Agenda Item 3

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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NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the meeting of the Joint Health Overview and Scrutiny Committee held on 27 May 2011 at Camden Town Hall, Judd Street, WC1H 9JE

Present Councillors: Alison Cornelius and Graham Old (L.B Barnet), Peter Brayshaw and John Bryant (Vice-Chair) (L.B Camden), Alev Cazimoglu and Anne Marie Pearce (L.B Enfield), Gideon Bull (Chair) and Dave Winskill (L.B Haringey), Kate Groucutt and Martin Klute (L.B Islington)

Officers: Melissa James (L.B Barnet), Rob Mack (L.B Haringey), Katie McDonald and Hannah Hutter (L.B Camden) and Linda Leith (L.B Enfield)

1. WELCOME AND APOLOGIES FOR ABSENCE

Councillor Gideon Bull (Chair) welcomed everyone to the meeting and introduced Councillors Alev Cazimoglu and Anne-Marie Pearce from the London Borough of Enfield as new members of the Committee.

An apology for absence was received from Cllr Maureen Braun, who was being substituted by Cllr Graham Old (L.B Barnet).

2. URGENT BUSINESS

There was none.

3. DECLARATIONS IF INTEREST

Councillor Gideon Bull declared that he was an employee at Moorfields Eye Hospital, but did not consider it to be prejudicial in respect of the items on the agenda.

Councillor Alison Cornelius declared that she was a Chaplaincy at Barnet Hospital, but did not consider it to be prejudicial in respect of the items on the agenda.

Councillors Peter Brayshaw and Kate Groucutt declared that they were Governors at University College London Hospital, but did not consider it to be prejudicial in respect of the items on the agenda.

4. MINUTES

The minutes of the meeting held on 25th March 2011 were agreed, subject to the following:

- Councillor Peter Brayshaw was absent and not present as stated;
- The amendment of the first sentence of paragraph four , Item 6, Vascular Surgery, to read, 'The Committee noted that if a mapping process considered Barnet and Enfield, and the areas north of the

boroughs together, the required minimum population size would be achieved.'

It was

RESOLVED

THAT the minutes of the meeting held on 25th March 2011 be approved.

Matters arising

The Chair suggested that no action be taken to invite the MP for Enfield North as stated in Item 9, Barnet, Enfield and Haringey Clinical Strategy.

5. QUALITY INNOVATION, PRODUCTIVITY AND PREVENTION (QIPP) PLAN

Liz Wise, QIPP Director and Ann Johnson, Director of Finance, NHS North Central London (NCL) gave a presentation to the Committee providing an update on commissioning plans that had been developed across the NHS in North Central London and the current financial position across the cluster.

The presentation, as attached at appendix A to these minutes, outlined:-

- The financial position
- History
- Current QIPP programme
- Brief overview of the population
- Challenges
- Healthcare landscape
- Balance of spend and services
- Historical financial performance
- Root causes and lesson learned
- Current position – PCT run rate
- 2011/12 NCL deficit before QIPP
- QIPP work streams
- Governance and Oversight; and
- Delivery

The Committee noted if the productivity levels of all local acute providers were brought up the top half of performers on a national basis, approximately 500 less hospital beds would be needed within the sector. Areas with better primary care services tended to spend less money on acute care. Over 50% of PCT expenditure in Barnet and Enfield was on acute services.

The Committee raised questions and concerns relating to budgets. In response to questions, it was noted that the Department of Health determined the funding formula. There were no issues in balancing the books for Camden and Islington, who both had stable finances and had better funding

levels – approximately 15% more - than the other boroughs in the sector. Barnet, Enfield and Haringey had a £60million deficit in 2009/2010 and £81million in 2010/2011. Approximately 30% of procedures had a national pricing formula. Pricing tariffs were not known until January/February and therefore the signing of contracts for procedures were often delayed outside of the financial year.

It was requested that a training seminar be put on for Committee Members to get a better understanding of the national and local pricing mechanisms and contracts.

Discussion took place regarding the QIPP work streams and it was noted that the budget projection by the end of 2011/12 was a deficit of £16.1million across the NCL. The Committee requested a progress report of the previous three months at its September meeting on each of the projects of the QIPP.

The Committee noted that Liz Wise and Ann Johnson would be reporting to every NCL Cluster Board on the QIPP and would ensure details would be passed to the Committee.

The Committee requested that at future meetings any presentations made were circulated in advance of the meeting with the agenda.

It was

RESOLVED

(i) THAT the report be noted;
(ii) THAT a seminar be put together for the Committee to understand the context of national pricing funding formulae and contracts; and
(iii) THAT a report be brought to the September meeting summarising the three month performance of the QIPP projects.

6. QIPP MEDICINES MANAGEMENT; AN OVERVIEW

Liz Wise, QIPP Director, NHS NCL, introduced the report which summarised a review of relative performance against prescribing practices across Barnet, Camden, Enfield, Haringey and Islington which had been undertaken as part of the QIPP process.

The Committee raised questions and in response the following points were noted, namely:-

- Although some drugs were expensive to provide, it was about prescribing them appropriately, for example, using antibiotics at the right time;
- Drugs for rare conditions were being looked at through the review;
- If a patient required expensive and specialised drugs, there was a separate budget;

- There was an extreme price differential between different drug formats. For example, some medicines were only commonly available in tablet form. For those patients who required the medicine in liquid format, special manufacturers had to be used whose charges were not regulated. In some cases, the charges were one hundred times higher than the more commonly available format. There was a procedure in place to ensure the prescribing of such "specials" were only made for those with the greatest need; and
- It was thought that when GP consortia come into being they would take over the responsibility for managing medicines. However, there would be medicine management advisors who would continue to provide guidance/advice.

Discussion took place regarding the pricing mechanisms of drugs and the pricing of prescriptions. The Committee noted that there was a British Drug Formulae and there were three types of prescriptions available; over the counter, prescription only medicines (the charging for which was a political decision set by the Treasury) and controlled drugs.

Further discussion took place regarding the advisory role for medicine management and concerns surrounding a possible postcode lottery on drug prescriptions once GP Consortia was in place. The Committee agreed that a letter would be written to the Secretary of State for Health highlighting the Committee's concerns regarding the large disparity in charges made to PCTs for medicines

It was

RESOLVED

(i) THAT the report be noted; and
(ii) THAT a letter be sent to the Secretary of State for Health highlighting the Committee's concerns regarding the large disparity in charges made to NHS commissioners for medicines.

7. BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY

The Committee received a verbal update from Nigel Beverly, NHS NCL and Enfield Borough Director in respect of Barnet, Enfield and Haringey (BEH) Clinical Strategy. The Committee noted that the Secretary of State had asked the Independent Review Panel (IRP) to review of the recent proposals set out by the London Borough of Enfield as well as NHS London's review of strategy and its compliance with the Secretary of States four tests for proposed reconfigurations. The IRP was due to report back to the Secretary of State by 4th July.

In the meantime the implementation of the clinical strategy was continuing; the business case was to be approved and the critical path agreed. The strategy was timetabled for completion by 2013. However, if no final decision

was taken soon, there was likely to be slippage. In addition, Barnet and Chase Farm Hospitals were having to prepare two options appraisals as part of its application for foundation trust status in order to take account of possible outcomes of the current review of the strategy.

Of particular concern were the implications for North Middlesex University Hospital if the strategy was not implemented. The PFI funded improvements to the hospital were based on the assumption that there would be additional levels of activity stemming from the implementation of the strategy. Further delay in implementing the strategy would cause financial challenge that could threaten its long term viability.

Representatives from Enfield stated that their submission had included a number of innovative solutions and stressed that they had no wish to undermine the position of the North Middlesex Hospital. They wished to ensure that the issue was finally resolved.

Concerns were raised by the Committee in relation to the impact that a further delay on a decision could have on health services in the area and agreed that a letter would be sent on its behalf to the Secretary of State requesting that the current uncertainty be ended and that a final decision be made as soon as possible.

It was

RESOLVED

THAT a letter be sent on behalf of the Committee to the Secretary of State requesting that the current uncertainty be ended and that a final decision be made as soon as possible.

8. VASCULAR SURGERY

Dr Nick Losseff, Medical Director - Secondary Care, NHS NCL was joined by Nicholas Law, Consultant Vascular Surgeon, Barnet and Chase Farm Hospitals NHS Trust. He informed the Committee that there had been wide spread clinical input into the proposed service model and it was agreed that larger numbers of people going to a single unit would have better outcomes.

Discussion took place regarding the concept of the single centralised arterial vascular surgery hub and how it would have support from day case and out-patient care in appropriate locations closer to patient's homes. The Committee noted that, on average, within three days of a routine aneurysm operation the patient would be transferred back to the location closer to the patient's home. The Committee were informed that it was expected there would be approximately 300 procedures carried out in the central hub per year. The vascular surgeons would be on an on-call rota and would be based at the hub when on-call.

In response to the Committee's questions regarding location of the hub it was noted that the Chief Executives of the Trusts would be written to, to start

discussions about which Trust would be best placed to deliver the services in the NCL. Once a location had been chosen, there would be specific criteria requirements the Trust would have to meet. Currently no one site in the NCL fulfilled the requirements. If the decision could not be reached co-operatively, there would be a designated process in place to find the appropriate location. It was hoped that by the end of August 2011 a location for the hub would be found.

In response to further questions the Committee noted that, there would be few blue light ambulances going straight to the hub as most patients would be seen at local hospitals first and then transferred to the hub. The Committee noted that the NCL vascular working group met on a quarterly basis. The project strategy that had been adopted by the NCL vascular group had been through a small consultation exercise. The existing cardiovascular network was one of the consultees which consisted of somewhere between 100-150 people, including carers and previous patients. The Committee were assured that it was not just a management decision but was also clinically driven.

Following a detailed discussion, it was

RESOLVED

(i) THAT the report be noted; and
(ii) THAT a paper be brought to the Committee's meeting in September regarding how the site for the hub would be chosen and the reasons for choosing a specific site location.
(iii) THAT the needs of the population immediately north of London, in Hertfordshire and Essex, be taken into account in any final decision by commissioners.

9. QUALITY ACCOUNTS – CAMDEN AND LISINGTON FOUNDATION TURST

The Committee gave its consideration to a report of the Camden and Islington Foundation Trust which provided the draft quality accounts for 2010/11. Ian Diley, Head of Performance and Regulation, gave an overview of the report and stated that it was a mandatory document for NHS trusts in England which was produced annually to allow trusts to provide a public account of work towards improving the quality of service provision.

The Committee raised concerns about the performance figures in relation to compliance with physical health assessment policy included in the report. It was commented that as policy moved towards more patients being supported in the community, the current performance figures displayed for Community Mental Health Teams in 2010/2011 were concerning. The Committee wished to seek further reassurance surrounding the figures to check there would be sufficient capacity to assist service users in the community in 2011/2012. The Committee also suggested that the figures would be better understood in number rather than percentage form.

The Committee also raised concerns about the performance figures relating to advice and services to carers. The Committee asked whether a breakdown could be provided of, for example, the number of people who were getting an actual service as opposed to just information. Members of the Committee were also concerned that the targets stated seem low, especially when they included the provision of information, and were surprised that some of the targets were not being met.

The Committee were of the view that that all carers (where identified) should be offered information, although clearly a much smaller number will receive a service. It might therefore be easier to distinguish between the two and have separate targets.

During the discussion the Committee suggested that next years quality accounts should also include a section on questions put to the board of governors, and requested that the Committees comments to be included in the report.

Following discussion it was

RESOLVED

(i) THAT the report be noted; and
(ii) THAT the Committee's comments be sent in a letter to CANDI signed by the Chair

10. CAMIDOC

Martin Machray, Associate Director, Communications and Engagement, NHS NCL, updated the Committee on its request for access to the report commissioned by Camden PCT into the circumstances leading to the demise of Camidoc. He informed the Committee that the front of the report had included assertions that it could not be released. A letter had been sent to the report authors asking whether these still applied and, if so, to which sections. It was stressed that NHS NCL were trying to get the document released as soon as possible and would get legal advice if the report authors still refused to authorise the release of the report.

The Committee were of the view that the report should be in the public domain as there were crucial questions which needed to be asked and lessons needed to be learnt.

11. NEW ITEMS OF URGENT BUSINESS

There were no items of urgent business.

The Chair requested that Camden's Health Scrutiny Committee's letter to the Secretary of State responding to the "listening exercise" on the Health and Social Care Bill be circulated to the rest of the Committee.

12. DATE AND VENUE OF NEXT MEETING

The Committee noted that the date and venue of the next meetings would be:

15th July 2011 at Islington

23rd September 2011 at Enfield

GIDEON BULL
Chair

NHS
North Central London

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

REPORT TITLE: Transforming Child and Adolescent Mental Health Services (CAMHS) In-Patient Services for young people living in Barnet, Enfield and Haringey

REPORT OF

Andrew Williams
Interim Borough Director – Haringey
NHS North Central London

FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE:** 15th July 2011

SUMMARY OF REPORT:

In 2008, a National Review of Child and Adolescent Mental Health Services took place. Across Barnet, Enfield and Haringey we are committed to developing our local services in line with recommendations from that review, with a focus on ensuring that universal, targeted and highly specialist services work effectively together to provide well integrated child and family centred CAMHS services that respond to individual need. The changes we are proposing in the attached consultation document, will impact on CAMHS services that we currently provide for 12-18 year olds with severe and complex mental health problems, including suicidal behaviour and/or emerging personality disorders, in need of specialist CAMHS services.

In the pre consultation period, as part of the process to develop the new service delivery model, we have looked at current activity and examined the evidence of best practice, and worked with local GPs, clinicians, local authority overview and scrutiny committees, and current and ex service users on an individual and one-to-one basis.

Mental healthcare professionals and commissioners believe that action must be taken to reduce the number of referrals and length of stay at in-patient units through an improved evidence-based care pathway with:

- New enhanced community outreach teams in each borough based on the Alliance team piloted in Enfield in 2010/11
- A single fit-for-purpose in-patient unit which is able to meet the needs of patients currently admitted into the two Barnet Enfield and Haringey Mental Health Trust units, and some patients currently admitted to expensive out-of-area units.
- Standard referral criteria across Barnet, Enfield and Haringey.

Subject to the outcome of the current consultation, Northgate, a 12-bedded NHS

adolescent unit on Edgware Community Hospital site, will close and part of the funding for the unit will be reinvested into an improved community model, including borough based enhanced community outreach teams. The teams will work very closely with and complement existing community CAMHS in each borough, and there will be a central treatment hub offering specialist support. The enhanced community outreach model has been successfully piloted in Enfield through the work of the Alliance Team.

The new service model will:

- Increase the capacity of CAMHS to provide care in the community and at home instead of in a hospital or care home environment
- If a stay in a hospital or residential unit is required, the new service model should reduce length of stays and support earlier discharge into the community
- Improve the skill mix of staff working with young people
- Improve access to a wider range of interventions
- Improve patient safety
- Improve multi-agency partnership working, particularly with schools and local authority children's services.

A public consultation on the proposals started on Tuesday 3rd May 2011, and ends on Tuesday 26th July 2011. As part of the consultation, the consultation document has been sent to a wide range of stakeholders across Barnet, Enfield and Haringey, and the proposal has or will be discussed at key meetings across the three boroughs, with particular attention given to consultation with young people. To date the response from the meetings that have been held has been essentially positive and in favour of the proposal, and a meeting with representatives from Barnet, Enfield and Haringey children's services has been arranged for 8th July 2011. Further work is being carried out with young people and users of CAMHS services to ensure their views are reflected in the consultation report.

CONTACT OFFICER:
Claire Wright
Head of Children's Commissioning
Enfield Office
NHS North Central London

RECOMMENDATIONS: The Committee is asked to provide a formal response to the proposals described in the consultation document, which is attached.

SIGNED: 

Andrew Williams
Interim Borough Director – Haringey
NHS North Central London

DATE: 29th June 2011

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North Central London

Transforming Child and Adolescent Mental Health Services (CAMHS) In-patient Services for young people living in Barnet, Enfield & Haringey

Transforming Child and Adolescent Mental Health Services (CAMHS) in-patient Services for young people living in Barnet, Enfield & Haringey

1. Introduction

The NHS across Barnet, Enfield and Haringey has developed proposals for transforming Child and Adolescent Mental Health Services (CAMHS) in-patient services for young people living in Barnet, Enfield & Haringey in line with national and international best practice

We want to find out what local residents think of these proposals.

In this document we will describe what mental health services are provided for children and adolescents in the three boroughs. We also present some information about CAMHS services in other London boroughs to give you an idea of what our proposals could look like in practice. We then go on to recommend what we need to do in Barnet, Enfield and Haringey to provide excellent mental health services for our younger residents.

NHS North Central London

Over the past few months, the commissioning PCTs in North Central London (Barnet, Camden, Enfield, Haringey and Islington) have come together as a single management team, NHS North Central London Cluster (NCL). This new structure will allow our PCTs the flexibility to transition to the future commissioning arrangements set out in the Government's July 2010 White Paper (Equity and Excellence: Liberating the NHS).

The vision for the NHS North Central London Cluster is to improve the health outcomes of our population over the next five years. In particular, it will improve health by addressing health inequalities within our population, focusing on our most deprived communities.

There are also differences in the quality of service being delivered across the NHS NCL Cluster, particularly in primary care, as well as risks to the potential long-term sustainability of some of our healthcare providers.

Additionally, the cost of healthcare is rising more quickly than the amount of funding available for our residents. The workforce responsible for delivering the service needs to change to adapt to future requirements.

Our strategic plan - Quality, Innovation, Productivity, and Prevention (QIPP) – will ensure that we deliver our priorities for 2011/12, and our strong single management team is now in place to help both the rollout of the QIPP plan workstreams, and support the GP Pathfinders across North Central London.

Additionally, we must continue to improve primary care services to support the move of hospital services into the community which will improve access for patients, giving them more services closer to home and the highest quality health services; all within a viable health economy.

Maintaining our relationships with local clinicians and providers, as well as the local authority, LINks and community and voluntary organisations, is going to be crucial over the next two years so that we do not lose the local knowledge that will be so important for the future and how we shape the local healthcare and health services.

NHS NCL is conducting this consultation across Barnet, Enfield and Haringey.

As part of the process to prepare this strategy by working with local GPs, clinicians, local authority scrutiny committees and current and ex service users, on an individual and one-to-one basis. We have spent the past few months testing these proposals in order to set them out fairly.

2. What do we mean by Children and Adolescent Mental Health services (CAMHS)?

Children and young people can be affected by a wide spectrum of mental health problems from lower level psychological problems such as phobia or bed-wetting to more severe, complex and persistent disorders, such as psychosis, chronic depression and self-harming.

Mental health problems in children are associated with educational failure, family disruption, disability, offending and anti-social behaviour. When children and young people suffer from mental health problems, it places demands on social services, schools and the youth justice system; so it is essential the NHS commissions a wide range of services to help meet the wider needs of these young people.

We currently commission and plan Child Adolescent Mental Health Services (CAMHS) according to a four-tier service model that was developed by the national Health Advisory Service (HAS)

The four tiers are:

- Tier one: These are universal non-specific services that are provided by organisations and contractors that work closely with the NHS. For example health promotion in schools and providing GP practices with information so that they are in turn able to offer general advice and information to their patients
- Tier two: these services are provided by specialists and professionals working directly in schools, GP practices or Sure Start Children Centres
- Tier three: These are specialised multi-disciplinary services for young people with more severe, complex or persistent disorders such as chronic depression, who self harming or suffer from psychosis
- Tier four: These are essential highly specialised services designed to support people with more severe, complex or persistent disorders in specialist day centres, outpatient services and in-patient wards.

Following the National Review of Child Adolescent Mental Health Services in 2008, it was recommended that we change the way we provide these services to a more modern model incorporating universal, targeted and highly specialist services dependent on the individual needs of the patient. The changes we are proposing across Barnet, Enfield and Haringey are in line with the national CAMHS review recommendations and will impact on services that we currently provide for 12–18 year olds with complex mental health problems in need of specialist CAMH services.

3. How do we deliver these services currently?

The NHS in Barnet, Enfield and Haringey jointly commission mental health services for children and young people in partnership with the councils in Barnet, Enfield and Haringey.

The Barnet, Enfield and Haringey Mental Health Trust (BEH-MHT) currently provides the majority of services to identify and address the emotional and mental health needs of young people across all three boroughs. Services are provided in a range of settings including schools, young people's homes, GP practices, specialist CAMHS clinics and adolescent in-patient units.

Mental health services for young people are provided by specialists who work in partnership with a range of professionals including social workers, teachers and GPs. This helps to ensure that there is co-ordinated and integrated support for children, young people and their families so that they can remain at home and continue attending school, training or employment and are supported to reach their full potential.

When a young person is too unwell to make best use of community-based mental health services they may need to be admitted to an in-patient adolescent psychiatric unit or therapeutic residential home so they can get the help they need before returning home.

The NHS in Barnet, Enfield and Haringey currently commissions BEH-MHT to provide the following services for young people with complex mental health problems aged 12–18 years old:

- 'Tier 3' multi disciplinary adolescent community teams in each borough. These teams see young people in a clinic in the community and work closely with a range of professionals including social workers, teachers, GPs etc to ensure an integrated approach to treatment.
- 'Tier 4' adolescent in-patient units:
  - *New Beginning* a 12-bed NHS acute adolescent psychiatric unit with an average length of stay of 42 days
  - *Northgate* a 12-bed NHS adolescent therapeutic unit with an average length of stay of nine months.

New Beginning: The NHS in Barnet, Enfield and Haringey commissions this unit exclusively for their patients. All acute referrals are admitted here unless patients do not meet the admissions criteria or the unit is full. If it is full, patients are admitted to another unit and then transferred back to this centre as soon as a bed becomes available. Patients admitted to *New Beginning* have an acute mental health need, they may be at immediate risk to themselves, and may require an emergency admission. When they are discharged they return home and continue to receive the necessary care and support from community CAMHS.

Northgate: This unit works with patients for longer periods of time than in *New Beginning* (the average length of stay is nine months) but patients go home at the weekends. The NHS in Barnet and Enfield commissions an agreed number of bed-days as set out in its contracts with BEH-MHT, while other

boroughs, including Haringey, commission bed-days as and when children and young people need them. Patients admitted to *Northgate* have complex mental health needs but admissions are planned as part of a longer term therapeutic intervention rather than an emergency admission.

Both units are located on the same site as Edgware Community Hospital, but are run as two separate units. They have separate entrances, staff, protocols and operational policies. Northgate School is also located on the hospital site and provides education for patients in both units.

In addition to the two in-patient units provided by BEH-MHT, it is sometime necessary to fund admissions to in-patient units provided by other NHS providers or the private sector. This is usually due to the fact that *New Beginnings* is full, the young person may not meet the admissions criteria for either of the units, or they may require residential therapeutic care (but not in a hospital) which would be jointly-funded with the local authority. [1]

The total annual BEH CAMHS budget (across all 4 Tier services) is approx £17m, of that approx 35% is spent on in-patient/residential Tier 4:

- £3m on *Northgate* and *New Beginning*.
- £2.9m on other Tier 4 in-patient/residential provision

These suggest an over-dependency and high-spend on in-patient provision across the three boroughs due to the limited investment in community services and lack of alternative community interventions commissioned.

It is also unusual to have two in-patient units with very different referral, admission and discharge protocols serving such a small demographic population. The existing model at *Northgate* is seen as outdated and not in line with current thinking; it has not developed in line with the modernisation of CAMHS nationally. The private sector has combined emergency and longer stay admissions into single units for some time. Other areas in London have already reconfigured their in-patient provision such as Simmons House, NHS Adolescent Unit in Islington, which has reduced average length of stay to three months and incorporated both emergency and planned admissions into a single unit with good outcomes.

4. How do these services perform?

National and international research studies have been undertaken to determine the most effective treatment model for young people with a diagnosed mental health illness. This will obviously vary according to the nature of the illness and individual circumstance and include a range of healthcare services, including community and in-patient treatment models.

National policy for CAMHS is to focus on early intervention and prevention and for the NHS, schools, councils and GPs to work together to, where possible, get young people the help they need in the community, keeping them with their families and carers and, where at all possible, out of hospital and/or other forms of institutional care.

[1] It cost approx £2.9m (March 2009-April 2010) to place children and young people in these out of borough placements.

There is limited evidence on the benefits of in-patient provision versus community provision. However conclusions from the Green and Worrall-Davies 2008 analysis are that there is now research evidence supporting the use of alternatives to inpatient care for certain groups of young people with mental health problems. The evidence suggests that treatment outcomes of several community models of care are similar to those obtained through residential treatment and may be sustained longer after follow up

Although there is no agreed and standard criteria for determining admission to CAMHS in-patient, a study carried out by the College Centre for Applied Research and the Royal College of Psychiatrists (O'Herlihy, Lelliott, Cotgrove; Andiappan and Farr 2008[2]) identified the two main factors as 'severe risk of harm to self' and 'physical health deteriorating due to mental illness'. With this in mind, commissioners recognise that in-patient provision is an essential part of the care pathway for some young people, but that it must be part of a seamless care pathway which includes a range of alternative interventions to becoming an in-patient.

Recent evidence has shown the importance of reconfiguring provision for the traditional 'Tier 4' cohort of young people to ensure it is multi-faceted, with multi-agency services that can include in-reach, outreach, intensive and crisis community initiatives, day provision, therapeutic fostering and other services that may be described as 'wrap around' (Green and Worrell-Davies 2008). These services should link more closely with traditional 'Tier 3' type provision in an improved and seamless care pathway for young people according to need.

As part of the process of gathering local evidence to inform a new service model, NHS Enfield commissioned a pilot project of enhanced adolescent community outreach called *Alliance*. The Alliance service is based on the models utilised by Brookside (North East London NHS Foundation Trust), Maudsley (South London and Maudsley NHS Foundation Trust) and Oxfordshire CAMHS, which provide good evidence-based models of care as alternatives to in-patient care. The *Alliance* team works alongside the current Enfield community adolescent team and the BEH-MHT in-patient units, providing intensive outreach and in-reach support to adolescents with the aim of preventing admissions and re-admissions and facilitating earlier discharge from hospital.

The cost of the pilot team is approx £138k per annum. Evaluation of the first quarter of data shows good results with significant reduction in the time young people spent in hospital. Savings of approximately £85,500 were achieved, measured by the number of days following discharge that clinicians anticipate the young person would have remained in hospital had intensive community support package not been available. The proposal is that savings should be re-invested into community services to develop even more early intervention and prevention services.

[2] O'Herlihy, A., Lelliott, P., Cotgrove, A., Andiappan, M., and Farr, H. (2008). The care paths of those referred but not admitted to inpatient child and adolescent mental health services. London: Royal College of Psychiatrists' Research and Training Unit.

Further analysis of the *Alliance* team is underway to gather as much evidence to inform best practice.

5. What are we proposing for the future?

Taking into account the review findings to date, mental healthcare professionals and commissioners believe that action must be taken to:

- Reduce the number of referrals and length of stay at in-patient units through an improved evidence-based care pathway with:
  - Increased community capacity in the existing adolescent teams
  - New enhanced community outreach teams based on the *Alliance* model in each borough
  - A single fit-for-purpose in-patient unit which is also able to meet the needs of patients currently being admitted to expensive out-of-area units
- Ensure a standard referral criteria is developed as part of the new pathway across Barnet, Enfield and Haringey

For those who require in-patient admission we are proposing that a new 15-bed unit is developed that will be able to facilitate admission for our high-risk young people including a percentage of the higher risk cases that are currently admitted to private hospitals out-of-borough.

By reconfiguring the current in-patient provision to just one unit we will be able to re-provide resources into the community to increase capacity, skills and expertise. This model will include an intensive community outreach team in each borough based on the *Alliance* model.

It must also be recognised that many patients who have previously been admitted to the Northgate Unit do not necessarily require a 'hospital admission' such as provided there. Those patients who cannot benefit from more intensive community based treatment may require a residential therapeutic placement which should be jointly planned with social care services, preventing dependence on a medical hospital model.

The new enhanced community teams will be able to work in a far more flexible way. They will work in partnership with a range of other children's services and provide intensive treatment to young people and their families and carers in the community, as well as providing in-reach to residential units and hospitals. This will ensure a co-ordinated approach and help prevent family break down, stability of foster care placements, support appropriate early discharge and reduce rates of re-admission.

The new service model will be implemented in a phased approach. Phase 1 would be the closure of Northgate immediately following this Consultation and staff would move into new positions in the new unit to ensure continuity of experience and expertise in working with this cohort of young people.

To make sure of continued safety and high-quality care, New Beginning will continue to operate until the new Unit is operational later in the year. This will ensure that the new enhanced community teams are fully embedded

and working effectively before changing the New Beginning unit.

The reconfigured service will provide a:

- Multi-skilled intensive outreach service that will provide crisis and home treatment, intensive community interventions and concurrent assertive 'in-reach' into in-patient provision.
- A 15-bed unit for higher risk patients who need hospital care. The team will continue to work with key children's services such as social services, schools, and other external services such as GPs that are essential for the coordinated and integrated care of vulnerable young people.
- A single point of access to mental health services for children and young people in all three boroughs.
- A single policy for referring young people who do need access to care from other CAMHS services.

Benefits to patients

The proposed service developments aim to achieve the following objectives and benefits for young people and their carers:

- Improve the 'Every Child Matters' five outcomes for young people with significant mental health difficulties,
- Specifically improve mental health outcomes for young people at risk of developing significant and/or long-term mental health difficulties
- Develop a modern service for adolescents with severe and complex mental health problems that takes account of clinical evidence and best practice
- Increase the range of options for managing young people who have suicidal behaviour and/or emerging personality disorders by offering a range of effective clinical interventions
- Develop intensive, community-based alternatives to in-patient care (assertive outreach, community treatment and day care)
- Reduce the use of in-patient provision (number and length of time of admissions) which evidence shows is not always the best treatment for the patient
- Provide better value for money on in-patient treatment both in-house and the private sector, releasing funds for re-investment in developing further effective treatments.

The new service model will:

- Improve the skill mix of staff working with young people
- Improve access to a range of interventions
- Increase the capacity of CAMHS to provide more care in the community and at home instead of in a hospital or care home environment.
- Reduce the number of young people placed out-of-area and for those still being placed ensure they recover more quickly so that they can come back to their local environment sooner
- Improve patient safety
- Improve access to specialist education facilities
- Improve multi –agency partnership working, particularly with schools and local authority children's services.

The phased approach continues with the community aspect implemented following this consultation and the new in-patient unit operational from December 2011.

6. What will happen when?

This document sets out the proposals and issues that need to be looked into for CAMHS in Barnet, Enfield and Haringey so that healthcare services in the three boroughs meet the needs of patients and deliver better care.

We are asking members of the public, and people with an interest in this area, to comment on our proposals over the next 12 weeks. The Consultation starts on **Tuesday 3 May 2011** and ends on **Tuesday 26 July 2011**.
Once this Consultation has ended we will review all your feedback and responses. The final strategy, using the comments we receive, will then go to the NHS North Central London Board to be discussed and agreed. The Board makes all the big decisions for the NHS North Central London Cluster which incorporates the NHS in Barnet, Camden, Enfield, Haringey and Islington.

When the final strategy is agreed by the Board we will decide the main actions that need to happen first. Some of these may need further discussion with patients and the public. We are hoping to begin developing detailed proposals and implementing them from August 2011.

This consultation booklet is also available from our websites, www.barnet.nhs.uk, www.enfield.nhs.uk, and www.haringey.nhs.uk and in hard copy on request to Claire Wright on claire.wright@enfield.nhs.uk

HAVE YOUR SAY

We want to hear from everyone who has an interest in child & adolescent mental health services – the public, service users, carers, people working in mental health and social care services, people working in other health services from community and voluntary organisations and others.

Tell us what you think about our proposed changes and whether they will achieve the service improvements we have described.

We will collate and analyse all responses submitted and produce a consultation report.

We will publish the consultation report and subsequent decisions on our website and make it available on request

This consultation booklet is also available from our websites, www.barnet.nhs.uk, www.enfield.nhs.uk, and www.haringey.nhs.uk and in hard copy on request to Claire Wright on claire.wright@enfield.nhs.uk

Appendix A: Glossary

Here are brief explanations of some of the technical and clinical terms used in this consultation booklet

Acute - disorder or symptom that develops suddenly. Acute conditions may or may not be severe and they are usually, but not always, of short duration.

Assertive Outreach Teams (AOTs) - multi-disciplinary teams of community staff to support people who have long term enduring mental illnesses with their recovery. Care and support may be offered in the service user's home or some other community setting, at times suited to the service user.

Assessment - a process to identify the needs of an individual and evaluate the impact of those needs on their daily living and quality of life.

Carers - relatives or friends who voluntarily look after individuals who are sick, disabled, vulnerable or frail, on a part-time or full-time basis.

Commissioners - team of people who purchase healthcare services from providers such as the Barnet, Enfield Haringey-Mental Health Trust for the local community.

Commissioning - the process by which commissioners decide which services to purchase and from which provider.

Crisis - a mental health crisis is a sudden and intense period of severe mental distress that may require urgent help at home or admission to hospital.

Crisis Resolution and Home Treatment Teams (CRHTs) - a team of mental health professionals who assess and manage all patients who are in crisis and need urgent mental health care. All admissions to hospital are also reviewed by this team.

Foundation Trusts - NHS Foundation Trusts have been were created to devolve decision-making from central government control to local organisations and communities, via local people signing up as Members and being elected as Foundation Trust Governors so they are more responsive to the needs and wishes of their local people.

GPs (General Practitioners) - family doctors who provide general health services to a local community. They are usually based in a GP surgery or practice and are often the first place patients go to with a health concern.

In-patient Services - services provided by the NHS where the patients/service users are accommodated on a ward and receive treatment there from specialist health professionals.

Mental Health - refers to a broad array of activities directly or indirectly related to the mental well-being component included in the World Health Organisation's definition of health, which is: "A state of complete physical, mental and social well-being, and not merely the absence of disease".

It is related to the promotion of well-being, the prevention of mental disorders and the treatment and rehabilitation of people affected by mental disorders.

Mental Health Act 1983 - the legislation under which individuals can be assessed and admitted to hospital compulsorily. Patients can be admitted for assessment and treatment under Section 2 of the Act for 28 days or specifically for treatment for six months under Section 3.

All assessments are undertaken by a social worker and two medical practitioners, one of whom will have special expertise in psychiatry and is

approved under Section 12(2) of the Act.

The Mental Health Act lays out a number of duties and responsibilities. Under section 17 leave arrangements, individuals in hospital can go on periods of leave if agreed by the Responsible Medical Officer (usually the consultant). Under section 136, the police can bring an individual from a public place to a place of safety, if the Police consider it necessary, for a mental health assessment.

Outpatient Services - services for patients to be seen by professional staff on a same-day basis in a hospital or clinic.

Primary Care - services provided by family doctors (GPs), dentists, pharmacists, optometrists and ophthalmic medical practitioners together with district nurses, health visitors and practice nurses, with administrative support.

Psychiatric Intensive Care - services to support mental health service users in a very severe acute phase of illness

Psychiatrist - a medical doctor specialising in the prevention, assessment, diagnosis, treatment, and rehabilitation of mental illness.

Psychologist - a mental health professional who specialises in talking therapies such as cognitive behavioural therapy.

Service Users/Patients - people who need health and social care for their mental health problems. They may be individuals who live in their own homes, are staying in care, or are being treated in hospital.

Social Care - personal care for vulnerable people, including:

- individuals with special needs because of their age or
- physical or mental abilities and children who need care and protection.

Social Inclusion - the state whereby vulnerable or disadvantaged people are able to access all of the activities and benefits available to anyone living in the community.

Stepped Care - stepped care recovery model seeks to treat service users at the lowest appropriate service tier in the first instance, only 'stepping up' to intensive/specialist services as clinically required.

Appendix B: Equality Impact Assessment

Service Information	**Service Name**	Child & Adolescent Mental Health Services (CAMHS) In-patient provision	
	Provider	BEH-MHT	
	Target Client Group(s)	Children and young people in Barnet, Enfield & Haringey admitted to or at risk of admission to a medium stay in-patient unit	
	Basic Service Description	Young people with complex mental health problems including emerging personality disorder; conduct disorder and those who may have suffered trauma when they were younger and who are not responding well to community-based CAMHS provision may be admitted to Northgate Unit. This is a medium stay (average length of stay is approx nine months) five-day a week adolescent therapeutic unit for 12-18 year olds	
	Responsible Leads	**Provider**	BEH-MHT
		Commissioner	NHS NCL lead (Enfield) - Emma Stevenson
	Proposed Change	In order to ensure more young people are treated in the community and supported to stay at home and continue in education, training or employment it is proposed that the Northgate unit closes and that resource re-invested into the community to develop further the current community CAMHS teams and develop a new intensive community outreach team. This will provide care closer to home with more young people remaining in the community, preventing inappropriate long admissions to hospital	

Equality Groups	**Age**	**Disability**	**Ethnicity**	**Gender**	**Religion/Belief**	**Sexual Orientation**
Impact(s) of Change	**None**	**None**	**None**	**None**	**None**	**None**
Mitigation Measures	Northgate provides a specialist in-patient service to 12-18 years olds who meet the admissions criteria.	Please see previous box	Please see previous box	See previous	See previous	See previous

	The changes will continue to provide a service to this cohort of young people but through improved community provision					
Public Engagement	A public Consultation on the closure of Northgate will take place from 3 May to 3 July 2011					
Training	Lessons learnt from the pilot team *Alliance* will be disseminated to staff in the new service. However specialist CAMHS clinicians will continue to deliver services to young people and so there will be no specific training needs other than ongoing CPD.					
Monitoring	Service changes will be monitored through the usual performance monitoring process with BEH-MHT					

Summary of Decision	It is recommended that Northgate adolescent unit is closed and resources re-invested into the community to increase capacity of the Tier 3 teams and develop new intensive outreach teams to support more young people in the community and closer to home.

Name	**Position**	**Signature**	**Date**
Emma Stevenson	**AD Commissioning**		**22.3.11**

HAVE YOUR SAY

We want to hear from everyone who has an interest in child & adolescent mental health services – the public, service users, carers, people working in mental health and social care services, people working in other health services from community and voluntary organisations and others.

Tell us what you think about our proposed changes and whether they will achieve the service improvements we have described.

We will collate and analyse all responses submitted and produce a consultation report.

We will publish the consultation report and subsequent decisions on our website and make it available on request

This consultation booklet is also available from our websites, www.barnet.nhs.uk, www.enfield.nhs.uk, and www.haringey.nhs.uk and in hard copy on request to Claire Wright on claire.wright@enfield.nhs.uk

QUESTIONNAIRE

Please mark appropriate answer with an X

Please tell us if you are:

Someone who uses mental health services				
A carer				
Working for the NHS				
Working for a local London Borough Council				
Representing a group or other type of organisation (Please state which)				
How many people from your group or organisation have contributed to this response	Up to 20	21-50	51-100	More than 100
None of the above				

If you are not responding on behalf of a group or organisation, please complete this section to help us ensure we have feedback from a wide range of people.

Are you:

Male	
Female	
Prefer not to say	

What is your age group?

Under 21	21-44	45-64	65 and over	Prefer not to say

Do you consider yourself to have a disability?

Yes	No	Prefer not to say

What is your ethnic group?

(a) WHITE:	
British	
Irish	
Other white	
(b) MIXED:	
White & Black Caribbean	
White & Black African	
White & Asian	
Other mixed	
(c) ASIAN OR ASIAN BRITISH:	
Indian	
Pakistani	
Bangladeshi	
Other Asian	

(d) BLACK OR BLACK BRITISH:	
Caribbean	
African	
Other black background	
(e) OTHER ETHNIC GROUPS:	
Chinese	
Other ethnic group	
Prefer not to say	

Please tell us what you think of the proposed service model

This consultation booklet is also available from our websites, www.barnet.nhs.uk, www.enfield.nhs.uk, and www.haringey.nhs.uk and in hard copy on request to Claire Wright on claire.wright@enfield.nhs.uk

Londonwide LMCs
The professional voice of London general practice

SENT VIA E-MAIL

Ms Ruth Carnall
Chief Executive
NHS London
Southside
105 Victoria Street
London SW1E 6QT

21 March 2011

Dear Ms Carnall,

Quality, Innovation, Productivity and Prevention (QIPP) Implementation in North Central London

We are writing to raise our concerns over the North Central London (NCL) NHS Cluster implementation of its QIPP plans, which clearly does not meet the requirements of the four tests identified by the Secretary of State as a condition of implementing service changes.

LMC representatives from the five PCT areas in North Central London met with the NCL QIPP leads on 11 March. It was clear from the NHS leads present that the Primary Care QIPP proposals had been developed with no engagement from, or consultation with independent GP or LMC representatives. It was also apparent that the views of the LMC representatives at the meeting would not be able to influence the documents and that decisions regarding future Primary Care QIPP priorities would be made irrespective of concerns or issues raised in our meeting.

In addition to our concerns regarding specific elements of the Plan, we are also extremely concerned that the NHS London Cluster management arrangements and 11/12 QIPP plans are solely focused on productivity as a means to creating financial balance to the detriment of developing consortia and General Practice infrastructure. QIPP Primary Care plans include proposals for PMS reviews, enhanced services reviews and list cleansing (as opposed to validation) exercises. There are no proposals for pump priming the primary and community care infrastructure in order to take on the increased secondary to primary care transfer of workload. The savings plans may instead destabilise practices, remove some of the existing levers for consortia to manage demand on secondary care services, and adversely impact on the ability of local GP commissioners to contribute to the delivery of **agreed** QIPP objectives.

We are concerned that

1. There is little clinical evidence base underpinning the proposals.
2. There has been no consultation with the LMC or local GPs, and no evidence of engagement with or support from local GP commissioners.
3. There is a lack of clarity about how, when, where and by whom decisions regarding the QIPP proposals have been, and will in the future be taken, which, taken with the lack of engagement or proper consultation, lead us to believe that proposals in the QIPP Plan will be imposed on future GP commissioners.

continued/..

Londonwide LMCs
The professional voice of London general practice

4. Enhanced services and PMS reviews will lead to a reduction in services and choice for patients and poorly planned list cleansing exercises may lead to erroneously removed patients being unable to access services until they have been reregistered.
5. There is no evidence of any informed engagement with the public, patients and local authorities.

It is clear from the above that, contrary to the four Lansley Tests, there has been no real engagement or consultation with local GPs, the LMCs, public, patients or Local Authorities. Until such time as proper consultation does take place, involving LMCs as statutory representatives of General Practice and GP commissioning consortia leaders as a minimum, we would appreciate your assurance that the current QIPP process and planning for specific projects be halted.

Copies of this letter are being sent to North Central London LMC Chairs and Vice Chairs, Caroline Taylor, NCL Chief Executive and Liz Wise, NCL QIPP Director. We look forward to hearing what action you intend to take.

Yours sincerely

Tony Grewal

Dr Tony Grewal
Medical Director
North Central London LMCs

On behalf of:

Dr John Brett, Chair	Barnet Local Medical Committee
Dr Martin Harris, Vice Chair	Barnet Local Medical Committee
Dr Caz Sayer, Chair	Camden Local Medical Committee
Dr Elizabeth Goodburn, Vice Chair	Camden Local Medical Committee
Dr Patrick Keating, Chair	Enfield Local Medical Committee
Dr Sinnappoo Karthikesalingam, Joint Vice Chair	Enfield Local Medical Committee
Dr Ujjal Sarkar, Joint Vice-Chair	Enfield Local Medical Committee
Dr Martin Lindsay, Chair	Haringey Local Medical Committee
Dr Neil Manttan, Vice Chair	Haringey Local Medical Committee
Dr Robbie Bunt, Chair	Islington Local Medical Committee
Dr Simon Hazelwood, Vice Chair	Islington Local Medical Committee

cc

Ms Caroline Taylor, Chief Executive	NHS North Central London
Ms Helen Petterson, Director of Transition and Corporate Affairs	NHS North Central London
Dr Andy Watts, Medical Director,	NHS North Central London
Ms Liz Wise, Director of QIPP	NHS North Central London

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

REPORT TITLE: NHS NORTH CENTRAL LONDON QUALITY INNOVAITON PRODUCTIVITY & PREVENTION CARE CLOSER TO HOME PROGRESS REPORT

REPORT OF: Liz Wise, QIPP Director, NHS North Central London

FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE: 15 July 2011**

SUMMARY OF REPORT:

The Care Closer to Home programme forms a key part of NHS North Central London's QIPP Plan and covers admissions avoidance, long term conditions and planned care. This programme aim to redesign services and systems to reduce admissions and re-admissions, provide more robust clinical and case management to patients with long term conditions and develop community based services as alternatives to outpatients and at lower cost. The programme aims to deliver a saving of £4.9m this year with an additional saving of £1.5m from an expansion of some initiatives across the five North Central London boroughs.

Crucial to the success of Care Closer to Home is strong clinical leadership from GP commissioners as well as engagement with primary, community and secondary care clinicians in the redesign of services. For patients requiring robust clinical and case management then integration across primary, community and secondary health care providers, as well as integration across health and social care is key to whole systems change.

CONTACT OFFICER:
Graham MacDougall
Associate Director Care Closer to Home
NHS North Central London
Graham.MacDougall@nclondon.nhs.uk

RECOMMENDATIONS: The Committee is asked to note the attached progress report and comment on the direction of travel for the Care Closer to Home programme.

Attached is the progress report.

SIGNED:

Liz Wise
QIPP Director
DATE: 29 June 2011

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NHS
North Central London

NHS NORTH CENTRAL LONDON
QUALITY INNOVAITON PRODUCTIVITY & PREVENTION
CARE CLOSER TO HOME PROGRESS REPORT

Introduction

This report updates the Joint Health Overview and Scrutiny Committee (JHOSC) on the current Care Closer to Home programme as part of North Central London QIPP Plan. The report covers the following areas:

1. Scope of Care Closer to Home programme
2. Current progress across boroughs
3. Financial and non-financial benefits
4. Risks to the current programme
5. Future plans

Scope of Care Closer to Home Programme

North Central London has an ambitious QIPP delivery plan aimed at redesigning services and systems, improving quality and increasing productivity with the aim of realising £137m savings crucial to its financial recovery. Care Closer to Home is a fundamental part of that programme and aims to realise £4.922m savings for 2011/12.

Care Closer to Home as a concept has been around for many years from service redesign led by the previous Modernisation Agency to more recent Healthcare for London and the development of polysystems. The latter resulted in PCTs undertaking clinical engagement work across primary and secondary care, often working jointly with Practice Based Commissioners to develop new pathways and service specifications for community based services as an alternative to hospital based care, particularly out-patient based care. Indeed most of the initiatives within the 2011/12 Care Closer to Home programme have originated from teams within each of the 5 boroughs.

Care Closer to Home can be separated out into 3 key elements:

1. **Admissions Avoidance**: these initiatives aim to provide robust clinical and case management of patients to prevent either an admission or a re-admission. These initiatives require all elements of the whole system to work together: commissioning, primary care, community services, social care and secondary care in an integrated way. An example of this work is the development of "*Virtual Wards*". This concept originated in Croydon and identifies service users who are at risk of admission, using primary and secondary care data, applies risk stratification, and "*admits*" high risk patients

into the "*virtual ward*" which aims to assess, treat and stabilise service users, in their own home, using the skills of a multidisciplinary team (MDT). The MDT, made up of a number of local providers, undertakes "*ward rounds*" as part of its assessment and management until they are fit for discharge.

2. **Long Term Conditions**: there is a considerable body of work that demonstrates that earlier diagnosis, supporting self-care, more robust ongoing clinical management and providing rapid response to crises, when required, provides a better pathway for patients with long term conditions. Much of the focus has been on Diabetes, Chronic Obstructive Pulmonary Disease (COPD) and Heart Failure. Both Diabetes and CHD National Service Frameworks have been around for many years and therefore many PCTs developed services for those patients in previous years. However this is not consistent across the 5 boroughs and therefore this remains a key development for Care Closer to Home QIPP. Like Admissions Avoidance above, the development of community based services for patients with these 3 conditions require providers across primary, community, secondary and social care to work together to as part of an integrated team to achieve maximum impact for patients.
3. **Planned Care:** this encompasses the majority of the initiatives within the current Care Closer to Home programme and these do not require the level of integration outlined above for admissions avoidance and long terms conditions. Community based services have been developed for dermatology, cardiology diagnostics, oral surgery, ENT and Ophthalmology. These initiatives are very much about redesigning current out-patient services into lower costs setting.

In all above cases, redesign aims to better define the patient journey, taking account of best practice, and redefines what care takes place within primary, community and secondary elements as well as better defining the transitions between those elements.

Current Progress across the Boroughs

The following table highlights progress for each initiative within each borough

BOROUGH	INITTIAVE	START DATE	SAVINGS
BARNET	Cardiology	1st April 2011	£250,000
	Urology	1st April 2011	£201,000
	ENT	1st April 2011	£105,000
	Gynaecology	1st September 2011	£232,000
	Ophthalmology	1st July 2011	£107,000
	Admissions Avoidance	1st January 2012	£97,000
CAMDEN	Cardiology	1st September 2011	£96,000

	Anticoagulation	1st April 2011	£890,000*
	Dermatology	1st April 2011	£530,000*
	Dermatology	1st July 2011	£135,000
	Virtual Wards	1st April 2011	£200,000
ENFIELD	Gynaecology	1st September 2011	£189,777
	Colorectal	1st July 2011	£0
	Ophthalmology	1st September 2011	£140,777
	Virtual Wards	1st April 2011	£160,000
	Care Homes	1st April 2012	£75,000
HARINGEY	Dermatology	1st April 2011	£45,000
	Diabetes	1st April 2011	£47,000
ISLINGTON	Anticoagulation	1st April 2011	£300,000*
	Dental/Oral Surgery	1st April 2011	£284,000
	COPD	1st April 2011	£0
TOTAL			**£3,988,554**

*Savings already realised

Current work is focusing on implementing the above services and on developing monitoring of those already operational.

Stakeholder Engagement

The majority of Care Closer to Home initiatives has been developed within the boroughs and within PCTs. Clinical engagement with both primary care secondary care clinicians on specific initiative has been focused at a borough level and GP commissioners have often led those discussions. Cluster level clinical engagement has taken place and focused on the wider QIPP agenda rather than on very specific initiatives.

Engagement with patients and the public has also focused at a borough level. PCTs have undertaken various levels of engagement and formal consultation with their residents on either very specific initiatives or on their strategy for care closer to home (e.g. a primary and urgent care strategy). Some boroughs have engaged with patients specifically on the development of pathways and service specifications. In addition there has been cluster wide discussion with LINKs as part of the wider QIPP agenda.

Some of the initiatives have been jointly developed between local borough health and social care teams to ensure an integrated approach to both development and delivery e.g virtual wards.

Financial and Non-Financial Benefits

Care Closer to Home aims to realise savings from the above initiatives of **£4.922m.** In addition, the programme has been asked to realise a further **£1.5m** savings from

additional initiatives. Most of the savings are due to the fact that services are redesigned and delivered at lower costs than current Payment by Results national tariff system and therefore the above table represents the net savings after the costs of providing the community based service.

As stated previously most of the above initiatives were developed within PCTs during 2010/11 with some further planning and implementation during 2011/12. Services can be commissioned via one of 3 routes

1. Contract variation with current provider
2. Any Willing Provider (Any Qualified Provider)
3. Invitation to tender (ITT)

Boroughs have undertaken the range of those options and hence there are different start dates for services. For areas that have been severely delayed then an assumption is applied that zero savings will be achieved for 2011/12. Monitoring of activity and finance for both the community based services and the remaining acute Trust based service will be undertaken as part of a wider monitoring tool to ensure savings are being realised. The monitoring tool includes elements of the non-financial benefits of those initiatives to ensure a full QIPP approach.

Included within the monitoring tool are the following **non-financial** benefits:

1. Clinical Outcomes	
%age of people feeling supported to manage their condition (EQ-5D/questionnaire)	
# Admissions Following Discharge from Community Service	
%age of referrals from community services to acute provider	
RAG Status for Clinical Outcomes	
2. Process Outcomes	
# Complaints	
Avg Response Time to Complaints	
# Complaints completed within NHS national requirements	
# Did Not Attend (DNAs)	
%age of patients seen by the service and referred back with management plan to GP	
RAG Status for Process Outcomes	
3. Other Outcomes	
%age of ethnicity recorded	General

The Financial and Non-Financial indicators will form a generic minimum dataset across all the initiatives as well as there being service specific outcomes. This dataset

will then be reported monthly, from July 2011, to capture performance all community based services that have commenced. Services will have "service-specific" outcomes which will also be monitored as part of QIPP performance management.

Risk to the Current Programme

The programme is ambitious and comprises a wide range of initiatives as outlined above. Most of the services have now commenced and will be monitored in terms of activity, finance and outcomes, the rest require to be operationalised. The outstanding areas are being project managed to ensure they meet their start date.

The most significant risk lies with achieving the £4.922m core savings and the £1.5m savings form additional projects. To meet both of those discussions have taken place with all borough teams and agreement to expand across NCL those service developments already operational within some of the boroughs. In particular:

1. Cardiology: development of community based cardiology clinical assessment and diagnostic service with a view to increasing treatment modalities
2. ENT: development of community bases assessment and treatment services for a specified range of ENT conditions
3. Gynaecology: development of community bases assessment and treatment service for agreed range of gynaecological conditions
4. Oral surgery: expansion of the dental referral management service and the development of community based Intermediate Minor Oral Surgery service (mainly wisdom tooth extraction).

The risk lies with the challenge of ensuring implementation this year particularly in achieving clinical leadership and sign up within consortia and Trusts to support and drive forward the developments and on achieving procurement and contracting route that is able delivery implementation during 2011/12.

In addition, cluster developments are taking place to develop plans to assist Trusts in the reduction of re-admissions within 30 days, part of the 2011/12 Operating Framework. Boroughs have worked with their whole system to identify opportunities for investment as part of the Re-ablement funding. This work will be further developed with Trusts to agree areas for investment this year in order to enable Trusts to reduce re-admissions.

Future Plans

NHS North Central London is currently developing its 4 year QIPP plan in line with all other London clusters. Part of this work will be working with all key stakeholders to develop areas for redesign. Some of these initiatives may be focused around very specific conditions;

1. Ophthalmology: particularly NICE approved glaucoma referral refinement service
2. Rheumatology: patients with a variety of inflammatory conditions could be managed within community based services
3. Heart Failure: both in assessment of breathlessness, integrated with COPD breathlessness assessment, and in the management of stable HF patients
4. Urology: the development of community based services which are integrated across primary, community and secondary care

In addition, work is underway to develop initiatives aimed at reducing re-admissions to hospital within 30 days of a discharge. For 2011/12, the focus may need to be on increasing capacity within re-ablement initiatives to ensure reductions for this year. In the medium to long term then sustainable change requires whole system change.

Graham MacDougall
Associate Director Care Closer to Home
Draft 16th June 2011

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

15 July 2011

Royal Free Hampstead NHS Trust - Care Quality Commission Report into Dignity and Nutrition for Older People

1.1 A significant number of residents from the boroughs represented on the JHOSC use the services provided by the Royal Free Hampstead NHS Trust. The trust was recently subject to a Care Quality Commission (CQC) inspection into dignity and nutrition for older people. The conclusion reached by the inspectors that the Royal Free was failing to meet the essential standards required by law in respect of these issues. In particular, improvements were found to be required for two outcomes:

- Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run; and

- Outcome 5: Food and drink should meet people's individual dietary needs

1.2 In the light of this, the Chair has written to the Trust inviting them to attend the meeting to respond to the issues raised in the CQC. The Chief Executive, Medical Director and Director of Nursing will be attending from the Royal Free to outline the Trust's response and answer questions.

1.3 A copy of the CQC inspection report is attached as well as the Trust's action plan for addressing the issues raised.

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Dignity and nutrition for older people

Review of compliance

Royal Free Hampstead NHS Trust **Royal Free Hampstead**	
Region:	London
Location address:	Pond Street Camden London NW3 2QG
Type of service:	Acute services
Publication date:	May 2011
Overview of the service:	The Royal Free Hampstead location is one of the Royal Free Hampstead NHS Trust 14 locations. The trust has 900 beds, sees about 700,000 patients a year and employs around 4,600 people. The location provides a range of specialist services which include Accident and Emergency, maternity, liver, kidney and bone

	marrow transplantation, renal, AIDS/HIV, infectious diseases, plastic surgery, immunology, paediatric gastroenterology. The Trust is a leading cancer centre with a range of specialist diagnostic and treatment services. Royal Free Hampstead was registered on 1 April 2010 with no conditions.

Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that Royal Free Hampstead was not meeting either of the essential standards we reviewed. Improvements were needed.

The summary below describes why we carried out the review, what we found and any action required.

Why we carried out this review

This review is part of a targeted inspection programme in acute NHS hospitals to assess how well older people are treated during their hospital stay. In particular, we focus on whether they are treated with dignity and respect and whether their nutritional needs are met.

How we carried out this review

The inspection teams are led by CQC inspectors joined by a practising, experienced nurse. The inspection team also includes an 'expert by experience' – a person who has experience of using services (either first hand or as a carer) and who can provide the patient perspective.

We reviewed all the information we hold about this provider, carried out a visit on 15th March 2011, observed how people were being cared for, talked with people who use services, talked with staff, checked the provider's records, and looked at records of people who use services.

What people told us

Overall, patients we spoke to on our visit were positive about their care, treatment and support. Patients and their families were involved in their care but sometimes staff tended to talk to their family members about the care and treatment instead of themselves. Patients would also like to be responded to more quickly. Patients told us that they had a choice of food which was satisfactory and that they could get food and drinks 24 hours a day. However staff did not always check that patients had enough to eat and drink. Patients would also like the opportunity to wash their hands before mealtimes.

What we found about the standards we reviewed and how well Royal Free Hampstead was meeting them

Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

- Overall, we found that improvements were needed for this essential standard.

Outcome 5: Food and drink should meet people's individual dietary needs

- Overall, we found that improvements were needed for this essential standard.

Action we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns, we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

What we found
for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*.

Outcome 1:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
- Understand the care, treatment and support choices available to them.
- Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
- Have their privacy, dignity and independence respected.
- Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

There are **moderate concerns** with outcome 1: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
Overall, patients we spoke to on our visit were positive about their care, treatment and support. Patients were happy about how they were treated and listened to by staff and were spoken to by staff using their preferred name. Patients had no concerns that they wanted to talk to staff about and had not been embarrassed or felt uncomfortable during their stay.

Patients' families were involved in their care and we saw family members assisting at mealtimes. However some patients told us that staff tended to talk to their family members about the care and treatment instead of themselves. We saw some staff interrupting other staff who were with patients without acknowledging the patient. It was also reported in the NHS Inpatient survey (2009) that the Royal Free hospital was worse than other hospitals at acknowledging patients presence.

The same survey reported that the Royal Free hospital is better than other hospitals at privacy for discussions. We observed contradictory evidence as staff discussed patients' care in front of them without their involvement and staff discussed patients'

care in an environment that did not allow for privacy.

Single sex bays or single room accommodation (side rooms) were in operation on the wards we visited and there were separate male and female toilet and washing facilities.

Patients feel that staff do not always respond to their needs quickly enough and this was supported by our observations of call bells not being responded to within the hospital's local timeframes. Posters stated that call bells are to be answered within three rings; however we saw incidents where the call bell had not been answered after a substantial number of rings. On arrival at a ward we noted that the majority of call bells were not within reach of patients. It was reported in the NHS Inpatient survey (2009) that the Royal Free hospital is worse than other hospitals at getting help – responding to the call bell quickly. We saw an incident of a patient's safety being a concern as their call bell was not within reach and they were falling out of bed.

We did observe examples of staff asking patients for their views and preferences but we saw on one occasion a patient was not listened to.

We observed some staff having informative engagements with patients and it was evident that patients understood their care and treatment. However we also saw a member of staff carrying out treatments without any interaction with patients and without respecting their privacy.

It was reported in the NHS Inpatient survey (2009) that the Royal Free hospital is better than other hospitals at privacy for examination and patients did not have any concerns about their privacy being upheld. However we saw incidents of care being carried out with open curtains. Staff told us about the 'red peg' system whereby a red peg is put on curtains around patients' beds when they do not want to be disturbed, however we did not see any red pegs being used.

Patients did not have any concerns about their dignity being upheld although we saw incidents where patients' dignity was not being upheld by staff. However, we saw examples of patients' independence being promoted by staff.

On the whole patients told us that they had been given enough information about their care and what will happen when they leave the hospital. We saw information about complaints, mealtimes, Patient Advice and Liaison Services (PALS) being displayed on the wards. We did not see menus by patients' bedsides and patients told us they would like more time to view menus before they were taken away. Patients told us that they did not have enough information about the facilities available at the hospital, such as shops.

Electronic feedback devices are available at the entrance/exit of wards where patients can give feedback about their stay. However not all patients had been asked for their feedback about their care and treatment in hospital and they told us they would like to have been asked.

Other evidence

Patient Environment Action Teams (PEAT) rated the Royal Free Hospital as good which is tending towards better than other hospitals for Privacy and Dignity.

Staff reported that they were trained and aware of involving patients in their care and respecting and responding to diverse needs. Staff explained how they treat people with dignity and respect by being aware of their tone and volume of voice, body language, holding discussions in private and ensuring families are involved in the care. Staff were aware that upholding privacy and dignity on a ward environment can be a challenge and can always be improved.

The hospital information says it has Bedside Guides available on the wards and different formats are available. The guide provides information about what to expect during a patient's stay in hospital including ward routines, visiting, hospital facilities and patient support services. However, patients we spoke to did not refer to the guides, and the guides were not seen on the two wards we visited.

When we talked with staff, they explained how they ensure that patients understand the process of finding out what might be wrong with them, and what will happen after that. Staff go through process with the patient and communicate with the patients' family. Staff know how to access specialist staff and other services such as translator services to ensure they can meet the patient's individual needs. Staff told us how they promote independence by supporting patients to work within their own limitations and involve physiotherapists to improve mobility and this was observed during the visit. Staff are trained to assess mental capacity of patients and refer patients to Independent Mental Capacity Advocacy (IMCA) where required.

The trust has a lead for dementia and most staff including volunteers are trained or will be trained on dementia awareness by April 2011.

The hospital regularly audits response times to call bells. In February 2011 across 10 wards it was found that 54% of call bells were not answered within 6 rings (30 seconds). A further 26% of call bells were not answered within 50 seconds. The audit found all bells were within reach of 94% of patients on the 10 wards audited.

The admission/discharge inpatient record has sections to document patients' needs. For example we saw that there are sections on preferred name; next of kin and their contact details; whether or not the patient has glasses/hearing aid; and do not attempt cardiopulmonary resuscitation (DNAR) statuses. However these sections were not always completed.

Overall we found patients records not filled out on two wards. The 'Patient's plan' which is the patients care plan was not completed in the records on more than one occasion.

On admission to wards staff ensure patients clearly understand their treatment by discussing it with them and their families. Information sheets about diagnoses are

available in different languages for patients. Staff ensure patients and/or relatives know how to raise a concern or complaint and staff know how to report complaints.

Staff told us that complaints are collected centrally and are shared with departments on a monthly basis. The hospital has a system to collect monthly real-time patient satisfaction information. The results are discussed at all levels from trust board level down to ward level.

There is a User Experience committee that collects information from patients and feedback to the trust. Some patients are admitted to hospital from care homes and staff visit these care homes regularly to get feedback from these patients regarding their experiences in hospital

Our judgement
Overall patients we spoke to on our visit were positive about their care, treatment and support. However this did not reflect the observations we made during our visit. We found that patients' privacy and dignity was not always respected and patients were not always responded to quickly enough by staff.

Outcome 5:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
- Are supported to have adequate nutrition and hydration.

What we found

Our judgement

There are **moderate concerns** with outcome 5: Meeting nutritional needs

Our findings

What people who use the service experienced and told us

In general people told us that the food was satisfactory.

Patients had a choice of meals that take into account their special dietary requirements and preferences such as kosher or vegetarian food, and patients have access to a choice of hot and cold food 24 hours a day.

However, although some patients had used menus to choose meals we did not see menus by patients' bedsides.

Patients told us that they are not given the opportunity to clean their hands before eating and we did not see people being offered the chance to clean their hands before and after eating.

We observed staff serving food from a heated trolley and taking it to patients in a timely manner although some patients told us that their food was cold.

On the whole people are assisted with eating, we saw the red tray system (patients who require assistance with food are served their meals on a red tray) in operation. We also saw family members assisting patients with their meal.
However, some patients had not been identified as needing support that may have

needed it. For example a patient was served a meal that was covered with cling film and they had difficulty removing it. We saw some patients not sitting comfortably when they were being assisted with eating and staff were not communicating with, or always watching patients whilst they were being assisted.

We saw uneaten food taken away from a patient by domestic staff. Domestic staff did not report or record that the meal had not been eaten and nurses were unaware that meals had not been eaten. Patients told us that staff did not always check that they had eaten their meals or that they had enough. We saw hot beverages being offered to patients in the morning but patients told us that staff rarely ask if patients have had enough fluids.

On one ward we saw some staff receiving nutrition support training. Staff told us this training was carried out weekly on different wards by the trust's leads for nutrition.

Protected mealtimes (PMT) were in operation on some wards and we did not see staff interrupting patients' mealtimes to carry out tests. Most staff were involved in the lunchtime process either serving meals or assisting with meals. Overall the lunchtime process was completed promptly. However some patients described mealtimes as a rush

Other evidence

The NHS Inpatient survey (2009) reported that the Royal Free hospital scored 4.4 out of 10 for the quality of food which was the same as other hospital's scores.

Patient Environment Action Teams (PEAT) rated the Royal Free Hospital as much better than other hospitals for food which included looking at the menu, choice, availability, quality, portion sizes, temperature, presentation, service and beverages.

Staff told us that on admission they record nutritional scores for patients and the majority of records seen had recorded patients' weight on admission. However many records did not show that patients weight had been reviewed a week later in line with their local policy.

Staff have access to specialist staff such as dieticians, and speech and language therapists (SALT) and the contact details for the trust's three nutritional nurse leads were displayed on the ward for staff. There is evidence that referrals are made to the nutritional nurse leads and nutritional and dietetic services for patients. However there was limited evidence in patients' records of specialist input from dieticians and nutritionists for patients who had been assessed using a nutritional screening tool as medium or high risk.

Halal, kosher, diabetic and vegetarian food options are available and on admission staff record a patient's ethnicity and ask about any dietary requirements. There was evidence of this assessment in most of the records we viewed.

Nursing assessment documentation for nutrition was seen in all records but some documentation showed inaccuracies, were not completed and not up-to-date.

Staff told us that food charts and fluid charts which record the patient's intake are recorded at midnight and midday (every 12hours). However the records did not support this. Of the records we reviewed food charts and fluid charts were often inaccurate, not completed and not up-to-date.

On a monthly basis staff carry out a well-being audit where 10 sets of notes are reviewed for the recording of hydration, use of sedation, weight loss and whether the patient returns to the same place that they were admitted from.

Staff told us that there is access to hot and cold food for patients outside mealtimes, and patients confirmed this. There is evidence that a choice of food that meets a range of individual needs is available and this is audited. The catering company that supplies the food for the hospital audit patient satisfaction and consistently find patients are happy with the taste, appearance and temperature of the food.

Staff told us that patients have a choice of food which they can choose from a menu and that pictorial menus for patients are currently being developed.

Our judgement
Overall patients we spoke to on our visit felt they had a choice of food, that it was satisfactory, and that they could access food outside of scheduled mealtimes. However we found that patients were not always appropriately assisted with their meals and there was inadequate monitoring of patients food and fluid intake which was reflected in the patients' records.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury Surgical procedures Diagnostic and screening procedures	17	1
	How the regulation is not being met: Overall patients we spoke to on our visit were positive about their care, treatment and support. However this did not reflect the observations we made during our visit. We found that patients' privacy and dignity was not always respected and patients were not always responded to quickly enough by staff.	
Treatment of disease, disorder or injury Surgical procedures Diagnostic and screening procedures	14	5
	How the regulation is not being met: Overall patients we spoke to on our visit felt they had a choice of food, that it was satisfactory, and that they could access food outside of scheduled mealtimes. However, we found that patients were not always appropriately assisted with their meal and there was inadequate monitoring of patients food and fluid intake which was reflected in the patients' records.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Dignity and nutrition reviews of compliance

The Secretary of State for Health proposed a review of the quality of care for older people in the NHS, to be delivered by CQC. A targeted inspection programme has been developed to take place in acute NHS hospitals, assessing how well older people are treated during their hospital stay. In particular, we focus on whether they are treated with dignity and respect and whether their nutritional needs are met. The inspection teams are led by CQC inspectors joined by a practising, experienced nurse. The inspection team also includes an 'expert by experience' – a person who has experience of using services (either first hand or as a carer) and who can provide the patient perspective.

This review involves the inspection of selected wards in 100 acute NHS hospitals. We have chosen the hospitals to visit partly on a risk assessment using the information we already hold on organisations. Some trusts have also been selected at random.

The inspection programme follows the existing CQC methods and systems for compliance reviews of organisations using specific interview and observation tools. These have been developed to gain an in-depth understanding of how care is delivered to patients during their hospital stay. The reviews focus on two main outcomes of the essential standards of quality and safety:

- Outcome 1 - Respecting and involving people who use the services
- Outcome 5 - Meeting nutritional needs.

Information for the reader

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Area for Improvement raised by CQC	Aim	Action	Measurement	Responsible	Completion date	Evidence of implementation
Outcome 1:Respecting and involving people who use services, patients were not always responded to quickly enough by staff	To ensure ward organisation is such that a timely response within 10 rings is made to a nurse call bell 80% of the time.	Implement nurse rounding on Health Services for Elderly people (HSEP) wards – to focus on whether the patient needs to use the toilet, whether the patient is positioned comfortably, whether the patient has pain and to ensure they have everything in reach including call bell and drink	Daily audit of rounding, 100% of patients reviewed hourly in the day, 2 hourly at night. Daily call bell audit of time to respond to call bells and number of patients who have call bells in reach Patient feedback	Pippa Street Divisional Director of Nursing, Urgent Care Call bell audits to be carried out by Jenny Kenward, Patient Experience Manager, Kevin Walsh, Deputy Director of Nursing.	30.06.11	Five consecutive audits showing nurse rounding carried out 85% of the time on HSEP wards, MAU, Stroke unit Five consecutive call bell audits showing 80% of call bells answered within 10 rings and call bell is within the patients reach on HSEP wards, MAU, Stroke unit Weekly audits to continue thereafter with increased expectations of compliance (targets of 90%) and reported to divisional boards and User Experience Committee
		Review of ward break times and allocation to ensure appropriate numbers of staff on ward at any one time Written protocol for management of breaks on HSEP wards which describe how break times will be staggered.	Audit of compliance with protocol	Jo James Lead Nurse	30.06.11	5 days of audit showing break time protocol adhered to on HSEP wards 80% of the time Audits to continue thereafter and reported to divisional boards and User Experience Committee
		Review role of discharge team to assist in completion of discharge planning documentation with consideration to releasing nursing time		Kate Slemeck Director of Operations	30.06.11	A review carried out and available plan for implementation

Area for Improvement raised by CQC	Aim	Action	Measurement	Responsible	Completion date	Evidence of implementation
		(i.e. ward sister/charge nurse)and development of ward based discharge co-ordinator				
Outcome 1:Respecting and involving people who use services, patients' privacy and dignity was not always respected	Ensure all measures are undertaken to protect patient privacy and confidentiality during ward rounds	Implement a consultant led protocol for privacy principles during ward rounds in the context of 4 bedded bays – to include: Patient centred communication, appropriate and sensitive communication, consideration of privacy when discussing any issues related to health and well being	Direct observation Patient feedback	Dr Khailee Cheah, Consultant, HSEP	30.06.11	3 ward round observations on each ward showing privacy principles maintained 95% of the time Weekly audits to continue thereafter and reported to divisional boards and User Experience Committee
		Consider roll out of protocol trust wide		Steve Powis Medical Director		
	To ensure that phlebotomy staff uphold expected standards of privacy and dignity	All phlebotomy and cannulation staff to be made aware of expected standards of behaviour. Implement programme of customer care training	Observational audit of staff to include 3 elements: introducing themselves, explanation of procedure and staff drawing of curtains around patients Patient feedback	Lenny Byrne, Divisional Director of Nursing, Specialist Services	30.06.11	Results of audit over 2 weeks showing 3 elements are met 95% of the time Training records demonstrating 80% of staff have completed training. Weekly audits to continue thereafter and reported to divisional boards and User Experience Committee
	To further develop staff self awareness of behaviour that may compromise patients privacy and dignity	Develop peer observational programme, based on appreciative inquiry, staff learn to observe and give feedback of staff practice, to include all members of	Essence of care Privacy and Dignity Benchmark carried out on wards Observational audit of privacy and dignity	Rebecca Myers Director of ODLD Benchmarking to be carried out by Naomi Walsh, Lead	30.06.11	Privacy and dignity benchmark completed 5 consecutive audits showing 90% compliance Weekly audits to

Area for Improvement raised by CQC	Aim	Action	Measurement	Responsible	Completion date	Evidence of implementation
		ward MDT	Patient feedback	Nurse, Practice Development		continue thereafter and reported to divisional boards and User Experience Committee
	To ensure staff do not enter behind curtains during patient care episodes	Further raise staff awareness of trust policies and procedures – reissue policy to ward MDT staff Raise awareness via handover and ward round Consider alternative to current disposable curtains i.e. changing to curtains that have no-entry sign printed on them	Observational audit Patient feedback	Deborah Sanders, Director of Nursing	30.06.11	Signature sheet showing all staff have been reissued with policy, have read and understood policy 5 observational audits on each ward showing no member of staff entering behind curtain without verbally checking first. Weekly audits to continue thereafter and reported to divisional boards and User Experience Committee
Outcome 5: Patients were observed not being appropriately assisted with their meal.	To ensure that all patients receive the correct level of timely and sensitive assistance they require with eating and drinking	Refinement and implementation of protocol for identifying the level of assistance required for each patient with eating and drinking	Observational audit at meal times Patient feedback	Jo James Lead Nurse	30.06.11	5 consecutive audits demonstrating the correct level of assistance was provided to patients Weekly audits to continue thereafter and reported to divisional boards
	At the end of meal service trays are not removed before nursing review and recording of what the patient has eaten	Implementation of 'green card' system	Observational audit at meal times Patient feedback	Jo James Lead Nurse	30.06.11	Audit showing green card system used on 5 consecutive days on each ward Weekly audits to continue thereafter and reported to divisional boards
	Ensure food choice available to patient is specific to nutrition needs of patients in	Implement HSEP specific menu	OCS audit of patient satisfaction	Jeremy Sharp Director of Facilities	30.06.11	Written confirmation and evidence of menu implementation from

Area for Improvement raised by CQC	Aim	Action	Measurement	Responsible	Completion date	Evidence of implementation
	HSEP	Ensure patients have access to menus at their bedside	Observational audit			OCS Observational audit shows for 5 consecutive days patients have access to menus Weekly audits to continue thereafter and reported to divisional boards
	Patients will be able to clean their hands before and after meals	Ensure 2 hand wipes available on every meal tray instead of current 1 Explain to patients the purpose of the hand wipes Offer alternative to patients who may wish to use soap and water	Observational Audit Patient feedback	Jeremy Sharp Director of Facilities	30.06.11	Observational audit demonstrates that for 5 consecutive days there are 2 wipes on each tray and patients are helped to use them Weekly audits to continue thereafter and reported to divisional boards
	To ensure that patients are positioned comfortably prior to meal times	The daily work plan will ensure that the 11.00 and 17.00 round considers patient position in preparation for meals and ensures patient in correct position for mealtime Reposition of patient where necessary during meal times	Observational audit at meal times Patient feedback	Pippa Street Divisional Director of Nursing	30.06.11	Observational audit showing for 5 consecutive audits patients are positioned correctly for eating. Weekly audits to continue thereafter and reported to divisional boards
	Increase volunteer support at mealtimes to further support patients in eating	Liaise with voluntary services to increase the number of volunteers trained in assisting patients with eating	Record of number of volunteers trained Record of number of volunteer episodes of helping patients with eating Each ward has a timetable of when volunteers will be	Jenny Kenward, Patient Experience Manager	30.06.11	The number of volunteers trained has increased by 50% and the number of volunteer episodes has increased by 20%

Area for Improvement raised by CQC	Aim	Action	Measurement	Responsible	Completion date	Evidence of implementation
			available to assist with mealtime			
Outcome 5 Inadequate monitoring of patients food and fluid intake which was reflected in the patients' records	To ensure nursing assessments are both accurate and acted upon, with all patients' having up to date care plans	Training on risk assessment and nursing assessment documentation with emphasis on why assessment and documentation are important	Training records Learning from incidents	Naomi Walsh, Lead Nurse, Practice Development	30.06.11	Training records showing 80% of staff have been trained Documentation audits show 85% completion on each record reviewed over 5 consecutive days
		Monitoring, embedding and maintaining standards of documentation including fluid balance and food charts and patient weight	Daily documentation audit	Pippa Street, Divisional Director of Nursing	30.06.11	Documentation audits show 85% completion on each record reviewed over 5 consecutive days Monthly audits to continue thereafter with improvement aim of 95% compliance reported to divisional boards
	Patients receive accurate nutrition risk scoring which translates into action at the point of meals service	Training on risk assessment & revision of high risk category actions	Training records Observational audit of meal times Learning from incidents	Naomi Walsh, Lead Nurse, Practice Development	30.06.11	Training records showing 80% of staff have been trained Observational audits over 5 consecutive days show 90% compliance Weekly audits to continue thereafter and reported to divisional boards
	To maximise the effectiveness of the dietetic input into the MDT	Review current input and effectiveness of dietetic input with HSEP consultants, nursing staff and SLT	Completed review and recommendations	Shirena Counter Head of Dietetics'	30.06.11	Written report outlining recommendations with a timescale for implementation

Area for Improvement raised by CQC	Aim	Action	Measurement	Responsible	Completion date	Evidence of implementation
Patients' views	The views of patients will be sought in relation to their specific experience of privacy and dignity and food to demonstrate the action plan implementation is improving their experience	A survey questionnaire will be used on a one to one basis with patients by volunteers from outside the ward	Survey results	Jenny Kenward, Patient Experience Manager	ongoing	Weekly reports of patient feedback
Trust wide	Consider the implications of the report and action plan on the wider organisation	Implement areas of good practice and audit schedules identified through the action plan trust wide	Privacy and dignity audits Nutrition audits Documentation audits Patient survey results	Divisional leadership teams	ongoing	Written divisional action plans Audit Schedule with compliance results as above
	Ensure all staff are informed of the inspection outcome	To write to all staff informing them of the inspection and findings	Communication to all staff	David Sloman Chief executive	26.05.11	Evidence of communication and distribution
	To have assurance that staffing levels can be maintained at each shift through timeliness of bank cover in the event of last minute sickness	To review escalation pathway for wards that are 2 or more nurses less than planned for the shift due to last minute sickness or unanticipated patient acuity. To develop and implement Red Flag ward metric process	Review of incident trends Number of wards Red Flagged in month	Deborah Sanders Director of Nursing	30.06.11	Written escalation process in place Methodology for identifying and reporting red flag wards in place
	To provide patient bedside information booklet to each bed	Publication and delivery of revised bedside guide (currently in production)	Audit of wards	Deborah Sanders Director of Nursing	14.06.11	Log of signatures of ward sister/charge nurse of delivery of guides.
	To learn more as an organisation directly from patients about their experiences developing a programme of engagement and change	To commission and tender for bespoke Royal Free programme	Tender completed and appointment made	Deborah Sanders Director of Nursing	Ongoing	Implementation plan from April Consulting for engagement programme and improving the experience of patients

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Agenda Item 8

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THE NHS IN NORTH CENTRAL LONDON	**BOROUGHS:** BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL
REPORT TITLE: Re-commissioning DRS (Diabetic Retinal Screening) services in North Central London	
REPORT OF: Liz Wise, QIPP Director, NHS North Central London	
FOR SUBMISSION TO: Joint Health Overview & Scrutiny Committee	**DATE:** 15 July 2011
SUMMARY OF REPORT: The aim of the presentation is to update the Joint Health Overview & Scrutiny Committee on the DRS services being delivered across north central London and proposals under consideration for the re-commissioning of DRS programmes. CONTACT OFFICER: Archna Mathur Head of Non Acute Commissioning NHS North Central London archna.mathur@nclondon.nhs.uk	
RECOMMENDATIONS: The Committee is asked to comment on the proposals under consideration and provide advice on the most appropriate engagement programme to support the re-commissioning of DRS services.	
Liz Wise QIPP Director NHS North Central London **DATE: 29 June 2011**	

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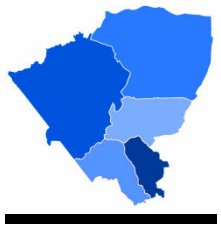

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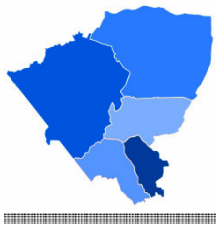
Re-commissioning of Diabetic Retinal Screening services in North Central London

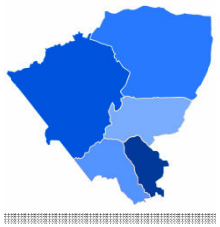
Archna Mathur – Head of Non Acute Commissioning, NHS North Central London

15 July 2011 – JHOSC



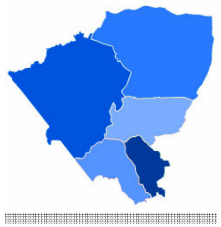
Summary and recommendations

- To update the Joint Health Overview & Scrutiny Committee on current diabetic retinal screening (DRS) services in Barnet, Camden, Enfield, Haringey and Islington and the options being considered for their re-commissioning across the NHS North Central London Cluster
- The Committee is asked to comment on the proposals under consideration and advise on the most appropriate engagement programme



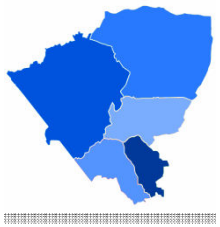
Background

- At least 2% of the UK population has diabetes
- Diabetic retinopathy is a leading cause of blindness in patients of working age in the UK
- Screening for diabetic retinopathy represents good clinical practice and cost-effective healthcare
- However, it also presents a significant workload for the NHS



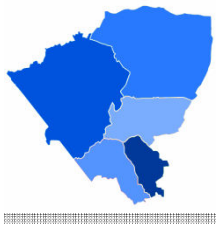
Current services

	Barnet	Camden and Islington	Enfield and Haringey
Programme size (patients)	16,500	17,428	27,091
2011/12 Budget	£410,000	£793,605	£684,945
Screening sites	2 – a GP practice & Edgware Community Hospital	6 – 4 GP Practices, and Royal Free Hampstead and Whittington Hospital	10 – 2 health centres, 5 optometrists, Chase Farm, North Middlesex and Whittington Hospitals
Appointments	Fixed - patients are sent an appointment but have opportunity to change if not convenient	Open - invite letters request patients to phone to book an appointment at a convenient time	Open
Uptake	81%	Not known as new service launched in December 2010	70%



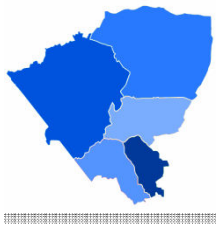
Why change?

- There is a need for NHS North Central London to review the way DRS services are commissioned because:
  - Uptake and access to screening for patients needs to be significantly improved and equal for all eligible patients in North Central London
  - There is an opportunity to commission a single, larger, screening service as recommended by the National Screening Programme (ie larger list of patients)
  - Feedback from EQA (External Quality Assurance) visits has demonstrated a need to make improvements to existing programmes
  - Contracts for all three programmes are coming to an end on 31 March 2012



Impact on patients

- Patients will be able to continue accessing DRS services in the usual way whilst the re-commissioning process is undertaken
- Currently patients can only access services in the borough where they are registered with their GP, resulting in low access figures
- Our aims are:
  - To ensure that patients can access services from multiple sites across the five boroughs irrespective of where they are registered. We could achieve this by having a single screening list instead of the current three lists
  - To ensure better patient safety through a single programme management office
  - To ensure services can manage fluctuations in demand & ensure continuity
- Changing the way we commission the services could mean a change to the number of sites at which screening is provided



Re-commissioning options

There are three options under consideration:

1) Do nothing – i.e. retain the three current programmes but make changes to individual programmes based on EQA recommendations
2) Commission a single North Central London Cluster-wide programme with a single screening list and one programme office (This involves undertaking a competitive tender process and is the English National Screening Programme recommendation)
3) Commission a joint Camden and Islington and Enfield and Haringey programme with a standalone Barnet programme i.e. two screening lists and programme offices

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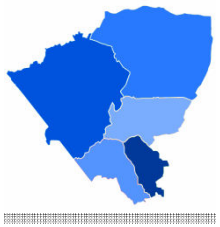

Preferred option – Option two

- Delivers improved access as one single list ensures registered patients can access the service from any point across North Central London
- Utilises the benefits of economies of scale through the provision of a unified tariff for a larger patient list, maximising current resources to lever service improvements
- Increases uptake through greater flexibility for the patient and improved IT functionality and programme management
- Delivers improved governance, patient safety and service continuity through centralised protocols and staff training

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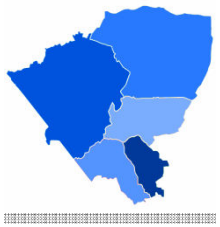

Who will benefit from a single Cluster-wide programme?

- Patients:
  - One single screening list to capture and maintain details of diabetic patients who require screening
  - Access to improved, high-quality screening service
  - Can access screening from any sites across North Central London and not just where they are registered with a GP
- Staff:
  - Clear management by one central programme office.
  - More opportunities for shared staff training and development, sharing of protocols and good practice to improve quality
- NHS North Central London:
  - Cost savings through better management of resources
  - More control over service improvements

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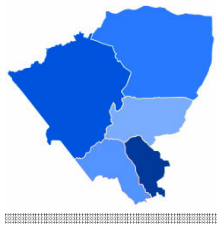
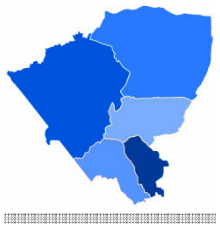


Our proposed engagement

- Patients:
  - Questionnaire to current users on what works well and not so well, and how the service can be improved
  - Website – upload questionnaire to capture wider views
  - LINks and voluntary organisation associations – write a letter and provide an article for inclusions in existing newsletters
  - Diabetes UK – write a letter to ask for their help in disseminating information to their members, ie via their regular newsletters and their meetings and fora
  - Patient representation in the development of the service specification document
- LOC (Local Optometric Committee):
  - Letter to explain the re-commissioning process



Your views

- The Committee is asked to comment on our proposals under consideration, particularly our preferred option (Option 2)
- We also would like your advice on the most appropriate engagement activities to support the re-commissioning of this service
- We would like to know if you have any concerns that we can address

If residents in your boroughs have any questions about DRS programmes in North Central London or would like further information, they can contact:

Archna Mathur (Head of Non Acute Commissioning)
archna.mathur@nclondon.nhs.uk

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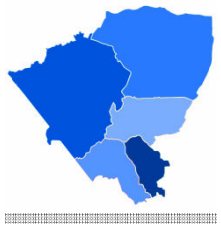

Thank you

- Any questions?

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THE NHS IN NORTH CENTRAL LONDON	**BOROUGHS:** BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL
REPORT TITLE: The future of Out of Hours (OoH) GP Services	
REPORT OF: Tony Hoolaghan Associate Director of Primary Care NHS North Central London – Islington Office	
FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE: 15 July 2011**

SUMMARY OF REPORT:
This report outlines the current and planned arrangements for Out of Hours GP Services in Camden, Islington and Haringey in 2011/12, including a provisional timetable for the re-tendering of the contract for these three boroughs.

CONTACT OFFICER:
Carol Mooney
GP Contracts & Performance Manager
NHS North Central London
carol.mooney@nclondon.nhs.uk

RECOMMENDATIONS: For information.

Attached is a presentation for the meeting on 15th July 2011 by Tony Hoolaghan on the future of out of hours services.

SIGNED:

Tony Hoolaghan
Associate Director of Primary Care

DATE: 29.06.2011

The future of Out of Hours (OoH) GP Services
This paper outlines the arrangements for the future of out of hours GP services in Camden, Islington and Haringey. Barnet & Enfield are under a separate contractual arrangement and it is not planned to tender for OoH services in these boroughs until 2013.

What is this document about?
An out of hours tendering process took place in 2010, but the contract was not signed with the provider who won the tender. This was based on the recommendations of an independent financial review and concerns about the financial viability of the provider going forward.

The contract with the existing provider of out of hours services at that time, CAMIDOC, ended on 30th September 2010 and Harmoni took over the OOH contract for City & Hackney, Camden, Haringey and Islington PCTs on 1st October 2010. Harmoni were appointed as an emergency, temporary, step-in provider, on the basis that they had considerable experience of providing out of hours services across both the UK and London. The decision to appoint Harmoni as a temporary provider was based on ensuring the continuity of a safe and viable service.

Harmoni provide call handling and GP out of hours services (weekday evenings/weekends/bank holidays) to the same specifications set for CAMIDOC.

Why do we need change?
The Harmoni contract was awarded for the period 01.10.2010-28.02.2011 and was extended on an ongoing, two month rolling basis from 01.03.2011. NHS NCL will lead procurement of out of hours services in the longer term in conjunction with key stakeholders, including local GP consortia and patients/LINk.

The current Harmoni arrangement is a temporary one and it has always been the intention of the commissioners to re-tender the contract. The provisional timetable is as follows:

Date	**Activity**
Summer 2011	Programme of work with GP Commissioners, NCL Commissioners, LINk and other relevant stakeholders to scope what is within the tender specification to ensure it has strategic fit to the NHS NCL Urgent Care strategy (i.e. Single Point of Access 111 initiative, Urgent Care Centres etc.)
Late summer early autumn 2011	Devise tender specification and plan
Mid Autumn 2011	Launch tendering exercise
Spring 2012	Tender awarded and provider begins to deliver service

Public Consultation and Engagement
NHS NCL will consult with and involve patients and LINk in the re-tendering of out of hours services.

If residents of your boroughs have any questions about the re-tendering of OoH services in Camden, Islington and Haringey or would like to receive further information or information in another format, please contact:

Carol Mooney
GP Contracts & Performance Manager
020 7527 1266
carol.mooney@nclondon.nhs.uk

Tony Hoolaghan
Associate Director of Primary Care
NHS North Central London

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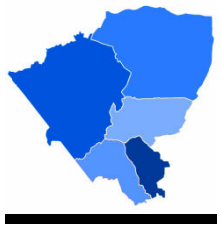

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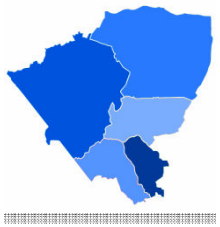
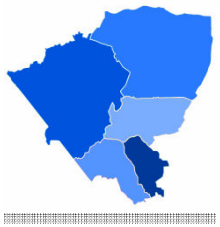
Future of Out of Hours GP Services
Camden, Islington & Haringey

Tony Hoolaghan
Associate Director, Primary Care



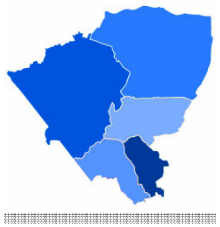
Background

- Out of hours (OoH) tendering process 2010
- Contract not signed with the provider who won the tender
- Contract with the existing provider, Camidoc, ended 30 September 2010
- Harmoni appointed as an emergency, step-in provider on 1 October 2010
- Continuity of a safe and viable service



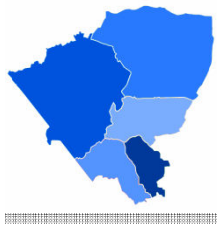
Harmoni Contract

- Provide call handling and GP out of hours services
- Contract awarded for the period 01 October 2010 – 28 February 2011
- Extended on an ongoing, two month rolling basis from 1 March 2011
- Procurement in the longer term to be led by NHS North Central London, with input from key stakeholders, including local GP Consortia and patients/LINk



OoH Procurement

- Current arrangement with Harmoni is a temporary one
- Intention has always been to re-tender the contract
- The tender exercise will include provision of OoH service across Camden, Islington and Haringey
- *Barndoc provides services for Barnet and Enfield residents and it is not planned to tender for OoH services until 2013*



OoH Procurement: Provisional Timetable

Date	Activity
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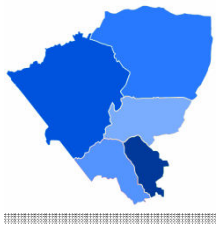

Any Questions?