NOTICE OF MEETING

NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Contact: Robert Mack

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Friday 4 October 2013 10:00 a.m.
Committee Rooms 1 and 2, Haringey Civic Centre, High Road, Wood Green, London N22 8LE

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

Support Officers: Andrew Charlwood, Linda Leith, Robert Mack, Philippa Murphy and Harley Collins

AGENDA

1. WELCOME AND APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST (PAGES 1 - 2)

Members of the Committee are invited to identify any personal or prejudicial interests relevant to items on the agenda. A definition of personal and prejudicial interests is attached.

3. URGENT BUSINESS

4. MINUTES (PAGES 3 - 10)

To approve the minutes of the meeting of 19 July 2013.

5. MOORFIELDS EYE HOSPITAL

To receive an overview of services provided by Moorfields Eye Hospital NHS Trust as well as information on its proposed moved to the King's Cross area.

6. ACCIDENT AND EMERGENCY (A&E) (PAGES 11 - 26)

To consider the A&E performance of NHS acute provider trusts within the north central London area as well as any patterns or emerging issues.

7. ACQUISITION OF BARNET AND CHASE FARM HOSPITALS BY ROYAL FREE (PAGES 27 - 28)

To receive an update on the acquisition of Barnet and Chase Farm Hospitals by the Royal Free.

8. CANCER AND CARDIAC SERVICE RECONFIGURATIONS

To update the Committee on proposed cancer and cardiac service reconfigurations.

9. BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY - UPDATE

To receive an update on the implementation of the Barnet, Enfield and Haringey Clinical Strategy (presentation to follow).

10. MEETING OF MEMBERS FROM BARNET, ENFIELD AND HARINGEY TO CONSIDER ISSUES RELATING TO BEH MHT (PAGES 29 - 34)

To report back on the outcome of a meeting of JHOSC Members from Barnet, Enfield and Haringey to consider:

- Three recent CQC inspection reports relating to Barnet, Enfield and Haringey Mental Health Trust (BEH MHT) and the action plans in response to them; and
- BEH MHT's Service Re-Design and Transformation project.

11. WORK PLAN AND DATES FOR FUTURE MEETINGS (PAGES 35 - 36)

Agenda Item 2

DECLARING INTERESTS FLOWCHART - QUESTIONS TO ASK YOURSELF

What matters are being discussed at the meeting?

Do any relate to my interests whether already registered or not?

NO → You can participate in the meeting and vote

YES

Personal interest

Is a particular matter close to me?

Does it affect:

- me or my partner;
- my relatives or their partners;
- my friends or close associates;
- either me, my family or close associates:
  - job and business;
  - employers, firms you or they are a partner of and companies you or they are a Director of
  - or them to any position;
  - corporate bodies in which you or they have a shareholding of more than £25,000 (nominal value);
- my entries in the register of interests

more than it would affect the majority of people in the ward affected by the decision, or in the authority's area or constituency?

NO

NO

YES

You may have a **personal interest**

Declare your personal interest in the matter. You can remain in meeting, speak and vote unless the interest is also prejudicial; or
If your interest arises solely from your membership of, or position of control or management on any other public body or body to which you were nominated by the authority e.g. Governing Body, ALMO, you only need declare your personal interest if and when you speak on the matter, again providing it is not prejudicial.

Prejudicial interest

Does the matter affect your financial interests or relate to a licensing, planning or other regulatory matter; and
Would a member of the public (knowing the relevant facts) reasonably think that your personal interest was so significant that it would prejudice your judgement of public interest?

YES

You may have a **prejudicial interest**

YES

Do the public have speaking rights at the meeting?

YES

You should declare the interest but can remain in the meeting to speak. Once you have finished speaking (or the meeting decides you have finished - if earlier) you must withdraw from the meeting by leaving the room.

NO

You should declare the interest and withdraw from the meeting by leaving the room. You cannot speak or vote on the matter and must not seek to improperly influence the decision.

Note: If in any doubt about a potential interest, members are asked to seek advice from Democratic Services in advance of the meeting.

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North Central London Sector Joint Health Overview and Scrutiny Committee
Friday 19th July 2013

Minutes of the meeting of the **NCLS Joint Health Overview and Scrutiny Committee** held at 10:00a.m. on **Friday 19th July 2013** at London Borough of Camden Town Hall, Council Chamber, Judd Street , London WC1H 9JE

Present:

Councillors	**Borough**
Gideon Bull (Chair)	LB Haringey
John Bryant (Vice Chair)	LB Camden
Peter Brayshaw	LB Camden
Alison Cornelius	LB Barnet
Jean-Roger Kaseki	LB Islington
Martin Klute	LB Islington
Graham Old	LB Barnet
Anne-Marie Pearce	LB Enfield

Support Officers

Harley Collins	LB Camden
Rob Mack	LB Haringey
Linda Leith	LB Enfield
Leah Mooney	LB Enfield

1. WELCOME AND APOLOGIES

Councillor Bryant (Vice Chair) welcomed everyone and advised that he would be chairing the meeting until Councillor Bull (Chair) arrived.

Apologies for absence were received from Councillor Alev Cazimoglu and apologies for lateness had been received from Councillors Bull and Cornelius.

2. DECLARATION OF INTEREST

There were no declarations made.

3. URGENT BUSINESS

There was no urgent business

4. MINUTES

The minutes of the meeting held on 6th June 2013 were agreed as a correct record.

5. THE WHITTINGTON HOSPITAL- TRANSFORMATION PROGRAMME AND FOUNDATION TRUST STATUS UPDATE

The JHOSC received the briefing presentation that had been included in the agenda papers for the meeting and a further presentation on the Whittington Health Clinical Strategy. The presentations provided information on the transformation programme and progress towards foundation trust status.

Members thanked the Whittington for the very detailed information that had been provided in the presentations and raised the following points:

- Members were pleased to note that the clinical strategy was driving the estate strategy but wanted further information on the timescales for the renewed bid for foundation trust status.
- There was significant discussion in the documents about delivering more services in the home and members expressed some concern that this would result in local authorities being relied on to provide additional services.
- What examples were there of technological innovations in health care working?
- What progress had there been on reducing the use of agency staff?
- How effective had smoking cessation programmes been?
- Was the Whittington working with other hospitals as a training provider?
- Would GPs be taking over the clinical care of patients when they were discharged from hospital?
- Not everyone had computers, how would patients without them access information?
- How many Community Matrons were there?
- The strategy was very discursive but did not include a great deal of information about bed numbers and staffing levels which made it difficult to make any assessment of the implications of the strategy. When would more detailed information be available about the number of beds and staffing levels?

The following information was provided in response to the above points:

- A great deal of work had taken place at the Whittington to extend best practice and develop an integrated care model across all aspects of the hospital's work. There was a new timetable from the NHS Trust Development Authority with more focus on quality and operational excellence. There would be an assessment of the hospital's position with the aim of being on track for Foundation Trust Status at the end of 2014.
- These were challenging times but the Whittington would be working with partners on a strategy for community engagement, an equalities impact assessment and a clinical strategy.
- There would be close working with CCG colleagues to ensure that current services would continue to be provided by the health service and would aim to deliver them more strategically.
- Best practice on the use of patient portals would be shared and its introduction at the Whittington would be revolutionarily transformational in the provision of care. The system being introduced would link social care, the Whittington, community services and GPs and be known as Whittington Health. The aim was that there would be a carers' portal at a later stage.
- Targets on smoking cessation were not monitored for individual effectiveness

- A bank of agency staff was used to ensure standardisation and a quality of service and had proved to be financially beneficial.
- Partnership in education was key in the relationship with UCLH and Middlesex University Hospital and the Whittington wanted to continue to be a top training provider in London.
- The models of care were being redefined and the individual patient needs in each case would be assessed and adjustments made.
- Information on the number of community matrons was not to hand but would be made available.
- The clinical strategy was still at the development stage and so detailed figures were not yet available. In the next 18 months there would be a reduction in beds and there would be a further review of bed numbers after the ambulatory care arrangements had been in place. Changes in procedures had already resulted in a reduction in the length of stay in hospital but the JHOSC was assured that there would always be enough beds in the hospital to meet the demand for them and that there would be a report back from the Whittington in the Spring on the implementation of the ambulatory care system.
- The Whittington would be developing an engagement plan that would be considered by the hospital's trust board in the autumn and it was agreed that draft plan would be considered by relevant health scrutiny committees

RESOLVED

1. That the engagement plan for the transformation programme be submitted to relevant health overview and scrutiny committees in the area during the Autumn;

2. That the Whittington Hospital Trust be asked to provide further information on community matrons, including how they were employed; and

3. That a further report be submitted to the JHOSC in Spring 2014 by the Whittington on progress with the transformation programme.

(Councillor Bull Chaired the meeting from this point.)

6. LEADERSHIP OF SERVICE CHANGE IN THE NEW NHS

Consideration was given to a briefing that provided details about how structures and leadership of service change in the NHS were organised at local and London level. The interface between the NHS and the Health Overview and Scrutiny committees was also described as well as the role of NHS England in Direct Commissioning and the interface with Public Health England and Clinical Commissioning Groups. There was also a presentation in support of the briefing, with a further explanation of:

- Planning and system leadership in the new NHS
- Role of NHS England in planning and system leadership in the new NHS
- Other stakeholders who would play an important role
- How the public were to be involved
- Building a stronger relationship with health overview and scrutiny

The previous leadership models were more dispersed and unclear and it was hoped that these arrangements would provide more clarity.

The following points were made in response to the briefing:

- Were these new arrangements essentially the creation of a strategic health authority?
- NHS England was still in the process of appointing staff, was there capacity there to support all this work?
- Health needs in London were very different to the rest of the country, was this being addressed in the strategy?
- It was key to these new arrangements that the changes were implemented with more momentum. There did not appear to be any specific new pathways proposed and no significant initiatives.
- Who was responsible for the strategic overview of health areas? There were a number of networks but how do these transfer into action?
- Councillors had seen a number of housing development proposals where it was not clear if they had been linked to any strategic look at health provision
- What is the role of Patient Participation Groups in these new arrangements and was there any information that could be provided to members?
- What were the governance arrangements and what transparency was there around board accountability and decision making?
- There was concern from JHOSC members that £500m was a large sum for an individual to be able to make a budgetary decision on.
- What opportunities were there for comments from the public to be heard?

In response the JHOSC was advised that:

- The new organisational structure and leadership had resulted in changes in responsibilities to those previously but were a much more strategic approach and there was accountability within the new structures.
- NHS England was aware of large planned developments. The specialist community role within NHSE would ensure that CCGs fulfilled their roles to provide hospital and GP services that were responsive to the needs of their communities. There would also be a key role for Health and Wellbeing Boards in this work.
- Information on Patient Participation Groups was being collated and would be available in the next few months.
- It was advised that under the new arrangements there was a main board for NHS England and a regional London team. Processes for decision making were being established and all governance arrangements were not yet in place. Regional directors had been delegated authority to manage contracts up to £500m.
- The London region was structured differently with one Area Director responsible for the North Central and East London Areas, with three sub regional areas sitting below the NC/EL areas.
- The new arrangements had only been in place for fifteen weeks and there would be opportunities for the public to participate and for their voices to be heard.

RESOLVED

That the briefing and presentation be noted

7. FAILING GP PRACTICES

The JHOSC received a presentation about the arrangements to address failing GP practices, which looked at the following:

- Background information
- GP contracts in this part of NCEL
- Managing GP Performance
- How do we identify poor performance?
- New national arrangements being developed - what had been produced and was in place contractually for the individual performer
- Position from GPOS Summary (Dec 2012 data)
- GP Live Performance Cases Summary (July 2013)
- Individual Performance
- Contractual or practice matter?
- Absolute failure of a practice
- Changes between the old and new practices

The following points were then made in response to the presentation:

- The huge demand on Accident and Emergency Services was an indication of the lack of access to GPs. The need for more services had been identified by the CCGs as the route of a number of health service problems. Primary care service should be more responsive to the public need for the service.
- A potential strength of the new structure was that it would be able to look locally at the needs of each CCG
- A particular issue in Enfield had been the transport links between primary care services.
- In work that it was undertaking, Islington HOSC had identified a huge diversity in appointment systems at GP practices and people in the borough were struggling to navigate the appointment processes. With little common ground in the systems, trying to scrutinise the issues for patients had raised more questions than had been answered. Islington members of the JHOSC were asked to share their findings on this issue.
- Quality, performance and the mechanisms to generate improvement were issues that needed to be reviewed
- Out of hours services was another area generating complaints from users who were unclear about the provision and dissatisfied with the service being provided.

RESOLVED

That the presentation and the points raised by the JHOSC be noted.

8. CANCER AND CARDIAC SERVICE RECONFIGURATIONS

The JHOSC considered a report that provided information on the:

- Engagement on urological cancer surgical services
- Background to the cancer proposals
- Cancer pathways
- Cardiovascular Services and conclusions.

Following on from the responses that had been received as part of the Engagement, NHS England had agreed that the proposals would benefit from a formal consultation exercise, which was expected to be launched later in the year along with further development of the proposals for specialist cancer services across North East and North Central London. No significant changes to the location of services would take place without further consultation.

During consideration of the report the following points were made:

- The cross party working taking place at scrutiny committees had worked but there was some concern about party politics coming into play in the run up to the local elections in May 2013. It was advised that the consultation would be taking place late November to late February and so would be completed well before the local elections in May 2013.
- Consideration would need to be given as to how health overview and scrutiny committees would feed into to consultation process. Whilst there was a statutory requirement to set up a joint committee to respond to NHS consultations, it was possible that the three joint committees covering north and north east London could fulfil this function. Legal guidance would be taken on this issue and liaison would take place between the JHOSC and the joint committees for inner and outer north east London.

RESOLVED

That a meeting be arranged between the Chair and the Chairs of the Inner North East London (INEL) and Outer North East London JHOSCs, relevant support officers and NHS Officers to discuss the consultation process and engagement with health overview and scrutiny committees.

9. WORK PLAN AND DATES FOR FUTURE MEETINGS

Consideration was given to the work plan report that outlined proposed items for discussion.

In addition, the issue of women not entitled or eligible for maternity care accessing services was raised. In response it was requested that further information be sought about what period of residency in the UK was required in order to receive care. Also what reciprocal arrangements were there between member states of the European Union and was it the case that pre-existing conditions had to be treated in the patient's home country?

Members of the JHOSC agreed that they would be mindful of the dates and items that would be considered at the scheduled meeting close to the local council elections in May next year and to purdah period restrictions.

The following meeting dates were also noted:

- 29th November 2013 (Barnet)
- 7th February 2014 (Enfield)
- 28th March 2014 (Islington).

RESOLVED

That a briefing be submitted to a future meeting of the Committee on the arrangements for reimbursement of costs incurred in NHS treatment of non UK residents.

Minutes End

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North Central London

A&E Performance at NHS Trusts and Foundation Trusts – October 2013

1. Barnet and Chase Farm Hospitals NHS Trust
2. North Middlesex University Hospital NHS Trust
3. Royal Free London NHS Foundation Trust
4. University College London Hospitals NHS Foundation Trust
5. Whittington Health

Barnet and Chase Farm Hospitals NHS Trust

Indicator	Performance 2012/13	Performance Q1 2013/14	Performance Q2 (July & August) 2013/14	National standard
Time to initial assessment	6 minutes	9 minutes	11 minutes	Median wait at or below 15 minutes
Time to treatment decision	72 minutes	78 minutes	65 minutes	Median wait below 60 minutes
Total time in A&E	95.2%	90.5%	89.9%	95% of patients to wait no longer than four hours from arrival to admission, transfer or discharge
Total time in A&E	345 minutes	259 minutes	258 minutes	95th percentile below 4 hours
Unplanned reattendance rate	6.90%	7.45%	7.41%	Rate below 5%
Left without being seen	3.49%	3.95%	3.44%	Rate at or below 5%
Attendance per 100k population (this is not a calculable figure as attendances cross borough boundaries, so actual attendance volumes have been provided instead)	158,489 attenders	40,598 attenders	26,550 attenders	

Barnet and Chase Farm Hospitals NHS Trust

BARNET SITE

- GP delivered UCC at Barnet AE (40% of attendances)
- Establishing PACE and TREAT at Barnet
- Introduction of Rapid access team for patients with MH problems
  - A&E
  - Dementia Patients on wards
- Introduction of emergency ambulatory care model
- PAU
- Flow Improvements
  - Home for lunch
  - DTOC

CHASE FARM SITE

- GP delivered UCC at Chase farm site (40% of attendances)
- Older peoples assessment centre at CFH
- Paediatric assessment centre at CFH
- Community Beds

Barnet and Chase Farm Hospitals NHS Trust

- Rapid Improvement Plan (RIP) led by Enfield CCG Urgent Care Board and Trust Development Agency Support
- Focus on delayed transfers of care and admission avoidance schemes – led by John Morton.
- Review of emergency pathway to include senior decision makers at the beginning of the patient journey

North Middlesex University Hospital NHS Trust

Indicator	Performance 2012/13	Performance Q1 2013/14	Performance Q2 (July & August) 2013/14	National standard
Time to initial assessment	9 minutes	11 minutes	11 minutes	95th percentile below 15 minutes
Time to treatment decision	68 minutes	78 minutes	65 minutes	Median wait below 60 minutes
Total time in A&E	96.16%	93.82%	96.64%	95% of patients to wait no longer than four hours from arrival to admission, transfer or discharge
Total time in A&E	240 minutes	343 minutes	240 minutes	95th percentile below 4 hours
Unplanned reattendance rate	3.53%	2.43%	2.66%	Rate below 5%
Left without being seen	2.37%	2.57%	2.40%	Rate at or below 5%
Attendance per 100k population (this is not a calculable figure as attendances cross borough boundaries, so actual attendance volumes have been provided instead)	150,131 attenders	39,037 attenders	25,822 attenders	

North Middlesex University Hospital NHS Trust

- Good performance in 12/13
- Achieving 13/14 YTD with improving performance in Q2
- Significant investment in new capacity and pathways from Dec 13 linked to BEH clinical strategy and London Quality Standards
- Member of Haringey UCB, receiving 3.8 M of central winter monies

Royal Free London NHS Foundation Trust

Indicator	Performance 2012/13	Performance Q1 2013/14	Performance Q2 (July & August) 2013/14	National standard
Time to initial assessment	19 minutes	22 minutes	18 minutes	95th percentile below 15 minutes
Time to treatment decision	54 minutes	48 minutes	45 minutes	Median wait below 60 minutes
Total time in A&E	95.71%	95.75%	97.09%	95% of patients to wait no longer than four hours from arrival to admission, transfer or discharge
Total time in A&E	239 minutes	239 minutes	239 minutes	95th percentile below 4 hours
Unplanned reattendance rate	7.54%	8.0%	8.1%	Rate below 5%
Left without being seen	3.35%	2.7%	2.7%	Rate at or below 5%
Attendance per 100k population (this is not a calculable figure as attendances cross borough boundaries, so actual attendance volumes have been provided instead)	92,472 attenders	23,624 attenders	15,688 attenders	

Royal Free London NHS Foundation Trust

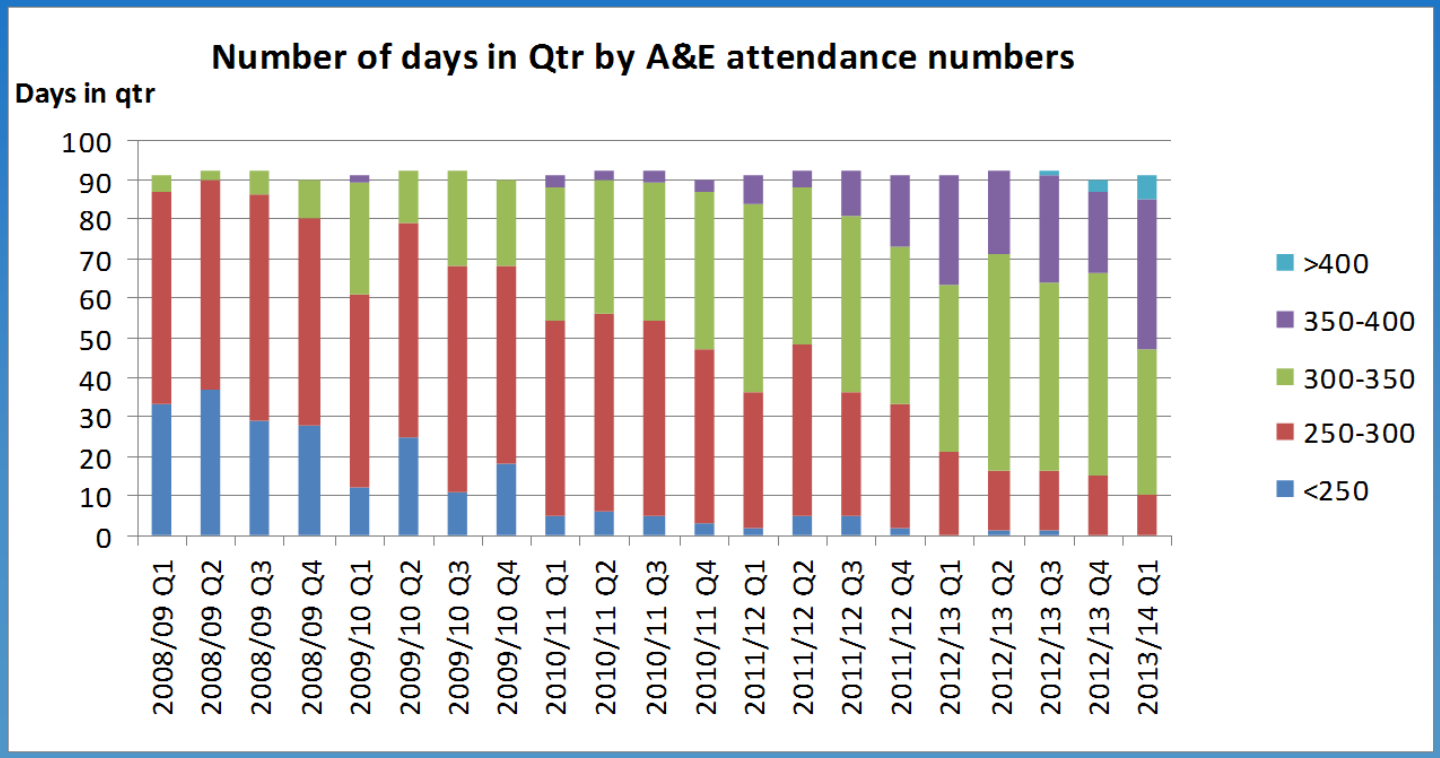
- The location and integration of the urgent care centre within A&E
- The TREAT service
- The PACE service
- Not just A&E, whole hospital
- Ownership
- Senior leadership and presence

University College London Hospitals NHS Foundation Trust

Indicator	Performance 2012-13	Performance 2013-14 Q1	Performance 2013-14 Q2	National Standard
Time to initial assessment	82	73	72	95th percentile below 15 minutes
Time to treatment	75	78	92	Median wait below 60 minutes
Total time in department	240	260	239	95th percentile below 4 hours
Unplanned re-attendance rate	7.5%	7.4%	7.9%	Rate below 5%
Left without being seen	2.4%	2.4%	2.8%	Rate at or below 5%
4 hr performance	95.4%	95.1%	96.1%	Rate over 95%
LAS performance	15 minutes – 82.5% 30 minutes – 97.8%	15 minutes – 87.8% 30 minutes – 99.3%	15 minutes – 85.2% 30 minutes – 99.4%	15 Minutes 95% (now 100%) 30 minutes 100%
Attendances	120,069	31,252	21,522 (mnths 4-5 only)	Comment: YTD 5.125% above same period last year
Senior clinician cover	ED Consultant M-F 08 – 23:00 Sat-Sun 09– 21:00			

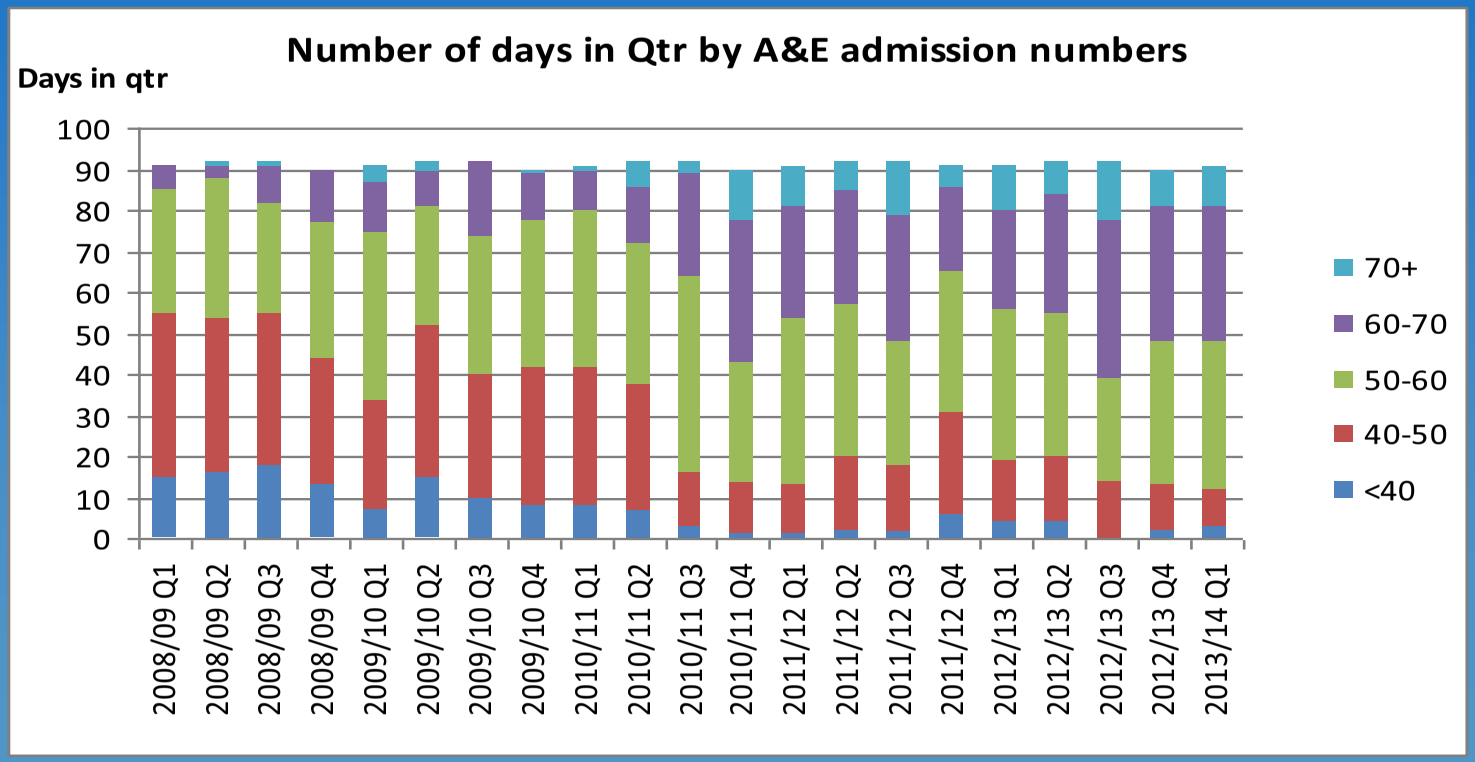
University College London Hospitals NHS Foundation Trust

Progressive increase in proportion of days with high or very high ED attendances



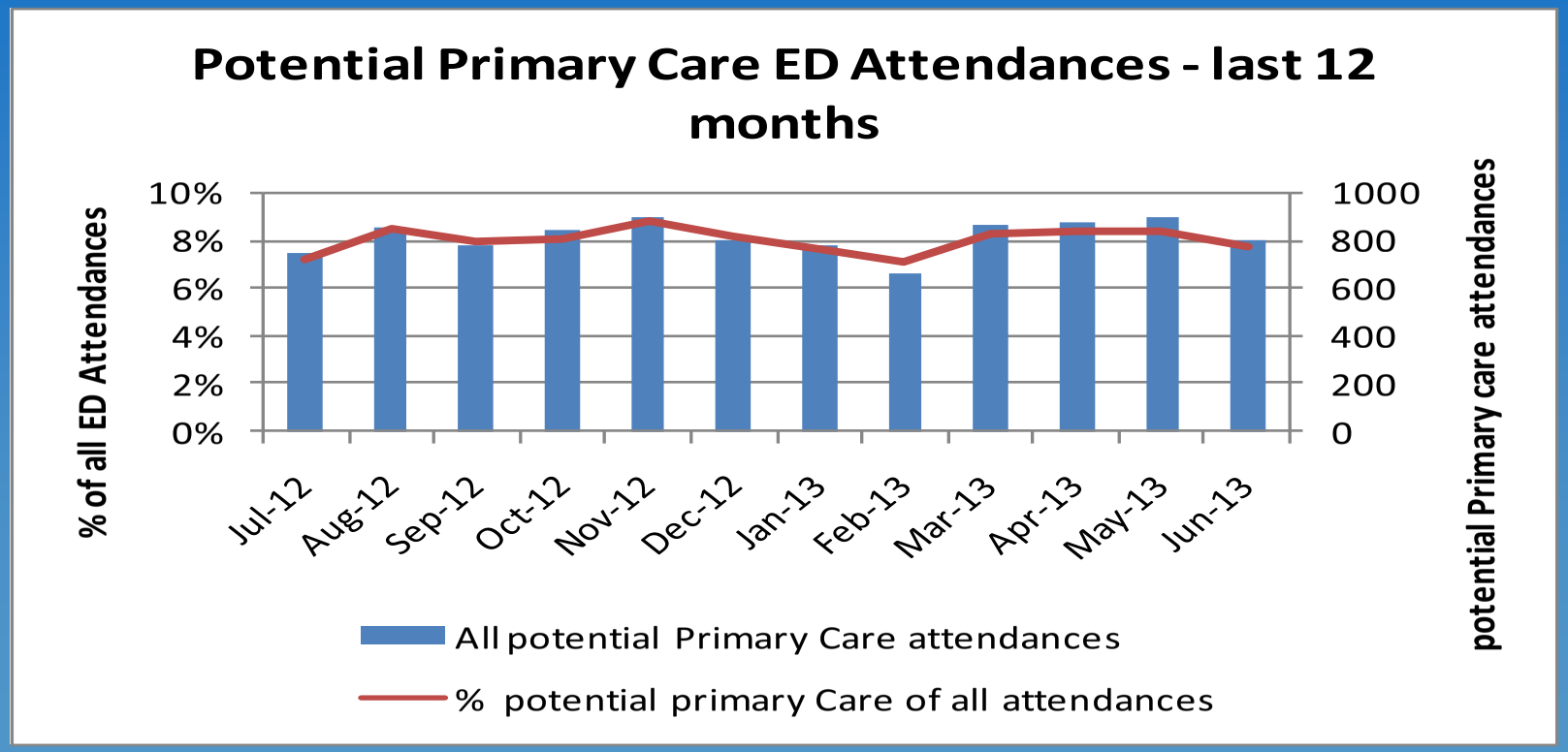
University College London Hospitals NHS Foundation Trust

Step change increase in proportion of days with high admissions in 2010/11 Q3 Increase in proportion of days with high / very high admissions in 2012/13 Q3



University College London Hospitals NHS Foundation Trust

Patients who might have been seen in primary care 07/12 – 06/13: total 9,760 (8%)



University College London Hospitals NHS Foundation Trust

Current issues:

- ED as barometer of the whole system
  - escalation triggers and actions
- Demand & capacity
  - ambulatory emergency care, step down facility
- Staff
  - ED staffing review
- Space
  - redevelopment project underway
- Transformation of model of care
  - Productive ED project

Whittington Health

Indicator	Performance 2012/13	Performance Q1 2013/14	Performance Q2 up to 9 Sept 2013/14	National standard
Time to initial assessment	9 minutes	11 minutes	12	95th percentile below 15 minutes
Time to treatment decision	86minutes	90 Minutes	69	Median wait below 60 minutes
Total time in A&E	95.03%	93.82%		95% of patients to wait no longer than four hours from arrival to admission, transfer or discharge
Total time in A&E	265 minutes	244 minutes	240	95th percentile below 4 hours
Unplanned reattendance rate	1.78%	2.2%	2.2%	Rate below 5%
Left without being seen	2.67%	4.4%	4.0%	Rate at or below 5%
Attendances	92,252	22,357		

Whittington Health

- Focus on time to treatment
- Workforce review / staffing strategy
- Ambulatory Emergency Care
- Access centre / flow and better us of beds
- Whole system approach to performance – hospital and community services
- New IT System

Royal Free London NHS
NHS Foundation Trust

BARNET AND CHASE FARM HOSPITALS NHS TRUST

Created in 1999 following a merger of the former Chase Farm Hospitals and Wellhouse NHS Trusts, the Barnet and Chase Farm Hospitals NHS Trust (BCF) provides services at its two general hospitals in Barnet and Enfield, and at four community hospitals in Barnet and Hertfordshire managed by other NHS bodies.

The BCF board concluded in July 2012 that for financial reasons it was not likely to become a foundation trust alone. At the end of November the then London Strategic Health Authority approved the recommendation of the strategic outline case submitted by BCF that the Royal Free should be asked to "proceed to develop an outline business case" for the acquisition.

The Royal Free has been working with our and BCF's main commissioners and the regulators to explore the viability of such a transaction. The following are important elements of that question of viability.

a/ In its role as vendor on behalf of the secretary of state for health the NHS Trust Development Authority (TDA) would need to be satisfied that this were the best organisational future for the services presently managed by BCF.

b/ The competition regulator would have to be satisfied that such an acquisition did not substantially lessen competition, or, if it did, that that was outweighed by patient benefits.

c/ The solution would need to be affordable for commissioners and the wider NHS, by whom it would have to be supported.

d/ The Royal Free should not be damaged by the acquisition, such that it could no longer provide high quality of services or were caused recurrent financial problems.

Regarding b/ in August the competition regulator concluded that "the merged organisation would continue to face a range of competitors for its services, and therefore the merger was unlikely to give rise to significant costs to patients or taxpayers as a result of a loss of choice or competition".

Naturally the Royal Free board is taking the lead throughout this process regarding d/, but that perspective will also be examined in detail by Monitor, the regulator of NHS foundation trusts.

Governance of the process is enabled by a vendor's and by an acquirer's programme board, each with much common membership.

Because of the recent reorganisation in the NHS and the vendor having modified its processes, the Royal Free has not yet submitted a business case to the vendor. Subject to continuing due diligence and a series of service level discussions between GPs and clinicians of the two trusts, that stage is approaching. If the TDA were to accept the business case, the next formal stage would be examination by Monitor. Assuming that all went well, the transaction could take place in the coming spring.

Royal Free
20 September 2013

North Central London Sector Joint Health Overview and Scrutiny Committee
Meeting of Barnet, Enfield and Haringey Members
Friday 13th September 2013

Present:

Councillors	**Borough**
Gideon Bull (Chair)	LB Haringey
Alev Cazimoglu	LB Enfield
Alison Cornelius	LB Barnet
Anne-Marie Pearce	LB Enfield
Barry Rawlings	LB Barnet
David Winskill	LB Haringey

1. APOLOGIES FOR ABSENCE

None.

2. DECLARATIONS OF INTEREST

None.

3. BARNET, ENFIELD AND HARINGEY MENTAL HEALTH TRUST - RESPONSE TO CQC INSPECTION REPORTS

Oliver Treacy and Andrew Wright from Barnet, Enfield and Haringey Mental Health Trust (BEH MHT) reported on the response by the Trust to three recent inspection reports by the Care Quality Commission (CQC).

They reported that the Trust worked in partnership with the CQC and had a very good relationship with them. The Trust was very open with them and did, on occasion, bring matters of concern to their attention. It was recognised by the Trust that the CQC had a positive role to play.

The three issues of concern that had been raised by the CQC were of a serious nature but it was not uncommon for mental health trusts across London to have similar issues raised with them. Almost all currently had outstanding issues that had been raised by the CQC and which they were currently acting upon.

Two of the issues had been raised by the CQC had been drawn to their attention by the Trust itself. These were the issues relating to the Oaks and the Home Treatment Teams.

The meeting considered the individual inspection reports as follows:

St Ann's: Two particular matters had been raised in respect of St Ann's. These were:

- The inappropriate use of seclusion rooms. If a patient required a bed, considerable efforts were made to find one. Should a bed not be available within the Trust, neighbouring trusts and then other providers outside London were tried. If there was no

other viable alternative, seclusion rooms had been used as a last resort. However, patients that were placed in seclusion rooms in these circumstances were not in seclusion. They were also moved out of them as soon as a bed became available. It was accepted that this was not NHS policy but the alternative would be not to admit people.

- Treatment of voluntary patients. It had been reported that staff had suggested to some voluntary patients that they could be detained under the Mental Health Act if they tried to leave the hospital as they were not yet ready to go home. It was more common for patients to complain about being discharged too early and it was always a balance for each individual patient.

There had been some situations where a bed had been required in the early hours of the morning and the choice had been to admit them to a seclusion room or move them to a hospital in the provinces. In terms of voluntary patients, the Trust had emphasised the need for a full assessment before decisions are taken and the correct use of procedures.

More patients were currently being referred to mental health services and this was causing greater pressure on beds. This was a trend that had been seen across London in the last two years and was linked to economic conditions. Similar pressures were being felt outside of London but not to the same extent. There was a need for pan London action on this issue.

Members noted that CQC inspections could focus on specific themes. Trusts would not be aware in advance of what these might be. Comment was made by Members that the methodology used in inspections was unclear. In particular, there was a lack of evidence of engagement with the Trust's partners, such as GPs. There was also a lack of evidence within the inspections reports of any systematic engagement with relatives of service users. In addition, some of the conclusions drawn did not appear to be consistent with the evidence as presented.

It was noted that a seminar for the JHOSC was planned on the implications of the Francis report. A representative from the CQC would be invited to this and this would provide an opportunity for Members to question them regarding the methodology used to reach conclusions within inspection reports. Officers from the Trust commented that inspections were only one means of addressing quality issues.

The Committee raised the issue of the high percentage of agency staff that were used on Finsbury ward and queried whether there might be a danger of patients rights being eroded due to staffing pressures. The Trust responded that efforts were made to ensure that wards were not staffed by a high proportion of agency staff.

In answer to a question, the Trust officers stated that there had been a substantial drop in demand for beds during the Olympic Games period in 2012, when 18-20 beds had been vacant. Since then, there had been a large increase in demand. Previously many patients had been unemployed but now the pattern was that many were employed and had previously been undertaking reputable jobs. This was part of an ongoing trend, linked to the wider economic conditions.

Chase Farm Hospital (The Oaks Ward): In respect of the issues raised concerning Chase Farm, the root cause of this was the mix of patients that there had been on the ward at that particular time. A number of actions had been taken to resolve the matters raised:

- Improvements had been made to the physical environment;
- Strengthening leadership. As part of this, a locum consultant had been appointed to oversee the ward;
- Support and development opportunities for staff; and
- Improving the level of activities for patients.

There was still work to be done but a lot of progress had already been achieved.

One important issue that had been raised was the need for information to be properly recorded. Not all action had been being recorded fully and the Trust was working to increase the awareness of staff – particularly junior doctors - of the need to do this.

The Panel noted that 37% of staff on the ward in question had been temporary. Such staff were often well known to Trust and could come from within the Trust's own workforce via the Trust's Staff Bank. There had also been a high level of sickness absence amongst staff on the ward. There was a full establishment now with all staff on full time contracts. The ward was therefore less reliant on agency staff.

Officers from the Trust reported that they had already undertaken service reviews of their own on the ward in question so the results of the inspection were of no surprise to them. Previously held concerns had been validated by the inspection. The high levels of sickness absence had been addressed. In some cases, this had been a reaction to the stress of working on the ward in question. In addition, new staff had now been recruited. This included a single permanent consultant – previously there had been two covering the ward. There was also a new ward manager.

The Trust had now been taking action to improve the ward for a year and had adopted a measured and considered approach. Their earlier concerns about the ward had been proven to be correct by the inspection and the subsequent action that had been taken to address them. They noted the Committee's concern in respect of the high levels of staff sickness.

Trust HQ (Community Mental Health Teams): In terms of the Haringey Home Treatment Service, Trust officers reported that some issues had been raised and action taken prior to the inspection. Team management was being strengthened as well as medicines management. Training was also being provided to relevant staff. In addition, there was an ongoing audit programme which was looking at the time that care workers spent with patients. There had been a specific issue within the team in question regarding leadership. The need to make specific appointments and to try to keep to them had been emphasised. There had also been issues in respect of the recording of visits and communication.

The Committee noted that vacancy rates were average for mental health trusts across London. There were currently no other services within the Trust that were currently a source of concern. They also noted that there were common issues in the three inspection reports, namely:

- Care and welfare issues;
- Record keeping; and
- Leadership.

AGREED:

That the above mentioned comments and observations of the Committee Members on the inspection report and, in particular, those relating to sickness levels and common issues be referred to the Trust as the Committee's response to the inspection reports.

5. SERVICE RE-DESIGN AND TRANSFORMATION

Simon Harewood, Interim Manager for Transformation at the BEH MHT reported on the current programme of service re-design and transformation.

There were currently 17 different pathways into the Trust's adult mental health services and this was a source of confusion. The new structure aimed to simplify this. The new structure would have only two routes into services. The new Crisis Resolution Home Teams (CRHT) would be available 24/7 for any urgent referral by patients or GPs and be borough based. The service would go to the patient rather than vice versa. The new Triage Teams would deal with all non urgent referrals in the first instance. It would be an assessment only service, based in each borough.

The changes aimed to remove the need for multiple assessments, with only one crisis assessment taking place. All existing staff posts had been deleted and new ones created, to ensure a fair and proper selection procedure for filling the new posts. It was predicted that there would be enough posts to accommodate everyone but this could not be guaranteed. There would no longer be an Acute Assessment Centre under the new system. Access to services would be easy and uncomplicated. Interim services were currently starting up.

The Committee noted that the grades of staff could be an issue. Although similar numbers of staff were still required, the new posts were not necessarily at the same grades. There were internal processes to deal with staff who were unsuccessful if applying for posts in the new structure. They could either be redeployed into a job on the same grade or on a lower grade but with protection.

The key message of the service re-design and transformation process was that, where possible, staff would now go to the patient. Mental health services across London were now working in this way and it had led to a big improvement in their quality.

In response to a question, it was noted that the Home Treatment Teams were not available on a 24 hour basis. However, the CRHT would be.

Committee Members made the following comments:

- The proposals appeared well thought out. However, partnership with adult social care services and the Police across the three boroughs was also important and needed to be taken fully into account. It was noted that the Trust were engaging fully with their partners. In particular, work was being done with the London Ambulance Service.

- It would be useful to have an update on progress in six months time, particularly on how the Trust was developing its work with partners.

In answer to a question, it was noted that the proposals would be more cost effective but their aim was, first and foremost, to provide quicker and easier access to services for patients. It was anticipated that the current number of beds would be maintained but that the proposals would help to avoid unnecessary admissions. A lot of work was being undertaken currently with GPs, who had been supportive. Engagement with the general public would follow. This would include promoting the new services and innovative methods of doing this would be looked at. The key message was that the changes were about improving, not about shutting, services.

Committee Members thanked officers from the Mental Health Trust for attending the meeting.

AGREED:

That the above mentioned comments be referred to the Trust and that health overview and scrutiny committees within Barnet, Enfield and Haringey be updated on progress in six months time.

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Joint Health Overview and Scrutiny Committee (JHOSC) for North Central London

4 October 2013

Work Plan/Future Dates

1. Introduction

1.1 This report outlines proposed future date(s) for the JHOSC and outlines issues that have been identified as possible future items.

2. Next Meeting

2.1 The next meeting of the Panel will be on Friday 29 November and take place at Barnet Town Hall, the Burroughs, Hendon NW4 2ER. Potential items for the meeting are as follows:

- Specialised commissioning
- Dentistry
- NHS England – public engagement
- Recovery of costs from non UK nationals using NHS services

3. Future Meetings

3.1 Future meetings of the Committee have been arranged to take place as follows:

- 7 February (Enfield); and
- 28 March (Islington).

4. Seminar

4.1 The Committee also agreed, at its meeting on 6 June, to organise a training session for Members on issues arising from the Francis Report. Arrangements for this are still proceeding. The likely date is Monday 18 November.

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