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ISLINGTON

Governance and Human Resources
Town Hall, Upper Street, London, N1 2UD

AGENDA FOR THE JOINT OVERVIEW AND SCRUTINY COMMITTEE ON HEALTH

A meeting of the Joint Overview and Scrutiny Committee on Health will be held in Town Hall, Upper Street, N1 2UD on **27 June 2014 at 10.00 am.**

John Lynch
Head of Democratic Services

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Despatched	:	20 June 2014

1.	Agenda Pack	1 - 32

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NOTICE OF MEETING

NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Contact: Robert Mack

Direct line: 020 8489 2921
E-mail: rob.mack@haringey.gov.uk

Friday 27 June 2014 10:00 a.m.
Islington Town Hall, Upper Street, London N1 2UD

Councillors: To be advised (L.B.Barnet), Peter Brayshaw and Alison Kelly (L.B.Camden), Alev Cazimoglu and Anne Marie Pearce (L.B.Enfield), Gideon Bull and Pippa Connor (L.B.Haringey), Jean Kaseki and Martin Klute (L.B.Islington),

Support Officers: Anita Vukomanovic, Linda Leith, Robert Mack and Harley Collins

AGENDA

1. WELCOME AND APOLOGIES FOR ABSENCE

2. ELECTION OF CHAIR AND VICE CHAIR (PAGES 1 - 2)

3. 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.

4. URGENT BUSINESS

5. MINUTES (PAGES 3 - 10)

To approve the minutes of the meeting of 28 March 2014.

6. ACQUISITION OF BARNET AND CHASE FARM HOSPITALS BY THE ROYAL FREE

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

7. COMMISSIONING SUPPORT UNIT - FURTHER DEVELOPMENT

To consider the future development of the North and East London Commissioning Support Unit.

8. NHS 111/OUT OF HOURS COMMISSIONING

To report on the future commissioning processes for the NHS 111 and out-of-hours services across the five boroughs.

9. SPECIALIST CANCER AND CARDIOVASCULAR SERVICES - UPDATE (PAGES 11 - 24)

To report further on the reconfiguration of specialist cancer and cardiovascular services.

10. MEETING OF BARNET, ENFIELD AND HARINGEY MEMBERS - MINUTES (PAGES 25 - 28)

To approve the minutes of the meeting of Barnet, Enfield and Haringey Members of the JHOSC of 24 March 2014.

11. WORK PLAN AND DATES FOR FUTURE MEETINGS (PAGES 29 - 30)

Agenda Item 2

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

27 June 2014

Election of Chair and Vice Chair

1.1 The terms of reference and procedures for the JHOSC state that:

> "A Chair and a Vice Chair for the JHOSC shall be appointed at its first meeting of each Municipal Year. The Chair and the Vice Chair shall come from different boroughs."

1.2 The JHOSC agreed revised terms of reference, scope and procedures at its meeting in January 2013. These were recommended to each borough represented on the JHOSC for adoption by their full Council, as required by the constitutions of each borough.

1.3 The procedures included a paragraph in relation to voting. This stated that; "voting will be on the basis of one vote per authority". This provision was taken from earlier joint health scrutiny committees that local boroughs have been involved in. The rationale behind this was to ensure that joint committees work by consensus and reports and recommendations reflect the views of *all* authorities involved.

1.4 However, legal officers in two boroughs subsequently queried the legality of this provision on the basis that it did not comply with the statutory voting requirements under Schedule 12 of the Local Government Act 1972. Although all Councils formally agreed to continue their involvement with the JHOSC, not all adopted the procedural rules as part of this process. As the provisions of the Local Government Act in respect of voting apply to the JHOSC, they override any previously agreed formal rules for the JHOSC to the contrary so this should not make any difference.

1.5 The formal position in relating to any vote must therefore be that each Member is entitled to a vote and, in the event of a tie, the Chair will have a casting vote. Although the voting arrangements previously agreed by the JHOSC are not suitable to be formal rules because of the restrictions in Schedule 12 of the 1972 Act, it is nevertheless open to the JHOSC if it so wishes to choose to continue the previous convention by one member from each authority choosing not to vote on any given occasion (and the Chair choosing not to use his/her casting vote).

1.6 Any vote required for the appointment of Chair or Vice Chair must therefore formally be on the basis of each Member having the right to vote and, in the event of a tie, the Chair having a casting vote.

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THE LONDON BOROUGH OF CAMDEN

At a meeting of the **NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **FRIDAY 28TH MARCH 2014** at 10am in the Council Chamber, Town Hall, Judd Street, London, WC1H 9JE

MEMBERS OF THE COMMITTEE PRESENT

Councillors Gideon Bull (Chair) LB Haringey, John Bryant (Vice Chair) LB Camden, Peter Brayshaw, LB Camden, Alison Cornelius, LB Barnet, Graham Old, LB Barnet, Jean-Roger Kaseki, LB Islington, Martin Klute, LB Islington, Anne-Marie Pearce, LB Enfield, Alev Cazimoglu, LB Enfield

HEALTH PARTNERS PRESENT

The minutes should be read in conjunction with the agenda for the meeting. They are subject to approval and signature at the next meeting of the NCL Joint Health Overview and Scrutiny Committee.

MINUTES

1. WELCOME AND APOLOGIES FOR ABSENCE

Apologies for lateness were received from Councillors Cornelius and Brayshaw.

2. DECLARATION OF INTEREST

For transparency, Councillor Brayshaw declared that he was a Governor at University College London Hospital. Councillor Cornelius also declared that she was an assistant chaplain at Barnet Hospital.

In relation to Item 9, Moorfield Eye Hospital, Councillor Bull declared that, as he was an employee of the Hospital, he would be stepping down from the Committee during the discussion of the item.

3. URGENT BUSINESS

There was no urgent business

4. MINUTES

Consideration was given to the minutes of the meeting held on 7th February 2014. The Committee commented on several action points as follows:

- Page 3, no response had been received from the Royal Free Hospital in relation to the last valuation of Chase Farm Hospital. **ACTION: Secretary to follow up with David Sloman and circulate to the Committee**.
- Page 5, clarification was requested on the review group and lessons learnt. **ACTION: Secretary to seek clarification and circulate the lessons learnt results to the Committee.**

- Page 9, the information requested from on the total spend across the five boroughs on mental health had not been received. Until it was received effective lobbying for increase funding could not take place by the Committee. **ACTION: Secretary to chase Liz Wise for the information.**
- Page 10, the letter to Norman Lamb was currently in the process of being written **ACTION: Secretary to check to ensure that the letter is sent and inform the Committee when this has been done.**

In relation to matters arising from the minutes, the following points were raised:-

- A report tabled at the last Enfield Clinical Commissioning Group by the Programme Director included a recommendation that the review of the implementation of the BEH Clinical Strategy would take place after 100 days. However in the North Middlesex board meeting, it had been stated that the review would take place after six months. It was requested that the timescale be clarified, **ACTION: Secretary.**
- One member of the Committee raised concerns that a planning application had been submitted to the London Borough of Enfield to build 100 homes on the Chase Farm site. The Committee requested a confirmation be sought to get a guarantee that any capital receipt the Royal Free Hospital get for the site be reinvested. **ACTION: Secretary.** The Committee noted that David Sloman of the Royal Free had stated at a meeting of Healthwatch Enfield that money would be reinvested, he was waiting for permission to publish the information.

Following discussion it was,

RESOLVED –

THAT the minutes of the meeting held on 7th February 2014 be signed as a correct record.

5. THE WHITTINGTON HOSPITAL – TRANSFORMATION PLANS

The Committee received an oral report from Steve Hitchins, the Chair of Whittington Health.

Mr Hitchins stated that new ambulatory care services were about to open and patients would start to be taken in from week beginning 31st March 2014. It was further noted that the two year plan would be taken to the Whittington Health Board on 1st April 2014. The business case had been submitted to the NHS Trust Development Authority (TDA). Whittington Health had improved from band four to band six in the Care Quality Commission's recent gradings. Whittington Health also had the lowest mortality rate in England. The Interim Chief Executive would take up his post on 1st April 2014. The Whittington Health's five year plan had been agreed with the TDA. It was stated that currently there was no clear vision for the future of Whittington Health; the vision would be developed over the next few months. The Committee noted that integrated care needed to be designed to meet the needs of the patients and community. Cabinet Members from Islington and Haringey had attended Whittington Health Board meetings, which had improved communication.

Discussion took place and members of the Committee raised questions and concerns in relation to the departure of the Chief Executive; the requirements for a five year plan;

foundation trust status; Whittington Health's vision, and employee buy-in to the transformation process.

In response to questions and concerns, Mr Hitchins reported that Dr Koh, the Chief Executive, was leaving her role on 28th March. She had been with the Whittington Hospital for three years. The chief executive vacancy would be advertised before the end of April. There was a requirement for every trust who had not yet achieved foundation trust status to have a five year plan. The five year plan was a visionary statement which would take more time to put together. The timescale for the plan was June 2014. The main focus of the hospital was on the upcoming Care Quality Commission (CQC) inspection. The foundation trust application was still important but the main issue was to become an integrated care organisation. In relation to the vision for the Whittington, it was noted that there was no overall big picture about what the integrated care organisation would look like. The Trust needed to be better engaged with its mental health partners and the vision needed to be enunciated by the community.

The Committee requested that the Committee receive a note clarifying where Whittington Health was in the integrated care process. It was further requested that the five year plan be brought to a future meeting before it was sent to the TDA.

ACTION BY: Steven Hitchins (Chair Whittington Health)
Secretary

In response to the request, it was noted that everything the Committee had previously seen on the future development of the trust was still relevant. However, what was needed was a document which gave the big picture and brought everything together. No date would be given in relation to when Foundation Trust status was planned for, there was no government timetable, therefore the CQC inspection was the main focus.

RESOLVED –

THAT the report be noted.

TO NOTE: All

6. PRIMARY CARE - FUNDING

The Committee received a presentation from Alex Manu of NHS England. It was stated that primary care generally meant GP services, which received 60-70% of the funding. The other relevant services were community services, dental and ophthalmology. The primary medical services need was modelled using the Carr-Hill formula, which took account of age-gender mix of registered patient lists, as well as factors in relation to health status of the population.

Discussion took place and Members of the Committee raised questions in relation to rents for GP premises; monitoring of performance for practices and GPs; and the formulas used and whether they were or would be reappraised. In response to questions, it was stated that premises were assessed on their current market rate and premises payments were based on this. The NHS would not pay more than what a district valuer assessed as appropriate for rent and rates. Some small improvement grants were available and GPs could submit bids to receive the funding. Funding was only given to those areas being used to deliver primary care services. In relation to publication of GP earnings, it was noted

that average earnings were published. However, GPs were self-employed so the amounts quoted were not salaries. CQC inspections and the Quality Outcome Framework (QOF) were in place to ensure performance management of practices and individual GPs. Funding was based on list size and population health statistics. NHS England did have concerns about the reliability of GP lists as a basis of funding. It was not known if QOF points were publically available. It was stated that this point would be checked and the Committee informed.

ACTION BY: Alex Manu (NHS England)
Secretary (Rob Mack)

Further discussion took place in relation to performance and it was noted that the Clinical Commission Groups were responsible for strategy and the improvement of general services whereas NHS England were responsible for performance. In response to questions about mental health grants, it was noted that there was a gap in understanding about mental health conditions by GPs. In response to concerns about the reduction in primary care funding in London, it was noted that it was not just about the funding formula but also about what primary care could do differently in the future to ensure it was sustainable and high quality.

Following a detailed discussion the Committee thanked Mr Manu for the presentation and it was

RESOLVED –

THAT the report be noted.

TO NOTE: All

7. PRIMARY CARE - CASE FOR CHANGE

Consideration was given to a report of NHS England. Jemma Gilbert introduced the report and stated that GP practices were feeling challenged both in terms of their finances and in respect of capacity. It was felt that not all practices were fit for purpose either. A great foundation of primary care had been built, which was highly regarded domestically and internationally. However this needed to be built on. Scale would be a very important factor in developing primary care, such as practices coming together collaboratively to solve sustainability issues. It was noted that the Call to Action had been published in January 2014. Engagement work had been undertaken following this.

Discussion took place on the timeframe for the case for change. It was noted that the delivery timeframe was five years. The first year was about describing the changes and getting the modelling right. An incentive was trying to be created for London practices which would encourage them to deliver change as a collective for their populations.

The consensus from the Committee was that it was a positive document but five years was too long to deliver and there needed to be quick wins. The Committee also felt that the document needed to be lobbying for more money for primary care. In response to concerns in relation to the variation between practices, it was noted that it was a statutory requirement of the Clinical Commissioning Groups for them to create forums where practices could come together to share systems and outcomes and to learn from each other.

The Committee thanked Ms Gilbert for attending the meeting and requested that the development of the case for change be put as a standing item on the Committee's work programme.

ACTION BY: Secretary (Rob Mack)

RESOLVED –

THAT the report be noted.

TO NOTE: All

8. CANCER AND CARDIOVASCULAR SERVICES UPDATE

The Committee gave its consideration to a report of NHS England. Neil Kennett-Smith from North East London Commissioning Support Unit highlighted the key aspects. It was noted that further engagement was to take place from the 28th April 2014 following the approval of the initial business case. A short plain English leaflet on the proposals would also be developed and distributed to all stakeholders.

Members of the Committee raised questions in relation to transitional funding and the engagement process. In response, Mr Kennett-Smith remarked that PricewaterhouseCoopers had been appointed. They were working with three partners to understand the financial impacts. There would be a £94 million benefit over the next three to four year period. Although it would deliver financial benefits, the main focus was on clinical outcomes. It was further noted that the plain English leaflet was currently being developed. It would go out with the engagement packs on 28th April, which would be after the final commissioner decisions on 25th April. Stakeholders would have six weeks in which to respond to the engagement information. Deborah Fowler of Healthwatch Enfield commented that six weeks was adequate to respond, but it did depend on how much consultation was being done elsewhere.

Further discussion took place in relation to the timescale for the transition of services. It was noted that everything should be in place by early 2015 but there would be further capital development during 2015 and 2016. Everything would therefore be completed by the end of 2016. In relation to the compensation payment to the University College London Hospital from Barts Hospital, it was noted that it was normal practice to seek compensation when a Trust would lose a service that generated a financial surplus. It was requested that a financial clarification on the position of compensation be sent to Members of the Committee.

ACTION BY: Neil Kennett-Smith, NELCSU
Secretary (Rob Mack)

One Member of the Committee remarked that it did appear to be a short engagement period although he acknowledged that the Committee had been kept well informed. Mr Kennett-Smith stated that the engagement report for phase one had been published on 11th March and the recommendations in the report were subject to final decision on 25th April 2014.

Following discussion, it was

RESOLVED –

THAT the report be noted.

TO NOTE: All

9. MOORFIELDS EYE HOSPITAL; PROPOSALS FOR RE-LOCATION

(The Chair left the meeting for consideration of this item and Councillor Bryant took the Chair)

The Committee gave its consideration to a report from Moorfields Eye Hospital NHS Foundation Trust. Tim Fry, Project Director, highlighted the key aspects of the report and gave a brief history of the project. He highlighted that with a new research, education and clinical care centre, a better standard of care could be delivered. It was stressed that there was no intention for Moorfields to relocate further than the King's Cross/St Pancras area.

Discussion took place and Councillors from the London Borough of Islington stated that, from an Islington health scrutiny perspective, there was not a great deal of concern as the relocation was only a couple of miles away. However, if the trust was to move further than King's Cross, that would be considered a major change.

In response to questions from the Committee, Mr Fry remarked that there were a number of sites being looked into. One building was already being used for health services whilst the other building was not. Due to the commercially sensitive nature of the process, no further information could be given to the Committee at this time. It was not known what proportion of patients currently arrived at the hospital via public transport. Mr Fry would find out the information and circulate it to the Committee.

ACTION BY: Project Director, Moorfields Eye Hospital (Tim Fry)
Secretary (Rob Mack)

The Committee remarked that it broadly supported the process to date, but it did highlight the importance of maintaining information. The Committee further stated that it was not a substantial change in service provision, subject to the relocation being local as set out in the report and past papers.

Following discussion, it was

RESOLVED –

THAT the report be noted.

TO NOTE: All

10. MEETING OF BARNET, ENFIELD AND HARINGEY MEMBERS

The Committee noted a statement from Barnet, Enfield and Haringey CCGs that stated that the Mental Health Strategies report would be going through Clinical Commissioning Group Boards in relevant boroughs during May and would not be publically available until after the local government elections. Members were concerned that this might mean that they were

unable to influence budget decisions on mental health services for the forthcoming year and requested that Enfield CCG, as lead commissioner, be approached to request earlier sight of the report. In addition, they also proposed that a meeting of JHOSC Members from Barnet, Enfield and Haringey be arranged to take place on 2 May to discuss the issue further. It was noted that this would be subject to confirmation by participating boroughs that meeting at this time would be consistent with local guidance regarding activity during the Purdah period before the local government elections.

ACTION BY: Secretary (Rob Mack)

11. WORK PLAN AND DATES FOR FUTURE MEETINGS

The Chair thanked the Members and Officers for their support over the year.

It was noted that the next meeting of the Committee would take place on 27th June at Islington Town Hall.

Minutes End

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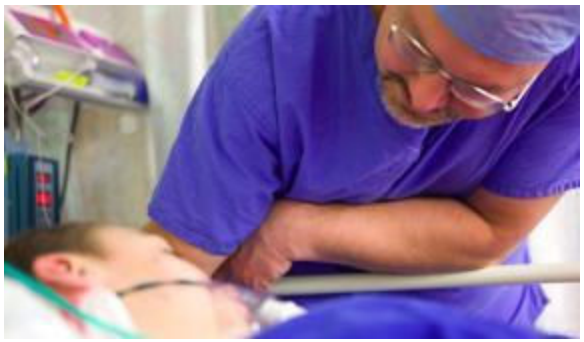
Cancer and cardiovascular services:

NCL JHOSC – 27 June 2014



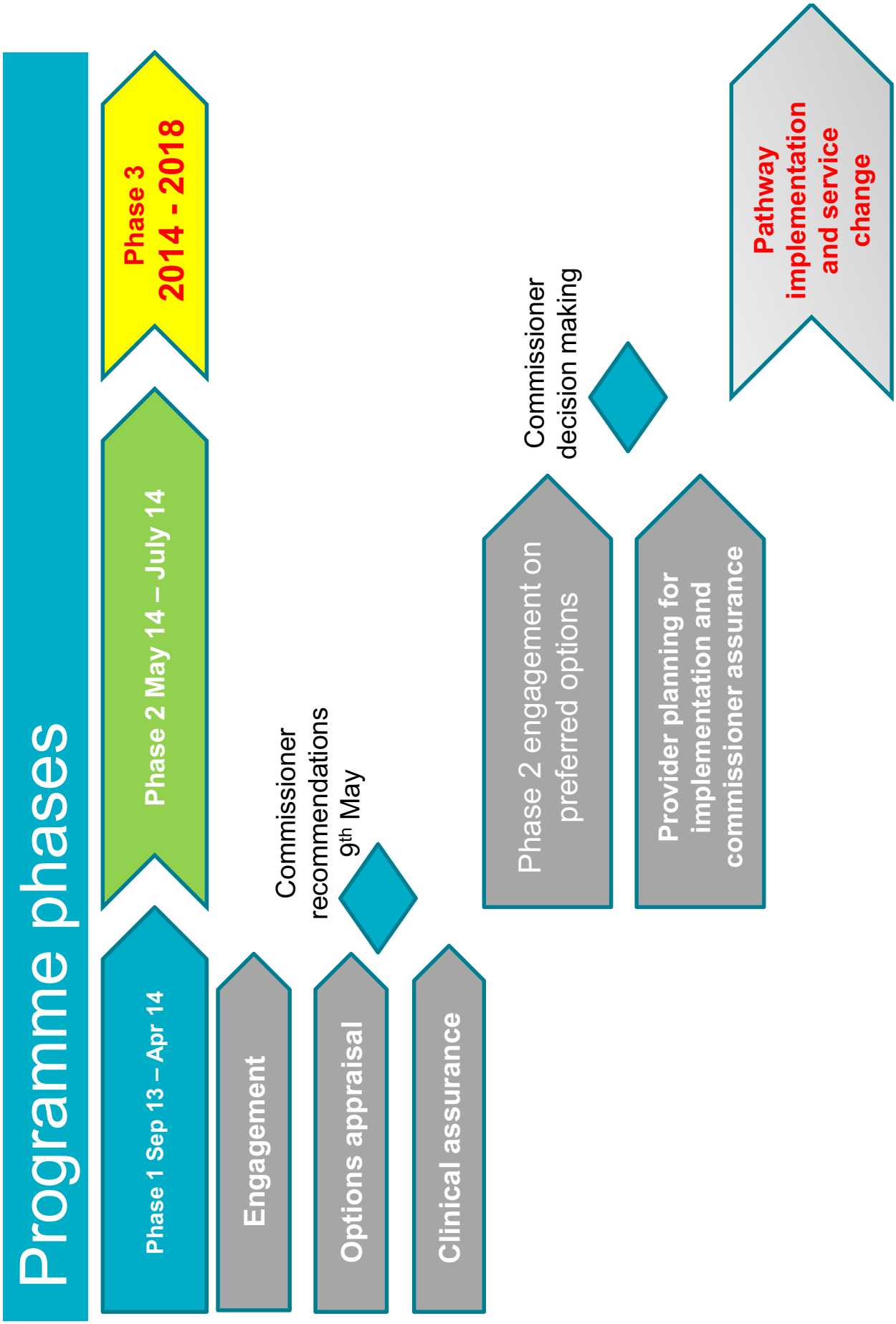
Cancer and heart disease: the imperative

How did we get here?

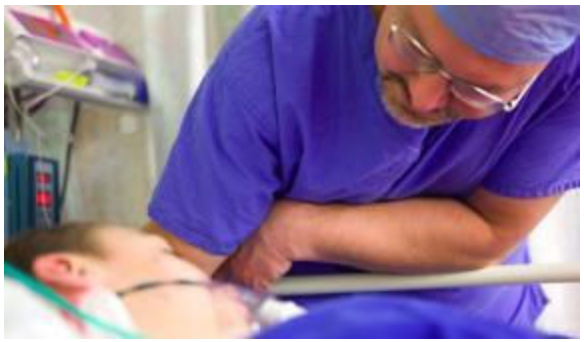
1	2010	A London-wide review concluded fewer specialist high-volume units would improve clinical outcomes for patients for cancer and cardiovascular disease
2	Early to mid 2013	Local clinicians developed the Case for Change
3	Late 2013	We engaged with local people on these proposals from Oct-Dec 2013
4	March-May 2014	NHS England published its engagement report, then business case and recommendations for change.
5	May-June 2014	Further phase of engagement launched and communicated to around 600 stakeholders

Commissioner ‘meeting in common’

- On 9 May, a commissioner ‘meeting in common’ was held in public between NHS England, and Camden, City and Hackney, Enfield, Haringey and Islington CCGs
- The purpose of this meeting was for commissioners to agree on the preferred options for the provision of specialist cancer and cardiovascular services and to agree on the next stage of engagement
- Unanimous decision reached in support of preferred options and to proceed with the next stage – engagement and planning for implementation
- Final commissioner decision meeting to be held in July 2014 following engagement, planning for implementation work and development of assurance framework


Programme phases
Phase 1 Sep 13 – Apr 14
Engagement
Options appraisal
Clinical assurance
Phase 2 May 14 – July 14
Phase 3
2014 - 2018
Commissioner recommendations 9th May
Phase 2 engagement on preferred options
Provider planning for implementation and commissioner assurance
Commissioner decision making
Pathway implementation and service change

What are the proposals?



Specialist cardiovascular services

What is the proposal?

Transfer The Heart Hospital (Marylebone) services to St Bartholomew's Hospital (West Smithfield)6, to create a single integrated cardiovascular centre.

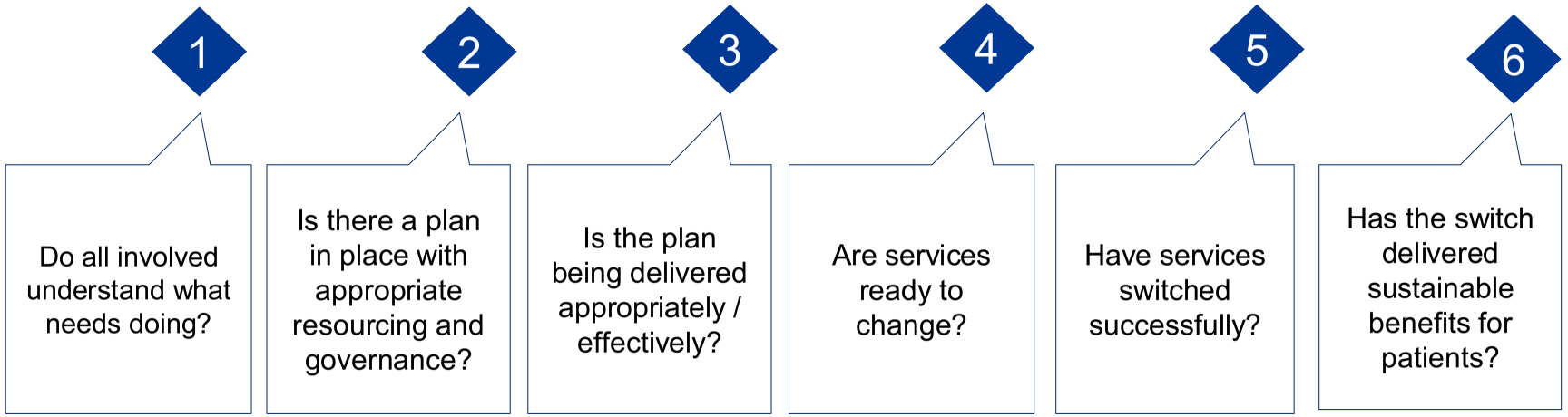
The Royal Free Hospital (Hampstead) and the integrated cardiovascular centre at St Bartholomew's Hospital would act as heart attack centres for the area.

Proposals for specialist cancer services

Pathway	Configuration	Royal Free	Barts Health	UCLH	Barking Havering Redbridge	Barnet, Chase Farm	Homerton	North Mid	Princess Alexandra
Brain	Current		S	S	S				
	Recommended			S	S				
Head & neck	Current		S	S		S			
	Recommended			S					
Bladder& Prostate	Current		S	S	S	S			
	Recommended			S					
Renal (kidney)	Current	S	S	S	S	S	S		S
	Recommended	S							
HSCT (blood)	Current	S	S	S					
	Recommended		S	S					
AML (blood)	Current	S	S	S	S	S		S	
	Recommended		S	S	S				
OG (stomach)	Current		S	S	S				
	Recommended			S	S				

Services would only transfer if safe to do so

Commissioner will conduct regular checks….



If approved, these changes would take place over 1-3 years

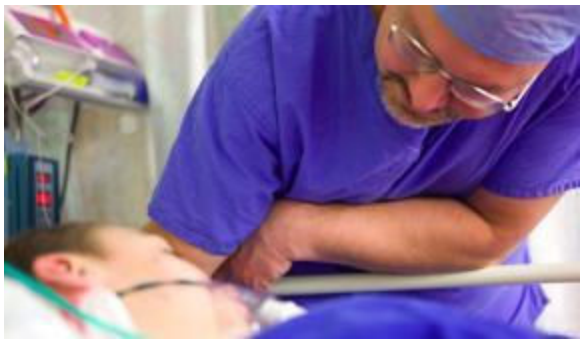
Phase two engagement

- Second engagement phase commenced 23 May 2014
- ~600 stakeholders (incl trusts, CCGs, Healthwatch) sent information, event details, link to documents and online survey
- Plain English summary leaflet of commissioners recommendations produced and distributed online and in hard copy at 8 locations
- Engagement events:
  - prostate discussion event in outer north east London
  - public events covering travel and patient information across the area
  - open offer to attend meetings

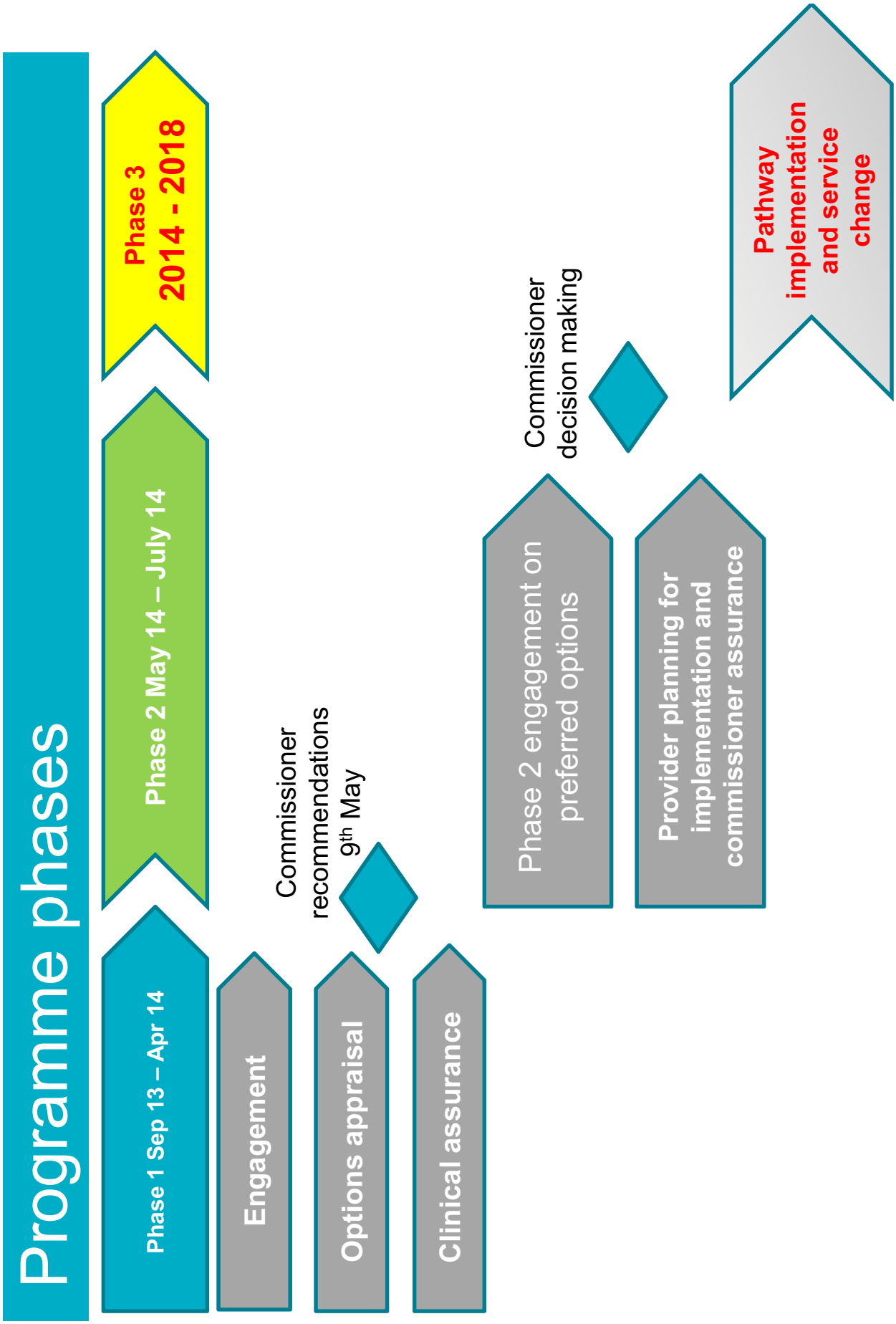
Engagement so far:

- Workshops have provided an opportunity for stakeholders to hear from commissioners, clinicians and NHS staff what steps have been taken to address concerns re travel and pathway integration issues
- Attendees have heard more about trust plans and provided their feedback on patient information leaflets
- Materials provided have included; copies of the Business Case, accompanying appendices, the Equality Impact Assessment, trust information leaflets, feedback forms, copies of the London Clinical Senate review of the process followed by NHS England
- Attendees have had their questions and comments heard and addressed by commissioners, clinicians and provider staff

Next steps



THE NHS CONSTITUTION
the NHS belongs to us all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Phase 3
2014 - 2018
Commissioner recommendations 9th May
Phase 2 engagement on preferred options
Provider planning for implementation and commissioner assurance
Commissioner decision making
Pathway implementation and service change

Ways to submit feedback:

You can give us your comments in the following ways:

- Fill out a survey
- Complete an online survey at: http://www.england.nhs.uk/london/engmt-consult/
- Email us at cancerandcardiovascular@nelcsu.nhs.uk
- Phone us on 020 3688 2440
- Write to us at:

Cancer and cardiovascular programmes

c/o North and East London Commissioning Support Unit

Clifton House

75-77 Worship Street

London, EC2A 2DU

North Central London Sector Joint Health Overview and Scrutiny Committee
Meeting of Barnet, Enfield and Haringey Members
Monday 24th March 2014

Present:

Councillors	**Borough**
Gideon Bull (Chair)	LB Haringey
Alev Cazimoglu	LB Enfield
Alison Cornelius	LB Barnet
Graham Old	LB Barnet
Anne-Marie Pearce	LB Enfield
Barry Rawlings	LB Barnet
David Winskill	LB Haringey

1. APOLOGIES FOR ABSENCE

None.

2. DECLARATIONS OF INTEREST

Cllr Cornelius declared a personal interest as an assistant chaplain at Barnet Hospital.

3. A&E PERFORMANCE ISSUES AT BARNET AND CHASE FARM AND THE NORTH MIDDLESEX HOSPITALS

Fiona Smith, Chief Operating Officer from Barnet and Chase Farm (BCF) Hospitals, reported that BCF was in the lowest performing five acute trusts in London in terms of its A&E performance and 18th out of the 22 trusts in London. However, it had met the 4 hour target for the last two weeks and other acute trusts were not performing as well. Data from 9 December to the present had been analysed. BCF's performance data had been fully validated which was not always the case with other acute trusts. There had been some 12 hour trolley waits. The trust's performance was not radically different from other acute trusts.

Performance in respect of queuing ambulances was now improving. The proportion of people arriving by ambulances had increased slightly and was now approximately a third of A&E activity. In addition, the number of overall attendances had increased. The number of ambulances arriving had so far been higher than the BEH Clinical Strategy modelling had suggested. This had predicted between 80 and 90 per day but over 100 had been arriving. It was not possible to determine at this stage whether this was due to winter pressures or was likely to be the "new normal". The higher volume of activity had nevertheless already been factored into future projections. It was the view of the trust that the higher level of activity was probably long term but they were not yet in a position to be certain of this.

Attendances at hospital were only just above expected levels but admissions were gone up. Bed occupancy levels were also high and this correlated with lower levels of A&E performance in respect of the four hour target. The majority of elderly people attending A&E came from their own homes but a significant number came from residential care

homes. The Trust was currently working with the CCG in Barnet to address this issue and an action plan was being developed. The focus of this was system wide. There was a top ten list of reasons why elderly people were admitted.

It was very early days for the hospital following the implementation of the Barnet, Enfield and Haringey (BEH) Clinical Strategy and work was being undertaken with clinicians to address the current challenges. Weekend discharges had increased significantly and appropriate support was being provided when required through the Post Acute Care Enablement (PACE) scheme.

In answer to a question, Ms Smith stated that she was aware that there were a large number of care homes in the Barnet area, some of which were very big. The proportion of admissions that came from these homes had not yet been calculated. In answer to another question, Gary Baines, from the East of England Ambulance Service, reported that his service were taking between 10 and 15 patients per day to either Barnet or Chase Farm hospitals.

Tim Peachey, the Interim Chief Executive of Barnet and Chase Farm Hospitals, stated that the changes brought in through the BEH Clinical Strategy had not been designed to save money but to make best use of clinical expertise and comply with the European working time directive. Part of the process involved a phased change to providing more care in the community. Whilst this process had already begun, the changes were likely to take several years to implement fully. Cold was not the only type of weather that could impact adversely on health. Wet weather and low atmospheric pressure could also have an effect, particularly on respiratory condition. It was possible to factor in meteorological conditions to projections.

Ms Smith acknowledged that social factors impacted on the number of admissions. The TREAT scheme to mitigate the number of admissions had been used to address this and provided access to social workers. Delayed discharges were significantly down due to successful partnerships. Figures were reviewed each week.

Committee Members expressed concern at the numbers of elderly people being admitted to hospital. It was felt that these were unlikely to go down. It was felt that work needed to be undertaken with care homes to see if any admissions were preventable. Ms Smith responded that each care home had a GP linked to them. Support nevertheless needed to be provided form them and work was being undertaken to address this.

David Donegan, Director of Operations from the North Middlesex University Hospital (NMUH), reported on the position in respect of NMUH. In terms of its A&E performance, it was 12th out of 22 in London and the second best in the north central London area. Following the reconfiguration undertaken as part of the BEH Clinical Strategy, NMUH's A&E was now the largest in London. The latest statistics showed no breaches in standards for ambulance handover times and or trolley waits. Although there had been a blip in performance due to building work, performance was better than last year.

There had been an increase in emergency admissions since last year and these were now slightly higher than before the implementation of the BEH Clinical Strategy. There had also been an increase in the number of ambulances arriving but this had been

mitigated by the London Ambulance Service's intelligent conveyancing system. 34% of people arriving by ambulance needed admission. The Trust was working with the Urgent Care Centre on the hospital's site to see if the pressure on A&E could be reduced. However, relevant targets were being met.

It was noted that A&E could look very busy from the outside but this was not necessarily the case on the inside. Julie Lowe, the Chief Executive of NMUH, commented that the numbers of patients attending were in line with expectations and modelling. The Trust was working with commissioners and other providers to reduce pressures, particularly those arising from residential care homes.

Paul Gates from the LAS, reported that the LAS aimed to proactively manage conveyancing of patients to A&E units through the intelligent conveyancing system. The process was subject to external review but so far it was felt that it was having the desired effect. It had worked best in inner London. Improvements were to be made though. In particular, there was a need to improve liaison with the East of England Ambulance Service.

Ambulance services were configured to respond to demand pressures. As part of this, there had been increases in the number of vehicles in some parts of London. Private ambulances were used from time-to-time. Although they would prefer not to use them, it was necessary due to a national shortfall of 2,000 in the number of trained paramedics.

Lorna Reith, the Chief Executive of Healthwatch Enfield, stated that performance statistics for BCF covered both sites. In order to obtain of clear picture of the changes in demand levels on services, it was necessary to disaggregate the data. She felt that it was important that the impact of the reconfiguration undertaken as part of the BEH Clinical Strategy was clear. In addition, she expressed concern at cancellation levels of planned surgery.

AGREED:

That further information be sought from the London Ambulance Service on the number of conveyances of people from care homes to A&E that had taken place during the winter period.

4. MENTAL HEALTH STRATEGIES REPORT

Members of the Committee noted that the meeting had originally been called to consider the Mental Health Strategies Report. Liz Wise, the Chief Executive of Enfield CCG, reported that it was not yet possible to release the report as it needed to be first considered by the relevant Clinical Commissioning Group (CCG) and provider trusts.

She reported that there had been a very significant overspend relating to acute mental health care. In particular, there had been high levels of delayed transfers of care. A number of preliminary recommendations had been made. A lot of expenditure had been incurred on care provided from outside organisations and consideration was being given to providing this internally. Delayed transfers of care were also being addressed. The report was currently in its final draft and would be considered by each CCG and the

Mental Health Trust. The report included some quite complex information regarding unit costs and further work on these was required. The CCGs had indicated a willingness to consider investment and were looking at putting this in whilst the issues were being worked through.

Maria Kane, the Chief Executive of Barnet, Enfield and Haringey Mental Health Trust, reported that the Trust was forecasting a deficit of £11 million for the forthcoming year. Reviews of services would be undertaken and efficiencies would be required. Ms Wise commented that there was a need for partners to work together more effectively. Accommodation was a key area for consideration. Ms Kane reported that this could involve site consolidation and was not likely to be an easy process, with some difficult decisions being required.

Committee Members expressed disappointment that the report had not been made available. Concerns were also expressed about the implications of the report, which could make it more difficult for people with mental health needs to access help. Ms Wise commented that nothing would be agreed till its impact had been fully assessed. However, no actions would be taken that compromised quality. Negotiations between commissioners and the Mental Health would be taking place shortly.

Committee Members queried whether the Purdah period rules applied to health scrutiny as it did not have any executive powers. They requested that the Mental Health Strategies report be made available to them at soon as was possible and, subject to appropriate legal advice being received about relevant Purdah regulations, another meeting of JHOSC Members from Barnet, Enfield and Haringey be arranged for early May to consider the report.

AGREED:

That that the Mental Health Strategies report be made available to appropriate JHOSC Members at soon as possible and that, subject to appropriate legal advice being received about relevant Purdah regulations, another meeting of JHOSC Members from Barnet, Enfield and Haringey be arranged for early May to consider the report.

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

27 June 2014

Future Dates/Work Plan

1. Future Dates

1.1 Members are requested to identify future date(s) and times for meetings of the JHOSC. Five meetings of the JHOSC were scheduled during the last Municipal year. However, the number of times that the Committee should meet in a year is at the discretion of Members as no specific number is set. The regularity of meetings and dates are normally agreed by consensus

2. Work Plan

2.1 Members are requested to consider potential items for future meetings of the Committee. Issues already identified as potential future items for meetings are currently as follows:

- Spend levels between primary and secondary care
- Complaints
- Primary care - Case for Change (standing item)
- Whittington Hospital; Five Year Plan/Development of Integrated Care

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