NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the meeting of the Joint Health Scrutiny Committee held on 19 November 2010 at Enfield Civic Centre, Silver Street, Enfield, Middlesex EN1 3XA

Present: Councillors: Alison Cormelius (LB Barnet), Peter Brayshaw and John Bryant (LB Camden), Christine Hamilton and Mike Rye (LB Enfield) Gideon Bull and Dave Winskill (LB Haringey) Kate Groucutt and Martin Klute (LB Islington)

Officers: Mike Ahuja and Andy Ellis (Enfield), Katie McDonald (Camden), Robert Mack and Carolyn Banks (Haringey), Pete Moore (Islington) and Jeremy Williams (Barnet)

1. WELCOME AND APOLOGIES FOR ABSENCE

Mike Ahuja welcomed everyone to the meeting and to Enfield's Civic Centre.

2. APPOINTMENT OF CHAIR AND VICE CHAIR

RESOLVED:

That Councillor Bull be appointed Chair for the life of this Joint Committee and Councillor Bryant be appointed Vice- Chair.

3. URGENT BUSINESS

There was none.

4. DECLARATION OF INTEREST

The following declarations were made:

Councillor Cornelius - Chaplaincy at Chase Farm hospital
Councillors Groucutt and Brayshaw - Governors at UCH
Councillor Bull - employee at Moorfields Eye hospital

5. TERMS OF REFERENCE AND PROCEDURAL ARRANGEMENTS

Further to previous meetings it had been agreed that this body had a role in responding to any sector wide proposals for changes to specialist services and that it would take a strategic role in scrutinising sector wide issues through regular engagement with the NHS North Central London. This engagement was particularly important as NHS North Central London was to be the transitionary body for the switch to GP led commissioning. It

was noted that the amended terms of reference were currently being confirmed by all boroughs.

There was some discussion around the quorum and it was agreed that it should be one from at least four of the participating boroughs. This would ensure that it would not be possible for the absence of one authority to prevent the Committee from functioning. Although it was hoped that a consensus would be achieved, the procedures would allow for minority reporting in the event of their being irreconcilable differences of opinion. However, it was recognised that this would detract significantly from the influence of the Committee. Since the recommendations and reports should reflect the views of all Authorities the meeting agreed that there should be one vote per Authority.

The meeting was of the view that the NHS North Central London should be asked to fund a post to provide support to the JHOSC. It was accepted that this body would become the key strategic health scrutiny body for participating boroughs. Clarification as to what the post would entail would need to be provided.

It was agreed that, for future meetings there should be a standing item from all boroughs on local health issues. Also the next meeting should consider a financial report on PCT's, progress on GP commissioning and on the setting up of Well Being boards.

RESOLVED:

1. That the terms of reference be agreed.
2. That the quorum be one from at least four of the participating boroughs
3. That in view of the need for recommendations and reports to reflect the views of all authorities there be one vote per authority.
4. That the NHS North Central London be requested to consider the provision of funding for one post for 2011/12 to provide policy and research support to the Committee.
5. That there be a standing item for future meetings on health issues in each borough.
6. That the next meeting receive reports on:-
    - Financial matters relating to PCT's
    - Progress on GP Commissioning
    - Progress on setting up of Well being boards

6. NHS NORTH CENTRAL FUTURE PLANNING 2011/12

The meeting received a presentation from Martin Machray, Assistant Director of Communications and Engagement, NHS Islington on future planning and challenges facing the health system over the coming years. The report, whilst it set out the context of health care and provision across the area, did not produce solutions. The NHS had to produce short and medium term plans on how to meet the challenges and consider how best

to engage with members and the public. Details of the challenges and priority clinical areas that lay ahead were described. It was noted that provision had to be made to address the challenges without any major reconfiguration and with a cut in funding in real terms, by 2014/15 in North Central area there could be a cumulative commissioning deficit of £591m, and this was not sustainable.

One of the key challenges was to ensure that up to date population data was being used. The Committee were concerned that official population figures were an underestimate of the actual position. It was proposed that the boroughs pool their own figures with the NHS and offer to provide appropriate officer support.

The current thinking was that GP consortia would need to be sufficiently large to be able to commission effectively. The current assumption was therefore that consortia were likely to be bigger than previously envisaged or, alternatively, a number of smaller consortia might work together to obtain commissioning support.

It was noted that major reconfigurations were not popular and that the NHS had no specific plans to undertake any locally. However, Members expressed concern that strategic thinking and planning might be lost with the demise of bodies that had previously been responsible for this.

GP's and clinical leaders had identified the following seven clinical areas that they considered needed to be focussed on.:-

a. Long Term Conditions
b. Maternity
c. Paediatrics
d. Cancer
e. Cardiovascular disease
f. Unscheduled care
g. Mental Health

These areas had the largest expenditure, the largest patient group with growing demand and where services were varied. With regard to the inequalities in cancer care Members asked to see the evidence behind this.

The proposals were for a menu of current service initiatives to be developed, collectively called a QUIPP (Quality Innovation Productivity and Prevention) Plan. A plan to address the budget deficit was hoped to be produced by January 2011. It was noted that an ongoing challenge was to improve clinical quality whilst reducing spend. A suggestion was made that there should be a London wide strategic group looking at the NHS across London. A four year QUIPP was being developed (2011/12-2014/15) known as a Commissioning Strategy Plan or CSP for North Central London. The current long list of initiatives could be grouped into

either clinical priority work streams or cross cutting QUIPP themes which it was agreed would be areas for this body to explore progress made. It was hoped that, with efficiencies to be made within the clinical priority areas the deficit could be reduced over the next four years to around £173m.

NHS North Central London would be looking to Local Authorities for support on how to reshape services so that they become more locally accountable.

In response to an enquiry about problems with internal tariffs it was noted that tariffs for over 70% of acute care were nationally set and that they were difficult to challenge. Although there were proposals over the next four years for the tariffs to become a minus figure as part of the efficiency drive, this would not resolve local issues and the NCL would remain accountable for its overspend. It was hoped that a white paper on public health sector grants due out in December 2010 would explore what were core public health functions and whether there was commissioning through Local Authorities or GP's, for which currently the budget was split. The surpluses held by acute providers and the underuse of some hospital buildings, especially as services moved out of them were considered to be major issues. It was felt that the decision must driven by primary care needs.

With regard to GP practices being fit for purpose, it was noted that they would have to conform and be part of the commissioning consortium which every practice would have to join by 2014. PCTs had previously had a role in improving performance of GPs and they had revenue and capital funding to support improvement. Consortia could possibly develop their own incentives for practices to improve. In addition, local authorities could have a role in assisting with the re-validation process for GPs.

RESOLVED:

1. That members be circulated with evidence supporting the report.
2. That future meetings receive reports on the challenges and that officers develop a programme to enable the Committee to examine the areas of proposed savings in more depth.
3. That regular reports be presented to this body on progress being made with regard to GP commissioners.
4. That information be provided on the flows of patients using A & E services

7. NHS NORTH CENTRAL COMMISSIONING STRATEGY PLAN 2011/12 – 2014/15

Kate O' Regan from the NHS North Central London gave an update on the work taking place in the mental health work programme. The Committee noted that each Trust provider had a different set of organisational

priorities. The Barnet, Enfield and Haringey Mental Health Trust Transformation Programme set out to facilitate whole system change to improve local mental health services and to achieve cost efficiencies. Details of the nine work teams working on the transformation programme would be circulated to members and a progress report would be presented to the next meeting.

Camden and Islington NHS Foundation Trust were undertaking a savings programme and would shortly be carrying out a formal consultation into a proposal to close impatient beds and to reduce the number of inpatient sites. The identification of new care settings out of hospital settings, was moving forward. This would mean that service users received care nearer to their homes. Alcohol, Dementia and meeting the needs of people from Black and minority ethnic groups had been identified as priority areas for further care pathway development work across areas including general hospital and primary care settings.

It was noted that changes affecting all five boroughs should come to this body, consideration needed to be give to consultations involving less than all five but more than one borough It was agreed that officers would consider a way forward and report back.

Some concern was expressed over methods that may be used to consult with service users and it was suggested that these should be held in local settings such as schools. The NHS advised that they had a very well established network of advice on how to involve service users and there was regular contact with them, this included regular newsletters and meetings had been held. It was agreed that CAMHS social care interface was crucial and that CAMHS was a service which operated better at a local level. Some concern was expressed about the way that CAMHS would be commissioned, which it was felt could be helped with the development of some common standards. Also there was a need to raise GP's awareness of mental health issues and to clarify mechanisms for GP consortium to consult locally. Members welcomed the proposals and agreed that they would look closely at how the transition worked. Furthermore it was considered that more work around prevention was needed.

RESOLVED:

1. That details of the nine work teams engaged on the BEH MHT Transformation Programme be circulated to Members and a progress report be presented to the next meeting.
2. That officers be asked to consider how strategic issues affecting more than one borough but less than all five could best be progressed and report back..
3. That this Committee give further consideration to engagement with GP's around mental health issues and capacity building.
4. That information be provided in respect of the local consultation on the proposals

8. TRANSITION TO GP COMMISSIONING

Members were advised of the NCL proposals for a single transition organisation and priorities to be delivered in the transition period. In addition to shifting commissioning responsibilities to GP consortia the White Paper "Liberating the NHS" proposed a national commissioning board, a national primary care function and transfer of health improvement functions (public health) to local authorities. Additionally PCTs were required to reduce management costs by half and shift funding into front line services.

It had been agreed that the five PCT's would establish a single transition team from April 2011 to lead the transition process and to enable the saving of over half of the current management costs and maintain existing services. It was proposed that functions would be centralised wherever possible and a borough presence would be provided to deliver savings plans, to support the development of GP consortia and the further integration of public health and joint commissioning. PCT Boards would remain in place until 2013 supported by the local borough-based teams.

There remained much uncertainty as to what part of the PCT would transfer to the national commissioning board, or the primary care services, what form the GP consortia would take, and how quickly staff would transfer to local authorities or elsewhere. It was noted GP Consortia could apply for pathfinder status from December 2010, which would enable them to take on commissioning responsibilities from PCT's from April 2011.

It was noted that by 31 March 2011 there would be over a 50% reduction in staff employed by the PCT. Members expressed serious concerns of the timescales, the potential loss of staff expertise and whether GPs would be ready for the changes.

It was considered that local Health and Well being boards could be involved in working with borough based teams building relationships with local authorities, GPs, Links and other stakeholders in designing the new NHS.

RESOLVED

That the report and concerns expressed be noted.

9. BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY

Subsequent to the halting of the strategy in May 2010 an update was given on the Barnet, Enfield and Haringey Clinical Strategy and it's review against the four tests which had been laid down by the Secretary of State for Health. The review against the four tests was in four stages, the accumulation of which would be that a BEH Strategic Coordination group

on 30 November 2010 would receive an analysis from an independent organisation advising on whether the four tests had been met. Following this it was hoped that the Strategy would be submitted to NHS London.

Members expressed concerns over the implications of the strategy not being implemented for the North Middlesex Hospital. It was noted that, in the event of this happening, the hospital would be unlikely to be able to obtain foundation status and might not survive as an independent entity.

It was hoped that the Strategic Coordination Group would submit its report and supporting evidence to the NHS London by 1 December 2010 and that they would aim to conclude their findings in January 2011.

RESOLVED

That the report be noted.

10. NOTES OF LAST MEETING

The notes of the Informal meeting held on 2 August 2010 were noted. The Committee reiterated the importance of getting the correct population data in order to maximise any grants available.

11. NEW ITEMS OF URGENT BUSINESS

None

12. ANY OTHER BUSINESS

AGREED:

1. Health and Well being Boards be requested to receive updates on the GP Consortia. GP Consortia to be invited to attend future meetings of this body.

2. That this Committee meet every two months. Date of next meeting Friday 21 January 2011 10AM – 1PM in Haringey.

3. That the Director of Public Health be invited to a future meeting to discuss the public health consultation.

GIDEON BULL
Chair