North Central London Joint Health Overview and Scrutiny Committee
19 September 2011

Minutes of the meeting of the Joint Health Scrutiny Committee held at the Civic Centre, High Road, Wood Green, N22 8LE on 19 September 2011 at 9.30am.

Present: **Councillors:** Councillor Gideon Bull (Chair) (L.B.Haringey), Councillor John Bryant (Vice-Chair) (L.B.Camden), Councillor Alev Cazimoglu (L.B. Enfield), Councillor Alison Cornelius (L.B. Barnet), Councillor Kate Groucutt (L.B.Islington), Councillor Martin Klute (L.B.Islington), Councillor Graham Old (L.B. Barnet), Councillor Anne Marie Pearce (L.B. Enfield), Councillor Barry Rawlings (L.B. Barnet) and Councillor Dave Winskill (L.B.Haringey).

Officers: Rob Mack (L.B.Haringey), Peter Moore (L.B.Islington), Sue Cripps (L.B. Enfield), Melissa James (L.B. Barnet) and Shama Sutar-Smith (LB Camden)

1 WELCOME AND APOLOGIES FOR ABSENCE (Item 1)

Councillor Gideon Bull welcomed everyone to the meeting. Members of the Committee and officers introduced themselves.

Apologies for absence were received from Councillor Maureen Braun (L.B. Barnet), Councillor Peter Brayshaw (L.B. Camden) and Helena Kania (Haringey LINk).

Councillor Graham Old substituted for Councillor Maureen Braun (L.B. Barnet). Councillor Barry Rawlings also represented L.B. Barnet). It was noted that in the event of there being a need for a vote, each borough was entitled to one vote irrespective of the number of representatives that it had present at the meeting in question.

Apologies for lateness were received from Councillor John Bryant (L.B.Camden).

2 URGENT BUSINESS (Item 2)

None.

3 DECLARATIONS OF INTEREST (Item 3)

Councillor Gideon Bull declared an interest in that he was an employee at Moorfields Eye Hospital but did not consider it to be prejudicial in respect of the items on the agenda.

Councillor Kate Groucutt declared that she was a governor at University College London Hospital but did not consider the interest 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.

4 MINUTES (Item 4)

In respect of the item regarding Out of Hours GP Services – Re-tendering of Contract, Councillor Winskill noted that it had been agreed to circulate the independent auditors report into the financial problems of Camidoc. Martin Machray reported that he had been awaiting a view from the Committee on how the report should be distributed. The Committee requested that the complete report plus summary be circulated to all Members.

RESOLVED:

1. That NHS North Central London be requested to circulate the full report and summary of the independent audit report commissioned by Camden PCT into the financial difficulties of Camidoc.

2. That the minutes of the meeting of 15 July 2011 be approved.

5 TRANSFORMING CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) IN-PATIENT SERVICES FOR YOUNG PEOPLE LIVING IN BARNET, ENFIELD & HARINGEY (Item 5)

Emma Stevenson, Andrew Williams and Claire Wright from NHS North Central London, Maria Kane and Eric Karac from Barnet Enfield and Haringey Mental Health Trust and two young service users of the Northgate Clinic were present for the discussion of this item.

Ms Wright reported that the consultation period had been extended until 2 September. There had been concerns expressed about the fact that the consultation period had included August which it was felt might limit responses due to it being the peak holiday period. However, the consultation with young people that had taken place had proven to be effective. 10 focus groups had taken place with young people and parents. 263 responses had been received on behalf of individuals and 9 on behalf of organisations. This compared with only 80 that had been received at the time of the last meeting of the Committee. The report on the results of the consultation exercise had been submitted to NHS London and would be considered by the NHS North Central London board on 29 September.

Ms Kane reported that the Mental Health Trust (MHT) had been involved in responding to some of the issues that had been raised. In particular, they had further developed the clinical model that the proposals were based upon. Their view was that it was better to provide care in the community than in hospital and modern models of treatment were based on this principle. Mr Karac reported that the model used in the proposed restructuring had been reviewed and, in particular, phase 1 of the transition plan. Views that had been expressed during the consultation process to date had been incorporated and there would now be a single pathway model with service users only requiring a single referral. They would move through the pathway and back into the community when appropriate. There would be a small number of high dependency beds for those who needed them and these would be available for as long as required. There would be intense interventions by community teams available and a menu of different treatments. Community based patients could also join in with groups that would be based at the new unit. Education provision would be integrated into the daily programme. The model was tried, tested and cost effective. Young people had also been involved in helping to develop it. The number of high dependency beds would be subject to periodic review. If it was necessary to find in patient accommodation elsewhere, efforts would made to identify appropriate provision that was local.

It was noted that approximately 35% of expenditure by the Mental Health Trust was for in patient care, amounting to approximately £6 million per year. The budget for Northgate was £1.2 million per year. £650,000 of this would be re-invested in the development of community teams whilst the remainder would be used for QIPP savings. Whilst efficiency savings would be delivered, the main objectives of the proposals were clinical through the implementation of an improved service model.

In response to a question, Mr Karac reported that there were a range of views about the proposals amongst psychiatrists. The two psychiatrists from Northgate were understandably disappointed by the proposal to close it whilst several others based elsewhere were positive about the changes. A number of consultant psychiatrists were now reluctant to refer to Northgate.

It was noted that the reducing the number of beds from 24 to 15 was feasible because under the new arrangements patients would not stay in hospital as long. In addition, Northgate was frequently not full. Intensive community support would significantly reduce the demand for beds. The latest analysis suggested that even 15 beds might prove to be too many. One option that could be used if there was a need for additional beds would be to use Simmons House, which was based in Haringey.

Mr. Machray stated that the full report on the response to the consultation would be shared with members of the Committee. Ms. Wright reported that the Alliance model of care that was being piloted in Enfield appeared to be working. There had only been the need to admit three patients to hospital since the last meeting. However, it was noted that performance figures were only available until the end of March. She stated that the new arrangements were not entirely reliant on Alliance, which only currently operated in Enfield. Other community based measures were being operated in other boroughs. Simmons House represented the successful model of in patient care that the current proposals aimed to emulate. It was accepted that up to date performance figures for the Alliance model needed to be produced. Work was still being undertaken on educational provision, which would be integrated into the care of patients. Assessments would involve the mainstream schools of children and young people concerned. Provision would be dependent on their needs.

Members of the Committee were of the view that, based on the figures that were available for overnight bed days, it was not clear yet that demand for beds was going down and, even if they were, whether this was a long term trend. The figures that were available showed fluctuations in demand. They also needed more evidence to reassure them that people were getting better more quickly. It was noted that demand for bed days was not always determined by clinical need alone.

It was noted that referrals to Northgate had been stopped. Due to the long length of stay of patients, this was felt necessary to do this in order to avoid the possibility of their care being interrupted due to the clinic being closed. It would be possible to re-open the unit if necessary. 51% of respondents to the consultation had been in favour of the proposals with 43% against. Amongst service users, there were roughly equal numbers in favour and opposed to the proposals. Mr Karac reported that a report had been drafted that described fully the whole of the patient pathway, including phases 1 and 2.

The Committee received evidence from two service users. The following issues were raised:

- It would be difficult to re-open Northgate. Many of the staff had moved to new jobs elsewhere.
- The focus groups that they had attended involved a lot of questions being asked about the Alliance model that operated in Enfield which, as they were from Barnet, had not been relevant to them. The largest number of service users came from Barnet so it would have made more sense to pilot the new arrangements there.
- If some psychiatrists were reluctant to refer young people to Northgate, this was likely to have an impact on occupancy figures. The reduced number of in patient beds commissioned would lead to greater use of hospitals outside of the area which were more expensive and not as good.
- Some people required longer stays in hospital and could be at risk of relapse if discharged too soon. Problems at home could also make it difficult for some people to recover in the community.
- Some of the questions raised by service users had not been answered during the consultation. They had responded by letter to the consultation and had yet to receive a reply.
- Northgate had recently been refurbished. However, the premises had not been properly secured .
- A number of service users could not cope with mainstream schools. The school on the site addressed the needs of such young people very well and the closure of Northgate threatened its future.

The service users agreed to share their response to the consultation with the JHOSC. Members of the JHOSC were also invited to visit Northgate. It was noted that there were no plans to close the school on the site, which operated as a pupil referral unit.

Ms Stevenson stated that there was a need to ensure consistency in the questions that were asked in the focus groups and this was why not all of the questions would have seemed relevant to respondents from Barnet. Other service users had been satisfied with the engagement process

Ms Kane stated that the refurbishment had been necessary to maintain the high standards required for premises by the Care Quality Commission. No staff had from Northgate had left the Trust's employment yet. Responding to concerns expressed by the Committee that the proposed changes might lead to a greater use of expensive private sector provision, she stated that the Mental Health Trust was committed to working with commissioners to ensure that out of area provision was only used when absolutely necessary. It was noted that the site on which Northgate was located was leased by the Mental Health Trust from Barnet PCT.

Ms Stevenson stated that there were risks associated with delaying implementing the new model. Admissions to Northgate had stopped and therefore alternative provision outside the borough was having to be used. The Committee were of the view that the closing of Northgate had undermined the consultation and pre-empted the decision.

In conclusion, the Committee expressed its concern at the consultation process which they felt had not initially been adequate. The Committee had not yet received full details of the results of the process but noted that there was no evidence of their being overall support amongst service users. They were of the view that the evidence base in favour of the proposed changes was still unclear. In particular, the latest figures performance figures for the Alliance pilot in Enfield and overnight bed days only went to the end of

March 2011. The success of the proposals was at least partially dependent on there being a substantial drop in demand for beds and, if this was not achieved, there was likely to be an increase in the need for expensive out of borough placements which would put at risk the savings that were aspired to. The Committee also had not as yet received full details of the care pathway and its phases. The proposals required the de-commissioning of provision before the new service was fully in place and there were therefore potential risks. As yet, the Committee had not received the necessary assurances that these had been fully addressed as part of an effective transition process..

The Committee therefore concluded that it had still not received the evidence necessary for it to be convinced that the new arrangements were in the interests of the local health service.

RESOLVED:

1. That the Chair be requested to write to the NCL Board urging it not to take any final decision on the proposals until all the relevant information required for them to take an informed decision was available, namely:
- Up to date performance figures for the last two quarters on overnight bed days and the effectiveness of the Alliance pilot model in Enfield
- Clarity on the evidence base
- Full details of the consultation programme and response
- Clear details on the transition process and its phases

2. That NHS NCL be requested to circulate the full consultation report to Members of the Committee.

3. That a visit to Northgate Clinic be arranged for all Members of the Committee.

6 QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION (QIPP) PLAN - PERFORMANCE (Item 6)

Liz Wise from NHS North Central London was present for the discussion of this item.

Ms Wise outlined the current performance figures for the QIPP programme. It was noted that there had been a significant under performance against targets to reduce spending on acute care. It would be difficult to address this through slowing down referrals as patients had a constitutional right to receive treatments within a specific time frame. There were many and varied reasons why QIPP targets for acute services were not on track. GP referrals had increased in one PCT area whilst there had also been pressures from demand for emergency treatment. In addition, there were also issues arising from how some treatments were costed and charged. Analysis was being undertaken on the number of referrals that led to treatment. In some cases, there were charging issues to be resolved concerning how patients were dealt by hospitals after initial referral.

It was noted that efforts had been made to protect staffing levels in contract management and informatics. Consideration was being given to whether there was a need to strengthen officer support for a period of time as staff were currently very stretched in dealing with contracts. The acute portfolio of contracts amounted to over £1 billion. In the short term, consideration was being given to bringing in turnaround specialists.

Patients did not always get to see the right consultant first time and referrals from one consultant to another were quite high across the sector. There were 167 projects that were currently showing green. However, 80 were showing red and total QIPP slippage was currently forecast to be £30 million. The forecasts had been prepared using a worst case scenario. Each borough was now being asked to produce a recovery plan. £10.4 million of the slippage was from the stretch target and £22 million from acute productivity. This included £2 million over performance by UCLH on referrals from Islington. Savings on procedures of limited clinical effectiveness had proven difficult to realise. Expenditure on these was led by referrals and more work was needed with clinicians and the acute trusts. Part of the slippage was due to fact that the measures had been implemented later than planned. There had been some success in addressing the issue of medicines management although more could still be done. It was noted that it was not possible to mandate clinicians to only prescribe certain medicines. The

overspend on continuing care was currently being looked at as well as Islington PCT's budgetary position. Variations in GP referral rates across the cluster were also being analysed. In particular, referrals from Enfield PCT were 15% higher than elsewhere. 1200 referrals from Enfield had been processed in April and May rather than March and this had compounded the problem.

It was noted that patients still had the right to choose where they wished to be treated and that there were no plans to cut Islington PCT's budget by 12.5%, as had been suggested. Although it was proving very difficult to balance to books, failing to do so by the end of the financial year was not an option.

RESOLVED:

That the update on the performance of QIPP Plan be noted.

7. SAFE AND SUSTAINABLE – REVIEW OF CHILDREN'S CONGENITAL HEART SERVICES IN ENGLAND (Item 7)

Simon Williams and Peter Kohn from the NHS London Specialised Commissioning Group was present for the discussion of this item.

Simon Williams outlined the work that had been undertaken to reconfigure congenital heart services in England. The aim of the review had been to ensure:

- Better diagnosis and follow-up care closer to patients' homes
- Fewer deaths and complications following the surgery
- Shorter waiting times for surgery
- Better trained surgeons
- Excellent care for all children with no postcode lottery.

A number of different options had been developed and consulted upon. The intention was that every centre chosen would have two full time surgeons and a throughput of around 500 – 600 procedures per year. In addition, it was intended that no centre would be more than four hours away from any patient by whichever mode of transport was the slowest.

Two centres were proposed for London. These were at GOSH and Evelina (Guys). This entailed services at the Royal Brompton/Harefield being discontinued. The forecasted number of procedures that would be undertaken in London was approximately 1250 per year. The minimum level that was required was 400 per unit per year and the ideal number 600. GOSH currently undertook over 500 per year. If three centres were maintained in London, the remainder would be split between Evelina and Royal Brompton. The numbers involved would mean that they were both beneath the threshold of 400. The intention was to increase work loads to ensure critical mass and, through this, improve outcomes, recruitment and retention of skilled clinicians and service development. A three centre model would not provide enough patients for all of the centres and result in an uneven distribution. In addition, the catchment areas would need to increased. However, the consultation had not finished and people were entitled to express a view contrary to this.

Concerns had been expressed that the discontinuation of services at the Royal Brompton might threaten the viability of other paediatric services there due to the absence of a paediatric intensive care unit. These services were children's respiratory services, including cystic fibrosis services and asthma. An independent review had been undertaken on this issues and had concluded that the services in question would remain viable. There were no significant concerns regarding the continuing viability of some other paediatric services at hospitals where it was proposed to discontinue surgery.

Ipsos Mori had undertaken a consultation exercise which had generated 70,000 responses. Strong support for two centres in London was expressed with only 12% against. There was some support for 3 centres for London as well as some for only 1. GOSH and Evelina were the two hospitals that were most strongly supported but there was a lot of support for all the units across the country. The Royal Brompton had been the 10th. best supported.

The Royal Brompton was mounting a legal challenge to the proposals through the judicial review process

and the verdict of this would be given in October. The expectation was nevertheless that the new configuration would become operational in April 2013.

It was noted that work was still continuing on the catchment areas for each hospital. Many hospitals had outreach services in other hospitals, including GOSH at Peterborough. However, patient choice had to be respected and many undertook considerable research before deciding which hospital to choose. The setting up of a single network of care for London was currently being considered by the Specialised Commissioning Group. Any changes to configurations within London were unlikely to have a significant affect on travelling times but it was likely to make a difference elsewhere.

Mr Williams stated that it was not expected that the changes would yield major improvements across the board. However, it was hoped to improve outcomes for cases where survival rates were currently very low. The longer term outcomes aspired to were concerned with a range of quality measures and not just mortality rates. Each of the units chosen would have 4 surgeons working together and undertaking approximately 125 operations per year. Services would be available 7 days per week. Some hospitals currently only had 2 consultants.

The Committee expressed their support for there being two centres for London and the two locations – GOSH and Evelina - that were proposed. However, they were mindful of the possible long term effects of the loss of services from some providers on their future viability and of the view that measures should be taken to minimise the impact of this. They were nevertheless supportive of the direction of travel and the development of more integrated patient pathways following surgery.

RESOLVED:

1. That the Chair be requested to write to the Specialised Commissioning Group with the Committee's views, as outlined above, in response to the consultation.

2. That copies of the health impact assessment and of the independent report reviewing if children's heart services and respiratory services could continue to be delivered safely at the Royal Brompton Hospital in the absence of an on-site paediatric intensive care unit be circulated to all Members of the Committee and

8 HEART FAILURE COMMUNITY CLINIC – PILOT (Item 8)

Caroline Cook and Dr Neel Gupta from North Central London Cardiovascular and Stroke Network were present for the discussion of this item and gave a presentation on the setting up of a pilot project to deliver a community based multi disciplinary integrated service in South Camden. This would be extended to the remainder of the cluster if successful.

Services were currently disjointed and there was often duplication of work. It was hoped that the new service would provide seamless care. The new model was based on NICE guidelines and was hoped to facilitate earlier diagnosis. All the necessary tests could be undertaken on the same day during one visit with a treatment plan sent to the GP, also on the same day. The specific venue for the location clinic had yet to be identified.

It was noted that there were a large number of people with heart failure who were not diagnosed. Although age was probably the most significant factor, the were a number of other risk factors including hypertension, diabetes, smoking and high cholesterol. Some communities had a slightly higher susceptibility, including the African Caribbean and South Asian communities. Diagnosis could be undertaken by blood test. However, increasing the percentage of those diagnosed was only one part of improving services. There was also a need to provide better care for those who were diagnosed.

In terms of location, various options were being explored. It was suggested that Stevenson House would be appropriate. It was noted that it was not clear where the service should best be located organisationally – whether in the acute or community sector. One option would be for it to be managed under a free standing n umbrella organisation.

It was noted that work was being undertaken by public health officers in NCL to address the low level of diagnosis and that they were also undertaking work on addressing low diagnosis rates for hypertension. One particular challenge that needed to be addressed as part of this was the transient population in many areas of the cluster.

RESOLVED:

1. That the pilot project be welcomed.

2. That the option of managing the service through the establishment of an umbrella organisation be supported.

3. That concern be expressed at the high numbers of undiagnosed patients in the community.

9 MEDICINES MANAGEMENT (Item 9)

The Committee noted the response received from the Secretary of State to the Committee's earlier letter regarding drug tariffs.

10 BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY

Members from Enfield expressed their disappointment at recent decision by the Secretary of State in response to the referral by Enfield's Health Overview and Scrutiny Committee. The Council was now considering its options. The Secretary of State had nevertheless acknowledged that not all of the infrastructure required for the changes outlined in the strategy was in place. Enfield Council was of the view that primary care in Enfield was significantly underfunded and were looking for support from the JHOSC in pursuing this issue with the Secretary of State. Without the necessary investment in primary care, the over reliance on acute care could not be addressed successfully. The 15% increase in GP referrals from Enfield bore this out. They were also of the view that any money from the sale of land at Chase Farm should be re-invested in the infrastructure.

RESOLVED:

That the issue of Barnet, Enfield and Haringey Clinical Strategy be placed on the agenda for the next meeting of the Committee.

11 DATES AND VENUES OF NEXT MEETINGS (Item 10)

- Monday 31 October – Enfield
- Monday 5 December – Barnet
- Monday 16 January – Camden
- Monday 27 February - Islington

FINISH:
The meeting closed at 13:30 pm.

CHAIR: