North Central London Joint Health Overview and Scrutiny Committee
14 November 2011

Minutes of the special meeting of the Joint Health Scrutiny Committee held at the Civic Centre, High Road, Wood Green, N22 8LE on 14 November 2011 at 10.00am.

Present: **Councillors:** Alison Cornelius and Barry Rawlings (LB Barnet), John Bryant (Vice Chair) (LB Camden), Alev Cazimoglu and Anne Marie Pearce (LB Enfield) Gideon Bull (Chair) and Dave Winskill (LB Haringey) Alice Perry (LB Islington)

Also in attendance; Mark Easton (Barnet and Chase Farm Hospitals), Claire Panniker (North Middlesex University Hospital), John Goulston (NHS London), Nick Lossef, Dr. Doug Russell, Jill Shattock and Caroline Taylor (NHS North Central London), Rob Mack (L.B.Haringey), Peter Moore (L.B.Islington), Sue Cripps (L.B. Enfield) and Sally Masson (L.B. Barnet)

1 WELCOME AND APOLOGIES FOR ABSENCE (Item 1)

The Chair welcomed all those present to the meeting.

Apologies for absence were received from Councillors Maureen Braun (L. B. of Barnet) who was substituted by Councillor Barry Rawlings, Councillor Peter Brayshaw (L. B. of Camden) and Councillor Martin Klute (L. B. of Islington).

2 URGENT BUSINESS (Item 2)

None.

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 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 Perry 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 BARNET, ENFIELD AND HARINGEY (BEH) CLINICAL STRATEGY - FEASIBILITY STUDY (Item 4)

The Committee received a presentation from John Goulston of NHS London. He reported that, in July, the Independent Reconfiguration Panel (IRP) had submitted its recommendations to the Secretary of State for Health. It had recommended that BEH Clinical Strategy should be implemented. However, representations were made to the IRP which suggested that the needs of Enfield residents might be better served by splitting up Barnet and Chase Farm NHS Trust and creating a new trust comprising of the North Middlesex and Chase Farm hospitals.

In September, the Secretary of State announced that he had accepted the IRP's recommendations. In doing this, he also directed NHS London to work with Barnet and Chase Farm and North Middlesex University Hospital (NMUH) NHS trusts to assess the feasibility of de-merging Barnet Hospital from Chase Farm hospital and merging Chase Farm hospital with NMUH. NHS London were requested to report back to him on the results of this by 16 December.

The feasibility work was only considering organisational issues and service reconfiguration was not within its scope. It as looking at the needs of residents of Barnet, Enfield and Haringey and not just Enfield.

Three criterion were being used to assess the options. The structure recommended should:

- Support the implementation of the BEH clinical strategy;
- Ensure the financial viability of NHS trusts and their progress towards Foundation Trust (FT) status whilst not destabilising the progress of other NHS trusts' progress towards FT status; and
- Be deliverable within the current legal and policy framework

Assessments would be undertaken on the following possible structures:
- The status quo;
- The merger of Chase Farm and North Middlesex with Barnet hospital as a stand alone trust.

Feedback had been obtained that the following other options should also be considered if the two main options proved not to be viable:
- The acquisition of any of the three hospitals by another organisation
- The inclusion of local community services in Barnet and Enfield
- The merger of all three hospitals to create a combined trust.

This process would include an assessment of the potential risks and benefits. Engagement was a key part of the feasibility work and NHS London was working closely with a range of stakeholders including elected representatives, patients and the public.

The Chair expressed concern that the exercise was being described as feasibility on Enfield hospitals as the hospitals in question served residents from a number of London boroughs local authority areas as well as south Hertfordshire. In addition, it could be considered that previous mergers had contributed to the financial challenge that had made the reconfigurations necessary. Councillor Winskill questioned whether small district general hospitals were likely to continue to be viable in the current climate with more and more services being transferred to hyper acutes.

Mr Goulston stated that it was accepted that the hospitals served a wider range of residents than just those in Enfield. However, the reference to just Enfield had come from the Secretary of State's direction. NHS London were nevertheless looking more widely. A full financial appraisal was being undertaken on all of the options. Part of this involved considering what would be a fair and equitable split in finances between the respective bodies. The work would include consideration whether Barnet would be viable as a stand alone trust. It would not be the smallest stand alone trust in existence as Hillingdon Hospital was also small and there was nothing intrinsically unviable about small trusts.

Councillor Cazimoglu expressed that further reconfiguration could affect the chances of trusts gaining Foundation Trust (FT) status which was the overriding priority at the moment. It was also possible that joining all three hospitals together could lead to further consolidation of services on different sites. Mr Goulston stated that FT status was the end point. Trusts had to demonstrate ongoing viability as part of this. The modelling process was based over ten years and on the implementation of the Clinical Strategy.

It was noted that NHS London was funding the feasibility study. The work was mainly being undertaken by senior staff with some limited assistance from external consultants. The models that were being developed were based on commissioner expectations and included, amongst other things, the shift to primary care and productivity gains.

Claire Panniker, the Chief Executive of the North Middlesex University Hospital (NMUH), reported that the crucial issue for the trust was that the Clinical Strategy was implemented quickly. In the absence of this, it would start to feel the impact in 2012/13 when it would be forecasting a deficit. At the time that the Public Finance Initiative (PFI) deal for the construction of new buildings was signed in 2007, the scheme had been affordable. This was prior to formal consultation on the Clinical Strategy. Since this time, two issues had arisen:
- Care closer to home had grown rapidly
- The economic climate had changed and there was now a squeeze on tariffs.

In 2008, the trust had obtained additional investment as it decided that the PFI should be upsized during construction so that there were enough beds to accommodate the additional activity that implementation of the Clinical Strategy would generate. NMUH would no longer be financially viable if the Clinical Strategy did not proceed.

Mr Goulston stated that the modelling was assuming a reduction in tariff of 1.5 % for the next 5 years and current levels of activity. In respect of the attainment of FT status, the current timetables for both of the trust would still apply if there was no merger. In the event of a merger, the new trust would have to be

running for a year before it could apply for FT status in order to provide the necessary track record. If a merger was agreed, it could possibly be implemented in 2013.

A resident asked what would happen to patients from south Hertfordshire after the reconfiguration. Mark Easton (Chief Executive of Barnet and Chase Farm Hospitals) reported that the vast majority of patients from South Hertfordshire would continue to use Chase Farm as most services would stay on the site. Although Barnet and Chase Farm had made a financial surplus in each of the last few years, there was nevertheless a historical deficit that needed to be addressed.

It was noted that the view of Enfield MPs was that a single acute trust covering the borough would fit in with the commissioning group and local authority structure and facilitate partnership working. Dr. Nick Lossef (Clinical Director NHS North Central London) reported that there had been some discussion between clinicians across the trusts in question. Clinical services needed to be supported by the organisational structure and not vice versa. As a result of this, a high level document had been produced by medical directors that gave a consensus view on the options.

Donald Smith, a local resident, highlighted the fact that NHS community services in Enfield were now undertaken by Barnet, Enfield and Haringey Mental Health Trust (BEH MHT) and their role therefore also needed to be considered as part of the feasibility study. There was a lack of community provision in Enfield. Although the issue of co-terminosity with Enfield commissioning group had been one of the drivers for the exercise, this ignored the needs of Haringey whose residents were major users of NMUH.

Caroline Taylor (Chief Executive of NHS North Central London) stated that if BEH MHT had been considered as part of the feasibility exercise, it could impact upon it and there was no desire to cause instability on other organisations. If a merger took place between Chase Farm and NMUH, it would have substantial dealings with not just two but four commissioning groups.

Mr Goulston reported that the costs of the feasibility study were mainly the time and effort of officers. The actual cost was approximately £100,000. Organisational change would have a cost should it be agreed. Amongst other things, a new board would need to be set up. This was likely to be in the region of £1.5 million in total.

RESOLVED:

1. That concern be expressed that the cost of the feasibility exercise is being funded by NHS London rather than the Secretary of State for Health.

2. That the views of local clinicians are fully considered as part of the feasibility exercise and the input of medical directors, as expressed in their collective response to the feasibility study, be shared with the Committee.

5. BARNET, ENFIELD AND HARINGEY (BEH) CLINICAL STRATEGY – IMPLEMENTATION (Item 5):

Caroline Taylor (Chief Executive of NHS North Central London) reported that, in October 2010, the Clinical Review Panel had advised that the clinical case for change was still relevant, and if anything had increased in the past few years. There was a need to improve health outcomes and reduce health inequalities by:

- Improving primary and community care to deliver care closer to home and support people with long term conditions
- Improving the quality and sustainability of hospital services

In reference to transport, a working group had been set up and had looked at both patient and public transport facilities. It had also considered the role of the voluntary sector in providing transport. The group had reported in May 2010. A group would be set up to take the recommendations forward. The report would be shared with the Committee.

Dr. Douglas Russell (Director of Primary Care, NHS North Central London) stated that it was acknowledged that progress with improving primary care was not as great as it should be and that he had

been brought in to facilitate change. The focus was on improving clinical quality and outcomes. There were clear benefits from better primary care, such as improved patient satisfaction levels, greater financial sustainability and better outcomes. The primary care strategy for the cluster would be submitted to the NCL board in January. There was a determination to bring in changes.

There were between 3 and 4 million patient consultations in primary care each year. The vast majority of interactions contacts were undertaken in a caring way by dedicated staff but some were very disappointing in quality. Considerable improvements had been made in Barnet and around 85% of patients were now saying that they were satisfied with services. Edgware Community Hospital was an excellent facility and Finchley Memorial Hospital was to be developed soon. New services were also being developed outside of hospital as part of the QIPP programme. Future developments would involve a full range of services being networked amongst groups of GP's. This would also enable diseases to be diagnosed earlier. Patients often had more than one condition and were increasingly having them for longer. Primary care required generalists who were multi skilled. Clinicians also needed to be able to share medical records easily and work in new ways.

Councillor Cornelius stated that the development of Finchley Memorial was crucial. It was noted that:

- A relatively small range of services were currently provided in the community in Barnet.
- The number of GP referrals from Barnet was going down. This was often with the support of hospital consultants.

Committee Members felt that assurances needed to be provided that real change was taking place and not merely isolated outreach sessions being provided in the community. Dr Russell stated that transformational change was planned. The sharing of records was fundamental as this would facilitate integrated working between teams. Work needed to be undertaken on how services could work together in the best way. This would help to reduce duplication and would also involve social care. There would also be integration with specialists and it was hoped that it would be possible to tap into their expertise without patients always needed to travel to see them. He had managed to implement considerable improvements in primary care in Tower Hamlets where sustained improvement had been made.

Dr Russell stated that there was much work to be done to improve primary care in Enfield. Recent policies had been overly focussed on buildings rather than services. They wished to explore opportunities for joint working with the local authority as part of developing services. A high percentage of patients used urgent care services due to frustration at not being able to easily access primary care services and it was intended to address the causes of this.

The Chair stated that the Clinical Strategy had required that primary care be improved before changes were implemented. Councillor Pearce stated that promises had been made that no services would be taken away before new services were in place to replace them and that this could include a need for some "double running" of services.

Ms Taylor stated that there had been improvements across the three boroughs but more had been achieved so far in Barnet and Haringey than in Enfield. However, there were specific plans to make improvements in Enfield. These included developments at Ordnance Rd and Highmead.. There were three possible sources of investment to improve primary care:

- Non recurrent funding which could be prioritised for primary care
- Joining up IT. A bid for capital funding had been made for this.
- Investing with money from savings made elsewhere.

However, the funding position across the three boroughs concerned was challenging.

Dr Russell stated that the expenditure required to implement the changes would be in the millions for each borough. There would be some double running of services over the next year. The funding was required for a number of issues including the provision of web based information services and additional clinical staff. This did not all need to be funded by new money. Ms Taylor stated that she understood the scepticism of many people. It was not possible to specific about sources of funding at this stage but the Committee would no doubt be wishing to monitor progress on a regular basis. The strengthening of primary care would help to address the deficit that there currently was at NHS Enfield.

Dr Russell outlined the improvements to primary care that had also been implemented in Haringey. The Chair commented that the new clinic at Lordship Lane was very good and that residents were pleased with it. However, there were issues with some primary care accommodation. Dr Russell commented that there was an expectation that all primary care services should be located by practitioners in appropriate buildings. There were a range of arrangements in place with some practices being owner occupied. PCT assets were in the process of being transferred to majority users and this process would be completed by the end of the financial year.

Concern was expressed that some surgeries were still using 0845 or 0844 telephone numbers which could be expensive for residents who only had access to mobile phones. Dr Russell stated that there were contractual issues that needed to be resolved. Responsibility for these was likely to transfer to the NHS Commissioning Board. Some patient experiences were not acceptable and contracts needed to delivered appropriately.

Dr Russell stated that access to services in the community would be different to that provided within hospital settings. There was no wish to remove specialists from hospitals. The emphasis would be on using them where they were most needed. This would enable them to undertake longer consultations with the patients who particularly needed their expertise. Ms Panniker commented that acute trusts recognised the cost implications of their work and were agreeable to targeting resources where they were most needed. Specialists from NMUH were being used to deliver clinics in the local community.

Councillor Bryant commented that the majority of NHS spending in Camden was now on primary care. However, it had taken 10 years for the changes to fully implemented. The current NHS structure was only likely to last a further 18 months and it would be challenging to implement the changes necessary within this short time frame. Dr Russell commented that there was a correlation between the proportion of expenditure made by NHS Camden and its healthy budgetary position. Primary care consultations were considerably cheaper than acute care and also led to better outcomes and improved patient satisfaction levels. The most challenging of the changes was getting clinicians and services to work together more effectively but good progress was being made in gaining their support. He was confident that considerable progress could be made in a year and a half. The experience from Tower Hamlets was that transformation could be very rapid.

A South Hertfordshire resident commented that urgent care centres in Hertfordshire were no longer running. Ms Taylor gave assurance that there would be liaison with South Hertfordshire to ensure that services complemented each other. A Councillor from Broxbourne District Council reported that the urgent care centres had not closed but were now operating as minor injury units. Severe problems in residents being able to register with a GP had been highlighted and the District Council was engaging consultants to look at the issue.

Mark Easton (Chief Executive of Barnet and Chase Farm Hospitals) outlined progress that had been made in developing Barnet and Chase Farm hospitals. Whilst Barnet would focus on emergency, maternity and paediatric care, Chase Farm would cover planned care. An additional maternity ward would be provided to deal with increased demand for maternity services. The additional maternity capacity would be available from 2014. There would also be additional capacity at NMUH. £15 million would be spent on remodelling Chase Farm. This would be funded by a loan from the strategic health authority for which a business case was currently being developed. £20 million would be spent on Barnet and this would involve remodelling A&E including provision for paediatrics. ITU would also be expanded. There would also be an additional CT scanner. The cost of the remodelling would be offset by the possible sale of derelict land on the site. The trust would have to demonstrate to the strategic health authority that it could afford the loan.

It was noted that diagnostics would still be provided at Chase Farm. In the event of an emergency, residents from South Hertfordshire would probably be taken to Harlow once the changes at Chase Farm had been fully implemented as this would then be the nearest alternative A&E. Ms Taylor agreed to provide the Committee with information on additional provision for ambulance vehicles that might be necessary for the implementation of the strategy.

Mr Easton stated that no land sales were yet planned for the Chase Farm site. Any proceeds from land sales would be re-invested in services by the trust although no guarantee of this could be given as this would need to be agreed by NHS London as the trust had not yet gained FT status.

Claire Panniker (Chief Executive, NMUH) outlined recent developments to NMUH. It received roughly half its patients from Enfield and half from Haringey. There were no significant patient flows from elsewhere. Its services were focussed on dealing with emergencies. It was fully Care Quality Commission (CQC) complaint and had received very positive feedback from recent inspections. The new hospital buildings had been opened in June 2011 and most of the site now contained state of the art facilities. Two thirds of patients for services that were to be reconfigured as part of the Clinical Strategy who would previously have been dealt with at Chase Farm before implementation would now be treated at NMUH. Action was being taken to ensure that the necessary developments to facilities and the work force were made. A business case was being developed and this would be used to develop 120 extra adult inpatient beds, including extra women's and children's beds, a Paediatric Assessment Unit, a new building to provide consultant-led maternity care at all levels, a larger special care baby unit, two new operating theatres and a women's out patients and additional inpatient ward. This was scheduled to be implemented by 2013. There would also be an increase in the number of A&E consultants. This would enable extended consultant cover to be provided in A&E.

The Chair commented that NMUH had made considerable progress in recent years. It had not been well regarded by residents and there was evidence that this perception was now changing. Councillor Cazimoglu commented that the hospital covered a deprived area and it did not need additional pressure placed on it. Councillor Pearce stated that although the hospital had improved immensely, transport remained a major issue and it was particularly inaccessible form the west of Enfield.

Ms Panniker responded that the hospital could not stay as it currently was as its financial position would deteriorate. Whilst the transport issue could not be underestimated, the vast majority of patients would continue to receive services in the same settings as before. It would be mainly people who were very unwell who would be affected by the change and they were comparatively small in number. The majority of patients currently treated at Chase Farm would continue to be treated there or at locations even closer to their home.

A Haringey resident asked how the needs of migrant and refugee communities would be addressed within the modelling. Many people from these communities were not registered with a GP. Dr Russell stated that there should be no excuse for not being able to access primary care. There were a number of GP practices that were very experienced at dealing with some communities. Ms Panniker reported that the urgent care model that was in place at NMUH enabled patients to register with GPs when they attended.

Mr Easton commented that very few clinicians only worked on one hospital site so any reduction in the services provided at one location would have limited impact on attracting and retaining staff. The feasibility exercise nevertheless needed to look at recruitment and retention issues. The uncertainty about the future of Chase Farm was having an effect on the ability of the trust to recruit. Changes in A&E provision had taken place in London in recent years with some areas of activity being specialised and not provided at every centre e.g. major trauma and stroke. As a result of this, Chase Farm was already no longer a major A&E department.

The Chair thanked NHS officers from all the trusts in attendance for their assistance. He was of the view that considerable work was required to reassure the local community about the future long term arrangements. The Committee would consider future arrangements for monitoring the implementation of the strategy, including the involvement of Hertfordshire County Council, once the potential judicial review issue had been resolved. It was essential that significant investment was placed into primary care in Enfield and that improvements were implemented speedily.

RESOLVED:

1. That the Committee consider further the arrangements for monitoring the implementation of the BEH Clinical Strategy, including the potential involvement of Hertfordshire County Council, once the issue of the potential judicial review by Enfield Council has been resolved.

2. That NHS North Central London be requested to share the report of the Transport Working Group on transport issues arising from the implementation of the BEH Clinical Strategy with the Committee.

3. That NHS North Central London be requested to provide information to the Committee on the additional number of ambulance vehicles that would be provided as part of the implementation of the strategy.

FINISH:
The meeting closed at 13:15 p.m.

CHAIR: