NOTICE OF MEETING

NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

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Thursday 17 January 2013 10:00 a.m.
Barnet Town Hall, the Burroughs, Hendon, London NW4 2ER

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 22 October 2012 (attached).

5. BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY (PAGES 11 - 12)

To consider an update on the implementation of the Barnet, Enfield and Haringey (BEH) Clinical Strategy.

6. BARNET AND CHASE FARM HOSPITALS

To receive an update from the interim Chief Executive of Barnet and Chase Farm Hospitals on the future development of the Trust.

7. UROLOGICAL CANCER SURGICAL SERVICES IN LONDON (PAGES 13 - 14)

To consider proposals to reconfigure urological cancer surgical services.

8. OUT OF HOURS SERVICES

To consider issues relating to the operation of the out of hours contract for Camden, Haringey and Islington.

9. PRIMARY CARE FUNDING ALLOCATIONS (PAGES 15 - 16)

To consider the primary care funding allocations for CCGs across the north central London area.

10. TRANSITION PROGRAMME PROGRESS UPDATE (PAGES 17 - 22)

To update the Committee on progress with the transition process.

11. FUTURE OPERATION OF THE JHOSC (PAGES 23 - 28)

To consider the future operation of the JHOSC.

12. FUTURE WORK PLAN (PAGES 29 - 30)

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

11 January 2013

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

22 October 2012

Minutes of the meeting of the Joint Health Scrutiny Committee held in Committee Room 1, Camden Town Hall, Judd Street on 22 October 2012.

Present: **Councillors:** Cllr Martin Klute (Chairman)

Cllrs Alison Cornelius, Barry Rawlings (LB Barnet), John Bryant (L B Camden), Alev Cazimoglu (L B Enfield, Anne-Marie Pearce (L B Enfield), Alice Perry (L B Islington), Peter Brayshaw (L B Camden), and Dave Winskill (Vice-Chairman) (L B Haringey)

Officers: Rob Mack (L B Haringey) Shama Sutar-Smith (L B Camden), Zoe Crane (L B Islington) and Lesley Blue (L B Camden)

1. WELCOME AND APOLOGIES FOR ABSENCE

The Chairman, Cllr Klute, welcomed the attendees to the meeting. There was an apology for absence from Cllr Graham Old (L B Barnet).

2. DECLARATIONS OF INTEREST

Councillor Peter Brayshaw declared that he was a governor at UCLH but did not consider it to be prejudicial in respect of items on the agenda. 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.

3. URGENT BUSINESS

There was none.

4. CHAIR'S REPORTS

The Chair reported that the ownership of the St. Pancras Hospital site would betransferred to Camden and Islington Foundation Trust in a recent decision by the new organisation, NHS Property Services.

Clarification of charging regime and regional tariffs:

The Chair had been in discussion with Islington CCG about work they were doing around charges; one hospital had been charging £160 for a blood test, but the actual cost was £5/10, so prices had been negotiated. 'In Health' a private company, had been brought in and reduced the waiting list for scans from 14 weeks to 2 weeks, this

was an example of good use of private providers. However, it was noted that there was a risk of 'loss leader' bids, where large private companies were involved in bidding for contracts, and it was important to prevent these bids from shutting NHS down.

The Committee noted that the Health and Social Care Act 2012 gave health scrutiny committees the ability to scrutinise NHS services delivered by the private sector.

At the last meeting the Chair had agreed to write, on behalf of the Committee, to express concern in respect of increasing the geographical areas of the UCL partners academic health science network. However, he had since met with Dr Fish from UCL, who had explained why a wider geographical area followed patient flows and funding for their work. He outlined discussions with Dr Fish on his current work in this area and reported on the ideas for collaboration which were being identified through this work and focussed on the following areas:

- Experience and survival of cancer
- Cardiovascular disease – early detection
- Mental Health – early detection and treatment
- Greater interaction with schools
- Improved management of Long Term Conditions

The Committee were reassured by the outcomes of this work and requested that a report on progress of the above five themes be presented to a future meeting of the Joint Committee, in approximately six months. However, they still had some concerns about the size of the areas and suggested that Dr Fish be asked to consider subsets within that area.

It was agreed that the next meeting of the joint Committee due to be held in December be cancelled, as the Transition Workshop was to take place on 28 November 2012.

The Committee noted that Ruth Carnell, Chief Executive of NHS London, had been quoted in some media coverage as commenting about elected representatives and their views on NHS reconfigurationsat a King's Fund event. Concerns were raised about the content of these comments and it was agreed that a response would be drafted on behalf of the Committee to them. It was nevertheless acknowledged that full details of the comments in question were not yet available. It was agreed that a link to any documentation of the comment be circulated.

AGREED:

1. That, in the light of the forthcoming JHOSC seminar on 28 November, the meeting of the Committee scheduled for 3 December be cancelled;

2. That a letter be sent on behalf of the Committee to the Chief Executive of NHS London expressing concern at comments reportedly made by her at a recent Kings Fund event, subject to confirmation of their substance through relevant documentation.

5. MINUTES

RESOLVED:-

That subject to the following amendments, the minutes of the meeting of the Committee held on 10 September 2012 be confirmed and the Chair be authorised to sign them:-

- Minute 8 – page 4 – should read November 2012 and not 2013.
- Transport Assessment should read Barnet and Chase Farm Hospital, not Barnet Council Planning Department.
- Minute 6 – page 4 – first sentence to conclude 'achieved by 29 August as envisaged by the hospital'.
- Minute 15 – UCLP discussion – South Herts and Hertfordshire should be mentioned.
- Minute 11 – in respect of the resolution, it was reported that a list of failing Trusts was not published in 2011/12 and the DH did not hold one, this list had been compiled by the press. The North Middlesex had six years of surplus including the first year of their PFI payments, NHS NCL had confirmed their financial viability to the committee in a letter from the ChiefExecutive to the committee Chair

6. NHS PROPERTY SERVICES

Tony Griffiths, Regional Director (London) for NHS Property Services was in attendance during consideration of this item to provide an outline of issues relating to estates. The implementation of a revised approach was reported to members, including the proposed operations, structure and governance arrangements with an implementation date of 1 April 2013. The governance arrangements were proposed as a Chair and 6 Non-Executive Directors, with 3,000 staff nationwide, but with a local area team with local focus and this would involve approximately 3,500 – 3,600 properties with an estimated running cost of £1billion.

There were four key areas of concern that the Regional Director clarified to members, as follows:-

- Existing tenants would be protected due to existing leases
- Discussion was ongoing in respect of a guarantee regarding local investment of disposal receipts
- Rents were protected by existing leases and therefore there would be no increases at this stage
- No decision had been made in respect of using Lift

It was also confirmed that planned disposals were to proceed but it was not possible to confirm how the money would be re-invested at this stage. It was reported that there were no PFI deals in this area. It was explained that the Lift contract was partly owned by private and Community Health Partnerships and PCTs and therefore the

NHS has an interest in the commercial running of the company, which was not the case in a PFI arrangement.

In respect of running costs, each site was treated individually with the rent of each property being either market value as determined by the District Valuer or based on actual costs for running costs; it was re-iterated that tenants were protected due to their leases and the lease terms were intended to clarify the rent methodology.

It was confirmed that the Non-Executive Directors would not be working full time but that the people appointed would have appropriate skills and knowledge. No details of salaries were available at the time of the meeting.

A discussion was held in relation to the terms and conditions of staff and in respect of proposed changes from 1 April 2013. The Regional Director confirmed that it was intended to be a 'lift and shift' approach for existing staff to remain on the same terms and conditions including remaining in the NHS pension scheme. It was noted that comparable terms and conditions for the future were being considered and the arrangements for new employees was still being investigated.

In response to members' questions, it was confirmed that the auditing of the company accounts would be undertaken by an Independent Auditor and the Accounts would be available to the public via Companies House.

7. FINANCIAL MANAGEMENT OF ACUTE CONTRACTS (DEMAND /CONTRACT MANAGEMENT)

Simon Currie, Interim Director of Contracts outlined a presentation to the Committee which described the issues relevant to the management of acute contracts from a financial perspective. Background information was provided on the acute contracting process, including the basis of contract payments, and the annual and monthly contracting cycle.The factors that influenced expenditure with acute trusts, both from a supply perspective and a demand perspective, were reported and the steps that commissioners take to mitigate the financial risk.

8. QIPP / FINANCE UPDATE

Harry Turner, Director of Finance for North and East London Commissioning Support Unit presented to members an update on QIPP progress, and on implementing schemes to assist in closing the remaining QIPP gap.

It was reported that at month 5, the reported forecast year end control totals remained on target for all PCTs. Achieving financial targets remained 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, although this also included 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, and Haringey)

9. ACHIEVING AN EDUCATION MODEL INTEGRATED WITH CAMHS PROVISION – UPDATE ON EDUCATION ARRANGEMENTS AT NORTHGATE PRU

The JHOSC received 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.

The report was compiled following discussions with SEN representatives from Haringey and Enfield, CAMHS and health commissioners and the head teacher of the PRU. The key issue was the loss of the Northgate clinic has led to less on site education placements at the Northgate PRU linked to CAMHS interventions. From September 2012, the New Beginnings clinic places continue to appear slightly over subscribed (approximately 13) and these young people will require access to educational services within the current financial year.

Northgate PRU was underutilised partially as a result of CAMH service changes. Base funding was 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.

It was reported that there was likely to be an increased 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 demanded full time education for those young people able to access it. There was a need 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) was 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 was currently in place with the DfE over the required place numbers and funding arrangements. Barnet, Enfield and Haringey Children's Services needed to collaborate in the 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.

RESOLVED:

i) That the Committee note the content of the report; and

ii) That the Committee express its support for the mixed model approach proposed.

10. TRANSITION PROGRAMME PROGRESS UPDATE

The Transition Programme Manager, Amy Bray, presented the report to the Committee. The report outlined 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.

To enable a smooth transition to the new system, an Interim Operating Model (IOM) had 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.

The impact of change on the following organisations was outlined:-

- NHS North Central London
- NHS Commissioning Board
- NHS Trust Development Authority
- Public Health
- Commissioning Support Units
- Clinical Commissioning Groups
- NHS Property Services Limited

Members considered the content of the report in detail and paid particular interest to the monitoring of costs of the transition budget, and specially the cost of redundancies and redeployment and any identified risks of transition. It was explained that the transition programme was ongoing and therefore officers were unable to provide information in relation to redundancies and redeployment costs as this information would not be available until the process had completed. It was requested that the risk register formed part of the discussions at the Transition Workshop on 28 November 2012, but the committee was asked to note that this live data which would change as the programme progressed.

RESOLVED:

i) That the Committee noted the content of the report following consideration of the implications for the overview and scrutiny function in the future at the Transition Workshop in November 2012; and

ii) That the Committee noted 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.')

11. FUTURE WORK PLAN

The future work plan as presented to members was agreed.

FINISH

The meeting closed at 1.04pm

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Agenda Item 5

NHS
North Central London

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

REPORT TITLE: Barnet Enfield and Haringey Clinical Strategy – Update January 2013.

REPORT OF:

Siobhan Harrington
Programme Director BEH Clinical Strategy
Dr Nick Losseff
Medical Director
NHS North Central London

FOR SUBMISSION TO:	**MEETING DATE:**
North Central London Joint Health Overview & Scrutiny Committee	17 January 2013

EXECUTIVE SUMMARY OF REPORT:

The report consists of a presentation updating JHOSC members on the progress on implementing the BEH clinical strategy.

The presentation covers

- progress on business cases and building works

The Full Business Cases for the capital investment at both the North Middlesex University Hospital NHS Trust and Barnet and Chase Farm Hospitals Trust have now been approved and building works have commenced on both sites.

- progress on workstreams

The clinical workstreams of Emergency Care, Maternity, Planned Care and Paediatrics are progressing. The Committee will be updated on the detail.

- update on primary and community care developments

The work underway to develop primary and community care across Barnet Enfield and Haringey will be presented.

- the role and the work of the clinical cabinet

The clinical cabinet is in place chaired by Medical Director Dr Nicholas Losseff. Dr Losseff will describe the role of the cabinet in defining explicit standards that the clinical workstreams will need to deliver by November 2013. The role of the cabinet in assuring quality and safety through the transition and in services delivered post the changed will be described. The cabinet is key in enabling communication between clinicians across primary and secondary care. It fosters joint ownership and co-design of all services.

Siobhan Harrington
Programme Director
NHS North Central London

RECOMMENDATIONS:

The Committee is asked to note the update
Attachments: No attachments.

Date submitted: 10 January 2013

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Agenda Item 7

NHS
North Central London

NHS NORTH CENTRAL LONDON	**BOROUGHS**: BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL
PRESENTATION TITLE: Urological cancer surgical services	
PRESENTATION OF: **Neil Kennett-Brown** Programme Director, Change Programmes North and East London Commissioning Support Unit **Thomas Pharaoh** Pathway Manager, London Cancer	
FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**MEETING DATE:** 17 January 2013

EXECUTIVE SUMMARY OF PRESENTATION:

Background

A 2010 pan-London cancer review found that access to and outcomes from cancer care were unequal across the city. Public engagement on the pan-London case for change and model of care was undertaken in 2010.

As a recommendation of the review, two integrated cancer systems were established in London to drive improved patient outcomes and experience. *London Cancer* is the integrated cancer system for north central and east London and west Essex.

Over recent months, clinicians representing all the hospitals providing urological cancer services in the area – together with GPs, nurses, health professionals and patient representatives – have been considering a local model of care for urological cancer surgical services specifically changes to complex surgery for bladder and prostate cancer and kidney cancer. This review has been led by *London Cancer*.

Why we need change

Whilst there have been significant improvements in cancer care in the UK over the past decade, there is further improvement needed to deliver world-class cancer services. Clinicians believe that the way in which services are currently organised does not allow us to deliver the highest quality of care, research and training that we are capable of. Clinicians believe that complex surgery for bladder and prostate cancer and kidney cancer should be centralised in specialist centres. We also need to diagnose urological cancers earlier, whilst improving the care and support of people who have finished their treatment and are either living with their cancer, in remission or recovery.

National and international evidence demonstrates a clear link between higher surgical volumes and better patient outcomes. Specialist centres which have frequently practising specialist teams and full facilities, with high patient throughput, generally have better patient outcomes.

Currently a number of hospitals undertake relatively small amounts of complex bladder, prostate and kidney cancer surgery each year. In 2010/11, hospitals across the *London Cancer* area each undertook between 54 and 89 complex operations for bladder and prostate cancer (a total of 296 operations) and between 10 and 72 complex kidney operations (a total of 292 operations). We also believe that there are up to 50 bladder and prostate patients each year who do not get the complex surgery that they would benefit from. These patients require highly specialist, once in a lifetime surgery to give them the best chance of controlling their cancer and reducing the risk of long term side effects such as incontinence.

Specialist treatment is only a small part of a urological cancer patient's care. The vast majority of patient care would always take place at local hospital units and GP surgeries.

Very complex surgery is not necessary for all patients. For instance, of around 1,500 cases of prostate cancer diagnosed in *London Cancer* every year, and 400 cases of bladder cancer, only 350 of these 1,900 patients require complex surgery. This is just under 1 in 5 of all patients.

Engagement going forward

Clinicians are finalising a case for change which we will widely share and discuss with stakeholders including patient and public groups and local representatives across North Central London, North East London, West Essex and South Hertfordshire. We are planning a number of stakeholder and clinical events, with clinicians available to attend meetings of groups to present the case for change. This period of engagement will be an opportunity to consider the views of stakeholders and any concerns of such as issues relating to patient choice and travel. A clinical representative of London Cancer would be pleased to attend a future meeting of the JHOSC to present recommendations for urological cancer surgical services.

Following our planned communication and stakeholder engagement process, we will need to agree with JHOSCs / HOSCs whether formal consultation is required. As we anticipate further reconfigurations in future covering a few other specialist cancers, we are seeking an opportunity to establish principles and processes going forward.

Other issues

Dr Tim Peachey, Interim Chief Executive, Barnet and Chase Farm Hospitals NHS Trust, will update JHOSC members on Chase Farm's bladder and prostate cancer surgical cases as part of item 6.

CONTACT OFFICER:
Nicole Millane
Communications, Transformational Change
North and East London Commissioning Support Unit

Neil Kennett-Brown
Programme Director, Change Programmes

DATE: 10 January 2013

North Central London

NHS NORTH CENTRAL LONDON	**BOROUGHS:** BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL
PRESENTATION TITLE: CCG Allocations 2013/14 in North Central London	
PRESENTATION OF: David Maloney Chief Finance Officer Designate Haringey CCG	
FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**MEETING DATE: 17 January 2013**

EXECUTIVE SUMMARY OF PRESENTATION:

- As requested by the JHOSC, this presentation provides the CCG allocations for the five North Central London CCGs (Barnet, Camden, Enfield, Haringey and Islington) announced on 18th December 2013 as part of the 2013/14 Operating Framework and published alongside the Everyone Counts: Planning for Patients 2013/14 guidance which outlines the incentives and levers that will be used to improve services from April 2013, the first year of the new NHS, where improvement is driven by clinical commissioners.
- The key messages are:
    - provide the JHOSC with the total allocations by CCG for their programme costs and running costs as notified;
    - clarify the scope of responsibility which these allocations are issued for by portfolio of spend;
- The Everyone Counts: Planning for Patients 2013/14 guidance is published alongside financial allocations to clinical commissioning groups and is available in full at http://www.commissioningboard.nhs.uk/everyonecounts/ which accompanied by other documents intended to help local clinicians deliver more responsive health services, focused on improving outcomes for patients, addressing local priorities and meeting the rights people have under the NHS Constitution.
- The allocations for CCGs are part of the overall new NHS and the committee is asked to note that not all allocations or operating details are yet published and will be updated as they become available. Working collaboratively with the respective parts of the new system will be a key requirement to optimise the aims.

CONTACT OFFICER:
Beverley Evans
Director of Finance
NHS North Central London

DATE SUBMITTED: 10 January 2013

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North Central London

NHS NORTH CENTRAL LONDON	**BOROUGHS**: BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL
REPORT TITLE: Transition Programme Progress Update – January 2013	
REPORT OF: Alison Pointu Director of Quality and Safety and Executive Lead for Transition NHS North Central London	
FOR SUBMISSION TO: North Central London Joint Health Overview and Scrutiny Committee	**MEETING DATE:** 17 January 2013

EXECUTIVE SUMMARY OF REPORT:

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

The NHS North Central London (NHS NCL) Transition Programme has now commenced the phased handover of functions from NHS North Central London to the new 'receiving' organisations that will manage and commission healthcare services from 1 April 2013. This handover follows months of comprehensive planning and preparation, and is underpinned by robust assurance processes and governance structures.

The purpose of this report is to articulate the changes to the healthcare system relevant to this final phase of transition, outline the key activities underway to support functional handover and manage risk, and to highlight the implications for NHS North Central London.

Sile Ryan
Transition Programme Manager
NHS North Central London

RECOMMENDATIONS:

The North Central London Joint Health Overview and Scrutiny Committee is asked to note this report.

Attachments include: Report.

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

DATE: 10 January 2013

TRANSITION PROGRAMME PROGRESS UPDATE – January 2013

Introduction

The NHS North Central London (NHS NCL) Transition Programme has now commenced the phased handover of functions from NHS NCL to the new 'receiving' organisations that will manage and commission healthcare services in the future. This handover follows months of comprehensive planning and preparation, and is underpinned by robust assurance processes and governance structures.

To enable a smooth transition to the new system, the Interim Operating Model (IOM) is in place to minimise disruption and avoid confusion. This I is aiding the embedding of the new organisations but, as previously reported, there will be no formal transfer of statutory functions, accountability, budgets or employment of staff ahead of April 2013.

The approach to assuring safe functional handover

As the programme enters the final stage of transition, sender and receiver organisations are focussed on completing all handover activities in advance of 31 March 2013.

The accountability for delivery within NCL remains with NHS North Central London until April 2013, even as new healthcare organisations shift from operating in shadow form to managing delivery. Robust assurance is therefore critical to both successful delivery of the Transition Programme for NHS North Central London and ensuring that the system remains stable and safe during this period of extensive change.

NHS North Central London uses a risk-based approach to delivery and assurance in partnership with receiving organisations. At the core of this approach is the imperative to ensure the safety and stability of the overall system is maintained and the requirement to achieve safe transfer of assets and liabilities from the old to new system.

To this end, detailed 'take-on' plans have been developed, which set out the tasks, sequence, timeframes and owners associated with the transfer of each individual function. The handover of functions from 'sending' to 'receiving' organisations involves meetings of functional leads and operational teams to review and agree comprehensive documentation, including operating models, readiness assessments, handover certificates and legal transfer schemes setting out assets and liabilities. These functional meetings are complemented by Director level meetings to sign-off readiness for transfer and the interim operating model, and to agree governance and assurance to April 2013.

The design of the assurance process has been done on a pan-London basis where possible and sensible, to ensure consistency, efficiency and sharing of good practice. 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.

During the final transition period there remains a core cluster team at NHS North Central London supporting the delivery of statutory PCT functions including quality and safety, finance and contracting. The team also supports local governance arrangements until 31 March 2013. The Transition and Legacy, Handover and Closedown Programmes continues to enable the smooth transition of functions and staff to the new receiving organisations.

Cluster governance arrangements have been refined to mirror this approach locally, providing clear routes for escalation and streamlined reporting. Local progress on transition is reported to the Core Cluster Executive Team and Cluster Wider Leadership Team (WLT), as well as

being escalated to the Transition Committee and existing Joint Boards of NHS North Central London.
Existing Committee terms of reference have been updated to reflect a greater role in assuring the local system. The Local Delivery Director for the NHS Commissioning Board is a non-voting member of the Joint Boards of NHS North Central London, as an integral mechanism for assuring both the sending and receiving systems.

Supporting and informing our staff during this transition is a key priority. The North Central London communications team continues to work closely with Human Resources and members of the North Central London Transition Programme Board to ensure that key messages are shared through managers, the intranet and newsletters. Internal communications has been strengthened to ensure that there are face-to-face staff briefings held (at least two per month) which are led by the CEO, as well as the weekly staff e-newsletter and the intranet. This communications team is also ensuring that "business as usual" communications and engagement continues at pace during the transition and closedown period.

NHS Commissioning Board (NHS CB)

As previously reported, the NHS Commissioning Board (NHS CB) was formally established as an independent body, at arm's length to the Government, on 1 October 2012. It is carrying forward the preparatory work begun as the NHS Commissioning Board Authority on reforming the healthcare commissioning landscape, while taking on initial statutory responsibilities. These responsibilities include the authorisation of clinical commissioning groups (CCGs) which are the drivers of the new, clinically-led commissioning system introduced by the Health and Social Care Act.

The NHS CB has published a series of guidance and strategies to shape and support commissioning and service delivery in a range of areas. These include: a three-year vision and strategy for nursing, midwifery and care staff that aims to build the culture of compassionate care in all areas of practice and was launched on 4 December 2012; a new operating model for commissioning specialised services, setting out a shift from a regional to a national approach; and a new operating model for GP IT services to ensure IT supports the new clinical commissioning arrangements.

Locally, NHS NCL has been working in close partnership with the NHS Commissioning Board London (NHS CBL) in preparation for the initial transfer of statutory responsibilities, which commences this month. A detailed plan for 'take-on' of functions has been developed and agreed. The handover of delivery items from 'sending' to 'receiving' organisations will involve detailed functional meetings supported by comprehensive documentation, including operating models, readiness assessments, handover certificates and legal transfer schemes. These functional meetings will be complemented by Director level meetings to sign-off readiness for transfer and the interim operating model, and to agree governance and assurance to April 2013.

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 governance arrangements designed to ensure the healthcare system remains safe as the new system begins to take on greater responsibility.

NHS Trust Development Authority (NHS TDA)

The NHS Trust Development Authority (NHS TDA) launched on 1 October 2012 and aims to provide leadership and support to the remaining NHS (non-Foundation) Trusts to deliver high quality, sustainable services in the communities they serve. Following the abolition of Strategic Health Authorities (SHAs), the NHS TDA will be responsible for overseeing the performance management and governance of NHS Trusts, including clinical quality, and managing their progress towards foundation trust status.

The NHS TDA executive team have been meeting with Finance Directors, Directors of Nursing and Medical Directors across the health system consulting on ways of working and how best to support NHS trusts. At the end of 2012, the NHS TDS published 'Toward High Quality, Sustainable Services: Planning Guidance for NHS Trust Boards for 2013/14', which sets out the expectations for what NHS Trusts will deliver in the coming year and how the NHS TDA will support them to achieve high quality and sustainable care for the patient and communities they serve. The guidance clarifies how the NHS TDA will operate and what new structures will be put in place to support NHS Trust Boards and their teams. In addition, the NHS TDS has provided trusts with technical guidance to support activities such as the development of operating plans.

In October 2012, the NHS TDA took on responsibility for non-executive appointments to NHS Trusts and for overseeing the 2013/14 planning round. It will be fully operational by April 2013. Prior to 1 April 2013, responsibility for the foundation trust pipeline, performance management of NHS Trusts and appointments of non-executive members to NHS Trusts and NHS Charities remains with the Department of Health and Strategic Health Authorities.

Public Health

NHS North Central London is working closely with Local Authorities and Public Health England (PHE) to plan and manage the transition of public health services.

The announcement of the public health budget allocations for Local Authorities by Department of Health has been postponed from 19 December 2012 until a yet to be confirmed date in January 2013. This announcement will provide local government with definitive allocations for 2013/14 and 2014/15.

All local staff consultations have now been completed and the majority of staff have been matched to roles in the new structures. Julie Billett was successfully appointed as the Joint Director of Public Health for the shared Camden and Islington Public Health service – this appointment will take effect from 1 February 2013. There are now substantive appointments for all Directors of Public Health (DsPH) within North Central London.

Haringey Public Health team presented their transition paper, including details on contracts, and plans for the service, to their Cabinet in December 2012. This paper was approved, thus confirming the political support for the transition arrangements in Haringey. The remaining four boroughs are planning to take similar papers to their respective Cabinets during February and early March 2013, and are working closely with NHS transition colleagues to align timescales with the NHS transition process.

All contracts have been identified and included in the transfer scheme submissions. Provisional breakdown of the contract values have been shared with all involved parties and will inform contract negotiations for 2013/14. In each borough, local teams (comprised of Councils and Clinical Commissioning Groups) have met with representatives from NHS North Central London and North and East London Commissioning Support Unit to discuss approaches to contract management in the future.

The pan-London sexual health contracts will not be extended in their current form due to reluctance of Local Authorities to commit to these contracts before the allocations have been announced. NHS London Sexual Health Programme is working with various stakeholders to determine whether a smaller programme could be established involving willing councils only.

A meeting at Chief Executive level between NHS North Central London and Local Authorities is planned to take place on 11 January 2013. As part of that meeting, NHS North Central London will be setting out the process by which the operational transfer of responsibilities will take place, in addition to providing an update on the legal process required by the Department of Health.

Commissioning Support Units (CSUs)

As Members are aware, the new clinical commissioning landscape will allow Clinical Commissioning Groups to choose whether they appoint internal commissioning staff, source support from the independent or voluntary sectors, or engage new NHS commissioning support units (CSUs).

As previously reported, the NHS Commissioning Board (NHS CB) will host the emerging CSUs with the NHS Business Services Authority (NHS BSA) acting as employment partner. This arrangement will continue to 2016, positioning the NHS CB to provide oversight and direction to CSUs, whilst allowing a degree of autonomy and independence for CSUs as they move along the path to externalisation over the next three years. The NHS CB is currently developing their strategy and approach to enabling externalisation in consultation with health system stakeholders.

Locally, the North and East London Commissioning Support Unit (NEL CSU) successfully underwent a detailed review and risk assessment of its business plans and strategies by NHS CB last year, known as 'Checkpoint 3'. This month, NEL CSU will commence 'Checkpoint 4', a self-assessment, which will further assure their business plans in terms of scale, staffing and financial due diligence. These checkpoints are key steps toward securing a formal 'licence to operate' by the NHS CB in April 2013.

NEL CSU has appointed staff to over 70% of positions within the organisation and is aiming to complete recruitment by 28 February 2013. NEL CSU and the NHS North Central London are working collaboratively to ensure a smooth transition of staff and functions for those staff joining the CSU from roles with the PCT Cluster.

The NEL CSU is an end-to-end service offer that will provide an extensive range of commissioning support to the twelve CCGs of North Central and East London

Clinical Commissioning Groups (CCGs)

All Clinical Commissioning Groups (CCGs) in NHS North Central London have now successfully submitted authorisation applications to the NHS Commissioning Board Authority.

Islington CCG is the first of our CCGs to achieve authorisation. Authorisation was awarded by the NHS Commissioning Board Sub-Committee Decision Panel for all Wave One applications on 5 December. One remaining condition is attached to the authorisation, namely the need to establish written agreements detailing the scope of collaboration with other CCGs. The NCL Collaboration Agreement is currently in draft and will be finalised over the next two months. This agreement will address the outstanding condition.

Haringey, Camden and Barnet CCGs submitted their applications in Wave Three. Site visits by NHS CB took place during November 2012. These CCGs will be subject to Moderation and Conditions Panels this month, following which they will have a 10 day opportunity to submit additional evidence or provide comment regarding identified risks or issues. The NHS CB Sub-Committee Decision Panel for Wave 3 applications will be held on 15 February 2013 and the CCGs will receive their decision letter shortly after this date.

Enfield CCG was our final CCG to submit its authorisation application, as part of Wave 4. The NHS CB undertook a site visit on 7 January 2013. Following the Moderation Panel and Conditions Panel, Wave Four CCGs will have their NHS CB Sub-Committee Decision Panel meeting on 6 March 2013 and will receive their decision letter stating their authorisation status shortly after this date.

Each of the five emerging CCGs in North Central London are in the process of recruiting and appointing the final members of their governing bodies and leadership teams. The majority of appointments to senior leadership posts (Chair, Chief Officer and Chief Financial Officer) in all

five CCGs in North Central London have been made, and work is continuing to secure appointees to a few key outstanding posts.

Table 1: Senior Leadership of CCGs of North Central London

Clinical Commissioning Group	Chair	Chief Officer	Chief Financial Officer
Barnet CCG	Sue Sumners	John Morton	Simon Jones (Interim)
Camden CCG	Caroline Sayer	David Cryer	Ian Winning (Interim)
Enfield CCG	Alpesh Patel	Liz Wise	Richard Quinton
Haringey CCG	Helen Pelendrides	Sarah Price	David Maloney
Islington CCG	Gillian Greenhough	Alison Blair	Ahmet Koray

NHS Property Services Limited

As outlined in the previous report, NHS Property Services Ltd is being established as a government owned limited company to take ownership of all PCT estate that will not transfer to provider NHS trusts in April 2013 when PCTS are abolished.

Significant planning is underway to ensure the successful launch of NHS Property Services in April 2013. Most of the leadership team has been in place since September 2012, and they are working with colleagues in the Department of Health and locally in London to agree the transfer of staff and assets. Tony Griffiths, Regional Director, London is responsible for the London estate portfolio and related transfers and has attended JHOSC previously to report to Members on progress.

The NHS North Central London Estates Department have mapped in detail the PCT-owned estate, associated estates staff and relevant property service contracts, which may need to be terminated or novated. They have worked in partnership with organisations in the health system to develop appropriate transfer strategies and plans.

Properties identified for transfer 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 estates transfer mapping exercise identified all estates and facilities staff with substantive or fixed term contacts that run past 31 March 2013 and which are aligned to NHS Property Services. These staff have been issued with offer letters for their future roles. The Programme is working with NHS Provider Trusts and other relevant organisations to finalise the transfer for staff that will not transfer to NHS Property Services.

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: Sile Ryan, Transition Programme Manager, Sile.Ryan@nclondon.nhs.uk.

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

17 January 2013

Future Operation of the JHOSC

1. Introduction

1.1. At the JHOSC seminar on 28 November, Members agreed that the JHOSC would continue to operate after the new arrangements for the NHS have been implemented fully on 1 April 2013. This report outlines the proposed new arrangements and updated terms of reference.

2. Recommendation

1. That the proposed arrangements, amended terms of reference and procedures be agreed and implemented from the start of the new municipal year;

2. That they subject to review in a years time;

3. That the necessary arrangements for the updated terms of reference to be approved formally by each Council be undertaken by participating boroughs;

3. Background

3.1. In January 2010, Chairs of health scrutiny committees in the north central London sector agreed to set up a JHOSC to engage with the NHS on the North Central London Service and Organisation Review, which was set up by the NHS to consider sector wide options for reconfiguring acute care. The proposals arising from this would have had wide ranging implications for health services across the sector and undoubtedly constituted a “substantial variation”, thus requiring formal consultation and the establishment of a JHOSC.

3.2. The principle of the establishment of the JHOSC and the terms of reference were agreed by each Council prior to the 2010 local government elections. Following this, appointments to the JHOSC were made by each of the constituent Councils. The number of representatives per borough (two) was also agreed prior to the local government elections

3.3. Following the general election the review process was suspended in the light of a change of policy by the incoming government. In the meantime, NHS North Central London was established formally and took on a more significant role than was envisaged when it was originally set up as a sector wide commissioning agency. Significant numbers of key strategic commissioning decisions began to be taken at sector level rather than by individual PCTs. In addition, NHS North Central London became the transitionary body for the switch to GP led commissioning.

3.4. The JHOSC met informally on 2 August 2010 and considered how to respond to the changing circumstances. It agreed to broaden the scope of the JHOSC so that it had a standing role in scrutinising strategic sector wide issues through regular engagement with NHS North Central London. In addition, it would also consider any proposals involving significant reconfiguration of services across the sector. Finally, it would also have a role, where appropriate, in responding to any proposals for changes to specialised services where there are comparatively small numbers of patients in each borough and commissioning was undertaken on a cross borough basis.

3.5. As a result of this, revised terms of reference were agreed by each participating authority. These were as follows:

"1. To engage with NHS North Central London on strategic sector wide issues in respect of the commissioning of health services across the area of Barnet, Camden, Enfield, Haringey and Islington; and

2. To scrutinise and respond to stakeholder engagement, the consultation process and final decision in respect of any sector wide proposals for reconfiguration of specific services in the light of what is in the best interests of the delivery of a spectrum of health services across the area of, taking account of:

- The adequacy of the consultation being carried out by the health bodies including the extent to which patients and the public have been consulted and their views have been taken into account

- The impact on the residents of those areas of the reconfiguration proposals, as set out in the consultation document

- To assess whether the proposals will deliver sustainable service improvement

- To assess whether the proposed changes address existing health care inequalities and not lead to other inequalities

- The impact on patients and carers of the different options, and if appropriate, which option should be taken forward

- How the patient and carer experience and outcomes and their health and well-being can be maximised whichever option is selected

- Whether to use the joint powers of the local authorities to refer either the consultation or final decision in respect of the North Central London Service and Organisation Review to the Secretary of State for Health.

3. The joint committee will work independently of both the Executive and health scrutiny committees of its parent authorities, although evidence collected by individual health scrutiny committees may be submitted as evidence to the joint committee and considered at its discretion.

4. To maintain impartiality, during the period of its operation Members of the Joint Committee will refrain from association with any campaigns either in favour or against any of the reconfiguration proposals. This will not preclude the Executives or other individual members of each authority from participating in such activities.

5. The joint committee will aim work together in a spirit of co-operation, striving to work to a consensual view to the benefit of local people"

4. Future Role of JHOSC

4.1. The JHOSC seminar on 28 November provided Committee Members with an overview of the new arrangements for the NHS that will be implemented fully from 1 April 2013. This will involve PCTs ceasing to exist and their formal role being taken over by, amongst others, Clinical Commissioning Groups (CCGs). The cluster organisation – NHS North Central London – will also cease to exist. Other new organisations will be established fully including the NHS Commissioning Board and Commissioning Support Units (CSUs).

4.2. Members of the JHOSC informally discussed whether there would still be a useful role for the JHOSC to undertake after 1 April. Members were of the view that the JHOSC had complemented local health scrutiny well and had been very effective so far in its role. However, it was still unclear at this stage how the new arrangements would develop and at what level and with whom overview and scrutiny could engage with most effectively within the new structures. Members were nevertheless of the view that the commissioning of NHS services on a cross borough basis was likely to continue and possibly increase. There was also still the potential for large scale reconfigurations to be proposed by the NHS, such as the one currently taking place in north west London. It was felt important that overview and scrutiny was proactive in its approach so that it was able to influence issues at an early stage rather than merely react to proposals once they had been developed.

4.3. The consensus reached was that the JHOSC should continue to meet but on a less regular basis. It was therefore agreed that the JHOSC would meet initially four times per municipal year and that the position would be reviewed in a years time.

5. Amended Scope, Terms of Reference and Procedures

5.1. It is proposed that the following amended terms of reference be adopted for the JHOSC following the implementation of the new NHS structures:

"1. To engage with relevant NHS bodies on strategic sector wide issues in respect of the commissioning and provision of NHS health services across the area of Barnet, Camden, Enfield, Haringey and Islington; and

2. To scrutinise and respond to stakeholder engagement, the consultation process and final decision in respect of any sector wide proposals for reconfiguration of health services in the light of what is in the best interests of the delivery of a spectrum of health services across the area of, taking account of:

- The adequacy of the consultation being carried out by the health bodies including the extent to which patients and the public have been consulted and their views have been taken into account

- The impact on the residents of those areas of the reconfiguration proposals, as set out in the consultation document

- To assess whether the proposals will deliver sustainable service improvement

- To assess whether the proposed changes address existing health care inequalities and not lead to other inequalities

- The impact on patients and carers of the different options, and if appropriate, which option should be taken forward

- How the patient and carer experience and outcomes and their health and well-being can be maximised whichever option is selected

- Whether to use the joint powers of the local authorities to refer either the consultation or final decision in respect of the North Central London Service and Organisation Review to the Secretary of State for Health.

4. To respond, where appropriate, to any proposals for change to specialised NHS services that are commissioned on a cross borough basis and where there are comparatively small numbers of patients in each borough.

5. The joint committee will work independently of both the Executive and health scrutiny committees of its parent authorities, although evidence collected by individual health scrutiny committees may be submitted as evidence to the joint committee and considered at its discretion.

6. To maintain impartiality, during the period of its operation Members of the Joint Committee will refrain from association with any campaigns either in favour or against any reconfiguration proposals that may be considered by the Committee. This will not preclude the Executives or other individual members of each authority from participating in such activities.

7. The joint committee will aim work together in a spirit of co-operation, striving to work to a consensual view to the benefit of local people"

6. Procedural Arrangements

6.1. In terms of the procedural arrangements, the following is proposed:

Representation

Each borough will be entitled to two representatives on the Committee. In the event of a Member being unable to attend, a deputy may be appointed by the borough concerned.

Chair

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

Q*uorum*

The quorum for the JHOSC will be one Member from four of the participating authorities. In the event of a meeting being inquorate, it can still proceed on an informal basis if the purpose of the meeting is merely to gather evidence. However, any decision making is precluded.

Voting Rights

Due to the need for recommendations and reports to reflect the views of all boroughs involved in the process, the JHOSC shall aim to operate by consensus if at all possible. A vote shall only be taken if every effort has it has been taken to reach agreement beforehand. Voting will be on the basis of one vote per authority. In the event of a tie, there shall be no provision for a casting vote on behalf of the Chair and the vote shall be deemed to have been lost.

Dissent and Minority Reporting

It is recognised that issues that emerge during the work of the JHOSC may be contentious and there therefore might be instances where there are differences of opinion between participating boroughs. The influence of the JHOSC will nevertheless be dependent on it being able to find a consensus. Some joint committees have had provision for minority reports but these powers can, if used, severely undermine the committee's influence. Whilst such provision can be made for the JHOSC, it is agreed that use of it is only made as a last resort and following efforts to find a compromise.

Writing Reports and Recommendations

The responsibility for drafting recommendations and reports for the JHOSC is shared amongst participating authorities.

Policy and Research Support and Legal Advice to the Joint Committee

This will be provided jointly by all of the participating authorities. Each authority is responsible for supporting its own representatives whilst advice and guidance to the JHOSC will be provided, as required, through liaison between relevant authorities. Consideration could be given by the JHOSC, in due course, to the provision of external independent advice and guidance, should it be felt necessary. This could be of benefit if it enables the joint committee to more effectively challenge the NHS and may be of particular assistance in addressing issues of a more technical nature, where lack if specific knowledge could put the joint committee at a disadvantage.

Administration

Clerking responsibilities are shared between participating Councils, with the borough hosting a particular meeting also providing the clerk.

Frequency and location of meetings

Meetings will rotate between participating authorities for reasons of equity and access. The JHOSC will meet four times per Municipal Year. However, an additional meeting may be called by the Chair in consultation with the Vice Chair or if requested by at least four participating boroughs.

Servicing costs

In the current financial climate, it is unlikely that it will be possible to meet any costs arising from the work of the JHOSC except on an exceptional basis. Any such financial commitments will need to be agreed beforehand and the cost split between the participating authorities.

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

17 January 2013

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 14 March in Enfield, are currently as follows:

- NHS Commissioning Board
- Maternity Services

1.3 There are currently no further dates scheduled for meetings.

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