NOTICE OF MEETING

NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

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Friday 19 July 2013 10:00 a.m.
Camden Town Hall Judd Street, London WC1H 9JE

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), Jean Kaseki and Martin Klute (L.B.Islington),

Support Officers: Andrew Charlwood, Linda Leith, Robert Mack, Peter Edwards and Shama Sutar-Smith

AGENDA

1. WELCOME AND APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST (PAGES 1 - 2)

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

3. URGENT BUSINESS

4. MINUTES (PAGES 3 - 12)

To approve the minutes of the meeting of 6 June 2013 (attached).

5. THE WHITTINGTON HOSPITAL - TRANSFORMATION PROGRAMME AND FOUNDATION TRUST STATUS UPDATE (PAGES 13 - 26)

To report on Whittington Health's transformation programme and progress towards foundation trust status.

6. LEADERSHIP OF SERVICE CHANGE IN THE NEW NHS (PAGES 27 - 32)

To consider how strategic direction for health services will be provided under the new arrangements for health.

7. FAILING GP PRACTICES

To consider arrangements to address failing GP practices.

8. CANCER AND CARDIAC SERVICE RECONFIGURATIONS (PAGES 33 - 36)

To update the Committee on proposed cancer and cardiac service reconfigurations.

9. WORK PLAN AND DATES FOR FUTURE MEETINGS (PAGES 37 - 38)

9 July 2013

Agenda Item 2

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
6 June 2013

Minutes of the meeting of the NCLS Joint Health Overview and Scrutiny Committee held at Islington Town Hall on 6 June 2013

Present

Councillors	**Borough**
Gideon Bull (Chair)	LB Haringey
Peter Brayshaw	LB Camden
Alison Cornelius	LB Barnet
John Roger Kaseki	LB Islington
Martin Klute	LB of Islington
Graham Old	LB Barnet
Barry Rawlings	LB Barnet
Anne Marie Pearce	LB Enfield
David Winskill	LB Haringey

Support Officers

Rob Mack	LB Haringey
Peter Edwards	LB Islington
Andrew Charlwood	LB Barnet

1 ELECTION OF CHAIR AND VICE-CHAIR

Resolved that:
1. Councillor Gideon Bull be elected as Chair of the Committee for the municipal year 2013/14; and
2. Councillor John Bryant be appointed as Vice-Chair of the Committee for the municipal year 2013/14.

2. WELCOME AND APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Alice Perry; Councillor John Roger Kaseki was attending as a substitute member. Councillor Gideon Bull had been appointed to the Committee in place of Councillor Reg Rice.

3. DECLARATIONS OF INTEREST

Councillor Brayshaw declared a personal interest as a member of the governing body of University College of London Hospitals. Councillor Cornelius declared a personal interest in the item on Barnet and Chase Farm as she was an assistant chaplain at Barnet Hospital. Councillor Bull declared a personal interest as an administrator for Moorfields Eye Hospital.

4. URGENT BUSINESS

None.

5. MINUTES OF THE 14 MARCH 2013

Resolved that:
The minutes of the meeting on the 14 March 2013 be approved, subject to the following amendments:

Item 6 Barnet and Chase Farm Hospitals NHS Trust Update –
The word 'transaction' in the 5th line of the second paragraph on page 2 of the minutes was amended to read 'acquisition'.

Item 10 Whittington Health – Trust Estates Strategy and 5 year Capital Investment Strategy
The words 'possibility of medical students moving…' in the 5th line of the second paragraph on page 12 were amended to read 'decision which had been taken to move medical students…'

Matters Arising
Jan Pollack, speaking from the public gallery, drew attention to an item arising from the minutes relating to the Whittington Hospital's proposals for 'Transforming Healthcare for Tomorrow' and asked whether the Committee was concerned, as she was, about the adequacy of the public consultation which had been carried out so far. In reply the Chair indicated that the Whittington's proposals would be the main item on the agenda for the Committee's next meeting in July and in the meantime invited Ms Pollack to write to him about her concerns.

6. BARNET AND CHASE FARM HOSPITALS; ACQUISITION BY ROYAL FREE HOSPITAL

Dr Tim Peachey, Chief Executive of Barnet and Chase Farm Hospitals, Caroline Clarke, Deputy Chief Executive of the Royal Free London Foundation NHS Trust and Alastair Finney, NHS Trust Development Authority updated the Committee on these proposals.

Caroline Clarke made a presentation on the transaction process and stressed in particular the Royal Free's objectives, namely excellent patient outcomes; excellent patient experience; excellent value for taxpayers; full compliance; and a new merged organisation with a viable cost base. She also outlined the potential benefits for patients, commissioners, Barnet and Chase Farm staff and Royal Free staff.

The Royal Free's Board was working hard to assess the benefits of the proposed acquisition and to prepare a business case by 31 July 2013. As part of the process of working up the business case the Royal Free was looking at how to make pathways better in a clinical sense as well as viable, testing how it could make some of its systems more efficient, and also exploring different ways of working across healthcare systems with GPs and commissioners. It was also intended to bring stability to Barnet and Chase Farm Hospitals after a turbulent past.

Dr Tim Peachey explained that once a decision had been taken to progress the acquisition in the way outlined in the report, it was for the Royal Free to run the process.

The following points were made in the questions and discussion which followed:

- The Royal Free were totally committed to the strategy for 'acquisition'.
- The distinction between acquisition and merger was clarified; in this case it was intended that a foundation trust would acquire the assets and liabilities of an NHS Trust. This would involve some changes to the Royal Free's constitution and governing body.
- The existing governing body of the Royal Free would have to approve the process and authorise the submission of the outline and final business cases.
- In the event that the Royal Free were to decide not to proceed as preferred partner, Dr Peachey explained that the Barnet and Chase Farm Hospitals would have three options: to repeat the process and seek another partner; to seek a private sector partner; or to enter the unsustainable provider regime.
- It was suggested that the acquisition could affect the critical mass of the Barnet and Chase Farm Hospitals. Caroline Clarke explained that the Royal Free were trying to secure a sustainable model for all component parts of the acquisition strategy and would have to comply with the new competition model and satisfy Monitor on this point as the regulator of foundation trusts.
- In essence, the Royal Free's involvement was based on its concern about the small scale of some of its conventional hospital services. It was looking to the acquisition in part as a way of spreading some of its costs as well as improving outcomes for patients.
- As far as possible the aim was to avoid compulsory redundancies by controlling vacancies and making savings in the back office areas.
- It was expected that Barnet would continue to be a busy general hospital and Chase Farm would do more elective-based work in future.
- It was pointed out that the presentation of the changes to local residents was all important especially in the light of the Whittington Hospital's recent experience and public concerns about selling off assets to fund future investment.
- Dr Peachey explained that the Barnet and Chase Farm Hospitals Trust currently rated '1' on Monitor's risk rating. The Trust's business case provided that any proceeds from land sales were pre-committed to the Barnet and Chase Farm Hospitals.
- The Chair stressed that the Committee had a part to play in helping the NHS Trusts to get the key messages across to local residents.

In response to a question from a member of the public, it was noted that monies raised from land sales would not include the St Ann's Hospital site as this was owned by Barnet, Enfield and Haringey Mental Health Trust.

Alastair Finney then explained the role of the NHS Trust Development Authority (TDA), a new statutory body which had come into effect on 1 April 2013 with responsibilities for functions previously held by the Department for Health, the Strategic Health Authorities and the Appointments Commission which included assurance of clinical quality, governance and risk in NHS Trusts, management of the 'Foundation Trust pipeline', and appointments to NHS Trusts. The TDA had five roles, the most significant of which were to support the NHS in planning sustainable services, to oversee support and performance manage all 101 remaining NHS

trusts, 21 of which were in London, including 5 in the North Central London area, and to support them through the process to obtaining FT status. The TDA also had a part to play in supporting the unviable trusts (which currently numbered 14 nationally) through mergers and acquisitions, interventions and improvement programmes.

The next steps for the TDA were decisions on the outline and final business cases with the aim of completion by Spring 2014.

The following points were made in the questions and discussion which followed:

- In this case, the decision on whether a trust was viable was for the TDA acting on the recommendations of the Boards of individual trusts. Referring more generally to the 14 trusts referred to in the presentation, it was thought that the boards of each of the individual Trusts would have decided at an earlier stage that they did not consider that they were sustainable in their current form.
- The TDA was a statutory organisation with a Board appointed by the Secretary of State. Meetings of the Board were held in public.
- The TDA would not approve the business case without a letter of support from NHS England and the local Clinical Commissioning Groups (CCG).
- On a more general point, it was unclear to the Committee where responsibility for the overall strategic approach rested in the new NHS structure. This was an important point for local authorities in terms of who they should seek to influence through the scrutiny role. Alastair Finney believed that whilst all NHS bodies, including the TDA and local CCGs, had a part to play in this, only NHS England could take a system-wide view, especially as the TDA had no accountability for existing FTs – in which case it was still not clear how local authorities could seek to exert some influence on pan-London issues.

The Committee noted that the work on the acquisition had so far cost the Royal Free circa £1 million and this sum was likely to double by the end of the process. The Chair thanked Dr Peachey, Caroline Clarke and Alastair Finney for attending the meeting and answering Members' questions.

Resolved that –
The Committee maintain a watching brief over developments relating to the proposed acquisition.

7. FRANCIS REPORT

The Francis report on the public inquiry into the failures of Mid-Staffordshire NHS Foundation Trust had highlighted a number of shortcomings in the local authority scrutiny role, as follows:

- Lack of detail in notes of some meetings about Stafford Hospital;
- The need for HOSCs to be more proactive in seeking information;
- An over-dependency on information from the provider rather than other sources, particularly patients and the public;
- Lack of resources, particularly in small borough committees; and
- The need for scrutiny to be conducted at arms-length rather than as a

'critical friend'.

It was suggested that the Joint Committee covered these points quite well, especially in asking challenging questions, in properly minuting meetings, in asking the right questions, in making visits where appropriate for purposes of investigation, and in ensuring that residents know that they can attend meetings and have a say. Issues relating to the quality of care could nevertheless be challenging to address.

Drawing on the lessons of the Francis report, it was clearly important that Overview and Scrutiny Committees should be prepared to independently verify what was being said rather than accept it at face value. A local campaign group could for example be asked for their comments, as could Healthwatch who should be invited to nominate a representative to serve on the Committee.

It was generally agreed that the Committee should liaise more with the Health and Wellbeing Boards on what they thought and expected the Overview and Scrutiny Committee to do, and what its priorities should be. Other points were that the Committee should co-ordinate its work programme with those of other health scrutiny committees in the area to avoid duplication and also that it should make better use of Healthwatch. It was also felt that boroughs should work together to scrutinise acute provider trusts in the area through, for instance, arranging joint meetings. Such an approach could be used to consider Quality Accounts.

Mr Smith, a member of the public present at the meeting suggested that the Committee should do more to advertise its meetings if it wanted more information on local issues and concerns. That might help local organisations and campaign groups to feed into the Committee's agenda and work programme.

Resolved that –
The Committee organise a training session for Members in October 2013 on issues arising from the Francis Report, to be hosted by the London Borough of Haringey.

8. MATERNITY SERVICES

The Committee received a report back on the Barnet, Enfield and Haringey Clinical Strategy following a meeting held at Enfield Civic Centre on 23 April 2013.

Copies of a fact sheet on developments around maternity and the BEH clinical strategy were circulated at the meeting, addressing questions raised at the meeting in April. A number of Members had also had visits to the North Middlesex Hospital in the interim, which they found informative and encouraging. Members asked a number of detailed questions about the capacity for handling the forecast numbers of births at the Barnet, Chase Farm and North Middlesex Hospitals and also at the Edgware Birthing Centre, which would not change as a result of the strategy. It was confirmed that North Middlesex University Hospital had no mothers-to-be diverted to other services, whilst Barnet and Chase Farm hospitals had 158 maternity diversions between sites. Expanding maternity services at Barnet and North Middlesex Hospitals would help to minimise mothers-to-be being diverted to other hospitals.

It was explained that capacity would increase at both Barnet and North Middlesex Hospitals to meet the needs of women giving birth in the area. Current and planned beds/couch numbers were illustrated for North Middlesex University Hospital and Barnet Hospital. Staff were monitoring the situation closely and mapping which hospitals expectant mothers were booking although not all would book sufficiently far in advance to assist with planning. The aim was to anticipate the trends based on the numbers forecast in the current year.

9. UROLOGICAL CANCER SURGERY

The Committee was invited to consider further the status of proposals relating to changes to urological cancer surgery services in the light of previously circulated legal advice provided to the Chair.

Councillor Klute reported that LB of Islington's lawyers had advised that it was not clear that these proposals amounted to a substantial change or variation and any challenge based on the assumption that it does amount to such a change or variation might well not succeed.

Neil Kennett-Brown, Programme Director, Change Programmes advised the Committee that a report had been made to NHS England making the case for consolidating the more complex urological cancer care services in specialist centres and acknowledging the feedback from some patient groups about the impact of the proposals particularly in terms of longer journey times for those with further distances to travel which they believed warranted a fuller process of public consultation.

In the light of the feedback obtained, NHS England had agreed that the proposals would benefit from a formal consultation exercise, which was expected to be launched later this year, along with developing proposals for other specialist cancer services across north east and north central London.

Mr Kennett-Brown offered to attend the next meeting of the Committee in July to discuss the process which would very likely involve the constitution of a wider Joint Health Overview & Scrutiny Committee covering North Central and North East London and possibly also some adjoining areas outside the Greater London area.

The Committee thanked Mr Kennett-Brown for attending the meeting and agreed to include this matter on the agenda for its July meeting.

10 NHS 111 SERVICE

The Committee received an update on the 111 Service from Dr Tim Ladbrooke, Medical Director for LCW (London Central & West Unscheduled Care Collaborative) and Neil Kennett-Brown, Programme Director, Change Programmes. The following points were emphasised in the presentation:

- NHS 111 was a new non-emergency telephone service for use when people need medical help or advice, but do not need to make a 999 emergency call. It went live to the public on 12 March 2013. Calls from landlines and mobile

phones are free.

- NHS 111 gives healthcare advice and directs patients to the right local service e.g. a local GP, another doctor, urgent care centre, community nurses, emergency dentist or late-opening pharmacy. In cases of emergency, an ambulance is despatched immediately without the need for any further assessment.
- The service is staffed around the clock, 365 days a year, by a team of fully trained advisers, supported by experienced clinicians.
- The local service was developed jointly with CCGs and GPs. after extensive engagement with stakeholders.
- The service is now being promoted to the wider public – public information distributed to all GP practices, pharmacies, dentists, hospitals, health centres, town halls, libraries and community venues.

The following points were made in the questions and discussion which followed:

- NHS 111 had replaced NHS Direct as the single number for urgent care advice. However, NHS Direct was also an NHS 111 service provider in some areas outside of North Central London.
- The Service is provided locally by London Central & West Unscheduled Care Collaborative (LCW), an established provider of unscheduled care in the inner North West London area.
- A&E activity had not increased as a result of the NHS 111 Service. There were a number of doorways to medical advice and health care. A&E was only one fixed point in the NHS –the NHS 111 Service aspired to make sure that patients were directed to the right service first time.
- The role of the London Ambulance Service was referred to in this context and it was explained that Clinical Commissioning Groups in London had recently agreed to make an additional investment in the Service, and the London Ambulance Service had embarked on a transformation programme, which members might be interested in.
- It was noted that NHS England was conducting an urgent national review of the sustainability of NHS 111 and the market of providers delivering the service. Members questioned the sustainability of the model in coping with demand at very busy times.
- There were also concerns about the triage of patient calls by call operators as there was a view that this required medical expertise. In response, it was pointed out that the service was using a programme written by doctors, with content supported by the Royal Colleges and stressed that call handlers were not making a diagnosis, merely advising on where and how to deal with patients' conditions. Call operators had undergone extensive training – 6 weeks' pathway training plus additional training as part of an induction. This was longer than the training previously provided for call handlers working in the Out-of-Hours service.

The Committee discussed service performance and noted that LCW was required to review performance on a regular basis, against national KPIs which included:

<u>The number of calls answered in 60 seconds: national standard is more than 95%.</u>
LCW's current performance was 92.5% which represented a significant

improvement towards the national standard.

The number of calls abandoned.
LCW's performance was currently under 1.5% compared with a national indicator of under 5%.

The number of calls where clinician callback was achieved within 10 minutes. LCW's current performance was 72.5%, the best across London.

The number of triaged calls which result in an ambulance dispatch: national standard is fewer than 12% of triaged calls.

Dr Ladbrooke confirmed that performance is continuing to improve against the key indicators since the launch date although he acknowledged that the service had fallen back over Easter and LCW had been seriously challenged by rising demand during this period. He felt that the Committee could gain a better understanding of the way that the service operated by undertaking a visit to the call centre.

Mr Smith, a member of the public present at the meeting, suggested that the NHS should give more publicity to where patients with minor ailments could go e.g. pharmacies and in reply it was explained that referral routes were in place, as part of the 111 Service. Members of the Committee were invited to visit a call centre and see how the service works in practice.

The Committee thanked Dr Ladbrooke and Mr Kennett-Brown for attending the meeting and agreed to include this matter in its Work Plan

Resolved that:
A visit to the 111 call centre for the area would be arranged for Members of the Committee.

11 **WORK PLAN AND DATES FOR FUTURE MEETINGS**

The Committee agreed dates for meetings in 2013/14. In addition, it was agreed that consideration would be given to holding a meeting during May, subject to clarification of purdah period rules. This would be principally to look at Quality Accounts for relevant acute provide trusts. It was noted that Barnet HOSC had scheduled a meeting during May and had been advised that the purdah rules did not apply to health scrutiny.

Resolved that:
1. That the following dates for future meetings of the Committee were agreed:
   - 19 July (Camden);
   - 4 October (Haringey);
   - 29 November (Barnet);
   - 7 February (Enfield); and
   - 28 March (Islington).

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2. That the following items to be added to the Forward Work Programme:
   Whittington Hospital
   Formal consultation on urological and other cancers
   A&E services
   Strategic direction
   Failing GP practices
   Diabetes – future options and care plans
   Dentists and opticians
   Specialist services commissioned by NHS England
   NHS 111 Service
   Quality Accounts; Royal Free, Camden and Islington and Barnet, Enfield and Haringey Mental Health Trusts (both together), Barnet and Chase Farm.

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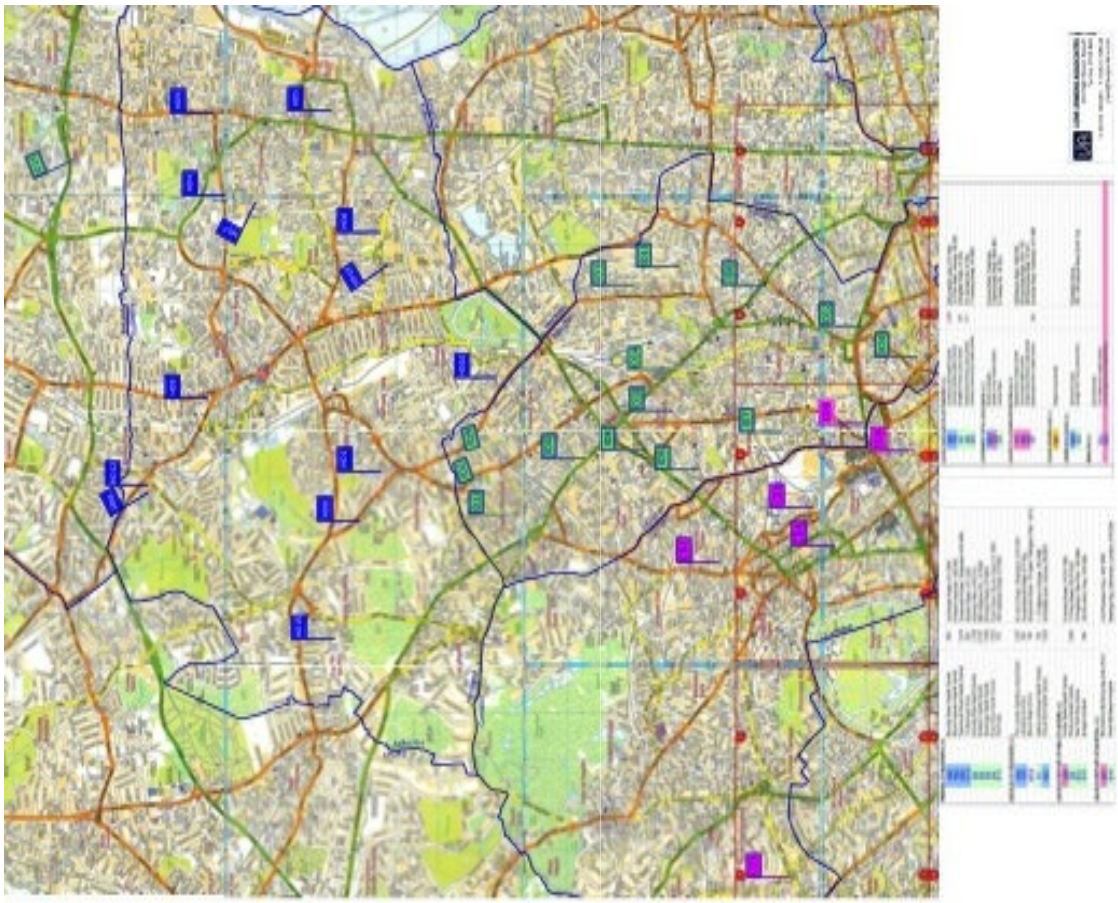
Whittington Health Clinical Strategy

Dr Greg Battle, Dr Martin Kuper
Medical Directors
Joint Overview and Scrutiny Committee 19 July 2013

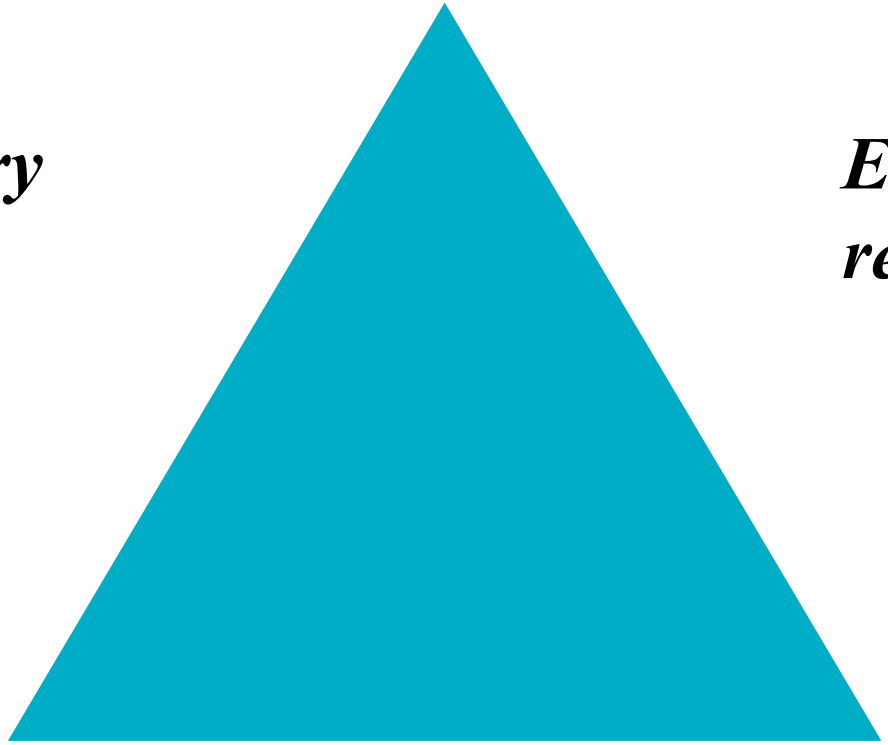


Hadley Primary Care Centre
The Meltham Health Centre
River Place Health Centre
Killick Street Health Centre

Fundamentals of Clinical Strategy

Ambulatory care

Enhanced recovery



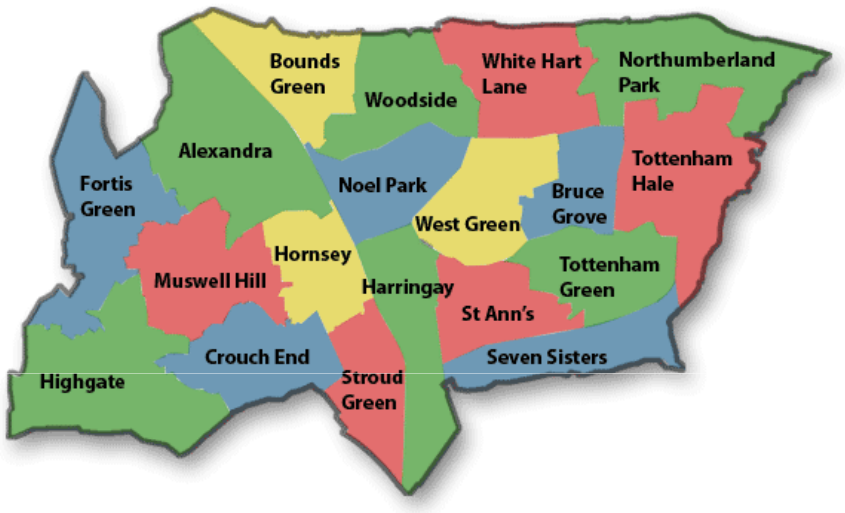
Integrated care

Whittington Health NHS

Integrated Care

- Launched in North East Haringey, discussing patients with North Middlesex hospital
- Coordinate health and social care
- Patients targeted:
  - Complex
  - 65+ / LTCs
  - Frequent ED attenders
  - High users of social services
- Now 4 locaity MDT teams up and running
- Discussed more than 500 patients

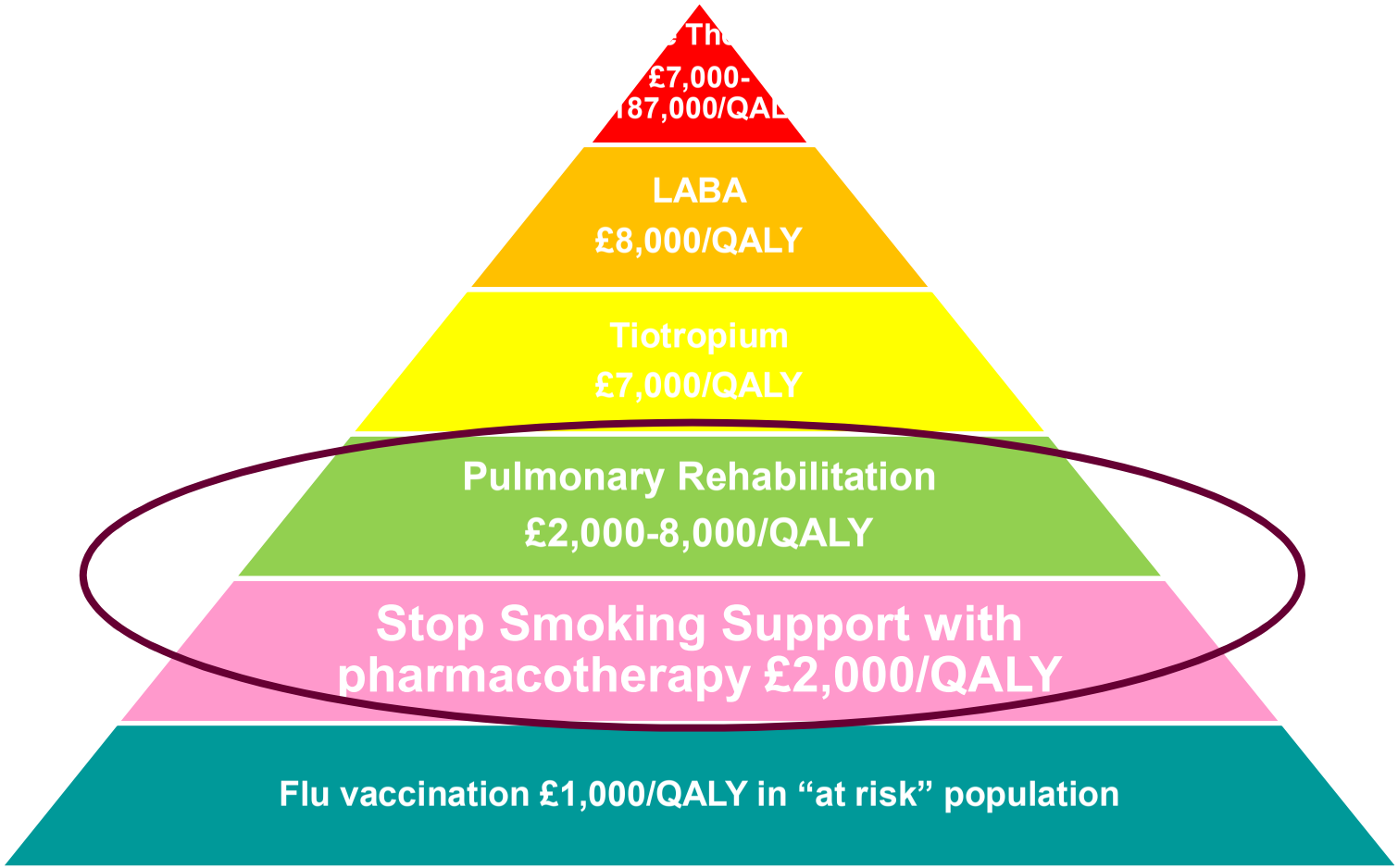
- <u>Integrated Care MDT Teleconferences</u>
  - 2 hours each week for each of the 4 areas – GPs have a set dial in slot
  - GPs – the lead clinician
  - Community Health Teams (DNs, CMs)
  - Hospital Pharmacist
  - Social Services
  - Consultant physician (NMH or Whittington)
  - Consultant psychiatrist (BEH MHT)



Preliminary results – but risk regression to mean

- 17% reduction in A&E attendance in first 170 patients
- 86% of the patients discussed in June and July at North East MDT had fewer admissions in the 6 months afterwards than in the 6 months beforehand

Improving population health *COPD - Islington LES*



JAMA 2011;306:1782-1793.

JAMA
The Journal of the American Medical Associa

Hospitalization-Associated Disability

"She Was Probably Able to Ambulate, but I'm Not Sure"

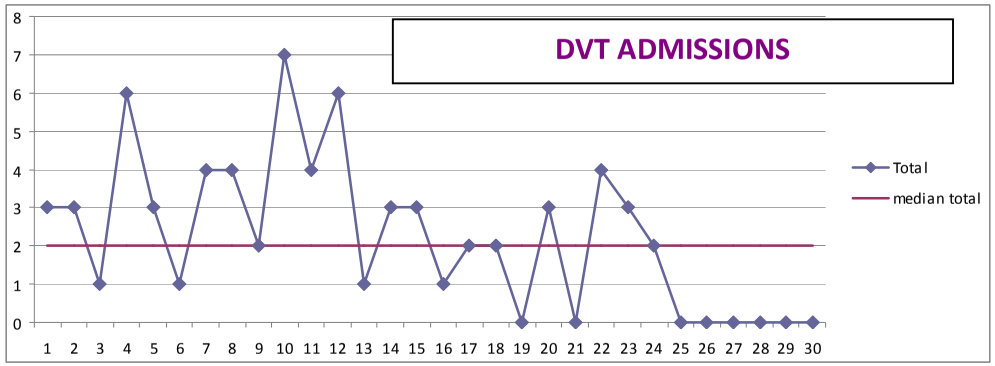
Kenneth E. Covinsky, MD, MPH
Edgar Pierluissi, MD
C. Bree Johnston, MD, MPH

- **hospitalization-associated disability develops between the onset of the acute illness and discharge from the hospital**
- **at least 30 % of patients > 70 years and hospitalized for a medical illness are discharged with an ADL disability they did not have before becoming acutely ill**

Whittington Health NHS

Ambulatory Care

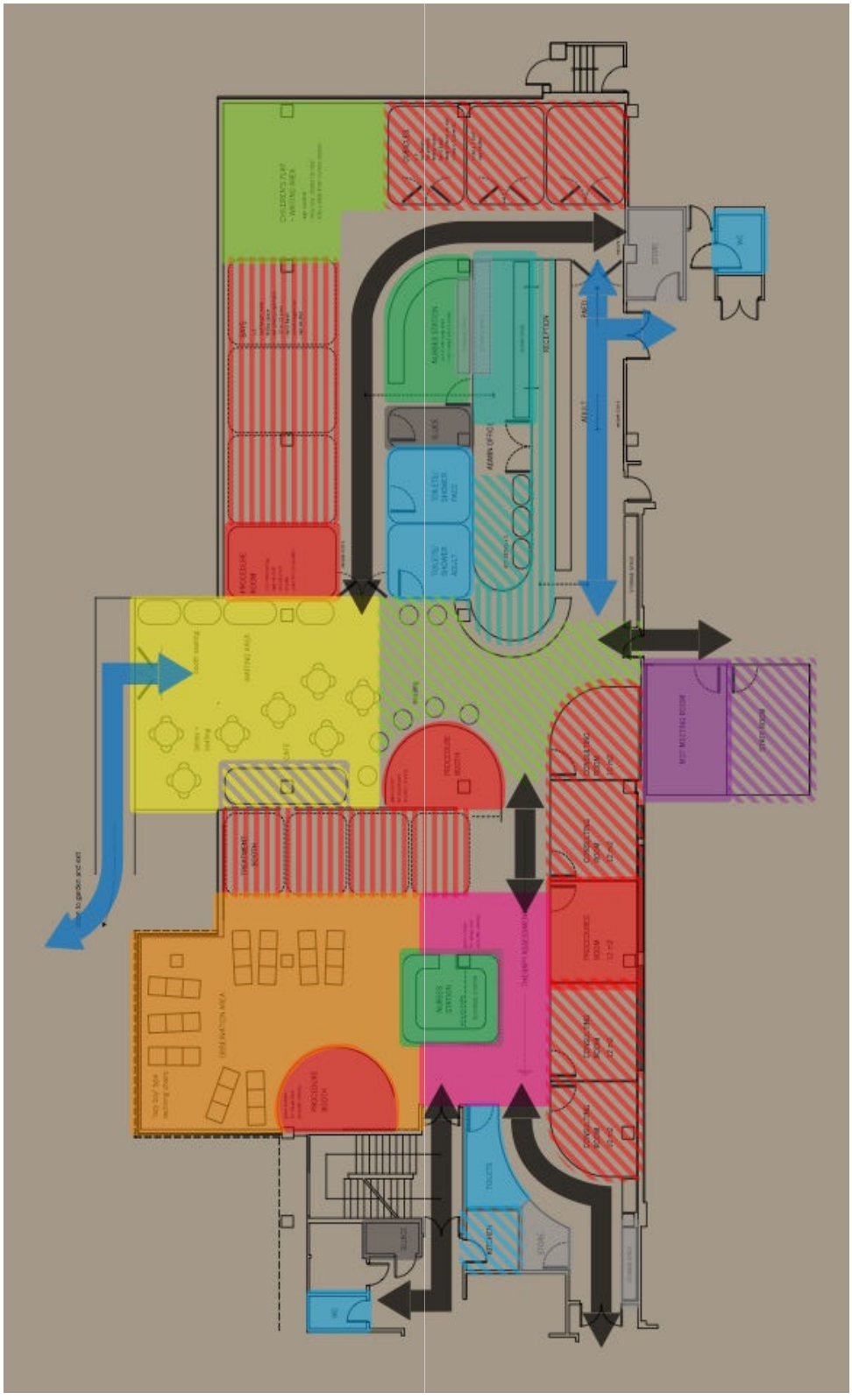
- Senior decision making, advanced diagnostics
- Consultants - Acute Medicine/ ED
- Ambulatory Care Coordinator
- Community Matrons
- Patient and staff designed area and pathways
- Leverage community services
- Avoid unnecessary admissions
- Support earlier discharge



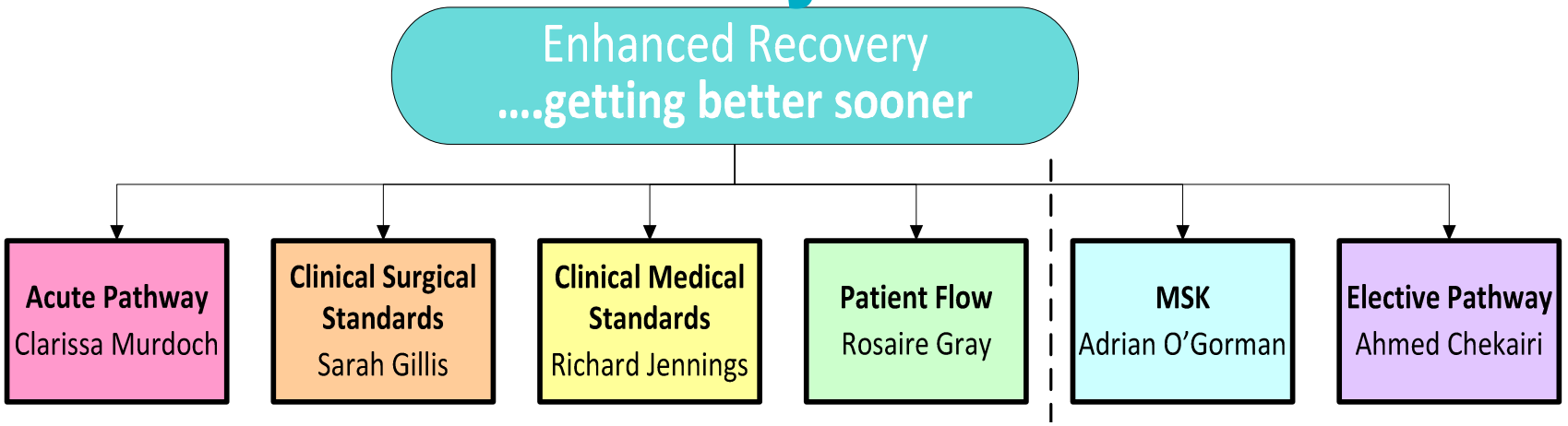
Ambulatory care figures

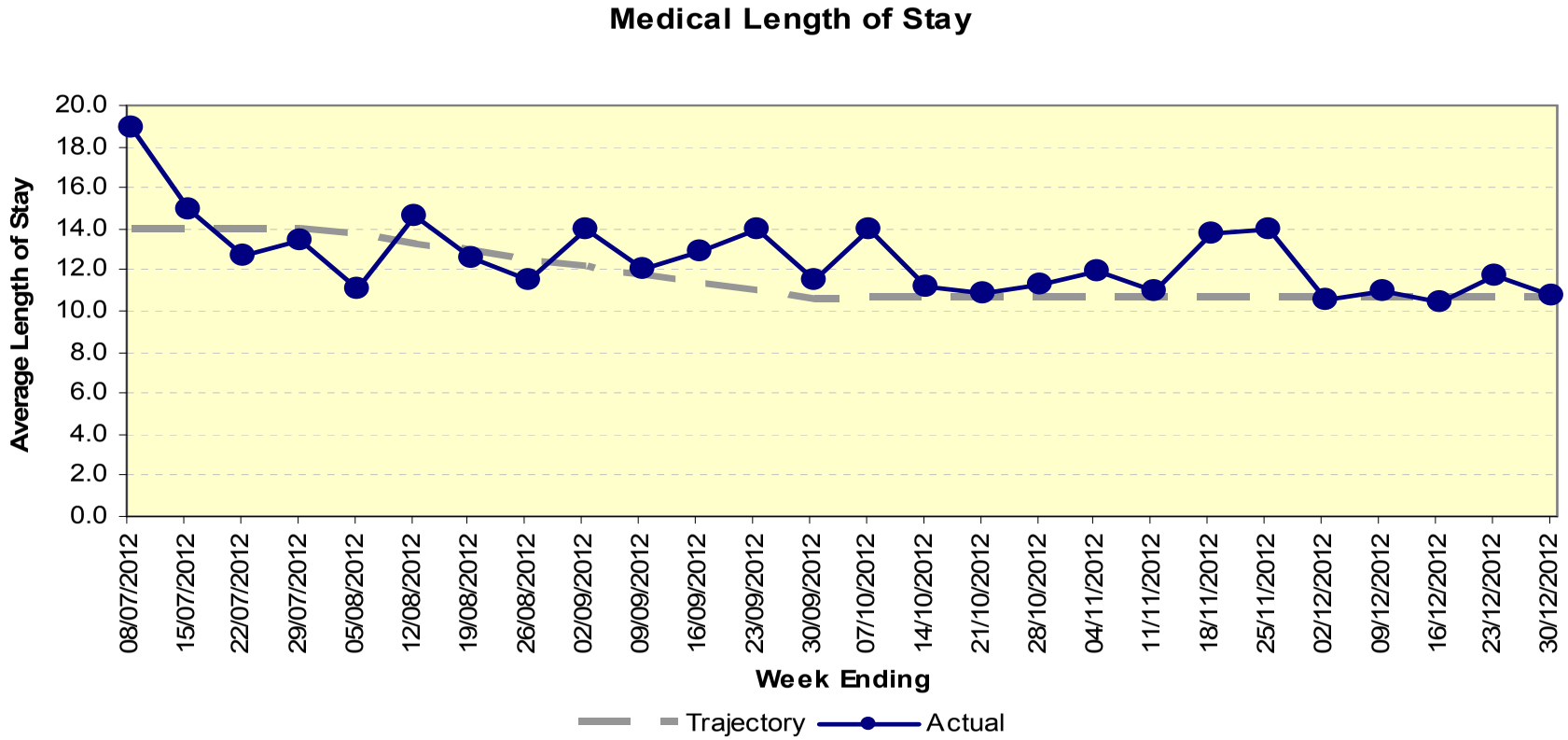
- 1515 patients seen last year with 2 cubicle spaces
- Now 3 spaces, patients seen up from 150 to 220 new patients per month ie over 2500 per year
  - 64% of patients are avoided admissions
  - 23% are able to be discharged early from medical wards
  - 13% other eg could have been seen in primary care
- 10% see 3 or more specialties ie complex
- 17 specialties involved per month
- Surgical patients increasing from 15 to 30 per month
- From next April will be 15 spaces…

Ambulatory Care – new build



Enhanced recovery from illness





Enhanced recovery from hip fracture

Measure	England	London	Whittington
Average time from admission to operation / hours	32	32	22
Average time to admission to orthopaedic ward / hours	9	16	9
% patients developing pressure ulcers	3	4	2
Mean length of stay / days	20	21	18
In hospital mortality	8	8	4
30 day mortality	14	13	9

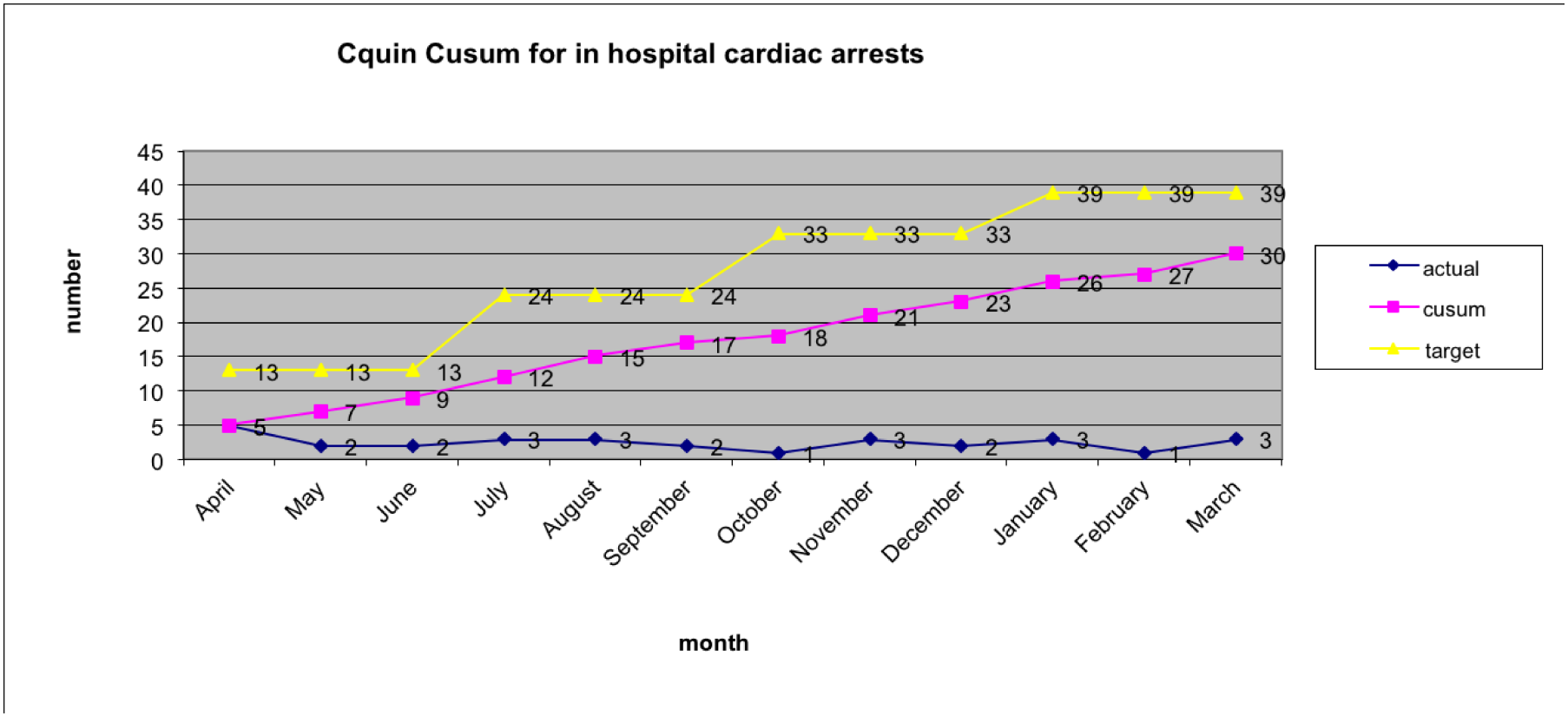
SHMI (Summary Hospital-level Mortality Indicator) &ranking: Oct 11-Sep 12 for NCL trusts

Trust	Ranking (of 142 nationally)	SHMI
UCLH	1	0.6849
Whittington Health	2	0.7128
Royal Free London	4	0.7602
North Middlesex	6	0.8012
Bart's Health	9	0.8262
Barnet & Chase Farm	13	0.8527

This is the first time in 2 years the Whittington has slipped from first place…

Whittington Health NHS

Whittington Health
in hospital cardiac arrest 2011/12



Agenda Item 6

NHS England (London Region)	**BOROUGHS** : BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL
REPORT TITLE: Leadership of service change in the New NHS	
REPORT OF: Paul Bennett Director of Delivery North, Central and East London NHS England	
FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**MEETING DATE:** 19th July 2013
SUMMARY OF REPORT: This briefing details how structures and leadership of service change in the New NHS are organised at local and London regional level. The interface between the NHS and the Health Overview and Scrutiny committees is also described as well as the role of NHS England in Direct Commissioning and the interface with Pubic Health England and Clinical Commissioning Groups. **CONTACT OFFICER**: Paul Bennett Director of Delivery North, Central and East London NHS England	
RECOMMENDATIONS: The Committee is asked to note the contents of this paper.	
DIRECTOR: Paul Bennett Director of Delivery North, Central and East London NHS England **DATE: 1 July 2013**	

PLANNING AND SYSTEM LEADERSHIP

The Health and Social Care Act 2012 sets out how in the new NHS, commissioners will lead service changes with much greater leadership by clinicians. In the new structures, leadership of health service changes in London that are essentially local will be best provided at the borough level by clinical commissioning groups (CCGs), working with Health and Wellbeing Boards.

Service changes that cut across boroughs or sectors of the capital and which require collective action will need to be led by a number of CCGs working together with NHS England. Across London NHS England will provide oversight of London as a world city, in collaboration with bodies such as the London Clinical Commissioning Council (a membership organisation of the 32 CCGs), and the London Clinical Senate (which provides independent strategic advice for CCGs, providers, Health and wellbeing boards and NHS England). NHS England (London region) has a duel role assuring delivery of CCG commissioning plans and as a significant direct commissioner of health services.

Depending on the issues under discussion, other stakeholders are also likely to have an important part to play, including NHS providers, academic health science networks, local authorities and health and wellbeing boards, and national bodies such as the NHS Trust Development Authority, Public Health England and Health Education England. Major service reconfigurations affecting several NHS trusts are most likely to require collective action by commissioners across boroughs and sectors. There will also be some issues that require CCGs to collaborate across London, such as commissioning of ambulance services and emergency planning and preparedness.

This new model of dispersed leadership that requires collaboration is already being adopted for example in South East London and WELC (Waltham Forest, East London and the City) where groups of CCGs with NHS England and Directors of Public Health are coming together to lead as a collective.

HEALTH OVERVIEW AND SCRUTINY – THE INTERFACE WITH THE NHS

The initial White Paper published by the government in July 2010 proposed the abolition of health overview and scrutiny committees (HOSCs), but following the “listening exercise” in the spring of 2011 the continuing role of health overview and scrutiny has been recognised in the Health and Social Care Act. The previous legislation governing health scrutiny has been modified to reflect the changes in structure to the NHS introduced by the Act. It enables officers and members of NHS bodies and providers to be called to attend before the HOSC to account. In practice this means councils have the power to engage with the local clinical commissioning group (CCG), which is responsible for commissioning many of the local health services, NHS provider trusts delivering services to local people, independent sector providers, and NHS England in respect of services commissioned for local people, which will include GP services, dentistry and a significant range of specialist and public health services.

Individual Overview and Scrutiny Committees have the power to refer matters of significant service change to the Secretary of State for consideration. Referrals apply to 'any type of provider of NHS-funded services, whatever their governance arrangements and ownership structure'.

The first super JHOSC in London was formed in November 2007. All 33 London Boroughs including two outer London Boroughs Essex and Surrey formed a JOSC to respond to NHS London's proposals for change to the NHS Services across London.

THE ROLE OF NHS ENGLAND IN DIRECT COMMISSIONING AND THE INTERFACE WITH PUBLIC HEALTH ENGLAND AND CLINICAL COMMISSIONING GROUPS

NHS England and the Department of Health published their detailed agreement showing how the NHS England will drive improvements in the health of England's population through its commissioning of certain public health services. The agreement sets out the outcomes to be achieved in exercising these public health functions and provides ring-fenced funding for NHS England to commission public health services. The services commissioned as part of this agreement are those where there is, for example, alignment with national clinical pathways and added value of central commissioning. The services included in the agreement are:

- National immunisation programmes
- National routine screening programmes (non-cancer)
- National routine cancer screening programmes
- Children's public health services from pregnancy to age 5
- Child Health Information Systems
- Public health services for people in prison and other places of detention
- Sexual Assault Referral Centres

Overall, NHS England has a budget of **£95.6 billion** to deliver the mandate. Within this overall funding, it has allocated **£65.6** billion to local health economy commissioners: that is, CCGs and local authorities. The agreement provides NHS England with **£1.8bn** from the public health budget for these programmes, in addition to other funding provided for public health in primary care. The agreement sets out how NHS England is accountable for the successful delivery of these programmes, and arrangements for expert support from Public Health England. It provides service specifications which include the public health evidence and advice needed to support effective commissioning.

THE WORK OF CCGs THAT IS COMMISSIONED BY NHS ENGLAND

In general CCGs are responsible for commissioning health services to meet all the reasonable requirements of their patients, with the exception of certain services commissioned directly by the NHS England i.e.:

- Health improvement services commissioned by local authorities,
- Health protection and promotion services provided by Public Health England.

CCGs play a key role in promoting integrated care and, as a member of the local Health and Wellbeing Board, in assessing local needs and strategic priorities. This means working collaboratively with local authorities and NHS England. CCGs may decide to pool budgets or have collaborative commissioning arrangements.

Commissioning responsibilities will include: planning services, based on assessing the needs of your local population; securing services that meet those needs; and monitoring the quality of care provided.

In most cases, CCGs will also be responsible for meeting the cost of the services provided. There will be some services they commission for their geographic area (e.g. A&E services) where the costs for an individual patient may be charged to another CCG (i.e. in an area where the patient is registered or, if unregistered, where they live).

NHS England directly commissions the following services:

- **Specialised Services**

  Specialised services are those provided in relatively few hospitals, accessed by comparatively small numbers of patients but with catchment populations of more than one million. These services tend to be located in specialist hospital trusts that can recruit staff with the appropriate expertise and enable them to develop their skills.

- **Primary Care Services**

  NHS England commissions many of the primary care services previously commissioned by PCTs. It is responsible for primary care contracts and has a duty to commission primary care services in ways that improve quality, reduce inequalities, promote patient involvement and promote more integrated care. NHS England is a single organisation and takes a consistent approach to managing contracts wherever it is appropriate to do so. Clinical Commissioning Groups (CCGs) have a significant role in driving up the quality of primary medical care but will not performance manage primary-care contracts.

- **Offender Healthcare**

  One of the NHS CB□s responsibilities will be to commission directly health services or facilities for persons who are detained in prison or in other secure accommodation and for victims of sexual assault.

- **Some Services for Members of the Armed Forces**

  NHS England commission health services for members of the Armed Forces and their families if registered with Defence Medical Services Medical Centres.

NHS England has 27 local area teams but acts as one single organisation operating to a common model with one board. Responsibility for public health services is held by Public Health England (PHE) and local authorities, although as described above, NHS England commissions, on behalf of PHE, many of the public health services delivered by the NHS.

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NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (JHOSC)	**BOROUGHS**: Barnet, Enfield, Haringey, Camden, Islington, South Hertfordshire **WARDS:** ALL
PRESENTATION TITLE: Cancer and Cardiac Service reconfigurations	
PRESENTATION OF: **Neil Kennett-Brown** Programme Director, Change Programmes North and East London Commissioning Support Unit On behalf of NHS England	
FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**MEETING DATE:** 19 July 2013

EXECUTIVE SUMMARY OF PRESENTATION:

Engagement on urological cancer surgical services

An engagement on urological cancer surgical services was undertaken between January and March 2013. This was initially launched by the Primary Care Trust clusters and, since March 2013, has been taken forward on behalf of NHS England as the lead commissioner of these services.

Many useful comments were received as part of the engagement. While respondents broadly supported the principle of centralisation for complex urological surgical services, concerns were expressed about the impact of the proposals on patients, particularly with regard to travel and patient choice. Assurances were also sought about the impact of the proposals on local hospitals and other hospital services.

NHS England has agreed that the proposals would benefit from a formal consultation exercise, expected to launch later this year along with developing proposals for other specialist cancer services across north east and north central London. The feedback received on the urological cancer surgical services engagement will continue to inform the development of the proposals.

While no significant changes to the location of services will be undertaken without further consultation, *London Cancer* will continue to work with local hospitals to improve services and standards of care for patients.

Background to the cancer proposals

A 2010 pan-London cancer review found that access to and outcomes from cancer care were unequal across the city. Public engagement on the pan-London case for change and model of care was undertaken in 2010.

As a recommendation of the review, two integrated cancer systems were established in London to drive improved patient outcomes and experience. *London Cancer* is the integrated cancer system for north central and east London and west Essex.

Building on the pan-London cancer review (the Model of Care for Cancer, 2010), *London Cancer* is looking at how best to implement the model of care locally with the aim of improving outcomes and experience for patients.

Cancer pathways

London Cancer has established a number of cancer pathway groups involving clinicians, GPs and patient representatives. These pathway groups are tasked with mapping out a comprehensive, seamless clinical pathway for every patient; improving access to screening and diagnostics; and driving the quality of care towards international best practice so that all patients have access to the full range of care of a world-class system. The aim is to make improvements to patient outcomes and experience along their whole pathway of care.

By building on the Model of Care, and with an ambition to provide the quality of care that patients deserve, *London Cancer's* pathway groups are currently developing a case for change for improving the following specialised cancer services across the *London Cancer* area:

- Brain and spine
- Head and neck
- Stem cell transplant and acute leukaemia services
- Urological
- Oesophago-gastric (upper GI)
- Thoracic surgery.

The cases for change will be shared with health overview and scrutiny members, patient representatives and the wider public as part of a planned commissioner-led engagement exercise ahead of formal consultation on any proposed changes to services.

It is anticipated that NHS England would be the lead commissioner and therefore the decision making body on any proposals for specialised cancer services.

Cardiovascular services

Separately, clinicians and their colleagues across north central and east London, jointly working through the academic health partnership, UCLPartners, are proposing to improve patient outcomes through integrating specialist cardiovascular services. The proposal is for some of the more specialist cardiovascular services and the services required to support this specialist activity, currently offered by both University College London Hospital (UCLH) NHS Foundation Trust and Barts Health NHS Trust, to come together in a single centre for global excellence at St Bartholomew's Hospital in late 2014. It is proposed that a commissioner-led engagement and consultation process for cardiovascular services be undertaken alongside proposals for cancer services.

The services provided at the London Chest Hospital, operated by Barts Health NHS Trust, are already planned to move to St Bartholomew's in 2014 and this new clinical proposal would see the cardiac services from UCLH's Heart Hospital also relocated to create one centre of excellence. The proposal will be subject to a full engagement and consultation process.

In principle, this change is of a similar scale to other recent improvements to the London health service, such as the establishment of the hyper-acute stroke units (HASUs) and London Trauma networks. These decisions were based on evidence that centralisation will save lives and improve patient outcomes, which has been shown with the HASUs and the trauma network.

It is proposed that a commissioner-led engagement and consultation process for cardiovascular services be undertaken alongside proposals for cancer services.

Commissioner responsibility for cardiovascular services is currently being reviewed. This will likely include NHS England as the lead commissioner for specialised cardiovascular services and clinical commissioning groups (CCGs) as commissioners for any non-specialised elements of the cardiovascular pathway.

Conclusion

The North and East London Commissioning Support Unit is supporting NHS England to establish programme management and a pre-consultation engagement process for the cancer and cardiovascular proposals. It is anticipated that the pre-consultation engagement process will take place during August/September. This is in addition to the engagement which has been led by providers since the announcement of the programme on 20 February 2013. Once the programme is clearer, we would be keen to work with the Chair of the JHOSC and Committee Officer to set out the engagement plan and gain feedback. This work is at an early stage and we would be pleased to arrange clinical representatives to attend a future meeting of the JHOSC to discuss their emerging recommendations.

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North and East London Commissioning Support Unit

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DATE: 4 July 2013

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

19 July 2013

Work Plan/Future Dates

1. Introduction

1.1 This report outlines proposed future date(s) for the JHOSC and outlines issues that have been identified as possible future items.

2. Next Meeting

2.1 The next meeting of the Panel will be Friday 4 October and take place at Haringey Civic Centre. Proposed items for the meeting are as follows:

- A&E:
  - Performance Statistics;
  - Any patterns;
  - Emerging issues (e.g. staffing)
- Acquisition of Barnet and Chase Farm Hospitals by Royal Free
- Dentistry:
  - Commissioning
  - Access
- Moorfields – Proposed move to Kings Cross
- BEH Clinical Strategy

2.2 Other issues identified as potential future items for meetings are currently as follows:

- Specialist services commissioned by NHS England
- CCG Commissioning – quality/cost criteria
- Clinical Care quality

3. Future Meetings

3.1 Future meetings of the Committee have been arranged to take place as follows:

- 29 November (Barnet);
- 7 February (Enfield); and

- 28 March (Islington).

3.2 At the last meeting of the JHOSC, it was suggested that a meeting be arranged during May 2014 in order to consider the Quality Accounts of local NHS provider trusts. It was felt that this might be possible as the purdah period before the local government elections may not apply to health scrutiny activities.

3.3 Preliminary legal advice has been obtained on the feasibility of this. Each local authority has slightly different rules and practices in relation to the purdah period. In addition, if there were to be any issues arising from a JHOSC meeting taking place during purdah, they would probably be directed at individual authorities rather than the JHOSC as a whole. For this reason, it is therefore suggested that each Council should seek its own legal advice if the wish remains to hold a meeting during the purdah period.

3.4 The election date will almost certainly be 22 May 2014, which means that the purdah period will commence when notice of the election is given on 14 April. NHS provider trusts have to allow 30 days consultation on their Quality Accounts and were this year required to make the draft available by the end of April. It may therefore be possible to arrange for the JHOSC to address relevant Quality Accounts if trusts are able to make them available prior to the start of purdah i.e. before 14 April.

4. Seminar

4.1 The Committee also agreed, at its meeting on 6 June, to organise a training session for Members in October 2013 on issues arising from the Francis Report. This will be hosted by the London Borough of Haringey.