NOTICE OF MEETING

NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

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Friday 7 February 2013 10:00 a.m.
Enfield Civic Centre, Silver Street,
Enfield, Middlesex, EN1 3XA

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

Members of the Committee are invited to identify any disclosable pecuniary or prejudicial interests relevant to items on the agenda. A member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting at which the matter is considered:

a) must disclose the interest at the start of the meeting or when the interest becomes apparent; and
b) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in their borough's Register of Members' Interests or the subject of a pending disclosure must notify their Monitoring Officer of the interest within 28 days of the disclosure.

3. URGENT BUSINESS

4. MINUTES (PAGES 1 - 8)

To approve the minutes of the meeting of 29 November 2013.

5. ACQUISITION OF BARNET AND CHASE FARM HOSPITALS BY THE ROYAL FREE (PAGES 9 - 18)

To receive an update on the proposed acquisition of Barnet and Chase Farm Hospitals by the Royal Free Hospital.

6. BARNET ENFIELD AND HARINGEY CLINICAL STRATEGY - IMPLEMENTATION

To receive an update on the implementation of the Barnet Enfield and Haringey Clinical Strategy.

7. HOSPITAL FOOD (PAGES 19 - 34)

To consider issues relating to the food provided for in-patients by local hospitals.

8. FUNDING FOR MENTAL HEALTH SERVICES (PAGES 35 - 48)

To consider funding issues relating to mental health services in respect of;
(a). Camden and Islington (reports attached from Islington CCG and Camden and Islington Foundation Trust); and
(b). Barnet, Enfield and Haringey.

9. PUBLIC HEALTH ENGLAND - ENGAGEMENT PLANS

To consider public engagement plans by Public Health England.

10. JHOSC REVIEW (PAGES 49 - 50)

To consider future arrangements for the JHOSC.

11. WORK PLAN AND DATES FOR FUTURE MEETINGS (PAGES 51 - 52)

29 January 2014

Agenda Item 4

North Central London Sector Joint Health Overview and Scrutiny Committee
29 November 2013

Minutes of the meeting of the NCLS Joint Health Overview and Scrutiny Committee held at Barnet Town Hall on 29 November 2013

Present

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

Support Officers

Rob Mack	LB Haringey
Andrew Charlwood	LB Barnet

1. WELCOME AND APOLOGIES FOR ABSENCE

An apology for absence had been received from Councillor Martin Klute.

2. 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 as she was an assistant chaplain at Barnet Hospital. Councillor Bull declared a personal interest as an administrator for Moorfields Eye Hospital.

3. URGENT BUSINESS

None.

4. MINUTES OF THE 14 MARCH 2013

Resolved that:
The minutes of the meeting on the 4 October 2013 be approved.

Matters Arising:
The Chairman reported that he had received an e-mail from John Pelly (Chief Executive of Moorfields Eye Hospital) welcoming the session at the JHOSC on 4 October 2013.

Rob Mack undertook to re-circulate the response received from the Royal Free

regarding their statistics for waiting time in A&E, as reported at the last meeting.

The Committee requested that an additional visit to the 111 service be arranged as the previous visit had been arranged at short notice, which had not allowed some Members to attend. Councillor Bryant reported that the visit that had already taken place had been particularly useful in the context of a Camden review into out-of-hours GP service provision. He informed the Committee that the Camden review would be recommending that, in the future, out-of-hours GP services and the 111 service be commissioned together as an all through service. Rob Mack undertook to schedule another visit to take place in January 2014.

The Committee agreed that the Barnet, Enfield and Haringey Clinical Strategy Programme Office should be requested to provide a briefing to the Committee on changes to the Clinical Strategy since 2009. Enfield Members commented that the Enfield Health Overview and Scrutiny Committee had a standing item on Primary Care Development as this had been one of the key enablers in the Clinical Strategy. The Chairman undertook to circulate the response provided at Prime Ministers Question Time by the Prime Minister to the MP for Enfield, Southgate on this issue.

Members noted that at the JHOSC Seminar on the Francis Report, there had been discussion on the requirement for trusts to follow-up Care Quality Commission reports and for progress to be monitored by scrutiny committees. The Chairman undertook to revisit this issue at his agenda planning meeting.

5. SPECIALIST CANCER AND CARDIAC SERVICE RECONFIGURATION

Neil Kennett-Brown (Programme Director, Change Programmes, North and East London Commissioning Support Unit), Professor David Fish (Managing Director at UCL Partners), Dr Edward Rowland (Consultant Cardiologist and University College Hospital), Hilary Ross (Director of Strategy at UCL Partners) and Prof Muntzer Mughal (Consultant Surgeon and Head of Upper Gastrointestinal Services at University College Hospitals) updated the Committee on the proposed reconfiguration of specialist cancer and cardiac services in North and North East London.

The Committee noted that specialist services for five rare or complex types of cancer were in scope for reconfiguration which constituted 3-4% of all cancer cases. Treatment for most cancer conditions would continue to be provided at the same sites as now. Members noted that some district hospitals would see a decline in activity as a result of the reconfiguration and noted the impact that this may have on the longer-term viability of these hospitals.

Neil Kennett Brown reported that there had been very little feedback on the proposals to date despite engagement with individual NHS trusts, health and well-being boards and local healthwatch's. The Committee questioned whether acute trusts had managed to achieve the right levels of patient representation and sought assurance that commissioners would listen to and act on responses to the consultation. Hilary Ross reported that UCL Partners had provided support in bringing patients and clinicians together to develop the proposals.

Prof Muntzer Mughal reported that the reconfiguration was focused on improving cancer survival rates and improving patient treatment, with the changes delivering a world class service and system of care. Current specialist services were operating below national standards. Most services would continue to be delivered at a local level; the reconfiguration would result in improvements to services at a local level and improve patient pathways. It was noted that the reconfigurations were only expected to affect 10 – 15 patients per borough per year.

Responding to a question from the Committee regarding the selection of preferred locations for specialist services, Neil Kennett Brown reported that consultation had taken place with clinicians on specifications for local and specialist facilitates. All options had been evaluated, short-listed and appraised to consider clinical outcomes, strategic fit and links to research/education. The Committee were informed that Dr Claire Stephens from Barnet Clinical Commissioning Group was the Cancer Clinical Lead for London. UCL Partners had set up London Cancer and the Board comprised of clinical experts and patients. It was noted that individual bids had been submitted and evaluated. Proposals were only taken forward where there was a strong consensus amongst the Board.

In relation to competition, it was noted that consultation was taking place with Monitor, the regulator for health services, who were considering the proposals with the Office of Fair Trading.

The Committee questioned how pathways at district hospitals would be improved. Prof Muntzer Mughal reported that whilst there would be investment in and an increased focus on providing treatment in specialist centers, there would also be an increase in specialists visiting district hospitals to provide diagnosis and aftercare as part of the revised pathways.

Members noted the strong clinical case for the service reconfigurations and questioned whether a further phase of consultation would take place at the detailed proposals stage. It was also queried whether any financial liabilities would transfer along with services.

Neil Kennett Brown reported that a further meeting would take place with the Chairmen from the affected Joint Health Overview and Scrutiny Committee areas on 9 January 2014 to provide feedback on the engagement process and the options appraisal. He added the need of formal consultation would be defined by the requirements of the Health and Social Care Act 2006.

Professor David Fish undertook to circulate an e-mail that he had sent to Councillor Brayshaw regarding the impact of the proposed changes to the rest of the Committee.

Responding to question regarding funding for the service reconfigurations, clinicians reported that they expected 30% of funding to come from outside of the local health economy, adding that all funding issues would be addressed at the business modelling stage of the project. The Committee requested details relating to the financing of the scheme at a future meeting.

The Committee requested a submission from commissioners and clinicians on the benefits for patients as a result of the changes.

A Member questioned whether a London-wide commissioning strategy existed following the dissolution of NHS London. Neil Kennett Brown advised the Committee that, although clinicians and NHS England worked collaboratively, the system post April-2013 was now more distributed. He added that the Call to Action, which would be considered as a separate item on the agenda, set out NHS England priorities.

In relation to the timeline for implementation, it was noted that the critical issue was the move of The Heart Hospital to St Bartholomew's Hospital which was expected at the end of 2014 to be fully operational by April 2015.

Professor David Fish informed the Committee that 70-75% of cancer patients currently had poor outcomes. Investment in early detection was required to embed prevention across all clinical work streams.

Resolved that –
The North Central London JHOSC supports the proposed changes to cancer and cardiac services. The Committee would nevertheless welcome further engagement on them in order to address any outstanding issues and monitor development plans, but do not at this stage feel that a full public consultation is required on any or all of the proposals. The Committee look forward to further engagement and consultation once the business cases, financial arrangements and governance arrangements proposed are further developed

6.

SPECIALISED COMMISSIONING

Simon Williams from NHS England tabled a paper which detailed serviced priorities for specialist commissioning. He reported that there were 143 specialist services, with 48 contracts being led by London providers. 35 services had been identified as priorities in nine separate categories. It was noted that these would need to link into local service issues.

The Committee were advised that there had been too much emphasis on commissioning treatment rather than preventative measures, resulting in an 8% increase in commissioning of specialist services. To achieve change, a whole pathway review would be required. It was highlighted that HIV cases had increased 100% in the last 10 years following a tail-off in public health campaigns on this issue. Members emphasised that a joint NHS England, primary care and public health response was required to address this.

Simon Williams highlighted that a greater level of co-commissioning of pathways was required. It was noted that translating this into action across the health economy would be challenging.

At the request of the Committee, Simon Williams clarified that the definition of specialised service had been defined in the Carter Report and the number had been capped at 143. It was noted that some specialised services had been transferred

into specialist commissioning rather than clinical commissioning groups post April-2013.

The Committee thanked Simon Williams for his presentation to the Committee.

7. CALL TO ACTION

Neil Kennett Brown (Programme Director, Change Programmes, North and East London Commissioning Support Unit) presented the NHS England Call to Action which outlined structural and strategic challenges facing the NHS nationally and in London. He reported that the Call to Action was seeking to enable NHS England to work with clinical commissioning groups in the North Central London area to question: how resources should be deployed; how to make significant improvements to the management of long-term solutions; how to use technology to improve access to services and patient outcomes; and how services can be re-designed to meet patient needs.

Members were advised that the Call to Action had been a recent subject for discussion at the Greater London Assembly Health Committee and there was a drive for a more strategic London-wide approach to all elements of NHS service provision. The Committee noted that the Mayor of London had no statutory powers in relation to health.

Whilst the Committee noted the potential for the Call to Action to herald a significant change in the NHS, it was highlighted that a reform of GPs would be required to achieve this. It was noted that larger medical centres had better outcomes for patients, but 40% of GPs in London were single-handed practices. Under the previous primary care trusts system, some GPs had achieved transformational change whilst others had not. It was emphasised that a joined up approach (e.g. the alignment of all GP contracts) would be required to deliver transformational change.

Resolved that –
The Committee receive a full report at the March 2014 meeting on NHS England's Call to Action in relation to GPs.

8. DENTISTRY

The Committee received an update from Alice Benton (NHS England) and Rita Patel (North East London Dental Commissioning Lead) on dentistry in North Central London. They advised the Committee that whilst they were in the Primary Care Directorate at NHS England, they commissioned dentistry in primary care settings, acute hospital trusts, specialist and out-of-hours services.

Members noted that oral health promotion (adults and children) were services that were now commissioned by local authority public health functions.

It was acknowledged that out of hours dentistry provision was a major issue and the Committee were informed that steps were being taken to address this through the establishment of triage services and an urgent referral pathway.

The Committee highlighted that NHS dentistry was only serving approximately 50% of the population and expressed concern regarding the accessibility and affordability of private dentistry.

Resolved that:
The Committee consider this as a substantive item of business at a future meeting to include submissions from individual borough clinical commissioning groups and public health, with specific reference to oral health promotional activity.

9. RECOVERY OF COSTS BY NHS TRUSTS FROM NON UK NATIONALS

The Committee welcomed Simon Blazer (University College Hospital London NHS Foundation Trust) and Lubna Dharssi (Barnet and Chase Farm Hospitals NHS Trust) who were in attendance to outline the approach of the two trusts to recovering costs from non UK nationals. Dr Wagman, a former NHS consultant, was also in attendance to address the Committee on this item.

Lubna Dharssi reported that Barnet and Chase Farm Hospitals NHS Trust had two overseas officers in post. The officers had interviewed over 400 patients and had recovered £200K from 200 overseas visitors in the last year. Where patients had absconded without payment, debts were pursued and in some cases the Home Office were advised resulting in some overseas visitors being denied entry back into the UK. It was highlighted that the Trust had to operate within Department of Health guidelines which meant that some treatments (such as emergencies or clinically urgent) could not be denied even if there were questions regarding the patients eligibility.

Simon Blazer reported that University College Hospital London NHS Foundation Trust had a similar structure in place regarding overseas visitors. A team of four overseas officers were in place and £1.9 million had been invoiced by the Trust across all six hospital sites from overseas visitors and private patients. It was noted that of the £1.9 million invoiced, approximately 50% had been collected which compared favourably to the national average of 35%. £200K had been written off at the advice of the debt collection agency and £100K was being paid in instalments. He added that his collection team operated Monday to Friday 9am–5pm and acknowledged that some presentations of overseas visitors could be missed due to these staffing limitations.

Simon Blazer added that all presentations at A&E were treated without charge, with charges only applying if the patient was admitted. Issues included failed asylum seekers due to them having no return date to their native country which made clinical decisions difficult and patients having communicable diseases meaning that there was a public interest in treating them to minimise the impact on the wider population.

The Committee requested statistics from both trusts on presentations of overseas visitors at A&E and maternity.

The Committee questioned how ward staff checked eligibility. Simon Blazer

reported that staff would review their records and if there was any query regarding the status of the patient, an interview would be conducted. EU citizens would be treated and costs recovered in accordance with reciprocal arrangements in place with EU Member States.

Dr Wagman informed the Committee that the current system was open to abuse and estimated that the cost of health tourism to the NHS was in the region of £2 billion a year. He considered that a system review, including changes to the Department of Health guidelines, was required to address this issue effectively.

The Committee noted that the government were currently consulting on a proposal to introduce a £200 visa levy.

Resolved that:
The minute extract above be referred to the Chief Executives of NHS trusts operating in North Central London and that they be requested to provide a response to the Committee on the issues raised, with their submissions reported to the March 2014 meeting.

10 JHOSC SEMINAR ON IMPLICATIONS OF THE FRANCIS REPORT

The Committee considered a paper which detailed the outcome of the North Central London JHOSC on the implication of the Francis Report for Health Scrutiny.

Members noted that access to complaints information and having guidance and support on how to access and interrogate effectively performance data that was available were some of the key themes emerging.

The Committee commented that there was a lack of coordination between the different monitoring agencies. It was also suggested that there needed to be an appropriate balance between performance targets and patient outcomes.

Resolved that:
The findings from the North Central London JHOSC on the implication of the Francis Report for Health Scrutiny be referred to the London Scrutiny Network for further discussion.

11 WORK PLAN AND DATES FOR FUTURE MEETINGS

The Committee noted the future meeting dates and work programme.

Members were informed that the Chairman would be holding a work programming workshop and that any updates to the work programme would be reported to the Committee in due course.

Resolved that:
The following items to be added to the Forward Work Programme:

- Mental Health
- Cancer and Cardiovascular Service Reconfigurations

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NCL Joint Health Overview and Scrutiny Committee

7 February 2014

Proposed acquisition of Barnet and Chase Farm Hospitals NHS Trust

UCLPartners
Academic Health Science Partnership

Royal Free London NHS
NHS Foundation Trust

How we got here

- Sept 2012 BCF chose RF as its preferred partner to achieve foundation trust status
- Nov 2012 strategic health authority agreed outline case
- Clinicians at both trusts, commissioners and regulators began exploring viability of acquisition in more detail
- Main considerations:
  - Benefits for patients
  - Economic benefits
  - Improved performance
  - Sufficient transition funding
  - Support from key partners
  - Best option for Royal Free

Current position and timetable

- Aug 2013 competition regulator gave go-ahead
- Jan 2014 RF submitted business case to Trust Development Authority
- CCGs meetings to 30 Jan – considering support
- Monitor's three-month assessment of five-year plan is underway
- May 2014 Royal Free council of governors
- 1 July anticipated day 1 of expanded organisation

Why does the RF want to do this? (1)

- Our vision:
  - to offer world class care and expertise
  - through our tripartite mission of service, research and teaching
- We measure our progress against five governing objectives

Why does the RF want to do this? (2)

- Excellent outcomes in clinical services, research and teaching
- Excellent experience for patients, staff and GPs
- Excellent value for taxpayers' money
- Safe and compliant with external duties
- A strong organisation

Why does the RF want to do this? (3)

- Excellent outcomes:
  - High quality services, nearer or in patients' homes
  - Swifter access to specialist services
  - Broader research base and more patients in clinical trials
  - Richer training experience for thousands of staff

- Excellent experience:
  - Consistently good patient experience on all sites, fewer hospital visits
  - More secure future for the organisation and better career prospects and training for many staff
  - Closer partnerships with commissioners and GPs

Why does the RF want to do this? (4)

- Excellent value for taxpayers' money:
  - More efficient and productive services
  - Lower costs as back offices combine
  - Economies of scale
- Safe and compliant with external duties:
  - Patient safety will be paramount
  - Robust clinical and corporate governance
  - Excellent access to services
- A strong organisation:
  - Better able to meet rising expectations despite financial austerity
  - A wider population can influence the shape of services
  - More depth and resilience

What services where after 1 July?

- BEH clinical strategy unaffected by acquisition, so:

Barnet Hospital

- rebuilt and expanded A&E department
- urgent care centre for adults, complex planned surgery, emergency surgery
- children's emergency department, full paediatric services, including neonatal services
- full maternity services, gynaecology services and an early pregnancy assessment unit

What services where after 1 July?

Chase Farm Hospital

- urgent care centre for adults and children
- planned surgery
- GP out-of-hours service
- paediatric assessment unit
- older person's assessment unit
- out-patient services, rehabilitation services, therapies and diagnostics
- antenatal and postnatal services

What services where after 1 July?

Royal Free Hospital

- wide range of local and specialist services
- accident and emergency department and GP-run urgent care centre
- major transplant centre for liver, kidney and bone marrow transplants; one of the UK's leading centres for the diagnosis and treatment of liver disease and one of the seven liver transplant centres in the UK; leading plastic surgery unit; leading centre for other specialties
- internationally renowned teaching and research

BARNET AND CHASE FARM HOSPITALS NHS TRUST

TO: Tim Peachey, Interim Chief Executive

FROM: Martyn Jeffery, Director of Estates and Facilities

DATE: January 2014

SUBJECT: Hospital Food - Steamplicity

For: Information

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1. INTRODUCTION

Barnet and Chase Farm Hospitals NHS Trust have been using Steamplicity, a plated patient dining system, for over 5 years with high levels of customer satisfaction.

Each meal is cooked in bespoke packaging that contains a patented steam-release valve. Like a mini pressure cooker, it regulates the temperature throughout the cooking process keeping the food in optimum condition. Food retains its colour, texture and more of the valuable nutrients. The microwave's energy creates steam from water present in the ingredients and as steam builds up the patented valve controls how the pressure is released and how long the food is cooked for.

As illustrated in the table below, using Steamplicity reduces costs such as equipment, maintenance, energy, sundries and labour. This means more money is spent on the food ingredients, providing a better quality meal which can consistently be repeated as the portions are measured off the ward.

	Steamplicity	Conventional	Cook Chill
Food cost	80%	40%	60%
Labour cost	10%	50%	20%
Sundries	10%	10%	20%

In an independent study comparing the relative food intake of patients eating Steamplicity and Cook Chill food, the results showed that food consumption increased with Steamplicity meals by 36%.

2. THE BENEFITS OF STEAMPLICITY

Improved Quality and Choice

Steamplicity meals are served to the patient straight after cooking ensuring they are hot and they retain more taste due to being pressure cooked and not re heated.

Patients are offered a choice of 38 hot meal options, 5 salads and 7 sandwiches every lunch and supper. Each meal includes a starter, main meal and dessert with the standard menu being supported by ethnic, religious and modified texture menus.

To assist the patients in making their choice, Steamplicity menus are available to every patient in the standard format (Appendix A).

Steamplicity menus are also available in:
Large print and pictorial
Braille
French
Bengali
Turkish
Farsi
Gujarati
Polish
Portuguese

With separate menus for:
Halal
Kosher
Caribbean
Modified texture

REDUCED COSTS

Waste
Medirest's plated meal system operates with approx 1% waste as patients' orders are taken less than 3 hours before the meal service. Patients get what they have ordered and not the patient's before. The amount ordered is delivered to the ward, there is no need for spares and if patients do change their mind this can be provided within 30 minutes. With a bulk system, meals are prepared much further in advance, there is a choice of 3 or 4 main course items and to give the last patients on the ward a choice there is typically waste of 20-25%.

Energy Use
Microwave ovens are used to steam cook meals which use circa 40% less energy than the conventional methods of cooking patients' meals on-site.

Labour
There is a considerable food production labour saving as this is done at Medirest's cuisine centre rather then on site.

Increased Nutritional Value
Steaming is one of the healthiest ways to cook food and retains high levels of nutrients in the food. To prove this applies to Steamplicity, Medirest commissioned a number of independent reports to scrutinise the product and collectively these reports demonstrated the positive nutritional values of Steamplicity meals. In particular, independent research by Leatherhead Food International showed that, when compared with traditional cooking methods, Steamplicity broccoli retained more than twice the vitamin C and nearly twice the folic acid. Steamplicity meals are packaged with a patented pressure

valve and the food in the Steamplicity meal which is predominantly raw is pressure cooked, retaining considerably more nutrients and the taste of freshly cooked food than traditionally cooked or regenerated systems.

The menus are approved by Trust dieticians and come with full nutritional analysis.

Flexibility
It only takes 3-4 minutes to cook a Steamplicity meal which allows meals to be cooked just after the patient has been made comfortable and ready for their meal. Not only does this mean there is less waste but also meals can be cooked outside the usual meal times to suit the patients' needs rather than resorting to sandwiches.

3. OVERVIEW OF THE PROCESS

Steamplicity meals are prepared in two cuisine centres with meals for Barnet and Chase Farm being supplied by Medirest's London Colney unit.

The meals have a 7 day shelf life with 5 days stock being held on site at any time in the catering department. Patients' orders are taken by Medirest hostesses at Barnet and nurses at Chase Farm (due to the contract set up) at circa 10am for lunch and 3pm for supper.

Ward orders are compiled by the Medirest catering department and delivered to the ward in insulated boxes (temperature probed on delivery) and decanted into ward refrigerators just in time for the meal service ensuring food safety and an audit trail throughout the process.

Whilst Medirest provide full training the cooking process is simple. All meals are temperature checked after cooking maintaining food safety up to being given to the patient ensuring the patient gets a hot meal every time.

Medirest's systems are rigorously checked biannually by STS, their external food safety organisation, giving the Trust the confidence in the safety of the process.

Equipment Required
Steamplicity is a simple system and only requires 3 13amp microwaves and refrigerator per standard ward though this is varied according to patient numbers per ward. Where there is insufficient space in the ward, we provide mobile units with the microwaves which are transported to the ward at meal times and returned to the central kitchen when not in use.

4. COSTS

Patients' meals at Chase Farm were switched from the Cook Chill contract in 2004 contract to Steamplicity in 2009 without changing the meal price.

The cost per patient day (breakfast, Steamplicity lunch and supper, 2 snacks and 7 hot drinks) is detailed below:
Chase Farm: £7.10
Barnet: £7.10

5. QUALITY CONTROL

Medirest measure customer satisfaction through their "Patient Navigator" Surveys which they carry out on 100% of the bed state over a year (Medirest are increasing to 200% in 2014). These ask over 40 questions relating to their meal experience including choice, assistance provided and the quality of the food.

The last three quarterly reports show the overall meal quality score for the two sites with the full report attached in appendix E and F and have been amended in Q 2 to include the three CQC questions asked in their surveys.

Site	Q1 2012/13	Q2 2012/13	Q3 2012/13
Chase Farm	78%	79%	81%
Barnet	100%	90%	92%

The scores could be affected by who provides the hostess service and the quality of the building.

Medirest also carry out client interviews with ward managers and nursing staff to ensure they capture the opinions of all parties especially as nurses order meals for some patients who are not able to order for themselves. STS carry out quality checks on Medirest systems.

EHO Inspections
Every business serving food must have a food management safety programme which is a systematic approach to control food safety hazards within a business in order to ensure that food is safe at the time of consumption. It is based on Hazard Analysis Critical Control Point (HACCP) principles as set out in Article 5 of Regulation (EC) No. 852/2004 on the hygiene of foodstuffs.

Environmental Health Inspections are carried out to ensure these systems are in place. Environmental Health inspections at both Barnet and Chase Farm have proved positive as the way the Steamplicity food is packaged, stored, cooked and served presents a low risk with regard to food bacteria.

All staff serving food must have food hygiene training before serving food to patients and Environmental Health Inspectors will check these records when they attend site along with other HACCP information.

Currently both Barnet and Chase Farm systems have a score of 5 (very good) following EHO Inspections. Greenfields Restaurant has a score of 4 (good) mainly due to its condition.

HACCP
The HACCP information at Barnet and Chase Farm consists of records of fridge temperatures both at the Medirest delivery point and on the wards are kept to ensure food is stored correctly and an appropriate food hygiene audit trail is maintained.

The meals are probed following cooking to ensure they are served at the correct temperature and this information is also recorded ready to be inspected by the Environmental Health Officer when they attend site**.**

Other HACCP information retained are the food hygiene safety training records and cleaning schedules.

PLACE

In the 2013 Patient Led Assessments of the Care Environment, food at Chase Farm Hospital scored 90.01% and food at Barnet Hospital scored 85.07% against a national average of 84.98%.

Appendix A

We consider the enjoyment of your meals very important and we have planned this menu to be well balanced to meet your needs. We use Steamplicity; a system which freshly cooks food under steam pressure to retain all the taste and goodness. We hope you enjoy your meals during your stay.

Eating and drinking is an important part of your treatment and care. If you are having difficulty finding food you can eat, please ask someone to contact the Catering Team and someone will visit you to discuss your needs.

Using this menu

- This menu is to help you choose your main meals. Breakfast will be served by your ward host, hostess or nurse.
- Some special diets are catered for on this menu. However, other menus are available for people with food allergies as well as for people who need Halal, kosher, Asian Vegetarian and Caribbean meals.
- If you have a special dietary requirement which the dietitian has told you about, look for the relevant symbol on the menu next to each dish.
- Although dishes do not contain nuts in the ingredients, we cannot guarantee that traces of nuts may not be present. Please ask for our **Allergy Menu** or alert your nurse if you have a nut or other severe food allergy.
- Menus are available in other formats including larger print with pictures, translated into 7 other languages and Braille.
- A choice of drinks will be offered to accompany your meals.

Special Diets

Diabetes
On this menu, most people with diabetes may choose starters and main courses freely but should select desserts marked ♥ which contain less than 15g added sugar. However some people with diabetes needing a lower fat diet should only select items marked ♥. Please ask for information regarding the carbohydrate content of your meals if required.

♥ **Healthier Choice.** Main courses have less than 15g fat per portion and have less salt, making them particularly suitable for some people with diabetes and those needing less fat and salt in their diet. Desserts marked ♥ contain less than 15g added sugar and less fat per portion.

E **Higher Energy.** These dishes are particularly high in calories.

S **Softer.** These meals are easier to chew.

V **Vegetarian.** These meals are suitable for vegetarians.

NGCI **No Gluten Containing Ingredients.** These meals do not have any gluten containing ingredients.

Starters

Soup of the Day S
White or Brown Roll and Butter or Margarine on request

Fruit Juice ♥ S V NGCI
Ask the Ward Host/Hostess for today's choice

Fish

All fish is from sustainable sources
NB – Fish dishes may contain small bones

Poached Salmon NGCI
Delicately steamed salmon fillet served with sliced potatoes in a creamy sauce and freshly steamed cabbage

Steamed Fish in Parsley Sauce ♥ NGCI
Steamed white fish with parsley sauce, served with mashed potatoes and garden peas

Steamed Fish in Parsley Sauce – softer version ♥ S NGCI
Steamed white fish with parsley sauce, served with carrot and swede mash

Fish and Chips E
Served with mushy peas

Cajun Salmon ♥ NGCI
Tender pieces of salmon in a tomato sauce with rice, onions and peppers

Beef

Beef Casserole and Dumpling
Tender chunks of beef in a rich gravy served with steamed broccoli, mashed potatoes and a dumpling

Savoury Minced Beef S NGCI
Traditional minced beef in gravy served with carrot and swede mash

Traditional Beef Lasagne E S
Traditional Italian style layered pasta dish served with courgettes tossed in basil oil

Roast Beef
Sliced roast beef served with Yorkshire pudding, roast potatoes, carrot and swede mash, broccoli and gravy

Chilli con Carne E NGCI
Served with rice

Lamb

Shepherd's Pie ♥ S NGCI
Traditional minced lamb with a potato top served with freshly steamed diced carrots and courgettes

Savoury Minced Lamb ♥ S NGCI
Minced lamb, served with boiled potatoes and carrot and swede mash

Pork

Sausage and Mash E
Traditional Cumberland sausages with a red onion gravy, served with mashed potatoes, diced carrots and garden peas

All Day Breakfast E
Not breakfast but a main meal version of a typical cooked breakfast containing a Cumberland sausage, mini omelette, mushrooms, baked beans and rosti potatoes

Chicken

Traditional Chicken ♥
Breast fillet of chicken in a rich gravy served with roast potatoes, carrot and swede mash, broccoli and sage and onion stuffing

Chicken Tikka Masala and Rice E NGCI
Tender pieces of chicken tikka masala on a bed of yellow rice

Chicken, Broccoli and Mushroom Pasta E
Breast of chicken pieces, broccoli, mushrooms and pasta in a creamy herb sauce with a hint of garlic

Chicken and Mushroom Pie E
A delicious chicken and mushroom suet pastry pie served with chips and mushy peas

Sweet and Sour Chicken
Served with rice

Vegetarian

NEW **All Day Vegetarian Breakfast** V NGCI
A vegetarian version of our All Day Breakfast containing an omelette, baked beans, mushrooms and rosti potatoes

Five Bean Chilli ♥ V NGCI
Chunky five bean chilli served with yellow rice (vegan)

Cauliflower and Broccoli Cheese E V NGCI
Delicately steamed cauliflower and broccoli florets with a rich cheese sauce with melted cheese and served with sliced potatoes

Pasta with Tomato and Basil Sauce E S V
Pasta with a rich tomato and basil sauce with mature cheddar cheese. Optional side salad on request

Plain Omelette V NGCI
A light fluffy omelette, served with sliced potato gratin, diced carrots and garden peas

Macaroni Cheese E S V
Pasta in a cheese sauce with mature cheddar cheese
Optional side salad on request

NEW **Chickpea and Sweet Potato Curry** E V NGCI
A mild vegetable curry served with yellow rice (vegan)

Cheesy Omelette and Spinach E V NGCI
A folded omelette with spinach, a hint of onion, mature cheddar sauce and potato gratin

Small, Simple and Light Selection

These special dietary meals that are served without vegetables offer a plainer, lighter meal option.

Plain Omelette S V NGCI
(special diet version) With mashed potatoes

Chicken Pasta E
(special diet version) Chicken pieces with pasta in a white sauce

NEW **'Meal' Soup**
If you wish a lighter meal or simply fancy a delicious bowl of soup served with a roll and butter instead of a main course, then choose from one of these 4 delicious flavours:

Cream of Tomato Soup S V NGCI
Mushroom Soup S V
Cream of Chicken Soup S
Country Vegetable Soup V NGCI
Codes apply to soup without roll

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North Middlesex University Hospital NHS
NHS Trust

JOINT SCRUTINY COMMITTEE
7th February 2014
Food in Hospitals

1. Introduction

North Middlesex Hospital use a patient catering system supplied under contract from The Compass Group represented by Medirest. The cooking system is called Steamplicity and has a unique patented cooking process that steams food to a prepared state in just four minutes using designed microwave equipment. The benefits of this system include cost savings, space reduction, fresher, more nutritious food, broader menu choice and the ability to cater for special diets more easily.

2. How we deal with maintaining high standards of food service

Options and patient choice is important when selecting a system and we believe that Medirest menus impact on the overall patient meal experience without the complexity of having an onsite production kitchen. Steamplicity meal production is produced off-site in a controlled environment by Medirest. This ensures that every meal provided is of a consistent, high standard and cooking conditions monitored. The audit process checks diligence records, staff training, food handling and transport logistics to ensure compliance within strict temperature controls and quality parameters.

Full patient satisfaction surveys are completed on a quarterly basis and action taken to ensure the desired standards are achieved following any negative feedback. An example of a typical meal postcard survey is attached. There is one question on NHS Patients Choice website relating to hospital catering at NMH which feed in to the KPI information, which is monitored by the Trust Executive Team regularly.

Trust staff undertake food sampling twice a year especially when there is a change in menu design or when our PLACE audits occur. We also meet on a monthly basis with the contractor to ensure their service performance is consistent. A monthly action report is supplied by our contractor that allows a first-hand view of the service provision and other practical issues – an example of this can be made available if required.

3. Identifying what choice patients are given

There is daily communication with patients about meal options where each patient is given a choice of starter, main and dessert from the Steamplicity menus provided. Medirest are able to provide a wide range of meal options suitable for a variety of diets or health requirements. A menu example of this is attached.

The Steamplicity menu offers 30 meal options catering for all vegetarians, gluten intolerant, soft textures, low salt, healthy options and high energy meals. Additionally a range of Halal, Afro Caribbean & Kosher meals are available from an alternative menu along with, where requested, a dedicated soft texture menu for those who have difficulty eating solid foods.

Our contract caterer also offers a variety of fruit, soups and snack items which can be served as a supplement and build up option as directed by dieticians for both inpatients and day patients who can further choose from seven sandwich choices.

Tea, coffee or hot chocolate is served through the day along with still water served and refreshed on a regular basis in jugs.

4. Feedback we have received from these patients

Frequent feedback is supplied at ward level to Medirest. They conduct their own patient satisfaction surveys each quarter with the results being presented to the Trust. These results are reviewed with improvements made where practicable in order to maintain a high standard of service to patients.

The Trust's own patient experience tracker generates weekly and monthly results which are reviewed on a ward by ward basis and again actions taken where necessary and specific improvement considerations given where applicable. With the varied ethnicity of the local area, an attempt, where possible, is made to meet varied ethnicity requirements, i.e. halal, kosher food etc.

5. Food production at NMH

Medirest's use of technology makes Steamplicity unique. Each meal is 'cooked' in its packaging that contains a patented steam-release valve - like a mini pressure cooker that regulates temperature throughout the cooking process. This maintains the nutritional value within the cooked food rather than it being dispersed by over cooking.

Medirest's menus are approved and are jointly reviewed with on-site dieticians every 6 months or when there is a menu update. Each review consists of sampling new dishes and an assessment of the meal's ingredients and calorific contents is made. These exercises are conducted through the Lead Dietician and include the Trust's Dietician Team who are involved in the food supply chain at NMH.

Medirest assist the Trust dieticians by arranging awareness visits to its Steamplicity Production Centre and conducting training with staff. Medirest arrange nutrition and dementia awareness seminars, which are deemed essential for this illness. The relationship between Medirest, the Trust and the nutritionists is important to monitor how food influences the wellbeing of all patient groups.

6. How we have enhanced our food provision with nutritionists over the past couple of years

The Trust has increased the variety of fresh fruit to encourage patients to eat healthier. Main meal soups have been added to the menu following requests from patients and nutrition professionals asking for this option. Jacket potatoes have been added alongside a number of fillings and this can be served as a main meal or as an addition to another meal when requested by dieticians.

The beverage trolley round has been enhanced to promote fluid intake. New quality products have been introduced across the site with Nestle Hot Chocolate, Nescafe Coffee and Tetley Tea now being served instead of unknown products.

Electronic Meal Ordering Tablets are being used across the site for patient meal ordering. This provides improved accuracy and eliminates administrative errors. The system provides those involved with a clear record of meals ordered and full traceability throughout a patients stay allowing dieticians to have visibility of the calorific intake of patients over the period of their hospital admission where that is being closely monitored. The system has future applications such as tracking patient moves and amended meal request provision, satisfaction surveying and allowing nutritional and dietary information to be available at the touch of a button.

With obesity becoming an issue in the UK we also work closely with the Trust's nutritionists to ensure portion sizes of meals are fit for purpose and are adequate to assist a balanced controlled diet following up on the potassium and salt content adjustment and where approved, offer additional build up/energy products.

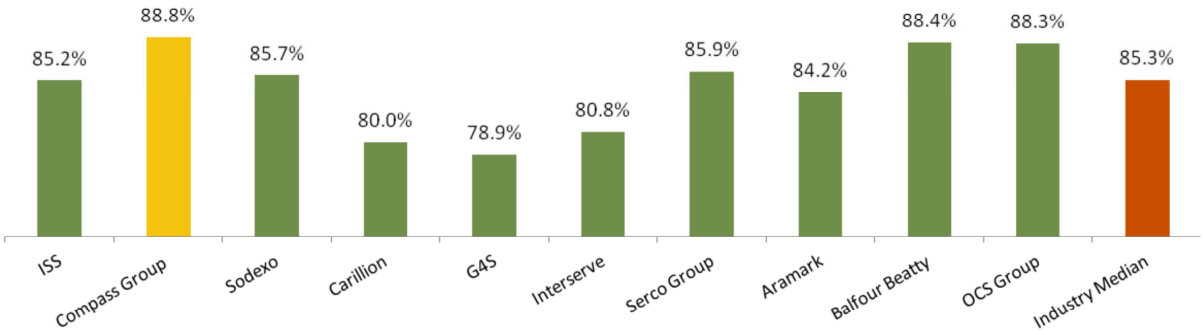
6. Cost per patient

Food costs per patient per day = £11.64 which is made up of £6.91 labour and £4.73 food and beverage cost. NMH via this catering contract, provide 20,306 meals a month to inpatients and 4,500 sandwiches to day patients. These are delivered to patients along with condiments by nursing staff who monitor consumption of any vulnerable patients, and reporting this, where necessary, to dieticians.

7. Overview of NMH food service

Comparative PLACE (Patient Lead Assessment of Care Environment) information compiled by our current contractor puts the hospital catering system in a strong market position in terms of quality of catering services. It also indicates that contracted supply services are of a higher quality and are better managed than those sites where in-house services exist with contracted services attaining 4.4% higher than self-operated industry median scores (see below).

The graph below gives indicative positioning of our site contractor's performance across the catering market sector in relation to submitted PLACE scores and is reassuring that the performance range is in the high percentile.



NMH PLACE scores results for 2013 were 91.24% with the Environmental Health Officers evaluation known as 'scores on the doors' being graded at 5* (excellent).

Kevin Howell
Director of Environment, January 2014

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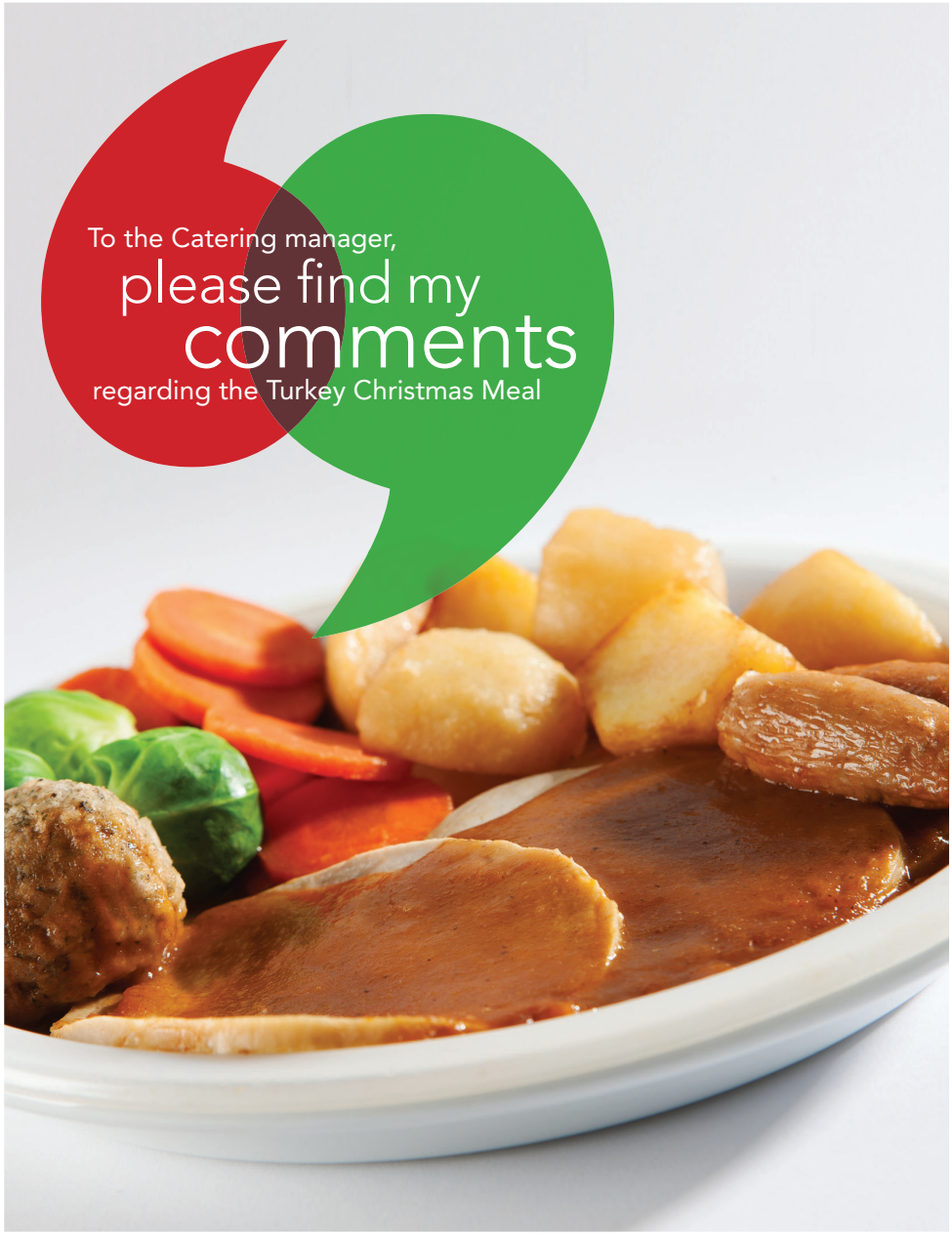


medirest

steamplicity
all the taste, all the vitality!

Postcard Surveys

We hope that you enjoyed your meal today.

Please take a couple of minutes to let us know what you thought of the dish so that Medirest can act on your feedback.

How would you rate the dish for how it: (please tick)

	Excellent	Very good	Good	Fair	Poor
Looked					
Smelled					
Tasted					
Felt in the mouth					

Was the food temperature: (please tick)

☐ Too hot ☐ Just right ☐ Too cold

Was the portion size: (please tick)

☐ Too big ☐ Just right ☐ Too small

Would you order this dish again? (please tick)

☐ Yes definitely ☐ Yes Maybe ☐ No

What, if anything, could we do to improve the quality of this dish? _____

_____

_____

What other dishes would you like to see on the menu? _____

_____

_____

Thanks for your feedback

Jacket Potato

A plain jacket potato served with your choice of filling:

Grated Cheddar Cheese E S V NGCI

Cottage Cheese ♥ S V NGCI

Tuna Mayonnaise E S NGCI

Plain Tuna ♥ S NGCI

Baked Beans ♥ V NGCI

Optional side salad on request

Salads

Chicken Salad NGCI

Ham Salad NGCI

Tuna Salad ♥ NGCI

Cheddar Cheese Salad V NGCI

Egg Salad ♥ V NGCI

Sandwich Selection

New and Improved:

Tuna Mayonnaise & Cucumber Sandwich
on Oatmeal Bread

Salmon Mayonnaise & Cucumber Sandwich
on Malted Bread

Chicken Breast and Sage & Onion Stuffing Sandwich E
on White Bread

Sliced Ham & Tomato Sandwich
on White Bread

Mature Cheddar Cheese & Tomato Sandwich V
on Malted Bread

Free Range Egg Mayonnaise & Cress Sandwich V
on Malted Bread

Falafel & Houmous Salad Sandwich V
on Malted Bread **(vegan)**

NB: A small selection of sandwiches made with gluten free bread is available from the diet bay.

Hot Desserts

Improved:

Served with custard

Gooey Chocolate Sponge and Chocolate Sauce E S V

Steamed Raspberry Jam Sponge E S V

Apple Crumble E V

Traditional Syrup Sponge E S V

NEW Sultana and Cranberry Sponge Pudding E V

Rhubarb and Apple Crumble ♥ V

Other Desserts

Fresh Fruit or Tinned Fruit in Natural Juice
Subject to availability/daily specials:

Fresh Apple ♥ V NGCI

Fresh Orange ♥ V NGCI

Fresh Banana ♥ S V NGCI

Tinned Peaches in Juice ♥ S V NGCI

Tinned Pears in Juice ♥ S V NGCI

Tinned Sliced Pineapple in Juice ♥ V NGCI

Tinned Fruit Cocktail in Juice ♥ V NGCI

Ambrosia Rice Pudding S V NGCI or

Ambrosia Rice Pudding (Low Fat) ♥ S V NGCI
Served hot or cold

Plain Custard ♥ E S V NGCI

Ambrosia Chocolate Custard Pot S V NGCI

Traditional English Trifle S V

Jelly S NGCI

Sugar Free Jelly ♥ S NGCI

Fruit Yoghurt S V NGCI

Diet Fruit Yoghurt ♥ S NGCI

Cheese and Biscuits V

medirest

Scan the QR code to find us on Facebook or follow the link below.

www.facebook.com/steamplicity

steamplicity
all the taste, all the vitality!

Lunch and Supper menu

Autumn/Winter 2013

Please leave this menu for the next patient.
Thank you

We consider the enjoyment of your meals very important and we have planned this menu to be well balanced to meet your needs. We use Steamplicity; a system which freshly cooks food under steam pressure to retain all the taste and goodness. We hope you enjoy your meals during your stay.

Eating and drinking is an important part of your treatment and care. If you are having difficulty finding food you can eat, please ask someone to contact the Catering Team and someone will visit you to discuss your needs.

Using this menu

- This menu is to help you choose your main meals. Breakfast will be served by your ward host, hostess or nurse.
- Some special diets are catered for on this menu. However, other menus are available for people with food allergies as well as for people who need Halal, kosher, Asian Vegetarian and Caribbean meals.
- If you have a special dietary requirement which the dietitian has told you about, look for the relevant symbol on the menu next to each dish.
- Although dishes do not contain nuts in the ingredients, we cannot guarantee that traces of nuts may not be present. Please ask for our **Allergy Menu** or alert your nurse if you have a nut or other severe food allergy.
- Menus are available in other formats including larger print with pictures, translated into 7 other languages and Braille.
- A choice of drinks will be offered to accompany your meals.

Special Diets

Diabetes
On this menu, most people with diabetes may choose starters and main courses freely but should select desserts marked ♥ which contain less than 15g added sugar. However some people with diabetes needing a lower fat diet should only select items marked ♥. Please ask for information regarding the carbohydrate content of your meals if required.

♥ **Healthier Choice.** Main courses have less than 15g fat per portion and have less salt, making them particularly suitable for some people with diabetes and those needing less fat and salt in their diet. Desserts marked ♥ contain less than 15g added sugar and less fat per portion.

E **Higher Energy.** These dishes are particularly high in calories.

S **Softer.** These meals are easier to chew.

V **Vegetarian.** These meals are suitable for vegetarians.

NGCI **No Gluten Containing Ingredients.** These meals do not have any gluten containing ingredients.

Starters

Soup of the Day S
White or Brown Roll and Butter or Margarine on request

Fruit Juice ♥ S V NGCI
Ask the Ward Host/Hostess for today's choice

Fish

All fish is from sustainable sources
NB – Fish dishes may contain small bones

Poached Salmon NGCI
Delicately steamed salmon fillet served with sliced potatoes in a creamy sauce and freshly steamed cabbage

Steamed Fish in Parsley Sauce ♥ NGCI
Steamed white fish with parsley sauce, served with mashed potatoes and garden peas

Steamed Fish in Parsley Sauce – softer version ♥ S NGCI
Steamed white fish with parsley sauce, served with carrot and swede mash

Fish and Chips E
Served with mushy peas

Cajun Salmon ♥ NGCI
Tender pieces of salmon in a tomato sauce with rice, onions and peppers

Beef

Beef Casserole and Dumpling
Tender chunks of beef in a rich gravy served with steamed broccoli, mashed potatoes and a dumpling

Savoury Minced Beef S NGCI
Traditional minced beef in gravy served with carrot and swede mash

Traditional Beef Lasagne E S
Traditional Italian style layered pasta dish served with courgettes tossed in basil oil

Roast Beef
Sliced roast beef served with Yorkshire pudding, roast potatoes, carrot and swede mash, broccoli and gravy

Chilli con Carne E NGCI
Served with rice

Lamb

Shepherd's Pie ♥ S NGCI
Traditional minced lamb with a potato top served with freshly steamed diced carrots and courgettes

Savoury Minced Lamb ♥ S NGCI
Minced lamb, served with boiled potatoes and carrot and swede mash

Pork

Sausage and Mash E
Traditional Cumberland sausages with a red onion gravy, served with mashed potatoes, diced carrots and garden peas

All Day Breakfast E
Not breakfast but a main meal version of a typical cooked breakfast containing a Cumberland sausage, mini omelette, mushrooms, baked beans and rosti potatoes

Chicken

Traditional Chicken ♥
Breast fillet of chicken in a rich gravy served with roast potatoes, carrot and swede mash, broccoli and sage and onion stuffing

Chicken Tikka Masala and Rice E NGCI
Tender pieces of chicken tikka masala on a bed of yellow rice

Chicken, Broccoli and Mushroom Pasta E
Breast of chicken pieces, broccoli, mushrooms and pasta in a creamy herb sauce with a hint of garlic

Chicken and Mushroom Pie E
A delicious chicken and mushroom suet pastry pie served with chips and mushy peas

Sweet and Sour Chicken
Served with rice

Vegetarian

NEW All Day Vegetarian Breakfast V NGCI
A vegetarian version of our All Day Breakfast containing an omelette, baked beans, mushrooms and rosti potatoes

Five Bean Chilli ♥ V NGCI
Chunky five bean chilli served with yellow rice **(vegan)**

Cauliflower and Broccoli Cheese E V NGCI
Delicately steamed cauliflower and broccoli florets with a rich cheese sauce with melted cheese and served with sliced potatoes

Pasta with Tomato and Basil Sauce E S V
Pasta with a rich tomato and basil sauce with mature cheddar cheese. Optional side salad on request

Plain Omelette V NGCI
A light fluffy omelette, served with sliced potato gratin, diced carrots and garden peas

Macaroni Cheese E S V
Pasta in a cheese sauce with mature cheddar cheese
Optional side salad on request

NEW Chickpea and Sweet Potato Curry E V NGCI
A mild vegetable curry served with yellow rice **(vegan)**

Cheesy Omelette and Spinach E V NGCI
A folded omelette with spinach, a hint of onion, mature cheddar sauce and potato gratin

Small, Simple and Light Selection

These special dietary meals that are served without vegetables offer a plainer, lighter meal option.

Plain Omelette S V NGCI
(special diet version) With mashed potatoes

Chicken Pasta E
(special diet version) Chicken pieces with pasta in a white sauce

NEW 'Meal' Soup

If you wish a lighter meal or simply fancy a delicious bowl of soup served with a roll and butter instead of a main course, then choose from one of these 4 delicious flavours:

Cream of Tomato Soup S V NGCI
Mushroom Soup S V
Cream of Chicken Soup S
Country Vegetable Soup V NGCI
Codes apply to soup without roll

Funding for Mental Health Services: Is there 'Parity of esteem'?

Introduction

The North Central London Joint Health Overview and Scrutiny Committee have invited Barnet, Enfield & Haringey Mental Health Trust, C&I and their respective commissioners to submit a report on funding for mental health services to their committee on 7th February 2014. This follows concerns across the NHS about 'Parity of Esteem' in funding for mental health services. The government policy for mental health services has emphasised that there should be a 'parity of esteem' for mental health services and it should not be considered a poor relation to physical health services.

What health needs and services are covered by BEH and C&I?

Whilst many people use the term mental health services the general public often have different ideas about what this means. As in the rest of health care the portfolio of provision within each Trust are different. The following table provides a brief summary of the portfolios of the two Trusts:

Area	Brief Descriptor	BEH provides	C&I provides
Urgent & acute care	Home treatment and inpatient care for people with variety of mental health needs	√	√
Psychosis	Services for people with schizophrenia and bipolar disorder	√	√
Complex Psychological conditions	Severe depression, eating disorders, personality disorders, post-traumatic stress, obsessive compulsive disorder etc (portfolios	√	√

	different between Trusts eg BEH has eating disorders, C&I have trauma services)		
Cognitive impairment	Dementia	√	√
Forensic	Secure provision for people who have also committed an offence and who have a mental illness	√	**X**
Common mental health conditions	Moderate anxiety, depression, simple phobias (provided by IAPT services)	√	√
Child & Adolescent MH services	Services for children and adolescents	√	**X**
Substance Misuse	Treatment of addictions for people with alcohol problems and substance misuse	**X**	√
Learning disabilities	Mental Health specialist services for people with a learning disability	**X**	√

For a number of services such as Forensic or eating disorders C&I service users are referred to BEH services as they require a larger population base to provide a viable service. Some specialist services are duplicated.

In the past 4-5 years the range of mental health services have been extended through the development of:

- IAPT services, which now provide treatments to thousands of people who suffer from common mental health conditions, for whom there was no provision previously.
- Memory Clinics, to diagnose dementia (evidence suggests that early detection, reduces later crises and delays admission to care services) plus other new dementia associated services.

- Autism/ Asperger's services diagnostic

Commissioners have provided additional resources in these areas. In addition over many years there has been pressure on forensic services which have increased expenditure in this area. Commissioners have also funded specific developments within the 'core' portfolio, such as a recently opened Crisis House in Camden.

Key points:

- **BEH and C&I both have a common range of 'core' mental health services, but have different portfolios.**
- **Commissioners have increased the range of services through funding new services in areas where there has been no provision to meet mental health needs.**

Demographic pressures in north central London

Over the recent past the populations of all 5 boroughs have increased, creating additional demand for health and other public services. The mental health needs have also shifted, there appears to be a movement west to east across London and an extension from inner to outer London as low and middle income families cannot afford some inner London boroughs. Islington now has a greater mental health need than Camden (10 years ago it was the reverse) and there has been a significant increase in needs in Haringey and Enfield. A weighted mental health population shows the equivalent of current population served if the mental health need was average for England. The mental health needs for both Trusts are very high, with the highest need levels in Islington, Haringey and Camden.

Area	Population	Mental health weighted population	MHWP/ Population
Camden	220,300	383,719	74%
Islington	206,200	410,405	99%
Total C&I	426,500	794,124	86%

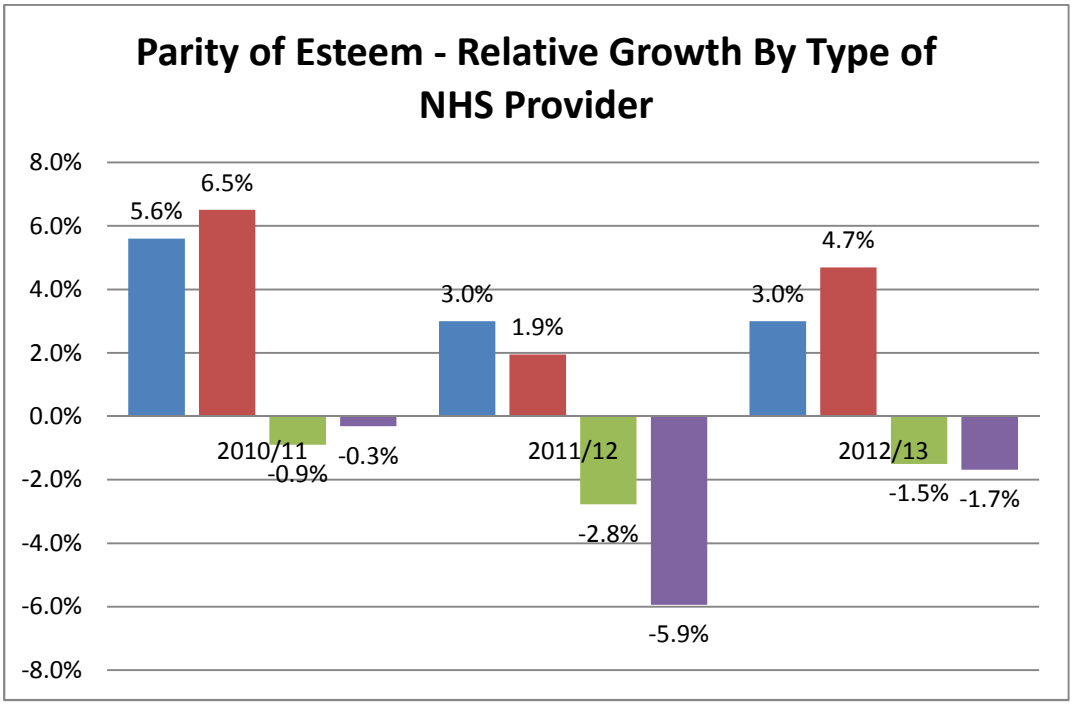
Haringey	254,900	359,399	41%
Enfield	312,400	356,369	14%
Barnet	356,400	381,604	7%
Total BEH	923,700	1,097,373	19%
Total NCL	1,350,200	1,891,497	40%

Figures from the Department of Health PRAMH model used to estimate MH need in the capitation formula

Key Point:

- **The mental health needs for both Trusts are very high.**

Relative income changes by year across North Central London



Acute Trusts are UCLH, RFH, Whittington (exc. community), North Middlesex & BCF.
Mental Health Trusts are C&I, BEH, SLAM, WL, NELFT (exe. community)

The chart shows over the period acute trust growth has always been positive in cash terms while the mental health trusts (with community) have always been negative. The real gap between acute providers and mental health Trusts is 4 to 7% a year. This is enormous. UCLH (+£143M = +21%) and RFH (+£73M =+14%) have been huge winners over the period 2009/10 to 2012/13. Whilst UCLH and RFH have had significant growth all the acute trusts have seen positive cash growth, whilst mental health trusts have shrunk over the period.

It is very clear that despite demographic and other pressures the relative resources for mental health services have reduced in real terms, whilst those for acute have increased significantly. Nationally, the resources for mental health reduced by 2% in real terms in 2012/13, despite the fact that mental health disorders have the highest prevalence of any condition as a group affecting 25% of the population. The lack of available treatment creates significant pressures for primary care and other parts of the public sector.

Unlike acute trusts mental health services have always been funded on the basis of block contracts, this means that funding is adjusted each year by applying the national cost of living increases and a reduction for efficiency. There is no automatic mechanism to fund additional need due to population growth or a change in the need profile of a borough in mental health services.

The picture of overall reduced income is despite the additional funding for services developments. Mental health trusts have therefore had to deliver significant efficiency programmes which they have, for the most part done very successfully for many years. Most acute Trusts have delivered significant proportions of their annual efficiency targets through the financial contribution made by their growth. The surplus component of activity growth plus the difference between marginal and full costs has enabled then to shield operational services from productivity and efficiency requirements. Monitor estimates that at best acute providers have delivered 2% efficiency per year.

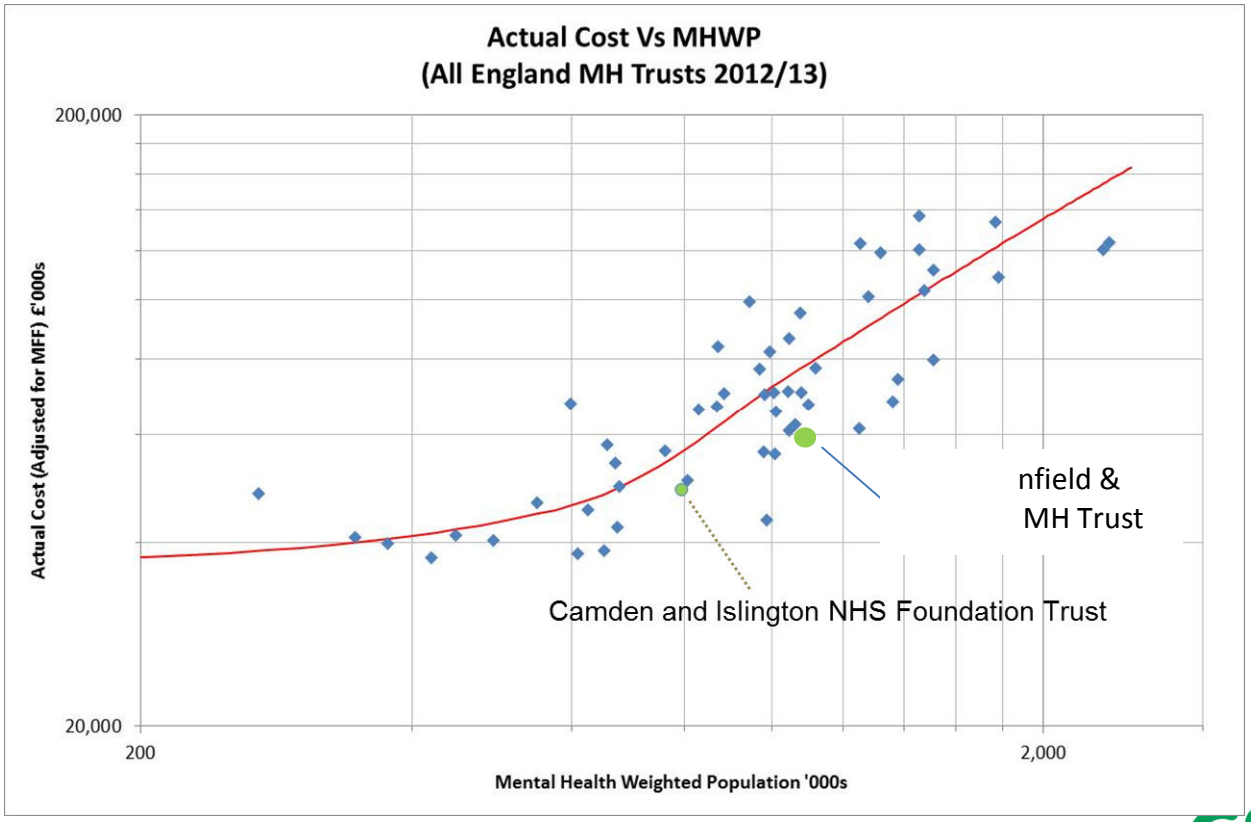
In the national guidance for payment in 2014/15 released in December 2013, the DH and Monitor required an additional 0.3% efficiency from mental health and community providers than acute Trusts. This is currently being challenged as there is no logic to this additional requirement.

Key Points:

- **There have been increased resources to Commissioners**
- **Acute Trusts have had significant growth**
- **Mental Health Trusts have had reduced income despite some developments and the highest health burden**

BEH and C&I Trusts relative efficiency

It could potentially be the case that both mental health trusts are inefficient. The chart below shows the correlation between the mental health weighted



population (MHWP) for Trusts and the reference costs for adult services (adjusted for market forces factor/ high cost areas and excludes specialist services, substance misuse etc)). There is a strong correlation between costs and weighted population served.

Both mental health trusts have lower reference costs relative to MHWP compared to the trend demonstrating efficient provision compared to other MH Trusts.

The chart also examines economies' of scale in mental health provision. Trusts which provide services below 1million MHWP have diseconomies of scale, whilst those above 1.5million MHWP appear to have economies of scale, with the except of those in rural areas with challenging transport networks.

Key Point:

Both Trusts are efficient providers

C&I efficiency programmes

Over the past few years C&I have delivered significant levels efficiency in the years from 2010-11, the Trust delivered:

2012/13	£7.3m
2011/12	£12.1m
2010/11	£3.7m
Total	£23.1m

This is 17% of initial turnover (2009/10 turnover was £137,954k). In 2013/14 we have a further efficiency requirement of £4.9m

The scale of change this required to deliver this has been extensive. In 2011/12 we delivered more than the previous 3 years' worth of efficiencies in one year. The scale required in 2011/12 and subsequent years meant that we decided to completely redesign services rather than take a 'salami slice' approach. Building on the clinical strategy we have aligned all services into care pathways focusing on recovery. Within this we have created a single point of entry for non-urgent care in each borough, created

new models for complex psychological disorders, adopted best international practice for our assertive outreach services and developed new structures for people with long term psychoses to promote personalization and recovery. In urgent care, we redesigned the care pathway introducing an assessment ward, including recently piloting Sunday ward rounds, and have significantly reduced average length of stay. The new Camden Crisis house adds another welcome alternative to inpatient admission for service users.

During this period we have:

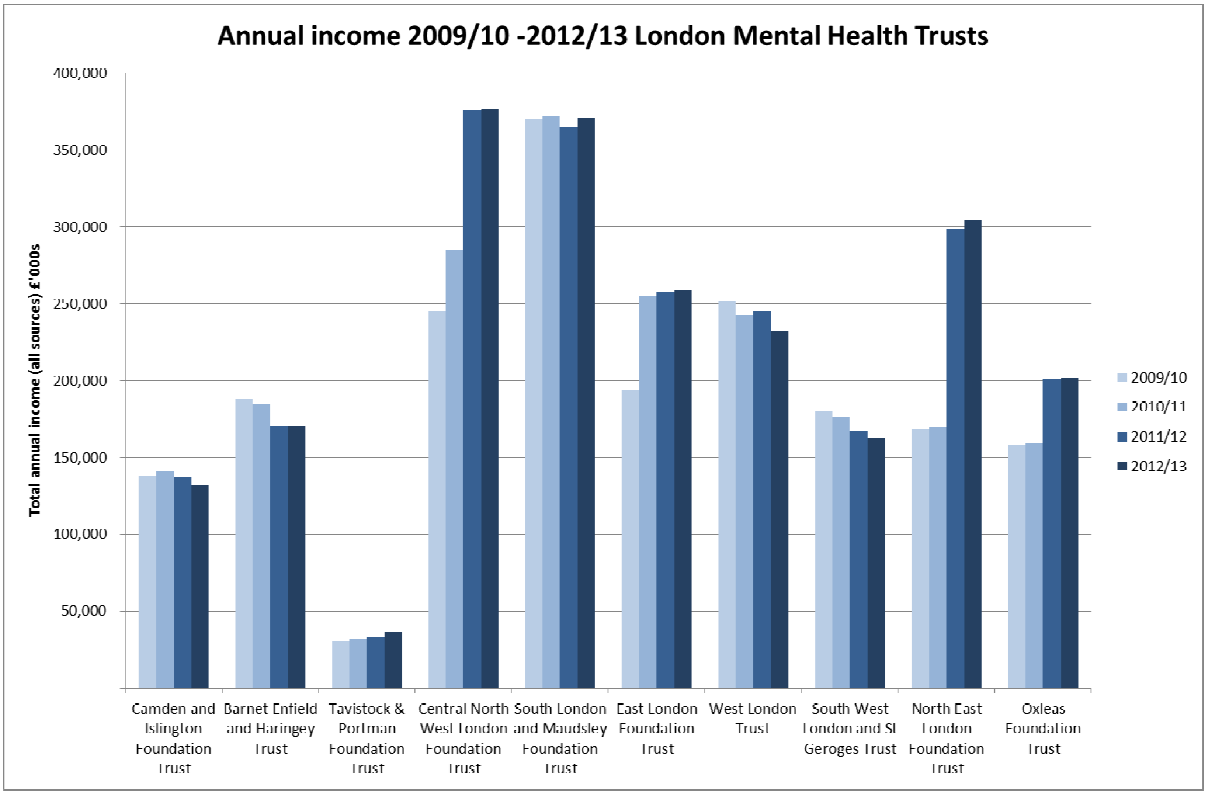
- Reduce acute inpatient bed capacity by 31%;
- Reduce our total estate by 25%, including reducing our acute inpatient sites from 4 to 2;
- Market tested and renegotiated most corporate and contracted services including catering, property maintenance, laundry, estate management, staff bank, pharmacy, transport etc;
- Working with commissioners brought back many high cost individuals to local services.
- Through consolidation of teams and senior staff reductions reduced the number of managerial posts by 40%;
- Completely reconfigured our community services along care pathways implementing new models of working, and reduced the average workforce grades.
- Sold St Luke's Hospital, which eliminated capital and other revenue costs

Key Point:

- **C&I has fundamentally redesigned its services in response to efficiency requirement and made substantial savings over the period.**

Wendy Wallace
Chief Executive
January 2014

Appendix



Where there are significant increases in funding in 2011/12 this is due to the acquisition of community services. The only Trust who did acquire community services and there is no evident increase is BEH, who acquired Enfield Community services, but had other reductions.

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Appendix:

NHS
Islington
Clinical Commissioning Group

MEETING:	Joint Overview and Scrutiny Committee North Central London
DATE:	
TITLE:	Funding of Mental Health Services in Camden and Islington
LEAD DIRECTOR:	
AUTHOR:	George Howard and Angela Neblett
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1. FUNDING FOR MENTAL HEALTH SERVICES IN CAMDEN AND ISLINGTON

Islington and Camden Clinical Commissioning Groups (CCGs) work closely with Camden and Islington Councils, to jointly commission Mental Health (MH) Services; building on the long history of productive joint working, between the Councils and Primary Care Trusts.

2. MENTAL HEALTH NEED

In Camden in 2013 there are 3,171 adults diagnosed with serious mental illness (SMI) registered with Camden GPs, 28,331 adults who have at one-time been diagnosed with depression, anxiety or both and 813 people with dementia. Camden has the 3rd highest SMI prevalence and 7th highest depression prevalence in London. There are 810 people diagnosed with dementia and registered with a GP. This is lower than London and national averages, reflecting a younger demographic.

In Islington there are 3,228 adults diagnosed with psychosis or a bipolar disorder. This is the highest percentage in England and nearly double the national average of 0.8%. 12.6% (22,692) of people aged 18 and over were recorded as being diagnosed with depression in 2011/12. This is higher than both London and England averages (8.1% and 11.7% respectively). In Islington there are 787 people recorded as having dementia. This is also lower than London and national averages, reflecting a younger demographic

3. INVESTMENT IN MENTAL HEALTH

Given the high level of MH need both Camden and Islington Primary Care Trusts (PCTs) historically made significant investments in mental health services; a picture which has been sustained by the CCGs. Work to develop a Mental Health Tariff is expected to produce technical benchmarking data across MH Trusts.

4. INVESTMENT 2009-10

5. Islington PCT funded Camden and Islington NHS Foundation Trust (C&IFT) at £34,639,000 in 2009-10 for adult MH and older people, excluding substance misuse.

6. Camden PCT funded C&I at £42,041,000 in 2009-10 for adult MH and older people, excluding substance misuse.

7. SERVICE REDESIGN

Joint Commissioning in Islington and Camden have worked work closely with C&IFT to innovate and adopt best practice to produce an efficient, high quality services to ensure increasing need is met.

Since 1998 significant investment in mental health services has led to the development of new teams and innovative ways of working with service users in community settings, including crisis teams, assertive outreach teams, early intervention services, crisis houses as an alternative to admission and the development of recovery centres and fast track assessment wards. Inpatient admission is now only one of a range of options open to service users.

97% of service users in Camden and Islington are supported to live at home or in the community. Significantly, up to 2011, this led to increased bed capacity becoming available. It was often the case that 70 to 75 beds are unused at any one time, out of a total of 302 inpatient beds (25%). The number of vacant beds reached 88 in April 2011, or 29% of the bed base.

In 2011 C&IFT and Islington and Camden PCTs jointly undertook a review of the Trust's inpatient provision. Their respective Boards concluded there was a case to consolidate the Trust's bed base and undertook a joint public consultation on proposals to reduce the number of beds by 95 beds (31% of capacity), and to reduce the number of sites from four to two. There was no evidence produced to alter the clinical case for change during the consultation and the changes were implemented as planned.

C&IFT also reviewed community mental health provision driven by a will to ensure all service users should be offered the appropriate evidence-based interventions for their diagnosis and needs, using National Institute for Health and Care Excellence (NICE) guidelines where available.

This required new ways of working in the community and C&IFT have undertaken an extensive reconfiguration of community mental health services in 2012-13 and 2013-14. The reconfiguration moved services from a generic model of care to a more specialised model of care, clustering service users with similar needs and providing a single point of access. Islington and Camden Shadow CCGs monitored performance closely during the transition period.

Throughout this period Camden and Islington CCGs have continued to invest in community MH Services e.g. Parental Mental Health in Islington and crisis house provision in Camden

8. Islington Investment 2013-14

Islington CCG funded C&I at £31,712,340 with an additional £425,000 local incentive scheme. Islington CCG also invested a recurrent £1,740,800 in new services to

support the accelerated development of integrated care in 2013/14. For example: Mental Health Reablement and additional community crisis beds.

Islington Council with Islington CCG fund a pooled budget for largely voluntary sector community mental health services of £4,474,000 as well as new investments in prevention to the value of £340,000. Islington Council invested a further £2m in MH community provisions, £2,530,870 in MH housing support Services and there is a further £3m invested by Islington Council to support the delegated social care functions under the S75 agreement.

The total Investment in mental health across statutory and independent sector in Islington is **£46,176,253.**

9. Camden Investment 2013-14

Camden invests recurrent funding of £1,379,115 in three new service developments. Funding of £678,583 has been allocated to expand the range and type of crisis services which are available to people with mental health problems living in Camden by opening a second crisis house in the borough with a particular focus on increasing the use of crisis accommodation by people from BME communities, men and people from the South of the borough. Additional funding of £263,812 has been allocated to expand the current Psychological Therapies Service to improve outcomes for people with either Long Term Conditions or Medically Unexplained Symptoms by addressing the common mental health problems associated with these and to ensure psychological interventions are a routine part of integrated services for people with LTC / MUS. Finally additional investment of £436,720 has been provided to support people with dementia to remain at home through early diagnosis, assessment and care planning and by increasing the capacity and capability of the crisis team to manage the needs of people with dementia presenting at A&E and therefore prevent avoidable hospital admissions for those in crisis.

Camden invests a further £1.3 million as part of Improving Access to Psychological Therapies. This service is commissioned to help people with more common mental health problems such as anxiety or depression and support at least 50% of those receiving a service to move to recovery. In November 2013, Camden CCG approved additional investment of £400,000 to increase the service offer to meet the needs of more complex patients being seen within the Camden Psychological Therapy Service and a further £800,000 to increase the capacity for Camden to support at least 15% of all people with anxiety or depression and ensure they receive a service.

Camden Council delegates a mental health budget to the Trust of £13,119,000.

This reflects a significant total investment in mental health across all sectors in Camden of **£59,359,436.**

10. Aggregate Investment

Aggregate investment across Camden and Islington is £105,535,689 in 2013-14.

As these figures demonstrate the reconfiguration of services and reduction of in-patient beds has not led to an overall reduction in spending on mental health services since 2009 – instead, funds have been reinvested to ensure better community services, better outcomes for patients and better value for money for the NHS.

11. It should be noted that some significant areas of investment are no longer held locally but are delivered locally. These include specialist Mental Health Services such as Prison Health, Criminal Justice Liaison and Diversion, Forensic MH, Eating Disorder and some Personality Disorder Services. Camden and Islington Joint Commissioning and C&I maintain close working relationships with NHS England Commissioners and local specialist providers to enable a whole system approach.

12. THE FUTURE

The Mental Health (MH) Tariff for mental health services is a system intended to give both commissioners and providers assurance that people receive the best treatment according to their individual needs, preferences, and the clinical evidence and that this treatment makes a difference. The development work undertaken by C&I puts it in a good position to deliver the new system. It is intended that the system is fully operational from 2015/16 (with 2014/15 as a 'shadow year').

The current system of block contracts, where providers including C&IFT are paid the same, irrespective of the number and complexity of service users treated, will be replaced by a system where funding is directly linked to complexity and mix of a service user's need and the cost of the evidence-based interventions they require for recovery.

This means that the balance of risk between commissioner and provider changes, with providers no longer having fully to bear any risk of higher than expected referrals from GPs or funding shortfalls for evidence-based treatments (as articulated through the debate on parity of esteem for the funding of mental health services).

To avoid risk of financial instability to commissioners and providers, contracting based on fixed prices within the block contract is being phased in. It is envisaged that 2014/15 will be a shadow year before the new system becomes fully operational in 2015/16.

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

7 February 2013

Future Operation of the JHOSC - Review

1. Introduction

1.1. At the meeting of 17 January 2013, the JHOSC agreed amended terms of reference and procedures. It also agreed that these would be reviewed in a years time. This report proposes that the current arrangements continue without further change, subject to periodic review to ensure that they remain effective and to respond to any further changes that there might be to the NHS.

2. Recommendation

2.1 That the current arrangements, terms of reference and procedures for the JHOSC be maintained subject to further periodic review; and

2.2 That a date be agreed for the first meeting of the JHOSC after the local government elections.

3. Report

3.1. At the JHOSC seminar on 28 November 2012, Members of the JHOSC informally discussed whether there would still be a useful role for the JHOSC to undertake once the new arrangements and structures for the NHS were implemented from 1 April 2013. Members were of the view that the JHOSC had complemented local health scrutiny well and had been very effective so far in its role. However, it was still unclear at that stage how the new arrangements would develop and at what level and with whom overview and scrutiny could engage with most effectively within the new structures.

3.2. Members were nevertheless of the view that the commissioning of NHS services on a cross borough basis was likely to continue and possibly increase. There was also still the potential for large scale reconfigurations to be proposed by the NHS. It was felt important that overview and scrutiny was proactive in its approach so that it was able to influence issues at an early stage rather than merely react to proposals once they had been developed.

3.3. The consensus was reached was that the JHOSC should continue to meet but on a less regular basis. It was therefore agreed that the JHOSC would meet initially four times per municipal year and that the position would be reviewed in a years time. The JHOSC meeting on 17 January formally approved the new arrangements for the JHOSC.

3.4. During the past year, the JHOSC has met slightly more frequently than was envisaged at the time and currently meets approximately every six weeks.

This is due to the number of issues that have arisen so far. It is hard to be certain as to whether this will continue but there are likely to be further reconfigurations of NHS services that affect all five boroughs involved in the JHOSC. There has also been an increase in the number of services that are commissioned on a cross borough basis. In addition, the Francis report has highlighted the responsibilities that HOSCs have in respect of providers of NHS services. Patients who use local acute services can come from a wide geographic area, including all five boroughs represented on the JHOSC. Scrutinising these services jointly may well be a more effective and efficient use of resources than each borough acting separately. Should the volume of issues requiring the JHOSC's attention decrease, the frequency of meetings can be reduced accordingly.

3.5. It is recommended that a date be set now for the first meeting of the JHOSC after the local government elections as this will assist with forward planning. The elections will take place on 22 May, which is slightly later than normal. Following this, sufficient time will need to be allowed for each borough to appoint its representatives to the JHOSC. It is therefore suggested that meeting should not be arranged before the start of July in order to ensure that each borough has been able to undertake the necessary action.

North Central London JHOSC

Forward Agenda

28 March (Camden)

- The Whittington Hospital – Transformation Plans *(30 mins)*
  Dr Yi Mien Koh, Whittington

- Programme budgeting – funding allocations for each borough *(30 mins)*
  NHS England

- Primary Care – Case for Change *(45 mins)*
  NHS England

- GP Funding *(30 mins)*
  NHS England

- NHS England – public engagement *(20 mins)*
  NHS England

- Out of Hours Commissioning – Evaluation *(30 mins)*

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