MINUTES OF THE NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE HELD ON MONDAY 31 OCTOBER 2011 AT 10.00 AM IN THE COUNCIL CHAMBER, ENFIELD CIVIC CENTRE, SILVER STREET, ENFIELD, MIDDLESEX, EN1 3XA

Present: Councillors Gideon Bull (Chair) (L. B of Haringey), John Bryant (Vice Chair) (L.B. of Camden), Peter Brayshaw (L. B. of Camden), Alev Cazimoglu (L. B. of Enfield), Alison Cornelius (L. B. of Barnet), Martin Klute (L. B. of Islington), Graham Old (L.B. of Barnet), Anne Marie Pearce (L. B. of Enfield), Alice Perry (L. B. of Islington), Barry Rawlings (L. B. of Barnet) and Dave Winskill) (L. B. of Haringey).

Officers: Rob Mack (L. B. of Haringey), Mike Ahuja (L. B. of Enfield), Sue Cripps (L. B. of Enfield), Sally Masson (L. B. of Barnet) and Peter Moore (L. B. of Islington).

Also present: Martin Machray, Dr Douglas Russell, Sarah Thomson and Felicity Bull (NHS North Central London), Rachel Tyndall (NHS London), representatives of FERAA, Haringey LINKs, Save Chase Farm Group and Bush Hill Residents' Association and Councillor Patricia Ekechi (L. B. of Enfield) and local residents.

1. **WELCOME AND APOLOGIES FOR ABSENCE (Item 1)**

   The Chairman welcomed all those present to the meeting and in particular Councillor Alice Perry (L. B. of Islington) attending her first meeting of the Committee.

   An apology for absence was received from Councillor Maureen Braun (L. B. of Barnet) who was substituted by Councillor Barry Rawlings. Councillor Alison Cornelius (L. B. of Barnet) advised that Councillor Graham Old was also representing the L. B. of Barnet. It was noted that the terms of reference for the JHOSC stated that, in the event of there being a need for a vote, each borough was entitled to a single vote irrespective of the number of representatives it had at the meeting in question.

2. **URGENT BUSINESS (Item 2)**

   Donald Smith, a local resident, referred to an article in the Health Service Journal on Friday 28 October 2011 concerning a report from NHS London outlining significant shortfalls in consultant presence in labour wards; only four maternity units in London met consultant labour ward requirements. He suggested that a response was required at a later date. Martin Machray (Head of Communications and Engagement, NHS North Central London) advised that he had not seen the report but would be happy to discuss the contents at a future meeting.

   The Chairman suggested that this be considered as an item for discussion at a future meeting.

   RESOLVED that a report be submitted to a future meeting of the JHOSC regarding consultant presence in labour wards and responding to the issues raised in the Health Service Journal report.

3. **DECLARATIONS OF INTEREST (Item 3)**

Councillor Gideon Bull declared an interest 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 Peter Brayshaw declared an interest that he was a Governor at University College London Hospital, but did not consider it to be prejudicial in respect of the items on the agenda.

Councillor Alison Cornelius declared an interest that she was Assistant Chaplain at Barnet Hospital, but did not consider it to be prejudicial in respect of the items on the agenda.

Councillor Alice Kerry declared an interest that she was an employee of the London School of Hygiene and Medicine, but did not consider it to be prejudicial in respect of the items on the agenda.

4. MINUTES (Item 4)

RESOLVED that the minutes of the meeting held on 19 September 2011 be agreed subject to the following:-

- the current spelling of Eric Karas (not Karac) from the Barnet, Enfield and Haringey Mental Health Trust; and
- deletion of 'had' after 'No staff' in paragraph 6 on page 3 (Transforming Child and Adolescent Mental Health Services - In-Patient Services for Young People living in Barnet, Enfield and Haringey).

5. NORTH CENTRAL LONDON PRIMARY CARE STRATEGY (Item 5)

An interim report had been circulated with the agenda on the Development of the North Central London Primary Care Strategy dated 7 October 2011.

The report detailed the background work being undertaken to develop the Primary Care Strategy the purpose of which was to further improve quality, capability and productivity in Primary Care. The strategy would define the medium and long-term goals, priorities, principles, investment criteria and performance expectations.

It was emphasised that this was an interim report and identified emerging themes. Consultation on the report was ongoing. The Committee questioned why NHS North Central London was introducing a top down report as this was only a temporary body lasting eighteen months.

Dr Douglas Russell (Medical Director, NHS North Central London) responded that universal, accessible high quality general practice supported by well developed primary care teams integrated with social care and the third sector was crucial in improving health service provision.

Kate Wilkinson (Save Chase Farm Group) stated that a Primary Care Strategy had already been agreed previously; she questioned why it was not possible to inherit the previous one.

Councillor Alev Cazimoglu stated that the problem was not the lack of a Strategy but the lack of funding in Enfield. She stressed that it was essential to know what Enfield would receive financially.

Dr Russell advised that this was a consultation paper which sought views. The Strategy would build on the current five borough-based primary care plans and determine how NHS North Central London and the successor organisations would invest in primary care in each of the five Boroughs over the coming years. He pointed out that 80% to 90%o of the public's experience of health care was in primary care and not hospitals. Sometimes, however, there were access difficulties and other factors such as GPs being dismissive which meant people attended local hospitals instead.

The aim of the strategy was to provide an effective service coupled with care and compassion. He added that patients needed to be at the centre of the consultation. It was necessary to ensure that GPs had the supporting services and that premises were fit for purpose, meeting minimum standards.

Dr Russell advised that in the North Central London area, 56% of income was spent on hospitals compared to 46% in the rest of London. The intention was that GPs would do as much as they could within Primary Care to avoid hospital admissions.

The Chairman questioned how this Strategy would be better than previous ones and as to whether GPs were supportive. Dr Russell responded that he had undertaken similar work in Tower Hamlets for a number of years and improved services there which were now recognised both nationally and internationally. He stated that it was necessary to have the support of clinicians and to listen to any scepticism and doubt and address such issues.

The Committee then questioned how the issue of poorly performing GPs would be addressed. Dr Russell said that GPs would have written personal development plans and have an annual appraisal of their performance with a qualified GP appraiser. GPs were required to apply for professional re-accreditation every five years. He emphasised that GPs did not have a contract for life – breach notices, remedial notices and even termination notices could be served on GPs. Care and compassion from GPs was essential. This started from a sense of vocation but would need nurturing by a culture of professionalism and continuing professional development and support, peer comparison and personal reflection.

Councillor Alice Perry questioned where resources would be provided from. Dr Douglas Russell responded that too much was being spent in hospital care even though GP referrals were going down (except North Middlesex and Chase Farm where they were increasing). Therefore it was necessary to have first class GP and Primary Care services.

Councillor Alev Cazimoglu advised that there was a Working Group in Enfield looking at why residents sometimes went to local hospitals rather than visit GPs. She pointed out that primary care in Enfield was significantly underfunded (£70m

for the current year). Without the necessary investment in primary care, the over reliance on acute care could not be addressed successfully. She added that she was concerned that spending on acute care could be even higher in 2012/13. Appropriate primary care needed to be in place before any reconfiguration on local hospitals took place.

Councillor Cazimoglu referred to a letter from MIND in Enfield which indicated that they were currently undertaking almost 3,000 counselling sessions per year with residents. The service was currently under treat due to budget cuts by NHS Enfield. She questioned who would be delivering this in the future.

Dr. Russell responded that it was vital to engage with the Councils and the public in the consultation with a view to reducing the numbers attending hospitals and not GPs. This involved engaging the five Boards to reduce hospital spend and increase primary care funding. He added that the support of local authorities for primary care was very important. He stated that it was hoped that some non-recurrent money could be made available if the benefits could be clearly demonstrated and it was supported by a clear plan on how improvements would be implemented.

The Chairman referred to problems of obesity especially among children and people's lifestyles, e.g. smoking or alcohol. Furthermore, the continuing lack of green spaces meant little or no exercise was being taken. Similarly, poor standards of housing were closely linked with poor health.

Councillor Anne Marie Pearce advised that Enfield Council's Planning Department had been asked to give careful consideration as to whether applications for take-aways should be approved near schools.

Martin Machray referred to the divide between health and wealth and the work of Professor Sir Michael Marmot which dealt with tackling health and well being and needed to be understood in relation to a range of factors that interacted in complex ways. These factors included material circumstances, e.g. whether one lived in a decent house with enough money to live healthily; social cohesion, whether one lived in a safe neighbourhood without fear of crime; psychosocial factors such as whether good support from family and friends was available; behaviours – whether one smoked, ate healthily or took exercise.

Similar work had been undertaken by The King's Fund, the UK health charity that shapes NHS policy and practice.

Councillor John Bryant observed that the report indicated that there appeared to be more registered patients in Camden and Islington that the actual population. The Chairman referred to 'ghost patients' – patients who were registered but no longer lived in the area. Dr. Russell responded that there was always a mismatch on such figures; this was because people did not always register with GPs and some only registered when sick.

Local authority population figures were based on various statistics including electoral registers and the National Census which was undertaken every ten

years. Currently people registering with GPs needed to show passports and evidence of where they were living. It was planned that in the future people could also register in Council offices. Dr Russell advised that there was a regular trawl through those registered with GPs to remove 'ghost patients'.

Kate Wilkinson referred to the 15% increase in referrals to the acute sector and hospital services being removed. This coupled with cuts to the voluntary sector had exacerbated the situation. She stated that any monies from the sale of land at Chase Farm should be ring-fenced to address the shortage of Primary Care.

Dr Russell advised that no monies would be ring-fenced. It was necessary to reduce expenditure on hospitals and increase Primary Care. He pointed out that most health expenditure was in the last two years of a patient's life. Under the Strategy, Patient at Risk (PAR) would be used in assessing people's illnesses. He added that new ways of working would make a difference to the quality of life.

In response to further questions from the Committee on poor performing GPs, Dr Russell stated that the voice of patients was fundamental to the Clinical Commissioning Groups.

Donald Smith expressed concern as to the lack of GP provision on new estates being built on former NHS land in N18. He stressed the need to commission a GP surgery whilst it was still NHS land. Dr Russell stated that the NHS Planning Sector and the Local Authority Planning Department could liaise on this matter.

John Jewson, FERAA, referred to the lack of GPs particularly in Enfield and the need for their assessment. He also referred to the limited time GPs could spend with patients and the need to send them to hospitals for x-rays.

Liz Henthorn, a local resident, urged that support services be provided for stroke victims. Councillor Anne Marie Pearce advised that a Stroke Navigator had recently been appointed.

Ivy Beard, a Broxbourne resident, questioned where the financial resources would come from. She stated that south Hertfordshire no longer funded the urgent care centres with a doctor present; it was just a nurse-driven facility whereby nurses diagnosed patients. This was why residents from Broxbourne went to Chase Farm A & E and why it was essential to keep Chase Farm Hospital open.

Councillor David Winskill stressed the need to ensure that Dr. Russell's project and initiatives should continue after the Clinical Commissioning Groups supersede the NCL cluster in 2013. He suggested that the Chairman write to NHS London to seek clarification on how the project would continue and its momentum sustained..

RESOLVED: That a letter be sent on behalf of the Committee to NHS London to seek clarification on how the strategic role in developing and monitoring the quality of primary care currently undertaken by NHS North Central London would continue after its demise.

Members then considered the report by Grant Thornton 'Independent Business Review of Camidoc Ltd'

Councillor Winskill requested detailed information on the finances of Camidoc, the Board's involvement and whether minutes of various meetings were available. It was noted that in 2009/10, £30,000 of pension contributions were used as working capital. Similarly, it was understood that national insurance deductions had not been made. He suggested a separate meeting with NHS North Central London to address this. This was supported by Councillor John Bryant.

Martin Machray agreed that it would be useful to have a working session to address this issue in a structured way.

RESOLVED:
1. That a letter be sent on behalf of the Committee to NHS North Central London outlining the further information that it wishes to receive in respect of the financial issues that led to the demise of Camidoc.

2. That a meeting of representatives of representatives of the health scrutiny committees of host boroughs be arranged to discuss the concerns expressed by the Committee with regard to Camidoc.

6. <u>BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY (Item 6)</u>

The Secretary of State's letter dated 12 September 2011, regarding the Independent Review Panel's (IRP) recommendations and decision on the Barnet, Enfield and Haringey Clinical Strategy, along with the IRP's recommendation to the Secretary of State was circulated with the agenda.

The Chairman stated the next Committee meeting to be held on 14 November 2011, would be examining the plans for implementation.

Councillor Alev Cazimoglu stated that Enfield's position remained the same and, as such, was opposed to any reconfiguration. The Council was not convinced that a case had been made to reconfigure Chase Farm Hospital and was of the view that the shortfall of £70m in funding for primary care had not been addressed. She added that advice was being sought for judicial review and this had been a cross-party decision.

Mike Ahuja advised that an underfunding case could be provided to the Committee.

Councillor Anne Marie Pearce wished to ensure that any monies from Chase Farm be ring-fenced and used for Primary Care purposes.

Ivy Beard, a Broxbourne resident fully supported Enfield's concerns on the retention of Chase Farm and the need for other services. She added that the borough had been hugely underfunded which had a knock-on effect on walk-in centres etc. The residents of Broxbourne and Cheshunt valued the Consultant Lead 24-hour A&E at Chase Farm Hospital.

Donald Smith advised that since 2003, promises had been made to improve transport to hospitals within the Borough of Enfield, however, nothing had happened and the situation was getting worse. He questioned whether NHS London had considered this problem and would assist in improving access to the services.

The Chairman expressed fundamental concern that if the Clinical Strategy was not implemented, the effect it would have on North Middlesex Hospital.

The Committee agreed to discuss the various issues at the next meeting on 14 November 2011, which was specifically to deal with the Barnet, Enfield and Haringey Clinical Strategy.

RESOLVED that the Chairman circulate the proposed agenda for the special meeting of 14 November 2011 for comments from other Councillors.

7. STRATEGIC AND QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION PLAN (QIPP) (Item 7)

Liz Wise, Quality, Innovation, Productivity and Prevention Director, NHS North Central London gave a presentation on the Commissioning Strategy and QIPP Plan for 2012/13 – 2014/15.

The objective of the presentation was to share the process and progress of the Plan and to provide an opportunity for the Committee to reflect on the priorities in the Plan. One cluster plan was required by the Strategic Health Authority; this was needed by the end of November 2011.

The population of the area involved was relatively young, deprived and diverse and 31% was from Black and Minority Ethnic Groups. The current population of 1.34m was expected to grow to 1.45m over the next decade.

A copy of the presentation is attached.

In response to questions from the Committee, Liz Wise advised:

- guidance was sought from NICE as to whether to carry out certain treatments;
- currently £11m was spent annually unnecessarily on medical treatments that did not work or did not work well;
- there were major concerns over child obesity;
- consultants employed to consider the financial gap of £80m were present in the summer of 2011 and noted short-comings on plans which had since been addressed;
- no monies would be passed directly from one PCT to another;

- lifestyle factors were often linked to deprivation and were important sources of inequalities and poorer health outcomes;
- considerable changes were underway in services dealing with mental health;
- there was a need to focus on interventions, e.g. diabetes awareness within particular communities; and
- those with long-term conditions and frail would be looked after in the community.

Martin Machray stated that with a cosmopolitan population, there was often social isolation and low esteem. Average life expectancy was highest in Barnet and lowest in Islington.

Councillor Alison Cornelius detailed work undertaken in Barnet to address obesity which involved the whole family and getting people to diet.

RESOLVED:

1. That any further comments on the QIPP Plan be sent to Liz Wise as soon as possible.

2. That further discussion focussing specifically on outcomes of QIPP programmes be arranged for future meetings of the Committee.

8. CANCER MODEL OF CARE (Item 8)

Rachel Tyndall, (Chief Executive Officer, NHS London) gave a presentation on implementing the Model of Care for Cancer.

Over 13,000 people die from cancer in London each year, with more than half of these under 75 years of age. The number of cancer cases in London was expected to increase as the population ages and continued to grow.

It was necessary to diagnose as quickly as possible and work to improve care and ensure equitable access to specialist, GPs, hospitals and healthcare professionals.

Cancer experts from a range of specialities had reviewed London's cancer services and published the case for change in December 2009, demonstrating the need for improving the capital's cancer services. A range of people were engaged between August and November 2010, on the proposed model of care, which had received widespread support.

In January 2011, the NHS in London began the implementation of the proposed Model of Care.

The case for change document made a series of compelling arguments for changing cancer services in London. The case for change highlights that:-

- later diagnosis had been a major factor in causing poorer relative survival rates;

- there were some areas of excellence in London but inequalities existed in access to and outcomes from care;
- treatment and care should therefore be standardised across London;
- specialist surgery should be centralised but common treatments should be localised where possible; and
- comprehensive pathways should be commissioned so that organisational boundaries were not a barrier.

It was noted that Professor Sir Mike Richards (National Cancer Director) had endorsed the case for change and had said that maintaining the status quo was not good enough – to provide world-class services across the whole of London and to address the existing inequalities between London Primary Care Trusts required radical change.

A copy of Rachel Tyndall's presentation is attached.

RESOLVED: that the cancer model of care and the implementation programme be welcomed.

9. FUTURE WORK PLAN (item 9)

Members considered the Work Plan for future meetings of the Committee.

14 November 2011 at Haringey

This would be a special meeting to consider the issue of the Barnet, Enfield and Haringey Clinical Strategy. The Chairman advised that he had sent an email to Councillors setting out the key issues and looked for feedback to his suggested agenda. Briefly these key issues were:

1. at what stage is the implementation process?
2. have the four tests for service change been met?
3. how has the transition process been affected by reductions in management capacity and the current financial challenges and what measures have been taken to mitigate these?
4. does the commitment from the PCTs to move services only when there is an established capacity and all facilities are in place at the designated hospitals still stand?
5. what progress has been made in addressing the transport issues?
6. what safeguards are in place to ensure that there is sufficient capacity to cope with demand for:
   - maternity services so that hospitals are not forced to turn women away: and
   - A&E services
7. what progress has been made in implementing the planned developments in primary and community care necessary to support the changes in the strategy and, in particular, the provision of additional health centres and urgent care facilities?
8. how will all local NHS trusts remain financially sustainable and, in particular, able to fulfil the demands of being foundation trusts and meeting PFI payments?

9. how will commissioners seek to engage with patients and the public in order to ensure that their views are considered and to build confidence in the new arrangements?

The Chairman stated that the public would be welcome at this meeting.

Councillor Dave Winskill suggested that Hertfordshire County Council be invited to attend this meeting particularly on the issue of reconfiguration of Chase Farm Hospital.

RESOLVED that representatives from Hertfordshire County Council be invited to attend this meeting.

5 December 2011 at Barnet
Items for this meeting:

- Transforming Child and Adolescent Mental Health Services (CAMHS) – In-patient Services for Young People living in Barnet, Enfield and Haringey;
- QIPP Performance – outcome issues to be included;
- Urgent Care;
- Vascular surgery; and
- Future Work Plan.

16 January 2012 at Camden
Item for this meeting:

Primary Health Strategy.

27 February 2012 at Islington
To be determined.

10. ANY OTHER BUSINESS

The Chairman wished to record the thanks and appreciation of the Committee to Dr Douglas Russell for his really helpful contributions at the meeting and looked forward to hearing more from him at future meetings.

RESOLVED that the Committee record its thanks and appreciation to Dr Douglas Russell for his very helpful contributions to the meeting.

……. **…….**
Chairman **Date**

MJE/JHO&SC21.10.11