NOTICE OF MEETING

NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Contact: Robert Mack

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Friday 19 November 2010 10:00 a.m.
The Conference Room, Enfield Civic Centre, Silver Street, Enfield, Middlesex, EN1 3XA

Councillors: Maureen Braun and Alison Cornelius (L.B.Barnet), Peter Brayshaw and John Bryant (L.B.Camden), Christine Hamilton and Mike Rye (L.B.Enfield), Gideon Bull and Dave Winskill (L.B.Haringey), Kate Groucutt and Martin Klute (L.B.Islington),

Support Officers: Sue Cripps, Katie McDonald, Robert Mack, Pete Moore and Jeremy Williams

AGENDA

1. WELCOME AND APOLOGIES FOR ABSENCE

2. APPOINTMENT OF CHAIR AND VICE CHAIR

3. URGENT BUSINESS

4. DECLARATIONS OF INTEREST (PAGES 1 - 2)

Members of the Committee are invited to identify any personal or prejudicial interests relevant to items on the agenda. A definition of personal and prejudicial interests is attached.

5. TERMS OF REFERENCE AND PROCEDURAL ARRANGEMENTS (PAGES 3 - 6)

Members are asked to note the Terms of Reference of the Joint Scrutiny Committee and agree the procedural arrangements, as set out in the attached report, including quorum, voting rights and administrative arrangements.

6. NHS NORTH CENTRAL FUTURE PLANNING 2011/12 (PAGES 7 - 20)

To consider current and future planning arrangements for the NHS in North Central London and, in particular, mental health.

7. NHS NORTH CENTRAL COMMISSIONING STRATEGY PLAN 2011/12 - 2014/15

To receive a presentation on the NHS North Central London Commissioning Strategy Plan for 2011/12 – 2014/15.

8. TRANSITION TO GP COMMISSIONING (PAGES 21 - 24)

To consider sector wide transitional arrangements for the switch to GP commissioning and the interim management structure for the NHS across the sector.

9. BEH CLINICAL STRATEGY (PAGES 25 - 38)

To receive an update on the review of the BEH Clinical Strategy.

10. NOTES OF LAST MEETING (PAGES 39 - 44)

To note the notes of the informal meeting of 2 August 2010.

11. NEW ITEMS OF URGENT BUSINESS

11 November 2010

Agenda Item 4

DECLARING INTERESTS FLOWCHART - QUESTIONS TO ASK YOURSELF

What matters are being discussed at the meeting?

Do any relate to my interests whether already registered or not?

NO → You can participate in the meeting and vote

YES

Personal interest

Is a particular matter close to me?

Does it affect:

- me or my partner;
- my relatives or their partners;
- my friends or close associates;
- either me, my family or close associates:
  - job and business;
  - employers, firms you or they are a partner of and companies you or they are a Director of
  - or them to any position;
  - corporate bodies in which you or they have a shareholding of more than £25,000 (nominal value);
- my entries in the register of interests

more than it would affect the majority of people in the ward affected by the decision, or in the authority's area or constituency?

NO

NO

YES

You may have a **personal interest**

Declare your personal interest in the matter. You can remain in meeting, speak and vote unless the interest is also prejudicial; or
If your interest arises solely from your membership of, or position of control or management on any other public body or body to which you were nominated by the authority e.g. Governing Body, ALMO, you only need declare your personal interest if and when you speak on the matter, again providing it is not prejudicial.

Prejudicial interest

Does the matter affect your financial interests or relate to a licensing, planning or other regulatory matter; and
Would a member of the public (knowing the relevant facts) reasonably think that your personal interest was so significant that it would prejudice your judgement of public interest?

YES

You may have a **prejudicial interest**

YES

Do the public have speaking rights at the meeting?

YES

You should declare the interest but can remain in the meeting to speak. Once you have finished speaking (or the meeting decides you have finished - if earlier) you must withdraw from the meeting by leaving the room.

NO

You should declare the interest and withdraw from the meeting by leaving the room. You cannot speak or vote on the matter and must not seek to improperly influence the decision.

Note: If in any doubt about a potential interest, members are asked to seek advice from Democratic Services in advance of the meeting.

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Joint Health Overview and Scrutiny Committee (JHOSC) for North Central London Sector

19 November 2010

Terms of Reference and Procedural Arrangements

1. Introduction

1.1 In January 2010, Chairs of health scrutiny committees across the five boroughs agreed to set up a JHOSC to engage with the NHS on a sector wide basis regarding the North Central London Service and Organisation Review. This review was set up by the NHS to consider options for reconfiguring acute (hospital) care across the north central London sector. The proposals arising from this were likely to have wide ranging implications for health services across the sector and would have undoubtedly constituted a "substantial variation", thus requiring formal consultation and the establishment of a JHOSC.

1.2 The principle of the establishment of the JHOSC as well as terms of reference for it were agreed by each Council prior to the 2010 local government elections. Following the local government elections, appointments to the JHOSC were made by each of the constituent Councils. The number of representatives per borough (two) was also agreed prior to the local government elections

1.3 However, following the general election the review process was suspended in the light of a change of policy by the incoming coalition government. In the meantime, NHS North Central London was established formally and took on a more significant role than was envisaged when it was originally set up as a sector wide commissioning agency.

1.4 A significant number of key strategic commissioning decisions are now being taken at sector level rather then by individual PCTs. In addition, NHS North Central London will be the transitionary body for the switch to GP led commissioning, as proposed in the government's recent health white paper "Equity and Excellence".

1.5 The JHOSC met informally on 2 August and considered how to respond to the changing circumstances. It agreed to broaden the scope of the JHOSC so that it has a standing role (on an "as and when" basis) in considering any sector wide proposals that involve significant changes to services that affect patients and the public across the sector. This will remove the need to set up a fresh JHOSC on every occasion and therefore reduce the administrative burden. The JHOSC can also have a role, where appropriate, in responding to any sector wide proposals for change to specialised services where there are comparatively small numbers of patients in each borough and commissioning undertaken on a cross borough basis. In addition, it was also

agreed that the JHOSC would take on a strategic role in scrutinising sector wide issues through regular engagement with NHS North Central London.

2. Terms of Reference

2.1 These proposed changes to the role of the JHOSC require an amendment to its terms of reference. The following wording has been proposed to each Council for approval:

"1. To engage with NHS North Central London on strategic sector wide issues in respect of the commissioning of health services across the area of Barnet, Camden, Enfield, Haringey and Islington; and

2. To scrutinise and respond to stakeholder engagement, the consultation process and final decision in respect of any sector wide proposals for reconfiguration of specific services in the light of what is in the best interests of the delivery of a spectrum of health services across the area of, taking account of:

- The adequacy of the consultation being carried out by the health bodies including the extent to which patients and the public have been consulted and their views have been taken into account
- The impact on the residents of those areas of the reconfiguration proposals, as set out in the consultation document
- To assess whether the proposals will deliver sustainable service improvement
- To assess whether the proposed changes address existing health care inequalities and not lead to other inequalities
- The impact on patients and carers of the different options, and if appropriate, which option should be taken forward
- How the patient and carer experience and outcomes and their health and well-being can be maximised whichever option is selected
- Whether to use the joint powers of the local authorities to refer either the consultation or final decision in respect of the North Central London Service and Organisation Review to the Secretary of State for Health.

3. The joint committee will work independently of both the Executive and health scrutiny committees of its parent authorities, although evidence collected by individual health scrutiny committees may be submitted as evidence to the joint committee and considered at its discretion.

4. To maintain impartiality, during the period of its operation Members of the Joint Committee will refrain from association with any campaigns either in favour or against any of the reconfiguration proposals. This will not preclude

the Executives or other individual members of each authority from participating in such activities.

5. The joint committee will aim work together in a spirit of co-operation, striving to work to a consensual view to the benefit of local people"

2.2 The amended terms of reference are not intended to reduce the power of individual health scrutiny committees to engage with their PCT on local issues. NHS North Central London have indicated that they will work with individual PCTs to support them in engaging with local health scrutiny committees.

3. Procedural Arrangements

3.1 In terms of the procedural arrangements, the following is proposed:

Quorum

- It is suggested that the quorum be one Member from each of the participating authorities. In the event of a meeting being inquorate, it could still proceed on an informal basis if the purpose of the meeting was merely to gather evidence. However, any decision making would be precluded.

Voting Rights

- Due to the need for recommendations and reports to reflect the views of *all* authorities involved in the process, one vote per authority would appear to be more appropriate then individual Members each being given a vote. It is nevertheless to be emphasised that decisions by the joint committee should be reached by consensus rather than a vote. Every effort should therefore have been made to reach agreement before a vote is taken.

Dissent and Minority Reporting

- It needs to be recognised that the issues that emerge during the work of the JHOSC may be contentious and there therefore might be instances where there are differences of opinion between participating boroughs. The influence of the JHOSC will nevertheless be dependent on it being able to find a consensus. Some joint committees have had provision for minority reports but these powers can, if used, severely undermine the committee's influence. Whilst such provision can be made for the JHOSC, it is recommended that use of it is only made as a last resort and following efforts to find a compromise.

Writing Reports and Recommendations

- The responsibility for drafting recommendations and reports for the JHOSC will be shared amongst participating authorities. It is recognised that this may be challenging due to the possibility of there being conflicting interests amongst participating authorities but in the current financial climate it is

unlikely that it will be possible to fund any external assistance except in exceptional circumstances.

Policy and Research Support and Legal Advice to the Joint Committee

- It is proposed that this will be jointly provided by all of the participating authorities. Each authority will support its own representatives whilst advice and guidance to the JHOSC will be provided, as required, through liaison between relevant authorities. Consideration could be given by the JHOSC, in due course, to the provision of external independent advice and guidance, should it be felt necessary. This could be of benefit if it enables the joint committee to more effectively challenge the NHS and may be of particular assistance in addressing issues of a more technical nature, where lack if specific knowledge could put the joint committee at a disadvantage.

Administration

- It is proposed that the authorities share clerking responsibilities between them, with the Borough hosting a particular meeting also providing the clerk.

Frequency and location of meetings

- It is proposed that the meetings rotate between the participating authorities for reasons of equity and access.

Servicing costs

- In the current financial climate, it is unlikely that it will be possible to meet any costs arising from the work of the JHOSC except on an exceptional basis. Any such financial commitments will need to be agreed beforehand and the cost split between the participating authorities.

North Central London NHS
Barnet - Camden - Enfield
Haringey - Islington

THE NHS IN NORTH CENTRAL LONDON	**BOROUGHS:** BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL

REPORT TITLE:
NHS North Central Future Planning 2011/12 – 2014/15

REPORT OF:
Caroline Clarke
Director of Strategy
NHS North Central London

FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE: 19 November 2010**

SUMMARY OF REPORT:

This report summarises the Case for Change across health services in North Central London. It brings together the challenges faced by the health system, both now and into the future, and describes the evidence under-pinning why we must change in order to improve clinical quality, productivity and services for patients.
At the JOSC, we will also describe to the committee current thinking on our approach to how best to meet these challenges going forward, and how best to engage with members and the public.
CONTACT OFFICER:
Caroline Clarke
Director of Strategy
NHS North Central London

RECOMMENDATIONS: The Committee is asked to comment on the case for change, and to discuss how best to engage across North Central to ensure that the challenges described are effectively met.

Attached is the summary Case for Change

SIGNED: 

Caroline Clarke
Director of Strategy
NHS NCL

DATE: Nov 10th 2010

North Central London NHS
Barnet - Camden - Enfield
Haringey - Islington

Health and Health Services in North Central London

Now and into the future – 2011/12 to 2014/15

Leading clinicians from across the North Central London met over a number of months in 2009 to consider the state of health and health services in the five boroughs of Barnet, Camden, Enfield, Haringey and Islington.

They looked at evidence that described the current position as well as looking to the future in terms of clinical and service quality. In reviewing this work, we are clear that GP Commissioners will be taking over the leadership for commissioning services and that the evidence in this document will be used as the basis for agreeing future commissioning priorities.

The Challenges

Health services in North Central London face significant challenges over the next four years, the most significant of which are:

- wide health inequalities with huge variations in life expectancy and wellbeing between communities within the five boroughs;
- big differences in the quality of service being delivered by the NHS;
- risks to the potential long-term sustainability of our healthcare providers.
- the cost of healthcare is rising more quickly than the amount of money available for our residents;
- the workforce responsible for delivering services constantly needs to change.

We also know that primary care services are underdeveloped in NCL compared to the rest of the UK, whereas we have a large number of hospitals, some with spare capacity.

This paper describes these and other challenges*. We ask all readers to consider how best these challenges might be addressed. NHS North Central London is seeking the views of everyone who has an interest in health services; clinical and non-clinical staff, local authorities, providers of health services and all our residents. To let us know what you think please contact ncl.queries@islingtonpct.nhs.uk

Our Population's Health Needs

The population of the five boroughs in North Central London is around 1.27 million and this is expected to grow to about 1.31 million by 2014, an increase of about 2.8 per cent. There is significant variation in healthcare needs across this population, and age, gender, ethnicity and levels of deprivation all impact on these health needs. In North Central London, there is a mix of areas of great wealth and high deprivation often very close together. The diversity of cultures across North Central London means a huge variety of health needs exist, and the services provided must match the needs of the local population.

GPs and other leading clinical staff have identified seven clinical areas that they believe need to be focussed on:

- Long Term Conditions, such as diabetes and breathing diseases
- Maternity
- Paediatrics
- Cancer
- Cardiovascular disease
- Unscheduled Care
- Mental Health

These seven have the biggest expenditure, the largest patient groups with growing demand, and those services where quality of delivery is most varied. Over the next four years the strategy for the NHS in North Central London is to focus on efficiency, quality, performance, access and workforce issues in these clinical areas.

* A more detailed evidence pack that underpins this paper is available at www.ncl.nhs.uk

We need to look at these clinical areas in all their care settings, including hospitals, primary care and at home. There are eleven NHS providers delivering healthcare in these areas. As we seek your views, these eleven NHS providers are looking at how they can ensure that they are ready for the future. Those NHS providers who do not yet have Foundation Trust status are preparing now to make an application.

Priority Clinical Areas

Long Term Conditions (LTC)

There is an increasing number of people with LTCs such as Heart Failure, Asthma, Diabetes and Coronary Obstructive Pulmonary Disease (COPD) and they rely on the NHS perhaps more than any other group of patients.

Most care can take place in the community; however, the majority of LTC care currently takes place in hospital settings which are expensive. More importantly patients and clinical staff also tell us that LTC care delivered in a hospital is often inconvenient and inappropriate.

There is still insufficient focus on finding ways to prevent unnecessary hospital admissions, or on care management plans to avoid readmission to hospital.

The infrastructure (buildings etc) supporting primary care provision is, in places, unfit for the future and has a significant impact on both quality of, and access to vital services.

Maternity

The NHS in North Central London is not yet meeting all women's expectations and needs in terms of offering choice of care provider, antenatal care setting and birth options.

Provision of safe and sustainable services in the future depends on how effectively we can resolve medical and midwifery workforce issues. The most significant relate to the recruitment, retention and age of our midwives, the ability to provide the required level of consultant presence on labour wards and ensuring adequate junior staff cover without over-reliance on locum staff.

Approximately 30 per cent of women in North Central London are still not assessed by a midwife before their 12th week of pregnancy, which can restrict their screening options and can compromise their antenatal care leading to a poorer outcome for them and their baby.

Birth rate predictions vary making it more difficult to plan for future capacity. The rise in women exercising their right to choose their care provider complicates capacity planning further, because women who are not resident in North Central London are choosing to give birth at an NCL hospital.

There is currently no area-wide agreed definition of low and high risk in pregnancy. We need this clarity to ensure that potential risks and complications are recognised and planned for. Women need to be encouraged to see pregnancy and birth as natural events with minimal medical intervention. The system needs to reflect their needs, avoid unnecessary appointments and offer more choice of care setting.

Paediatrics

When children are ill, their parents and carers want fast access to the best possible care for them. High volumes of children and young people attend Accident & Emergency (A&E) with a range of emergency and non-emergency conditions. Most families would prefer to go somewhere other than Accident & Emergency if such services were open and close to home. This would be more convenient for them and less costly to the local health economy, allowing emergency services to focus on those patients who need their expertise most.

Children attending Accident & Emergency departments in North Central London are often assessed by junior medical staff who are not paediatric specialists. This results in higher levels of admissions, which should be avoided.

Some healthcare providers in North Central London only undertake very small numbers of inpatient paediatric surgery and are therefore not meeting the standards expected by the Royal Colleges, or by recognised best practice.

Cancer

The number of people diagnosed with cancer across London and the rest of the country is growing dramatically. In North Central London we are seeing a real increase of an additional 275 diagnosed patients each year. Incidence of cancer is affected by a range of factors; age, obesity, smoking and low levels of physical activity for example. This suggests that the NHS should focus place greater emphasis on prevention measures.

There are inequalities in cancer care, both in terms of prevention measures and access to treatment. Inequalities relate to socio-economic deprivation particularly with regard to risk factors for cancer, especially smoking, but also in terms of gender, ethnicity, religion, disability and age where inequalities also exist.

North Central London has achieved a consistently lower uptake and coverage of screening for breast, lung and colorectal cancer. There are wide variations between Primary Care Trusts and services in terms of uptake. The delivery of screening services is complex with issues around primary care engagement, commissioning and ensuring the quality of services, all of which contributes to a mixed picture across North Central London.

North Central London has a higher level of cancer being diagnosed at a later stage when compared to London as a whole. This has a significant impact upon survival and treatment options. We need to improve cancer awareness in the general population, as well as to those at highest risk and with primary care clinicians. Addressing system delays and improving system efficiency and configuration will also enable cancer to be diagnosed at an earlier stage.

Better data collection, a focus on pathways and compliance with best practice standards would all have a positive impact on the quality and experience of care.

We have some of the best cancer services in the world within North Central London; however, we want to drive up the quality and reduce variability of the patient experience and health outcomes.

Cardiovascular Disease

We believe the early adoption of innovative, new techniques, together with a better planned approach to implementation, would improve patient outcomes, patient experience and reduce the length of stay for certain procedures.

Health outcomes for people undergoing certain complex hospital procedures could be improved if they are performed in hospitals that undertake sufficient numbers of these specialist procedures and by consultants with the greatest specialist skill. This is not always the case. Also, waits for transfers between hospitals are too long for unplanned cardiac surgery patients.

Not all patients that experience severe, sudden chest pain currently get early access to angiography (diagnostic test) and angioplasty (a widening of the blood vessels in the heart), although evidence suggests many patients would benefit from this.

The impact of the European Working Time Directive has reduced the availability of junior medical staff and new non-medical staff roles are needed to provide sufficient numbers of appropriately qualified staff.

Unscheduled Care

People place great value on rapid access to services in an emergency (including the ambulance service, A&E and other out of hour's services) and the security of knowing that these services are available whenever needed. North Central London patients use A&E over other services when they urgently need care or advice. This leads to a strain on resources, as highly trained staffs are diverted from treating emergencies to treating urgent, but not life-threatening cases. This results in patients waiting to be seen in A&E for longer than necessary and an overspend for the NHS on A&E services.

Currently there is often limited access to diagnostics and availability of staff to make clinical decisions at the point of need. This slows the process of diagnosis and treatment for patients, which in turn can lead to poorer health outcomes and emergency patients needing to stay in hospital longer than required.

Discharge from hospital is often delayed because of poor discharge planning, lack of community or home support and delays in clinical decision making.

Mental Health

Across North Central London fewer people have access to specialised mental health care than elsewhere in London. There appears to be obstacles to accessing these services when needed and equally, difficulty in discharging back into the patient's community as quickly as should happen.

There is a particularly high number of people in the south, in Camden, Islington and parts of Haringey, with mental health needs. There is clinical consensus that the move towards treating in the commuity whenever possible should continue with hospitals, and residential treatment is focused on those who benefit most from this approach.

As well as improving the quality and accessibility of mental health services, there needs to be a focus on improving the mental wellbeing of the population as a whole.

The areas recognised by clinicians and others in greatest need of attention are; alcohol dependency, dementia and meeting the specific needs of people from Black & Minority Ethnic (BME) communities.

Future commissioning approaches should also ensure that services offer treatment-focused interventions which comply with best practice guidance from the National Institute of Health and Clinical Evidence. Funding for mental health services is complex and is dependent upon local authority resources as much as those from the NHS.

Strengthening Our Healthcare Providers

To address the health challenges outlined above it is widely accepted that there needs to be improvements to the health services provided.

In primary care provision there is:

- a variation in access driving low levels in patient satisfaction;
- a variation in quality and performance of GP practices;
- an historical allocation of funding rather than current patient need;
- an high proportion of small GP practices, often operating poor quality buildings in some parts which are not fit for purpose into the future;
- a duplication of services across primary and community services; and
- a lack of integration along many care pathways.

The table below describes the current position of our major hospital and specialist service providers.

Table 1 - Provider Trusts and Foundation Trust Status

Trust	Type	Foundation Status Achieved	Looking to Foundation Status
Barnet & Chase Farm Hospitals	Acute		✓
Barnet Enfield & Haringey	Mental Health		✓
Camden & Islington FT	Mental Health	✓	
Great Ormond St Hospital	Specialist		✓
Moorfields Eye Hospital	Specialist	✓	
National Orthopaedic Hospital	Specialist		✓
North Middlesex Hospitals	Acute		✓
Royal Free Hospital	Acute		✓

Tavistock & Portman FT	Mental Health	✓	
University College Hospitals	Acute	✓	
The Whittington Hospital	Acute		✓

Specifically, Barnet and Chase Farm, and the North Middlesex Hospital are awaiting the outcome of the review of the Barnet, Enfield and Haringey Clinical Strategy before submitting their plans for the future. The Royal Free and the Whittington are working to produce plans under a number of options: 1) as stand-alone organisations; 2) as merged entities either with each other or with University College Hospitals, or 3) as either a bi-partite or tri-partite organisation.

Developing a Financially Sustainable System

Over the past decade, there have been unprecedented levels of investment in the NHS. Funding available to commissioners has increased in real terms and healthcare providers have achieved increased activity and a reduced waiting times.

North Central London currently spends approximately £2.5 billion per annum, as broken down in the following table

Table 2 Breakdown of NCL Commissioning Spend

	£'million
NHS Acute and Foundation Trusts	1,151
Mental Health	369
Primary Care	300
Specialised Commissioning	143
Community Services	187
Primary Care Prescribing	174
Other	208
Total	2,532

Now, as a result of the global recession and the level of public sector debt, NHS funding will increase by 1% per annum against an expected 4% increase in demand owing to population growth and developing new procedures.

In North Central London, this is likely to translate into a cumulative commissioning deficit of over £600m by 2014/15. This is not sustainable.

A Skilled and Sustainable Workforce

There are around 30,000 people working within the NHS in North Central London and as services change, the skills they have, the locations they work in and the things that they are required to do are also changing. This is true for clinical and non-clinical staff and we need to make sure these individuals are best positioned for the changes that lie ahead.
Some of the external factors that will bring change for the workforce in North Central London are the same as those facing the nation as a whole, for example, moving to Foundation Status, and transferring the commissioning function to GP-led consortia. Others are specific to our area, for example, the changes in community service provision.

Table 3 NCL Workforce Breakdown

Organisation Type	WTE June 2010	Percentage (%)
Acute Trust	24,260	
Specialist	4,253	18%
Foundation Trust	6,353	26%
District General Hospitals	13654	56%
Mental Health Total	4,352	
Foundation Trusts	2,278	52%
Mental Health Trust	2074	48%
Primary Care Trusts Total	4,734	
Community Services	3,503	74%
Commissioning and Contracting	1,231	26%

Within the five boroughs there are also 887 GPs working from 269 practices with 78 of these being single-handed.

There are many significant issues facing this workforce as we move into the future. Among these are shortages in some staff groups and specialties, a difficulty in recruiting to some specialties (e.g. paediatrics) and some specialists experiencing relatively low volumes of work when compared with national guidelines (e.g. vascular surgery). There are also issues around age of the local workforce (e.g. maternity) and impact of the European Working Time Directive.

Preparing for the future

It is widely accepted that the current challenges to our population's health, and the health services being provided for them, need to be addressed. Over the course of the next two months, NHS North Central London is looking to share this document, and the evidence that supports it, as widely as possible. We want to hear from you:

- If you think that there are issues we have not addressed or if you think we are focusing on the wrong things.
- If there is other evidence we should be considering.
- If you have any proposals or suggestions for tackling the challenges we face.
- If you would like us to meet with you or your organisation to discuss these issues in greater detail. This may be one particular priority area or it may be you are interested in everything.

Let us know by:

- contacting us at ncl.queries@islingtonpct.nhs.uk or
- calling Anna Bokobza on 0207 685 6242

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North Central London
NHS
Barnet - Camden - Enfield
Haringey - Islington

THE NHS IN NORTH CENTRAL LONDON	**BOROUGHS:** BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL

REPORT TITLE: **AN UPDATE ON THE MENTAL HEALTH WORK PROGRAMME**

REPORT OF:
Caroline Clarke,
Director of Strategy & Transformation,
NHS North Central London.

FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE: 19 November 2010**

SUMMARY OF REPORT:

This report provides a general update of the work taking place in the mental health work programme. In addition to the work that is taking place at a sector level, a separate Barnet Enfield and Haringey Mental Health Transformation Programme has been established, which is a joint arrangement between Barnet, Enfield and Haringey Mental Health Trust and the three local commissioners (NHS Barnet, NHS Enfield and NHS Haringey). This has a shorter timescale and sets out to facilitate whole system change to improve local services, whilst also establishing cost efficiencies. An update on this work will be provided at the next meeting.

Camden & Islington NHS Foundation Trust are undertaking a savings programme in conjunction with their commissioners NHS Camden and NHS Islington. They are shortly to undertake a formal consultation under s.244 of the NHS Act 2006 into a proposal to both close inpatient beds and reduce the number of inpatient sites. An update on this work is attached as appendix one.

CONTACT OFFICER:
Kate O'Regan
Programme Manager (mental health)
NHS North Central London
Kate.ORegan@islingtonpct.nhs.uk
Tel: 020 7685 6236

RECOMMENDATIONS: The Committee is asked to note the content of this report and to raise any concerns or queries and to give their views on the work that has been taking place to improve local mental health services. .

Attached is Appendix one, An update on the proposed statutory consultation in Camden and Islington.

SIGNED: 

Caroline Clarke
Director of Strategy & Transformation
NHS North Central London

DATE: 10 November 2010

AN UPDATE ON THE MENTAL HEALTH WORK PROGRAMME

What is the mental health work programme about?

The Mental Health Programme Board started in July 2009 and was in existence for a year. The group consisted of provider trust Chief Executives and Medical Directors as well as lead commissioners from the primary care trusts. A work programme was established and the key achievements include:

- The development of clinical model which was approved by the Clinical Advisory Group (CAG) in May 2010;
- The completion of a mental health section in the overarching case for change document. This was refreshed and submitted to NHS London in September 2010;
- The establishment of a number of subgroups (December 2009) which have focused on the development of sector-wide care pathways;
- The completion of a mental health communications and engagement strategy (July 2010);
- A specification for the completion of a bed modelling exercise to establish the demand and capacity requirements for inpatient beds required for the sector (work in progress);
- Some initial estates scoping work (May 2010) to explore opportunities for site rationalisation i.e. providing inpatient services from fewer sites.

In August 2010 a decision was made to stand down the NCL Service and Organisational review, including the mental health Programme Board. This has been replaced by work in Barnet, Enfield and Haringey and in Camden and Islington recognising specific local issues. Also each provider trust has a different set of organisational priorities. Barnet, Enfield and Haringey Mental Health NHS Trust is currently in the process of completing an Integrated Business Plan as part of its application to become a foundation trust. There will shortly be clarity about whether the trust will be able to proceed with their application.

The change in government has led to a number of policy changes as set out in the NHS White Paper. More specifically there is the need to undertake further engagement activities and to test the review work done to date in mental health against the four criteria identified by the Secretary of State. These are:

1. Clarity about the clinical evidence base underpinning the proposals.
2. Support of the GP commissioners involved.
3. Genuine promotion of choice for their patients.
4. Genuine engagement of the public, patients and local authorities

The mental health communications and engagement strategy has been re-drafted to take account of these changes. The different engagement and communications activities are outlined further below.

Why do we need change?

We need to re-design the sector's mental health services as there is a need to both improve quality and safety, and also to deliver services in the future within a projected funding shortfall. More specifically inpatient services have been identified as a particular area where improvements need to be made.

As well as improving the quality and accessibility of mental health services, there will be a shift in focus around improving the well-being of local populations in line with recent policy guidance. A national mental health policy is currently being consulted on and it is clear that the main policy drivers match those in the 'New Horizons' guidance issued by the previous government. Improving quality will include the implementation of the personalisation agenda, which supports further individualisation in the delivery of care.

What will happen to the patients currently receiving the affected services?

There will be a number of important changes in the way that care will be provided in the future. This includes the identification of new care settings which support the move of care out of hospital settings, which will mean that service users receive care nearer to home. This is in line with a national trend to reduce inpatient provision and both the main provider trusts in NCL have plans to make further reductions and develop community services.

At a sector level work is underway to further develop new care pathways. These will be designed to deliver integrated care packages to meet both mental and physical health needs and improve outcomes. There will be a clearer focus on the treatment that service users can expect and a single point of access to all services. All provider mental health trusts are re-organising their services along 'service lines' in preparation for a new payment system. This is called 'Payment by Results' and follows a system used in other parts of the NHS where provider organisations are paid for by their activity i.e. the actual work that they do rather than via a block contract. A draft tariff (for payment) will be developed over 2011/12 and local prices need to be in place by 2013.

Two priority areas have been identified for further care pathway development work which will include working across other areas including general hospitals and primary care settings. These are:

- Alcohol
- Dementia
- Meeting the needs of people from Black and minority ethnic (BME) groups

Who will benefit from our proposal?
All current service users will benefit from the proposed service improvements. Access to specialist mental health services will also increase as community services will be re-designed to offer an enhanced assessment service. This will mean that more people will be seen by specialist mental health services.

Will this save money?
Yes. Moving care out of high cost hospital settings will save a significant amount of money. This will enable some reinvestment to take place in community services.

Are the other services as safe and high quality?
National concerns exist about the safety of mental health inpatient services. Service users also prefer to be treated in community settings. People who require care in hospitals will always be able to access this.

Public Consultation and Engagement
A range of communications and engagement activities have taken place about mental health services in NCL. These include:

1. The completion of a mental health communications and engagement strategy for NCL and ongoing working group;
2. A service event attended by 30 service users from across the sector on the 20th July 2010 with a subsequent event planned for early 2011;
3. An ongoing series of meeting with the NCL service user network (at which all borough user groups are represented) and publication of a regular newsletter for service users (to be completed);
4. The start of a dialogue with local GPs about mental health including discussion at a GP event on the 7th October 2010. Mental health has been identified as their third highest priority after unscheduled care & long term conditions;
5. A workshop was held for local commissioners on the 29th September 2010 and a follow up meeting was held on the 21st October 2010. A series of further meetings has been arranged;

6. A meeting was held with the designated lead Director of Adult Social Services (for mental health) Mun Thong Phung, Director of Adult, Culture and Community Services from Haringey Council. An outcome of this meeting was that a local authority commissioning representative has been co-opted to join the NCL mental health commissioners' group.

Your views

We would like your views on the work that we have been doing to improve local mental health services.

If residents of your boroughs have any questions about the work or would like to receive further information or information in another format, please contact:

APPENDIX ONE

Changing hospital mental health services in Camden and Islington – update for NCL JHOSC

1. Consultation background

Following improvements in community services, C&I now provides over 97% of its services outside an inpatient setting. This is due to the development of a host of initiatives, including:

- Daytime intensive treatment
- Crisis beds and flats
- Intensive home treatments
- Extension of many of these services to older people

In addition, much work has been put into making assessments, referrals, access to treatment and discharge from hospital quicker and smoother.

It is in the position of having a large and growing number of bed vacancies, and is consulting over reducing the number of inpatient sites from four to two, in order to remove overhead costs and allow future focus on community services.

This consultation is being conducted jointly with NHS Islington and NHS Camden, the local commissioners.

2. Current consultation position

The current consultation is in its pre-consultation stage. Discussions are being held with stakeholders regarding readiness to proceed to formal consultation. The changes being proposed are deemed to be a substantial variation of the 'substantial variation' of the provision by the Trust of protected goods and services.

The Trust is consulting the Overview and Scrutiny Committees in both Camden and Islington as part of the pre-consultation process. The Committees will also consider the consultation paper during the formal consultation period.

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3. Next steps

Discussions are currently being held with NHS London on when the consultation will proceed to formal consultation stage.

C&I plans to keep the JHOSC updated on progress, but to formally work through the two local OSCs through the consultation process and to work up its final recommendations with the local OSCs.

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North Central London
NHS
Barnet - Camden - Enfield
Haringey - Islington

Transition to GP Commissioning

Stephen Conroy
NCL Director of Communications and Engagement

stephen.conroy@islingtonpct.nhs.uk

SUMMARY

This paper provides an update on the NCL transition programme up to 2013 when PCTs are abolished.

RECOMMENDATION

The JOSC is asked to **NOTE** the report.

Introduction

This paper outlines the NCL priorities and the proposal for a single transition organisation.

The White Paper, 'Liberating the NHS' 2010, sets out a agenda to shift commissioning responsibilities to GP consortia. It also proposes a national commissioning board, a national primary care function and transfer of health improvement functions (public health) to local authorities.

The NHS Operating Plan, that preceded the White Paper, required PCTs to reduce management costs by half and shift funding into front line services. The NHS London requirement is for the savings to be made by the end of this year as this allows non-recurrent investment in developing GP commissioning.

NCL Priorities

NCL has a number of agreed priorities that it must deliver in the transition period:

- Sustainable financial position
  - Getting a grip on the current financial position
  - Delivering savings on commissioning spend.
- Delivering management cost savings of 54%.
- Maintaining the quality and safety of local services.
- Strategy
  - BEH Clinical Strategy
  - Plans for 11/12 and beyond.
- Supporting GP Commissioning Consortia and new Local Authority roles.
- Supporting our people in planning their personal futures.

A single transition organisation for NCL

The PCTs recognise that they will be unable to function effectively while reducing management costs by half (principally staffing costs). Therefore, the five PCTs propose to establish a single transition team from April 2011 to lead the transition process and to enable the saving of over half of the current management costs and maintain existing services. To enable this, the proposal is to centralise functions wherever possible and to provide a local borough presence that will: deliver savings plans; support the development of GP consortia and the furhter integration of public health and joint commissioning.

PCT Boards will remain in place until abolished in 2013 supported by the local borough-based teams. However, PCT Boards will delegate further responsibilities to the NCL Board to enable the single transition organisation to work effectively.

The end state of the new local NHS is not known, and there is no clear view of what parts of the PCT will transfer to the national commissioning board, or the national primary care services, nor what the form of GP consortia will be and how quickly health improvement staff will transfer to local authorities. This means that the transition organisation must focus on the core business and be flexible to move when services are ready to transfer to their end states. For example, GP Consortia can apply for pathfinder status, approved by NHSL, which enables them to take on commissioning responsibilities from PCTs from April 2011.

At the end of 2013, or sooner if the end state is in place, the NCL transition organisation will cease to exist along with its constituent PCTs.

NCL recognises that there are different starting points for PCTs in terms of their level of integration with local authorities and the preparedness of local GPs to take on commissioning. The intention is that the borough based teams build on relationships with local authorities, GPs, LINks and other stakeholders to design the new local NHS over the coming months. It is possible that borough Health and Well Being groups could lead this work, but this would be for local discussion and decision.

Timetable

The transition organisation is currently being designed and owing to the likely number of staff that will be affected, it will require formal consultation with staff. PCT Boards will discuss the proposal on 18th and 19th November. Staff consultation will begin as soon as possible and implementation is planned to be completed by the end of March 2010.

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North Central London
NHS
Barnet - Camden - Enfield
Haringey - Islington

Barnet, Enfield and Haringey Clinical Strategy

Stephen Conroy
Sector Director of Communications and Engagement
stephen.conroy@islingtonpct.nhs.uk

SUMMARY
This paper provides an update on Barnet, Enfield and Haringey Clinical Strategy and its review against the four tests laid down by the Secretary of State for Health

RECOMMENDATION
The JOSC is asked to **NOTE** the report.

Barnet - Enfield - Haringey

Barnet, Enfield and Haringey Clinical Strategy
Review against the four tests laid down by the Secretary of State for Health

Since 2006, Barnet, Enfield and Haringey PCTs, together with the hospitals at Barnet, Chase Farm and North Middlesex, have been working together with local and acute clinicians to deliver safer healthcare services across Barnet, Enfield and Haringey.

The BEH Clinical Strategy was drawn together by local GPs and hospital consultants following extensive public engagement, culminating in a formal public consultation from July to October 2007, and was agreed by the three PCT Boards in their statutory role in December 2007

The consultation was supported by a case for change, pre-consultation business cases, an equality impact assessment and a travel analysis. Subsequently, following a referral from the local Joint Overview and Scrutiny Committee, a review by the Independent Reconfiguration Panel supported the proposals, subject to 13 recommendations, concluding that *"The Panel accepts that the health care services reviewed in Barnet, Enfield and Haringey need to change"*. A challenge for a Judicial Review by Enfield Council was also dismissed

The Barnet, Enfield and Haringey Clinical Strategy began implementation in July 2009 of its two phased-programme, separating out the business cases according to site and service. (Appendix B)

This implementation was halted by the Health Secretary, Andrew Lansley in May 2010, when he introduced a moratorium on all significant service changes pending the outcome of a review of the planned changes against four tests.

The *Revision to the Operating Framework for the NHS in England 2010-11* and the letter of 29 July from NHS Chief Executive David Nicholson on service reconfiguration provided guidance of how this would be approached. This paper reflects that guidance and details the approach for the BEH Clinical Strategy.

Review against four tests

Since then, the Barnet, Enfield and Haringey Clinical Strategy has been going through a process to review it against the four tests which state that NHS service changes must have:

- Support from GP commissioners
- Strengthened public and patient engagement
- Clarity on the clinical evidence base, and
- Consistency with current and prospective patient choice.

Following discussions and engagement with the local authorities, LINks, GPs, hospital clinicians and other stakeholders, a process was agreed by a Strategic Coordination Group, whose membership (Appendix A) includes representatives from local authorities and LINks in Barnet, Enfield, Haringey and Hertfordshire, as well as local GPs and acute trust clinicians, together with the PCTs, for the local NHS to take account of the four tests and take forward these challenges.

This process is progressing the review of the Clinical Strategy against these four tests in line with government policy, and is in four stages:

1. Review: Clinical Evidence Review and Economic Business Case Review (Published Oct)
2. Engagement: The evidence from the Reviews will be provided for GP Commissioner decision making and public and patient engagement (Oct-Nov)
3. Consolidation: The Strategic Review Groups of each of the PCTs will provide reports on:
    - GP responses
    - Public and patient engagement

It was agreed by the Strategic Coordination Group that an independent organisation, UCL Partners, be used to analyse these reports, including responses from GPs and the Public, then assess how the four tests have been met. This analysis will be provided to the Strategic Coordination Group for its meeting on 30 November 2010.

4. Recommendations:

The role of the BEH Strategic Coordination Group is:

- Oversight of the review of the BEH Clinical Strategy against the four criteria and consideration of any interdependencies
- Coordinate the process and review the returns to make sure that stakeholders have been involved.
- Summarise the review and any proposals for submission to the formal review process being established by the SHA.

The Group will receive the analysis from the independent organisation as to whether the four tests set by the Secretary of State have been met or not. The role of the Group is to draw conclusions and recommendations.

This will then be submitted to NHS London following the BEH Coordination Group meeting on 30 November 2010.

This process is being led locally by the Chief Executive of NHS Enfield, governed by the Strategic Coordination Group (Appendix A).

SHAs have been charged by the Secretary of State to revisit planned, ongoing and completed consultations, and respond to external requests for the same to ensure they are consistent with these tests for service change. This does not necessarily mean that formal consultation and implementation plans should be unpicked. (*Revision to the Operating Framework for the NHS in England, June 21, 2010*).

In line with this guidance, NHS London will review these outputs for its assurance that the four tests are met.

Process

There is an urgency to progress the local process due to the work already undertaken in implementing changes to Women's and Children's services as part of the Clinical Strategy. Prolonged uncertainly will be detrimental to staff and is likely to affect retention and recruitment, which, in turn, has the potential to impact on the delivery of highest quality patient services. On the other hand, it is important to ensure that there is sufficient

time to engage with the GPs as future commissioners and local stakeholders. The local process began in September and will be complete by November 2010. (Appendix C – Timeline)

The fundamental drivers for change that led to the development of the BEH Clinical Strategy remain and in 2010 are even more compelling. These are:

- **Reducing health inequalities** - life expectancy for Enfield men living in the least deprived areas of the borough is 8.8 years higher than for men living in the most deprived areas. The difference is nearly 10 years for women (Enfield JSNA 2010-12)
- **Improving the health of the population** - the rate of early deaths for men in Haringey from heart disease and stroke are both worse than the England average
- **Improving primary care to provide accessible, quality and affordable care** – there is a variable quality of primary care and the range and access to services locally in Barnet
- **Improving the quality and sustainability of local hospital care** - performance and quality needs to be improved in local health services to ensure they have a long term, robust future.

This review is an opportunity for the local NHS to facilitate a local resolution, and a number of principles have been identified that must underpin the process:

- ***The outcome is not predetermined*** - a variety of outcomes from the review are possible.

- ***Local ownership and transparency*** - the review must be locally owned by GP commissioners and the wider GP body, local authorities and LINks, and patients and the public have the opportunity to engage in the process, mindful of the fact that this is not a formal pre-consultation or consultation. Therefore, it is important that representatives participating in the review process have a clear mandate from those that they represent and that the process is transparent and inclusive.

- ***Independent challenge*** – strong local ownership must be balanced with a confidence that the process has sufficient external challenge and independence so as not to be perceived as biased or in any way predetermined. External independent organisations have been approached to facilitate local engagement and the Local Medical Committees are also taking an active role in engaging GPs.

- ***Locally appropriate*** - the process of engagement is being co-created with the input of local authorities, GPs and LINks. How the engagement runs may be specific to each area, and each will determine how best to use existing local arrangements and decide who is most appropriate to represent local views.

Local Engagement

The local process of the review has been running from August 2010 to November 2010, when the Strategic Coordination Group will send its conclusions to NHS London which has been asked by the Secretary of State for its assurance that the tests have been met.

PCTs in their boroughs have agreed their local processes, with their local authority and LINk representatives, to implement the review against the four tests. This also ensures wide engagement where local GPs can assess the clinical and economic evidence and make recommendations to their Strategic Review Group about the outcome of the assessment against the four tests.

To facilitate this, a Clinical Evidence Review Panel (Membership – Appendix A) was convened to review the clinical evidence for the service changes envisaged in the Clinical Strategy - assessing women's services, children's services, urgent care, planned care and primary care.

The Panel's findings were published in mid-October and was made available to all audiences and posted on the PCTs' websites. Londonwide LMC provided input and advice into the process and recommended that GPs support the review process in whatever way they can.

The review concluded that the evidence still supports the Clinical Strategy and in fact is more compelling than when the Strategy was first consulted upon.

The Panel identified five cross-cutting themes that would impact on the implementation of the Clinical Strategy:

- Importance of viewing the effects of change on the whole health economy
- Changing demographics of the local population
- Significant pressures on medical staff since the introduction of the European Working Time Directive
- Improved pre-hospital care for the critically-ill – the number of paramedics greatly increased since 2007
- Flat or no financial growth in the NHS.

It examined the evidence in four areas, paediatrics, maternity, urgent care and planned care and concluded overall that "*the clinical case for change has in fact increased over the past few years. The evidence still points in the direction of the BEH Clinical Strategy, and the publication of the NHS White Paper has strengthened the levers.*"

There is also a report from a review of the economic business case which is being reassessed in the current financial context. It acknowledged that the Clinical Strategy was not about addressing financial issues but about providing better clinical services for patients in the acute hospitals and in community settings, and concluded that implementing the BEH Clinical Strategy is a step in the right direction and will help both the acute trusts and the PCTs address their future challenges in both primary and secondary care for patients

Following the publication of the two reports, an extensive engagement programme has taken place in the four boroughs (see appendix A attached), with the PCTs in Barnet, Enfield, Haringey and Hertfordshire each undertaking their local engagement plans to seek comments from a range of stakeholders, including GPs, patients and the public.

The next steps

PCTs in their boroughs have agreed the local engagement process, with their local authority and LINk representatives, while local commissioners and GPs have also been asked to review the evidence. This is to ensure wide engagement where local GPs can consider the clinical and economic evidence and make recommendations to the Strategic Coordination Group on its assessment. It is important to stress that each local stakeholder engagement process is designed to suit the needs of the borough.

The Strategic Coordination Group is currently aiming to submit its report and supporting evidence to NHS London by 1 December 2010. NHS London will consider its assurance on the basis of this report and aims to conclude its findings in January 2011.

NHS London will continue its embedded assurance approach and anticipates considering a report and any other evidence as the basis of its final assurance in December, taking account of any further guidance from the Department.

Appendix A – Membersip

Clinical Review Panel

Dr John Riordan - (Panel Chairman) (External)	Former Acute Trust Medical Director
Ms Alison Arnfield	Director Level Nurse Representative (External)
Dr Peter Barnes	NHS Enfield Commissioning Lead. Retired GP
Dr Jean Beney	Barnet GP
Dr John Bentley	NHS Barnet Commissioning Lead
Dr Simon Caplan/Dr Julian Chadwick	Haringey GP
Dr Jatin Pandya	NHS Haringey Commissioning Lead
Prof Hilary Pickles	Freelance Director of Public Health (External)
Dr Pavan Sardana	Enfield GP
Dr Eleanor Scott	Londonwide LMCs representative
Dr Clare Stephens/Dr John Bentley	NHS Barnet Commissioning Lead

Support to the Panel:

Dr Helen Barratt	UCL Partners
Mr Michael Wilson	Commissioning Support for London

Observers:

Mr Ian Kaye	Barnet LINk
Mrs Shirley Legate	Hertfordshire LINk
Mr John Lynch	Enfield LINk

Strategic Coordination Group

Cabinet Leads from four Local Authorities:
Enfield – Cllr Don McGowan (delegated to Ray James)
Barnet – Cllr Helena Hart
Haringey – Cllr Dilek Dogus
Broxbourne – Cllr Jermey Pearce
Hertsmere – Cllr Pat Strack

Representative GPs from each of the four PCTs:
Enfield Dr Sanjay Patel, Peter Barnes
Barnet – Philippa Curran, Clare Stephens
Haringey –Mayur Gor, Dr Jatin Pandya
Herts – Andrew Parker (delegated to Jacqui Bunce)

Chairs & Chief Executives from each of four PCTs:
Enfield – Karen Trew & Nigel Beverley
Barnet – David Riddle, Cameron Ward & Alison Blair
Haringey – Richard Sumray & Tracey Baldwin
Herts – Delegated to Jacqui Bunce

Two Acute Trusts Medical Directors:
NMUH – Stanley Okolo
B&CF – Ian Mitchell

LINks representatives from each of the four areas:
Enfield – John Lynch
Barnet – Ian Kaye
Haringey – Helena Kania
Hertsmere & Broxbourne – Shirley Legate

Appendix B - Summary of the Hospital Changes

In July 2009, the decision was taken to implement the Programme in phases, separating out the business cases according to site and service. Women's and Children's services are being implemented first and will be complete by summer 2011, while work on urgent care, emergency inpatients and planned care developments, are already underway and will be completed by 2013.

These moves will allow the consolidation of emergency and consultant-led obstetric and neonatal specialist services on the Barnet and North Middlesex University Hospital sites and the development of Chase Farm Hospital as an elective and ambulatory care site with a day-time Urgent Care Centre, a 24-hour GP-led service and a Stand Alone Midwifery-led Unit (SAMLU).

Phase 1 - Women's and Children's Services

- Obstetric, neonatal, inpatient emergency paediatric, emergency gynaecology services are moving from Chase Farm Hospital to be provided at Barnet Hospital and North Middlesex Hospital
- A stand-alone Midwife-Led Unit and Paediatric Assessment Unit is going to be provided at Chase Farm Hospital.

Phase 2 - Urgent Care, emergency inpatients and planned care developments.

Urgent Care:

- Centralising A&E services and the associated emergency inpatient beds at Barnet and North Middlesex Hospitals
- Urgent Care Centres at the front end of A&E
- Chase Farm Hospital will have a day-time Urgent Care Centre (including paediatric and older people's assessment units).

Planned Care at Chase Farm Site:

- An elective inpatient centre will be provided on the Chase Farm site
- Outpatients, diagnostics, rehabilitation, intermediate care etc. will be maintained or developed.

To support these changes and to provide care closer to home, Barnet, Enfield and Haringey PCTs have developed strategies to transform primary and community care and are implementing new services in the community.

These strategies entered the implementation phase in June 2009 since when workstreams have been working to deliver the changes.

Appendix C – Timeline

BEH Clinical Strategy Review Against the 4 Tests Timetable
July – November 2010

Date	Timetable
May	SoS Andrew Lansley announces a moratorium on current reconfigurations
29 July	Guidance from Sir David Nicholson on how to apply of the 4 tests
July/Aug 20 August	Development of the GP Commissioner and Public Engagement Process Process agreed by BEH Strategic Coordination Group
August	Establishment of Clinical Review Panel and identification of evidence givers
13 Aug – 7 Sept	UCLPartners review of Clinical Evidence from 2007-2010 in preparation for Clinical Review Panel
13-17 September	Clinical Review Panel held
17 Sept – 13 Oct	Clinical Review Panel Report approval process
13 Oct	Clinical Review Panel Report Published
14 Oct-11 Nov	GP Engagement Undertaken
14 Oct-11 Nov	Public & Patient Engagement Undertaken
11 Nov – 22 Nov	Analysis of 4 tests undertaken by UCLP
30 Nov	BEH Coordination Group compiles final report for NHS London

APPENDIX D - REVIEW – BEHCS ENGAGEMENT DIARY

SEPTEMBER 2010

	w/c 30 August	w/c 6 Sept	w/c 13 Sept	w/c 20 Sept	27 Sept
Sometime in week					
Monday		6pm – Haringey Health Scrutiny Panel	BEH CS Clinical Review Panel sits	Herts - Teleconference with Charles Walker MP	10.30 NHS Enfield staff meeting Haringey OSC - Meeting with D Tyrrell/D Stroud with Haringey OSC representatives (Review of BEH) Informal meeting with Enfield Scrutiny Chair and officers
Tuesday			BEH CS Clinical Review Panel sits Barnet PEC meeting	Economic Business Case Review meeting	BEH Programme Board BEH Strategic Coordination Group
Wednesday	Economic Business Case Review meeting	Pan-BEH Communications meeting	BEH CS Clinical Review Panel sits Enfield CEO meeting local MP - M Offord 7pm: Barnet Health OSC meeting	Enfield GP-led event ref consortia 10.30 - NHS Enfield AGM 14.00 - NHS Enfield Public Board Pan-BEH Communications meeting Haringey LINK meeting	
Thursday	Enfield Locality Directors meeting – discuss BEH	7.30 - Enfield Health Scrutiny Panel – Special White Paper Meeting – Nigel Beverley	BEH CS Clinical Review Panel sits 7pm: Public meeting on review of NHS services called by Jeremy Corbyn MP	2-4 NHS Haringey Public Board meeting	2.30 – NHS Barnet Public Board meeting Enfield BEH Strategic Review Group
Friday		3 – White Paper presentation to Enfield Equality & Diversity Stakeholders meeting Enfield CEO meeting local MPs T Villiers, Mike Freer	BEH CS Clinical Review Panel sits		
Sat / Sun					

OCTOBER 2010

	w/c 4 October	w/c 11 October	w/c 18 October	w/c 25 October
Sometime in week			4-page wraparound for Times-Series in Barnet, Enfield, Haringey and Broxbourne – 255,000 readership + 5,000 run-ons	Poster advertising Enfield public meetings circulated to GP surgeries, dentists, opticians, pharmacists libraries, supermarkets
Monday	Economic Business Case Review meeting 6pm – Haringey Health Scrutiny Panel			9.30 NHS Enfield staff meeting Press release ref public meetings sent to Enfield press
Tuesday	Enfield LINk bimonthly meeting	12 - BEH Strategic Coordination Group Barnet – GP cluster North meeting	7pm – Enfield Health Scrutiny Panel – BEH CS Review update Barnet OSC Hertsmere PBC group	
Wednesday	NHS Barnet Staff Engagement /Management Meeting Pan-BEH Communications meeting	13 – Publication of Clinical Review and Economic Review reports – mass engagement Enfield Council Leader & Health Lead meeting Enfield Council HSP Chair meeting Barnet CEO attended Barnet Carers Centre meeting Barnet CEO met Irene Findlay & Cllr Helena Hart to discuss the process. Haringey – Clinical Exec Committee	6pm – Haringey Overview Scrutiny Panel (Special) Pan-BEH Communications meeting Haringey Association of Voluntary and Community Organisations Broxbourne Council Health Forum	
Thursday	NHS Barnet Trust Board Meeting – BEH Update NHS Enfield Trust Board Meeting – BEH Update Enfield LMC Meeting	Enfield BEH Strategic Review Group Barnet Older People's Assembly meeting Enfield PBC Meeting Haringey patient panels	Enfield GPs meeting ref Review of BEHCS Barnet GPs meeting ref review of BHECS Herts South Locality PBC Group Enfield Trust Board Seminar - discuss BEH	Enfield Strategic Review Group BEH Strategic Coordination Group
Friday	NHS Enfield – quarterly meeting with MPs		Barnet +55s meeeting	
Sat / Sun				

NOVEMBER 2010

	w/c 1 November	w/c 8 November	w/c 15 November	w/c 22 November	w/c 29 November
Sometime in week					
Monday	**Haringey Health Scrutiny Panel (Child Protection)**	7pm – Public meeting - Southgate		NHS Enfield staff meeting	Haringey Health Scrutiny Panel (Budget)
Tuesday	2pm – Public Meeting, Edmonton Green Haringey Council meeting Barnet SJLC	Haringey – GP consortia – Central/North East/South East Enfield Health Scrutiny Panel – update	Enfield Strategic Review Group	Six-weekly meeting – CEO and Lead, LBE	30 –Strategic Coordination Group meets to develop conclusions
Wednesday	Enfield LBE CEO Barnet Health OSC Meeting Pan-BEH Communications meeting Hertsmere PBC	Haringey – GP consortia – West Enfield LINk – drop-in session	Pan-BEH Communications meeting	**NHS Haringey Public Board meeting** UCL Partners analysis of feedback against 4 tests sent SCG Enfield Health Scrutiny Panel Public meeting	
Thursday	2pm – Public Meeting – Enfield Town Barnet Strategic Review Group		18 – Informal meeting between Enfield GPs and Health Scrutiny Panel BEH Implementation Board	**NHS Barnet Public Board meeting** NHS Enfield Public Board meeting	
Friday		UCL Partners receives data and local report to analyse feedback against 4 tests	19 – Briefing to Enfield MPs by local GPs 19 – Joint BEH OSC - Haringey	LB of Enfield hoststa meeting with David Kerr, representative of the SoS	
Sat / Sun					

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London Borough of Islington

DRAFT

Joint Health Scrutiny Committee – Informal Meeting

2 August 2010

Minutes of the informal meeting of the Joint Health Scrutiny Committee held at the Town Hall, Upper Street, Islington, N1 2UD on 2 August 2010 at 3.00p.m.

Present:	**Councillors:**	Councillor Martin Klute (L.B.Islington), Councillor Christiana During (L.B.Enfield), Councillor Maureen Braun (L.B.Barnet), Councillor Gideon Bull (L.B.Haringey), Councillor Dave Winskell (L.B.Haringey), Councillor Paul Braithwaite (L.B.Camden), Councillor John Bryant (L.B.Camden), Councillor Peter Brayshaw (L.B.Camden),
	Officers:	Trevor Cripps, Rob Mack (L.B.Haringey), Jeremy Williams (L.B.Barnet), Peter Moore, Rachel Stern (L.B.Islington), Shama Sutar – Smith (L.B.Camden).

1 INTRODUCTIONS (Item 1)

Councillor Klute welcomed everyone to the meeting. Members of the Committee and officers introduced themselves.

2 APPOINTMENT OF CHAIR FOR THE MEETING (Item 2)

RESOLVED:

That Councillor Martin Klute be appointed as Chair for the meeting.

3 APOLOGIES FOR ABSENCE (Item 3)

Apologies were received from Councillor Christina Hamilton (L.B.Enfield).

3 DECLARATIONS OF INTEREST.

Councillor Brayshaw declared an interest in that he was a Governor at UCLH and Councillor Bull declared an interest in that he worked at Moorfields Hospital.

4 BRIEFING FROM NORTH CENTRAL LONDON SECTOR (Item 4)

Caroline Clark, Director of Strategy and Transformation and Stephen Conroy, Director of Communications and Engagement at the North Central London Sector were present for discussion of this matter.

Caroline Clark stated that the North Central London Sector had two main functions – the five Primary Care Trusts (PCTs) allocated their acute sector budgets of £1.6 billion for the sector to commission hospital services and there were also a range of delegated functions from the Strategic Health Authority with regard to planning and performance management in regard to the acute sector and primary care. The sector would also be the transitional body for GP commissioning and would be in existence until the PCTs and the Strategic Health Authority (SHAs) were abolished and the system was ready for GP commissioning to start

In response to a question as to how the Chief Executive and the Chair of the North Central London sector were appointed it was stated that this information was in the public domain. From 1 April 2010 the Chief Executive had been appointed full time, whereas previously it was a part time post. The LBI postal address and email addresses had been used in order to save money by not having to introduce new technology systems. However, all the Chief Executives of the five PCT's invested time in contributing to the work of the sector and had a five borough approach.

A presentation was made to the Committee, a copy of which is interleaved and the following main points were made -

- PCT's would be replaced by GP consortia by 2013
- The consortia would be geographical, have an accountable officer and have to provide services for unregistered patients. Their size was undefined and their allocation would be confirmed.
- There would be a Shadow NHS Commissioning Board from 2011 – The Board could assign GPs

to consortia and hold the consortia to account

- Local Authorities would have an influence over strategic decisions
- All acute trusts would have to become Foundation Trusts by 2013 or merge with another existing Foundation Trusts.
- In terms of funding there was a predicted £500 million commissioner gap by 2016/17 – the risk in 2010/11 was £60-£80 million – the demand growth was likely to be 4% but additional funding for the NHS was only likely to be 1% and there was also little capital available
- It was felt that there were too many acute hospital beds in the sector and there was a higher average length of stay than in other parts of the country – a large percentage of children attending Great Ormond Street came from outside London in view of it's specialist nature – specialist services could be improved
- Primary care was underdeveloped and there were significant health inequalities in different areas
- There were 1.3 million registered patients in the sector and 860 GPs in 269 practices making 6 million appointments per annum – on the Commissioning side there were around 16 PBC's with 266 referrals seen per annum and 5 Professional Executive Committee Chairs and 5 Local Medical Committee Chairs
- A number of initiatives had been taken in relation to the Darzi review and the Barnet/Enfield/ Haringey reorganisation – it was stated that whilst work had been started on North Middlesex hospital in January 2010 this had been dependent on savings proposals around the Chase Farm hospital site. The proposals at Chase Farm were now being reviewed in the light of guidance from the new coalition government. The North London sector would be carrying out a post election stock take in August 2010
- Previously there had been a clinical advisory group that had included a GP Chair, Medical Directors, UCLP, Nurse Directors, a Public Health Director and George Alberti. They had met intensively from August to December 2009 and monthly up to June 2010. They had reviewed evidence from the Darzi review and Royal Colleges and had considered the Healthcare for London proposals in a local context looking at pathways and service models and made recommendations to NCL about services and the number of sites
- North Central London sector had concluded that the clinical priorities were specialist acute services including cardiovascular, cancer, stroke and trauma, HPB, and neuro-oncology, local acute services and a shift to primary care including in patient paediatrics, obstetrics, urgent care and management of long term conditions and mental health acute services and inpatient beds
- Following the Darzi review the proposal was to have two major acute sites (one in the north of the sector and one in the south of the sector) and a multi specialist acute provider where highly specialised and tertiary services that require major acute type infrastructure could be delivered. There would be a rationalisation of specialist services across the Royal Free and UCLH, such as Cardiac, neurosurgery and ENT and a maximum number of two local hospitals
- There was a need to focus on fewer sites in order to ensure sites provided appropriate, high quality clinical care for patients. However, there was little consensus among practitioners on where those sites should be located

During discussion of the presentation the following main points were made –

- In response to a question it was stated that the North Central London sector had been delegated their responsibilities by the SHA and from the PCT's and that they saw their role as being responsible for the transition from PCTs to GP commissioning
- The Chair enquired as to the current status of the North Central London Service and Organisation review as the L.B.Islington Health scrutiny committee had been informed by the PCT that the process had been suspended. Caroline Clark responded that the letter from the Secretary of State had indicated that the process should be suspended and subject to review and challenge in order to ensure that it satisfied the requirements of the new NHS operating framework. . The process had been halted at the scenario stage and would restart again following engagement with GPs
- In response to a question Caroline Clark stated the proposed stock take was a process to look at engagement and service structures challenges. Given that there was an anticipated £500million funding gap there was a need to look at alternatives to address this
- It was proposed that the North Central London sector would be replaced by GP commissioning

and that this would be overseen by the NHS commissioning board but the White Paper was still unclear on a number of areas and there were a series of consultations arising from the White Paper that needed to be responded to

- A representative from L.B.Haringey referred to the previous proposal for neighbourhood health centres and that the original proposal was to have five and this had now been reduced. Assumptions had been made that patients would be diverted from hospitals to health centres and had the reduction of in the number of these been taken account of by North London Central sector in their funding calculations.
- The new Health Minister Andrew Lansley had stated that he felt that the previous health proposals for London were too 'top down'
- Stephen Conroy indicated that in terms of buildings GPs in Camden had stated that they did not require new buildings to deliver health care and they were happy with existing premises, however this was not the case in all areas of the sector
- Members expressed concern that the presentation had indicated a patient population of 1.3 million for the sector; however it was well known that a lot of the boroughs' populations were not registered. There were a significant number of people who currently just attended at A&E when they had a problem and in addition there was a transient population - there was a need for the GP commissioning bodies to take this into account. Caroline Clark responded that the NHS Commissioning Board would impose duties on the GP commissioners to take things such as unregistered patients etc. into account
- A Member from L.B.Camden enquired about the timeframe for JOSC involvement in any proposals coming forward and stated that scrutiny should be involved at an early stage when proposals were formulated. Stephen Conroy responded that he would take this proposal back for consideration
- In response to a question as to whether the GP Commissioning Boards would be co-terminus with local authority boundaries, it was stated that this would not necessarily be the case It was stated that if a GP commissioning body was set up that covered areas of both Haringey and Islington, different strategies may need to be implemented in different local authority areas. There was also a need for a representative from other interested parties such as pharmacists, LiNKs, nurses and the relevant local authorities to be part of this commissioning process and the North London Central sector should feedback these views
- A Member from L.B.Haringey stated that there was a need to establish who would be accountable for decisions and the issue of co-terminosity was important. If GPs would not commission certain services patients may have to transfer to where they could access these services and wrong commissioning decisions would affect patients
- Caroline Clark stated that the next 18 months was intended to be a transition period and services would not be changed until alternatives had been decided upon
- With regard to the Chase Farm, the hospital needed £130 million spent on it to bring it up to an acceptable standard
- It was stated that decisions should be local and not imposed on an area
- Members expressed the view that as elected representatives they hoped that the North Central London sector would work with them as they all had the best interests of residents at heart. When proposals were formulated these should be shared at an early stage
- In response to a question as to how the anticipated £500 million shortfall would be dealt with, it was stated that £350 million were hospital costs and the remainder mental heath primary care costs. Hospitals would need to make 4%-5% of savings over the next four to five years to ensure the gap did not increase. Measures were already being taken such as reducing agency staff, sharing costs to make efficiencies such as in HR and work was being done to anticipate future funding problems and find solutions and to address them as early as possible
- A Member from L.B.Barnet indicated that the population growth predicted for the borough was 60,000 in the next 10 years and enquired whether adequate provision was being made to take this into account. Caroline Clark responded that the funding formula did take account of future population growth and health inequalities but there was still the issue of rising costs in the health service due to new treatments
- In response to an enquiry as to whether there would be enough health professionals to meet the increased demand for services it was stated that there could be problems in the areas of A&E,

and paediatrics, and the consultants' view was that there needed to be fewer, better treatment centres but where these should be located was contentious

- The view was expressed that, given the proposals for more local authority engagement, there needed to be a clearer indication of how this was to be achieved and how they could be represented at the commissioning level. There was also a need to address the area of mental health as this was an area that should not be neglected. Stephen Conroy indicated that the North Central London sector saw mental health as an important issue

Stephen Conroy then outlined for the Committee the principles of the Concordat that the North London Central sector intended to put in place for future engagement with local authorities –

- Scrutiny powers under the Health Act 2006 section 7 will remain
- Improve public and patient engagement
- Openness and transparency
- Prioritise scrutiny activity as follows -
  - Substantial
  - Non-substantial,
  - A priority for the Health Scrutiny Committees
  - Not a priority for Health Scrutiny Committees

Possible indicators of insufficient consultation could include:

- The NHS fails to alert Health Scrutiny Committees of an issue
- No or insufficient stakeholder engagement
- Members/Officers not updated by NHS
- Scale of changes underplayed by NHS
- A loss of confidence of stakeholders due to NHS failure to adhere to the principles of the concordat

- There was a need for the sector to work with council officers to establish a framework as to how proposals for change would proceed. Substantial variations may need full consultation but minor changes may need only to be referred to the scrutiny committee to inform them what was going on if local GPs and patients were in agreement with the proposals
- Members expressed the view that there needed to be a London wide framework for engagement with scrutiny, given that the changes would be common across all sectors. They also stated that London Councils should be asked to consider this
- A Member from L.B.Camden stated that there should be engagement at an early stage to avoid past mistakes and that the sector needed effective scrutiny
- Given that there is likely to be a number of big changes in the health service there would be a need to establish the JOSC formally at some point with specific terms of reference and that this meeting had been helpful in clarifying the position for future engagement. Stephen Conroy responded that the sector had found the meeting useful as well and there was a need to look at revisiting the strategy for the future
- Stephen Conroy added that where there were not substantial variations and things needed to be progressed quickly it would be useful to consult the JOSC or individual health scrutiny committees. A meeting of the full JOSC might not be able to be arranged quickly and if this was the case then individual health scrutiny chairs should be consulted
- In response to a question it was stated that the sector had met with the LINk chairs and invited them to attend the sector board as it was felt that the more that people worked together the better
- A Member from L.B.Enfield enquired who would provide services in the community once the PCT ceased to exist, in particular mental health services. It was stated that work was being carried out to look at community services and whilst there would be a GP commissioning board, mental health services would still have their own mental health trusts and these would continue to exist as at present

RESOLVED:

(a) That London Councils/Centre for Public Scrutiny be requested to consider whether there should

be a London wide framework set up for dealing with proposals for change given that there were common issues across London such as the emergence of sector wide NHS bodies with a strategic role in commissioning.

(b) That it be noted that the North Central London sector had indicated that they were willing to engage with the JOSC, and if necessary individual Health scrutiny committees, as soon as proposals are at a formative stage and to also take back the further comments made above by the JOSC for consideration.

The Chair thanked Caroline Clark and Stephen Conroy for attending.

5 POSSIBLE FUTURE ENGAGEMENT WITH HEALTH OSCS AND NHS NORTH CENTRAL LONDON (Item 5)

In the discussion the following points were raised:

- If a formal JOSC was established for statutory consultation it should be investigated whether issues could also be referred on a borough wide basis – the view was expressed that during the consultation on stroke/trauma there was a JOSC established but this had not precluded individual boroughs considering these proposals. There would also be a collective view from the JOSC if all the boroughs could agree
- It was stated that as all the individual boroughs had agreed the proposed terms of reference of the JOSC there was a need to decide how to take the JOSC forward

RESOLVED:

(a) That the scope of the JOSC be widened so that it had a standing role (on an as and when discretionary basis), in considering any sector wide proposals that involve significant changes to services that affect patients and the public across the sector. This could be broadened, if felt appropriate, to cover specialised commissioning where services are organised across 5 boroughs and whilst, the number of patients in each borough may be small, the aggregate total was significant. This would remove the need to set up a fresh JOSC on every occasion and therefore reduce the administrative burden. It could also enable proposals to be scrutinised which would probably not otherwise have been looked at in detail. The JOSC whilst undertaking this role should, in addition, take on a strategic role in scrutinising sector wide issues through regular engagement with NHS North Central London sector.

(b) That the London Scrutiny Network be contacted to ascertain the arrangements that were being made in other sectors concerning JOSC's and scrutinising NHS proposals

6 HEPATOBILIARY AND PANCREATIC SERVICES (Item 6)

RESOLVED:

That the report be noted.

The meeting ended at 5.20 pm

CHAIR:

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