NOTICE OF MEETING

NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

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Friday 26 June 2015 10:00 a.m.
Islington Town Hall, Upper Street, Islington
London N1 2UD

Councillors: Alison Cornelius and Graham Old (L.B.Barnet), Danny Beales and Alison Kelly (L.B.Camden), Abdul Abdullahi and Anne Marie Pearce (L.B.Enfield), Pippa Connor and Charles Wright (L.B.Haringey), Jean Kaseki and Martin Klute (L.B.Islington)

Support Officers: Anita Vukomanovic, Andy Ellis, Robert Mack, Pete Moore and Vinothan Sangarapillai

AGENDA

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

2. FILMING AT MEETINGS

Please note that this meeting may be filmed or recorded by the host Council for live or subsequent broadcast or by anyone attending the meeting using any communication method. Although we ask members of the public recording, filming or reporting on the meeting not to include the public seating areas, members of the public attending the meeting should be aware that we cannot guarantee that they will not be filmed or recorded by others attending the meeting. Members of the public participating in the meeting (e.g. making deputations, asking questions, making oral protests) should be aware that they are likely to be filmed, recorded or reported on.

By entering the meeting room and using the public seating area, you are consenting to being filmed and to the possible use of those images and sound recordings.

3. APOLOGIES FOR ABSENCE

4. 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 a matter is considered:

(i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and

(ii) 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.

5. MINUTES (PAGES 3 - 8)

To approve the minutes of the meeting of 20 March 2015 (attached).

6. ACADEMIC HEALTH SCIENCE NETWORK

To receive a report on the work of the Academic Health Science Network covering north central London and its role in assisting the transfer of medical research into practice within the NHS.

7. SPECIALIST CANCER AND CARDIOVASCULAR SERVICES - UPDATE ON IMPLEMENTATION OF RECONFIGURATION

To receive an update on progress with the implementation of changes to specialist cancer and cardiovascular services in the north central London area.

8. NHS 111 AND GP OUT OF HOURS SERVICES - RECOMMISSIONING (PAGES 9 - 66)

To report further on the commissioning of an integrated NHS 111 and the GP Out-of-Hours Contract for north central London.

9. MEETINGS OF BARNET, ENFIELD AND HARINGEY MEMBERS (PAGES 67 - 84)

To approve the minutes of the meetings of Barnet, Enfield and Haringey Members of the JHOSC of 23 March and 19 May 2015.

10. FUTURE DATES AND WORK PLAN (PAGES 85 - 86)

To agree on future dates for meetings of the Committee and a work plan for the forthcoming year.

Agenda Item 1

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

26 June 2015

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 a vote and, in the event of a tie, the Chair having a casting vote.

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MINUTES OF THE NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE HELD ON FRIDAY 20TH MARCH 2015 AT 10AM IN THE COUNCIL CHAMBER, TOWN HALL, JUDD STREET, LONDON, WC1H 9JE

MEMBERS OF THE COMMITTEE PRESENT:

Councillors: Alev Cazimoglu (Vice Chair), LB Enfield, Alison Kelly, LB Camden, Danny Beales, LB Camden, Alison Cornelius, LB Barnet, Graham Old, LB Barnet, Jean-Roger Kaseki, LB Islington, Martin Klute, LB Islington, Anne-Marie Pearce, LB Enfield,

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

An apology for lateness was received from Councillor Klute. An apology for absence was received from Councillor Bull.

2. DECLARATION OF INTEREST

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

3. URGENT BUSINESS

There was no urgent business

4. MINUTES

Consideration was given to the minutes of the meeting held on 16th January 2015. The Committee requested that the breakdown of the number of delayed discharges over all Trusts be re-circulated.

RESOLVED –

THAT the minutes of the meeting held on 16th January 2015 be signed as a correct record.

5. ACCIDENT AND EMERGENCY - PERFORMANCE

The Committee requested that in future, if possible, when reports were asking for the same information from multiple organisations they all be asked to provide it in a similar framework and format to make reading the information and drawing comparisons easier.

Dr Jonathan Fielden from University College London Hospital provided an overview to the Committee of A&E performance over the past year and, in particular, over the winter months. In response to questions, from the Committee the following points were made:

- Weekly meetings had been held by the Trust to discuss response times.

- Admissions from A&E had reduced slightly over the Christmas period. This was due to a reduction in people attending A&E and improved processes.
- A lot of work had been undertaken 4-5 years ago on the centralisation of hyper acute stroke units. However, the stroke network had recently been disbanded, which meant that it was increasingly difficult to maintain the flow of patients home. There were currently 14 patients waiting to move from the hyper acute stroke unit.
- Hospitals were working as close as possible to ensure a smooth patient flow. However, the interface between health and social care needed greater support as this was the area where the patient pathway was most challenged.
- Following the end of the "Camden Choose Well" campaign, A&E attendances had risen. It was thought there were a number of reasons why, including how people accessed care.
- Statistics were collected on A&E attendances and work was being done with the local Clinical Commissioning Group (CCG) to ensure residents had the correct information about services in order to reduce the number of people coming through.
- The CCG had worked on developing new models of care and a variety of initiatives had been trialled with GPs, such as enhanced GPs, working with care homes on frailty issues and community pharmacies.
- Other avenues of reaching people were through facilitating greater involvement with Health and Well Being Boards.
- In relation to mental health, there was an on site mental health service in the A&E department who provided 24 hour 7 days a week cover.
- There were still national and local issues regarding the number of beds of mental health patients. UCLH remarked that they received patients from all over London and the country, which added to the complexity.

The Committee requested that a report be put together by all of the acute trusts for a future meeting of the Committee on what was being done to reduce the number of people attending A&E. It was requested that all the trusts work together on the report to ensure a consistent approach to reporting the information. In response the Trusts stated that they would be happy to produce a report but asked for sufficient time to pull it together to ensure all organisations could give the information requested in the layout requested.

The Committee noted that providers would like to see more support for clinical networks. Standards of care had dropped in clinical networks and providers wanted to ensure they could provide high quality care as before. The Committee requested that NHS England be asked for their views on funding in relation to clinical networks.

The Committee noted that patient attendances at UCLH from each CCG area showed that Camden and Islington had a reduced increase compared to the other boroughs. However, their numbers were still significant. Work was being undertaken with CCGs, with particular focus on 19-40 year olds who were attending A&E rather than GPs. There were a number of factors, including being new to the area as it was a transient population. There was also a culture within this age range, driven by instant communication and technology, of receiving products/services immediately.

Julie Lowe from North Middlesex University Hospital (NMUH) Foundation Trust gave a presentation to the Committee on A&E performance over the past year and, particular, the winter months.

Further discussion took place, the following was noted:-

- NMUH's 'Breaking the Cycle' week had made a dramatic effect on A&E performance. However, in the longer term it would not be possible to sustain as it was very resource intensive. Nevertheless, it was hoped that the initiative would be repeated in the near future. The Breaking the Cycle initiatives included having ward rounds twice daily, with each patient discussed with a senior manager, doctor and nurse. There had to be clear decisions on what would happen with each patient. Engagement with Health and Well Being Boards (HWB) and CCGs differed from borough to borough. In Haringey, the HWB was very much part of the discussions and workshops that were progressing on the development of services.
- In recent times, there had been an announcement each year about how much winter money each Trust would receive. However, for 2015/16 it would need to be negotiated into the contract with the CCG. NMUH had particular concerns about the mental health crisis lounge and were anxious that funding for it to be embedded.
- There were currently an additional 30 beds for patients who were transitioning through patient pathways. All 30 were always utilised.
- The winter hub had funding up until April 2015. There had been discussion around whether it was required for 2015/16 and if commissioners had the resources to fund it. However, it was stressed that the Trust was keen to continue the mental health aspects of the hub all year round as it was not just in the winter months those issues occurred.

Dr Richard Jennings of Whittington Health Foundation Trust updated the Committee regarding its A&E performance over the winter months. The following points were noted:-

- The current performance figure for patients being seen within the 4 hour A&E target was 94.88%. The Trust was confident that the 95% target would be achieved within the year.
- To enable the Trust to deal with the challenges over winter, an additional 53 beds had been provided. There had also been extra resources in the Urgent Care Centre. An additional GP had for the Urgent Care Centre had also been resourced. In addition, due to the increased demand in the evenings, an extra paediatric clinician was provided. During the weekend, an additional experienced medical registrar saw patients who had been pre-identified for discharge.
- Integrated care had enabled the Trust to have a flexible capacity in providing care in the community. There was also extra capacity in the enablement teams, which addressed the needs of patients who were nearing discharge. There was a senior operational and medical presence at the access meetings that happened twice daily and oversaw patient flow. On the acute ward, bed capacity was looked at daily. Within the last two weeks, a new acute assessment area in the A&E department had opened and it was hoped that this would impact proactively. Patients should rapidly be assessed and treated as soon as they entered the hospital. This was a permanent change whilst the other measures were reactions to increased seasonal demand.
- Whittington Health had a large ambulatory care centre which had been recognised as a model for a one-stop shop approach for patients with complex issues. The model differed from traditional ambulatory care. The model provided patients with complex medical needs the facilities for a one-stop and same day service, enabling the management of complexity and sickness in an area separate to A&E.
- There was a virtual multi-disciplinary team meeting to discuss those who might need emergency A&E care. The meetings involved GPs, pharmacists and psychiatrists,

and aimed to reduce the risk of them needing unplanned secondary care. It was currently small scale but consideration was being given to rolling it out in nursing homes.

In response to questions from the Committee it was noted that medical staff numbers in A&E were not reduced at weekends and that this was the same for all trusts. However, in-patient wards differed and there were normally reduced staff numbers at weekends. It was confirmed that the higher the skill level in the A&E triage, the faster patients went through the system.

The Committee requested further information on work undertaken by the trust with local nursing homes and the role of enablement teams as well as a site visit to visit the new ambulatory care centre.

Kate Slemeck from the Royal Free Foundation Trust gave a presentation to the Committee which gave an overview of its A&E performance during the winter months.

In response to questions from the Committee, the following points were noted:-

- Weekly meetings took place between the Trust, CCGs and relevant local authorities which discussed the schemes in place. Part of the winter scheme saw another 21 beds open up, along with 60 beds on the Chase Farm site.

The Committee had, at its last meeting, requested further information from trusts on the number of delayed transfers of care and the numbers of these that had come through care homes. It was requested that this be broken down borough by borough.

In response to questions about the number of visits to hospital, Paul Gates, Director of Operations, North Central London Ambulance Service stated that there was a London Ambulance Service workshop set up for April, when they would be talking to the six care homes which used the service most frequently to understand why it was they called the service rather than taking patients to hospital.

After a lengthy discussion, it was

RESOLVED –

1. That a joint report be put together by local acute trusts for a future meeting of the Committee on action being taken to reduce the number of people attending A&E;

2. That NHS England be requested to report to a future meeting of the Committee on the issue of funding for clinical networks;

3 That further information be requested from Whittington Health on work undertaken with local nursing homes and the role of enablement teams within the hospital, as well as a site visit to visit the new ambulatory care centre.

4 That further information be requested from each of the acute trusts on numbers of delayed transfers of care for each quarter of the last year and the originating boroughs.

6. LONDON AMBULANCE SERVICE (LAS) - UPDATE

Paul Gates, Director of Operations, North Central London, London Ambulance Service NHS Trust gave a presentation to the Committee which outlined the service demand in the area, recruitment and retention, patient handover times, ambulance deployment, intelligent conveyancing the use of private ambulances and whole systems working.

In response to questions from the Committee, the following additional points were made:-

- Across London, the LAS was looking to recruit 250 staff which broke down to 23 posts in North Central London.
- A recruitment drive in Australia and New Zealand had just finished and, as a result of this, 200 paramedics would be coming to work in London. Other routes of recruitment included a 20 week residential training course and university programmes.
- The cost of using private ambulances was on par with the cost of paying overtime to employees.
- The greater the staff numbers, the quicker response times were likely to be. There had been a significant push last year to increase the number of ambulances on the road and, through doing this, targets were met.
- An annual staff survey was carried out, the results of which were published online. The current survey results were not positive and it was acknowledged that there was a lot of work to do. There had been changes in the top tier of management and a new injection of staff would be coming into the organisation. The recruitment and retention of London staff was complex. A lot of people studied in London and, once fully qualified, would move back out of London as the salaries for paramedics did not differ hugely whether you were working in or outside of London. The Committee requested more information on recruitment and retention in London.
- There was currently 305 hours per day of private ambulance use. From September/October 2015, there should be less reliance on private providers, with their use down to 150-200 hours per day.
- The demand for ambulances was highest in Camden.
- A national piece of research had taken place and it was reported that ambulance services were picking up unmanaged demands on the NHS.
- Paramedics joining the service from Australia and New Zealand would be provided with affordable housing.

RESOLVED –

THAT the LAS be invited to report back to the Committee in September on action taken to improve staff morale and recruitment and retention issues.

7. WHITTINGTON HEALTH FIVE YEAR PLAN

Siobhan Harrington of Whittington Health NHS Foundation Trust gave a presentation to the Committee which outlined the key aspects of the five year plan.

Discussion took place regarding the integration of services. It was noted that Islington was currently running an integrated care pilot which had enabled a wide view to be taken over services such as social care and GPs.

The Committee noted that the staff morale was mixed. There had been a lot of changes in senior leadership and to ensure good staff morale going forward, confidence was needed in the direction of the organisation. The staff survey results would be published on the website. Nurses had been recruited from Portugal and the Philippines. They had been offered housing as part of the relocation package. In relation to a question about catering contracts and whether externally employed staff were working on zero hours contracts, Ms Harrington stated that she did not have the information to hand and agreed to circulate it to members of the Committee after the meeting.

The Committee noted that potential savings schemes were being considered but there were currently no proposals to sell off estates. It was acknowledged that in the past communication with the community about estates had not been adequately undertaken, leading to misunderstandings. The Trust was committed to engaging with the community on any proposals that might emerge.

RESOLVED –

THAT further information be provided by Whittington Health on whether externally employed catering staff were being employed on zero hours contracts.

8. UPDATE FROM THE NORTH CENTRAL LONDON MATERNITY NETWORK

Julie Juliff of the North Central London Maternity Network outlined the key aspects of the report.

The Committee commented that it was reassuring that North Central London still had a maternity network. In response to questions, Ms Juliff remarked that the network was working with GP's to identify possible spaces for more clinics. There was a drive to move out into children centres. Evening and weekend clinics were also being researched.

Discussion focused on transitional care and it was noted that this was a problem in a couple of acute Trusts. An audit of services in North Central London was being developed. Concerns were raised with regards to mental health during and after pregnancy. The Committee noted that there was a specialist perinatal mental health service at the Whittington, but none of the other Trusts had this level of service. Services were therefore dependant on where women lived and where you chose to have their baby. A workshop was planned to map the pathway for future services, which would be chaired by a Camden GP. It was noted that there had been a lot of lobbying being done for services in this area.

RESOLVED –

THAT a further update be provided to the Committee at its September meeting.

9. WORK PLAN AND DATES FOR FUTURE MEETINGS

It was noted that the next meeting of the Committee would take place on 26th June at Islington Town Hall and that dates for the remainder of meetings for 2015-16 would be agreed then.

NCL Joint Health Overview and Scrutiny Committee

26 June 2015

Commissioning NHS 111 and Out-of-Hours Service

Introduction

The five CCGs in north central London (NCL) (Barnet, Camden, Enfield, Haringey and Islington) are planning to commission a combined NHS 111 and GP out-of-hours (OOH) service across the five boroughs. The options for commissioning this service were debated by the CCGs at their governing body meetings, which were held in public last year.

The CCGs want to commission an integrated NHS 111 and GP OOH service to enhance the comprehensive level of care that is currently provided for patients in these boroughs.

What is NHS 111?

NHS 111 is a free telephone number to help people with urgent, but not life-threatening, conditions get advice and access the most appropriate service to meet their needs. Trained advisers use a tool called NHS Pathways to triage patients and direct them to the best service.

NHS 111 was introduced across the country in 2013 and replaced NHS Direct.

What is the GP out-of-hours (OOH) service?

GP OOH services are available from 6:30pm-8am Monday to Friday and 24 hours a day on weekends and bank holidays. OOH services are accessed through calling NHS 111 and give people access to primary care, for urgent problems, when their GP surgery is closed, usually at night or over the weekend. GPs and other clinicians are able to offer advice over the telephone or face-to-face appointments if needed.

Current services

Currently we commission three providers to deliver separate NHS 111 and out-of-hours services to patients in north central London.

- The NHS 111 service for all five CCGs in NCL is provided by London Central and West Unscheduled Care Collaborative (LCW), a GP-led notfor profit organisation.
- The out-of-hours GP service for Camden and Islington is provided by Care UK, and in Barnet, Enfield and Haringey is provided by Barndoc Healthcare.

These providers have all demonstrated excellent performance over the years of their current contracts . North central London residents have access to NHS 111 and out-of-hours services that are as good as, or better than, any in London. This is demonstrated through the evidence that is presented at the monthly clinical quality review meetings and also a comparison of NHS 111 provider performance across England (accessible on the NHS England website). However, themes from complaints, incidents and feedback also reveal examples of poor patient experience that need to be improved.

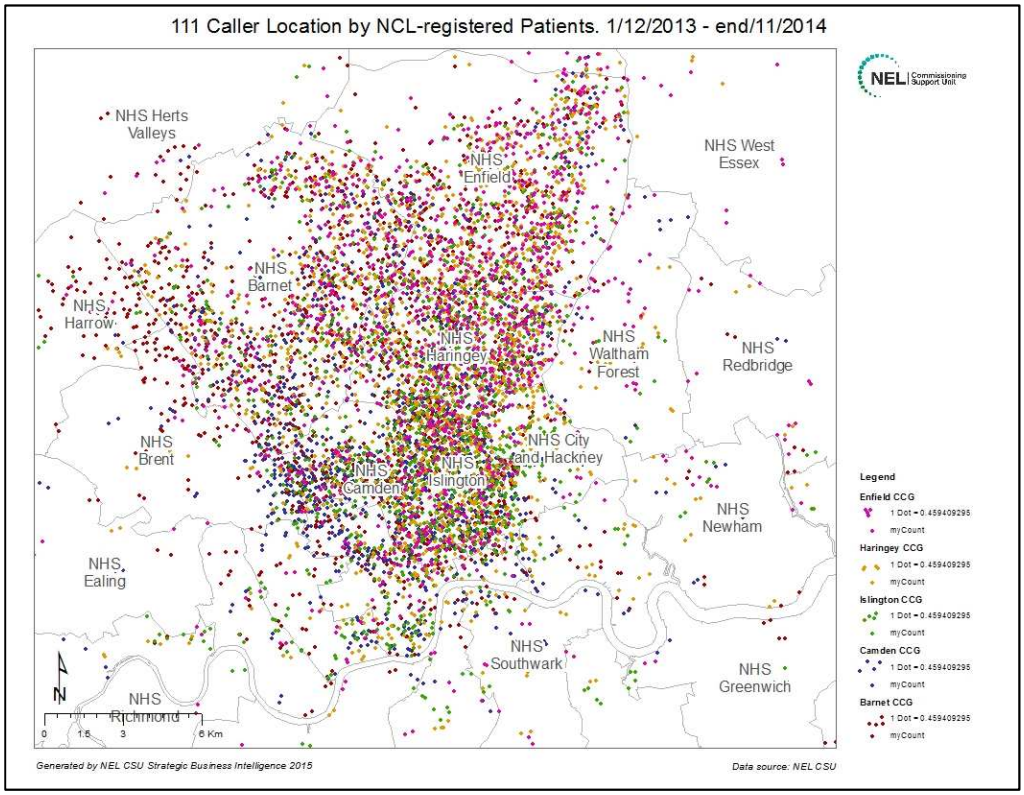
Case for change

The current contracts for these services are all drawing to an end, which means NCL CCGs are legally required to undertake a procurement process. While the existing contracts were

set to expire in March 2015, the contracts have been extended to allow CCGs time to refresh and improve the service specification and procure the best possible service for the population.

It is clear from our data and was demonstrated when we presented to the JHOSC in January (see appendix) – that the NHS 111 and out-of-hours services work very closely together, with OOH seeing by far the majority of referrals from NHS 111. It therefore makes sense to commission NHS 111 and OOH as a single contract, with a single specification, so that we can ensure patients receive a more joined-up service with fewer handovers between medical staff and better information sharing. Currently patients often have to be triaged twice, giving their information to both NHS 111 and the OOH provider, and we want to make this simpler. Planning to have a single contract does not mean that one provider would be commissioned to provide the service. It is anticipated that a number of providers may commit to working together to provide a single integrated service, and we have been encouraging this through market testing events.

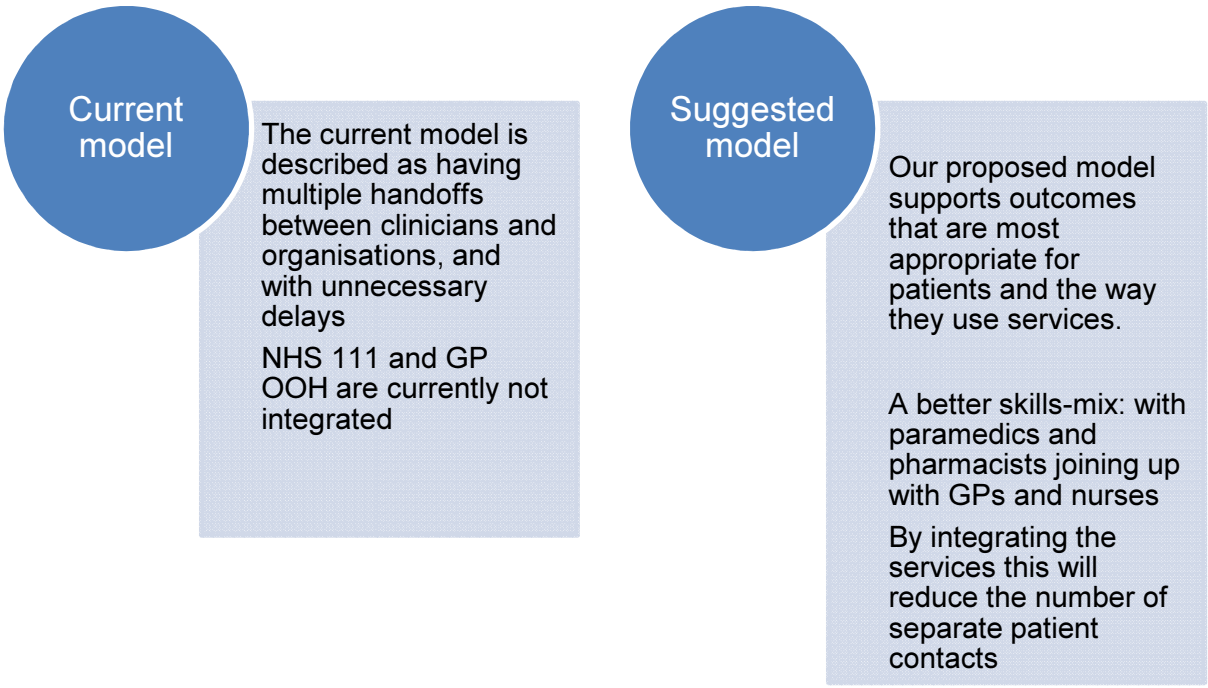
We have also stated our intention to commission NHS 111 and OOH as a single service across the five NCL boroughs, using a single contract with a lead provider(s) but working with local providers – which could include NHS trusts, GP collaboratives or private and voluntary sector providers. We believe this is the right model because it matches how patients actually access these services. Callers to NHS 111 are often not near to their registered GP practice when they call, but they are usually somewhere within the NCL area – so it makes sense for NHS 111 to be able to refer them to services near to where they actually are. Commissioning NHS 111 and OOH as a single service will allow this and provide more choice of access points. As noted above, NHS 111 is currently commissioned and provided as one service across North Central London. The inclusion of OOH services within this arrangement will enable the integration referred to above, while retaining scope for OOH services to be provided by a range of providers locally, as now.



Commissioning at this larger geographical scale, and requiring providers within the model to work together to provide an integrated service, will also allow us to develop systems and infrastructure that are more flexible and reactive to patients' needs. For example, we want

the service to employ a wider skills-mix of health professionals including pharmacists and paramedics as well as GPs and nurses - so that patients have access to health advice and treatment that matches their needs, all from a single point of contact via NHS 111. Deaf service users also sometimes experience a poor service, and we want to develop systems to improve this. This is achievable if we commission at a five borough scale, and would be much less viable if we commissioned separate services.

This is also an opportunity to redevelop the NHS 111 and OOH service as an integral part of the NCL health system, and ensure that it works intuitively with other aspects of primary care and emergency care and helps relieve pressure on the overall system.



How we have engaged with patients and the public

The initial plan to jointly commission NHS 111 and OOH services as a single service was developed based on extensive feedback from service users and clinicians. In particular, the Review of Urgent Care carried out in Camden and Islington in 2013/4 recommended a more joined-up approach to commissioning urgent care services and specifically NHS 111 and OOH services.

We have undertaken a very considerable engagement programme over the past six months, which has included:

- Presentations to JHOSC and local health and overview scrutiny committees.
- Individual CCGs have discussed NHS 111 and OOH plans at local engagement events, including discussions with hundreds of individual service users and meetings with targeted groups such as disabled service users and refugees.
- Two phases of focused engagement events (nine in total) held at venues across NCL and advertised through local newspapers and CCG websites, attended by dozens of interested service users and allowing for in-depth discussion of the proposals.
- Presentations at GP locality meetings across NCL to ensure local doctors understand what is planned and how they can be involved.
- An online survey to find out the views of stakeholders and service users on our commissioning plans.
- The setting-up of a Patient and Public Reference Group, involving service users from all five boroughs and Healthwatch representation – this is looking in detail at the

proposed service specification and will have a fact-finding visit to the current NHS 111 provider. Members who have expressed an interest are being invited to participate in the Procurement Panel when it goes ahead.

Issues identified

Throughout this engagement period, the service users, stakeholders and clinicians we have met with have overwhelmingly welcomed the proposal to bring the NHS 111 and OOH services together – they recognise that this brings the opportunity to reduce the number of patient handovers and deliver a more seamless service.

People have made a number of suggestions which have been valuable to us as we have gone forward to develop the service specification. These include:

- *People would like to see more clinical involvement in delivering the NHS 111 service.* In fact the NHS 111 call handlers already have direct access to clinicians when they need it, but under the new proposals this would include a wider range of healthcare practitioners, all working within the same service. This would mean fewer delays for callers.

- *People want to see involvement from local clinicians and access to local knowledge within the service.* While we cannot mandate for the recruitment of local staff, we can specify that staff must have excellent knowledge of local services. It is also our intention that the new service will offer more attractive career options and make OOH work a positive choice for staff. Local GP federations are currently developing in several areas, and we envisage these playing a role in the delivery of OOH care in the future.

- *People are worried about the idea of a private provider winning the contract for the OOH service, and think this is more likely if we commission a contract that covers five boroughs.* We are required to treat different types of provider fairly in any procurement process. The contract must be awarded based on the ability to deliver a high quality service at an appropriate cost. However we are working very hard to ensure that a range of types of provider, including NHS organisations, GPs and voluntary sector organisations are able to participate, and it is anticipated that the eventual service will be delivered by a number of providers working together.

- *People want to make sure the new service is more accessible for patients with sensory impairments, learning disabilities or language barriers.* We agree that these are all areas for improvement. There are plans in place and technological solutions being developed at a London and at a national level to respond to the access challenges faced by different groups within the population. Commissioning the service at a five borough scale would make it much easier for us to mandate effective solutions to improve access for all.

- *People have told us they don't know about NHS 111, and that lack of publicity means people use ambulances and A&E instead.* We know this is a problem. We have excellent local NHS 111 and OOH services, but some negative national media coverage has made it a challenge to communicate that. Developing improved awareness in service users through communications and engagement will be part of the implementation of the new combined service. There is also national and London-wide work underway to respond to the recommendations of the national review of urgent and emergency care by Sir Bruce Keogh, which will further support increased clarity for the public.

Next steps

We have heard from a wide range of members of the public during our engagement programme. Further detail about the outcomes from this are provided in Appendices to this paper. We do understand, however, that for some of our stakeholders we have not yet made the case for the commissioning of NHS 111 and out-of-hours as a single service across five boroughs. We think the evidence is clear that this is the best match for how patients actually use the current services, and that commissioning in this way provides the most effective way of delivering these services and will enable us to develop and improve the services over the next five years.

To respond to remaining concerns, we have taken the decision to undertake a further period of engagement, specifically focused on our intention to commission the integrated service across five boroughs. This will include:

- Publication and wide circulation of an engagement document, outlining the case for NCL-wide commissioning and encouraging residents and stakeholders to submit their views.
- An online and postal questionnaire.
- Meetings with clinicians and key stakeholder groups to discuss and develop further the clinical case for change.
- An additional ‘market-testing’ event, to ensure that all potential providers have the fullest possible information about the planned service and opportunities to participate.

JHOSC members are asked note the progress made to date and support the CCGs’ proposed approach for the programme.

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Integrating NHS 111 and GP out-of-hours services in north central London

Public engagement events

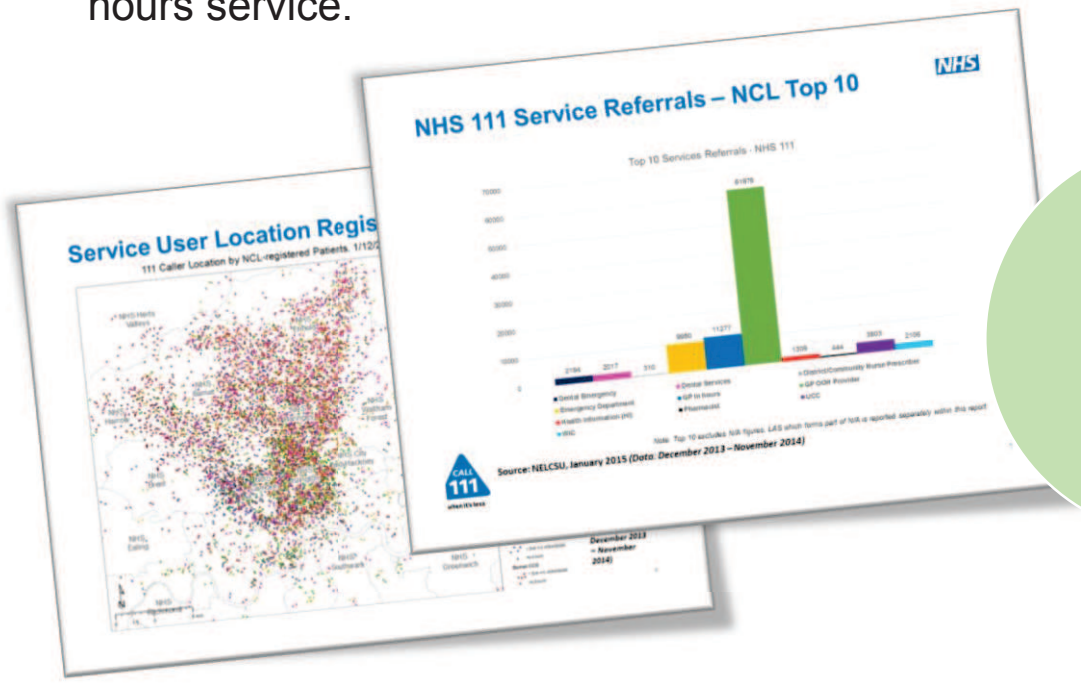
Summary of discussion

April 2015

Commissioning NHS 111 and GP out-of-hours services

Background and context

NHS 111 and GP out-of-hours services are already available to residents in north central London. The five CCGs – Barnet, Camden, Enfield, Haringey and Islington – are seeking to strengthen these services to improve patients' experience. To achieve this, the CCGs are planning to commission an integrated NHS 111 and GP out-of-hours service.



Why integrate services?

Patient flows

A review of the patient flows demonstrates that the majority of patients who currently use NHS 111 and GP out-of-hours services live in north central London, but use services across the area not necessarily within their borough of residence.

Joining these services together will enable patients to access services more easily in different boroughs.

Clinical activity

The majority of NHS 111 referrals are made to GP services (49%), rather than other services like London Ambulance Service (9%) or Urgent Care services/A&E (6%), during the out-of-hours period.

Access to GPs and other clinicians should be more timely, reducing the number of handovers.

The integrated service will enable clinicians to prescribe without the need for duplication or unnecessary referral.

Current model vs new model

Current model

The current model is described as having multiple handovers between clinicians and organisations, with unnecessary delays for patients.

NHS 111 and GP out-of-hours services currently not integrated.

Proposed model

Delivered by a mix of skilled doctors, nurses, paramedics and pharmacists.

Supports outcomes that are most appropriate for patients and the way they use services.

Would reduce the number of separate patient contacts.

This type of model will require collaboration between a range of providers.

Public information events

Camden and Islington	23 February 2015
Enfield and Haringey	3 March 2015
Barnet and Enfield	6 March 2015

Attended by residents of those boroughs to listen to the proposals and feed back their thoughts.

Key emerging themes

- Good quality services
- Involvement of local doctors
- Quality of engagement
- Involvement of mental health services
- Procurement process
- Geography
- Involvement of pharmacies

Involvement of local doctors

- GPs' working practices have changed over the years.
- Current model – less than 30% of the out-of-hours service is provided by local GPs.
- It is becoming increasingly difficult to attract the GP workforce to work in out-of-hours care.
- An integrated model would enable a mix of skills available for patients with doctors, nurses, pharmacists, paramedics, dental nurses and health advisors working together to provide advice, assessment and care.
- We would ensure that the provider of the service meets the Royal College of GPs' quality standards.
- The provider would need to have an understanding of local services.

Clinical quality

"Who will man the NHS 111 service? Is it a 24-hour service?"

"NHS 111 has failed many disabled people in the last two years due to lack of continuity."

"A doctor came to the house and treated my baby really quickly."

"Will the health advisor issue repeat prescriptions"

"There are lots of accents and languages and interpreters used in the service who are not medically trained!"

"Has a pilot been conducted anywhere?"

"I had a good experience when I rang NHS 111 in the middle of the night."

- Majority of NHS 111 calls are received during evenings and weekends and most callers are referred to the GP out-of-hours service.
- NHS 111 is a two-year pilot service which began in April 2013. (There are nine across London and six more across the UK). Key lessons learnt from them are to integrate NHS 111 and GP out-of-hours, sharing patient records, digitally where possible.
- Clinical quality is of the utmost importance. We monitor the GP out-of-hours and NHS 111 services closely for quality, governance and safety, and this will continue.
- Recommissioning GP out-of-hours services means we can improve the clinical model.
- Health advisors and pathway clinicians would work together. Some calls would go through to a health advisor whilst other, more complex, calls would go to the pathway clinician.
- Health advisors are trained for 12 weeks and pass an exam before they can receive NHS 111 calls.
- Prescriptions will only be issued by a doctor, nurse or pharmacist.
- NHS 111 uses *Language Line*, staffed by medical interpreters. Calls are audited regularly to assure the quality of interpretation.
- Information about patients with a care plan will be shared between health care professionals to reduce duplication and provide greater detail and insight into their condition.

Quality of engagement

"Will patients be involved in designing the new service?"

"Why aren't you doing more to tell us what is going on?"

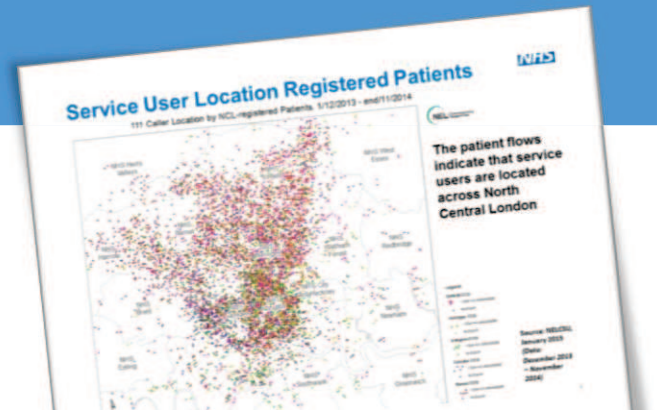
- Bringing NHS 111 and GP out-of-hours services together is about how the providers are organised, not how the services are delivered.
- A consistent piece of feedback from the events was to undertake further engagement – further public information events are planned for April and May.
- We have service user and Healthwatch involvement – Healthwatch are members of the Patient and Public Reference Group (PPRG) and sit on the NCL Urgent Care Programme Board.
- Members of the PPRG are helping to design the new integrated service.

Geography

"Is the five borough based contract because NHS England would not accept a smaller contract than this?"

"On the basis of your activity slide, why are Hackney and Harrow not included in these plans?"

- Multiple providers of NHS111 and GP out-of-hours services in London and NHS England recommends (lesson learnt from pilots) a single provider due to the high volume of activity.
- Initial thinking was for a single provider of NHS 111 to be commissioned for London. There are examples of single providers for NHS 111 across large geographical footprints – 33 CCGs commission a single NHS 111 service across the West Midlands.
- Locally, we have been successful in negotiating a smaller footprint across the five boroughs, rather than the whole of London.
- 95% of the activity occurs within the north central London boundaries. At this point there is not a significant proportion of activity in the other areas.
- The five CCGs work closely on numerous commissioning activities and share a five year strategic vision.



Pharmacy

"Are there any 24 hour pharmacies in north central London?"

- The new NHS 111/out-of-hours service will have a stock of common medicines that patients may need after hours (for example, pain relief and antibiotics).
- There are a number of pharmacies across north central London that are open till midnight.
- There is a 24-hour pharmacy in London, in Earls Court.

"How do we manage pharmacists' opening hours?"

The commissioning process

"Why are we going for a single provider?"

"Can members of the public see the service specification to provide assurance that this is the model that is being tendered?"

- The service specification is not yet finalised but will not restrict bids to a single provider.
- Once finalised and agreed, the specification will be in the public domain for all to see. Patients are involved in the development of that specification.
- We are seeking to use a Lead Provider model, which will allow small groups of providers to come together.
- Because the geographical footprint is across five boroughs, we think it is unlikely there is one single provider who could effectively provide the whole integrated service.
- All local GP groups have been involved in the process so far through invitations to an event where we outlined the process and plans.

What are the positive elements and concerns you might have about the planned integrated service?

Positive elements

- Assurance of quality − this will be a better service in the long run.
- A seamless service between NHS 111 and GP out-of-hours.
- Patients have a much better understanding of how the services operate.
- Inclusion of specialist services, such as dental and mental health services.
- Advantage of NHS 111 and GP out-of-hours together – improved triage.
- Clinical advice available at the end of the phone.
- It's clear in the specification that the patient will not be bounced around the system.

Concerns

- Information and data governance.
- How do community services fit in with this model?
- How are disabled people who live on their own supported?
- Target children with education around how to use the NHS (from primary school).
- Loss of jobs with current providers.

How can we strengthen our plans?

Clinical model

- Ensure quality of the provider
- Strong performance management and targets within the contract.
- Ensure that performance is reported to CCGs and to patients/public.
- Deal with the diversity of language and cater for the hard of hearing.
- Rapid response needs to be made more seamless.
- Patients want local GPs delivering the out-of-hours service.
- Special instructions on how to use the NHS 111 service.

Communications and engagement

- Tell everyone about the new service.
- Communicate what we have now and what will remain in the new service.
- Use a variety of methods to share plans and engage with the local people including TV, radio and print media, websites and social media.
- Hold further public information events.
- Explore providing information about the new service at a range of locations (for example, football matches, supermarkets, libraries).

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Integrating NHS 111 and GP out-of-hours services in north central London

Public engagement events summary report

June 2015

Commissioning NHS 111 and GP out-of-hours services

Background and context

- NHS Clinical Commissioning Groups in north central London (Barnet, Camden, Enfield, Haringey and Islington) are seeking to improve the local NHS 111 service. This includes integrating the NHS 111 and the GP out-of-hours to enable them to work better together.
- The current contract for the NHS 111 service needs to be renewed which means we now have a real opportunity to learn from experiences and make NHS 111 work better for patients.

NHS 111

NHS 111 is a free telephone number to help people with urgent, but not life-threatening, conditions get advice and access the most appropriate service to meet their needs.

The service is available 24/7 including bank holidays.

GP out-of-hours

GP out-of-hours (OOH) services are available so that people can still access primary care, for urgent problems, when their GP surgery is closed at night or over the weekend.

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Public information events

Our aim is to ensure the voices of patients and carers are at the heart of our decision-making and we recently hosted a series of public engagement events across north central London as an opportunity to hear from local people who have used the NHS 111 or out-of-hours services.

These events were held in the boroughs of Barnet, Camden, Enfield and Haringey and were led by the NHS 111 clinical lead for north central London, Dr Sam Shah:

- Enfield 28 April
- Haringey 5 May (2 events)
- Camden 13 May
- Barnet 18 May and 4 June

In addition, Islington CCG undertook a separate series of more than 15 workshops and meetings with over 250 Islington residents.

The meetings were open to all residents and enabled local people to share their views and experiences of existing services so that we can work together towards developing the best possible service.

The next few slides capture the key messages, emerging themes and patient feedback.

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Key emerging themes

- **Involvement of local doctors**: people want to be able to speak to a local doctor when patients call the GP out-of-hours service
- **Information governance**: how will patient records be shared?
- **Equitable access**: how will the services support people with learning disabilities, who have a hearing impairment or other disability, or who do not speak English as a first language?
- **Ease of use**: some people that have used the NHS 111 service found it challenging to use and sometimes callers are asked too many irrelevant questions
- **Clinical quality**: people want to know that NHS 111 call handlers have the proper qualifications and training
- **Promotion of services**: there is a lack of public awareness of NHS 111 and GP out-of-hours services
- **Scale of procurement**: people want to know that local providers will be able to participate and not be discouraged by the scale of the procurement.

Why we are proposing to integrate services?

Patient flows

- Our research shows that the majority of patients who use NHS 111 live in north central London but use services across the area - not necessarily within their borough of residence.
- An integrated service would enable patients to access services more easily from OOH bases in different boroughs.

Clinical activity

- Ensure that access to GPs and other clinicians is more timely.
- Reduce the number of handovers.
- An integrated service would enable clinicians to prescribe without the need for duplication or unnecessary referral.

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Models for future delivery

Current model

The current model has multiple handoffs between clinicians and organisations, and unnecessary delays

NHS 111 and OOH currently not integrated

Suggested model

This type of model will require collaboration between a range of providers. Local GPs and other providers are encouraged to work together

Skills mix: nurses, paramedics, pharmacists and GPs

Supports outcomes that are most appropriate for patients and the way they use services.

Reduces the number of separate patient contacts

Patient feedback: positive elements of the proposed integration of services

I hope that it puts an end to patients being passed around the system

I feel assured that there will be a streamlined patient journey and I won't have to repeat myself over and over

Good to see the five boroughs working together to ensure that we get access to services across north central London

Inclusion of specialist services such as dental, pharmacy and mental health services

There are too many options to access urgent care help and sometimes it is confusing. I am happy that it has been simplified and that I will only have to dial one number as a starting point.

Pleased that the CCGs are listening to service users and involving us in the development of the service specification.

It is clear from the supporting information that the CCGs have done their research and demonstrated learning from past projects

Integrating services across the five boroughs puts an end to the postcode lottery. All residents will get cover regardless of where they are registered

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Patient feedback: what are you most concerned about?

Information governance. How will my records be shared and will they sold onto other companies?

How do you protect against prioritising costs over clinical quality, where the cheapest provider wins the contract?

How confident are you of finding the right provider?

Does the size of the procurement mean that only the big private companies will be successful?

Large scale projects have a more profound impact if they fail. Do you have a plan to manage against providers that fail?

Staff shortages in the NHS. How will the proposed service ensure that it is appropriately staffed?

How are you making sure that there will be equitable access for users with a hearing impairment or another disability?

Can you make sure that the involvement of local GPs is assured?

Will patients be expected to travel further to access services?

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Patient feedback: how can we strengthen our plans?

Can you ensure that the service specification strengthens specific areas such as dealing with diverse languages and disability?

Can the CCGs consider how best to utilise technology?

Will you advertise the service and educate people about how and when to use it?

Will you make it easy for patients to feedback on services provided?

Can you ensure providers have highly skilled staff?

Can you ensure that plans also address daytime GP access?

Will you provide regular updates to PPGs?

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Next steps:

- ❑ We are continuing to engage with patients and services users at every opportunity and throughout each phase of the programme.
- ❑ We are also developing a service specification with input from the patient participation reference group (PPRG).
- ❑ If you wish to provide some input or feedback on the proposed service then please contact feedback@nelcsu.nhs.uk or call 020 3688 1615.
- ❑ A full list of frequently asked questions (FAQs) is available on the individual CCG websites.

If you wish to learn more about our proposals and the rationale please visit your respective CCG website:

Barnet CCG - www.barnetccg.nhs.uk
Enfield CCG - www.enfieldccg.nhs.uk
Islington CCG - www.islingtonccg.nhs.uk
Camden CCG - www.camdenccg.nhs.uk,
Haringey CCG - www.haringeyccg.nhs.uk,

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Joint Health Overview and Scrutiny Committee

NHS 111 and GP Out-of-Hours

NHS NCL Clinical Commissioning Groups

Dr Sam Shah
Clinical Lead – NHS 111 Governance

NHS 111

NHS 111 is a free telephone number to help people with urgent, but not life-threatening, conditions get advice and access the most appropriate service to meet their needs. Trained advisers use a tool called NHS Pathways to triage patients and direct them to the best service.

NHS 111 was introduced across the country in 2013 and replaced NHS Direct. In north central London (Barnet, Enfield, Haringey, Islington and Camden), the NHS 111 service is currently provided by London Central & West Unscheduled Care Collaborative (LCW)

GP Out-of-Hours

GP out of hours (OOH) services are available so that people can still access primary care, for urgent problems, when their GP surgery is closed at night or over the weekend.

In Camden and Islington, GP out of hours services are currently provided by Care UK. In Barnet, Enfield and Haringey, the GP out of hours service is currently provided by Barndoc.

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NHS 111 – Activity Overview

The following slides highlight activity via the NHS 111 service within North Central London (NCL). They cover a 12 month period (December 2013 – November 2014). In total there were 180,479 patients triaged by LCW (NCL NHS 111 provider) during this 12 month period. 139,536 of these patients either reside within NCL or are registered with a GP within the boundaries of the 5 NCL CCGs. The other patients are those that are registered with a GP elsewhere. **This report will focus on the 139,536 patients registered or residing.**

This activity is broken down to indicate the following:

- Demographics
- Caller activity
- Presenting symptoms and service referrals

It is also important to note that some North Central London patients (approx. 5%) will have got through to another NHS 111 provider and this activity is not included.

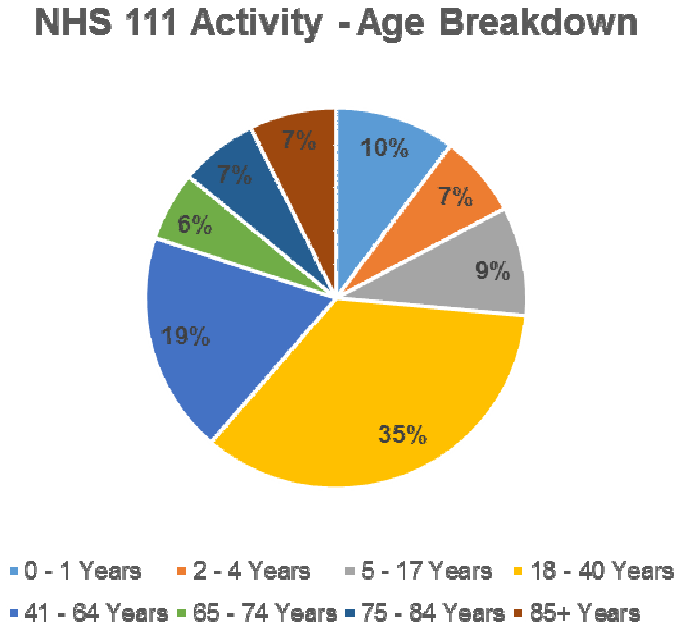
Quality and Monitoring

Clinical leads from North Central London CCGs meet with the 111 provider each month to undertake call audits, a review of quality and receive performance and activity information. Joint meetings are convened between 111, GPOOH and other providers.

Quality meetings provide a forum to discuss clinical governance matters and address any concerns about performance should they arise. This includes assurance of the workforce and training etc.

The CCGs are committed to monitoring quality and governance through regular contract meetings and as a method of continuously improving services in partnership with providers. The commissioning cycle includes service improvements based on previous governance concerns and evidence from 111 learning programmes.

Demographics - Age



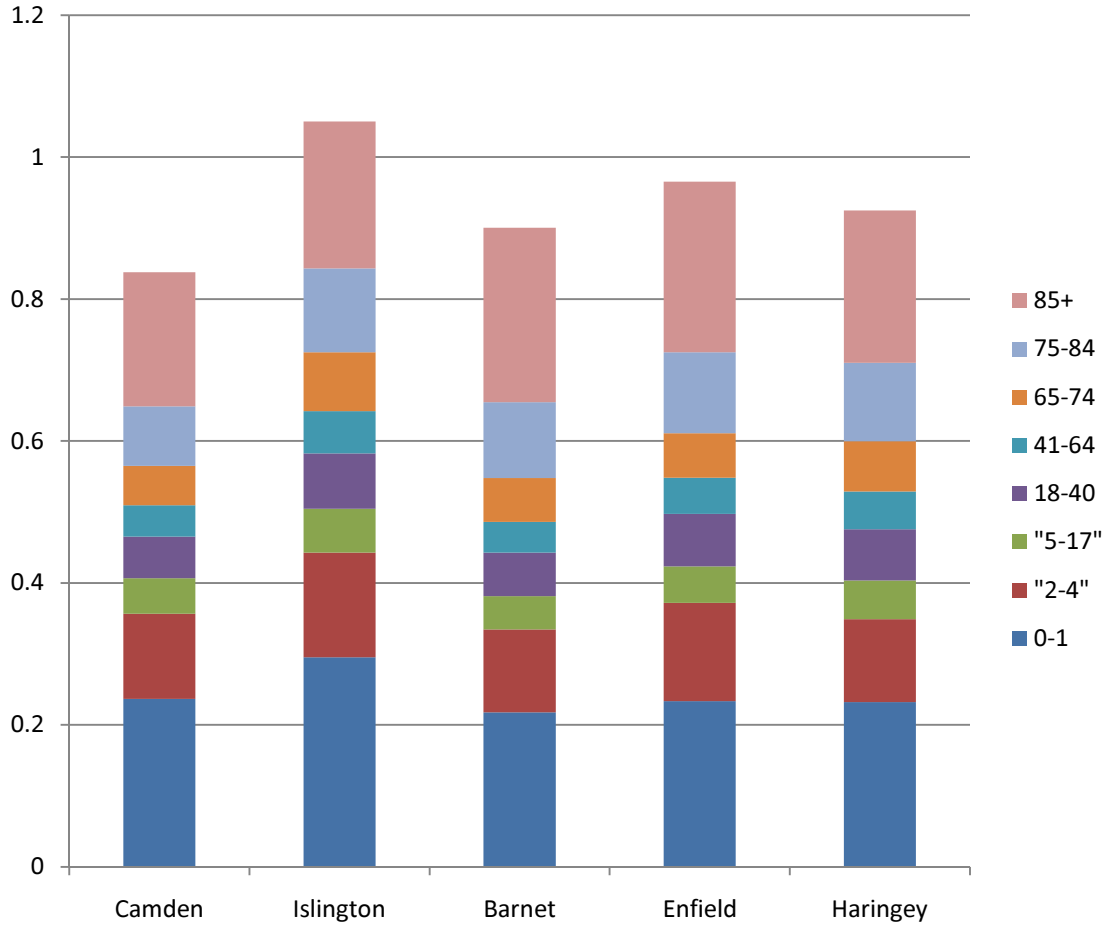
People aged between 18 and 64 year of age are the biggest users of 111

Age Breakdown	Barnet CCG		Enfield CCG		Haringey CCG		Camden CCG		Islington CCG		Grand Total	
0 - 1 Years	3,538	10%	3,259	10%	2,918	10%	1,900	9%	2,635	11%	**14,250**	**10%**
2 - 4 Years	2,471	7%	2,628	8%	1,882	7%	1,224	6%	1,553	6%	**9,758**	**7%**
5 - 17 Years	3,254	9%	3,450	11%	2,734	10%	1,572	8%	1,948	8%	**12,958**	**9%**
18 - 40 Years	9,571	27%	10,080	31%	10,502	38%	8,077	40%	10,406	42%	**48,636**	**35%**
41 - 64 Years	6,242	18%	6,121	19%	5,522	20%	3,685	18%	4,652	19%	**26,222**	**19%**
65 - 74 Years	2,268	7%	1,917	6%	1,571	6%	1,084	5%	1,361	6%	**8,201**	**6%**
75 - 84 Years	2,811	8%	2,271	7%	1,615	6%	1,367	7%	1,181	5%	**9,245**	**7%**
85+ Years	4,682	13%	2,317	7%	1,188	4%	1,258	6%	821	3%	**10,266**	**7%**
Grand Total	**34,837**	**100%**	**32,043**	**100%**	**27,932**	**100%**	**20,167**	**100%**	**24,557**	**100%**	**139,536**	**100%**

Source: NELCSU, January 2015 ***(Data: December 2013 – November 2014)***

CALL 111 when it's less urgent than 999

Demographics - Caller Age Segmented against the GLA Population Projection Data (2014 mid-point)



Source: NELCSU, January 2015 ***(Data: December 2013 – November 2014)***

The use of 111 by proportion of population is similar for each age group when comparing boroughs. There is some increased use for those aged '0 – 1' in Islington and those aged 85 and over in Barnet. There are differences in utilisation by age group.

Note: the Figure illustrates the Age composition of (unique) Callers, adjusted to the prevalence of each Age group in each Borough. That is, 8,523 Callers aged 18-40; as compared to 109,644 inhabitants in Islington aged 18-40. We hence illustrate the proportion of each Age Band which utilise the Service.

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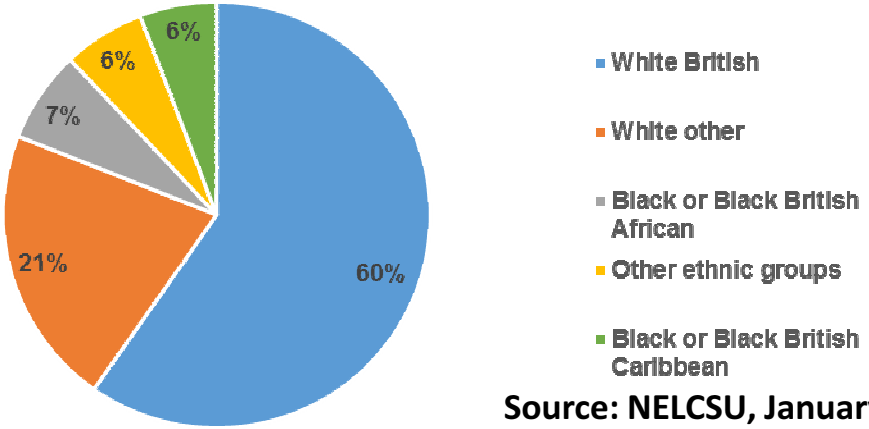
Demographics - Ethnicity

Ethnicity Breakdown - Top 5



The majority of service users described themselves as white, however almost a fifth of users did not state their ethnicity.

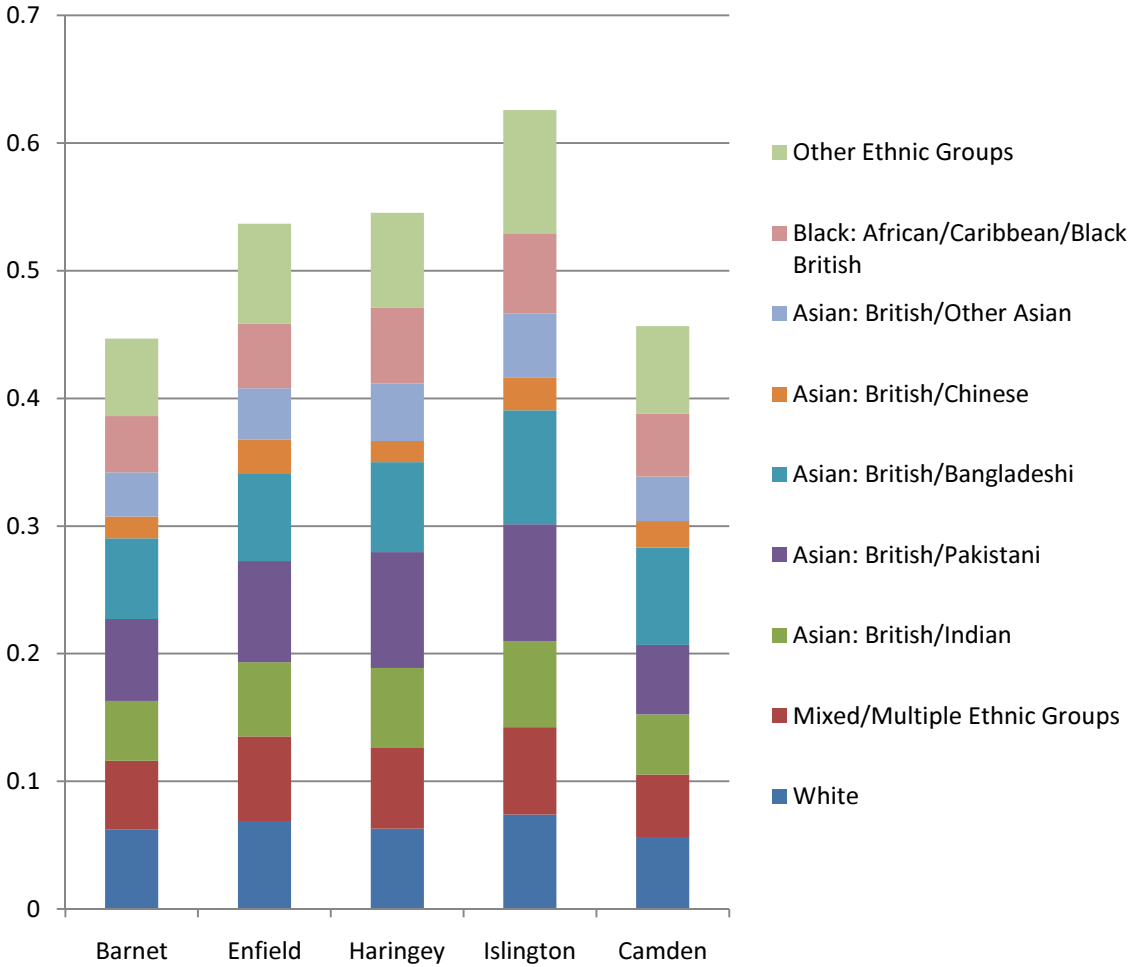
Source: NELCSU, January 2015 *(Data: December 2013 – November 2014)*

Ethnicity Breakdown	Barnet CCG		Enfield CCG		Haringey CCG		Camden CCG		Islington CCG		Grand Total	
Asian or Asian British Bangladeshi	161	0%	480	1%	440	2%	1,197	6%	602	2%	**2,880**	**2%**
Asian or Asian British Indian	1,776	5%	946	3%	599	2%	433	2%	357	1%	**4,111**	**3%**
Asian or Asian British Pakistani	432	1%	236	1%	281	1%	108	1%	99	0%	**1,156**	**1%**
Black or Black British African	1,030	3%	1,661	5%	1,799	6%	782	4%	1,251	5%	**6,523**	**5%**
Black or Black British Caribbean	396	1%	1,523	5%	2,209	8%	337	2%	988	4%	**5,453**	**4%**
Chinese	151	0%	95	0%	81	0%	169	1%	123	1%	**619**	**0%**
Mixed other	672	2%	811	3%	746	3%	519	3%	652	3%	**3,400**	**2%**
Mixed White and Asian	196	1%	145	0%	166	1%	156	1%	152	1%	**815**	**1%**
Mixed White and Black African	118	0%	127	0%	169	1%	119	1%	138	1%	**671**	**0%**
Mixed White and Black Caribbean	280	1%	456	1%	414	1%	202	1%	425	2%	**1,777**	**1%**
Not stated	6,097	18%	5,412	17%	5,005	18%	3,248	16%	4,130	17%	**23,892**	**17%**
Other Asian	951	3%	586	2%	553	2%	405	2%	367	1%	**2,862**	**2%**
Other Black background	89	0%	173	1%	183	1%	106	1%	152	1%	**703**	**1%**
Other ethnic groups	1,319	4%	1,534	5%	1,272	5%	744	4%	929	4%	**5,798**	**4%**
White British	16,527	47%	12,323	38%	8,750	31%	8,175	41%	10,115	41%	**55,890**	**40%**
White Irish	512	1%	440	1%	652	2%	718	4%	747	3%	**3,069**	**2%**
White other	4,125	12%	5,094	16%	4,612	17%	2,743	14%	3,330	14%	**19,904**	**14%**
Grand Total	34,832	100%	32,042	100%	27,931	100%	20,161	100%	24,557	100%	**139,523**	**100%**

Note: In addition to ethnicity not stated, there were an additional 13 patients whose ethnicity was not recorded.

CALL 111 when it's less urgent than 999

Demographics – Caller Ethnicity Segmented against 2011 ONS Census Ethnicity Data



Source: NELCSU, January 2015 ***(Data: December 2013 – November 2014)***

Service utilisation by ethnic group would indicate that there are differences in service utilisation by group.

Note: the Figure illustrates the Ethnic composition of (unique) Callers, adjusted to the prevalence of each Ethnic group in each Borough. That is,10.381 White Callers as compared to 140,352 White inhabitants in Islington. We hence illustrate the proportion of each Ethnic group which utilise the Service.

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Note: In addition to ethnicity not stated, there were an additional 13 patients whose ethnicity was not recorded.

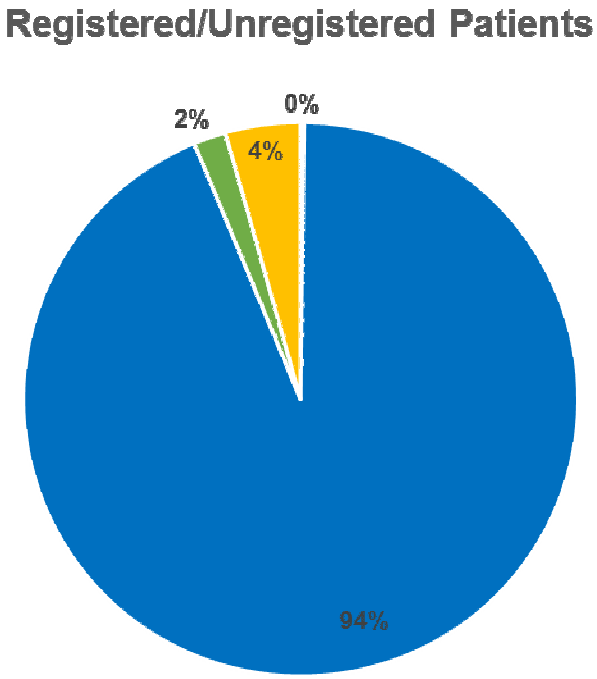
Awareness of NHS 111 and GP Out of Hours

When NHS 111 was launched nationally in 2013 it was not widely advertised. There were initial well-publicised difficulties with call volumes, but services across the country are much more stable than they were in April 2013.

The NHS England 111 Learning and Development programme has tested a number of marketing initiatives. The findings would suggest that general advertising is unlikely to result in behaviour change and that a more targeted approach is required for groups within local populations.

Based on the NHS England research, local CCGs will work closely with local authorities and other partners around marketing the services. We have already started this work with the Choose Well campaign, and could seek to do some more targeted work together around behaviour change.

Demographics – Registered/Unregistered



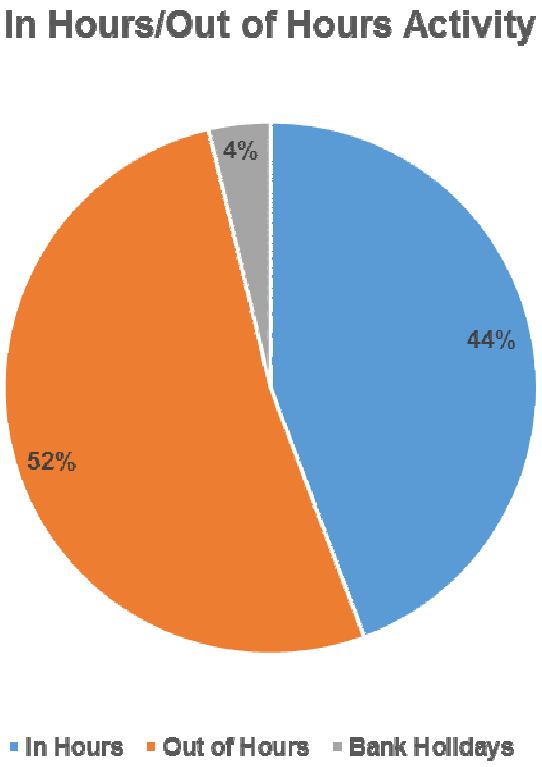
96% of service users were registered with a GP.

Registered/Unregistered Patients	Barnet CCG		Enfield CCG		Haringey CCG		Camden CCG		Islington CCG		Grand Total	
Overseas	64	0%	35	0%	58	0%	63	0%	51	0%	**271**	**0%**
Registered	32,730	94%	30,382	95%	25,784	92%	18,831	93%	22,809	93%	**130,536**	**94%**
Registered (GP Unknown)	623	2%	534	2%	646	2%	340	2%	486	2%	**2,629**	**2%**
Unregistered	1,420	4%	1,092	3%	1,444	5%	933	5%	1,211	5%	**6,100**	**4%**
Grand Total	**34,837**	**100%**	**32,043**	**100%**	**27,932**	**100%**	**20,167**	**100%**	**24,557**	**100%**	**139,536**	**100%**

Source: NELCSU, January 2015 *(Data: December 2013 – November 2014)*

CALL 111 when it's less urgent than 999

Caller Activity – In Hours/Out of Hours



44% of calls were made between 0800 – 1830 Monday to Friday

56% were made whilst GP surgeries were closed

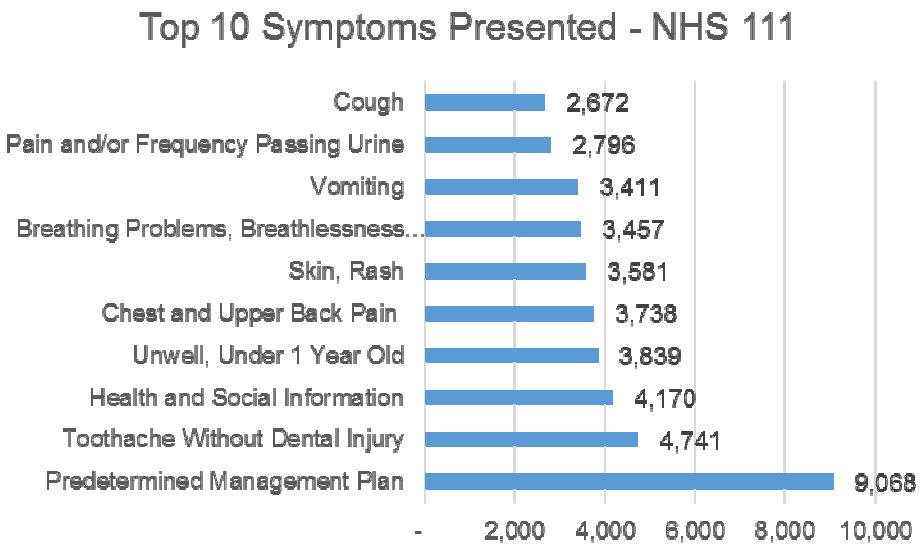
In Hours/Out of Hours Activity	Barnet CCG		Enfield CCG		Haringey CCG		Camden CCG		Islington CCG		Grand Total	
In Hours	15,421	44%	14,329	45%	12,260	44%	8,865	44%	10,945	45%	**61,820**	**44%**
Out of Hours	18,135	52%	16,555	52%	14,631	52%	10,494	52%	12,681	52%	**72,496**	**52%**
Bank Holidays	1,281	4%	1,159	4%	1,041	4%	808	4%	931	4%	**5,220**	**4%**
Grand Total	**34,837**	**100%**	**32,043**	**100%**	**27,932**	**100%**	**20,167**	**100%**	**24,557**	**100%**	**139,536**	**100%**

Source: NELCSU, January 2015 ***(Data: December 2013 – November 2014)***

NB some statistics are adjusted to the nearest whole number

CALL 111 when it's less urgent than 999

Top 10 Symptoms – Overall

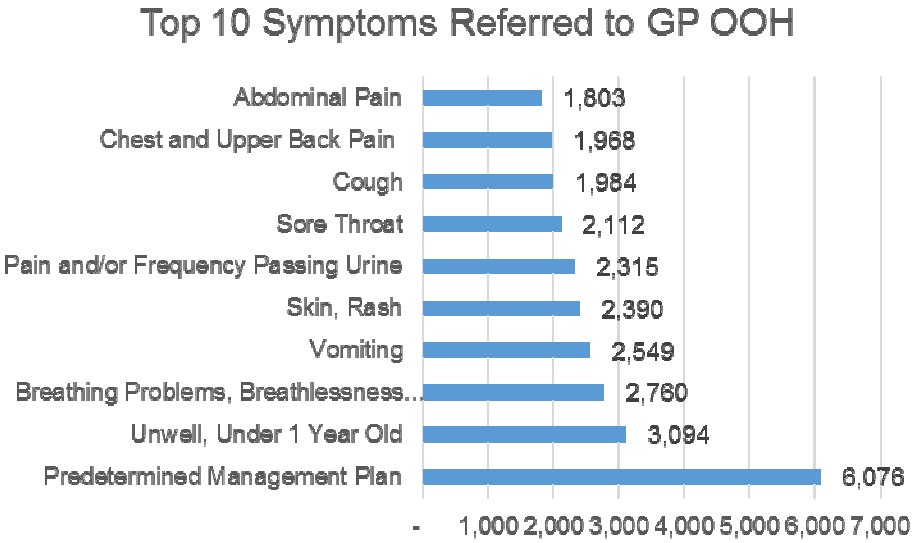


Top 10 Symptoms Presented - NHS 111	Barnet CCG	Enfield CCG	Haringey CCG	Camden CCG	Islington CCG	Grand Total
Predetermined Management Plan	2,456	1,893	1,665	1,447	1,607	9,068
Toothache Without Dental Injury	1,154	1,122	1,024	568	873	4,741
Health and Social Information	1,156	924	831	574	685	4,170
Unwell, Under 1 Year Old	929	858	822	520	710	3,839
Chest and Upper Back Pain	834	828	790	605	681	3,738
Skin, Rash	861	804	723	525	668	3,581
Breathing Problems, Breathlessness or Wheeze	919	830	649	505	554	3,457
Vomiting	816	848	703	465	579	3,411
Pain and/or Frequency Passing Urine	665	603	564	493	471	2,796
Cough	727	629	550	358	408	2,672
Grand Total	**10,517**	**9,339**	**8,321**	**6,060**	**7,236**	**41,473**

Source: NELCSU, January 2015 ***(Data: December 2013 – November 2014)***

CALL 111 when it's less urgent than 999

Top 10 Symptoms – Referred to GP Out of Hours



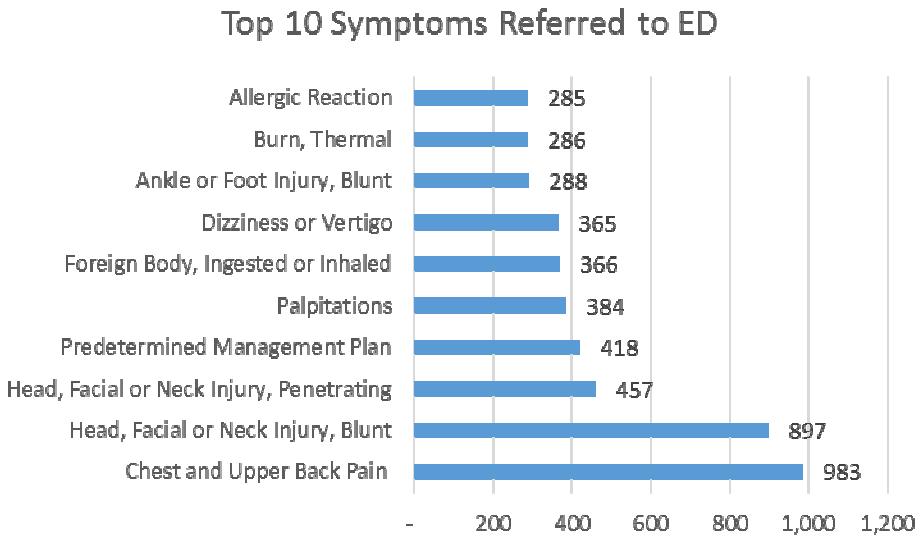
These are cases with presenting symptoms that were referred to the GP OOH service

Top 10 Symptoms Referred to GP OOH	Barnet CCG	Enfield CCG	Haringey CCG	Camden CCG	Islington CCG	Grand Total
Predetermined Management Plan	1,867	1,554	1,317	61	1,277	**6,076**
Unwell, Under 1 Year Old	760	679	667	417	571	**3,094**
Breathing Problems, Breathlessness or Wheeze	782	708	547	258	465	**2,760**
Vomiting	636	638	549	298	428	**2,549**
Skin, Rash	607	561	481	284	457	**2,390**
Pain and/or Frequency Passing Urine	572	515	471	378	379	**2,315**
Sore Throat	513	487	439	303	370	**2,112**
Cough	556	483	411	230	304	**1,984**
Chest and Upper Back Pain	522	456	430	170	390	**1,968**
Abdominal Pain	417	448	362	239	337	**1,803**
Grand Total	**7,232**	**6,529**	**5,674**	**2,638**	**4,978**	**27,051**

Source: NELCSU, January 2015 *(Data: December 2013 – November 2014)*

CALL 111 when it's less urgent than 999

Top 10 Symptoms – Referred to Emergency Departments



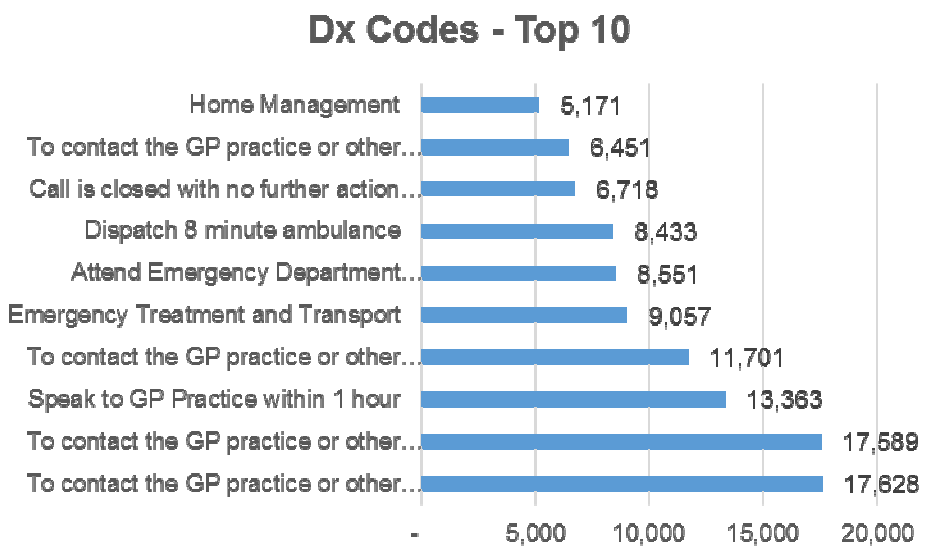
These are cases with presenting symptoms that were referred to an emergency department

Top Ten Symptoms Referred to ED	Barnet CCG	Enfield CCG	Haringey CCG	Camden CCG	Islington CCG	Grand Total
Chest and Upper Back Pain	181	162	227	236	177	**983**
Head, Facial or Neck Injury, Blunt	221	120	213	170	173	**897**
Head, Facial or Neck Injury, Penetrating	100	55	99	106	97	**457**
Predetermined Management Plan	83	65	107	76	87	**418**
Palpitations	76	67	70	90	81	**384**
Foreign Body, Ingested or Inhaled	75	42	101	82	66	**366**
Dizziness or Vertigo	64	60	90	78	73	**365**
Ankle or Foot Injury, Blunt	68	50	41	65	64	**288**
Burn, Thermal	65	43	54	65	59	**286**
Allergic Reaction	58	47	76	51	53	**285**
Grand Total	991	711	1,078	1,019	930	**4,729**

Source: NELCSU, January 2015 *(Data: December 2013 – November 2014)*

CALL 111 when it's less urgent than 999

Dx Codes – Top 10



DX Codes are used to decide the most appropriate service for a patient based on their answers to questions.

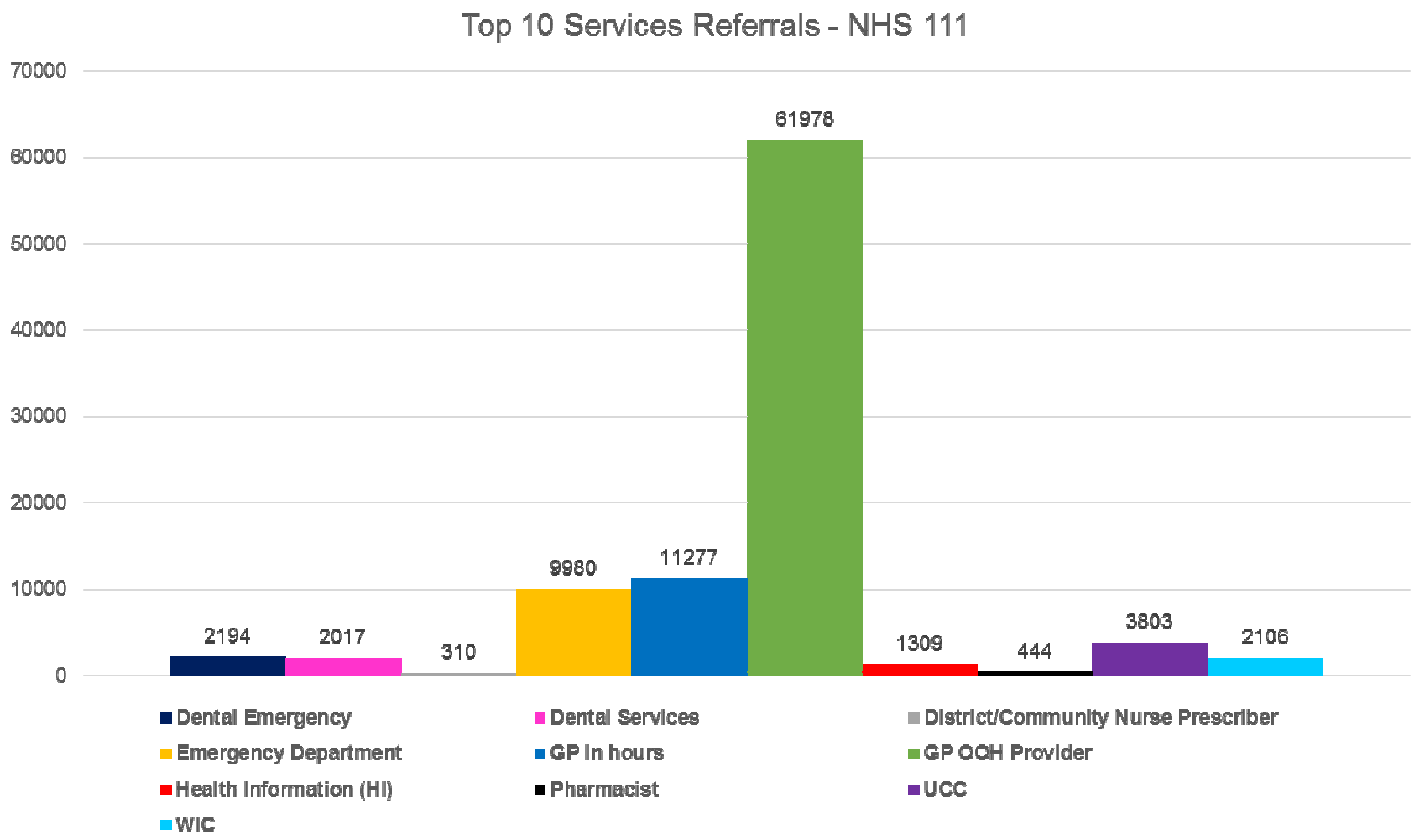
Almost half of all users need a GP *(this is for day time and evenings / weekends)*

Dx Codes - Top 10	Barnet CCG	Enfield CCG	Haringey CCG	Camden CCG	Islington CCG	Grand Total	% of Total Dx Codes
To contact the GP practice or other local service within 2 hours	4,193	4,153	3,588	2,571	3,123	**17,628**	**13%**
To contact the GP practice or other local service within 6 hours	4,119	4,071	3,633	2,594	3,172	**17,589**	**13%**
Speak to GP Practice within 1 hour	3,524	2,999	2,531	1,909	2,400	**13,363**	**10%**
To contact the GP practice or other local service within 24 hours	2,872	2,563	2,416	1,754	2,096	**11,701**	**8%**
Emergency Treatment and Transport	2,106	2,238	1,797	1,255	1,661	**9,057**	**6%**
Attend Emergency Department within 1 hour	1,852	1,965	1,768	1,255	1,711	**8,551**	**6%**
Dispatch 8 minute ambulance	1,973	2,114	1,736	1,040	1,570	**8,433**	**6%**
Call is closed with no further action needed	2,042	1,463	1,252	995	966	**6,718**	**5%**
To contact the GP practice or other local service within 12 hours	1,530	1,487	1,271	993	1,170	**6,451**	**5%**
Home Management	1,320	1,232	1,035	683	901	**5,171**	**4%**

Source: NELCSU, January 2015 *(Data: December 2013 – November 2014)*

CALL 111 when it's less urgent than 999

NHS 111 Service Referrals – NCL Top 10



Note: Top 10 excludes N/A figures. LAS which forms part of N/A is reported separately within this report.

Source: NELCSU, January 2015 ***(Data: December 2013 – November 2014)***

CALL 111 when it's less urgent than 999

Demand profile: Urgent & Emergency Care

The referral profile demonstrates that a small proportion of cases are referred from NHS 111 to emergency health care services.

NHS 111 uses an accredited triage tool, NHS Pathways. Monthly audits would indicate that the tool is being used appropriately and supported by clinical assessment. Therefore there is no evidence to suggest that NHS 111 is directing ‘non-emergency’ cases to A&E.

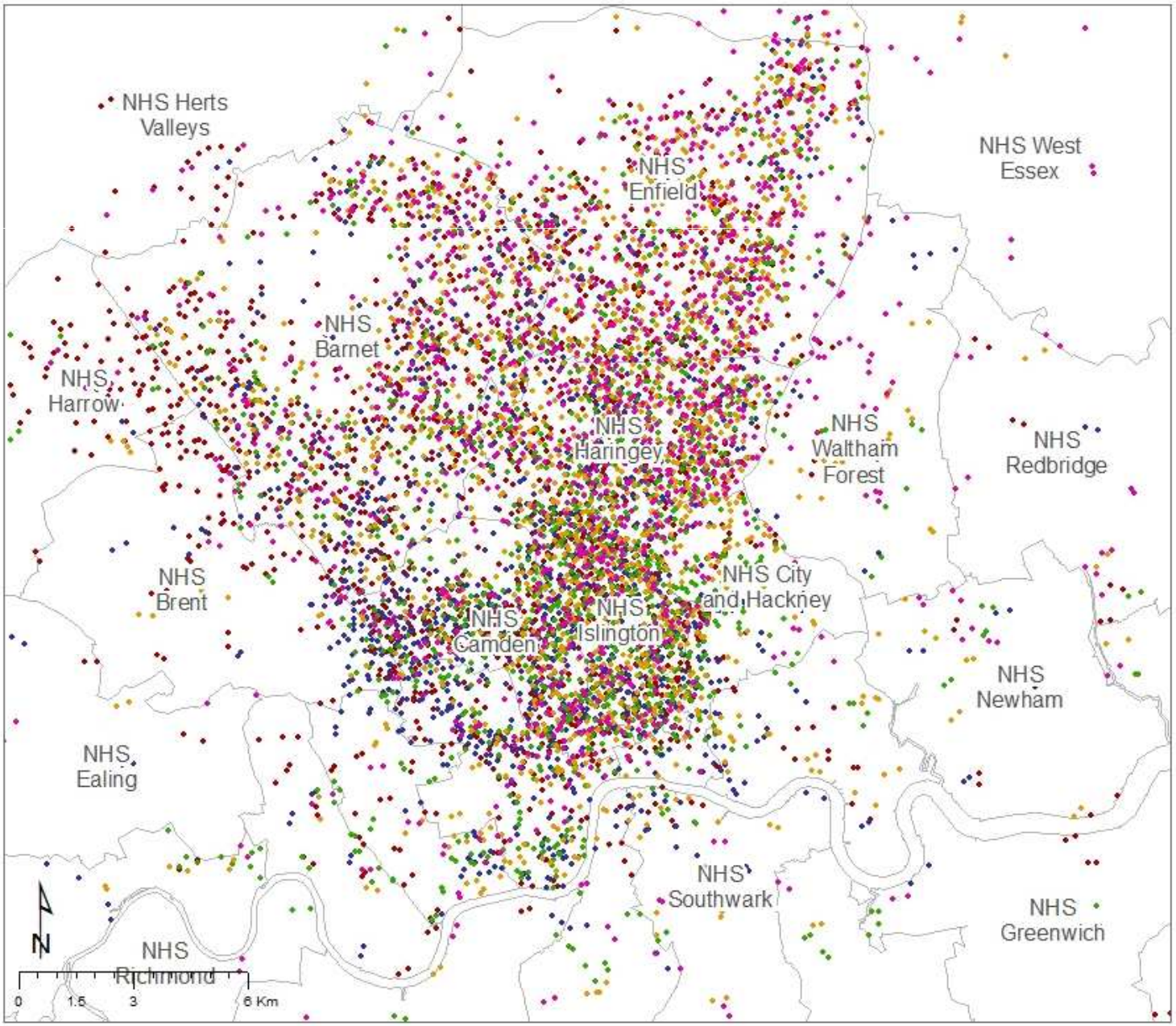
The current service includes an initial triage combined with a clinical assessment for specific cases such as those requiring an ambulance or those with complex conditions. It is expected that the future service will continue to offer this and also use a broader skill mix of staff such as pharmacists.

The skill mix model combined with more timely access to a GP will help support the urgent care system.

CALL 111 when it's less urgent than 999

Service User Location Registered Patients

111 Caller Location by NCL-registered Patients. 1/12/2013 - end/11/2014



Generated by NEL CSU Strategic Business Intelligence 2015

Data source: NEL CSU

The patient flows indicate that service users are located across North Central London

Note: The colours represent registration in different CCG areas

Legend

Enfield CCG
1 Dot = 0.459409295
myCount

Haringey CCG
1 Dot = 0.459409295
myCount

Islington CCG
1 Dot = 0.459409295
myCount

Camden CCG
1 Dot = 0.459409295
myCount

Barnet CCG
1 Dot = 0.459409295
myCount

Source: NELCSU, January 2015 *(Data: December 2013 – November 2014)*

Commissioning 111 and Out of Hours Services

NCL CCGs are planning to commission an integrated 111 and Out of Hours service to start in April 2016. This is aligned to the way in which patients use current services, and will allow us to continue to develop services over the next five years.

Patients in North Central London are not typically located near their GP practice when they express an urgent care need, therefore services need to be designed that are sensitive to access needs

The commissioning process is designed to improve access to services. The expected changes are between providers and should support improved access for patients during the out-of-hours period.

The procurement will be based on national quality standards for 111.

Integration of services

Patient flows

The patient flows demonstrate that the majority of 111 and OOH patients flows are within the North Central London but not necessarily within their borough of residence. Integrating services will enable patients more easily to access services from OOH bases in different boroughs.

Clinical Activity

The majority of referrals are currently made to GP services during the OOH period based on the clinical needs of patients. Access to GPs and other clinicians should be more timely, reducing the number of handovers. The integrated service will enable clinicians to prescribe without the need for duplication or unnecessary referral.

Integration of services

Skill Mix – Workforce

Workforce has been identified as a focus for urgent care development by NHS England. This model is designed to incorporate the recommendations from the NHS England learning programme that promotes use of skill mix. An NCL-wide model with integration of OOH and 111 will offer the flexibility to move staff to where they are most needed to meet changes in patient use throughout the day/year.

Urgent Care System Resilience

As part of wider support for the urgent and emergency care system the 111 and OOH services need the ability to respond to changes in demand in the rest of the system. The current model allows organisations to respond individually but still results in duplication for patients and inefficiencies in operational delivery that can result in delays. An integrated model is proposed as a collaboration of providers would have to operate collectively and respond jointly to system wide changes.

Engagement and Involvement

The commissioning of 111 and OOH does not include any plans to substantially alter access to services. The CCGs have already started a process of involving the public and will continue to do so.

The public will be involved in a number of ways, including:
- Patient representatives involved in the procurement
- Public and patient events
- Involvement of local GPs on behalf of their registered populations
- Utilising learning from complaints, feedback, incidents and compliments
- Feedback received through local authorities and other service providers

Models for future delivery

The new service will include use of skill mix including nurses, paramedics and pharmacists as well as GPs

The specification is unlikely to state ratios of staff as this will vary for different times of the day and different periods in the year. However any provider will be monitored in their ability to manage their case load

The model of care is being developed to support outcomes that are most appropriate for patients and the way they use services. We want to reduce the number of separate patient contacts, which means integrating services. It is unlikely that any existing provider will be able to deliver all parts of this integrated model

Therefore it is expected that local providers will collaborated and most probably submit joint tenders based on their own areas of expertise.

Triage

NHS Pathways is currently the only accredited clinical decision support tool that is available for use within 111.

Providers will be able to use any tools that have been accredited for use within NHS 111 and that comply with the commissioning standards. Therefore if other tools are available and comply with NHS 111 licensing requirements then providers can seek permission to change their decision support tool in the future.

As a result of the NHS England learning and development programme and other local evaluations, changes have been made to the existing model of delivery and a clinical assessment stage has been included to optimise triage outcomes following initial Pathways assessment.

Information Technology

Information technology platforms in health have developed individually, however integration between IT platforms remain a challenge. The integrated service will have to meet interoperability standards that allow integration and the ability to track the entire patient journey between 111 and GP OOH.

With the development of GP 0800 – 2000 working, it is also proposed that an option is included to allow direct booking where local CCGs would like to commission this feature.

Integration with other urgent and emergency care services will be promoted through the use of the directory of services and using the NHS IT standards.

Local CCGs and their GP members will have the option to include access to GP records as part of the new model. The principle of record sharing is supported as it allows personalisation of care.

Procurement Process

The CCGs are initiating a procurement process to identify the right delivery model – this will most probably involve a group of providers working in collaboration and which could include existing or new providers.

The procurement will be governed by the assurance process that has been set out by NHS England. This process is designed to ensure consistency across England. Therefore the quality element will form the majority of the score for any procurement. The process will enable new providers to apply.

The scoring process has not yet been determined and the CCGs will be advised on the scoring options that can be included. *For example, there may be an expectation to demonstrate local delivery mechanisms; or to provide information about performance management*

Procurement Process

The process is being supported by a procurement team who are identifying the different options for pricing so that CCGs can determine the approach that will provide optimal clinical quality.

The existing 111/OOH contracts across NCL are worth just over £42 million. The exact value of the new contract is yet to be determined but will be in the range of £40 – £50 million. We are not cutting any services but we are investing effectively to improve quality.

Timeline

Agree all procurement documentation - end of March 2015
Commence Procurement Process - April 2015
Mobilise contract - December 2015
New Service start - April 2016

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MINUTES OF THE BARNET, ENFIELD & HARINGEY NCL JHOSC SUB GROUP
MONDAY, 23 MARCH 2015

Councillors Connor, Pearce, Cazimoglu (Vice-Chair, in the Chair), Old and Cornelius

Witnesses Maria Kane, Chief Executive, Barnet, Enfield and Haringey Mental Health NHS Trust.

Andrew Wright, Director of Strategic Development, Barnet, Enfield and Haringey Mental Health NHS Trust.

Graham MacDougall, Director of Strategy and Partnerships, Enfield Clinical Commissioning Group

Keith Dean, Mental Health Programme Manager, Enfield Clinical Commissioning Group

Apologies Councillor Bull

BEH.1 WELCOME

Councillor Cazimoglu, Vice-Chair in the Chair, welcomed representatives from Barnet, Enfield and Haringey Mental Health NHS Trust and from Enfield Clinical Commissioning Group to the meeting.

BEH.2 APOLOGIES FOR ABSENCE

It was noted apologies for absence had been received from Councillor Bull.

BEH.3 DECLARATIONS OF INTEREST

Cllr Connor declared a personal interest as her sister worked as a GP in Tottenham.

There were no disclosable pecuniary interests or prejudicial interests declared by members.

BEH.4 MINUTES

RESOLVED: That the minutes of the meeting held on 15 July 2014 be approved as a correct record.

BEH.5 BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST - UPDATE

Barnet, Enfield and Haringey Mental Health NHS Trust and CCG Commissioning Update

Maria Kane, Chief Executive, Barnet, Enfield and Haringey Mental Health Trust, provided an update on the Trust's financial position. The sub-group noted, with concern, that Barnet, Enfield and Haringey Mental Health NHS Trust was the only mental health trust in the country operating with a deficit.

The Trust was forecasting a £4.7m deficit budget for 2014/15 and Ms Kane informed the sub-group that an increased financial deficit was expected for 2015/16. The deficit

for 2015/16 was expected to be £13.3m, subject to the outcome of continuing contract negotiations.

Ms Kane informed the sub-group that the Trust continued to focus on the quality of care provided. However, it was noted that the Trust was in the process of developing plans to address the challenges of increased activity with real terms reductions in funding. It was noted that the Trust had recently been successful in winning new business, with contracts for new services in Forensic mental health, and had strengthened its senior leadership team with a new Executive Director of Patient Services and new Executive Director of Workforce.

The sub-group was informed that the Trust had adopted an enablement focused model of care. It was explained that this was about helping patients to care for themselves as much as possible and to reduce dependences on services. It was recognised there was strong evidence nationally and internationally that, over time, this model would improve services for patients and would allow the Trust to help manage the increased demand for its services.

The sub-group was assured that the Trust had been working with key stakeholders to convert “Live, Love, Do” into tangible deliverables and outcomes against which providers could be commissioned and against which each patient could measure their recovery process. It was noted that CCGs were seeking one off funding to fund this significant change management programme.

During the discussion, reference was made to the following:

- Historical financial challenges faced by the local health economy.

- The independent report from Mental Health Strategies concerning the underlying funding of local mental health services across Barnet, Enfield and Haringey.

- The Rubicon Review, carried out by Rubicon Consulting, that concluded that there were some changes that the Trust could and should make in order to help improve its financial sustainability, such as the introduction of enablement focused services and changes to the Trust’s estate.

The sub-group was informed that if the Trust was unable to become financially sustainable, in its current form in the long term, then local commissioners would need to seek alternative arrangements for the provision of services. Ms Kane informed the sub-group that it was the Trust’s view that it would be very disruptive to patients and staff if the Trust was to be merged with another organisation and, importantly, it would not solve the fact that local mental health services were not currently financially sustainable. It was noted that the Trust would continue to work with the NHS Trust Development Authority and local CCGs to explore options for the future.

Graham MacDougall, Director of Strategy and Partnerships, Enfield Clinical Commissioning Group, reported that mental health was one of six key strategic initiatives for the CCGs of North Central London. This included the development of Value Based Commissioning for Psychosis. It was noted that a tri-borough commissioning strategy was in place, across Barnet, Enfield and Haringey, in addition to individual CCG strategies which all focused on prevention, wellbeing and recovery.

During discussion, reference was made to a number of issues, including:

- NHS Planning Guidance that had recently included mental health waiting times as part of delivering parity of esteem with physical health. It was noted that additional funding had been made available to the Trusts nationally to reduce waiting times and to position them to deliver new targets, although BEH-MHT had not received any additional funding from the three local CCGs for this.

- The NHS Planning Guidance that stated "*mental health spend will rise in real terms in every CCG and grow at least in line with each CCG's overall allocation growth"*.

- Mr MacDougall commented that the NHS, in its planning guidance, had given an unprecedented opportunity for providers to work collectively together in a formal arrangement to deliver care to particular populations. Mr MacDougall went on to provide information on mental health investments that had been made across Barnet, Enfield and Haringey CCGs.

- The Mental Health Crisis Care Concordat. It was noted that this was a national agreement between services and agencies involved in the care and support of people in crisis. The sub-group was informed that Barnet, Enfield and Haringey CCGs had been working with the Trust to finalise a review of the mental health crisis pathway and to develop an action plan that delivered against the principles set out in the concordat.

- The work of the Clinical Quality Review Group and Sustainability Steering Group.

- The implications of the Dalton Review and the Care Act 2014 in relation to local mental health services.

- Recent articles in the Times newspaper (12 March, 2015) concerning child mental health.

- The Better Care Fund (formerly the Integration Transformation Fund) and how money was being spent to improve the way health services and social care services worked together.

- The work of Simon Stevens, Chief Executive of NHS England, in developing a five year forward view for the NHS and the implications of this for local mental health services. It was noted that the Trust had recently written to Mr Stevens to raise concerns about funding for 2015/16.

- The mental health needs and effectiveness of service provision for people in the criminal justice system across North Central London.

- The impact of delayed discharges, targets and reporting associated with delayed discharges, the use of private sector beds, and the recent improvements that had been made across all three boroughs.

- The excellent work being carried out by Somerset Partnership NHS Foundation Trust in relation to mental health.

St Ann's Hospital Update

Andrew Wright, Director of Strategic Development, Barnet, Enfield and Haringey Mental Health NHS Trust, provided an update on the redevelopment of St Ann's Hospital. The sub-group was informed that:

- Many of the buildings at St Ann's were out-dated and hindered the provision of high quality health services.

- The mental health wards at St Ann's were no longer fit for purpose.

- A number of buildings at St Ann's were vacant or partially occupied and the Trust was spending money on maintenance rather than patient care.

- Major changes were required to improve the health facilities on the site for the future.

Mr Wright informed the sub-group that the Trust had submitted an outline planning application to Haringey Council in 2014. The proposals included:

- The retention of all existing health services on the St Ann's site in improved, modern facilities.

- The creation of a brand new mental health inpatient building.

- Up to 470 residential dwellings (including an element of affordable housing).

- The creation of new areas of public open space.

The sub-group was informed that the outline planning application had been considered by Haringey's Planning Sub Committee on 16 March 2015 and had been approved, subject to referral to the Mayor of London.

The sub-group was asked to note that over a third of the site would be required to accommodate existing and future health facilities. Mr Wright commented that the only source of funding for the proposed new health facilities would be from the sale of the surplus land.

The next step for the Trust would be to seek formal approval (during summer 2015) from the NHS Trust Development Authority (TDA). Approval from the TDA would enable:

- A final planning application for the new mental health facilities to be made to Haringey Council by the autumn of 2015.

- Work to start on the new health facilities by spring 2016, with a two year build period for completion. The residential development was envisaged to start around the same time, with a phased build programme over four to five years.

During discussion, reference was made to the following:

- Affordable housing provision. It was noted 14% affordable housing had been agreed and that there would be a further affordable housing contribution should the value of the surplus land be more than the Trust required for the new mental health inpatient facilities.

- The need for the Trust to engage and consult with a wide range of stakeholders, including service users, in work to design the new health facilities.

- The work of an independent Commission, chaired by Lord Crisp, that had been set up, in February 2015, to review the provision of inpatient psychiatric care for adults in England, Wales and Northern Ireland.

The Chair thanked officers from Barnet, Enfield and Haringey Mental Health NHS Trust and Enfield CCG for their attendance at the meeting.

RESOLVED:

1. **That the update from Barnet, Enfield and Haringey Mental Health NHS Trust be noted.**

2. **That the update on CCG Commissioning be noted.**

3. **That the update on the redevelopment of St Ann's Hospital be noted.**

4. **That the sub-group hold an additional meeting on 19 May 2015 to enable joint consideration of Barnet, Enfield and Haringey Mental Health NHS Trust's Quality Account for 2014/15.**

5. **That representatives from each of the three CCGs (Barnet, Enfield and Haringey) be asked to attend the 19 May 2015 meeting to provide an update on mental health funding arrangement and contracts for 2015/16.**

6. **That the venue for the meeting on 19 May 2015 be confirmed outside of the meeting.**

BEH.6 DURATION OF MEETING

10.00 hrs to 11:36 hrs

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MINUTES OF THE MEETING OF THE NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - BARNET, ENFIELD AND HARINGEY SUB GROUP - HELD ON TUESDAY 19 MAY 2015

MEMBERS: Councillors Abdul Abdullahi and Anne-Marie Pearce (LB Enfield), Alison Cornelius and Graham Old (LB Barnet), Charles Wright and Pippa Connor (LB Haringey)

Officers: Andy Ellis, Jane Juby (LB Enfield), Christian Scade (LB Haringey)

Also Attending: Andrew Wright (Director of Strategic Development, BEH Mental Health NHS Trust), Mary Sexton (Director of Nursing, Safety and Quality, BEH Mental Health NHS Trust), Maria Kane (Chief Executive, BEH Mental Health NHS Trust), Graham MacDougall (Director of Strategy and Partnerships, Enfield CCG), Jill Shattock (Director of Commissioning, Haringey CCG), Maria O'Dwyer (Barnet CCG)

2 members of the public. Deborah Fowler (Healthwatch Enfield)

1. WELCOME

Attendees were welcomed to the meeting.

Attendees were reminded of the policy for filming or recording the meeting as follows:

Please note, this meeting may be filmed or recorded by the host Council for live or subsequent broadcast or by anyone attending the meeting using any communication method.

Although we ask members of the public recording, filming or reporting on the meeting not to include the public seating areas, members of the public attending the meeting should be aware that we cannot guarantee that you will not be filmed or recorded by others attending the meeting.

Members of the public participating in the meeting (e.g. making deputations, asking questions, making oral protests) should be aware that they are likely to be filmed, recorded or reported on.

By entering the meeting room and using the public seating area, you are consenting to being filmed and to the possible use of those images and sound recordings.

2. APOLOGIES FOR ABSENCE

No apologies were received.

3. ELECTION OF SUB GROUP CHAIR

Cllr Old nominated Cllr Pearce as Chair. This was seconded by Cllr Connor.

Cllr Pearce was duly **ELECTED** as Chair, **for the duration of the meeting only**.

4. DECLARATIONS OF INTEREST

Cllr Connor declared a personal interest – her sister was currently working at a GP practice in Tottenham.

There were no disclosable pecuniary or prejudicial interests declared by members.

5. MINUTES

Page 1 - Cllr Connor commented that her sister continued to work in a GP practice in Tottenham; the Minutes implied that this was no longer the case.

Cllr Old asked if the redevelopment of St Ann's Hospital was still on schedule, as outlined in the Minutes. Andrew Wright confirmed that it was.

Subject to the above, the Minutes of the meeting Monday 23 March 2015 were duly **AGREED.**

6. DRAFT QUALITY ACCOUNT (2014/15) FOR BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST

Mary Sexton, Director of Nursing BEH Mental Health NHS Trust, introduced the Draft Quality Account 2014/15 as follows:

- The Account was an annual statutory document, required by all NHS service providers.
- The document's format and content was determined to a certain extent by guidance.
- This year's Account would, however, incorporate a more user friendly, visual format with additional information as a result of feedback on the previous year's document.
- The priorities for 2014/15 and 15/16 had been agreed via a number of stakeholder events; this ensured that they were meaningful to those involved.
- The final Account would include a summary document to make it more accessible to service users.

- Data within the Account incorporated both local statistics and national benchmarking. All data would be subject to external audit and a statement would be included in the final Account to this effect.
- The Account sought to develop and build on last year's priorities and work which were being taken forward by groups such as the Clinical Quality Review Group.
- The Trust was also working closely with the Patient Experience Committee to ensure that previous work continued to be developed.
- A number of challenges remained; for example, improving GP engagement.
- The Account would be taken to the Public Trust Board on 29 June for final sign off and would be published via the Trust's website on 30 June.

The following questions and comments were then taken:

Q: There is a lot of very positive work and information within the Account, which is to be commended. Communications with GPs seem to have improved significantly and this should be maintained. Please could you, however, expand on the position regarding the continued funding of the Primary Care Academy (page 22)?

A: Discussions around the continued funding of the Academy are still in progress. We will be keeping the situation under close review.

Q: Page 32 refers to a 90% service satisfaction level in the Service User Experience Survey. However, there seems to have been a decline in satisfaction during February and March. Were there any particular reasons for this?

A: This has been noted. A number of factors have contributed to this; in particular occupancy pressures.

Q: (Page 35) Would you say the Staff Engagement Task Force remains an effective group?

A: It is a relatively new initiative but we believe it is starting to make inroads into improving staff engagement and satisfaction. Staff satisfaction is a fluid issue; during January to March the Trust undertook a staff restructure and this kind of activity can impact upon results. We believe, however, that staff feel well supported and that their voices are heard.

Q: (Page 45) The use of CORE by the Complex Care Teams seems to show declining clinical improvement between 2010/11 and the present. Is there any explanation for this?

A: It is an accurate picture; however, it is difficult to compare year on year data and so identify any particular trends. We are aware of the situation and are closely monitoring it.

Q: What sort of engagement does the Trust undertake with CCGs?

A: There are a number of formal mechanisms including, for example, the Clinical Quality Review Group. 'Focus on Sessions' help the Trust and

CCGs collectively look at particular issues and areas for improvement. We have a very positive relationship with the CCGs.

Q: (Page 8) On average, how long did it take for those complaints acknowledged outside of the 3 day target to be acknowledged?
A: The longest time taken to acknowledge a complaint was 5 days. During the last two quarters the Trust has met its target of acknowledging within 48 hours.

Q: (Page 8) On average, how long did it take to investigate those complaints not investigated within the target timescale?
A: The timescale for investigation is 25 days. No complaint took longer than 30 days to investigate. Any complaints investigated out of timescale only occurred during the year's first quarter.

Q: The Account refers to a move to individual service lines, rather than one service line across all 3 Boroughs. What was the reason for this change?
A: There are a number of reasons, the primary one being that CCGs are borough based and too much time was spent de-aggregating data for their use. Also, GPs wished for a single point of contact within their Borough and patients requested it; they wanted to be known as a 'Haringey patient', for example, rather than a 'dementia patient'. It made them feel less stigmatised and more a participant in their communities.

Q: Has the Trust now moved to a 'payment by results' contract?
A: No, but we are working towards an 'activity based' contract.

Q: Could there have been greater continuity from last year's priorities to the priorities in this year's Account?
A: The selection of this year's priorities was determined by the stakeholder events we held; the priorities therefore reflect what people wanted. However, some of the work/priorities undertaken in 14/15 have now become embedded in core learning; so this work has not been lost.

Q: What is the timeline for sending letters of discharge to GPs?
A: This varies. Some take 2-3 weeks. The target of sending assessment, review and discharge letters to GPs within 24 hours of a service user being seen in our mental health services remains a challenge and particularly difficult in some circumstances, for example, for staff who undertake visits and are therefore often out of the office. Consequently, we are in the process of agreeing more specific timelines for different working practices.

Q: Would the use of email speed up the process?
A: Yes, however, we have found that not all GPs are enabled to receive emails; we are working to improve this.

Q: Why is the level of compliance for mandatory staff training only 84%? Should it not be 100%?

A: There are quite a number of courses that are mandatory and it is sometimes a challenge to be able to release staff to attend them, given current occupancy pressures. We are aiming for full compliance and to this end, are looking at blended learning styles which may help staff meet requirements.

Q: Why do there appear to be low satisfaction levels for the National Staff Survey and the Service User Experience Survey?

A: The Patient Survey is undertaken annually and samples the experience of 800 patients. We have found, however, that the results of this survey often differ from the real time feedback we gather at a local level, which tends to be more positive. Patient experience is very individual and our staff are very aware of that. Patient feedback can also change over time once a patient leaves the service.

With regard to the Staff Survey; again this is an annual exercise. Media coverage, changes within the organisation and high levels of ward occupancy may have affected results. However, the Trust has made some real improvements in particular areas. For example, in respect of the 'would you recommend the Trust' indicator; we discovered that staff felt that they would recommend their team, but did not know enough about other teams to recommend the Trust as a whole. As a result, we are working to improve staff knowledge and experience of other areas of the Trust. The Task Group is also looking at other issues, including where responses seem 'disconnected' for example, staff may feel supported but may not feel there are enough development opportunities.

In respect of bullying and harassment, the Trust is working to understand these issues and to be clear about the standards it expects.

It was commented that staff should feel they have somewhere 'safe' to go to report any concerns and it was suggested that an explanation of the statistics and the things being done to address lower survey scores should be added to the Account. It was also requested that comparative data with other London Boroughs be added. **ACTION: Mary Sexton.**

Q: (Page 22) Referring to the levels of communication with GPs for those over 75, what are the actual numbers behind the percentages?

A: This will need to be checked **ACTION: Mary Sexton.**

Q: (Page 23) Referring to levels of attendance at Primary Care Academy training sessions, could GP CPD sessions be utilised to improve attendance?

A: We do try to do this where possible and we do have higher levels of attendance when we do. However, it is a challenge to fit them into an often busy programme.

Q: (Page 23) The usage of the GP advice line seems low, are GPs aware of it?

A: The advice line was actually implemented at the request of GPs, so they are aware of it. However, usage has been lower than we might have expected. We are committed to continuing to provide the advice line at the moment but we may review this in the future.

Q: (Page 24) Are the results of Physical Health Checks passed to GPs and what is the timescale for doing so?

A: Health checks for patients with enduring mental illness are undertaken every 12 months. Some patients may need health checks more often. Communication with GPs regarding health checks occurs, in the case of community patients, only if there is any significant change to a patient's circumstances or there are any concerns and in the case of a hospital patient, on the point of discharge.

Q: (Page 27) Referring to incident reporting, how was the target of increasing this by 10% determined?

A: It was felt there should be some sort of starting point and that this should be immediately achievable. The target will be reviewed after 6 months.

Q: (Page 28) Can you explain why there were significant increases in the numbers of serious incidents reported in May and September?

A: There are no particular factors which could explain this; serious incidents tend to be quite random in nature. There was no commonality between them.

Q: (Page 29) Are the Trust's levels of follow up contact with patients within 7 days below national average?

A: No, 98% is the national average.

Q: If no contact is established after 7 days, what action is taken?

A: A variety of actions are undertaken including welfare checks which may involve the Police visiting the home address.

Q: Are there may instances of this happening?

A: Not many. It is a small percentage.

Q: Do you take the opportunity to obtain patient feedback when contacting patients after discharge?

A: We have not done this to date but may well look at that. We acknowledge that doing so may provide more reflective feedback.

Q: (Page 34) Are the 6 questions listed in the Account for the Carer Experience Survey the total number of questions that were asked?

A: I believe these were all of the questions asked but will check this **ACTION: Mary Sexton.**

Q: (Page 39) It may be more useful to have population figures for those who use the Trust, rather than by London Borough with regard to the number of complaints?

A: It may be a statutory requirement to provide population statistics by London Borough, but I will check this **ACTION: Mary Sexton.**

It was proposed that if this was a statutory requirement, that information be added on the numbers of residents in Barnet, Enfield and Haringey who access the Trust's services **ACTION: Mary Sexton.**

Q: (Page 44) What would be a 'placebo' statistic for EQ-5D?

A: The scale would need to be checked. It should be noted that these are, however, patient reported.

It was suggested that the addition of benchmark figures from other Trusts would be helpful **ACTION: Mary Sexton.**

Q: (Page 46) Are the levels of reliable improvement during treatment within the Complex Care Teams going down and what are the reasons for this?

A: Yes, it is going down. It is a patient reported measure and it is difficult to compare year on year due to the fact that the patient group changes. Levels of occupancy on wards and higher sectioning levels may have affected results. It is sometimes difficult to achieve positive perceptions with patients who often have very complex needs and challenges.

Q: (Page 49) Why did the Trust not participate in the audit for prescribing for substance misuse (alcohol detoxification)?

A: The resources were not available at the time to participate in the audit; however, that will not be the case this year.

Q: (Page 52) Could the Trust indicate the timescale for resolving the IT coding issues?

A: The Trust has just gone live on a new upgrade for the RiO system which will address this.

Q: (Page 53) How many young people have been placed in employment support in partnership with Twinings?

A: I will need to obtain these figures after the meeting **ACTION: Mary Sexton**

It was requested that details of placements in Enfield and Haringey, as well as Barnet, be included in the Account **ACTION: Mary Sexton**

It was **AGREED** that a letter be drafted from the Sub-Group summarising all of the comments made and that this be sent to Mary Sexton by 20 June. It was **AGREED** that comments provided for last year's Account also be included in this letter.

7. CONTRACTING AND FUNDING ARRANGEMENTS UPDATE

Graham MacDougall, Enfield CCG, gave the following update:

- No signed contract was yet in place.
- An agreed activity and finance schedule had, however, been submitted to NHS England.
- Areas of in year/long stop activity were still to be agreed and were currently under negotiation.
- It had been a significant year for the Trust, which was working closely with the CCG to agree levels of activity, efficiency of delivery and readiness to prepare and transform services. An independent company, Carnall Farrar, had been commissioned to look in more detail at the Trust's financial position.
- The Trust had operated against a deficit of £4.7m in the previous year, which would rise to £10m in the current year.
- Stabilisation of the Trust's financial position was a key area of discussion with CCGs. The Trust also wished to discuss further the sharing of risk around the deficit.
- It was acknowledged that the deficit position would impact upon staff recruitment and retention.

The following questions and comments were then taken:

Q: Is the Trust the only one in London at present to be operating with a deficit?

A: During 15/16 there will be 2-3 other Trusts in London that will be operating with a deficit.

Q: Are there any other sources or pools of funding available to the Trust to mitigate the deficit? There is a concern that service quality will drop as a result of financial instability.

A: The previous Government had committed funding over 5 years for mental health services, but this was specifically targeted at children's mental health. There was also additional money provided over the last quarter to support the Crisis Concordat. In 14/15 CCGs and the Trust did write to NHS England to request transformation funding, but this request was refused. The Trust will, however, continue to seek funding from NHS England and other sources if available. It should be noted that CCGs are also in a challenging place financially. The work of Carnell Farrar is quite extensive and will be a good source of information for future transformation programmes. It will also be key in helping the Trust and CCGs focus more on preventative work. Barnet CCG has received Parity of Esteem funding but has been mandated to target this principally at primary care.

Q: Of the four service areas the Trust operates, which is currently experiencing the biggest pressures?

A: Probably inpatient services. Occupancy levels are at 100% and an extra ward has been temporarily opened, in addition to private sector beds being used.

Q: What is the percentage of CCG budgets that is currently spent on adult mental health?

A: I would need to check this **ACTION: Graham MacDougall**

Q: What particular factors for mental health are contributing to the rising pressure on services?

A: There are a variety of factors. Changes to benefit payments have led to an increased migration of people from inner to outer London boroughs. In addition, a reduction in social care provision (for example, day services, voluntary sector community services) which might support people outside of hospital has also led to increased demand. Lastly, the increased use of legal highs, and higher levels of dementia diagnoses have contributed to increased pressure on mental health services.

Q: Are there any plans to merge/share services with other organisations in the longer term?

A: There are none apparent yet. The Trust is looking at a range of options which may include partnership working with other organisations such as Housing Associations. Under the 5 Year Forward View and the Dalton Review, the Trust is being encouraged to look at more creative partnerships. Increasing preventative work and early interventions may also help to increase self-care and management and therefore reduce demand on in hospital services. Use of new technologies will be key in helping to reach people. Such measures will, however, require a significant transformation programme and investment.

Q: What is the current, immediate position regarding mental health services and funding? Has all of the funding passed to CCGs been transferred through to the Trust?

A: Different CCGs are in different positions. Enfield has invested 5% of the 7.1% uplift in Parity of Esteem funding received; it has also invested in community services. Enfield CCG currently has a deficit of £14.4m and a savings plan of £12m; it has therefore not been possible for the CCG to invest in the Trust at a higher level. The uplift is not ring-fenced.

Barnet CCG is in a similar position and has operated under a deficit for a number of years. It has invested both in the Trust and in the IAPT service. Barnet has received an uplift of 4% for Parity of Esteem. 3.8% of the total amount has been invested in mental health services as a whole (i.e. some investment has been made outside of the Trust).

Haringey CCG has received an uplift of 3.4-5% for Parity of Esteem. Again, investment has been in a basket of services. It has invested 5% of Parity of Esteem, so has exceeded the uplift.

It was noted that all of the above information would be included in the report to be produced by Carnall Farrar.

The Group requested that the proportions of investment by CCGs in the Trust by each Borough be provided **ACTION: Graham MacDougall, Maria O'Dwyer, Jill Shattock.**

Q: Will the Carnall Farrar Report be a public document?
A: I will need to check **ACTION: Graham MacDougall.**

Q: What is the Trust doing to address the issue of patients travelling long distances to access a bed?
A: A lot of work has gone into addressing this issue. We are working with local authorities to streamline patient pathways. However, 11 days ago the Trust experienced an unpredicted large 'spike' in demand; as a consequence we have had to open a temporary extra ward.

A Commission has been set up to look at the provision of acute inpatient psychiatric beds. This review is ongoing and will be reporting in September.

Distances travelled by patients for beds have reduced recently, most are now found within the London area. However, it should be noted that many private beds are more difficult to access, as private operators are more selective.

Q: Is the Trust's financial position sustainable for the next year and the year after that? The Sub-Group should be made aware of any potential significant downturn of services or other issues that may be as a result of the Trust's position.
A: The Trust's financial position is a matter of ongoing negotiations with commissioners. The Trust has a number of expectations that it has planned for over the coming year which are positive and deliverable. I don't envisage services ceasing but it will be a very challenging year. There will, as mentioned previously, no doubt be an impact on our ability to recruit and retain staff and the Trust is doing all it can to support them.

Q: Should there be any cause for concern over the sustainability of running the St Ann's development once complete, given the deficit?
A: There is an in year and a long term situation to bear in mind. We have a transformation plan that will help address the position in the longer term which will require investment. The new facilities at St Ann's will actually help reduce the Trust's costs in running these services.

Q: What is the Trust's annual budget?

A: £190m.

Q: A forecast deficit for this year of £14.3m has previously been given, how has this now been reduced to £10m?

A: There may have been a transformation component to this. There has also been an increase in performance against our own internal Cost Improvement Targets.

Date of Next Meeting

It was **AGREED** that a September date be set for the next Sub-Group meeting at the Joint Health Overview & Scrutiny Committee meeting to be held in June. This would align with the publication of the Carnall Farrar Report.

The meeting ended at 12pm.

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

26 June 2015

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 meets 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.

1.2 The Committee has been meeting on Friday mornings. However, the Committee can decide to meet on another date/time if it so wishes although the Committee will no doubt wish to ensure that any changes do not cause difficulties in attending for NHS colleagues.

2. Work Plan

2.1 Members are requested to consider potential items for future meetings of the Committee. In keeping with the terms of reference of the JHOSC, potential items should be ones that impact on all boroughs represented on the Committee.

2.2 Issues already identified as potential future items for meetings are currently as follows:

- Action by acute trusts to reduce A&E attendance;
- Funding for Clinical Networks;
- Maternity Update (Sept 2015);
- LAS Update (Sept 2015);
- Primary Care Update - “Case for Change” (Nov 2015);
- Winter Pressures Review (March 2016)
  - Accident and Emergency – Performance
  - LAS
- Dementia;
- NMUH – Foundation Status;