NOTICE OF MEETING

NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Contact: Robert Mack

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Monday 10 September 2012 10:00 a.m.
Professional Development Centre, Laycock Street, London N1 1TH

Councillors: Alison Cornelius and Graham Old (L.B.Barnet), Peter Brayshaw and John Bryant (L.B.Camden), Alev Cazimoglu and Anne Marie Pearce (L.B.Enfield), Reg Rice and Dave Winskill (Vice Chair) (L.B.Haringey), Martin Klute (Chair) and Alice Perry (L.B.Islington),

Support Officers: Linda Leith, Robert Mack, Pete Moore, John Murphy and Shama Sutar-Smith

AGENDA

1. WELCOME AND APOLOGIES FOR ABSENCE (PAGES 1 - 2)

2. DECLARATIONS OF INTEREST (PAGES 3 - 4)

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

3. URGENT BUSINESS

4. MINUTES (PAGES 5 - 12)

To approve the minutes of the meeting of 9 July 2012 (attached).

5. BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY - IMPLEMENTATION (PAGES 13 - 22)

To report on the implementation of the Barnet, Enfield and Haringey Clinical Strategy, with particular reference to the further development of primary care.

6. REFERRAL MANAGEMENT (PAGES 23 - 24)

To receive a report on the cluster's referral management strategy, with particular reference to borough integrated service proposals.

7. MEDICINES MANAGEMENT (PAGES 25 - 26)

To report on medicines management and the potential for supply chain issues arising.

8. ACUTE TRUSTS - FINANCIAL HEALTH CHECK

To provide an overview of the financial health of acute trusts within NCL cluster, with reference to the implications of PFI contracts. (TO FOLLOW)

9. QIPP UPDATE (PAGES 27 - 28)

To provide an update on progress with the QIPP for 2012/13.

10. CLINICAL COMMISSIONING GROUPS (CCGS); FINANCIAL REGIME

To receive a verbal briefing on the financial regime in respect of Clinical Commissioning Groups within the cluster.

11. UCLP; ACADEMIC HEALTH SCIENCE NETWORKS (AHSN) - EXPRESSION OF INTEREST (PAGES 29 - 30)

To report on a potential bid to establish an academic health science network covering the north central London cluster.

12. TRANSITION PROGRAMME PROGRESS UPDATE - SEPTEMBER 2012 (PAGES 31 - 36)

To update the Committee on the next phase of transition from 1 October 2012 which will involve a shift from the current system to the new, with the new 'receiving' organisations leading in planning and preparing for 2013/14.

13. FUTURE WORK PLAN (PAGES 37 - 38)

To consider the JHOSC's future work plan (attached).

31 August 2012

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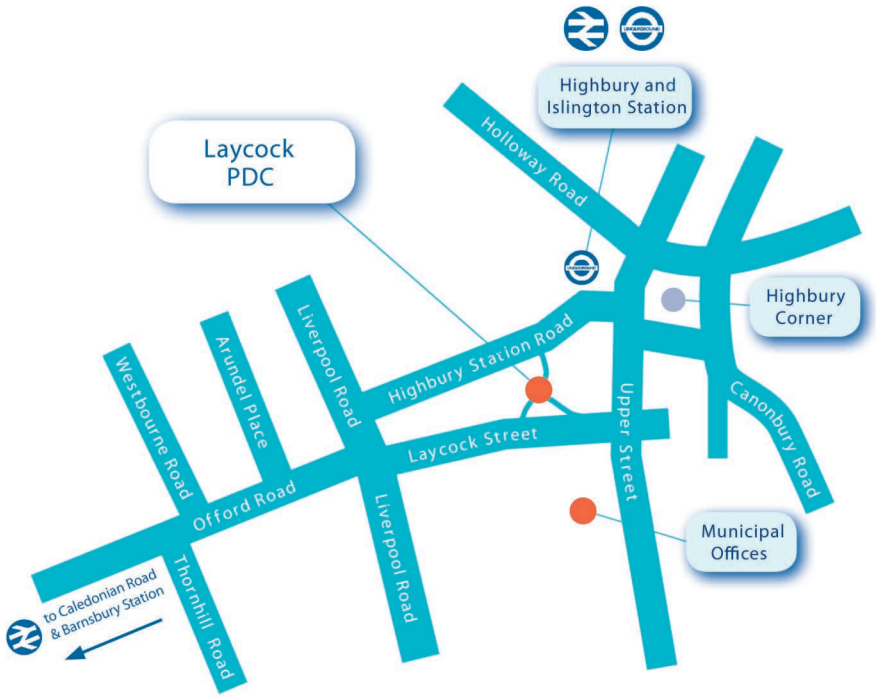

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Agenda Item 2

DECLARING INTERESTS FLOWCHART - QUESTIONS TO ASK YOURSELF

What matters are being discussed at the meeting?

Do any relate to my interests whether already registered or not?

NO → You can participate in the meeting and vote

YES

Personal interest

Is a particular matter close to me?

Does it affect:

- me or my partner;
- my relatives or their partners;
- my friends or close associates;
- either me, my family or close associates:
  - job and business;
  - employers, firms you or they are a partner of and companies you or they are a Director of
  - or them to any position;
  - corporate bodies in which you or they have a shareholding of more than £25,000 (nominal value);
- my entries in the register of interests

more than it would affect the majority of people in the ward affected by the decision, or in the authority's area or constituency?

NO

NO

YES

You may have a **personal interest**

Declare your personal interest in the matter. You can remain in meeting, speak and vote unless the interest is also prejudicial; or
If your interest arises solely from your membership of, or position of control or management on any other public body or body to which you were nominated by the authority e.g. Governing Body, ALMO, you only need declare your personal interest if and when you speak on the matter, again providing it is not prejudicial.

Prejudicial interest

Does the matter affect your financial interests or relate to a licensing, planning or other regulatory matter; and
Would a member of the public (knowing the relevant facts) reasonably think that your personal interest was so significant that it would prejudice your judgement of public interest?

YES

You may have a **prejudicial interest**

YES

Do the public have speaking rights at the meeting?

YES

You should declare the interest but can remain in the meeting to speak. Once you have finished speaking (or the meeting decides you have finished - if earlier) you must withdraw from the meeting by leaving the room.

NO

You should declare the interest and withdraw from the meeting by leaving the room. You cannot speak or vote on the matter and must not seek to improperly influence the decision.

Note: If in any doubt about a potential interest, members are asked to seek advice from Democratic Services in advance of the meeting.

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Agenda Item 4

North Central London Joint Health Overview and Scrutiny Committee 9th July 2012

Minutes of the meeting of the Joint Health Overview and Scrutiny Committee held at Hendon Town Hall, The Borroughs, Hendon, London, NW4 4BG on 9 July 2012 at 10.00am

Members of the Committee present: Cllr Martin Klute (Chairman), Cllr Alison Cornelius, Cllr Graham Old and Cllr Barry Rawlings (L.B. Barnet), Cllr John Bryant (L.B. Camden), Cllr Alev Cazimoglu and Cllr Anne-Marie Pearce (L.B. Enfield), Cllr Dave Winskill (Vice-Chairman) and Cllr Reg Rice (L.B. Haringey). Cllr Arjun Mittra (L.B. Barnet) present in the audience

Officers present: Rob Mack (L.B. Haringey), Mike Ahuja (L.B. Enfield) and Rachel Stern (L.B. Islington) and Andrew Charlwood (L.B. Barnet)

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 Joint Health Overview and Scrutiny Committee (JHOSC).

MINUTES

1 WELCOME AND APOLOGIES

The Chairman, Cllr Klute, welcomed the attendees to the meeting.

Apologies for late arrival were received from Cllr Reg Rice (L.B. Haringey) and Mark Easton, Chief Executive Barnet and Chase Farm Hospitals NHS Trust.

Apologies for absence were received from Cllr Peter Brayshaw (L.B. Camden) and Cllr Alice Perry (L.B. Islington).

2. DECLARATIONS OF INTEREST

Cllr Alison Cornelius (L.B. Barnet) declared a personal but non-prejudicial interest in the items on the agenda as she was an assistant chaplain at Barnet and Chase Farm Hospital.

3. URGENT ITEMS

The Chairman reported that, as requested at the last meeting of the Committee, NHS North Central London had provided information on the Primary Care Investment Strategy within Barnet, Enfield and Haringey with particular reference to the three hospital sites and clarification of land sales at the hospitals.

The Committee noted that this information had been tabled at the meeting. Members agreed that there had been insufficient time to consider the information contained therein and that the tabled report was not as comprehensive as had been expected. It was moved that consideration of the item be deferred and that a full report be presented to the September meeting.

RESOLVED:

1) that NHS North Central London be requested to provide a full report to the September meeting of the Committee on the Primary Care Investment Strategy within Barnet, Enfield and Haringey with particular reference to the three hospital sites and clarification of land sales at the hospitals.

2) that NHS North Central London be requested to submit the above report in time for publication of the agenda for the meeting to enable the Committee to give due consideration to the information contained therein.

4. MINUTES – 28 MAY 2012 MEETING

- *Estates Management (Item 7):* The Committee noted that NHS North Central London had provided further details on sites, their current ownership, whether the site would be retained or transferred and, if transferred, the provisional transferee. Members considered that the list of sites did not provide all the information requested as percentage occupation figures were missing.

  It was noted that the Chair had written to the Secretary of State to express concern that a joint application by the three trusts currently on the St Pancras Hospital site to be granted the building had been turned down on a technicality.

  RESOLVED;

  1) That a copy of the letter from the Chair to the Secretary of State regarding the St. Pancras site be circulated to Committee Members.

  2) That, when appointed, the lead officer for NHS Property Services Limited (PropCo) for London be invited to the JHOSC and local health overview and scrutiny committees.

- *Barnet, Enfield and Haringey Clinical Strategy – Implementation:* Cllr Alison Cornelius (L.B. Barnet) raised concerns that the Transport Impact Assessment for the Barnet Hospital site has only identified a requirement for an additional 21 car parking spaces. She reported that at the previous meeting Mark Easton, Chief Executive Barnet and Chase Farm Hospitals NHS Trust, had stated that a multi-storey car park could not be accommodated on the site. The Committee were informed that this had not been discussed with the L.B Barnet Head of Planning and she requested that the minutes of the 28th May 2011 meeting be amended to reflect Mr Easton's comment.

  The Committee were informed that there had been no consultation so far with local Members on the planning application. It was noted that Cllr Alison Cornelius and Cllr Graham Old had undertaken a site visit at Barnet Hospital on 3rd July 2012 and had identified that the staff car park was full and 150 staff were parked in visitor parking bays. Due to the shortage of parking on site, staff were being forced to park outside of the site, in some cases illegally.

  Mark Easton tabled a briefing on the current status of the planning application and parking at the site. He advised the Committee that they had been working with the L.B Barnet planning department on planning considerations including parking and the development of a Green Travel Plan. He added that if planning permission was not achieved by 29th August 2012, there would be an impact on the November 2013 service transfer date. Members were informed that parking, including the possibility of having a multi-storey car park, was an issue that was being considered regularly by the Board. The Committee would be updated with any progress on this issue.

  The Chairman advised the Committee that Barnet and Chase Farm Hospitals NHS Trust were considering a merger to enable NHS Foundation Trust status to be achieved. The Committee were disappointed that this information had been obtained via the media rather than directly from the Trust. It was noted that the full report commissioned by NHS London on the feasibility of Chase Farm Hospital merging with the North Middlesex Hospital had not been made public as yet. Members requested further information on the changes that had led to Barnet and Chase Farm Hospitals to seek a merger. In addition, they felt the implications for the North Middlesex Hospital needed to be taken into account.

  Mr. Easton reported that the board of Barnet and Chase Farm Hospitals were considering possible merger partners in the light of an external review that had been commissioned by them on future options. The conclusion had been reached that the Trust would not be able to achieve foundation trust status as a single entity. There were likely to be considerable financial challenges in the forthcoming years and, in particular, commissioners were likely to require large cost savings. A detailed report on this issue would be

considered by their board on 12 July. If the board agreed to proceed, there would be an options appraisal on possible merger partners. Preferred partners would be identified by October 2012. A full consultation would take place if a formal merger was proposed as a result of the options appraisal.

RESOLVED:

1) that the NHS London Director of Finance, Hannah Farrah, be invited to the September meeting of the Committee to provide an update on the financial viability of NHS Trusts within the cluster, with particular reference to the implications of PFI contracts.

2) that the minutes of the meeting held on 28th May 2012 be agreed.

5. CHILD AND ADOLESCENT MENTAL HEALTH SERVICES – TRANSFORMATION OF IN-PATIENT SERVICES IN BARNET, ENFIELD AND HARINGEY

Ceri Jacob, Acting Borough Director, NHS NCL Barnet, Phil DiLeo, Head of Additional Needs and Disabilities Service, Haringey and Brian Davis, Principal Educational Psychologist, L.B. Barnet presented reports on: Barnet, Enfield and Haringey Child and Adolescent Mental Health Services (CAMHS) Tier 4 Service Development; and Achieving an Education Model Integrated with CAMHS Provision.

Ceri Jacob advised the Committee that the Trust were implementing the Integrated CAMHS 3.5/4 Service. She added that the Young Peoples Board (YPB) continued to meet and were being supported at the current time by NHS NCL Communications Team. It was noted that the YPB were assisting in developing an evaluation framework. Members were informed that there were three representatives on the YPB and they met every two months.

Brian Davis presented a report which had been tabled on the maintenance of education provision for children and young people with serious emotional wellbeing and mental health concerns as CAMHS reforms were being implemented. The Committee were informed that there was uncertainty regarding future funding arrangements at the Northgate Pupil Referral Unit as a result of the loss of the clinic which had seen a reduction in funding of £115,000. It was noted that there had been a recent agreement with Haringey regarding joint block commissioning and that Enfield would possibly join in 2013 when the new funding model was implemented.

The Committee emphasised the importance of collaborative working between education and health to ensure that current service provision was not destabilised.

RESOLVED that detailed funding and service models proposed for the PRU at Edgware Hospital Barnet be presented to a future meeting of the Committee.

6. NHS NORTH CENTRAL LONDON STRATEGIC COMMISSIONING AND QIPP PLAN

Sylvia Kennedy, Associate Director Strategy and Planning, NHS NCL and Nick Day, Head of Programme Office NHS NCL delivered a presentation on the NHS NCL Commissioning Strategy and QIPP Plan 2012/13 to 2014/15.

The following points were noted in relation to questions:

- In some areas, GPs were not fully complying with their Personal Medical Services (PMS) or General Medical Services (GMS) contracts. Analysis of PMS contracts were currently being undertaken to detail costs in specific areas. Post 2013, these would transfer to commissioning and support services. The Committee agreed that JHOSCs and HOSCs should be consulted to consider whether contracts had been commissioned correctly.
- Budget allocations for CCGs would not be available until October. It was reported that financial plans were being based on current PCT budget allocations. Members were informed that CCGs and local authority public health functions would individually commission services. Other services would be commissioned by a Central Board. The Committee highlighted the importance of all commissioning bodies signing up to a co-ordinated plan.
- The Committee queried whether there would be a review of GP contracts and whether this information would be made available to the National Commissioning Board.
- GPs would commission two types of GMS contracts – standard or enhanced services (such as increased hours). Commissioning would be informed by patient participation groups.

RESOLVED: that referral management, with particular reference to borough integrated service proposals and issues relating to the re-tendering of services, be discussed at a future meeting.

7. PRIMARY CARE STRATEGY; UPDATE

Dr Henrietta Hughes, Acting Medical Director, NHS NCL and Denise Tyrrell, Programme Director Primary Care Strategy, NHS NCL presented a written summary on the Primary Care Investment Strategy for the north central London cluster.

The following points were noted in relation to Members questions:

- In relation to the commissioning strategy for blood tests, it was expected that tests would be undertaken close to where the patient lived.

- To address the issue of overtrading of acute services and preventing hospital admissions, post-graduate salaried GPs would be deployed to look at groups of patients (e.g. in care homes) to ensure that medicines were being managed appropriately and that there was communication between carers. GP networks would share good practice.
- Funding allocations were based on the number of GP practices and this would be reflective of population size.

RESOLVED that NHS NCL be requested to take account of concerns relating to medicines management with particular regard to shortage as a result of supply chain issues.

8. INTEGRATED CARE

Sylvia Kennedy, Associate Director Strategy and Planning, NHS NCL and Graham McDougal, Associate Director of Integrated Care, NHS NCL delivered a presentation on integrated care in North Central London.

The following points were noted in relation to Members questions:

- In relation to cultural barriers that had historically prevented service integration, the Committee were advised that there were some elements of services that could be integrated effectively. Sylvia Kennedy reported that service providers were taking a more systematic approach and it was recognised that long-term solutions were required.
- Managing multiple care pathways would be dependent on the conditions being managed. Enhanced levels of collaborative working would be required for patients with complex or multiple conditions. Approaches would need to change as the patient moved through the system. The Committee emphasised the importance of having coordinated care plans.
- Integrated services would be governed by strict information sharing protocols. Only direct care providers would have access to patient records.

9. TRANSITION UPDATE

Patsy Ryan, NHS NCL Interim Deputy Director of Communications presented a paper updating the committee on developments within North Central London as part of the NHS national transition process.

The Committee noted that:

- Anne Rainsberry, the NHS Commissioning Board's London's Regional Director, would be visiting NHS North Central London on 12 July for a session with staff, the executive team and CCG chairs.

- Proposals for joint Harrow and Barnet public health functions and for joint Camden and Islington public health functions will be discussed at the NHS North Central London's Joint PCT Board meeting on 20 July.

- Development of the Full Business Plan (FBP) for the Commissioning Support Service covering North Central London was now underway for submission to the NHS Commissioning Board in August 2012.

- Accountable Officers had been appointed by Camden Clinical Commissioning Group (CCG), Enfield CCG and Islington CCG. The posts for Barnet and Haringey CCG were being advertised nationally currently.

RESOLVED:

1) that NHS NCL be requested to provide a half day briefing to JHOSC Members in November 2012 on:
    - CCG transitional arrangements; and
    - The role of CSS and NCB London regional office so that the Committee is able to consider its future role

2) that a further update be provided at the next meeting of the Committee.

10. FUTURE WORK PLAN

The Committee were asked to consider the future work plan. It was agreed that the items referred to above be added to the Committee's work programme.

11. PFI FUNDED HOSPITAL DEVELOPMENTS

The Committee had requested information on any PFI schemes that were currently in operation within the cluster and, in particular, any that were a source of concern in respect of their long term affordability. It was noted that NHS North Central London did not hold such information. However, NHS London and the Department of Health would have access to it. Information was available on the Treasury website although there appeared to be some omissions. It was noted that the North Middlesex Hospital had a PFI scheme and that concerns had already been expressed about its long term affordability in the event of there being issues with the implementation of the BEH Clinical Strategy. It was also noted that both the Whittington and Barnet and Chase Farm Hospitals also had PFI funded developments.

CLOSE 13.00 hrs

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Agenda Item 5

NHS North Central London

NHS NORTH CENTRAL LONDON	**BOROUGHS** BARNET, ENFIELD, HARINGEY **WARDS:** ALL

REPORT TITLE: Barnet, Enfield and Haringey service developments and investment that support the implementation of the Barnet, Enfield and Haringey (BEH) Clinical Strategy.

REPORT OF: Siobhan Harrington , BEH Clinical Strategy Programme Director

FOR SUBMISSION TO:	**MEETING DATE:**
North Central London Joint Health Overview & Scrutiny Committee	10 September 2012

EXECUTIVE SUMMARY OF REPORT:

- The purpose of this report is to inform the JHOSC of the primary, community care and care closer to home service developments and investments that support the implementation of the Barnet, Enfield and Haringey (BEH) Clinical Strategy.
- Key achievements to date are:
  - Increasing physical capacity in Primary Care for example Finchley Memorial Hospital
  - Extending opening hours of GP practices and pharmacies across all three boroughs
  - Moving care traditionally delivered in hospital to community settings
  - A developed Primary Care Strategy with a planned investment of £46.7million across the five boroughs in North Central London over the next three years
- Improvements to date and improvements planned are aimed at :
  - Improving access for local people
  - Improving the delivery and quality of care
  - Integrating care through providers working together around the needs of the patient
- £46.7million will be invested in North Central London primary care services in the five boroughs over the next three years detailed in the Primary Care Strategy document “Transforming the primary care landscape in North Central London”.
- The Primary Care Strategy is intended to underpin the borough implementation plans and is one of the enablers to the delivery of the BEH Clinical Strategy.
- Contact: Varuna Balmogim, BEH Programme Manager
  Varuna.Balmogim@nclondon.nhs.uk

RECOMMENDATIONS: The Committee is asked to note the content of this paper

DATE: 31 August 2012

BEH Clinical Strategy links to Primary and Community Services

Introduction

The purpose of this report is to inform the JHOSC of the primary and community care developments and investments that support the implementation of the Barnet, Enfield and Haringey (BEH) Clinical Strategy.

The report summarises the primary care strategy investment in Barnet, Enfield and Haringey as requested by the Joint Health Overview Scrutiny Committee meeting on the 9 July 2012, however it is important to note that investments and developments supporting the BEH Clinical Strategy include community service developments, the development of care closer to home and changes in ways of working.

Members are reminded that implementation of the BEH Clinical Strategy includes changes to emergency services, maternity, planned care and paediatrics across Barnet, Chase Farm and the North Middlesex University Hospitals. These acute service changes are due to be implemented by November 2013. This report will cover the following areas:

1. Background
2. Explanation of the planned primary care investment for 2012 to 2015
    a. How does the primary care investment listed in this report relate to local primary care strategies
    b. How the ratios were arrived at? (Assumptions used)
3. Report on the investment over a 5 year period: looking at the last 2 years, this year and the next two years
4. Conclusion

1. Background

1.1. The JHOSC received a presentation on the implementation of the BEH Clinical Strategy on the 28 May 2012 by Caroline Taylor, NHS North Central London Chief Executive Officer.

1.2. Henrietta Hughes, the acting Medical Director for NHS North Central London, attended the JHOSC in July and presented an update to the "Transforming the primary care landscape in North Central London".

1.3. A whole system transformation is underway for Barnet, Enfield and Haringey to improve access and quality of care for local people.

1.4. This includes the implementing the BEH Clinical Strategy, Primary Care Strategy, Integrated Care Strategy, moving care closer to home agenda and improving urgent care services.

1.5. The BEH Clinical Strategy consultation took place in 2007, since then there have been a number of developments and projects to improve primary and community services across Barnet, Enfield and Haringey to support the delivery of the strategy.

1.6. The Primary Care Strategy supports the BEH Clinical Strategy. Both strategies complement each other and are key drivers to ensure that the local people get the

right care at the right time first time. The local Clinical Commissioning Groups (CCGs) and NHS North Central London are committed to ensuring that local people can see that changes mean real improvement in the services they receive.

1.7. The delivery of the Primary Care Strategy in Barnet, Enfield and Haringey is one of the many enablers for key plans for the transformation of health care locally

1.8. There has been investment in buildings to increase capacity in community settings in all three boroughs. In Barnet there has been the ongoing development of Edgware Community Hospital, Finchley Memorial Hospital, Vale Drive Primary Care Centre, Oak Lane and Edgwarebury Lane. In Enfield there has been the development of Forest Road and the Evergreen centre. In Haringey new capacity was developed in the Lordship Lane development and Hornsey Central.

1.9. Services that have historically been delivered in hospital settings are now being delivered in community settings such as dermatology, gynaecology, ophthalmology, diabetes and ear, nose and throat (ENT) services.

1.10. All three boroughs now have strategies to implement integrated care, where primary care providers, community care providers, social care and voluntary sector providers, as well as hospital providers, are working together to deliver joined up services in the community.

1.11. Whittington Health, the North Middlesex Hospital and Chase Farm Hospital have all developed urgent care centres, with plans in progress for a centre in Barnet Hospital. There are also a number of Walk in Centres.

1.12. There has been investment in end of life services in all three boroughs. This has supported care of people in the community and enabled advance care planning that supports people to plan and choose where they may die. This has resulted in additional investment in community palliative care services.

1.13. This paper focuses on examples of service developments and investments to primary and general community services. There have been further investments in both mental health and public health in the three boroughs which are not referenced in this paper.

2. Explanation of the primary care investment for 2012 to 2015

2.1. The successful implementation of the BEH Clinical Strategy requires investment across the whole healthcare economy in North Central London. This includes financial investment but also investment in changing ways of working in primary care, as well as at Barnet and Chase Farm Hospitals NHS Trust and North Middlesex University Hospital NHS Trust.

2.2. Table 1 below shows the Primary Care spend as at 18 January 2012. The overall strategy is to make the best of existing resources as well as increasing investment in Primary care and Community Health services where appropriate.

Table 1.

HOW MUCH MONEY WILL North Central London/PCTS SPEND IN 2011/12?	**£000's**					
	Barnet	**Camden**	**Enfield**	**Haringey**	**Islington**	**NC London**
Total spending by PCT 2011/12 as at Month 6 projected to full year	**£579,500**	**£518,499**	**£482,704**	**£469,554**	**£481,540**	**£2,531,797**
HOW MUCH IS THAT PER HEAD "CRUDE POPULATION"?						
"Crude Population" numbers @ 1st July 2011	351,286	247,303	277,429	244,489	191,810	1,312,317
£s per head "Crude Population"	**£1,650**	**£2,097**	**£1,740**	**£1,921**	**£2,511**	**£1,929**
HOW MUCH IS THAT PER HEAD "REGISTERED PATIENTS"?						
"Registered patient" numbers @ 1st July 2011	373,715	251,016	299,119	272,236	217,000	1,413,086
£s per head "Registered Patients"	**£1,551**	**£2,066**	**£1,614**	**£1,725**	**£2,219**	**£1,792**
HOW MUCH IS THAT PER "UNIFIED WEIGHTED POPULATION"?						
"Unified Weighted Population" numbers 2011/12	327,404	256,243	289,265	275,792	236,084	1,384,787
£s per head "Unified Weighted Population"	**£1,770**	**£2,023**	**£1,669**	**£1,703**	**£2,040**	**£1,828**
% difference between "Registered patients" and "Unified Weighted Population"	***-12.4%***	***2.1%***	***-3.3%***	***1.3%***	***8.8%***	***-2.0%***

a) DH funding can be viewed on a per capita basis in various ways. The weighted capitation formula produces a PCT 'Unified Weighted Population'. This is a hypothetical population that DH uses as a target to guide most of the PCT's allocation. It is based on a weighted combination of 19 socio-economic factors that are seen as convenient proxies for health needs.
b) The apparent massive funding differential using "Crude" or "Registered" populations is significantly reduced to the range of £1,669 per capita in Enfield to £2,040 in Islington. Using UWP means that the Barnet population theoretically reduces whilst Camden, Enfield, Haringey and Islington theoretically increase.
c) The difference between Registered Patients and UWP also highlights a funding challenge in Barnet.

2.3. NHS North Central London agreed the next steps in delivering better primary care services across Barnet, Camden, Enfield, Haringey and Islington at its March Joint Board meeting.

2.4. £46.7million will be invested in North Central London primary care services in the five boroughs over the next three years as detailed in the "Transforming the primary care landscape in North Central London". This Primary Care Strategy document is intended to underpin the borough implementation plans which specify the practical details. The combined strategy and implementation plans will determine how the NHS in North Central London will invest in primary care in each of the boroughs over the coming years. The result of this investment will be in the improvement in clinical, service quality and people being able to access services closer to home. This in turn will support a reduction in hospital usage and costs.

2.5. The £46.7 million comes from the return of "top sliced" 2% of our general allocation from NHS London. It is part of our preparation to reduce our historical over-reliance on hospital care, and provide more out of hospital care resulting in financial recovery and on-going financial balance. Table 2 details the investment across the five boroughs for the next three years.

Table 2. Primary Care investments for the current year and the next 2 years detailed in the Primary Care strategy for the 5 boroughs

	Barnet	Enfield	Haringey	Camden	Islington	NCL year total £000s
2012/13	£2,910	£2,797	£2,697	£1,798	£1,798	£12,000
2013/14	£4,835	£3,953	£3,665	£2,751	£2,751	£17,505
2014/15	£4,419	£3,945	£3,629	£2,630	£2,630	£17,253
Total	**£11,714**	**£10,695**	**£9,991**	**£7,179**	**£7,179**	**£46,757**

2.6. Our aim is to offer a high quality primary care team service, linked, when necessary, to more specialist services; all of which will enable people to live the best possible lifestyle in respect of their personal health and wellbeing.

2.7. The strategy recognises that transformational changes are needed to support the development and capacity of primary care and underpins the development of our five borough-based implementation plans by defining the medium/long term goals, priorities, principles, investment criteria and performance expectations. The strategy focuses on:

- Promoting health, wellbeing and illness prevention
- Addressing health inequalities
- Further improving the quality of primary care services, particularly in General Practice, to enhance the patient experience with better outcomes.

2.8. The borough teams have actively engaged with GPs and local stakeholders from February 2012 to May 2012 to develop the local Primary Care implementation plans. Each borough has a different starting point in their planning process to create the universal patient experience described in Section 4 of the strategy – “A patient’s perspective - This is how we want it to be” and has developed their own approach to implementation.

2.9. The borough implementation plans have identified the following clinical priorities for 2012/13:

- Access
- Frail elderly
- Long term conditions
- Continue early implementation of text message reminder capability, web based information systems and premises improvements.

2.10. The borough clinical priorities for 2013 to 2016 are being further developed and will be shared with the Borough Overview and Scrutiny Boards.

3. Report on the investment over a 5 year period: Looking at the last 2 years, this year and the next two years (2010 to 2015)

This report details key examples of primary care, community services and care closer to home developments and investments for Barnet , Enfield and Haringey. Reference is made to developments since the BEH Clinical Strategy Consultation in 2007.

3.1. Barnet Developments and Investments

3.1.1. Past Developments and Investments

- The development of Oak Lane, Edgwarebury Lane, Lane End Medical Practice and Vale Drive were key to improving access to community services and intermediate care and improving primary care premises. A total of £250,000 was invested in these premises from 2007
- Developed the GP lead Health Centre in Cricklewood
- There is an annual investment of £25,000 each year in GPs with special interests.
- Implemented a referral management system for all GP and dental referrals to make sure patients get to the right service first – £500,000 invested annually.
- Investment of £3,155,440 since July 2008 in improving access to primary care with now 88% of GP practices providing extended opening hours.
- Expansion of Information Communication Technology (ICT) and enablement services.
- An investment in a rapid response service as part of the intermediate care and in enablement developments to prevent 30 readmissions. (Rapid Response £416,000, Enablement £195,000; January 2012)
- Commissioning of an integrated community Chronic obstructive pulmonary disease (COPD) service providing community clinical with specialist support, admission avoidance, case management, pulmonary rehabilitation and home oxygen assessment and review. (£560,000 ; June 2011)
- A single telephone number was introduced so that acute providers could access intermediate care assessment and services from one point of access.
- Invested £450,000 over the last two years in additional Health Visitors
- Invested £150,000 in home enteral feeding service for adults
- In November 2011 a nurse navigation scheme opened at Barnet A&E to redirect people with primary care problems to GPs and pharmacies
- More services provided in the community resulting in fewer patients having to be seen in hospital (Musculoskeletal, COPD, diagnostics, urology, gynaecology, ENT, minor oral surgery, community anticoagulation, ophthalmology, cardiology and dermatology)
- Developed integrated health and social care teams for rapid response frail elderly as part of system wide redesign of frail elderly services
- Further development of an integrated approach with children's services particularly speech and language therapy and CAMHs Tier 3
- Initiated redesign of dementia and stroke integrated community pathways
- A rapid response palliative care service for people in their own home £119,000 in 2011/12 and £250,000 in 2012/13

- Significant developments at Edgware Community Hospital including a new renal unit developed to allow community based dialysis and outpatient clinics. Opened in October 2011
- Implemented enhanced GP support to care homes as pilot
- Two fully functioning walk-in centres at Edgware and Finchley

3.1.2. Barnet Primary Care Implementation Plan (Current and next 3 years)

- Barnet Primary Care Implementation plan identifies that £11.7m will be invested in primary and community services over the next 3 years; of this £2.9m has been allocated for 2012/13.
- The Finchley Memorial Hospital and Edgware Community Hospital are key developments in Barnet that will assist in the development of primary and community care capacity.
- The new Finchley Memorial Hospital will provide consulting and treatment rooms, therapy suites, x-ray facilities, and pharmacy and inpatient beds. These have been designed to provide flexibility in use. The hospital will serve a higher proportion of older adults and facilitate the re-design and delivery of community-based pathways which will focus on:
  - Management of long term conditions to help people stay healthy and maintain their independence;
  - Rehabilitation of people who require additional support to recover from an acute health event;
  - Assessment, diagnosis, and treatment of people with a common need that can be safely and quickly managed without the use of highly specialised diagnostic and therapeutic interventions: e.g. dermatological and musculoskeletal problems;
  - An infusion suite where people will have infusions that historically have meant time in hospital;
  - Primary and urgent care.

- Edgware Community Hospital will be utilised to complement provision at Finchley Memorial Hospital with, for example, expanded provision of day surgery, and integrated long term conditions clinics. Services will not necessarily be duplicated across both sites, allowing a greater range of services to be provided in total.

3.2. Enfield Developments and Investments

3.2.1. Past Developments and Investments

- 85% of GP practices in Enfield have signed up to offer extended hours (up to 20:00). This is part of the additional £1.9m spent on primary care since 2007/08. Out of Hours GP services are provided by BarnDoc from 6:30pm to 8:00am every night, and all weekends and bank holidays
- Two new developments and improvements in practices in Evergreen and Forest Primary Care Centres. Five single handed practices have come together as one in Evergreen with investment of £588,000

- Development of a hub and spoke model, for integrated community-based dermatology service with an investment of £ 527,000 was opened in July 2012
- The development of increased diagnostics in the community over the last 5 years with ultrasound scans, Dexa scans, MRI and echo tests available in the community. This has resulted in £1 million investment since April 2007
- Investment of £68,000 in a Community Parkinson's Disease Specialist Nurse in April 2011
- Investment in a fracture liaison and falls prevention service, £173,684 in 2012/13 and £247,728 in 2013/14 of this £150,000 is from social care funding
- The development of a consultant led integrated care multi disciplinary team (MDT) to support admissions avoidance and readmissions from care homes with a high rate of acute admissions was established in the North of Enfield and will now be rolled out to the South of Enfield. A total investment of £708,000 annually over the next 4 years.
- Single point of contact phone number which will be delivered through NHS111 from April 2013 with an investment of £400,000
- Twenty community hospital beds in Magnolia ward plus investment of an additional eight beds in 2011.
- Development of self management strategy with appointment of seven community nurses to support patients' self management and consisting of an investment of £398,000
- New services being provided in the community which have been provided in hospital settings previously, e.g. ophthalmology at Chalfont Road and a sexual health outreach service for under-18s, with an investment of £1.1million since 2007
- The development and commissioning of London Ambulance Service emergency care practitioners working in the community and preventing hospital admission where appropriate as well as delivering emergency care closer to home.
- Rapid response team and extension of hours available
- Rehabilitation beds and centre – completed in Chase Farm with a £2.7million investment

3.2.2. Enfield Primary Care Implementation Plan (Current and next 3 years)

- Enfield Primary Care Implementation plan identifies that £10.6m will be invested in primary and community services over the next 3 years; of this £2.7m has been allocated for 2012/13. This investment will assist in improving access to and the quality of primary care in Enfield.
- At the core of the Implementation Plan is the ambition to develop GP-led integrated Primary Care Networks. There will be four networks in Enfield.
- A significant investment in information technology allowing patients to be reminded about appointments by text, giving out timely information on services and managing conditions through improved data sharing will enable practices to achieve better outcomes for patients.
- During Year 1 (of a 3-year plan), the integrated Primary Care Networks will enable an improvement in access to primary care. Years 2 and 3 will see the development of new services or expansion of pilot schemes

- Estates development to improve patients access in two Edmonton practices and Ordanance Road are planned with a potential further two sites to be developed.
- The Enfield implementation plan was presented to the Enfield Health and Wellbeing board on 11 June 2012 and is now available on the internet.

3.3. Haringey Developments and Investments

3.3.1. Past Developments and Investments

- Developments to four large neighbourhood health centres, all providing primary care through GP practices, Community services via Whittington Health and care closer to home.
- Lordship Lane – capital investment of £300,000. The development of clinics for people with long term conditions and increased provision of diagnostics such as ultrasound scanning.
- GPs with special interest developed in musculoskeletal services, dermatology and ENT
- 84% of GP practices in Haringey have signed up to offer extended hours (up to 20:00).
- Laurels Healthy Living Centre – Investment of £400,000 in April 2011
- Tynemouth Road – community midwifery team and women's services
- Community anti-coagulation service
- Community pharmacy network providing emergency hormonal contraception (EHC) and Chlamydia screen and treat services.
- North East Haringey Collaborative of GP practices piloting integrated care approach including running case conferences for complex patients 65 years or older
- Hornsey Central – Investment of £300,000 in March 2011with the introduction of additional clinics supported by diagnostics such as ultrasound scans. Community services now being delivered for gynaecology including hysteroscopies in the community; diabetes; dermatology and ophthalmology. Community physiotherapy centre developed with gym. New pharmacy service with extended hours of opening 7 days per week.
- Assessment and Urgent Care Centre provided at Whittington Hospital and NMUH, including a GP led front-end
- Investment in rapid response services and enablement to prevent people being admitted to hospital
- Ambulatory care service now delivered at the Whittington hospital

3.3.2. Haringey Primary Care Implementation Plan (Current and next 3 years)

- Haringey Primary Care Implementation plan identifies that £9.9m will be invested in primary and community services over the next 3 years; of this £2.6m has been allocated for 2012/13. This investment will assist in rebalancing the health system to

ensure more investment in the primary and community settings allowing greater care closer to home.

- The development of networks is vital for the delivery of the integrated care and urgent care strategies. Haringey have four collaboratives which will continue as the infrastructure for their local networks.

4. Conclusion

4.1 This paper has informed the JHOSC of examples of primary and community care investments and developments that have happened and are planned to happen that will be part of the wider health system changes that complement the acute service changes happening in the BEH Clinical Strategy.

4.2. High quality safe sustainable health services for local people in Barnet, Enfield and Haringey is the overarching aim of the BEH Clinical Strategy, the NCL Primary Care strategy and the ongoing development of health services. Alongside investment local health services continue to require culture change in the way care is delivered to meet the needs of local people.

4.3 Communicating these changes and engaging local communities and people in these changes will remain a priority over the coming months.

North Central London

NHS NORTH CENTRAL LONDON	**BOROUGHS:** BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL
PRESENTATION TITLE: Referral Management in NHS North Central London	
PRESENTATION OF: Dr Henrietta Hughes, Acting Medical Director, NHS North Central London	
FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**MEETING DATE:** 10 September 2012

EXECUTIVE SUMMARY OF REPORT:

Referral management is a system by which GP referrals to community or secondary care services are reviewed by a peer in order to ensure that the correct referral pathway is being used.

New pathways are being developed to enable care closer to home, to improve the patient experience and to deliver better value for money within the NHS. For example, musculoskeletal pathway for lower back pain. Patients referred to this service are initially reviewed by a senior physiotherapist who determines whether further investigations such as MRI scan and onward referral is made to Rheumatology or Orthopaedics. In addition, referral to certain specialist clinics will derive more benefit from the initial appointment if a set of investigations has been carried out prior to the referral. For example, when referring for investigation of infertility, this would include investigations such as blood tests, ultrasound scan and semen analysis. With this information the Gynaecologist is able to initiate and plan treatment.

Certain referrals are excluded from referral management systems. These include maternity, two-week wait referrals for suspected cancer and some locally determined referrals.

Referral management systems are used in Camden, Enfield and Barnet and are being considered in Islington. Haringey has a triaging system for community pathway referrals. The emphasis is on quality improvement of referrals. Where systems are more recent there may also be cost savings. The Borough Directors and the CCGs lead on this work.

Demand management is a different issue which is not addressed through referral management systems. This is managed in the consultation by exploring the patient's ideas, concerns and expectations and by explaining options for investigation and referral based upon the clinical findings and evidence based medicine.

CONTACT OFFICER:
Dr Henrietta Hughes, NHS North Central London

RECOMMENDATIONS: The Committee is asked to comment on the information above and the slides.

Attachments include: PowerPoint presentation

Dr Henrietta Hughes
Acting Medical Director
DATE: 30 August 2012

Agenda Item 7

NHS
North Central London

NHS NORTH CENTRAL LONDON	**BOROUGHS:** BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL

PRESENTATION TITLE: Supply of Medication in NHS North Central London

PRESENTATION OF:

Dr Henrietta Hughes
Acting Medical Director
NHS North Central London

FOR SUBMISSION TO:	**MEETING DATE:**
North Central London Joint Health Overview & Scrutiny Committee	10 September 2012

EXECUTIVE SUMMARY OF REPORT:

The supply of medications can be affected by a range of issues from manufacturing by a pharmaceutical company, supply chain problems, to factors relating to the international exchange rate of Sterling. This report summarises the supply issues identified and the ways that NHS North Central London, the Department of Health, the Medicines Healthcare products Regulatory Agency (MHRA) and the All Party Pharmacy Group have mitigated the risks.

The All Party Pharmacy Group published a report on 15 May 2012 summarising the current situation. Certain medications face a worldwide supply shortage due to manufacturing problems for example Immunoglobulins. The situation for other, high cost, medications which do not have manufacturing problems are related to the current exchange rate and the cost of drugs in different EU countries. Under EU legislation, free trade exists between member states and this also includes medication. Medication purchased in one EU country and exported to another is described as 'Grey Exportation' or 'Parallel Exportation'. This is commonly carried out by smaller wholesalers. The effect of the current exchange rate is that there may be a net exportation of medication leading to supply shortages in the UK.

Manufacturers mitigate this risk by using exclusive wholesalers for distribution of medication, ensuring that the supply matches patient need. For example, the pharmacist faxing the prescription before the medication is delivered and using a quota system to reduce the movement of medications.

The Department of Health has issued guidance to the wholesalers advising that the interests of UK patients should override all other considerations. A holder of a wholesale dealer's license could be in breach of the Regulations if they chose to trade medicines for export that were in short supply in the UK and that they could face regulatory action against their license, and/or criminal prosecution. The Department of Health have announced that the MHRA would be taking a "proactive, targeted programme of inspection of holders of wholesaler dealer licenses".

In NHS North Central London, the Medicines Management team work closely with the community pharmacists and GPs to inform of potential delays, ensure that patients are not put at risk due to supply chain issues, and assist with alternative prescriptions if required.

Delay of production of Flu Vaccination 2012

Two manufacturers of the Flu Vaccine have identified delays of 2-4 weeks in the production and availability of the vaccine. The many alternative manufacturers do not report any delays to production. NHS North Central London has addressed this by communicating with the manufacturers, the Local Medical Committee and affected practices. A central supply of Flu Vaccines is available for cold chain collection by practices. Practices have come forward to offer supplies and are working in a collaborative way to address the temporary shortfall. Housebound patients will not be affected by this.

CONTACT OFFICER:
Dr Henrietta Hughes
NHS North Central London

RECOMMENDATIONS: The Committee is asked to comment on the information above and the slides.

Attachments include: PowerPoint presentation

Dr Henrietta Hughes
Acting Medical Director
DATE: 30 August 2012

North Central London

NHS NORTH CENTRAL LONDON	BOROUGHS BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON WARDS: ALL

PRESENTATION TITLE: QIPP 2012-13 Update

PRESENTATION OF:

Lorraine Robjant

Assistant Director, Service Transformation, Financial Recovery and QIPP

NHS North Central London

FOR SUBMISSION TO:	MEETING DATE:
North Central London Joint Health Overview & Scrutiny Committee	10 September 2012

EXECUTIVE SUMMARY OF PRESENTATION:

- This presentation provides the JHOSC with an update on progress of the 2012-13 QIPP Programme
- Most QIPP schemes within the overall programme are forecast to deliver at or very close to their target
- Two schemes are rated Red and two Amber
- NHS North Central London and the PCTs continue to manage and mitigate for the following risks:
    - NHS Transition leading to staff turnover in key QIPP delivery areas
    - Completeness and accuracy of reported data
    - There is a degree of slippage against the target; however work continues to identify means to close this gap. This includes proposals being worked up in the following areas:
        - Pain Management
        - Comprehensive Falls System
        - Review of Elective Activity for BEH
        - Preventing Alcohol–Related Admissions
        - Patient Navigator Scheme

CONTACT OFFICER:
Nick Day
Head of PMO
NHS North Central London

Lorraine Robjant

Assistant Director, Service Transformation, Financial Recovery and QIPP
DATE: 30 August 2012

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UCLPartners: An Academic Health Science Network in development

Introduction

This paper refers to the call by the Department of Health to establish Academic Health Science Networks, and summarises the local response to this call, which is led by UCLPartners. A brief summary of UCLPartners is also provided.

The Joint Overview and Scrutiny Committee is asked to:

- comment on the proposal to create an local Academic Health Science Network
- comment on the early priorities
- consider supporting UCLPartners AHSN and encouraging Local Authorities in the area to become members.

Academic Health Science Networks

In June 2012, the Department of Health launched a call for the establishment of Academic Health Science Networks (AHSNs) across the country[1].

Each AHSN is expected to bring together a broad range of organisations to work collaboratively for the benefit of a population of approximately 3 – 5 million. Members of an AHSN are expected to include: the local NHS and providers of NHS funded care (e.g., independent and third sector), the local authority, higher education and research institutions, industry, and patient and carer organisations.

The functions of an AHSN include but are not limited to:

- driving service improvement and the use of proven innovations
- facilitating better education and training for the current and future workforce
- sharing information with patients and with different parts of the health and social care system
- promoting involvement in research
- embedding research discoveries and learning into practice
- working with industry to develop, test and commercialise new ideas for economic benefit

The national designation process for AHSNs involves the submission of an Expression of Interest by 20th July 2012 and a full Prospectus by 30th September 2012. Panel interviews will take place during October/ November 2012. Designation announcements for AHSNs will be made at the end of November 2012.

UCLPartners

UCLPartners was designated as an Academic Health Science Centre (AHSC) by the Department of Health in April 2009. AHSCs have related functions to AHSNs but AHSCs are of a smaller scale (in terms of geography and number of organisations) and they focus more on new discoveries rather than embedding research findings and proven innovations in to practice.

UCLPartners (UCLP) is currently a partnership of 16 NHS provider Trusts and 3 Universities serving 3.5m people across north central and north east London. Its purpose is to deliver measurable health gain for patients and populations – in London, across the UK, and globally – through innovation in healthcare delivery, new discoveries through research, and improved education and training.

[1] http://www.dh.gov.uk/health/files/2012/06/Academic-Health-Science-Networks-21062012-gw-17626-PDF-229K.pdf

UCLPartners – An Academic Health Science Network in development

In response to the call for the establishment of AHSNs, UCLP began a process of co-producing an Academic Health Science Network which will serve a population of 5.5million across north central and north east London, south and west Hertfordshire, south Bedfordshire, and south and west Essex. This geography reflects historical patient and trainee flows between providers in the different counties.

UCLP will continue to develop our culture of collaborative partnership working by building upon our currently stated UCLP values:

- Patient-led, organising care around patients' needs and preferences
- Population-focused, taking a system-wide view to drive improved health outcomes at speed and scale
- Drawing on academic expertise across disciplines in biomedicine and beyond
- Working across boundaries, spanning primary, secondary and tertiary health care, social care, public health, industry and third sector organisations

The principal strategic goals will be to:

- Support and facilitate **measurable improvements** in health and wellbeing of our population, recognising the importance of reducing health inequalities
- Enhance **economic gain** for the population through better health, innovation and its implementation into practice

The early priorities for UCLP AHSN will be aligned the most pressing needs of the population and the system:

- **Early diagnosis and prevention** of the causes of premature death in our population, most notably cancer and cardiovascular disease which together contribute to two-thirds of premature deaths
- **Long-term conditions** which affect an increasing number of lives and accounts for 70% of health care spend. The initial focus will be people living with multiple chronic conditions, and with mental illness.

UCLP submitted a successful Expression of Interest[2] and is now consulting with its members to submit a full Prospectus by 30th September 2012.

[2] http://www.uclpartners.com/lotus/wp-content/uploads/2012/07/UCLP_AHSN_EOI.pdf

NHS
North Central London

NHS NORTH CENTRAL LONDON	**BOROUGHS**: BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL

REPORT TITLE: Transition Programme Progress Update – September 2012

REPORT OF:

Alison Pointu
Director of Quality and Safety and Executive Lead for Transition
NHS North Central London

FOR SUBMISSION TO:	**MEETING DATE:**
North Central London Joint Health Overview & Scrutiny Committee	10 September 2012

EXECUTIVE SUMMARY OF REPORT:

Members of the Joint Health Overview and Scrutiny Committee have received regular Transition Programme updates throughout the Transition period.

We are now entering the next phase of Transition from 1 October 2012, where we will see a shift from the current system to the new, with the new 'receiving' organisations leading in planning and preparing for 2013/14. They will also take on much of the delivery agenda for 2012/13 and the PCT cluster will hold the new system to account for the operational delivery of 2012/13 priorities.

The purpose of this report is to provide an overview of recent developments in the system and describe the implications for NHS North Central London and the new 'receiving' organisations that will replace it.

Amy Bray
Transition Programme Manager
NHS North Central London

RECOMMENDATIONS:

The Committee is asked to comment on the contents of this report and consider the implications of what this might mean for the overview and scrutiny function in the future.

The Committee is also asked to note the latest development status of the NHS Commissioning Board Authority, Public Health transition, Clinical Commissioning Groups and North Central and East London Commissioning Support Unit.

Attachments include: No attachments.

Alison Pointu

Director of Quality and Safety and Executive Lead for Transition
DATE: 30 August 2012

TRANSITION PROGRAMME PROGRESS UPDATE – SEPTEMBER 2012

Introduction

From 1 October 2012 there will be a shift from the current system to the new, with the new organisations leading in planning and preparing for 2013/14. They will also take on much of the delivery agenda for 2012/13 and the PCT cluster will hold the new system to account for the operational delivery of 2012/13 priorities.

This approach is intended to minimise the risk of a 'big bang' transition of functions and staff on 1 April 2013 and provide resilience for delivery, as well as providing receiving organisations with the opportunity to build teams in parallel with taking on responsibility for functions, with support from 'sending' organisations.

During the transition period there will remain a core cluster team supporting statutory PCT functions and governance arrangements until 31 March 2013.

As we prepare for handover of functions from existing 'sending' organisations to new 'receiving' organisations, it is critical that clear, consistent handover plans are in place to enable the smooth migration of functions. The core Cluster Transition Team is working with each Directorate across the organisation to ensure functions are packaged appropriately for handover to the relevant receiver(s).

The Transition Programme and its composite Legacy, Handover and Closedown Programme and enabler workstreams will be on-going throughout the transition period (to April 2013). Progress will be reported to the North Central London Senior Leadership Team weekly and overall Cluster migration status will be reported monthly to the pan-London System Transition Group (STG). Strong links will be maintained with the STG to ensure the Cluster is sighted on and prepared for developments in transition as they occur.

NHS Commissioning Board Authority (NHS CBA)

From 1 October 2012, the NHS Commissioning Board will become a Non-Departmental Public Body, assuming its full statutory functions and acting as a host to other new receiving organisation that continue to emerge including the Commissioning Support Units (formerly Commissioning Support Services) and Clinical Commissioning Groups.

With the appointment of Anne Rainsberry as Regional Director of the NHS Commissioning Board London (NHS CBL), work is underway on its design so that it can begin operating from October and take on its full range of responsibilities from April 2013.

Appointments have now been made to the senior leadership team at the NHS Commissioning Board Authority (NHS CBA). Each Director now in post is working closely with their emerging teams to ensure the Board Authority is ready for its launch in October.

At the time of writing, finalised structures for the Board were due to be released by the end of August 2012 following a period of engagement, review and refinements to reflect feedback. Cluster representatives were involved in Design Groups to shape these structures, specifically in the areas of Primary Care and Direct Commissioning.

From 1 October, the NHS Commissioning Board London will report to the accountable officers within Sending organisations (i.e. PCT Cluster Chief Executives) for the in-year delivery of specific functions. The NHS CBA will also be responsible for planning for 2012-13-14.

Public Health

It is understood that the majority of Public Health functions will transfer from the Cluster to Local Authorities, Public Health England (PHE) and the NHS Commissioning Board in April 2013. It is likely that specific functions such as screening and immunisation will transfer at an earlier stage.

Nationally, a joint operating model between Public Health England and the NHS Commissioning Board is currently being developed as part of the design process for the commissioning of screening and immunisation. Outstanding issues are currently being worked through with national colleagues, including differences in views about the role of Public Health and variances in the NHS Commissioning Board Local Area Team or Public Health England structure as elsewhere.

Transition plans have been developed by each of the local Public Health teams across North Central London, and used to develop an understanding of key local issues and input emerging intelligence on national timescales. Implementation of these plans will depend on the resolution of any issues during the transition period, and to a degree on the readiness of Local Authorities and Public Health England to receive public health functions in advance of April 2013.

Local planning is also dependent upon the timely receipt of national guidance – specifically in relation to the legal basis for people transition (TUPE or Transfer Orders), Shift phase guidance for the novation of contracts, and the financial allocations for Public Health.

Local teams are being encouraged to prepare contingency plans in the event that the guidance produced is not sufficiently prescriptive, and we are working closely with NHS London to keep abreast of any developments.

NCL has an established dialogue with NHS London through weekly London Public Health transition meetings which provide an opportunity to escalate issues that require a regional and/or national solution and also to share best practice across London.

Each local team is close to completing a register of all Public Health contracts which they currently commission. This has been supported by work within the cluster contracts and finance teams to provide a breakdown of the Public Health service lines of the block contracts.

Work is on-going with the NCL Cluster HR team to ensure local Public Health teams are receiving the necessary support and clarity they require on emerging people transition issues. There are regular briefings with local teams, and where necessary, any issues arising have been escalated.

Finance and HR are working together to establish the 'overhead allocations' – which maps the future destination of NCL cluster staff who have a Public Health element to their work but may not necessarily face the Local Authorities. It is essential that we have a clear understanding of which functions are currently provided, where the funding will flow, where the role of the individual will be mapped to, and the future destination of the individual themselves in order to ensure that local councils are clear on which services they may need to acquire in the future through arrangements with organisations such as the CSU, PHE, CCG and NHSCB.

Where Public Health functions are merging (in Barnet and Harrow and in Camden and Islington) joint Transition Group arrangements are now in place for the duration of the transition period. The swift appointment of a single Director of Public Health in each of these areas is critical to driving the local transition forward.

Commissioning Support Units (CSUs)

Following confirmation that all 23 NHS Commissioning Support Units will progress to be hosted by the NHS Commissioning Board from 1 October 2012, the NHS Commissioning Board Authority is now using the term 'commissioning support unit' (CSU), rather than the previously used term 'commissioning support service' (CSS) so it can begin to distinguish these NHS organisations from others in the wider commissioning support services market.

From 1 October 2012 the North Central and East London Commissioning Support Unit (NCEL CSU) will be hosted by the NHS Commissioning Board, as it becomes responsible for delivering agreed functions on behalf of 12 Clinical Commissioning Groups. The NHS CBA is currently developing these hosting arrangements through a series of working groups focusing on key areas such as HR, informatics, intellectual property and estates.

The outcome of the business review and assurance process for the majority of commissioning support services to be provided at scale has been agreed. The Board Authority has named the CSUs that will offer business intelligence, clinical healthcare procurement and business support services.

The outcome of the 'Checkpoint 3' business review process will be a provisional licence to operate. These outcomes for each CSU have now been discussed with Managing Directors. The Full Business Plan for the NCEL CSU was prepared and shared as part of the Checkpoint 3 timeframes in August 2012. Future checkpoints are expected in December 2012 and in Spring 2013. Site visits of each CSU will be undertaken by the NHS CB and NHS London as well as independent business experts in October. Each CSU submitted proposals for its future name and brand identity as part of the Full Business Plan which, subject to agreement, will form an integral element of the license to operate arrangements.

Draft guidance on HR and recruitment has been shared with CSUs. The governing body of a CSU cannot be a 'Board' or have Non-Executive Directors. Appointments have now been made to all Director-level posts within the NCEL CSU, and job matching is underway to ensure staff are appointed to all tiers of the organisation.

Clinical Commissioning Groups (CCGs)

From 1 April 2013, England must have complete coverage by established Clinical Commissioning Groups (CCGs) to ensure the whole population is appropriately served. In order for CCGs to take on the full range of their statutory duties they must be authorised to do so by the NHS Commissioning Board (NHSCB). First applications by CCGs to the NHS Commissioning Board Authority to become authorised were submitted on 2 July; site visits undertaken in September; and decisions made in October. Final decisions on authorisation are expected in January 2012.

Islington CCG successfully submitted its authorisation application in wave one in July. A subsequent mock site visit by the NHS Commissioning Board proved to be a valuable learning experience, and the feedback from NHS London is now being used to help prepare the CCG's governing body for the site visit with the NHS CBA on 18 September.

Preparations are underway by Haringey, Camden and Barnet CCGs ahead of their application submissions in wave three.

Each of the five emerging CCGs in North Central London is in the process of recruiting and appointing the members of their governing bodies and leadership teams.

To reflect the changing nature of the system from October, new contractual arrangements are being developed between the CSU and CCGs in the form of Service Level Agreements. A 'Learning by doing' event has been scheduled for early October to enable a simulation of how CCGs, the NHS Commissioning Board and CSU will operate within the new health system to commission effectively from providers. The event will test the architecture of the organisations, as well as identifying what enablers and blockers are likely to support and challenge commissioning.

Meetings have taken place across the Cluster team to discuss collaborative working and the support CCGs may require in helping to decide which collaborative working options they would like to take forward in the future. As part of this discussion, risk-sharing proposals have been developed, seeking to encourage CCGs to prepare for the future by adopting an agreed approach to risk sharing during the shadow-operating period.

Enfield CCG continues to work on their application for the delegation of all remaining eligible budgets. An informal review is taking place with some members of the Cluster team on 29 August, and a second review will be scheduled prior to the NCL Director Panel review on 26 September. The final sign off of Enfield CCG's application for delegated responsibility is scheduled with the sub-group of the joint boards on 3 October, prior to the submission of their wave 4 application for authorisation on 1 November.

In addition, the new working arrangements for the Clinical Commissioning Council have now been agreed. New terms of reference were agreed at the Council meeting in July, transforming the Council into a collaborative organisation for the 32 London CCGs. The working arrangements for the Council have been developed in a series of meetings with designate Chief Officers/Chief Clinical Officers. Howard Freeman has been appointed as chair for two years.

If residents of your boroughs have any questions about Transition at NHS North Central London or would like to receive further information or information in another format, please contact: Amy Bray, Transition Programme Manager, Amy.Bray@nclondon.nhs.uk

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

10 September 2012

Future Work Plan

1. Introduction

1.1 This report outlines the work plan for future meetings of the JHOSC.

Next Meeting

1.2 Potential items for the next meeting of the Committee, which will take place on 22 October in Camden, are currently as follows:

- Estates – Prop Co
- Transition
- QIPP – Update
- A&E Admissions – waiting times

1.3 Dates for future meetings are as follows:

- 3 December (Haringey).

Transition Seminar

1.4 In addition to the above-mentioned regular meetings, a seminar on transition and the shifts in responsibilities and accountability from the current structure to the new is currently being arranged to take place in November. Further details will be circulated in due course.

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