NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the meeting of the Joint Health Scrutiny Committee held on 21 January 2011 at Haringey Civic Centre, High Road, Wood Green N22 8LE

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

Officers: Hannah Hutter (Camden), Melissa James (Barnet), Pete Moore (Islington), Rob Mack and Carolyn Banks (Haringey)

1. WELCOME AND APOLOGIES FOR ABSENCE

Cllr John Bryant (Vice Chair) welcomed everyone to the meeting and gave apologies for lateness in respect of Cllr Gideon Bull (Chair).

2. URGENT BUSINESS

There was none. It was noted that an updated slide on proposed QUIP savings would be circulated shortly.

3. DECLARATION OF INTEREST

The following declarations were made:

Councillors Bryant and Winskill declared a personal interest in respect of item 8 – Low Priority Treatments.
Councillor Brayshaw - elected patient Governor of GULCH
Councillor Groucutt – Governor at GULCH
Councillor Cornelius – Chaplaincy at Barnet hospital (not Chase Farm as stated in the minutes of the meeting held on 19 November)
Councillor Bull – Employee at Moorfields Eye hospital

4. MINUTES

The minutes of the meeting held on 19 November 2010 were noted.

Regarding the challenges in using up to date population data, Members were advised that, although the figures across the boroughs had been checked, no further work had been carried out. It was noted that there was an opportunity with changes to GP consortia to ensure that the data was accurate.

It was agreed that in addition to Health and Well Being Boards, individual borough's Overview and Scrutiny Committees should receive updates on the GP Consortia.

It was agreed that Committee papers be circulated by hard copy as well as electronically and at least 7 – 10 days before the meeting.

5. VASCULAR SURGERY

Nick Losseff, Consultant Neurologist and Clinical Director, NHS North Central London gave an update on work being undertaken in the NHS in North Central London in response to the recently published Cardiovascular Strategy for London. This strategy proposed that there should be five specialist vascular centres in London.

Currently there were three specialist providers of arterial vascular surgery. These were based at Barnet Hospital, the Royal Free Hospital and University College Hospital. However, it was felt that none of these centres delivered the volume of work needed to develop a critical mass of patients or clinical expertise considered necessary to further improve patient outcomes. The benefits to patients of specialist centres were perceived to be significant and it was envisaged that they would mirror what had already been achieved in other specialities such as stroke and coronary heart disease. There was evidence that surgeons and institutions that maintained high volumes of vascular surgery achieved mortality rates 2-4% lower than surgeons that perform low volumes each year.

Efforts were being made to find a co-operative solution that was acceptable to the three service providers in the first instance, thus removing the need for an independent designation process to be run. A group of North Central London vascular surgeons had meet to discuss provision and an offer had been made to them by NHS NCL to host further talks. Also all Primary Care Trusts had been sent a letter and summary document and other stakeholders would be engaged in the process.

It was considered that it would be useful to have a set of criteria and guidance as to what the critical mass should be in determining where the centre of excellence should be located, similar to that which had been presented for the changes made to the delivery of stroke services. It was felt that a set of objective measures would assist with determining where and how the central unit of excellence would be created and how the specialist and non specialist work would be divided between institutions.

The principal argument against the proposals was the locality issue and the expectation that residents would want to go to their local hospital. It was noted that the number of patient affected was relatively low, at around 150

patients annually. Also there was an argument from surgeons that their current mortality figures were low. However, it was acknowledged that there were efficiency savings to be made by the proposals and many other parts of the country had already gone down this route. Indeed the NCL was considered to be behind the rest of the country and Europe in this area. The QIPP showed that vascular surgery was only around 25% of the vascular services, therefore leaving 75%of work still to be carried out at local hospitals. Members requested that further details on the number of cases and mortality rates dealt with by each of the three hospitals be provided. In response to members concerns that the performance of local hospitals may be affected by taking more complex procedures away from them, it was noted that it was likely to be the same surgeons carrying out procedures at the specialist centre.

It was noted that, although there was no response from the Royal Free within the papers sent to members, both the Royal Free and UCLH were keen to proceed with the proposals. There was some discussion about the hospitals being in competition with each other and a perception that only the teaching hospitals in Central London would be selected for the more complex surgery. However, the meeting was informed that the Royal free and UCLH were not going to be competing against each other. It was noted that, because of the high co-dependencies for high level surgery, it was likely that the specialist vascular services would be provided at a teaching hospital.

It was hoped to implement the changes during 2011/12. The NCL Cardiac and Stroke Network had agreed to work with officers on the changes to create a world class service.

RESOLVED:

1. That the report and appendices be noted.
2. That objective criteria be developed to determine the location of the proposed specialist centre and that the specification for the centre emulates best practice in the rest of the UK and Europe.
3. That Members be provided with further details on the number of cases including mortality rates for Barnet, Royal Free and UCLH.
4. That Cllr Cornelius be requested to provide officers with details of the precise information that she had requested in respect of blue light figures for the Barnet area.
5. That a further progress report be presented to the Committee in due course.

6. QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION – COMMISSIONING PLANS FOR 2011/12

An update on the planning process in respect of NHS North Central London Quality, innovation, productivity and prevention (QIPP) programme was given by Sylvia Kennedy, Director of Clinical Strategy.

Details of the issues and challenges relating to the seven priority areas of long term conditions, maternity, paediatrics, cancer, cardiovascular, mental health and unscheduled care were outlined.

Due to budget deficits within Barnet, Enfield and Haringey PCT's, the net position at the end of the current financial year for NCL was anticipated to be a deficit of £59m. If no savings were made over the next four years, it was predicted that the level would increase to an unacceptable deficit of £780m. There were a number of reasons for the deficit including the high population growth and the increase in the number of older people, particular in the northern part of the sector. Also there had been changes to calculation methods, market forces factor and technical changes in pricing. Additionally it was known that acute services in the area were operating at below the national average, whereas if they were in the top quartile around £30m would be saved per year and if they were the best in the country this figure would increase to around £100m. Additionally the primary care facilities were not well developed, especially in the north of the region. Plans had therefore been produced to address this debt and improve quality of care. Six broad categories of savings had been identified:- primary care, prescribing, acute, mental health/continuing care community/other and corporate. There would be associated work plans for finance, transition, workforce and contracting. A final plan was to be submitted to NHS London on 28 February 2011.

There were 12 priority worksteams within the QIPP Plan and 4 enabling workstreams. Each workstream had a number of individual initiatives sitting within it. It was agreed that future meetings receive progress reports on the work streams and targets. It was noted that the finalised QIPP Plan would be available in the next two months. It was suggested that there should be a seminar arranged to explain in detail the 12 priority workstreams and to ensure that there was an understanding of the major issues facing the NCL.A stakeholders event had been planned for 3 March, details of which would be shortly circulated to Members. It was agreed that there needed to be discussions with the emerging GP consortium at an early stage.

RESOLVED:

1. That a further report on work in progress be presented to the next meeting.
2. That the next meeting receive in depth reports on medicines management, care closer to home and unscheduled care.
3. That consideration be given to arranging a seminar to examine the twelve priority worksteams in more detail.

4. That details of the NCL stakeholder event had been planned for 3 March, be circulated to Members of the JHOSC

7. UPDATE ON THE MENTAL HEALTH WORK PROGRAMME

Further to the previous meeting updating members on the work taking place in the mental health field at a sector level, members were informed of a separate Barnet, Enfield and Haringey Mental Health Trust Transformation programme which had been established and consisted of 9 individual projects grouped into two broad areas of developing community services and specialist services.

The same broad strategic direction of development for mental health services had been agreed across the Borough's of Barnet, Enfield and Haringey. This was to be based on the recovery model, greater development of community services and reducing reliance on in patient care, providing the most clinically and cost effective value for money services and working in partnership to develop and implement an ongoing change programme. A summary of the strategies and the mental health programme was noted. Members were advised that there had been a significant amount of engagement with mental health boards, carers and users and it was hoped that in future service users would be more involved. It was noted that in Enfield community services had merged with mental health services and that this had bought huge benefits.

Also there was currently a local consultation being undertaken by the Camden and Islington NHS Foundation Trust in conjunction with their commissioners NHS Camden and NHS Islington .into the proposal to close inpatient beds and reduce the number of sites. The three affected local authorities were also represented on the transformation group. Furthermore the need to get GP involvement was recognised.

With regard to the child and adolescent eating disorder service it was noted that the services for under 18s was provided at the Royal Free hospital whereas the adults service was provided at St Ann's hospital, it was felt that this did not enhance continuity of care. However It was noted that there was a review of the existing care pathway and a new one was to be developed.

RESOLVED:

1. That the report be noted.
2. That information on the Whittington Integrated Care Organisation be circulated to Members of the JHOSC.

8. LOW PRIORITY TREATMENTS

Members were informed of the updated Low Priority Treatments extended policy which included additional procedures recommended by Commissioning Support for London (CSL) and incorporated changes made in the light of secondary care clinical feedback. It was considered that extending the list of low priority treatments would ensure that the limited budget would be utilised to ensure the maximum advantage of the maximum number of people and was anticipated to deliver financial benefits of £2,535,480 from 2011/12. It was noted that following discussions with GP's and secondary care providers some additional procedures had been added. Details of public consultations were noted, together with the rationale behind the decisions. The policy had been drawn up in the context of the principles framework used by three of the NCL PCT's and the new NHS Constitution. It was noted that requests for funding treatments could be made to the IFR Panel by GP's on an individual and exceptional basis.

Although there was an expectation that GP's might be able to provide alternative solutions, there was some concern expressed over the duration of the policy and whether the systems would be cost effective in that greater numbers would reach the critical level and be eligible for treatment.

Additionally although there was evidence that some non effective treatments were still being carried out, hospitals were moving towards no longer carrying them out as part of the programme for reasonable clinical behaviour.

The meeting agreed that there was a need to monitor numbers going through the system and costs and requested to be updated on the effectiveness of reducing the number of procedures on the list and the comparative impact of the extended policy across the sector.

RESOLVED:

That a further report outlining progress, including information on the effectiveness of reducing the number of procedures included on the list and the comparative impact across the sector, be submitted to the JHOSC in due course.

9. NCL UPDATE

Financial Update 2010/11

A financial deficit of £60m was projected to be carried forward into the next financial year. Representations had been made to the Challenge Trust Board for assistance, the outcome of which would be known by the end of January 2011. It was noted that the deficits would not be passed onto GP consortia.

PCT Budgets

For this current year the Challenge Trust Board mechanism was likely to help PCT's deliver a balanced budget but it was not likely to be continue into 2011/12.It was noted that GP's were likely to get together in respect of some functions such as around acute contracts. Nationwide, PCT's were making reductions and a single management structure had been created. A paper setting out full financial details was due to go to the NCL Board on 20 January 2011 seeking agreement to these changes.

GP Commissioning development

It was noted that all 5 GP consortia in NCL would be applying for Pathfinder status by March 2011 and would be coterminous with boroughs. Acute commissioning would remain at the NCL level for the time being.

BEH Clinical Strategy

NHS London was currently assessing the review of the Strategy against the four reconfiguration criteria set out in the revised operating framework for 2010/11. It was noted that Enfield had raised opposition to the strategy as they considered that the four tests had not been met. Consequently meetings had been set up with the 3 local MP's and Enfield were seeking agreement to referring the strategy back to the Secretary of State.

10. NEW ITEMS OF URGENT BUSINESS

There was none

11. DATE AND VENUE OF NEXT MEETING

Agreed as follows:-

25 March – Barnet
27 May – Camden

GIDEON BULL
Chair