MINUTES OF THE MEETING OF THE NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE HELD ON FRIDAY, 7TH FEBRUARY, 2014

MEMBERS: Councillors Alev Cazimoglu and Anne-Marie Pearce (LB Enfield), Alison Cornelius, Barry Rawlings and Graham Old (LB Barnet), Peter Brayshaw and John Bryant (Vice Chair) (LB Camden), Gideon Bull (Chair) and Dave Winskill (LB Haringey), Jean Kaseki and Martin Klute (LB Islington)

Officers: Linda Leith, Jane Juby

Also Attending: Dr Tim Peachey (CEx, B&CF), Professor Stephen Powis (Medical Director, RFH), Diana Mohar (NMUH), Fiona Smith (B&CF), Kim Fleming (Director of Planning, RFH), Kevin Howell (Director of Environment, NMUH), Julie Lowe (CEx, NMUH), Deborah Sanders (Director of Nursing, RFH), Wendy Wallace (CEx, C&IFT), George Howard (Islington CCG and Islington Council), Maria Kane (CEx, BEH MHT), Andrew Wright (Director of Strategic Development, BEH-MHT), Liz Wise (Chief Officer, Enfield CCG), Dr Deborah Turbitt (Deputy Regional Director for Health Protection, London), David Sloman (CEx, RFH)

1. WELCOME AND APOLOGIES

No apologies for absence received.

2. DECLARATIONS OF INTEREST

Cllr Cornelius declared a personal interest as an assistant chaplain at Barnet Hospital.

3. URGENT BUSINESS

Cllr Klute requested that NHS England attend a future meeting to explain their proposal not to consult nationally on the privatisation of the commissioning support units. .

Following complaints, it was important that each local authority should ensure that agendas for JHOSC meetings are on their websites.

4. MINUTES

The Minutes of the meeting 29 November 2013 were **APPROVED** subject to the following:

- That Cllrs Cazimoglu and Bryant be noted as present;

- That the statistics for overseas visitors to A&E and maternity services requested at page 6 were circulated.

5. ACQUISITION OF BARNET AND CHASE FARM HOSPITALS BY THE ROYAL FREE

David Sloman, Chief Executive, Kim Fleming, Direct of Planning, Deborah Sanders, Director of Nursing and Professor Stephen Powis, Medical Director, Royal Free NHS Foundation Trust gave a presentation the main points of which are summarised as follows:

- In September 2012 Barnet and Chase Farm Hospitals decided to choose the Royal Free as its preferred partner to achieve Foundation Trust status;
- The focus was on patient and economic benefit;
- The Strategic Health Authority agreed in November 2012;
- In August 2013 the acquisition was given the go ahead by the competition regulator;
- The Business Case was submitted in January 2014 to the Trust Development Authority;
- The Monitor's three-month assessment of five-year plan is underway;
- The target date for acquisition is 1 July 2014;
- The final decision will be taken in May at the Royal Free's Council of Governors;
- Between now and July residents will be informed and consulted;
- The vision and guiding principles were to offer excellent care and patient experience, excellent expertise through world class research and teaching, excellent value for money and a strong organisation with more depth and resilience;
- Existing strategies would be adhered to and wherever possible, the aim would be to deliver care close to patients' homes.
- The Royal Free would deliver a wide range of local and specialist services.

The following questions were then taken:

Q: Will there be the services in primary care available to replace those currently being offered through hospitals? What will the boundary lines be?

A: One of our other key principles is to work with the CCG and other partners to plan what will be provided in the community; working in partnership is essential. We have in fact planned for a loss of income to the Trust due to patient funding being directed into community provision. We are working with CCGs and GPs to work out a treatment partnership and we are confident we will get this right. For example, we are already moving the treatment of kidney patients out of the Royal Free to sites closer to where people live. We want to remove the confusion and fragmentation of secondary care level.

Q: Is there a standing stakeholder reference group? Patient engagement is key as many people are anxious and worried their services may change and need to see the detail of what is going to happen to feel reassured.

A: We have already engaged with lots of stakeholders but your point regarding a reference group is well taken and we will take this away **ACTION: David Sloman**.

Q: When The Royal Free NHS Foundation Trust acquires Barnet & Chase Farm does this mean it will have Foundation Trust status?

A: Yes.

Q: What assurances can you give that no land sales at the Chase Farm site will take place until Barnet & Chase Farm has Foundation Trust status (any sale of land prior to this will mean the money raised is not ring-fenced for investment back into the site but will go to the Treasury)? Can you give an assurance that there are no discussions, negotiations or valuations currently being undertaken which indicate that you are looking at the sale of land on the Chase Farm site.

A: Dr Tim Peachey (Interim Chief Executive, Barnet & Chase Farm Hospital NHS Trust) stated in response that there was no plan to divest of any land on the Chase Farm site before the (acquisition) transaction was completed. There was no plan to put any land on the market. He also added, in response to an enquiry from a Member, that the sale of land at Elmbank would be used to pay back the debt already incurred for building work at the Barnet Hospital site.

David Sloman also added that there was a commitment that any sale of land at Chase Farm site would be invested in services for Enfield residents.

It was subsequently stated that the Foundation Trust always looked to see how it could put its assets to best use, for example the building at Coppetts Wood had not been in use for a significant number of years and therefore was being sold for reinvestment.

It was requested that details of the Foundation Trust's investment programmes for the next 5 years be brought to the June meeting. David Sloman stated that he was happy to bring this detail to the June meeting, but could not commit to the level of granularity available at that time. **ACTION: David Sloman.**

It was also noted that if the acquisition proceeded, then there would be no change to the configuration of services provided on existing sites, as set out in the BEH Clinical Strategy. The acquisition aimed to improve patient experience and access and provide more financial

depth and resilience. There was, additionally, always a premium on patient safety.

Deborah Sanders, Royal Free, added that the acquisition would also provide greater security and career opportunities for staff, which would improve staff engagement and consequently, patient experience. An increase in scale would also allow better training opportunities.

A Member commented that, although the specialist centres referred to earlier were welcomed, the success of these would be dependent on the right levels of primary and community care being developed. Residents wanted to see evidence of this in place before any services were removed.

A further question was taken as follows:

Q: A Member asked if we had the sites to be treated locally, and would this be in primary care with transfer of responsibility and funding?
A: The Trust has worked closely with CCG partners. The Business Case takes account of the loss of funding. The CEx agreed that the new model of care was the right one, with integrated care pathways.

Q: What will be the level of investment after the acquisition for research and teaching?
A: There is currently, within a total £550m turnover, around £35m-£50m invested in teaching, and several millions invested in research. Investment will be strengthened after the acquisition but it is difficult to give figures at the moment.

6. BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY – IMPLEMENTATION

Liz Wise, Chief Officer Enfield CCG, gave the following update on the implementation of the BEH Clinical Strategy:

- The Strategy's aim was to improve quality of care, provide a more senior doctor presence, increase maternity provision, make A&Es specialist emergency centres, create a dedicated planned care hospital at Chase Farm and help to provide a sustainable hospital and medical workforce.
- Maternity changes had been completed to plan on 25 November and emergency, paediatric and planned care changes were implemented on 9 December.
- The programme was now consequently in closedown.
- Urgent Care Boards had been set up to monitor post-implementation. These would review activity flows, final costs,

benefits realisation and process. The Boards were also helping to manage current winter demands.

- Early impact assessments: B&CF/NMU first to be compliant with new clinical workforce standards, improved physical environment, recruitment of 200 additional staff at North Middlesex Hospital, improved staff morale and reduction in delayed discharge.
- The Urgent Care Centres were now up and running with the North Middlesex UCC extending its opening hours to 15 hours a day.

The following questions were then taken:

Q: A Haringey resident stated that the review group involved with the Strategy had expressed a wish for the lessons learned to be published – it's disappointing that this has not happened.

A: We are keen to look at these.

Q: Patient experience has not really been mentioned. At the last Health & Wellbeing Scrutiny Panel we received a presentation from the London Ambulance Service where it was noted that there were ambulances queuing at hospitals and handover and journey times were up. How are these being monitored?

A: Every winter is challenging and this winter has been no different despite the mild weather. This is impacting the whole of the NHS system which in turn is affecting us. We have as much A&E capacity as we had before. Performance has gone up and down but we are constantly tracking it across the system. Intelligent conveyancing (where ambulances are directed in a certain pattern to prevent queuing) is an issue and is being looked at.

A Member stated at this point that greater transparency from the CCG would be welcomed; if there were issues or problems then Councillors should be informed.

Q: Funding has been made available from the Government to help prevent people visiting A&Es. Is enough being offered to people at home to stop them presenting to an A&E in the first place? Are you confident enough is being done in this respect?

A: There is always more we can do. Such preventative work requires a lot of upfront investment. All CCGs do look at the most vulnerable residents in this respect and this is why we are trying to put as much care as possible closer to home. Integrated care programmes like this do take a while to build up. The CCG is developing a 2-5 year plan; which the JHOSC may wish to see at a future meeting.

Q: There are 20% more ambulances being called than expected; this is a sizeable number and is a good indicator of need in the population – is there any analysis of the reasons for this?

A: We are collecting this information. We also need to look at what happens to patients subsequent to them being taken to hospital by ambulance – do they go home or are they admitted? Is there a link with any particular GP practice and what are the reasons? There is evidence available so far to suggest that certain care homes have been using an increased number of ambulances; and we need to understand the reasons for this and ensure ambulances are not being used as 'alternative transport' for elderly patients. In general, only 35% of people transported to hospital by ambulance are subsequently admitted at NMH.

An Enfield resident stated that ambulances were queuing outside hospitals and were also having longer journeys.

This was confirmed by another resident; who also mentioned that demand for ambulances appeared to be highest at 8am and 9pm and suggested this may coincide with carers visiting elderly residents.

It was **AGREED** that the London Ambulance Service be invited to attend the next meeting **ACTION: Secretary**

It was **AGREED** that the spend levels between primary and secondary care across the five boroughs would be an item on a future JHOSC agenda.

7. HOSPITAL FOOD

Dr Tim Peachey gave a brief explanation of meal provision at Barnet & Chase Farm Hospitals as follows:

- Catering was sub-contracted to a company called Medirest, through a PFI.
- Meals were cooked and prepared individually for each patient under the 'Steamplicity' system.
- Meals were chosen by the patient no more than 3 hours before serving and a change of meal option could be accommodated up to 30 minutes beforehand.
- A menu was also available 24 hours a day for emergency admittance.
- The cost per patient per day for meals was £7.10.
- Satisfaction ratings across Barnet & Chase Farm Hospitals was high, although it was slightly lower at Chase Farm than at Barnet; this may be linked to the overall environment/ambience in which meals were taken.
- Menus were available in multiple languages, including braille.

The following questions were then taken:

Q: Can you explain why the cost per patient at North Middlesex Hospital is £11, for the same catering system?
A: This may be due to how costs are measured; staff costs associated with serving/clearing away may have been included, for example.

Kevin Howell, Director of Environment at North Middlesex Hospital, confirmed that this was the case.

A Member raised the issue that diabetic patients had been served sugary food/desserts at the North Middlesex Hospital – this was noted and the matter would be followed up **ACTION: Kevin Howell.**

Q: Is there a wheat free option at B&CF Hospitals?
A: Wheat free products are identified on menus with a logo, and there is an option provided at every meal.

Q: How can you explain the differences nationally in food spend in hospitals?
A: This may be due to the level of wastage and, as referred to previously, how costs are measured. Barnet & Chase Farm Hospitals have a very low level of wastage due to the fact that food is prepared less than 3 hours before service and the amount ordered is the amount prepared.

Q: Has the food offer changed at Barnet & Chase Farm Hospitals over the last few years?
A: The current contractor has been in place for several years – the menus would have certainly changed but the basic offering would therefore be the same.

Deborah Sanders outlined the arrangements for the Royal Free Hospital:

- A cook/chill system was used to prepare meals.
- Nursing staff took an active part in helping patients select their meals and portion sizes.
- Focus groups helped taste and rate food.
- Homemade soups were being offered which were made on site from local ingredients.
- Salads were also offered, prepared on site which reduced packaging volumes.
- The breakfast offering was being reviewed.

It was acknowledged that the message generally that good nutrition was the key to good recovery was now well embedded in hospitals in the UK.

It was **AGREED** that an update on the food offering from the Whittington and UCL Hospitals should be requested **ACTION: Secretary.**

Q: Is there a requirement for the payment of minimum wage to contracted workers?

A: Maria Kane responded that the B&CF MHT was a Living Wage employer. She added that the Trust used a cook/chill system and provided additional food options such as a smoothie group and Sunday roast clubs. A community meeting every 2 weeks was held to review the food offering. It was a continuing challenge for the MHT to encourage and motivate patients to eat well. The spend per head per patient was £10.19.

Q: Does the CQC undertake hospital food inspections?

A: Yes, they do. The CQC inspectors will watch a meal service and taste the food. They will also monitor how people are supported to eat and drink.

Wendy Wallace, CEx of the Camden and Islington FT added that they also used a cook/chill system, which provided more menu choice (this was felt particularly important where the majority of patients were long term). A cooked breakfast had now been introduced on a Sunday.

The question was asked as to whether any patient groups walked around hospitals to get direct feedback from patients and who was asked for their feedback, since elderly and vulnerable patients could often 'gloss over' any problems. It was noted visiting relatives and friends should also be asked for their feedback to mitigate this.

MHTs were asked how patients with eating disorders were treated at meal times. It was noted that this depended very much on an individual's issues but for example, a patient may eat with a member of staff and/or have a personalised eating plan which may include added nutritional supplements. The environment in which a person with an eating disorder would take their meals was also considered.

8. FUNDING FOR MENTAL HEALTH SERVICES

Wendy Wallace, CEx Camden and Islington Foundation Trust, Maria Kane, Chief Executive Barnet, Enfield & Haringey Mental Health NHS Trust, and Liz Wise, Chief Officer, Enfield CCG, gave presentations, the main points of which were as follows:

- The BEH MHT continues its focus on improving services for patients;
- The Trust had consistently met its operational and financial performance targets for the last 5 years;
- There was a clear long term strategy to integrate mental and physical health services and reduce the need for patients with

both mental and physical health conditions from being admitted to hospital wherever possible;

- Due to major increases in the numbers and acuity of patients, the Trust faced a very difficult situation in continuing to provide safe services, with no additional funding available.
- Services were consequently under increasing pressure, particularly inpatient services.
- Parity of esteem issues were acknowledged around the funding of mental health services;
- In addition to the current level of CCG investment into the BEH MHT; it also spent c. £4m in 2013/14 to date on private placements in order to accommodate the increased demand for inpatient admissions.
- The Trust was working with the CCG to agree the best way forward. A jointly commissioned project with Mental Health Strategies was underway to benchmark current levels of investment, assess financial viability and provide options to align service provision to funding levels. A final report is due on 14 March.

The following questions were then taken:

Q: Are Recovery Houses now being used to relieve pressure for beds on the Trust's hospital wards?

A: The Recovery House model was to be used preventatively; however they have needed to be used as a step down measure. Of the 7 beds available, 3 are currently taken up by people of no fixed abode. There is an increasing need for mental health services in the community and it is becoming increasingly difficult to meet this need.

Q: Has the closure of mental health beds over the last few years contributed to the problem?

A: No, there are just more people with mental health needs who require admission; this may be due to the current economic climate and people finding it difficult to cope.

A Member requested more information on the total spend across the 5 boroughs on mental health to enable Members to lobby for increased funding. **ACTION: Liz Wise.**

Q: Who determined the configuration of the BEH MHT? Why have 3 boroughs been grouped together?

A: Many MHTs are in fact larger than this; it reflects the fact that there were 3 borough community health services that merged when the PCTs were formed.

Q: Is the closure of St Ann's on the agenda?

A: BEH-MHT is progressing its plans to redevelop St Ann's Hospital as there is a need improve the quality of the current

wards and therefore the Trust would need to consider the sale of parts of this site not currently used for investment in improvements on the part of the site to be retained for NHS use.

Wendy Wallace, CEx of the Camden & Islington FT commented that their funding was based on block contracts; there was therefore no facility to respond to changes in demand.

C&I FT was, however, significantly ahead of other acute services in preventative work and had been reducing the numbers of beds required largely successfully for a number of years.

The question was asked of MHTs if they had any problems of intensive occupancy associated with delayed discharge.

C&I FT responded that their housing pathways were very good and that their delayed discharge figure is 1%, which may be the lowest in the country and that they are very connected with the local authorities in their area and have been integrated with social care services for 20 years. BEH MHT responded that this year had seen significant pressures due to increasing demand.

It was agreed that there was an argument in principle that the formula for calculating mental health funding should be based on need. It was **AGREED** that a letter from the JHOSC be sent to Norman Lamb. It was also **AGREED** that further detail on the 'mental health weighted population' should be provided as it may assist in the case for funding **ACTION: Committee Secretary.**

Cllr Kaseki declared an interest as a Governor of the MHT.

A request was made to rearrange the meeting on 17 March in order to receive the Mental Health Strategies report due on 14 March **ACTION: Chair**

The following further questions were then taken:

Q: In austerity, what is the strategy for MHTs to tackle poverty in mental health service users?
A: MHTs do try and work to get patients into employment, which is the main factor in tackling poverty in mental health service users.

Q: Can the BEH MHT work with Haringey Council to unblock housing stock to release the Recovery House beds?
A: It isn't always the Council's responsibility to house a patient, there is also a significant demand for housing stock in Haringey and issues such as the payment of benefits sometimes take a while to resolve, which again causes delay in discharge. We have a responsibility to make sure patients have somewhere

safe to go, so cannot discharge them until we are sure that they do.

9. PUBLIC HEALTH ENGLAND – ENGAGEMENT PLANS

Deborah Turbitt, Deputy Director Health Protection, Public Health England (London), gave a presentation, the main points of which were as follows:

- Public Health England was a new organisation, created in April 2013 as part of the overall transformation of the NHS.
- 5 main priorities for 13/14 had been set, with 2 supporting priorities.
- PHE was now starting to engage with health economies. It's primary purpose was to provide evidence based professional, scientific and delivery expertise and advice, ensuring effective arrangements were in place locally and nationally for preparing for and responding to health protection concerns and supporting local authorities and CCGs by providing evidence, knowledge and advice on local health needs.
- PHE's overall main mission was to protect and improve health and to address health inequalities.

The following questions were then taken:

Q: Where does the Public Health England budget for mental health sit?

A: One of our top 5 priorities does include mental health and wellbeing – there is a workstream for this. Public Health England does have a mental health strategy for London. From April of this year Londoners will also be able to access an app which will give help and advice on mental health issues and accessing services.

Q: Is there a Public Health lead for mental health – we do need to develop a more preventative and robust approach?

A: The Lead would be Paul Plant, who is Deputy Director for Health Improvement.

Q: Public Health allocations across London are very different. Is this going to be looked at?

A: Yes, it is being looked at. Allocations were previously based on PCT spend. Work is going on at a national level to look at a fairer funding system. My understanding is that, consequently, there will be a further adjustment.

Q: What proportion of local authority Public Health funding is for the local authority to allocate and what is mandatory spend/prescribed by bodies such as yourselves?

A: The allocation to local authorities is primarily for local authorities to allocate, save for, as you know, certain mandatory areas of spend. Your Director of Public Health would be able to advise on the proportions of each within your own local authority.

Q: What level of involvement do you have in gathering health intelligence for local authorities?

A: We have Knowledge and Intelligence Teams in Public Health England who will gather intelligence for local authorities, there is a team for London. The team can provide detailed borough profiles and can also provide bespoke information for a particular need.

Q: In 2016 councils will have greater freedom over their public health spending; how much flexibility will there be?

A: If it can be justified that it is in the interests of public health, and a benefit can be demonstrated, it will be for local authorities to decide how the money is spent. You will, however, need to account for any such spend to Public Health England.

10. JHOSC REVIEW

The recommendations:

- that the current arrangements, Terms of Reference and procedures for the JHOSC be maintained subject to further periodic review;
- that a date be agreed for the first meeting of the JHOSC after the Local Government elections;

were **AGREED.**

11. WORK PLAN AND DATES FOR FUTURE MEETINGS

The date of the next meeting was noted as 28 March 2014.

The items on the forward agenda were noted and **AGREED.**

It was also requested that the London Ambulance Service be invited to attend this meeting, or if this was not possible, the next thereafter **ACTION: Secretary.**

The meeting ended at 1.15pm.