive and senior management of the council will at all times respect the independence of scrutiny
- The executive and senior management recognise the value that scrutiny can add to service improvement and will ensure that appropriate referrals are made to scrutiny for specific investigations
- The executive will engage non-politically with scrutiny

- The executive and senior management will co-operate positively with scrutiny in developing and undertaking its work programme and in particular relevant portfolio holders will actively participate in the evidence gathering process, the consideration of emerging findings and the deliberation on recommendations and will attend meeting when requested by the scrutiny committees to share information and thus support scrutiny in delivering improvements in services
- The executive will give serious and challenging consideration to scrutiny recommendations
- The executive will inform scrutiny publicly of its view of the recommendations that are made and will advise scrutiny councillors of the reasons for any recommendations being rejected or accepted when recommendation are presented at cabinet
- The executive and senior management will participate in the monitoring of the implementation of recommendations made by scrutiny reviews that are agreed

SUPPORTING ACTIVITY

In order to support the consolidation of this protocol and improve the integration of scrutiny, the following will be put in place

- Mandatory facilitated awareness raising session for all councillors – inclusive of the executive
- Specific training for scrutiny councillors to include for example methodologies and prioritisation
- Quarterly meetings between Scrutiny Chairman, Vice Chairman, Leader, Deputy Leader and Chief Executive to:
    - discuss development of the work programme
    - update on ongoing projects
    - discuss in-year referrals
    - identify problem areas
- Leader, Deputy Leader and Chief Executive to contribute to the review of the implementation of the reconfiguration in 6 and 12 months from the date of implementation