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 Joint Health Overview and Scrutiny Committee
15 July 2011

Minutes of the meeting of the Joint Health Scrutiny Committee held at the Town Hall, Upper Street, Islington, N1 2UD on 15 July 2011 at 10.00am.

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

Officers: Rob Mack (L.B.Haringey), Peter Moore, Heather Scowby (L.B.Islington), Linda Leith (L.B. Enfield) and Melissa James (L.B. Barnet) Shama Sutar-Smith (LB Camden)

1 WELCOME AND APOLOGIES FOR ABSENCE (Item 1)

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

Apologies for absence were received from Councillor Alev Cazimoglu (L.B. Enfield). Councillor Andrew McNeil substituted for Councillor Maureen Braun (L.B. Barnet).

Apologies for lateness were received from Councillor Peter Brayshaw (L.B.Camden).

2 URGENT BUSINESS (Item 2)

None.

3 DECLARATIONS OF INTEREST (Item 3)

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

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

4 MINUTES (Item 4)

That the minutes of the meeting on 27 May 2011 be agreed, subject to the following -

- That the declarations of interest on page 3 of the minutes be amended to read that Alison Cornelius was 'Assistant' Chaplain at Barnet Hospital.
- That the typographical errors in the title of item 9 on page 8 of the minutes be amended to read 'Islington' rather than 'Lisington' and 'Trust' rather than 'Turst'.

5 TRANSFORMING CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) IN-PATIENT SERVICES FOR YOUNG PEOPLE LIVING IN BARNET, ENFIELD & HARINGEY (Item 5)

Emma Stevenson, NHS North Central London, Eric Karac, Clinical Director, Barnet Enfield and Haringey Mental Health Trust, Tony Theodolou, Assistant Director Children's Services L.B. Enfield, Julia Britton, Co-Director Open Door, Shaun Collins, Assistant Director, Barnet Enfield and Haringey Mental Health Trust and young service users representing the Northgate Clinic were present for the discussion of this item.

The Chair stated that the Committee would hear from a group of young people comprising of patients and ex-patients of the Northgate Clinic.

The Committee was shown a short video-clip which introduced the Northgate Clinic, which had been put together by the young people from the Clinic.
The young people made a submission to the Committee, during which the following main points were made -

- It was important to recognise the difference between adolescent and adult mental health services and ensure that an appropriate service for adolescents was retained. Young people valued the approach that included peer support which differed from models for adult therapies.
- Units such as the Northgate Clinic were crucial for the recovery of young people with complex mental health issues and its closure would devastate the young people concerned. The clinic provided a safe place for young people to recover and be properly supported. Young people valued the residential aspect of the programme that offered them a period of protection from their home environment and did not leave them unsupported following therapy sessions.
- There had been suicide attempts amongst inpatients upon hearing that the Northgate Clinic could close in the future.
- It was difficult to understand how the same therapies could be delivered using the proposed Alliance model as only three members of staff had been employed to co-ordinate the care.
- Service providers at the Northgate Clinic would find it difficult to implement the changes proposed due to the uncertainty of the new model.

During the discussion amongst the Committee, the following main points were made –

- The delivery of alternative therapies, such as psychodrama, should be explored, to address the concerns that the Northgate Clinic was based on an out-dated model of care
- It was questioned as to why the Alliance model had only been piloted in Enfield and was not being trialled alongside the other boroughs within the North Central London Cluster
- Group therapy was a valued model of care that should continue to be practised going forward however it was not as suitable in a home setting
- The consultation process began in May 2011. The initial consultation document on the proposals for the new service model was only available in PDF format initially which meant that it had been impossible to fill out electronically. In addition, an address had not been provided for the return of the form via post. The deadline for returning consultation forms had been extended by a further two weeks to address this problem and was now available in Microsoft Word format
- The proposals for a new model had been advertised via a press release, a discussion at youth parliament and by holding focus groups amongst current and ex-patients of the Northgate Clinic. Options for further engagement opportunities were being explored. The Committee were of the view that the schedule of consultation should be published for the purpose of transparency
- The Northgate Clinic was still operational. However, when the consultation had begun, it had been closed to new admissions and clinical staff had been asked to calculate when the patient's care packages would end. The unit could not operate group sessions below a certain capacity so a plan had been put in place to support the remaining patients in the community.
- The Chair stated that the clinic should not have closed as the consultation process was ongoing and that this sent out the impression that a decision had been made, which was not fair on the young people or the staff at the clinic
- The Alliance model had been adopted in other parts of the country and was based on clinical evidence. It demonstrated a positive impact on decreasing the inpatient admission rate whilst supporting people in the community
- It was stated that the proposed number of 15 beds for the new model was felt to be adequate. Although the combined number of beds for the Northgate and New Beginning Clinics was 24, the Northgate Clinic did not often reach full capacity. There was also additional beds at Simmons House
- There was no reference to the education element of the clinic or mention of the school in the report and it was essential that the school was retained
- The New Beginning Clinic provided support to young people in acute crisis and it would not be clinically safe to close it down rather than the Northgate Clinic
- The whole care pathway encompassing tier 3 was being reviewed, not just the services at the Northgate Clinic
- Concern was expressed that the Northgate Clinic was being closed whilst a new model of care was

being developed and the effect the gap in provision of care would have on young people
- Staff from Northgate would be reallocated amongst the adolescent mental health teams in the three boroughs and some staff would transfer to New Beginnings
- Barnet, Enfield and Haringey commissioned services differently to Camden and Islington. The differences between the demographics of the population and the mental health needs of the boroughs were recognised. The community based model would reach the needs of the diverse population and it was agreed that work across the whole sector would need to be looked at for continuity and best practice
- Tony Theodolou, Assistant Director-Children & Families, Enfield stated that initially concerns about the proposals were shared however they were broadly supportive of a move towards a community based model of practice
- Julia Britton, Co-Director Open Door, stated that she was broadly in favour of enhanced community care and that initially she shared concern regarding the Alliance model but had learnt that although there were only three members of staff they were not a stand alone service, and it would provide integrated packages of services.
- Barnet PCT owned the building occupied by the Northgate Clinic.

RESOLVED:

1. That, in view of the flaws in the consultation process and in order to facilitate further meaningful engagement with stakeholders, patients and the public, the consultation period be further extended and, in keeping with the Cabinet Office Code of Practice on Consultation, August is not included in any additional consultation period that is allowed.

2. That, in the interests of transparency, a full schedule of the consultation process should be provided.

3. That, in order that the Committee can be convinced that the new arrangements are in the interests of the local health service, the following clarification and further information be submitted to its next meeting:

    - The arrangements for the schooling of the young people and how the changes will impact on this;

    - Information on the new care pathway for vulnerable young people so that the Committee is able to have a better understanding of how it is proposed that the new arrangements will operate in practice; and

    - Further evidence on how resources freed up by the reconfiguration will be re-invested appropriately and on the transitionary arrangements.

4. That the concern of the Committee at the effective closure of the Northgate Clinic prior to the start of consultation period be noted by commissioners. .

The Chair thanked everyone for attending and the Committee agreed that the item should be included for discussion at the next meeting.

6 QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION (QIPP) PLAN (Item 6)

Loraine Robjant, NHS North Central London, Dr Tony Grewal, London LMCs and Graham MacDougall, NHS North Central London were present for the discussion of this item.

(i) Update

Lorraine Robjant gave a presentation which provided an update on commissioning plans that had been developed across the NHS in North Central London and outlined the current financial position.

The presentation outlined –

- QIPP workstreams

- QIPP plan
- QIPP plan progress
- Additional opportunities
- Building the next 4 year QIPP Plan

During the discussion, the following main points were made -

- A breakdown of the individual projects in the QIPP plan should be provided in accordance with the rag rating system. 117 projects were still in the design and planning stage and 128 projects had been implemented
- The NCL QIPP plan for 2011/12 totalled £137.4m. £14.6m of the previously unidentified £25m stretch had been provided for within current acute contracts, reducing the stretch target to £10.4m
- A member expressed concern at the number of projects in red and amber and it was reported that they were already 4-5 months into the financial year and there was a challenge ahead. It was stated that the rag ratings for each of the projects in the plan were updated regularly
- Discussions were being held with the acute hospitals in North Central London and contract negotiations had been agreed
- The prediction of people staying longer in hospital due to the effects of the Local Government cuts was something that was being taken into account as part of the QIPP planning and budgeting process

(ii) LMC concerns

During the discussion, the following main points were made -

- GPs were being asked to justify referrals to hospitals to address the issues of over-referring but this posed a threat of further delays in the already bureaucratic referral process - this could be detrimental to the GP/patient relationships
- Pump priming the primary and community care infrastructure was necessary. Discussions had taken place with all borough teams and agreement to expand across the NCL those service developments already operational within some of the boroughs, in particular - cardiology, ENT, gynaecology and oral surgery
- The biggest challenges going forward were the cleansing exercises of patient lists and to have the necessary resources in primary care to take on services currently provided in hospitals.

(iii) Care Closer to home

Graham MacDougall introduced the report on the current Care Closer to Home programme.

During the discussion, the following main points were made -

- The vast majority of initiatives in the Care Closer to Home programme were driven by local authorities, GP commissioners and clinicians in hospital
- The Care Closer to Home programme could be separated into three key elements – admissions avoidance, long term conditions and planned care
- Care Closer to Home aimed to make savings from the initiatives of £4.922m and the programme had been asked to realise a further £1.5m savings from additional initiatives
- Services could be commissioned via one of three routes – contract variation with current provider, any willing provider or invitation to tender
- Monitoring of activity and finance for both the community based services and the remaining acute Trust based service would be undertaken as part of a wider monitoring tool to ensure savings were being realised. The monitoring tool included elements of the non-financial benefits of those initiatives to ensure a full QIPP approach
- When looking at the progress for each initiative within each borough the savings made by Haringey since April 2011 were substantially lower than for other boroughs
- The role of pharmacists should be looked at and enhanced and this was being looked at
- Concern was expressed that community based clinical facilities, such as at Stevenson House and Hornsey Neighbourhood Health Centre, might not be being fully utilised.

RESOLVED:

1. That the update on the QIPP Plan be noted and a further update be provided to the November meeting with a breakdown of the projects in accordance with the “RAG” rating.

2. That a specific and substantive item be placed on the agenda for a future meeting of the Committee on care closer to home.

7 THE ROYAL FREE HOSPITAL - RESPONSE TO CARE QUALITY COMMISSION REPORT INTO DIGNITY AND NUTRITION FOR OLDER PEOPLE (Item 7)

David Sloman – CEO, Dominic Dodd, Chair, Prof. Steve Powis – Medical Director and Debbie Sanders – Director of Nursing, Royal Free Hampstead were present for the discussion of this item.

David Sloman introduced the report. During the discussion, the following main points were made -

- An immediate response to the concerns raised by the Care Quality Commission (CQC) inspection was being undertaken
- Compliance in all areas had been reviewed and confirmed to be safe
- An action plan had been drawn up which comprised of 34 interventions to address the issues raised
- An opportunity for learning had been created and there would be a drive to improve the performance across the wider organisation by implementing best practice, with a particular focus on self certification and the patient experience
- In terms of self certification, a standard inspection regime had been drawn up which mirrored the standards of the CQC inspections. Three mock inspections had been held over a six day period, the outcomes of which had been positive
- Privacy and dignity audits, nutrition audits and documentation audits would be undertaken alongside reviews of patient survey results
- One to one sessions between patients and staff were being held to learn directly from patients about their experiences and for staff to develop greater empathy and further develop staff self awareness of behaviour that may compromise patients privacy and dignity
- The 'too posh to wash' culture amongst staff was not an issue at the hospital and the most senior staff often washed patients to convey the right attitude
- They had been in discussions with Age UK following their invitation to the Camden HSC earlier this week, and consulted other experts and independent advocates in the voluntary sector for nutrition advice. The number of volunteers trained had increased to further support patients in eating
- Nurse rounding which ensured that patients were sitting comfortably in preparation for meal times was appropriate to ensure that the food did not go cold by the time it was served and that patients were ready to eat.
- It was noted that patient satisfaction levels for acute providers in north central London were in the bottom quartile nationally.

RESOLVED

That the response from the Royal Free NHS Trust on the CQC inspection report be noted and that it be noted that the Camden Health Scrutiny Committee would be receiving further updates on the implementation of the action plan.

8 RE-COMMISSIONING OF DIABETIC RETINAL SCREENING (DRS) (Item 8)

Archna Mathur, NHS North Central London and Quentin Sandifer Director Public Health for Camden were present for the discussion of this item.

Archna Mathur gave a presentation which provided an update 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 presentation outlined –

- Background
- Current services
- Why change
- Impact on patients
- Re-commissioning options
- Preferred option – option two
- Who will benefit from a single Cluster-wide programme?
- Proposed engagement

- Views

During the discussion, the following main points were made -

- Feedback from the External Quality Assurance (EQA) visits had demonstrated a need to make improvements to existing programmes, contracts of which were due to end on 31 March 2012. There was a particular need to increase uptake.
- There was an opportunity to commission a single, larger screening service as recommended by the National Screening Programme.
- Currently patients could only access services in the borough where they were registered with their GP, resulting in low access figures there would need to be a site in central London
- A single screening list would ensure that patients could access services from multiple sites across the five boroughs, irrespective of where they were registered
- Of the three proposed options, the preferred option was to commission a single North Central London Cluster-wide programme and one programme office, the benefits of which included cost savings through better management of resources, more control over service improvements and benefits for both patients and staff
- Engagement on the re-commissioning process was proposed to include contact with patients via a questionnaire on the website and writing letters to LINKs, Diabetes UK and the Local Optometric Committee (LOC)
- Diabetic retinal screening (DRS) was a specialized service therefore could not be undertaken by high street opticians, unless they had the right expertise
- Expanding the number of people who could practice DRS would be useful to improve uptake and access to screening by patients and the target was to have a 80-90% take up in the NCL cluster
- Work was being undertaken to understand why the current budget for the three contracts was so varied, with the Camden and Islington Budget nearly double the budget for Barnet. This would involve a breakdown of what each of the expenses were, such as overheads, sites, capacity and staffing requirements
- Under option 2, there would be a need to undertake competitive tendering for the service contract due to procurement rules. Providers would need to demonstrate that they provide quality services
- There were no plans to decrease the number of sites providing DRS services
- Committee Members were concerned at the possible implications of competitive tendering but were reassured that patient safety and the provision of equality in the service would be critical elements within the procurement process.

RESOLVED

That the preferred option (option 2) be supported in principle by the Committee and the need for appropriate safeguards in respect of patient safety be fully taken into account within any procurement process that might be required.

9 OUT OF HOURS GP SERVICES - RE-TENDERING OF CONTRACT (Item 9)

Tony Hoolaghan, Associate Director of Primary Care, NHS North Central London was present for the discussion of this item.

Tony Hoolaghan gave a presentation and introduced the report which outlined the current and planned arrangements for the Out of Hours (OoH) GP services in Camden, Islington and Haringey in 2011/12, including a provisional timetable for the re-tendering of the contract for the services.

The presentation outlined –

- Background
- Harmoni contract
- OoH procurement
- OoH procurement provisional timetable

During the discussion, the following main points were made -

- The contract with the existing provider of the OoH (Camidoc) service ended on 30 September 2010 and Harmoni had been appointed as an emergency provider for the period of 1 October 2010 to 28 February 2011 and this had been extended on an ongoing two-month rolling basis from March 2011

- Procurement in the longer term would be led by NHS North Central London, with input from key stakeholders, including local GP Consortia and patients/LINks
- The re-tender of the contract exercise would include provision of OoH services across Camden, Islington and Haringey. It was not as yet clear whether Hackney and City would also be included in the procurement process. It was possible that they could elect to make their own arrangements.
- Barndoc provided services for Barnet and Enfield residents and it was not planned to tender for OoH services until 2013
- The contract with Harmoni was constantly monitored to ensure complaints were addressed and further information could be provided following the meeting if required.
- Concern was expressed about poor attendance at the monitoring committee. It was noted that attendance had deteriorated during the recent changes that had taken place across the sector but this has now been addressed and appropriate medical directors should now be attending.
- In respect of Camidoc, preliminary agreement had been achieved into releasing the executive summary of the independent report that had been commissioned into their financial problems prior to their demise. This would be made available to the Committee in due course.

RESOLVED

1. That the update on the current and planned arrangements for the Out of Ours (OoH) GP services in Camden, Islington and Haringey be noted
2. That further information on the monitoring of OoH complaints process be circulated to the Committee.

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10 NEW ITEMS OF URGENT BUSINESS (Item 10)

None.

11 DATE AND VENUE OF NEXT MEETING (Item 11)

The date for the next meeting was provisionally set for 12 September 2011 at Enfield.

FINISH:

The meeting closed at 13:30 pm.

CHAIR:

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Agenda Item 5

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:** 19th September 2011

SUMMARY OF REPORT:
The NHS in Barnet, Enfield and Haringey is committed to developing local Child and Adolescent Mental Health services (CAMHS) in line with the recommendations of the National CAMHS review, which was published in 2008. The review recommended the development of a range of CAMHS services, 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 appropriately to what can be very different individual needs.

The changes proposed in the document that went out to consultation, will impact on CAMHS 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. We are currently too dependent on inpatient services, and the proposed changes are intended to develop a more mixed model of provision, whereby in patient admission, for both short and medium lengths of stay, will remain an option, but there will be more investment in and a greater emphasis on community based care.

We recognise that the service users from the Northgate clinic made a powerful presentation to the last meeting of the Joint Health Overview and Scrutiny Committee on 15th July, and that equally members of the Committee raised a number of concerns both at the meeting and in the subsequent letter that required action and a fuller response from ourselves. We welcome the opportunity to explain the actions we have taken since the meeting and to respond to the questions raised, and requests for further explanation which are provided in the attached report.

CONTACT OFFICER:

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

RECOMMENDATIONS: The Committee is asked to note the contents of the attached report and provide a formal response to the proposals described in the consultation document.

SIGNED:
Andrew Williams
Interim Borough Director – Haringey
NHS North Central London

DATE: 5th September 2011

Report for the Joint Health Overview and Scrutiny Committee

Transforming CAMHS Inpatient Services for young people living in Barnet Enfield and Haringey

NHS North Central London

19th September 2011

1. Statement of Intent

The NHS in Barnet, Enfield and Haringey is committed to developing local Child and Adolescent Mental Health services (CAMHS) in line with the recommendations of the National CAMHS review, which was published in 2008. The review recommended the development of a range of CAMHS services, 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 appropriately to what can be very different individual needs.

The changes proposed in the document that went out to consultation will impact on the CAMHS 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. We are currently overly dependent on inpatient services. The proposed changes are intended to develop a more mixed model of provision, whereby inpatient admission, for both short and medium lengths of stay, will remain an option. However, there will also be more investment in, and a greater emphasis on, community based care.

We recognise that the service users from the Northgate clinic made a powerful presentation at the last meeting of the Joint Health Overview and Scrutiny Committee on 15th July, and that equally members of the Committee raised a number of concerns both at the meeting and in the subsequent letter that required action and a fuller response from ourselves. We welcome the opportunity to explain the actions we have taken since the meeting and to respond to the questions raised, and requests for further explanation.

2. The current model

The NHS in Barnet, Enfield and Haringey currently commissions Barnet, Enfield and Haringey Mental Health Trust to provide the following services for young people with severe and 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 exclusively commissioned by NHS Barnet, Enfield and Haringey and until recently Camden. Average length of stay of 42 days.

  - *Northgate Clinic* a 12 bed NHS adolescent therapeutic unit with an average length of stay of nine months.

In addition to the two inpatient units provided by BEH-MHT, which are on the same site, it is sometimes necessary to fund admissions to inpatient units provided by other NHS providers or the private sector.

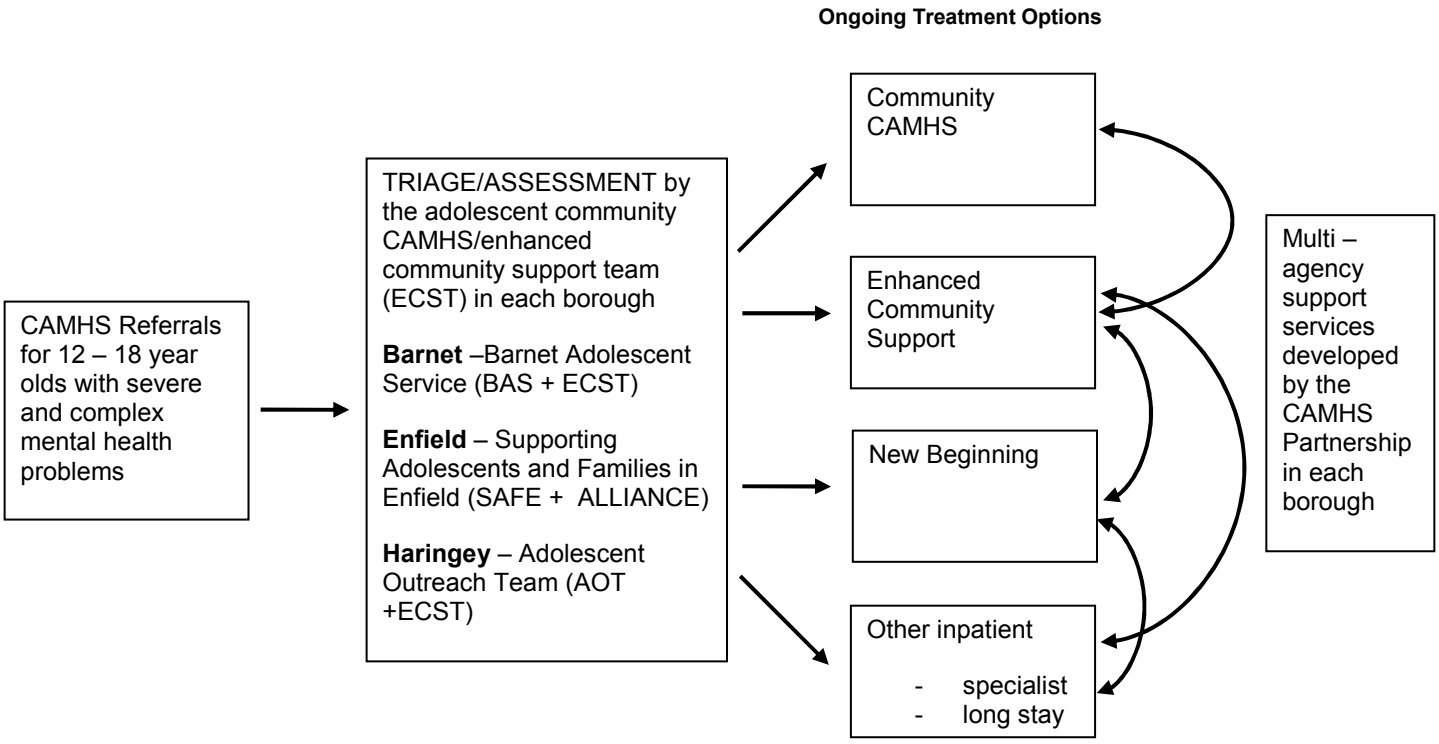
The total annual BEH CAMHS budget (across all services) is approx £17 million, of that approx 35% is spent on inpatient/residential Tier 4. In 2007/2008, which was the last year that the national CAMHS data mapping exercise was carried out, 26% of total spend nationally went on inpatient/residential Tier 4 activity. This shows an over-dependency and high spend on inpatient provision across the three boroughs due to the limited investment in community services and lack of commissioned alternative community interventions.

3. The proposed model

There is a growing body of evidence to support the development of a flexible range of inpatient, day patient, enhanced community, and community services that meet the, what can be very different, needs of children young people and their families with severe and complex mental health problems. (Green and Worrall Davies 2008, and Sergeant et all 2010). We are proposing a phased transformation of the services we commission, with an increased emphasis on prevention and early identification and intervention. Initially, we want to develop:

- New Enhanced Community Support teams in each borough based on the team piloted in Enfield in 2010/11. The teams would be based with, and work alongside, the existing Tier 3/community adolescent CAMHS Teams in each borough. This will increase capacity in community services and facilitate increased access to a range of treatments options.
- A single fit-for-purpose inpatient unit which is able to meet the needs of most of the 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, including clear referral processes to other units for more complex or specialist inpatient admissions if necessary.
- A new evidence based model of care to underpin the whole pathway, and to allow the smooth transition of young people into adult services should they continue to require help when they reach the age of 18.
- A personalised approach, which links mental health intervention with supported education, with the aim of ensuring continuity of education and maximising life chances.

This describes the preferred model of care subject to the findings of the public consultation and engagement exercises.



If the preferred model of care is agreed, young people would be referred into the adolescent community CAMHS/Enhanced Community Support teams in each borough, and a decision taken as to which pathway to follow, depending on the presenting issues, associated risk assessment, family circumstances and so on. The adolescent community CAMHS/Enhanced Community Support teams in each borough will have responsibility for maintaining oversight of all young people in:

- the existing community CAMHS/Tier 3 teams
- the new Enhanced Community Support teams/Tier 3.5,
- inpatient/Tier 4 provision,

Thereby ensuring that each young person receives a tailored package of care and that care is co-ordinated.

Currently, community CAMHS adolescent teams see patients on average 1-2 times weekly, with additional contact during times of crisis/acute emergency. This is in addition to the indirect support that the CAMHS adolescent teams provide to professional networks and carers. The Enhanced Community Support teams would work as a bridge between the existing inpatient and community services. With an Enhanced Community Service, the patient receives as many contacts per week as is necessary at the most appropriate location, if possible agreed with the young person: home, school, clinic, other community setting etc. The Enhanced Community Support teams will also see young people in inpatient units to ensure links with community services and their community are developed and maintained, with the aim of keeping inpatient stays to a minimum where possible, ensuring a planned transition back to the community, thereby minimising disruption to the home and school environment. The skill mix of the proposed Enhanced Community

Support would complement the skill mix of the existing community teams in each borough in order to maximise access to a range of treatment options.

New Beginning would be remodelled to create a new 15 bedded therapeutic environment, which offers flexibility in terms of the kind of therapy/programme offered according to the needs of the young person, and which allows for both emergency and planned admissions, including both day case and inpatient stays. It is anticipated that most young people would return to the community CAMHS/Enhanced Community Support teams after a short admission but the new model would allow for longer admissions where it is needed. The new unit will work closely with the community CAMHS/ Enhanced Community Support teams, and there will be continuity of contact with key CAMHS professionals, working as part of broader multi-agency teams that include schools. The remodelled New Beginning will be up and running from 2012/13. In the interim New Beginning will continue to operate as an acute/crisis adolescent unit, and if a young person requires a longer inpatient stay then this will be spot purchased, for example from Simmons House in Haringey.

Examples of care pathways under the proposed model

Patient 1

Referred to specialist CAMHS because of depression and severe anxiety with recent episodes of self harm. Has not attended school for 2 weeks. On assessment is found to be significantly depressed. An inpatient admission is considered, but the home situation is stable and it is agreed to refer the young person to the Enhanced Community Support team. Initially, there is daily contact with the service at home, with the focus on motivational work to support engagement in therapy. This is followed by a period of Cognitive Behaviour Therapy to address the anxiety and depression. Family work is undertaken to help the family provide the necessary support. As the young person's condition improves the Enhanced Community Support team supports transition back into school and the number of contacts is reduced. The case is subsequently transferred to the Tier 3 CAMHS Team and the young person remains at home and attends school regularly with ongoing support from Tier 3 Community CAMHS.

Patient 2

Admitted to New Beginning via Accident & Emergency, and is newly diagnosed with manic depressive disorder. After the initial crisis is over, is referred to the Enhanced Community Support team who make daily contact at the unit to support early discharge. Discharged back into the community after 2 weeks and is seen daily at home for 1 month with home tutoring provided by the education service. Condition improves and after 3 months, the Enhanced Community Support team supports transition back into school, and the case is transferred to the Tier 3 Community CAMHS Team.

Patient 3

Severe case of repeated self harm referred initially under Section 3 to a secure unit and is then referred to New Beginning. Referred to the Enhanced Community Support team at the point of transfer to support the 'step down' and facilitate earlier discharge back into the community. Because of a change in home circumstances caused by a breakdown in family relationships it becomes apparent that the young person requires a longer than

anticipated stay at New Beginning and a medium stay therapeutic regime at the unit is agreed. The Enhanced Community Support team is reengaged when discharge is being considered to support reintegration back into the community. It is no longer possible for the young person to live at home and the young person is discharged into Rodean Close, supporting people accommodation. The young person returns to mainstream school and continues to receive support from the Enhanced Community Support team.

Patient 4

Young person with emerging personality conduct disorder, at risk of exclusion from school, is referred to the Enhanced Community Support team at the point of admission to New Beginning to enable the team to support a short admission by engaging the young person as an inpatient. The Enhanced Community Support team member attends family therapy meetings with the family, and also attends meetings at school to facilitate reintegration back into school. The case is transferred back to the Tier 3 CAMHS Team but because of the relationship already established with the key worker from the Enhanced Community Support team, it is agreed that they will continue to see the young person.

4. Capacity and bed numbers in new model

If the proposal is accepted, we anticipate a reduction in demand for inpatient beds as evidenced in Enfield through the 'Alliance' pilot project. Northgate Clinic would close permanently, allowing for some of the funding for the unit to be reinvested into the adolescent community CAMHS/Enhanced Community Support teams. Until June 2011, the New Beginning unit was commissioned by 4 PCTs with access to on average 3 beds each. The remodelled unit will have 15 beds and, at least initially, will be exclusively commissioned by Barnet, Enfield and Haringey who will have access to on average 5 beds each. Our analysis of the case mix suggests that additional inpatient beds may need to be spot purchased occasionally; this will be in extremis, or to meet the needs of young people with more specialist needs e.g. forensic cases, and young people with combined mental health and severe learning disability problems. We will work with other commissioners in the NHS North Central London Cluster and other PCT Clusters, to ensure that there is an optimum mix of inpatient provision. Currently, in addition to the two unit provided by Barnet, Enfield and Haringey Mental Health Trust, we have potential access to a number of units offering a range of suitable provision including Simmons House in Haringey.

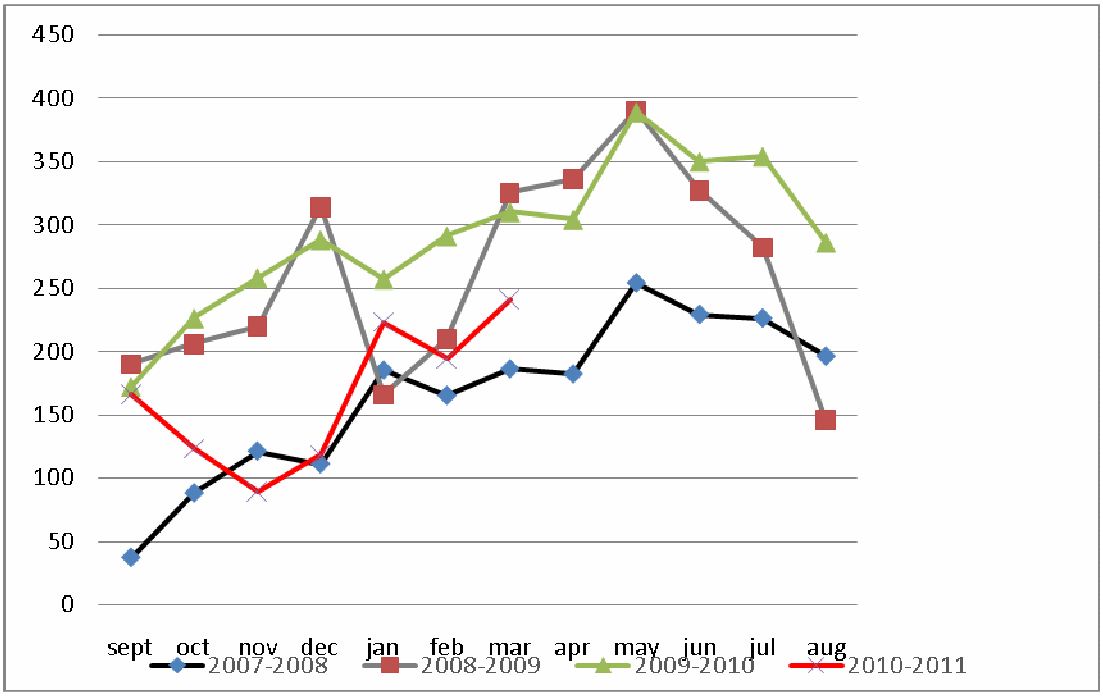
5. The evidence base

The Northgate Clinic model was developed some 30 years ago using the knowledge available at the time. Whilst some young people with severe and complex mental health problems have undoubtedly benefitted from the Northgate Clinic model, more recent evidence suggests that other modes of treatment, based on shorter admissions, can show at least as good outcomes with less disruption to the lives of young people and their carers. It has also been evidenced that keeping links with the young person's community makes the transition back to community services and every day life more successful.

There is a growing body of evidence to support the development of a flexible range of inpatient, day patient, enhanced community, and community services that meet the, what can be very different, needs of children young people and their families with severe and

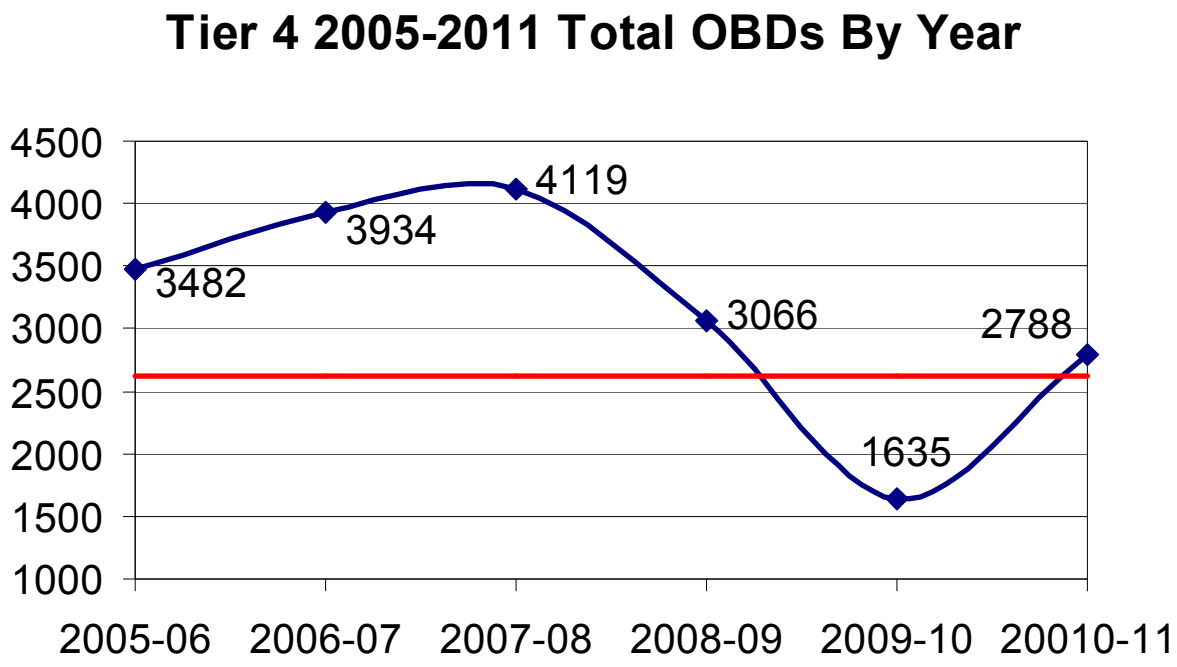
complex mental health problems. (Green and Worrall Davies 2008, and Sergeant et all 2010).

We know from the work of the Alliance Team in Enfield, who have piloted the Enhanced Community Support team model, that that over the first nine months of the pilot inpatient admissions were reduced by 176 days. As can be seen from the following graph there has been an overall reduction in the number of bed days being used for all admissions to Tier 4 services.



Looking at impact on individual cases, of the 23 young people referred to Alliance in the first 6 months of the pilot: 12 did not require inpatient admission, 5 required inpatient admission but length of stay was reduced, 1 was an inpatient with no change of length of stay and there were 5 open cases at the end of the period so impact could not be assessed. Whilst not all of the young people who did not require inpatient admission would have needed it if Alliance had not existed, this sample gives an idea of how we expect the model to work going forward and reflects what other people have found elsewhere.

In Islington, an intensive piece of work had been done since 2007/08 to reduce Tier 4 admissions - using a similar model to that being proposed in Barnet, Enfield and Haringey. There was additional investment into the Assertive Outreach Team (Enhanced Community Support team), of a similar order to that being proposed in Barnet, Enfield and Haringey. Simmons House, which was then a medium stay unit with a similar ethos to Northgate Clinic, was re–commissioned to take emergency as well as planned admissions, with a reduced length of stay for the latter, so that 3 to 6 months is the norm. The impact on number of Overnight Bed Days is shown in the graph below.



The links between the Enhanced Community Support team and Simmons House have been highlighted as being critical to the success of the model. In the model proposed for Barnet, Enfield and Haringey, continuity will be established through the Enhanced Community Support Teams.

The evidence base for the proposal is strong, and based on similar service models successfully introduced elsewhere. We have looked at a range of units, including Brookside and the Coburn Unit which are local units, where there is integrated, step up/step down provision on the one site, including intensive care/high dependency, acute/crisis, medium stay and day care provision, with close integration with, and pathways into, community provision. This has been demonstrated to be effective in terms of both standards of care with improved outcomes and reduced costs.

6. Finance

Commissioning intentions were to increase investment in community provision and reduce the number of, and length of stays in high cost Tier 4 inpatient provision. If the proposal to close Northgate goes ahead it will free up resources. Commissioners plan to reinvest £650k to develop the new comprehensive community model. This is in addition to the £125k that has already been invested into the Alliance Team in Enfield. In setting the financial envelope for the new service at £775k, commissioners took account experience from elsewhere, and the impact that the Alliance Team has had in its first year of operation, for an investment of £125k.

If a specialist inpatient placement is required at another unit, then the placement will be funded by commissioners.

The development of the proposal has been overseen by a multi-agency project group made up of Local Authority and Health Commissioners, and Mental Health Trust colleagues. If the proposal is approved, this group will continue to meet monthly to oversee the implementation of the new model, monitor the impact of the changes, including on individual young people, and make adjustments where necessary.

7. Education

If a child or young person is sent out of their borough of residence for treatment, the responsibility for education remains with the borough of residence. Responsibility will also remain in part with the school the young person is on roll with. Currently young people who are patients of New Beginning and Northgate Clinics are able to attend the Northgate Pupil Referral Unit (PRU), which is on the same site and provided by London Borough of Barnet, who then bills the borough of residence for the cost through recoupment arrangements.

A recent Ofsted inspection recognised the high quality education provided by Northgate PRU, and graded it as outstanding in terms of both overall effectiveness and capacity for sustained improvement. The decision taken about the Northgate Clinic will have implications for the PRU. Thus, Barnet Council is looking into available options, in discussion with the relevant leads from the core service users i.e. Enfield and Haringey Councils. Leads from other councils who have also used the service will be kept informed of developments.

There is agreement across the leads in the core councils that we need to work together to ensure that there is a sustainable model for the education of young people with severe and complex mental health problems in the short term, and thereafter to look at medium and long term options. In terms of the proposed new community based model, in putting greater emphasis on prevention and early identification and intervention, our intention is to work closely with PRUs, special and mainstream schools and colleges, with the aim of ensuring continuity of education and maximising life chances, through personalised approaches which link mental health intervention with supported education.

Where an inpatient admission to New Beginning is needed we would be working with the young person's school primarily to offer education packages which are tailored to the young person's need. These can be delivered in association with the home/hospital tuition services that exist in each borough, or by Northgate PRU. On completion of the inpatient episode, our aim would be to ensure a supported return to school on discharge back into the community, including back into mainstream schooling.

If a young person needs an admission to an in-patient clinic other than New Beginning, then access to education will be considered when making decisions about the spot purchase arrangements. Education remains a priority for all our young people.

There are multi-agency complex needs panels in each of the three boroughs, and terms of reference will be amended to ensure that these panels have responsibility for ensuring that there is an integrated package of care, including education, in place for all young people in, or requiring a stay in, an in-patient adolescent mental health unit.

8. Transition arrangements

The Northgate Clinic is currently only closed to new referrals, and stopped accepting new referrals in January 2011, with the last patients discharged at the end of March 2011. The Clinic has not been permanently closed. If the outcome of the consultation is not to implement the new clinical model and not to close Northgate Clinic, the unit will begin accepting referrals and become fully operational once more.

We now appreciate that the decision to stop accepting new referrals to Northgate Clinic has given people the understandable impression that we were pre-empting the outcome of the consultation, this was not our intention and we apologise for any distress this may

have caused. Our first priority has been towards the patients we provide care to. In this case, a decision was taken that Northgate Clinic could not continue to admit patients for year long care and treatment with the threat that once the consultation was complete the Clinic would be closed and their care cut short. Thus, a carefully planned clinically led process was put in place to stop admission for the duration of the consultation, with existing patients moved onto other services as numbers fell below optimum levels to maintain a safe and effective service.

9. Engagement Process

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

The consultation started on Tuesday 3rd May 2011, and was originally intended to close on Tuesday 26th July 2011, however on the advice of the Joint Health Overview and Scrutiny Committee it was extended to 2nd September 2011 to allow for further consultation with young people. There was a press release announcing the start of the consultation, which included information about where the consultation document could be found, and the consultation document and a letter outlining the proposals and requesting a response was sent to wide range of stakeholders, including local politicians (Councillors, MPs and MEPs), Directors of Council Adults and Children's Services, Children's Trust Chairs, Overview and Scrutiny Committee Chairs, the Chair and Secretary of Local Medical Committees, GP Consortia Leads, NHS Trust Chief Executives and the Chair of the Link in each borough.

There was concern about the low level of responses, and a further press release was issued at the beginning of July 2011, and a reminder was sent to the stakeholders included in the original cascade. The consultation was also promoted through other press and media avenues including Local Authority websites and newsletters, and local youth media.

A list of meetings, where the consultation document was presented or discussed is attached as Appendix A. In addition to presenting the proposal for response at a range of children's commissioning and partnership meetings across the three boroughs, 10 focus groups were held with young people including existing and ex-service users

Whilst acknowledging the concerns of the JHOSC, that normally August is considered a quiet month for consultation, in this instance it has proved particularly productive as young people on holiday and not attending school have had time to contribute to the consultation fully.

10. Next Steps

The Consultation finished on 2nd September 2011, and the deadline for completion of the Consultation Report is 9th September 2011, at which point it will be published on the main NHS and Council websites and will be available to the JHOSC. A final decision about the proposal will be taken by the Joint Committee of Primary Care Trusts at its meeting on 29th September 2011 and the Committee will take account of the views of the Consultation Report and the JHOSC when making its decision.

Whatever the outcome of this report, we plan to utilise the work with service users and key members of staff working within mental health services, and to further engage with our

service users and ex service users to help develop and improve local mental health services for Barnet, Enfield and Haringey.

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Appendix A

Transforming CAMHS Inpatient Services for young people in Barnet, Enfield and Haringey

Consultation Summary

Stakeholder/Stakeholder Group	Lead for consultation	Form of consultation	Date
London Borough of Enfield, Schools and Children's Service DMT	Claire Wright	Part of regular update	04/05/11
London Borough of Enfield, Schools and Children's Service DMT	Claire Wright	Substantive item on the Agenda – presentation and discussion	06/07/11
Integrated (multi-stakeholder) Planning Group: Emotional Wellbeing and Mental Health Haringey	Sarah Parker and Shaun Collins	Substantive item on the Agenda – presentation and discussion	09/05/11
London Borough of Enfield Commissioning Group	Claire Wright	Substantive item on the Agenda – presentation and discussion	17/06/11
London Borough of Enfield CAMHS Joint Commissioning Group	Claire Wright	Substantive item on the Agenda – presentation and discussion	20/06/11
London Borough of Barnet – Executive Management Group	Vivienne Stimpson	Substantive item on the Agenda – presentation and discussion	11/05/2011
London Borough of Barnet – Children's Trust	Vivienne Stimpson	Presented and noted by the Childrens Trust Board and feedback encouraged	09/062011
Enfield Youth Parliament	Claire Wright	Agreed format for young peoples consultation used	05/07/2011
Enfield Council Health and Wellbeing Overview and Scrutiny	Claire Wright	Substantive item on the Agenda – presentation and discussion	07/07/2011

Stakeholder/Stakeholder Group	Lead for consultation	Form of consultation	Date
Barnet, Enfield and Haringey -Joint Health/LA meeting	Sarah Parker	Dedicated meeting to discuss the proposals	08/07/2011
Barnet Young People's Meeting	Vivienne Stimpson	Presentation and discussion	03/07/2011
Enfield Children's Trust	Claire Wright	Substantive item on the Agenda – presentation and discussion	15/07/2011
Joint Health Overview and Scrutiny Committee	Emma Stevenson	Substantive item on the Agenda – presentation and discussion	15/07/2011
Enfield Alliance patients – Focus Group	Sam Morris and Claire Wright	Agreed format for young peoples consultation used	26/07/2011
Alliance patients – Focus Group	Sam Morris and Claire Wright	Agreed format for young peoples consultation used	28/07/2011
Northgate patients – Focus Group	Sam Morris and Emma Stevenson	Agreed format for young peoples consultation used	04/08/2011
Haringey young people in the Youth Offending Service – Focus Group	Elizabeth Stimpson and Sarah Parker	Adapted format for young peoples consultation used	24/08/2011
Haringey CAMHS Adolescent Outreach Team – Focus Group	Sarah Parker	Adapted format for young people's consultation used	25/08/2011
Haringey Opendoor (voluntary sector organisation providing CAMHS) – Focus Group	Sarah Parker	Adapted format for young people's consultation used	01/09/2011

Stakeholder/Stakeholder Group	Lead for consultation	Form of consultation	Date
with young people			
Haringey Opendoor (voluntary sector organisation providing CAMHS) – Focus Group with parents	Sarah Parker	Discussion about the proposals in the Consultation Document which they had been sent in advance.	01/09/2011
Enfield CAMHS Supporting Adolescents and Families in Enfield – Focus Group	Elizabeth Stimpson and Claire Wright	Adapted format for young people's consultation used	01/09/2011
Barnet Adolescent Service – Focus Group	Elizabeth Stimpson	Adapted format for young people's consultation used	02/09/2011
To note			
Barnet Overview and Scrutiny Committee	Vivienne Stimpson	Outcome of consultation requested as an item	20/09/2011
Haringey Overview and Scrutiny Committee	Sarah Parker	Consultation on the proposal offered as an item, but not required as being considered by the JHOSC on the 15/07/2011	June 2011
Haringey Children's Trust	Sarah Parker	Proposed item for Children's Trust on 19th July 2011, but omitted from the Agenda in error. Consultation document has been circulated to members with request for comments on the proposal.	July 2011
Clinical Commissioning Consortia in Barnet, Enfield and Haringey	Vivienne Stimpson, Claire Wright and Sarah Parker	Proposal circulated for response	August 2011

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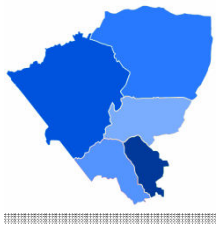
North Central London

QIPP Update

Lorraine Robjant

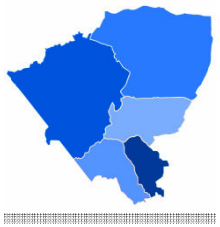
Assistant Director of Service Transformation, Financial Recovery and Programme Management Office

www.ncl.nhs.uk



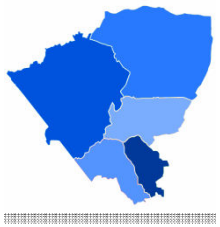
QIPP

- Quality: long term conditions, referral management, mental health transformation
- Innovation: new care pathways and collaborative initiatives e.g. urgent care and virtual ward
- Productivity: acute and primary care
- Prevention: long term conditions; mental health pathways



QIPP Workstreams

Clinical Areas	QIPP Workstreams	Enablers
Unscheduled Care	*Acute Productivity*	*Aligning Incentives*
Care Closer to Home	*QIPP in Primary Care*	*Workforce*
Mental Health	*Decommissioning, thresholds and LPTs*	*IT*
Cardiovascular	*Operating and management Costs*	*Estates*
Cancer	*Medicines Management*	
Maternity	*Staying Healthy*	
Paediatrics	*PCT Community Service schemes*	



QIPP

Target for 2011/12 - £137 million

- Scope and design - £ 24million
- Implementation - £ 113 million

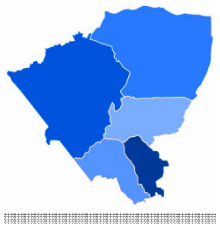
Performance against target

- Forecast outturn - £ 105 million
- Shortfall against plan - £ 32 million

QIPP Plan Implementation

80 red rated projects	• Value of £40m
59 amber rated projects	• Value of £22m
167 green rated projects	• Value of £51m

306 projects currently being implemented - value of £113m



QIPP Full Year 2011/12

- Forecast 78% achievement before further impact of recovery plan
- Recovery plan under development where slippage has occurred
- Further non-acute £10.4m QIPP stretch gap (£3.5m identified so far)

Programme	Annual plan £m	Forecast £m	Variance £m	% Achieved
Acute Productivity	46.7	24.1	-22.6	51.7%
Cardiovascular	0.1	0.1	-0.0	76.3%
CC2H	4.9	4.0	-1.0	80.3%
Unscheduled Care	1.6	1.4	-0.2	87.8%
PLCEs	11.3	2.9	-8.5	25.3%
Decommissioning And Clinical Thresholds	1.5	0.1	-1.4	8.8%
Medicines Management - Acute	5.1	4.4	-0.8	84.9%
Transitional support to trust productivity	0.0	17.5	17.5	
Acute	71.3	54.4	-16.9	76.3%
Specialist Commissioning	4.1	4.1	-0.0	100.0%
Medicines Management - Borough	4.2	4.2	0.0	100.0%
Mental Health	6.6	4.5	-2.1	68.1%
QIPP In Primary Care	2.3	1.3	-0.9	59.7%
Local QIPP	14.1	16.4	2.2	115.7%
Management Costs	10.1	8.2	-1.9	81.2%
Non acute	41.3	38.6	-2.7	93.5%
Stretch QIPP	25.0	14.6	-10.4	58.4%
Total QIPP	137.6	107.6	-30.0	78.2%

Additional Opportunities

- Recognise some schemes will slip
- Need to identify further opportunities:
  - in new areas as part of external review
  - by spreading current initiatives more widely across the cluster
  - by accelerating delivery of existing schemes
  - And, by benchmarking our cluster against others to identify improvement areas

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Safe and Sustainable

Children's congenital heart services in England

NHS

Specialised Services

Children's Congenital Heart Services in England

Simon Williams – Divisional Director NWL
London Specialised Commissioning Group

Clinicians and parents have asked for this review to ensure:

- Better diagnosis and follow-up care closer to patients' homes
- Fewer deaths and complications following the surgery
- Shorter waiting times for surgery
- Better trained surgeons
- Excellent care for all children– no postcode lottery!

We are now consulting on four areas…

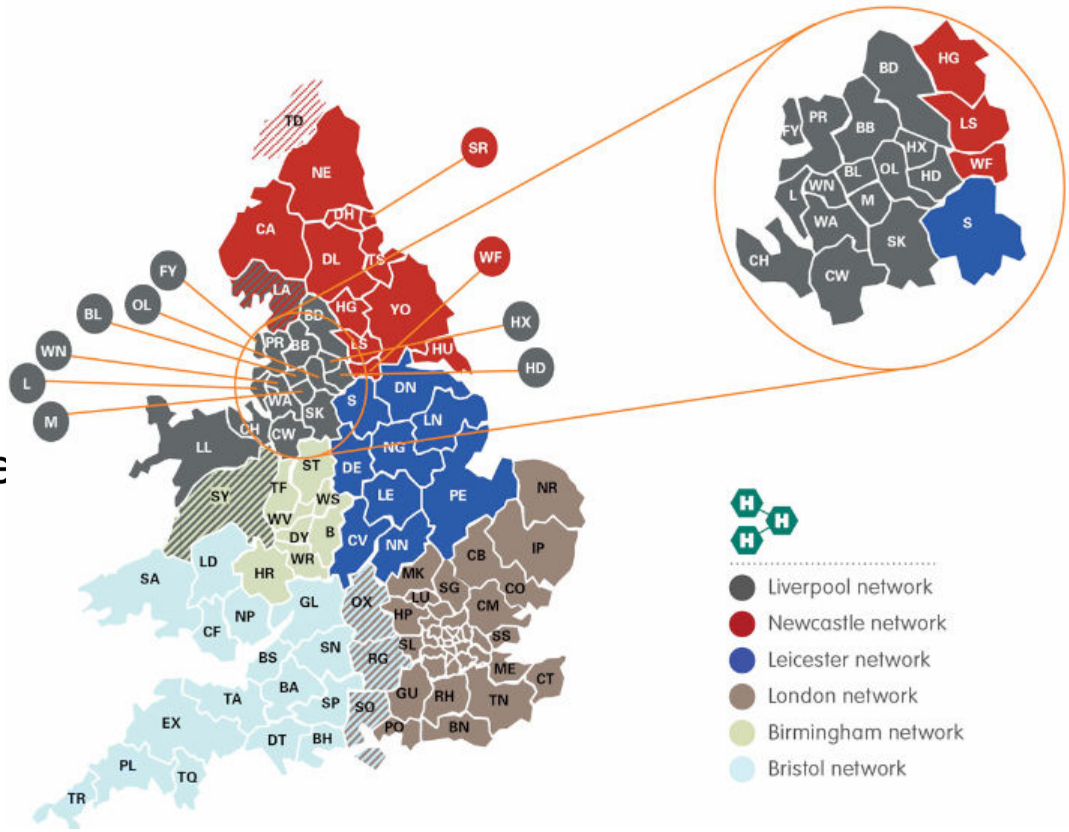
- **Standards of care**
  - NHS wants better care for everyone
  - Are they the right standards?
- **Congenital heart networks**
  - Networks would strengthen the local assessment services
  - Is this the right model of care?
- **Larger surgical centres**
  - Reduce from 11 to 6 or 7
  - Do you agree that fewer larger centres improve outcomes for children?
- **Measuring quality**
  - New systems for the analysis and reporting of mortality and morbidity data
  - Do you agree new systems are necessary?

Option A

Option A

Seven surgical centres at:

- Freeman Hospital, Newcastle
- Alder Hey Children's Hospital, Liverpool
- Glenfield Hospital, Leicester
- Birmingham Children's Hospital
- Bristol Royal Hospital for Childre
- 2 centres in London

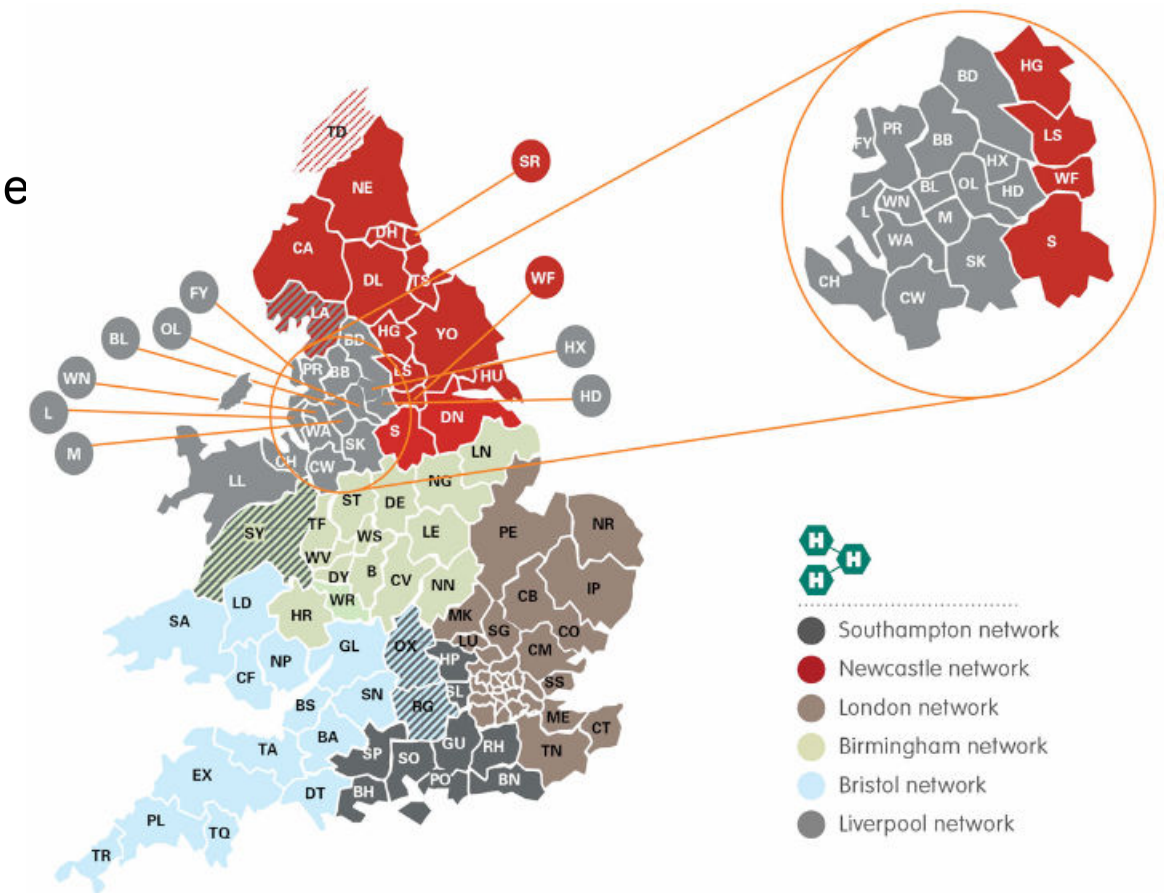


Option B

Option B

Seven surgical centres at:

- Freeman Hospital, Newcastle
- Alder Hey Children's Hospital,
- Liverpool
- Birmingham Children's Hospital
- Bristol Royal Hospital for Children
- Southampton General Hospital
- 2 centres in London

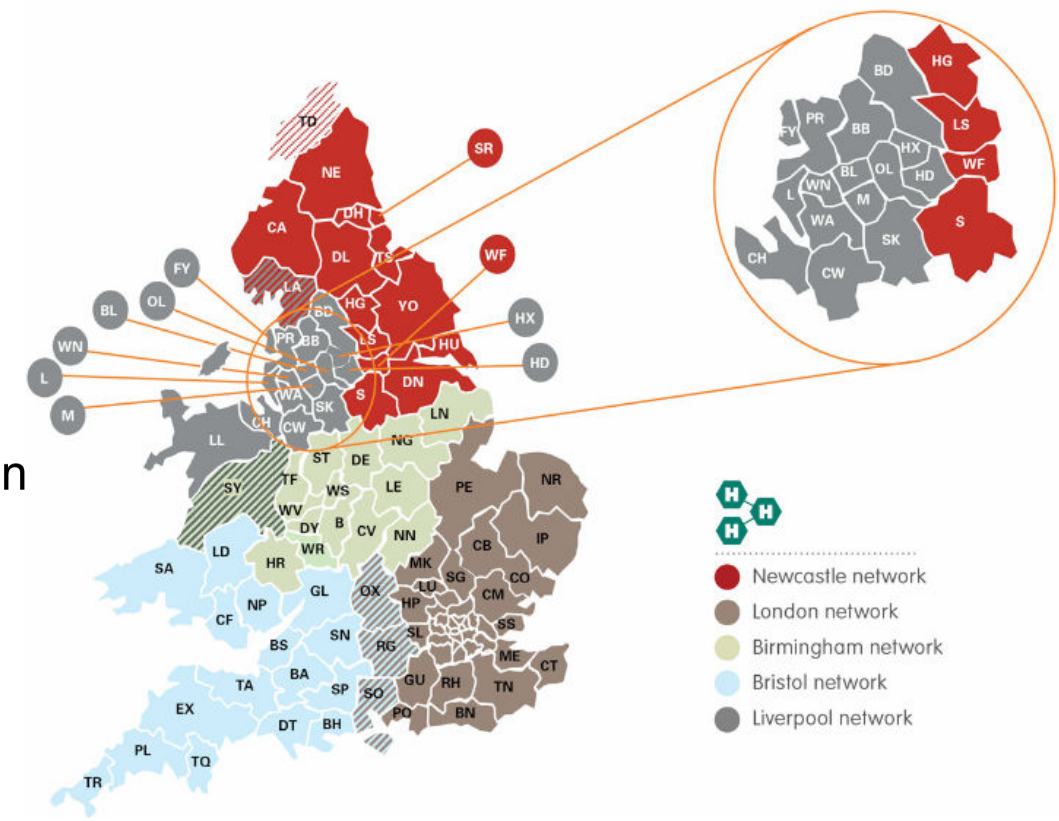


Option C

Option C

Six surgical centres at:

- Freeman Hospital, Newcastle
- Alder Hey Children's Hospital, Liverpool
- Birmingham Children's Hospital
- Bristol Royal Hospital for Children
- 2 centres in London

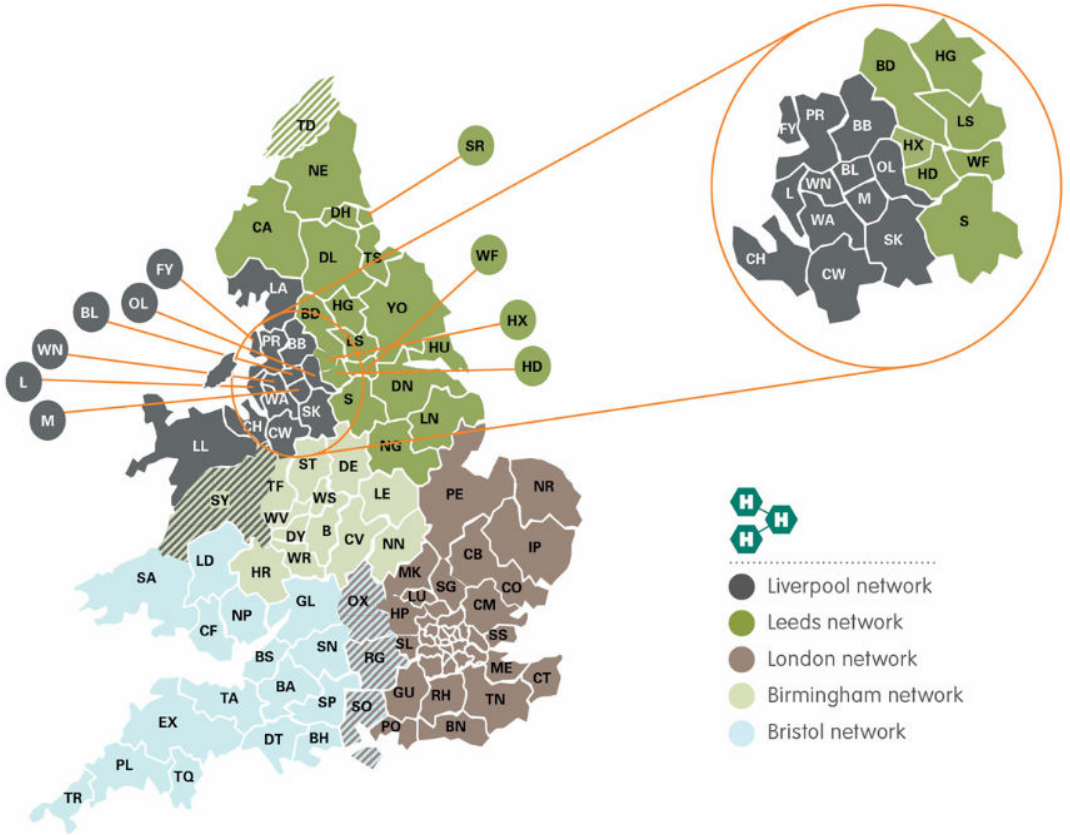


Option D

Option D

Six surgical centres at:

- Leeds General Infirmary
- Alder Hey Children's Hospital, Liverpool
- Birmingham Children's Hospital
- Bristol Royal Hospital for Children
- 2 centres in London



2 centres are proposed for London

- JCPCT recommended that two surgical centres is preferred to cover the populations of London, East of England and South East England.
- The question of whether two centres in London is the right number is being asked during consultation as well as which two centres they might be.

Why 2 centres?

- The forecast activity levels for London and its catchment area (currently around 1,250 paediatric procedures per year) mean that two centres would be well placed to meet the proposed ideal number of 500 procedures a year.

Why not 3 centres?

- With three London centres achieving the ideal procedure numbers, patients would have to be diverted from neighbouring catchment areas into London.
- Our analysis shows this would significantly, and unjustifiably, increase travel times and impact on access for patients outside of London, South East and East of England.

Why GOSH & Evelina?

- Evelina was the highest ranked centre in England.

- GOSH has three nationally commissioned services in their current location (cardiothoracic transplantation, ECMO and complex tracheal surgery) which would need to be re-located if GOSH were not designated.

- Because the PICU at the Royal Brompton Hospital exists predominantly to support cardiac surgery, it scored lower than the Evelina Children's Hospital on the sub-criterion involving 'the negative impact for the provision of paediatric intensive care and other interdependent services is kept to a minimum'.

Interim findings from the Public Consultation – key messages

- Mori's independent report shows there is strong support (75% of individuals) for the proposal to have two not three surgical centres in London. Just 12% of individuals did not support the proposal – some wanting three centres, some wanting just one.
- The analysis also shows that the majority of those who responded support the notion that GOSH and Evelina should carry out surgery – there is much less support for the Royal Brompton Hospital.
- Of those responding, two thirds supported the proposal (65%), 8% preferred Royal Brompton and GOSH, 16% preferred Royal Brompton and Evelina while 11% said none of these.
- Of those respondents who didn't specify a preferred option, there was strong support for GOSH and Evelina (ranked third and fourth for preference) to be part of a future configuration of services. There was less support for the Royal Brompton – tenth overall just ahead of Oxford.
- No decisions will be made until later in the year.
- The Royal Brompton has raised concerns about the potential impact of the proposed changes on some of their other services – we have therefore asked a group of independent experts to review the evidence and provide their advice to the decision makers.

Key dates

16 February 2011- Joint Committee of Primary Care Trusts (JCPCT)

1 March 2011 – consultation on the 4 options launched

1 July 2011 - consultation closes

5 October 2011 – OSC consultation closes

Winter 2011/12 – JCPCT to make a decision on the final reconfiguration

April 2013 – the new centres and networks expected to be operational

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Agenda Item 8

North Central London CardioVascular & Stroke Network

North Central London Joint Health Overview and Scrutiny Committee

Title	**Heart Failure Community Clinic Pilot**
Date	**19th September 2011**
Report of	**NCL Cardiovascular and Stroke Network**
Author	**Caroline Cook**
Paper for	**Information**

1. Introduction

This paper provides a summary of the intention to pilot a community based heart failure clinic in South Camden.

2. Background

It is estimated that Heart Failure affects 1 – 2% of the population in the UK and the incidence and prevalence of heart failure increase significantly with age. Although there has been a decline in mortality from coronary heart disease, there has been a subsequent increase in patients living with heart failure. As this is a condition which mainly affects older people, it will become more prevalent with the aging population[1].

The prognosis for heart failure is not good, with 14% of newly diagnosed patients dying within the first six months[2] and the average life expectancy approximately 3 years following diagnosis[3]. The effects of heart failure on a patient's quality of life can be significant, mainly due to the physical limitations of the condition which then leads to social limitations and possibly anxiety and depression.

In recently published data from the National Heart Failure Audit, the mean length of stay in the UK was nine days following a heart failure admission, much higher than the European average. Mortality from heart failure admission is also significantly higher in the UK than in Europe.

The expenditure for heart failure is high and accounts for approximately 1 – 2% of the NHS budget. This equates to approximately £625 million, of which about 60% is inpatient costs. In addition, heart failure accounts for approximately 5% of admissions, and readmissions within three months have been estimated up to 50%[4]. Heart failure also places a burden on primary care, with patients needing 11 to 13 contacts per year with a member of the primary care team.

[1] Bridging the quality gap: Heart failure (2010)
[2] Heart, vol 95, pp 1851 – 56 (2009)
[3] Managing chronic heart failure: learning from best practice (2005)
[4] National Heart Failure Audit. Second report for the audit period between July 2007 and March 2008 (2008)

North Central London
CardioVascular
& Stroke Network

3. Heart Failure in North Central London

According to the Quality Outcomes Framework (QOF) data for 2009/10, there are approximately 1.38m patients registered with North Central London GP practices. It should be expected that, for the NCL Cluster, 16,600 patients are on the GP practices' heart failure registers (based on an estimated prevalence of1.2%). However, the OQF data also shows that in 2009/10 there were only 7599 patients recorded on disease registers, leaving approximately 9,000 undiagnosed. This is significant as early diagnosis and initiation of medication is crucial to increase life expectancy and improve quality of life. This also has an impact on the financial burden on the NHS as health costs associated with the most severe symptoms are between 8 and 30 times greater than those with mild symptoms[5].

Cluster-wide, a small to moderate increase in those over 65 diagnosed with heart failure is expected between 2010 and 2016[6], and, recent calculations by the NCL Cardiovascular and Stroke Network predict that the Cluster should expect approximately 1024 new cases of heart failure per year. Standardised Hospital Episode Statistics data for 2008/09 shows that admissions rates for heart failure were higher for the NCL Cluster, than London and England. Mortality rates for 2006 – 2008 were also higher in NCL Cluster than London and England, according to the Office of National Statistics.

In spring 2010, work began on an exemplar heart failure pathway and service specification for NCL, but was halted due to lack of capacity and a restructuring within the NHS. Furthermore, new NICE Guidance was published in August 2010, which recommended new ways to deliver integrated care to patients with heart failure, including diagnosis and assessment by a heart failure specialist and the provision of care by a multi-disciplinary team to ensure the best possible clinical outcomes.

4. Proposed Change

The current model of heart failure services in NCL, in which provision of care is across three sectors, results in duplication of some services, inefficiency, and a narrow perspective. Many patients with heart failure do not require access to technology only available in secondary care and the overwhelming majority can be managed using echocardiography and blood tests in a community setting. Therefore, there should be no barrier to providing the majority of heart failure services within a primary care or community context.

In light of this, and the latest published NICE Guidance, the project team within the NCL Cardiovascular and Stroke Network are currently developing a business case to undertake a pilot which would transfer the patients seen by a heart failure specialist in UCH into a community based clinic. As recommended in the NICE Guidance, the clinic will be staffed by a multi-disciplinary team led by a heart failure specialist. In addition to a consultant cardiologist, this team will consist of a GP with a specialist interest in heart failure, heart failure specialist nurses, phlebotomists and cardiac technicians, as well as administrative staff. The service will integrate primary and secondary care services, ensuring patients receive 'joined up' care and are less likely to 'slip through the net'. It will aim to ensure patients are managed in the community and their medication is optimised to avoid unnecessary admissions. This new model of care, together with an

[5] European Journal of Heart Failure, vol 3, pp 283-91 (2001)
[6] North Central London Strategy Plan 2010-2014 (2010)

increased uptake of NT-proBNP testing in primary care, should also lead to an increase in early diagnosis of patients with heart failure.

Echocardiogram facilities will be available on-site to diagnose new patients with a raised NT-proBNP or confirm heart failure for patients whose diagnosis has not been previously confirmed by an echocardiogram. Patients will be assessed by a heart failure specialist to determine severity and aetiology and a management plan will be developed with the MDT together with patients and carers. Medication will be initiated and up-titrated until optimised. Once optimised patients will be offered a referral to cardiac rehabilitation and other relevant support services, such as, social care or palliative care. All patients will be given information about their condition and lifestyle advice on diagnosis and this will continue to be promoted at further appointments. Patients will be discharged back to their GP with their management plan for continued monitoring when this is clinically appropriate. However, following discharge GPs will still be able to access specialist advice from the clinic or arrange a face to face review by a member of the team if required.

The Heart Failure Pathway Redesign is already within the NCL Cardiovascular Disease (CVD) QIPP Programme and expects to transfer heart failure care across the Cluster into a community setting. It may, however, be unwise to do this with a high risk patient group. A pilot would provide an opportunity to test the service model with a smaller group of patients and make amendments (using a PDSA approach) before rolling the pathway out across the Cluster. The pilot will be evaluated after six months to ensure it is safe, producing the best possible clinical outcomes, improving patients' perceived quality of life, improving access to services, improving patient experience, is working towards reducing health inequalities and is providing value for money.

If the business case is approved, it is expected that the clinic will be operational at the beginning of January 2012 and will be evaluated after six months.

5. Impact

It is anticipated that the proposed service will have a positive impact on the health of the NCL Cluster population. The model promotes early detection and diagnosis of heart failure, which leads to improved clinical outcomes for patients. Transfer of care into the community and greater integration with primary care will mean patients will have much easier access to specialist heart failure knowledge, care and support. Having access to a multi-disciplinary team will mean that patients are seen by the clinician most appropriate for their needs and will be easily referred on to appropriate support services.

An Equality and Diversity Impact Assessment has been undertaken and will be submitted to the NCL Board for approval with the business case. This demonstrates that there should be no detrimental effects on and does not discriminate against any groups with protected characteristics.

6. Stakeholder Engagement

Key stakeholders have been involved with the development of the pathway and service specification through the NCL Heart Failure Task Group, whose membership includes secondary care clinicians, heart failure nurse specialists, public health representatives and members of the NCL Cardiovascular and Stroke Network. Primary care and

commissioning representatives have attended to participate in discussions around the pathway and specification. Patient representatives will be included on the membership at future meetings.

At the time of writing, a Steering Group is being established which will take this project forward. The Steering Group membership will include a UCLH heart failure consultant, NCL commissioning representatives, a GP, a heart failure nurse specialist, representatives of the Camden and Islington Local Presences and UCL Partners.

It is also planned to provide information for discussion to the NCL Patient Advisory Panel at their meeting on 12th September 2011. The Panel will be presented with a consultation paper in advance of the meeting and will be asked to feedback on a number of points. The project manager will attend to receive these comments and also to facilitate an open discussion. The feedback will then be incorporated in to the service model and specification before these are approved.

7. Next Steps

Action	Timescale
Business case for pilot agreed by NCL Senior Leadership Team	30th September 2011
Service specification approved	30th September 2011
Service operational	2nd January 2011

8. Conclusion

The Committee is asked discuss the proposal and provide feedback on the proposed changes.

From the Rt Hon Andrew Lansley CBE MP
Secretary of State for Health

Department of Health

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Joint Health Overview and Scrutiny Committee
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19 JUL 2011

Dear Councillor Bull,

Thank you for your letter of 24 June 2011 on behalf of the Joint Health Overview and Scrutiny Committee for north central London about medicines management. It is encouraging to hear of the savings you have achieved from local prescribing budgets.

In your letter, you refer to the increasing cost of specially manufactured medicines ('specials'). The Department is aware of the cost to the NHS of these medicines and we also recognise that the system needs to be reformed. We are working with the Pharmaceutical Services Negotiating Committee (PSNC), who represents pharmacy contractors in discussions with the Department, on proposals for new payment arrangements for these products.

The Drug Tariff, a Secretary of State determination, outlines what NHS dispensing contractors will be paid for the products supplied as part of providing pharmaceutical services and the fees for providing those services.

As you know, specials may be prepared in the dispensary by the contractor (referred to as extemporaneous dispensing) or manufactured by a third party. Whether a pharmacist chooses to extemporaneously prepare the product or obtain it from a specials manufacturer may depend upon various factors, for example the availability of the raw materials, the business of the pharmacy that day, the staff available that day and the number of other unlicensed medicines required that day. However, as these products are not listed in the Drug Tariff, payment is based on how the product is sourced – where it is prepared in the dispensary, the contractor will be paid the cost of the ingredients along with a fee for

preparing the product but where it is sourced from a third party they will be paid the invoice price of the product.

In 2005, the Department issued *Proposals to simplify the reimbursement arrangements for NHS dispensing contractors: A consultation*, which included proposals for the simplification of specials reimbursement. The aim of the proposal was to create a more transparent system for specials reimbursement linking the cost of reimbursement to the cost of the product while providing value for money for the NHS. Following the consultation, DH progressed those areas, which were considered critical before returning to specials.

This is a complex area and I am sure you will understand the need to maintain a degree of flexibility in reimbursing contactors to ensure that these specialised medicines continue to be available for individual patients. As part of this work, we are looking to increase opportunities for saving in this area, although the diversity and number of preparations makes particularly challenging.

You also ask who will be responsible for securing best value from medicines procurement in the modernised NHS. The NHS Commissioning Board will be responsible for holding primary care contracts. Without wishing to pre-empt the Board's future decisions in any way, we would nevertheless expect it to have due regard for securing best value from procurement and use of medicines as it takes this work forward.

You will no doubt be aware that, on 8 July 2011, Sir David Nicholson, Chief Executive of the NHS and Chief Executive designate of the new Board published his initial thoughts on the design of the new NHS Commissioning Board in *Developing the NHS Commissioning Board.* Further information is available at:
http://healthandcare.dh.gov.uk/commissioning-board/

I hope this is helpful.

Yours ever.

ANDREW LANSLEY CBE

NHS NCL overview on ‘specials’ within overall Medicines Management:

NHS NCL recognise this is an area of spend and that efficiency savings need to be made. ‘Specials’ work is a key part, and initiative, of medicines management for QIPP. This work is being led at borough level by the medicines management teams and has two work streams. These are:

1. Work with acute trusts to reduce transfer to GPs for specials initiated or recommended by acute trust clinicians, and consider facilitating supply of specials initiated by GPs to acute trusts
2. Reduction in specials expenditure through audit and follow up with individual practices. Measure latest cost per 1000 patients. London target<£200/quarter

Both of these workstreams are already beginning to make savings.

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