North Central London Joint Health Overview and Scrutiny Committee
16 April 2012

Minutes of the meeting of the Joint Health Scrutiny Committee held at the Civic Centre, High Road, Wood Green, N22 8LE on 16 April 2012 at 10.30am.

Present: **Councillors:** Councillor Gideon Bull (Chair) (L.B.Haringey), Councillor John Bryant (Vice-Chair) (L.B. Camden), Councillor Peter Brayshaw (L.B. Camden), Councillor Alison Cornelius (L.B. Barnet), Councillor Martin Klute (L.B.Islington), Councillor Graham Old (L.B. Barnet), Councillor Barry Rawlings (L.B. Barnet) and Councillor Dave Winskill (L.B.Haringey).

Officers: Rob Mack (L.B.Haringey), Peter Moore (L.B.Islington), Linda Leith (L.B. Enfield) 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 introduced themselves.

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 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)

The following comments were made:

Item 4 (Minutes); In respect of the transformation of CAMHS (page 4), Councillors Bull and Cornelius reiterated their wish to attend a meeting of the young persons project group. It was noted that the group was happy to meet with the Members but had stated that it wished to defer this until it was better established. Officers from NHS NCL agreed to ask the YPP Board again and send an update on their progress to the Chair.

It was noted that a response had not yet been received to either of the two letters written on behalf of the JHOSC to the Chief Executive of Barnet and Chase Farm hospitals requesting information on the number of instances of maternity units at either Barnet or Chase Farm being temporarily closed. It was agreed that the Chair would write another letter to the Chief Executive expressing the Committee's concern at the lack of a response.

Item 5 (NHS North Central London Primary Care Strategy 2012 to 2016): It was noted that a specific Medical Director to develop primary care in Enfield had now been appointed. In respect of the 11th bullet point on page 5, it was agreed that the following would be added at the start of the sentence:
"In response to concerns that underperforming GP practices needed to improve their performance, it was noted……."

Item 6 (Barnet, Enfield and Haringey Clinical Strategy – Implementation): It was agreed that the risk register for the project would be re-circulated.

Item 7 (Further Development of the NHS North Central London Strategy and QIPP Plan 2013/14 – 2014/15/Month 9 Finance Update): In respect of the underspend on capital projects, it was noted that the figure that had been quoted was a nominal allocation that constituted the maximum amount that NHS North Central London could bid for from the Department of Health. However, there was very little

prospect of any applications being successful as the Treasury was not currently minded to approve any. The only exceptions to this rule were emergency works.

Item 8 (Contract Management of Acutes); It was noted that activity data for each site of Barnet and Chase Farm hospitals was still awaited and it was hoped to circulate this shortly.

RESOLVED:

1. That, subject to the above mentioned amendment, the minutes of the meeting on 27 February be approved.

2. That the Chair write on behalf of the Committee to the Chief Executive of Barnet and Chase Farm Hospital expressing concern at the lack of response to the Committee's request for information on the number of instances of maternity units at either Barnet or Chase Farm being temporarily closed

5 ORAL SURGERY (Agenda Item 5):

Tina Raphael from NHS North Central London (NCL) reported on action that was being taken to move some oral surgery procedures out of hospital and into community settings. It was noted that a procurement process was currently underway to ensure that intermediate minor oral surgery providers had been procured in all of the boroughs within the cluster. Procurement was taking place for all boroughs with the exception of Barnet, who had already undertaken a formal procurement process.

There were significant savings that could be made by relocating services into the community. Procedures cost between £600 – 980 each in hospital whilst in the community they could cost less than £200 so there were significant cost savings to be made. The process hoped to ensure consistency across the five boroughs. It was considered that approximately 50% of procedures could be performed in the community. Nevertheless, some would still need to be undertaken within hospital. Referrals were also increasing every year.

All dentists had been asked to refer non emergency oral surgery referrals via the relevant referral management centre for their borough. However, some referrals were made privately and, in addition, some were also made by dentists from outside the NCL area.

It was noted that there had been 48 expressions of interest from potential providers with 22 invited to tender. The final decision on who the contracts would be awarded to was likely to be made in mid May. All existing providers were amongst those who had applied. Current contracts would be carried over until new contracts were awarded to successful providers.

Surgery that was likely to be moved from hospital to community settings included procedures for retained roots and removal of wisdom teeth, which were not regarded as needing input from consultants. There had been consultant input in the work that had been undertaken as part of the procurement process. Surgeons used by providers had to be on the NHS specialist list or equivalent and needed relevant accreditation. Providers also needed to be suitably equipped. Any co-morbidities would be taken into account at the triage stage when deciding whether or not treatment in the community was the best option.

The main providers of hospital based surgery were UCLH and Barnet and Chase Farm hospitals and it was considered that there would be sufficient throughput remaining to maintain critical mass and their viability. The procurement process could not be restricted to specific types of provider and a range of organisations had expressed an interest. This included groups of dental practices as well as acute providers. There was no specific intention to develop the market further and there were no large new players amongst providers that had responded.

It was noted that the disparity between the cost of performing procedures in hospital and in the community was due to tariff levels within payment by results. Some dentists were still referring patients directly to hospitals rather than via the referral management service. It was important that each borough worked closely with dentists and that confidence was developed in community based services. General anesthetics were only given when required clinically and in an acute setting. Sedation could be

appropriate, with strict monitoring, for minor procedures and provided in community setting. There was an inner and outer London rate for providers. The changes would increase the number of service providers and were therefore likely to improve access. Quality indicators for the service had been developed and it was agreed that these would be shared with the Committee.

The Committee thanked Ms. Raphael.

RESOLVED:

That the quality indicators for intermediate minor oral surgery providers be circulated to Committee Members.

6 PROPOSAL FOR THE PROVISION OF A VASCULAR SERVICE FOR NORTH CENTRAL LONDON (Item 6)

Dr Nick Losseff reported on the outcome of the project to centralise complex arterial vascular surgery within the cluster. Commissioners, working with clinicians, had now finalised the local solution and the Royal Free Hospital had been selected as the hub. It was important to emphasise that it would be just the most complex procedures that would be centralised at the Royal Free and these only represented a small proportion of surgery. The Royal Free now had state of the art facilities and its co-dependencies complemented the service best of all the available options. The decision had been taken jointly on the basis of what clinicians felt was best for patients.

It was noted that it was not feasible to provide surgery around the clock on every day of the week. However, if there was a need for consultant input out of hours, this could be covered through the network of vascular clinicians that had been established. It was also possible to deal with cases remotely. Consultants could come into hospital if need be although it would be unusual for there to be a need for this. The proposals had been presented to and supported by the Clinical Commissioning Group (CCG) Cabinet, which comprised of the chairs of the 5 emerging CCGs across the cluster.

The Committee welcomed the successful conclusion to process and the fact that it had been achieved by way of consensus.

RESOLVED:

That the selection of the Royal Free Hospital as the hub for complex arterial surgery within the cluster be endorsed.

7 TRANSFORMATION OF CAMHS; UPDATE AND EDUCATION MODEL (Item 7)

Dr Denny Grant from L.B. of Enfield gave an overview of the education model for CAMHS on behalf of Barnet, Enfield and Haringey local authorities. It was, however, noted that the report that had been presented was focused first and foremost on Enfield. Dr Grant reported that the clinical model had now been agreed and further consultation was currently taking place with staff and adolescents. Final financial agreement from commissioners was awaited in respect of the scope of the reconfigured service. It was currently sometimes necessary to place young people in private sector provision pending implementation of the new system and this was proving to be expensive.

Enfield Council had agreed to continue to use the Northgate Pupil Referral Unit (PRU) but had asked for a review to be undertaken in six months time so that a final decision could be taken regarding the longer term. Enfield was working with Barnet and Enfield to try to obtain a consensus on the education model across the three boroughs. The model needed to be sustainable and commissioned upfront so that security was provided within it. Adolescent provision was quite unpredictable and the three boroughs wished to ensure that Northgate school was sustainable and not undermined. Education needed to be available in an inpatient setting but, as with clinical care, it was desirable to get young people back into the community and community based education as soon as possible.

.It was expected that there would be fewer children and young people being referred. The boroughs were moving to a community based model of care based on the Alliance scheme that was already working in

Enfield. Whilst there was a future for the PRU, it was unlikely to have the same numbers of pupils, which would reflect the changes in clinical care with more care in the community and fewer service users being admitted to Tier 4 inpatient services.

It was noted that some pupils stayed on at the unit after they had been discharged from Northgate. It was normally preferable if they attended their local school. Members of the Committee highlighted the positive feedback that had been received concerning Northgate from service users. However, Dr Grant stated that there had been concerns about Northgate for some time as the number of service users using the facility was not considered to be sustainable as it was consistently below full capacity. There were also developments in mental health care which raised questions about the model on which it was based. This did not detract from the fact that both the PRU and unit had been consistently good and highly valued. It was nevertheless acknowledged that there was a great deal of loyalty from service users to Northgate. However, whatever service CAMHS service users were using tended to get good feedback which was positive for CAMHS services overall. It was also reassuring that users felt that a high quality of care was being delivered. However, this also reflected on preference for care; there were some young people who had refused to go to Northgate and it had not been an attractive proposition for all. The Alliance model that was now being used in Enfield and which it was intended to replicate in Barnet and Enfield had proven to be very successful. All the Councils were committed to developing a sustainable and coherent model of education and there would be a need for the PRU for the foreseeable future.

Committee Members requested further statistical evidence regarding the Alliance model and the effect of the changes on demand for in-patient admissions. It was agreed that these would be brought to the July meeting of the Committee.

It was noted that Barnet's Principal Education Psychologist had fed into the report and agreed that he would be asked to confirm the Barnet position to Committee Members. In addition, it was agreed that a date would be sought for the Chair and Councillor Cornelius to attend a meeting of the young persons project board.

RESOLVED:

1. The further statistical evidence regarding the Alliance model and the effect of the changes on demand for in-patient CAMHS admissions be submitted to the July meeting of the Committee.

2. That position of Barnet Council in relation to the future operation of the Pupil Referral Unit be confirmed to the Committee.

3. That the Chair and Councillor Cornelius' request to attend a meeting of the YPP Board be referred back to the young people and that an update be provided to the Chair on the Board's progress.

8. ESTATES MANAGEMENT (Item 9)

Martin Machray from NHS North Central reported on the process for determining future arrangements for PCT owned estate in the light of the Health and Social Care Bill. The PCTs in the cluster currently held a large amount of estate, many of which had multiple users. The guidance suggested that where one provider was responsible for over 50% of the premises, ownership should pass onto them. Where there were other significant users, there should be a discussion with them. A new organisation called PropCo would take over some estate, particularly where there were multiple users. All NHS estate would either pass onto PropCo or NHS provider organisations.

The Committee requested that a list be put together of all PCT estate in each of the boroughs within the cluster and that this be circulated to all Members of the Committee. In addition, it requested that NHS North Central London undertake to keep chief executives in the cluster informed of any disposals. It was also felt that, in complex cases, local agreement should be sought regarding transfer of estate prior to the involvement of PropCo in order that any proceeds from disposals could instead be used locally.

Mr Machray agreed to compile a suitable list. Additional information would be provided to the next meeting on the issue of LIFT properties and freehold issues. Whilst NHS North Central London was happy to give the Committee an undertaking to keep Councils informed of any proposals to dispose of

PCT owned property, such an undertaking could only apply till April 2013 when NHS North Central London would cease to exist.

The Committee were of the view that disposals of surplus estate should be used to provide investment in local services rather than used centrally and agreed to write to the Secretary of State expressing this view, with copies to local MPs. In addition, it was felt that there was a need for greater clarity in the arrangements. It was requested that list of properties include detail on those sites whose future was currently under discussion and those that were considered as no longer fit for purpose. In addition to chief executives, it was also felt that Council leaders, relevant Cabinet Members and chairs of health overview and scrutiny committees should also be kept informed of any proposals to dispose of PCT properties.

It was noted that there were strict rules about what could be done by NHS bodies in respect of specific sites. The proportion of PCT properties that were used for GP practices was comparatively small. The Committee felt that the key question concerned what would happen to the proceeds from any sales of NHS properties by PropCo. It was possible that these could be diverted from being used to address local health priorities to deal with other government priorities.

RESOLVED:

1. That a letter to the Secretary of State for Health be drafted on behalf of the Committee requesting assurances that any local proposals in respect of the future of former PCT estates will be looked at sympathetically by PropCo.

2. The NHS North Central London be requested to provide a list of PCT estate in each of the boroughs within the cluster and that this be circulated to the Committee together with information on sites whose future is currently under discussion and those that are considered as no longer fit for purpose.

3. That NHS North Central London be requested to keep chief executives, Council leaders, relevant Cabinet Members and chairs of health overview and scrutiny committees informed of any proposals to dispose of PCT owned sites.

9. BARNET, ENFIELD AND HARINGEY MENTAL HEALTH TRUST (BEH MHT) QUALITY ACCOUNT (Item 8)

Dr Martin Jones and Clara Wessinger from BEH MHT introduced its draft Quality Account 2011/12. It was noted that there had traditionally been under reporting of patient safety incidents so an increase was an indication of greater openness and transparency. The number of incidents was nevertheless quite low in view of the size of the trust.

Committee Members raised the following issues:

- It was suggested that feedback from service users could be obtained through randomised interviews;
- Improving communication with GPs was important and was an ongoing issue;
- In respect of emergency re-admission, it was felt that an indication of the number of patients involved might provide greater clarity. In addition, information on what was being done to address such instances would be welcome;
- More information on the absolute number of patients and the different types of treatment given would give those reading the report a clearer impression of the work of the trust.

It was noted that the trust was in the lowest 20% for the percentage of staff who would recommend their trust to people. It was the first time that this measure had been used and progress would be monitored. An action plan to address the issue was being developed. Members also felt that the effect on morale of uncertainty regarding the future of particular trust premises should be monitored.

The trust agreed to include a wider range of background information, such as the number of patients with a diagnosis, medicines, the number of beds and average length of stay in future reports in order to provide a greater narrative. In addition, the Committee felt that information on the percentage of patients with recoverable conditions would be of benefit as it would provide a means of demonstrating the effectiveness of interventions.

RESOLVED:
That the above mentioned comments by the Committee be noted by the trust and responded to in future reports.

10 FUTURE WORK PLAN (Item 10):
In respect of the agenda for the meeting on 28 May, the Committee noted that a recent report on the implementation of the BEH Clinical Strategy to Barnet's Health Overview and Scrutiny Committee had shown changes to the investment strategy. It was agreed that the report on the issue to the next meeting would include the outline business case.

It was also noted that the report on QIPP outturn would refer to the financial inheritance that would pass onto the new structures from 2013 and agreed that this be linked to the item on transition. The Committee also asked that a representative from the CCG Cabinet be invited along to the meeting. The Committee agreed to defer discussion on the primary care strategy to the July meeting. In the meantime, individual boroughs would each consider their local plans. There would nevertheless be reference to primary care within the item on the BEH Clinical Strategy at the next meeting as making improvements were a key part of this.

11 The meeting closed at 12:55 pm.