NOTICE OF MEETING

NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Contact: Robert Mack

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Monday 22 October 2012 at 10:00 a.m.
Camden Town Hall, Judd Street,
London WC1H 9JE

Councillors: Alison Cornelius and Graham Old (L.B.Barnet), Peter Brayshaw and John Bryant (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: John Murphy, Linda Leith, Robert Mack, Pete Moore and Shama Sutar-Smith

AGENDA

1. WELCOME AND APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST (PAGES 1 - 2)

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

3. URGENT BUSINESS

4. MINUTES (PAGES 3 - 10)

To approve the minutes of the meeting of 10 September 2012 (attached).

5. NHS PROPERTY SERVICES

To receive an outline of issues relating to estates from the Regional Director (London) for NHS Property Services Ltd. and the Associate Director of Estates, NHS North Central London.

6. FINANCIAL MANAGEMENT OF ACUTE CONTRACTS (DEMAND/CONTRACT MANAGEMENT) (PAGES 11 - 24)

To receive a presentation on the management of acute contracts.

7. QIPP/ FINANCE UPDATE (PAGES 25 - 38)

To receive an update on progress on overall QIPP targets and measures taken to address PCT deficits within the sector.

8. ACHIEVING AN EDUCATION MODEL INTEGRATED WITH CAMHS PROVISION - UPDATE ON EDUCATION ARRANGEMENTS AT NORTHGATE PRU (PAGES 39 - 44)

To report on education provision for young people in Barnet, Enfield and Haringey accessing Child and Adolescent Mental Health Services (CAMHS).

9. TRANSITION PROGRAMME PROGRESS UPDATE (PAGES 45 - 50)

To update the Committee on progress with the transition process.

10. FUTURE WORK PLAN (PAGES 51 - 52)

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

12 October 2012

Agenda Item 2

DECLARING INTERESTS FLOWCHART - QUESTIONS TO ASK YOURSELF

What matters are being discussed at the meeting?

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

NO → You can participate in the meeting and vote

YES

Personal interest

Is a particular matter close to me?

Does it affect:

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

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

NO

NO

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

Prejudicial interest

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

YES → You may have a **prejudicial interest**

YES

Do the public have speaking rights at the meeting?

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

NO → You should declare the interest and withdraw from the meeting by leaving the room. You cannot speak or vote on the matter and must not seek to improperly influence the decision.

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

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North Central London Joint Health Overview and Scrutiny Committee
10 September 2012

Minutes of the meeting of the Joint Health Scrutiny Committee held at the Laycock Centre, Islington- on 10 September 2012 at 10.00am.

Present: **Councillors:** 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).

Officers: Rob Mack (L.B.Haringey), Peter Moore, Rachel Stern, (L.B.Islington), Linda Leith (L.B. Enfield)

1 WELCOME AND APOLOGIES FOR ABSENCE (Item 1)
The Chairman, Cllr Klute, welcomed the attendees to the meeting.

2 URGENT BUSINESS (Item 2)
None.

3 DECLARATIONS OF INTEREST (Item 3)
Councillor Alison Cornelius declared that she was an Assistant Chaplain at Barnet Hospital, but did not consider it to be prejudicial in respect of items on the agenda.

4 CHAIR'S REPORTS

The Chair reported that in relation to the issue of the ownership of property the Department of Health had indicated that there had been movement on this matter and that there would now be an independent disputes procedure. The Chair detailed the letter to Members of the JOSC and that he would circulate a copy to Members of the Committee. **CHAIR**

Discussion took place as to whether the issue of the proposed ownership of the St. Pancras Hospital site had resulted in a formal disputes procedure and the Chair stated that he would discuss this with Councillor Bryant at LB. Camden and write formally as Chair of the JOSC to the Secretary of State in relation to this matter. **CHAIR**

It was also noted that the JHOSC intended to invite the Head of the NHS Property Services Limited (PropCo) for London to a future meeting. **ACTION**

Reference was also made to minute 9 at the last meeting of the Committee in relation to the half day training briefing proposed to JHOSC members in November and it was proposed that this should take place on Wednesday 28 November 2012 at 1.00p.m. to 4.00p.m at the Laycock Centre, Islington. **ACTION**

5 MINUTES (Item 4)

RESOLVED:

That subject to the following amendments the minutes of the meeting of the Committee held on 9 July 2012 be confirmed and the Chair be authorised to sign them –

- Minute 4 page 7 – amend to read – Councillor Alison Cornelius, L.B.Barnet, raised concerns that Mark Easton, the Chief Executive of Barnet and Chase Farms Hospitals NHS Trust, had stated that he believed L.B.Barnet's Planning Department had told the trust that a multi-storey car park would not be granted planning permission on the site. The Committee were informed that this had not been discussed with the London Borough of Barnet Head of Planning or his department and she requested that the minutes of the 28 May 2012 be amended to include Mr.Easton's comment. Mr. Easton

wanted to put the record straight, at the July meeting, by saying that advice from within the hospital was that the L.B.Barnet would be unlikely to grant planning permission for a multi-storey car park;

- Minute 4 – page 7 – second paragraph – delete last two sentences and replace with – It was noted that Councillor Alison Cornelius and Councillor Graham Old had undertaken a site visit at Barnet Hospital on 3 July 2012 and had identified that the staff car park was full and 150 staff were parked in patient/visitor parking bays. Due to the shortage of parking on site, staff were also being forced to park outside the site or illegally within the site.

6 MATTERS ARISING FROM THE MINUTES

The Chair enquired whether the planning application for the car park at Barnet General had been achieved by 29 August as envisaged.

Councillor Cornelius stated that this matter had been due to be considered on 5 September but now would not be considered until 19 September.

Concern was expressed that the transport plan had not been updated by the NHS since the proposals for merger had been originally submitted.

Reference was also made to page 11 of the minutes of 9 July and that the situation in Camden and Islington had been complicated due to the Director of Public Health being appointed to another post. It was stated that replacement was an NHS appointment, although it was hoped that the relevant Local Authorities would have some input into this.

7 ORDER OF AGENDA

The Chair stated that the order of agenda would be as follows –

Barnet, Enfield, Haringey Clinical Strategy – Implementation
Referral Management
Clinical Commissioning Groups Financial Regime
Medicines Management
Acute Trusts Financial Health Check
Transition Programme Progress Update
UCLP Academic Health Science Networks
QIPP Update
Future Work Programme

8 BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY – IMPLEMENTATION (Item 5)

Siobhan Harrington BEH Clinical Strategy Programme Director NHS North Central London and Caroline Taylor, Chief Executive NHS North Central London were present at the meeting.

Siobhan Harrington outlined the report.

The JHOSC were informed that the proposals for the full business plans for developing the two hospital trusts would be considered by NHS London, and in the case of North Middlesex University Hospital, also by the Department of Health and the Treasury, and it was hoped that approval would be obtained by November 2013. This was an ambitious timescale and there was a need to link it in with primary and community care.

Siobhan Harrington added that there was CCG engagement in the 3 boroughs concerned and the future of Chase Farm and the transport issues in transferring services to Barnet General were being addressed.

In response to a question it was stated that £46.7 million was planned to be invested in primary care across the 5 boroughs over the next three years and it was intended to bring these proposals to the respective individual borough health scrutiny committees. Specific areas such

as the sharing of IT/premises were areas which would be looked at. There would be a need to ensure any changes are appropriately consulted on and residents were engaged over the coming months.

Reference was made to paragraph 1.11 in relation to walk in centres and Caroline Taylor stated that there were now 3 or 4 walk in centres in operation in the cluster at present.

The Chair referred to paragraph 4.2 of the report and the need to continue to require culture change.
Siobhan Harrington responded that there was a need to look at how services can be developed and were patient focused and to look at the needs of the local population.

Reference was made to the fact that there needed to be an improvement in services in Western Enfield and concern was expressed at the reduced hours for the walk in service at the Evergreen Centre. In addition it was stated that there was historical variation in spend in the different boroughs. Siobhan Harrington stated that the £46.7 million additional funding would be based on the number of practices in each borough.

Caroline Taylor referred to table 1 in the report and that whilst L.B.Camden and L.B.Islington had different levels of spend they were both producing consistently higher levels of performance than the other boroughs. There was a need to ensure that value for money was obtained and that this needed to be done in conjunction with Local Authorities, given that funding for public health would be transferring to Local Authorities from April 2013. It was important that the Clinical Commissioning Groups worked with Local Authorities.

Members were informed that it was still not yet clear how the public health funding allocation would be decided.

Caroline Taylor informed the JHOSC that there were proposals for changes in the opening hours of the walk in service at the Evergreen Centre, since as the centre first opened there had been a significant increase in primary care services and the patient surveys have indicated that there had been improvements in primary care. It had been recognised that there was a need for the centre to be open at weekends and at bank holidays and there had not been a large response to the consultation on the changes.

Councillor Camizoglu asked for her view to be recorded that if a consultation process is carried out then the results should be adhered to and the preferred option should have been pursued.

Although the results of the consultation had not been in favour of the closures and that it was rare to not comply with the results of a consultation, a “best value” decision had been taken to reduce opening hours; however an offer had been made to work with the Council with regard to this.

In response to a question in relation to difficulties that patients have experienced in getting GP appointments it was stated that practices were being contacted as to appointment availability and that mystery shopping of practices was proposed.

Councillor Pearce referred to the proposed changes to the Barndoc contract in Enfield and whether she could be provided with details of this.

RESOLVED:

(a) That Members be circulated with a note of how the formula has been developed in relation to the allocation of the £46.7 million primary care funding. **ACTION**

(b) That the publically available details of the procurement process for GP Out of Hours services in Barnet, Enfield and Haringey be supplied to Cllr Pearce.

The Chair thanked Siobhan Harrington and Caroline Taylor for attending.

9 REFERRALS MANAGEMENT (Item 6)

Dr.Henrietta Hughes, Acting Medical Director, NHS North Central London was present for discussion of this matter. She stated that referral management was about improving the quality of referrals that were made by GPs.

In response to a question it was stated that the 2 week cancer referral period was a maximum and often referrals were quicker than this.

Dr. Hughes stated that there was a useful website available to GP's in relation to referral management and that the website link could be made available to Members.

It was stated that L.B.Enfield had had referrals management in place since 2006, whereas L.B.Islington did not currently have this in place, although GP's were aware of pathways. Dr.Hughes stated that there were concerns that too many referrals were made to the acute sector and generally there should be more consistent criteria applied and GP's should be more aware of what local pathways were.

In response to a question as to the proportion of referrals that are being referred back and whether these had reduced Dr.Hughes stated that this depended on which stage boroughs had reached in the evolution of referral management. Reference was made to the fact that GP's were paid for high quality referrals and that the cost and impact of this should be provided to the Committee.

The Chair thanked Dr.Hughes for her presentation.

RESOLVED:

(a) That details of the website referred to above be circulated to Members of the Committee. **ACTION**

(b) That the cost and impact of referrals by GP's be referred the Boroughs' Scrutiny Committees for consideration as part of their future work plans. **ACTION**

10 MEDICINES MANAGEMENT (Item 7)

Dr.Henrietta Hughes, Acting Medical Director, NHS North Central London was present for discussion of this item and made a presentation to the Committee thereon.

Dr. Hughes referred to the fact that the Department of Health guidelines 2010 stipulated that the interests of UK patients should override all other considerations and that the 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.

In response to a question it was stated that Clinical Commissioning Groups (CCGs) would take over the medicines management that was currently carried out by PCTs and the local CCGs were considering ways in which they could work collaboratively.

Dr. Hughes referred to the 'flu vaccination programme for 2012/13 and that there were multiple manufacturers of the 'flu vaccine and GP practices purchased supplies as individuals or on block contracts. She added that two manufacturers were currently quoting 2 -4 weeks delay.

The Chair thanked Dr.Hughes for her presentation.

11 ACUTE TRUSTS – FUTURE FINANCIAL HEALTH CHECKS (Item 8)

A letter from Caroline Taylor, Chief Executive, NHS North Central London, dated 4 September 2012, was laid round.

The Chair stated that he was reassured that the contents of the letter appeared to indicate that there were no apparent problems with PFI initiatives in the North Central London region.

Councillor Rice expressed the view that there were problems at North Middlesex with the PFI and it was stated that there had been a recent report that had highlighted North Middlesex as one of 20 failing NHS Trusts as a result of the PFI initiatives.

Members also stated that they were sceptical about the information provided about Barnet and Chase Farm in relation to its financial situation.

RESOLVED:
That the website link in relation to the 20 failing Trusts referred to above, be forwarded to the Chair. **ACTION**

12 QIPP UPDATE (Item 9)

Nick Day, Head of Programme Office, NHS Central London was present for discussion of this item and made a presentation to the Committee thereon.

During discussion of the presentation the point was made that there needed to be an indication as to whether demand and referral management measures put in place are effective. Nick Day responded that NHS North Central London has an 'overlap' model in place to ensure that demand and referral management measures introduced are not "double-counted".

RESOLVED:
That a report be submitted to a future meeting of the JHOSC with regard to any referral/demand measures put in place to reduce demands on the commissioning budgets and whether these were effective.

13 CLINICAL COMMISSIONING GROUPS: FINANCIAL REGIME (Item 10)

Harry Turner Interim Finance Director, NHS North Central London, was present for discussion of this item and gave a verbal update to the Committee.

Harry Turner stated that the current financial position was that it was anticipated that as at month 4 NHS North Central London were projecting financial balance.

Existing budgets are being divided on the basis of future allocations to Clinical Commissioning Groups, Local Authorities. PropCo etc. and these will be used by the Department of Health to inform funding allocations for 2013/14. There were on-going discussions with Local Authorities and Clinical Commissioning Groups to understand and be sighted on these financial changes as they roll out.

In response to a question as to how financial balance would be possible given that 3 of the 5 PCT's were currently in deficit, Harry Turner stated that at present the PCTs were on track not to be in deficit, however if this situation were to change there were financial management escalation procedures that could be put in place together with stringent monitoring controls to manage this. He added that the more unknown factor was the allocation in future years given the proposed public spending restrictions and the changes to funding formulae and organisational structures noted above.

Councillor Winskill enquired whether if a PCT was in deficit whether this deficit would be transferred to the Clinical Commissioning Group and if CCGs were envisaged to be allocated the same funding that PCTs previously received. In addition he enquired how the funding formula would be allocated for the public health area and how Local Authorities can influence this.

Councillor Camizoglu expressed the view that given that the Enfield PCT deficit did not appear to have changed, she could not see how there would be no deficit by the year end.

Harry Turner responded that whilst it had not yet been tested, there were escalation processes in place and if in the second half of the year PCTs appeared to be heading for deficit, strict financial procedures would be put in place to address this. This could result in more central control of spending by NHS North Central London.

Harry Turner stated that he was aware that there had been significant lobbying by Local Authorities in relation to the allocation of public health funding. He noted that the Department of Health remained committed to determining funding allocations by December. Whilst it was known that public health funding was protected for 2013/14, the impact of the changes to funding allocations noted above, was not known over the next 5 year period. In the past the NHS has had growth funding year on year, whereas in future the economic situation may result in a different approach to the Pace of Change movement in resource allocation : in the past there has been a gradual levelling up of funding to Target, whereas now it is more likely that there will be levelling down as well as up. This is the more unknown risk factor referred to above.

The Chair thanked Harry Turner for attending.

14 UCLP: ACADEMIC HEALTH SCIENCE NETWORKS (ASHN) – EXPRESSION OF INTEREST (Item 11)

Dr. Amanda Begley, Director of Innovation and Implementation, UCL partners, was present for discussion of this item and outlined the report.

During discussion the following main points were raised –

- There had been a large transition in the services in the acute sector and there needed to be a focus on where this had worked well and this should be translated in relation to future provision
- There should be a focus on early diagnosis and a long term focus on reliance on the pharmaceutical industry
- In response to a question as to whether the effectiveness of the network would be diminished if the geographical spread of the work was too wide, it was stated that the areas chosen were ones where it was felt that there could be effective collaborative working. There would be a need to build up relationships, however UCL Partners felt that the proposed area could work and operate effectively
- The view was expressed that there were a number of residents in the area proposed for expansion that at present used hospital services in the NHS North Central London cluster
- Members of the JOSC stated that whilst they expressed support for the work of UCL Partners and expansion they were concerned that a too wide spread of resources could diminish the effectiveness of its services and the Chair should advise the Department of Health accordingly

The Chair thanked Dr.Begley for attending.

RESOLVED:
That, subject to the above mentioned comments, the bid by UCL partners be supported.

15 TRANSITION PROGRESS – UPDATE – SEPTEMBER 2012 (Item 12)

Patsy Ryan, Interim Director of Communications, NHS North Central London was present for discussion of this item, together with Laura Zymanczyk, CCG Development Workstream Lead, NHS North Central London.

Patsy Ryan outlined the report and the following points were raised –

- The Committee were of the view that the work that had been carried out by NHS North Central London during the transition had been excellent.
- It would be helpful if the terms of reference of the CCG Council could be shared with the Committee.
- Reference was made by Councillor Old to the latest position on the appointment of the

Director of Public Health in Barnet and Harrow.

RESOLVED:

(a) That Councillor Old is informed of the latest position with regard to the appointment of the Director of Public Health for Barnet and Harrow. **ACTION**

(b) That the terms of reference for the CCG Council be provided to the Committee. **ACTION**

16 FUTURE WORK PROGRAMME (Item 13)

The following additional items were agreed for future consideration –
Accident and Emergency waiting times, particularly at Barnet General
Mental Health new arrangements
Workforce Development progress
Demand and referral management
PropCo London Regional officer to be invited to a future meeting.

17 NEW ITEMS OF URGENT BUSINESS

None.

18 DATE AND VENUE OF NEXT MEETING

The next meeting would be held on 22 October in L.B.Camden.

FINISH

The meeting closed at 13:15 pm.

CHAIR:

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Agenda Item 6

NHS
North Central London

NHS NORTH CENTRAL LONDON	**BOROUGHS** BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL
PRESENTATION TITLE: Financial Management of Acute Contracts (Demand/ contract management)	
PRESENTATION OF: Simon Currie Interim Director of Contracts NHS North Central London	
FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**MEETING DATE:** **22nd October 2012**

EXECUTIVE SUMMARY OF PRESENTATION:

- ***This presentation describes the issues that are relevant to the management of acute contracts from a financial perspective.***
- ***The presentation provides background information on the acute contracting process including the basis of contract payments, and the annual and monthly contract cycle.***
- ***The presentation covers the factors that influence expenditure with acute trusts both from a supply perspective and a demand perspective, and the steps that commissioners take to mitigate the financial risk.***
- ***The demand side perspective covers those factors which are largely external to the trust, such as the referral thresholds and patterns of GPs, the quality of care provided by community based providers such as care homes, patient health factors and patient behaviours. The presentation describes the ways in which commissioners seek to influence demand side factors through focussing on the quality of community service provision, through health promotion (including vaccinations), avoiding acute exacerbations of chronic conditions and through patient education.***
- ***The supply side perspective covers those factors which an acute trust influences that impact on the level of commissioner expenditure. This includes activity carried out which could be avoided (such as cosmetic surgery), opening up additional capacity/services, and includes pricing factors. The presentation describes the ways in which commissioners seek to influence supply side factors, principally by using contract levers.***

Simon Currie
Interim Director of Contracts

10th October 2012

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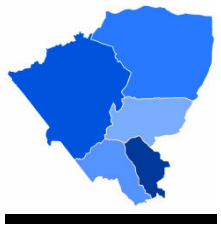
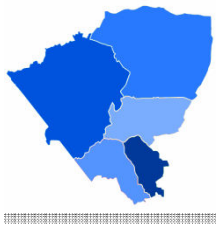


NHS
North Central London

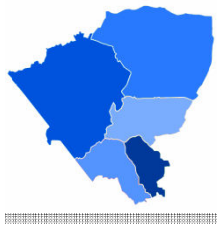
Financial Management of Acute Contracts (demand/ contract management)

Simon Currie
Interim Director of Contracts



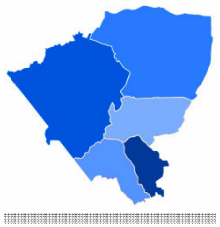
General introduction

- Acute contracts are largely ‘cost and volume contracts’, that is the commissioner takes the volume risk
- Volume drivers can be split into demand led (eg the number of A&E attendances) and supply led (eg the ratio of consultant to consultant referrals).
- The approach to managing the risk is different for the two types



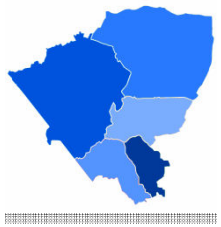
Open Access System

- The health system is largely an open access system – for example anyone can walk straight into A&E
- Demand for the system is difficult to predict, in part because demand is influenced significantly by supply
- Access is protected through eg NHS Constitution right to treatment within 18 weeks, and A&E 4 hour maximum wait



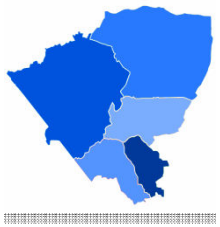
NCL Contract Position

- NCL currently commissions around £1.2bn of acute contract activity per annum
- Around £580m of this relates to ‘block’ or ‘cap and collar’ contracts which give a high degree of finance risk protection
- The remaining contracts have no such restrictions so represent a greater risk to commissioners



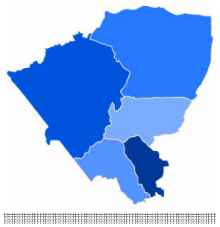
Payment by Results

- Acute expenditure calculated according to PbR framework - units of activity x price
- Rules-based system covered by national guidance, although some room for interpretation, and some flexibility
- National tariff set for around 70% of expenditure
- Local prices agreed for the remainder



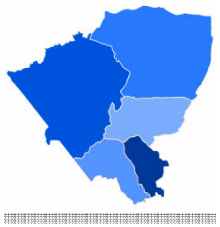
Annual Contract Cycle

- Contracts set annually with each provider
- Include an estimate of the likely volume of patients to be seen by each trust and how much will be paid based on treatment provided
- Also includes impact of contract levers to control spend, and impact of ‘demand management’ to control volumes



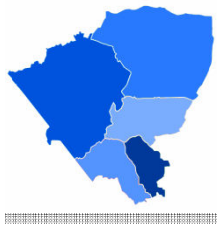
Monthly Contract Cycle

- Each month trusts submit a ‘bill’ to the commissioners
- Commissioners analyse and scrutinise the submission
- Routine rules based challenges are raised on common issues each month
- Additional contract queries are raised on other areas where charges appear incorrect



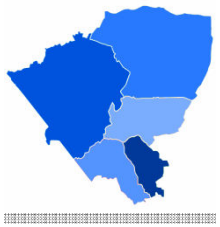
Supply driven volume

- Volume created by direct actions of trusts, such as high patient follow up rates, consultant to consultant referrals and ‘unnecessary’ admissions
- Volume created by indirect actions, such as opening a new clinic, reducing waiting times for surgery and keeping escalation beds open when not required



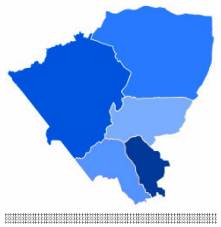
Contract levers

- KPI targets for ratios including first to follow up outpatients, daycase to outpatient procedures, and consultant to consultant referral ratios
- Price levers such as urgent care centres offering minor A&E type activity at reduced prices
- Controls over areas such cosmetic procedures and weight loss surgery



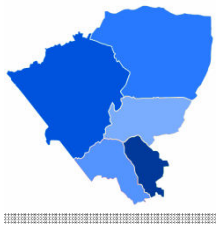
Demand driven volume

- Volumes driven by health factors such as poor care of the elderly, or acute episodes in people with long term chronic conditions
- Volumes driven by service provision such as ability to access a GP
- Volumes driven by behavioural factors such as a preference to choose A&E rather than visit a GP



Managing activity levels

- Tightly managing GP referrals for outpatient appointments
- Proactively supporting care homes to reduce emergency admissions
- Providing greater support to COPD patients to prevent admissions
- Falls management schemes to reduce the number of falls related admissions
- Patient education programmes



Future arrangements

- Acute commissioning largely falls to CCGs from 1st April 2013
- Contract management will be provided by the N&EL Commissioning Support Unit
- Expect that current levels of performance will be the baseline for the CSU
- Stephen Rubery – NCL Contracts Director
- Will Huxter – Director of Contracts & Quality

NHS North Central London

NHS NORTH CENTRAL LONDON	**BOROUGHS** BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL
PRESENTATION TITLE: QIPP/ Finance Update 2012-13	
PRESENTATION OF: Harry Turner Director of Finance North and East London Commissioning Support Unit	
FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**MEETING DATE:** **22 October 2012**

EXECUTIVE SUMMARY OF PRESENTATION:

- This presentation provides an update on QIPP progress, and on implementing schemes to assist in closing the remaining QIPP gap.
- At Month 05, the reported forecast year end control totals remained on target for all 5 PCTs. Achieving financial targets remains a significant challenge for Barnet, Enfield and Haringey PCTs in particular, and key to achieving this will be QIPP delivery.
- Of the QIPP schemes already in implementation, the forecast outturn for each QIPP category at the year end is RAG-rated Green in eight categories, Amber for five categories, and Red for six further categories, though this also includes the unidentified QIPP.
- The following five key schemes to help close the remaining QIPP gap have been identified and are in development:
    - Alcohol-related admissions (Cluster wide)
    - Pain management (Barnet, Enfield, Haringey)
    - Comprehensive Falls Service (Barnet, Enfield, Haringey)
    - Patient navigator (Barnet, Enfield, Haringey)
    - Review of elective procedures (Barnet, Enfield, Haringey)
- Further details of progress for each scheme can be found in the accompanying presentation.

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

DATE: 11 October 2012

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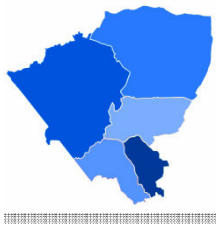


NHS
North Central London

NHS North Central London QIPP/ Finance Update 2012/13

Joint Health Overview and Scrutiny Committee

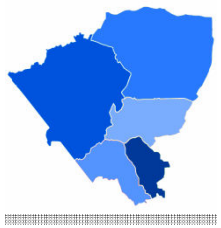
22 October 2012

Harry Turner

Director of Finance

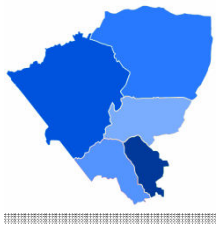
North and East London Commissioning Support Unit

www.ncl.nhs.uk



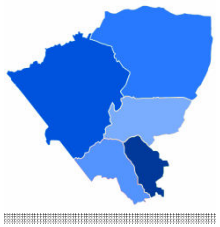
Outline

- **Month 05 Indications**
- **Closing the Gap**



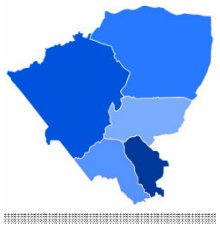
Month 05 Indications

- At Month 05, the reported forecast year end control totals remained on target for all 5 PCTs.
- Barnet, Enfield and Haringey all significantly reduced both year to date and forecast outturn expenditure at month 5. The year to date deficit reduced by £1.5m the majority of which was due to reduced acute spend.
- Achieving financial targets remains a significant challenge for Barnet, Enfield and Haringey PCTs in particular, and key to achieving this will be continued delivery of the QIPP plan in the remaining months of the year.
- Performance of individual QIPP categories is shown in the next slide



Month 05 Indications

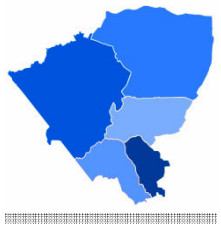
STRATEGIC PROGRAMME	SUB-PROGRAMME	RAG (Full Year Outturn)
Clinical & Cost Effectiveness	Acute Productivity	R
	Continuing Care	G
	Contract Management	G
	Medicines Management (Acute)	A
	Medicines Management (Primary Care)	G
	PoLCE	R
	Referral Management	A
Integeratd Care	Commissioning Approach	G
	Mental Health	G
	New Pathways of Care	R
	Older People	A
	Unscheduled Care	R
Prevention	Prevention	G
Primary Care	Primary Care	A
Other Clinical Priorities	Children & Young People	G
	Maternity	A
	Sexual Health Tariff	R
	Stroke Trauma & CVD	G
Unidentified QIPP	Unidentified QIPP	R



Closing the Gap

We are currently working to identify and implement further schemes – includes:

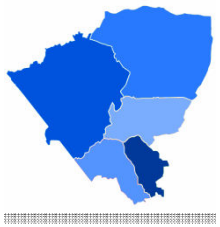
- Alcohol-related admissions (Cluster wide)
- Pain management (Barnet, Enfield, Haringey)
- Comprehensive Falls Service (Barnet, Enfield, Haringey)
- Patient navigator (Barnet, Enfield, Haringey)
- Review of elective procedures (Barnet, Enfield, Haringey)



Closing the Gap

Alcohol-related admissions (Cluster wide)

- Meetings to take stock of current arrangements completed in 4 boroughs
- Final discussion (Islington) arranged for w/c 22nd Oct 12.
- From discussions held so far, all boroughs actively looking to develop their alcohol activities with both acute providers and in community services.
- It is also evident that some cross borough information sharing would be beneficial to share best practice.



Closing the Gap

Pain management (Barnet, Enfield, Haringey)

Enfield (next steps)

- 5th Oct 12 – Acute Trusts draft service delivery model ready for discussion
- 12th Oct 12 – Acute Trusts meet and agree joint service delivery model
- 18th Oct 12 – Submit final service delivery model to NCL Project lead

Barnet

- Business case is being drafted. Scheme impact likely to be predominantly in 2013/14. Agreed that scheme will build on existing MSK provision, and explore overlaps with specialities such as rheumatology / orthopaedics.

Haringey

- Agreed to build on existing MSK provision and explore overlaps with other specialities such as rheumatology / orthopaedics.
- Service costing delayed slightly – awaiting Acute Trust finance information
- Next implementation steps being finalised - includes GP education programme.

Closing the Gap

Comprehensive Falls Service (Barnet, Enfield, Haringey)

Enfield:

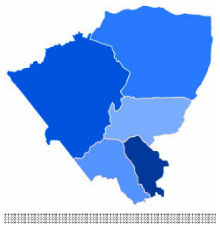
- Follow up Falls Model workshop complete. Stakeholders agreed the new model for service and early identification of people susceptible to falls. Next meeting (Nov 12) will finalise the model, build business plan assumptions, and commence cost benefit analysis.
- Dec 12 - finalise the business model and agree commissioning / procurement decisions with key senior stakeholders.

Barnet:

Stakeholder workshop in September identified key areas

- Early identification of patients susceptible to falls.
- A unified, comprehensive falls service, seamless pathway with single point of access. Strengthening prevention and innovative community services.
- Care homes, managing dementia, and people with learning disabilities.

Task and finish groups in Oct / Nov 12 to work up detail of new Falls system model - commence business plan development in Dec 12.

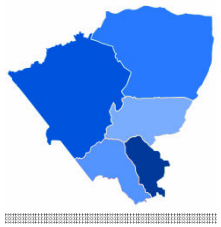


Closing the Gap

Comprehensive Falls Service (Barnet, Enfield, Haringey)

Haringey:

- Multi-stakeholder workshop held on 25th Sep 12.
- Two task and finish groups formed, aligned to priority areas identified by stakeholders, to work in October.
- Access: early identification of people at risk of falls, and may benefit from therapy, medical intervention or environmental risk reduction.
- Service: aligning current services, aiming for a comprehensive Falls service single point of access.
- Final workshop in Nov 12.

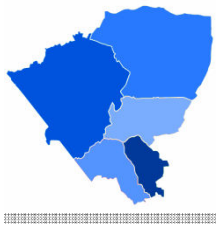


Closing the Gap

Patient navigator

- Barnet, Enfield and Haringey are pursuing this potential opportunity and are continuing the preparation of their PIDs.

- Enfield are leading this initiative and are coordinating meetings with North Middlesex University Hospital, and Barnet & Chase Farm Hospital, on behalf of Barnet, Enfield and Haringey.



Closing the Gap

Review of elective procedures (Barnet, Enfield, Haringey)

- Comprehensive data analysis review of planned elective care activity, to identify immediate QIPP opportunities and also longer term opportunities. Benchmarking indicates possible savings if activity could be aligned to SHA and National levels.
- Presentation of key findings to Barnet and Haringey CCGs and smaller GP working groups mid / late Oct 12. Following which action plans will be drawn up.
- Joint NCL Barnet and Chase Farm and North Middlesex University Hospital QIPP/CIP Boards are a possible 'vehicle' to deliver opportunities identified.

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North Central London

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

REPORT TITLE: Achieving an education model integrated with CAMHS provision – update on education arrangements at Northgate PRU

REPORT OF:

Kate Kennally Director Adults' Social Services and Interim Director Children' Services Barnet

FOR SUBMISSION TO:	**MEETING DATE:**
North Central London Joint Health Overview & Scrutiny Committee	22nd October 2012

EXECUTIVE SUMMARY OF REPORT:

Introduction and Background

JOHSC has requested an update on education arrangements at Northgate PRU, and the education arrangements for young people accessing CAMHS generally, with particular regard to the effect of transformation of CAMHS services across Barnet, Enfield and Haringey. There are other relevant contextual changes including national developments for raising the participation age, SEN and Alternative Provision.

Key messages

The cessation of the tier 3 clinic at Northgate has impacted on usage of Northgate PRU in the short term as anticipated. The expansion of the onsite tier 4 clinical unit is not complete. The funding risk to Barnet in the current financial year from potential loss of recoupment from other authorities requires consideration.

Going forward the placement, provision and funding options for Northgate PRU need to be considered collaboratively in order to stabilise, maintain and fully utilise the facility.

CONTACT OFFICER:

Dr. Brian Davis
Principal Educational Psychologist/Head Complex Needs Barnet
NHS North Central London

RECOMMENDATIONS: The Committee is asked to note the contents of the report and the current identified options for moving forward collaboratively to maintain appropriate integrated arrangements for the delivery of CAMH/education services.

Attachments include: No attachments

Kate Kennally
Director for Adult Social Care and Interim Director for Children's Services Barnet

Achieving an education model integrated with CAMHS provision – update on education arrangements generally and at Northgate PRU

Introduction

This report is provided at the request of JOHSC and Barnet Children's Services Senior Leadership Team. The committee seeks an update on the Northgate PRU and the CAMHS clinic arrangements, but with a particular focus on education for young people who may be required to access CAMHS services as there was concern this may be destabilised by CAMH service changes.

A report was previously provided in July 2012. This report as with the previous report, is drafted by Barnet Childen's Services and compiled following discussions with SEN representatives from Haringey and Enfield, CAMHS and health commissioners and the head teacher of the PRU. The previous report indicated that Haringey were minded to support in principal the establishment of a block of education places at Northgate PRU for Haringey access and that Enfield were keeping the need for future placements under review.

At the Edgware Hospital site, the Northgate clinic, now not operational, previously focused on CAMS tier 3 intervention and young people were provided with education from the PRU.

The tier 4 clinical unit of New Beginnings at Edgware Hospital, continues to operate at the site with 12/13 beds, with planned expansion to 15-18. The community intervention model for tier 3 is being phased in for delivery in all three boroughs.

Moving forward, the expanded New Beginnings tier 4 clinic places (approximately 15 – 18 at any one time) are in effect to be block commissioned (by the three health areas working in collaboration).

Notionally this could then be regarded as five to six open places for each of the three boroughs (Barnet, Enfield and Haringey) although accurate apportionment would affect this slightly; in practice actual numbers from each authority placed will vary according to immediate need. Other authorities might seek both clinical and educational placements.

There is an attempt to provide an integrated education/mental health provision model both in the community support and intervention approach based in children's localities and in the Northgate tier 4 clinic/PRU based facilities. However this creates a challenge in providing a spectrum of highly personalised arrangements which suit the treatment and educational needs of the young people and partnerships with host mainstream schools and colleges.

The young people placed at a clinic such as New Beginnings will require clinic based intervention for various periods. Their disengagement from school-based education will also vary from partial to complete, being on or off roll of a mainstream school, providing various challenges for the provision of education ranging from wholly on site to support to gain access to mainstream school or college eventually. In practice education and CAMHS providers have had to try and work flexibly with the child's immediate needs at the centre in collaboration with host schools in home authorities

where possible. Rarely does the child's educational provision need after initial intervention exactly match their need for clinic intervention and the time scales for continued access may be different; for example they may finish clinic but continue to be engaged in their education at the PRU.

Young people provided for may be extremely vulnerable, for example at risk of self harm.

Key Issues

Loss of the Northgate clinic has inevitably in the short term led to less on site education placements at the Northgate PRU linked to CAMHS interventions. However from September this year, the New Beginnings clinic places continue to appear slightly over subscribed (currently approximately 13) and these young people will require access to educational services within the current financial year. It is reported from Northgate that 13 (16) are currently accessing the clinic and requiring education support (3 recently discharged, Barnet 8, Haringey 5, Enfield 3). The PRU could cater for 28.

As previously identified, in the current financial year, as a result of reduced placements Barnet has identified at risk recoupment income as a result of reduced use of the PRU by Enfield and Haringey and in part by other authorities. This is hard to judge but is estimated at around £114k in total mainly to be split between these two authorities. Barnet's understanding is that the cost of the service to a child should be split cross authorities according to the cost of the overall service for the full year, proportionately according to use, so other authorities should expect a request for funds to help spread the cost for this financial year.

Education (Northgate)

Northgate provides highly personalised and flexible broad based secondary phase education arrangements for boys and girls aged from 11 to 19, not able to fully access their mainstream school for psychological reasons. This can be provided either solely through on site attendance or in combination through negotiated plans with other services and schools. Wherever possible joint work with a school or college will be central to implementation of an education plan either immediately on placement or after a period of support and transition.

From September 2011 admission to the PRU has not been based solely on placement at the clinics but in agreement from the placing borough and the Barnet Complex Needs Panels. This introduces greater flexibility and potential for personalisation, manages risk and improves accountability and monitoring. The nature of the placement and provision is variable according to need and may not need to be solely linked to mental health intervention.

Northgate has been judged as outstanding by OfSTED. It is further under the national spotlight as it has been selected by the Teaching Agency to be the only pupil referral unit in London to be an early implementer in 'teacher training for behaviour' working with Charlie Taylor (architect of the Taylor report on alternative provision). Our provider will be Goldsmiths University.

Northgate School trained staff will be delivering training modules and behaviour workshops. In addition staff will also be observing and training teachers in other main stream settings if they are struggling with managing behaviour.

Over the summer the Teaching Institute encouraged Northgate to become a teaching school. The application process was lengthy and detailed. The application was completed and we are awaiting a response. Requests from schools and academies in other boroughs for assistance have started to emerge. A training intern programme is also in place.

Education (National)

Our schools and settings will be impacted by the proposals for the raising of the participation age in education to age 18 creating place pressures across the board but in particular for young people with social emotional and behavioural difficulties. This comes into place in 2015. There is a shortage of places for young people with SEBD across North London and independent out of borough CAMHS/Education placements can be expensive.

The draft SEN legislation is a recent publication requiring the Children's Services and Health offer on SEN to be clear by 2014. This will include our arrangements for CAMHS services. The Taylor review of Alternative provision including PRUS (on providing extended and personalised education with the possibility of shared and commissioned provision with mainstream schools and academies) is relevant as are the new proposals for a revised funding model for both SEN and alternative provision (to be in place for 2013/14).

Review of new Funding Models

Placing boroughs and in any case Barnet, Enfield and Haringey, should expect to make a financial contribution to the running of the PRU in 2012/13 under existing financial arrangements.

The new funding model for 2013/14 ceases inter authority recoupment and suggests a maintained PRU will need to agree how many places it will maintain and for what purposes with their local authority, in this case Barnet and the Education Funding Agency and the DfE. PRUs will recoup any agreed "top up" funding from placing authorities.

For 2013/14 Barnet proposes to implement the guidance on school funding reform and preparatory work for this is underway. Options for identifying and drawing down funding and full implications of these different options are still sketchy but all boroughs have worked hard to try and establish their place requirements and how they should be classified for SEN and alternative provision going forward.

Northgate can service 28 places in total. 15- 18 places would need to be dedicated to young people placed at CAMHS tier 4 to match the clinical placement requirement.

There are two main options which currently appear possible.

Place plus option – each PRU directly receives £8k per place against a place number agreed with the home authority. Each placing authority or school with a child provides

the rest of the cost of the place as “top up”. This could mean that viability funding (the recoupment gap) for Northgate given any shortfall on placements remains largely with Barnet or underfunding leads to destabilisation. Alternatively Barnet, Enfield and Haringey could agree to fund at the required level through appropriate top up arrangements, spreading the cost of any unfilled places.

Hospital provision option – as this is currently understood, the funding for places is provided by National top slicing and the places are thereafter available to any placing authorities. However we will need to continue to discuss the feasibility of this approach with the DfE.

In addition to the above main options the PRU can still provide services which can be charged for where appropriate.

There is concern at the DfE and in Barnet that the funding changes immediately and in the future, in line with a new model, must in the short term allow for continuity and stability. The DfE view is that the outcome should be “business as usual”.

In Northgate’s case it seems prudent to identify for 13/14, 18 places as hospital provision for an integrated mental health intervention/education provision and 10 places for “place plus” funding, providing a different kind of placement experience, not closely linked to CAMHS tier 4, open to placing authorities and schools.

In response to the request to be kept informed of developments, the JOHSC is asked to note the following with a view to taking a cross borough collaborative approach.

Summary of key points

Northgate PRU is currently underutilised partially as a result of CAMH service changes. Base funding is provided by Barnet DSG and the financial liability for any shortfall in funds lost from recoupment for 2012/13 should be spread by agreement across Barnet Enfield and Haringey.

There will be an increasing demand in relation to raising of the participation age, increases in population numbers and young people with social emotional and behavioural difficulties and the expansion of tier 4 New Beginnings. Increased demand could also come from flexible arrangements with host schools to support inclusion and reintegration and prevent exclusion. The Taylor review demands full time education for those young people able to access it. There is a need in any case to fully utilise the 28 places available as the EFA or DfE may question continuation of this capacity.

A mixed model for funding (including place plus and hospital provision) is being proposed for Northgate PRU 2013/14 to maintain stability for integrated services, increase flexibility to support personalisation and increase use of the facility. A dialogue is currently in place with the DfE over the required place numbers and funding arrangements. Barnet, Enfield and Haringey Children’s services will need to collaborate in this discussion and agree the preferred position together. Dialogue will take place with Barnet and other borough schools to increase the role of Northgate in the delivery of services.

If residents of your boroughs have any questions about this paper or would like to receive further information or information in another format, please contact: Dr Brian Davis - brian.davis@barnet.gov.uk

Agenda Item 9

NHS
North Central London

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

REPORT TITLE: Transition Programme Progress Update – October 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	22 October 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 have now commenced the final phase of Transition, as outlined in David Nicholson's letter to Cluster Chief Executives in August 2012. As this phase progresses, we will see an increasing shift from the current system to the new, with the new 'receiving' organisations leading in delivery for 2012-13 and planning for 2013-14. This approach is reflected in new governance arrangements which have now been implemented across the country, ensuring new organisations such as the NHS Commissioning Board can provide assurance of in-year delivery.

The purpose of this report is to articulate the changes to the healthcare system relevant to this final phase of transition, including the launch of some of the key 'receiving' organisations, the introduction of new governance arrangements and the implications for NHS North Central London.

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 following emerging 'receiving' organisations within the new system:

- NHS Commissioning Board (NHS CB)
- NHS Trust Development Authority (NTDA)
- Public Health transition
- Clinical Commissioning Groups (CCGs)
- North and East London Commissioning Support Unit (NEL CSU)
- NHS Property Services ('Prop Co.')

Attachments: No attachments.

Alison Pointu
Director of Quality and Safety and Executive Lead for Transition

Date submitted: Wednesday 10 October 2012

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NHS NORTH CENTRAL LONDON TRANSITION PROGRAMME PROGRESS UPDATE

Introduction

The 01 October 2012 heralded a 'shift' within the way the healthcare system is organised, with the launch of a number of new organisations that will manage and commission healthcare services in the future.

Organisations that had been operating in shadow form until October launched earlier this month and are rapidly mobilising to ensure they are able to take on much of the delivery agenda for 2012-13. These organisations will also take the lead in planning and preparing for 2013-14.

To enable a smooth transition to the new system, an Interim Operating Model (IOM) has been put in place to minimise disruption and avoid confusion for staff by building new working relationships across the system. This will aid in embedding the new organisations but there will be no formal transfer of statutory functions, accountability, budgets or employment of staff ahead of April 2013.

What does the 'shift' mean for NHS North Central London?

The PCT cluster will remain accountable for delivery until April 2013 and will therefore seek assurance from the new organisations until that time.

To ensure the safety and stability of the overall system, new organisations will not take on functions and staff until they are ready to do so, therefore it is likely that this migration will be staggered over the coming months to ensure they can simultaneously establish teams to deliver these functions. To enable consistent migration of functions, the PCT cluster has developed handover plans, to be shared with and agreed by the relevant receiving organisation(s) at the appropriate time.

During the final transition period there will remain a core cluster team supporting the delivery of statutory PCT functions including quality and safety, finance and contracting. The team will also support local governance arrangements until 31 March 2013. The Transition and Legacy, Handover and Closedown Programmes will continue to enable the smooth transition of functions and staff to the new receiving organisations.

Governance and accountability mechanisms will need to be clear in relation to which decisions can be taken by which organisation. Pan-London governance arrangements have been refreshed to reflect changing lines of assurance in the system during this final phase of transition, including the establishment of new Committees to focus on sending activity and receiving activity.

Cluster governance arrangements are being refined to mirror this approach locally, providing clear routes for escalation and streamlined reporting. Local progress on transition will be reported to the Core Cluster Executive Team and Cluster Wider Leadership Team (WLT), as well as being escalated to the proposed Transition and Closure Committee and existing Joint PCT Boards. Existing Committee terms of reference will be updated to reflect a greater role in assuring the local system. The Local Delivery Director for the NHS Commissioning Board will become a non-voting member of the Joint PCT Boards, as an integral mechanism for assuring both the sending and receiving systems.

NHS Commissioning Board (NHS CB)

Until 1 October 2012, the NHS Commissioning Board Authority had been operating in shadow form as a Special Health Authority. On 1 October 2012 the NHS Commissioning Board became an independent body at arms' length from government. Over the coming months the

NHS CB will continue and build on existing work. A key responsibility which the NHS CB will be involved with is the authorisation of clinical commissioning groups (CCGs).

Regional Director of the NHS Commissioning Board London, Anne Rainsberry, has been working closely with her senior leadership team to design the London regional organisation structures in readiness for taking on full functionality. These emerging structures were shared in September, and recruitment is now underway to ensure teams are in place. In August and September Anne Rainsberry and Director of NHS Operations and Delivery (London region), Simon Weldon, have visited NHS North Central London to discuss the work of the Commissioning Board and elements of the structures.

Going forward during the final phase of transition, the NHS Commissioning Board London will assure the new and existing systems for in-year delivery, through a complex set of governance arrangements designed to ensure the healthcare system remains safe as the new system begins to take on greater responsibility.

More information about the NHS Commissioning Board can be found on their website at //www.commissioningboard.nhs.uk.

NHS Trust Development Authority (NTDA)

The NHS Trust Development Authority (NTDA) launched on 1 October 2012 and aims to provide leadership and support tothe remaining 103 NHS (non-Foundation) Trusts to deliver high quality, sustainable services in the communities they serve.

Services provided by Trusts vary from hospital-based to community-based services, ambulance services and mental health services, and the NTDA will play a key role in ensuring the quality of these services is consistent across the country. This is the first time a dedicated organisation of this nature has been created.

Chief Executive of the NTDA, David Flory, is working closely with his senior leadership team to complete recruitment to remaining posts within the organisation's structure. A relatively small NHS organisation, the NTDA will have approximately 230 members of staff. Delivery and Development Directors will lead on the relationships with NHS Trusts around the country, covering a portfolio of Trusts that may not be limited to a single geography. Alwen Williams, currently Chief Executive of NHS North East London and the City, is leading this work for London.

The central office of the NTDA is in London, with further offices in Taunton, Manchester and Leeds.

The website of the NHS Trust Development Authority can be found here: http://www.ntda.nhs.uk.

Public Health

Local planning across North Central London continues to be dependent upon the timely receipt of national guidance – specifically in relation to 'Shift' phase guidance for the novation of contracts and the financial allocations for Public Health. The pace of development of new organisations such as NHSCB and Public Health England (PHE) poses questions for how functions such as emergency planning, infection control and screening and immunisation will be managed in the future.

NHS North Central London 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 public health team is working with its local authority and the NCL cluster teams to establish a register of the current public health contracts and commissioning arrangements. They are also reviewing and agreeing preferred options for transferring these contracts from NHS NCL to the local authorities. The Department of Health (DH) has made additional transition funding available to each council to support the transition process.

A joint Director of Public Health has been appointed for Barnet and Harrow, and staff engagement on the new staff structure began in early October. Camden and Islington are in the process of advertising for a joint Director of Public Health, and have made interim arrangements until the appointment is made. On-going staff engagement in both areas has been prioritised to provide reassurance and support.

Haringey have confirmed that they will operate as a standalone Directorate of Public Health within the council. Enfield have committed to sharing their proposed staffing structure with NHS North Central London by 19th October.

Commissioning Support Units (CSUs)

Nationally, the NHS Commissioning Board and NHS Business Services Authority (NHS BSA) have agreed that the NHS BSA will provide an employment partnership service for commissioning support unit (CSU) staff during the hosting period up to 2016. This means the NHS CB will provide oversight and direction to CSUs, while the NHS BSA will be the legal employer of CSU staff. The aim of this approach is to ensure relative independence for CSUs as they take the journey to externalization.

An extensive piece of work is now underway by the NHS Commissioning Board which will enable the externalisation of CSUs by 2016. Formal decisions or announcements will not be made until the NHS CB have developed the strategic policy approach, however stakeholders will be engaged in the development of the work as it progresses over the coming months. The NHS CB is encouraging and working with CSUs to start to explore and develop partnership agreements, while ensuring CSUs are compliant with the legislative framework. Following Checkpoint 3, CSUs will start to be granted greater autonomy, and the NHS CB will begin to adopt a risk-based approach to assurance (known as the 'licence to operate'). A 'balanced scorecard' approach will be trialed from November, providing a route for CSUs to report progress across four assurance domains (customer, business, delivery, and staff) on a monthly basis to the NHS CB.

The NHS CB is currently carrying out a review and risk assessment of CSUs full business plans in order to provide further feedback on their development. Locally, the North and East London Commissioning Support Unit (NEL CSU) successfully submitted its Full Business Plan in August and has received informal feedback to inform further development. Checkpoint 4 in November will involve a review and assessment of CSUs' financial risk.

Final senior appointments are underway to the NEL CSU, and matching continues with staff across North Central London and North East London clusters.

The NEL CSU participated in the recent 'Learning by Doing' event held in early October, where scenarios outlining the future relationships between CCGs, CSU's and the NHS CB were simulated.

Clinical Commissioning Groups (CCGs)

As outlined in the previous report, Islington CCG successfully submitted its authorisation application in July as part of the first wave of CCGs seeking authorisation. A mock site visit by the NHS Commissioning Board provided a number of lessons learned which have now been shared with CCG colleagues more widely to benefit wider authorisation experience. Formal

feedback on wave one CCG site visits, including Islington CCG is expected later in October. The site visit itself took place in September, with positive feedback received.

Authorisation applications were successfully submitted for Barnet, Camden and Haringey CCGs in early October as part of the wave three application process. A successful mock site visit was held with Camden CCG earlier this month, and further mock site visits are planned shortly for Haringey CCG and Barnet CCG.

Enfield CCG secured confirmation of delegation of all remaining eligible budgets earlier this month, and is now undertaking preparations for submission of their authorisation application documents on 1 November as part of wave four.

As previously reported, 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. Chairs and Chief Officers are in place for all five CCGs.

New contractual arrangements are being developed between the CSU and CCGs in the form of Service Level Agreements. These are now in place for two of the five CCGs across North Central London, with discussions underway to finalise the remaining three agreements.

A 'Learning by Doing' event was held on 5 October, simulating how CCGs across North Central and East London would interact with the NHS Commissioning Board and Commissioning Support Service. Feedback indicates it was a valuable experience, with key lessons emerging which will feed into a report to be released in early November.

NHS Property Services Limited

Under the Health and Social Care Act, PCTs will be abolished from April 2013. At this point, all PCT-owned estate will need to be transferred to new owners. Some of the PCTs' estate will transfer to provider NHS trusts (including Foundation Trusts).

The intention to establish NHS Property Services Ltd (or 'PropCo') was announced by former Secretary of State Andrew Lansley in January 2012 as a government-owned limited company to take ownership and manage that part of the PCT estate not transferring to NHS providers.

Properties will include some operational estate, estate with multiple occupiers, office and administration spaces, and surplus estate. Existing contractual arrangements with service providers that deliver and maintain NHS properties will remain in place to support the needs of these properties.

The transfer of property will also include transfer of the associated estates staff and termination or novation of the relevant property service contracts. The staff, contracts and PCT-owned estate for NHS North Central London are currently being mapped by the cluster's estates department to determine precise numbers and the appropriate transfer strategy.

NHS Property Services has appointed to its Management Team and four Regional Directors who will oversee regional areas coterminous with the NHS Commissioning Boards four sub-national areas. Regional Directors will provide leadership, co-ordination and manage business development. Tony Griffiths will be responsible for the London estate portfolio on behalf of NHS Property Services Limited.

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

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

22 October 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 is scheduled to take place on 3 December in Haringey, are currently as follows:

- BEH Clinical Strategy – A&E Modelling
- Maternity Services
- QIPP/Finance – Update

1.3 There are currently no further dates scheduled for meetings.

Transition Seminar

1.4 In addition to the above-mentioned regular meeting, a seminar on transition and the shifts in responsibilities and accountability from the current structure to the new has been arranged to take place on 28 November between 1:00 p.m. and 4:00 p.m. Further details will be circulated in due course. This was originally planned to take place at the Laycock Centre in Islington but this is not free for the times in question. It is therefore proposed that it instead takes place at Haringey Civic Centre, which is available and has been provisionally booked.

1.5 Amongst the issues that will be considered at the seminar is the future of the JHOSC and whether there is likely to be a continuing need for it.

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